The unheard story

THE IMPACT OF GENDER ON SOCIAL INCLUSION FOR OLDER WOMEN

Women's Health East
Investing in Equality and Wellbeing for Women

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We are sincerely grateful to everyone for supporting this work.

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Women's Health East acknowledges the traditional custodians of the land on which we work, the Wurundjeri people of the Kulin nation, and pay our respects to elders past, present and emerging.

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inner east pcp primary care partnership

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KEY TERMS

Social inclusion
There is no universally agreed upon definition of social inclusion, however, the Australian Social Inclusion Board (ASIB), the Australian Government's advisory body on social inclusion, defines social inclusion as having the resources, opportunities and capabilities to:

- learn (e.g. participate in education and training);
- work (e.g. participate in employment, unpaid or voluntary work, including family and carer responsibilities);
- engage (e.g. connect with people, use local services and participate in local, cultural, civic and recreational activities); and
- have a voice (influence decisions that affect them) (ASIB, 2010).

Social exclusion
Levitas et al. (2007) describe social exclusion as *'… a complex and multi-dimensional process. It involves the lack or denial of resources, rights, goods and services, and the inability to participate in normal relationships and activities, available to the majority of people in society, whether in economic, social, cultural, or political arenas. It affects both the quality of life of individuals and the equity and cohesion of society as a whole'* (Levitas et al., 2007, p. 9).

Social capital
Social capital refers to the resources available to an individual as a result of their social connections, networks and groups (Berkman, Kawachi et al. 2014). These resources can include information, influence and solidarity, and can facilitate mutual benefit for both the individual and the community (Sander, 2002).

Social isolation
Social isolation and loneliness are often used interchangeably, however, it is important to highlight that these are two separate concepts.

Social isolation is an objective concept, and considers the overall level of people's integration into the wider social environment in which they live. A person who is socially isolated has minimal contact with others and little connection with their community. This isolation is a result of poor functional social support and may be voluntary or involuntary (Grenade & Boldy, 2008). Social isolation is one of the key contributors to social exclusion.

Loneliness
Loneliness is a subjective experience that occurs when there is a mismatch between the quality and quantity of the social relationships that a person has versus those that they want. Loneliness is the unwanted lack or loss of meaningful relationships and personal connections and companionship (Naufal, 2008; Perlman & Peplau, 1981).

Healthy ageing
Healthy ageing is described as *'…the process of developing and maintaining the functional ability that enables wellbeing in older age'* (World Health Organisation, 2015, p.28).

A person's functional ability to develop and maintain their wellbeing is impacted by both their intrinsic capacity – that is their personal, health and genetic characteristics – as well as the environment (both physical and social) in which they live (Arnott & Porteous, 2017).

Elder abuse

Elder abuse can be defined as any act that results in harm to an older person that occurs within a relationship where there is an implication of trust. The abuse can be physical, psychological, sexual, financial, social and/or neglect (Australian Institute of Family Studies, 2016).

SEX, GENDER AND GENDER IDENTITY

Throughout this discussion paper, the authors refer to 'women' and 'men', and their different experiences of ageing. However, the authors would like to acknowledge that gender identity is not a binary concept and that some people may identify with a gender that blends elements of being a man or a woman, some people may not identify with a gender, and some people's gender may change over time. The authors would additionally like to acknowledge that those people whose gender identity sits outside the binary of 'woman' and 'man' are particularly vulnerable to discrimination and have specific health concerns.

Furthermore, the terms 'sex' and 'gender' are used interchangeably at times throughout this paper, depending on the source data being used to highlight particular health and social issues. The authors would like to stress that we recognise that 'sex' and 'gender' are distinct terms with differing impacts on people's lives.

EASTERN METROPOLITAN REGION (EMR)

The Australian Bureau of Statistics (2016a) *Community Profiles* provide key demographic data regarding the older population living in the Eastern Metropolitan Region of Melbourne. In 2016 there were 1,042,205 people living in the EMR, 176,107 of which were 65 years and older. Forty three per cent were male, 57% were female. Females made up 63% of residents 85 years and over. There were approximately 4000 Aboriginal and Torres Strait Islander residents in the EMR, 280 of which were 65 years and over. Thirty eight per cent of EMR residents 65 years and older were born in a non-English speaking country. The top three non-English speaking countries of birth among older EMR residents were China, India and Malaysia.

Forty three per cent of males 65 years and older completed Year 12 or equivalent, compared to 32% of females 65 years and older. The typical weekly income for residents 65 years and over was $300-399. Twenty four per cent of older EMR residents required assistance with core activities, increasing to 47% from 85 years. Thirteen per cent of older residents provided unpaid assistance to a person with a disability. Sixty per cent of older residents lived with their partner, 20% lived alone, 4.5% were a lone parent and 14.5% had 'other' household types (ABS, 2016a).

HOW TO USE THIS REPORT

This report is intended for organisations, groups and practitioners to assist them to provide more inclusive services and address the particular needs of older women to be more socially included. The report may benefit local government health planners, aged care workers, positive ageing and community development officers, health promotion and ageing well practitioners in community health services, neighbourhood house staff and committees, volunteer groups and committees, aged care organisations and services, volunteering organisations, and any other organisations, groups or practitioners that enable community members to learn, work, engage and have a voice.

Please refer to appendix one for a more detailed explanation of the theoretical underpinnings of social inclusion and health ageing.

OVERVIEW

There are particular populations within our society who face significant barriers to social inclusion. Discrimination and inequity over a lifetime, due to factors such as gender, Indigeneity, ethnicity, sexuality and disability, result in older people having very different experiences of ageing, health, and belonging. Women's lived experience of growing up in Australia in the past century is framed in the broader context of gender inequality and highlights the compounding effects of gender and ageing.

This inequality means that certain community members, including older women, are more likely to be living in poverty, face discrimination when engaging with the labour market or accessing services, face cultural or language barriers to connecting with the local community, hide their identity for fear of discrimination, and be at increased risk of violence and abuse. In older age this impacts on a person's ability to maintain their health and wellbeing, to access services and to feel valued and visible within their community.

Using the Australian Social Inclusion Board's definition of social inclusion – Having the resources, capabilities and opportunities to learn, work, engage, and have a voice – it is clear that older women and men have differing access to 'resources, capabilities and opportunities'. Older women are more likely to experience housing and financial insecurity, live alone, have lower levels of financial and digital literacy, live with a chronic illness or disability and to have caring responsibilities. While older men may be at greater risk of isolation, and may be less likely to participate or engage with their local community or have strong social connections, all older people face particular barriers to being able to learn, work, engage and have a voice. If we consider the ageism that exists throughout our society, and its gendered nature, 'having a voice' is of particular importance for older women.

It is imperative that organisations, groups and practitioners working to address social exclusion consider the diverse needs of older Australians. As our focus group participants point out, many individuals seek to participate in community programs, or access services. However, services are not always capable of meeting their needs. It is likely that unintentionally discriminatory practices are preventing inclusion simply because services are not considering, or do not have the capacity to take into account, the diversity of older Australians.

Stakeholders working in social inclusion and community programs must begin to address inequality across all areas of their work with older people, including:

- Housing insecurity, poverty, financial literacy;
- The impact of caring responsibilities;
- Access to services (including financial, transport and literacy considerations);
- The impact of chronic illness and disability;
- Opportunities for civic engagement and decision-making;
- Personal safety (real and perceived) outside and within the home; and
- The risk of abuse and violence.

More broadly, policy makers need to place greater emphasis on the structural barriers that put certain people at risk of exclusion. Our social structures and policies, and the values we hold, need to change if we are to create an inclusive society for older people, and in particular older women.

Our older community members should be able to enjoy their later years and should be able to take advantage of the extra spare time

to connect with their community; staying active, learning and engaging and feeling valued by their community. But the reality is that older age is clearly a time of significant vulnerability for some people. Some may be feeling the effects of a lifetime of disadvantage or may be experiencing hardship for the first time. It is clear that women and other members of our ageing population are at significant risk of social exclusion, and those risks are complex, varied and inequitable.

IT IS CLEAR THAT WOMEN AND OTHER MEMBERS OF OUR AGEING POPULATION ARE AT SIGNIFICANT RISK OF SOCIAL EXCLUSION, AND THOSE RISKS ARE COMPLEX, VARIED AND INEQUITABLE.

INTRODUCTION

Gender plays a significant role in shaping the experiences of people's lives, including older people. For older populations, social inclusion is recognised as an enabling contributor to healthy ageing. However, there is limited attention in guiding literature to the intrinsic link between gender, social inclusion and healthy ageing, despite social inclusion being an indicator of healthy ageing, and gender being an established determinant of overall health. A review of the key documents guiding social inclusion practice, and consultations with practitioners working to address social exclusion of older community members reveals many missed opportunities for furthering our understanding of this relationship.

The purpose of this report is to highlight how current narratives continue to disadvantage women by failing to recognise the lifelong impacts of inequality that are further compounded in later years. In fact, this has implications for many older populations, including men, culturally and linguistically diverse (CALD) community members, people living with a disability, Indigenous community members and gender and sexually diverse people, as their distinct needs are also lost when the experiences of older people are regarded as homogenous.

The steps to completing this report and gaining an understanding of the current social inclusion and healthy ageing context involved consultation of both key resources and leading practitioners. The authors reviewed key international, national and local documents that guide contemporary practice in social inclusion and healthy ageing in order to understand the current context. Additionally, a committee of leading regional practitioners was established to advise on current knowledge and practice surrounding the consideration of gender on social inclusion and healthy ageing within the sector.

Two focus groups were also held with practitioners working in both social inclusion and healthy ageing in order to gain insights into practitioner understanding of the impact of gender on social inclusion for older women and to determine how practitioners could be better supported to build their capacity in this area.

THE PURPOSE OF THIS REPORT IS TO HIGHLIGHT HOW CURRENT NARRATIVES CONTINUE TO DISADVANTAGE WOMEN BY FAILING TO RECOGNISE THE LIFELONG IMPACTS OF INEQUALITY THAT ARE FURTHER COMPOUNDED IN LATER YEARS.

GENDER AND SOCIAL INCLUSION

The World Health Organisation (WHO) classifies gender as one of the 'structural determinants of health', meaning gender is recognised as having influence over all social determinants and, along with other structural determinants such as race/ethnicity and social class, has the greatest impact on health inequities (Solar & Irwin, 2010). As a structural determinant of health, gender will impact on healthy ageing for older women, causing inequity in health outcomes.

"Although women have longer life expectancies relative to men (Australian Institute of Health and Welfare, 2017a, 2017b), they are also more likely to have less financial resources (Australian Human Rights Commission, 2009), live alone or in care (Eshbaugh, 2008), experience more marginalization, and suffer more chronic illnesses and disabilities, thus having high need to access the health care system (Boneham & Sixsmith, 2006; Carroll, 2008; Department of Health, 2010). There is a need to be cognisant of the 'feminization' of ageing and the associated challenges in order to cater to the needs of older women (Davidson et al., 2011; World Health Organization, 2002)". (Brijnath et al. 2018,p. 16-17).

The experience of social inclusion and healthy ageing is influenced strongly by a variety of intersecting determinants. WHO (2002) points out that it is imperative that we recognise that older people are not a homogenous group and that individual diversity increases with age. There are certain populations within the Victorian community who have unique experiences and specific needs regarding social inclusion and healthy ageing, and this paper will endeavour to explore these particular issues throughout. Some of the population groups with specific needs include:

- Aboriginal and Torres Strait Islander people;
- Culturally and linguistically diverse people;
- Gender and sexually diverse people; and
- People living with a disability.

Much of the current local and national literature exploring social inclusion, social isolation and healthy ageing does acknowledge the increased risks of these priority groups, including publications by the Australian Social Inclusion Board (ASIB), the National Ageing Research Institute (NARI) and the Coalition of the Ageing (COTA), and all are endeavouring to ensure this is reflected in government policy related to tackling social exclusion. However, what is not always explored and considered in the literature is the intrinsic and cross-cutting influence of gender.

Even when acknowledging and exploring the specific needs of certain populations at greater risk of social exclusion, the intersectionality of gender with these groups' unique disadvantages must always be recognized. The way a person's gender intersects with their Indigeneity, ethnicity, sexual orientation and ability creates distinctive experiences for women and men across all population groups. Unfortunately, limitations in the available data has meant that throughout this paper we are at times unable to disaggregate the data by intersecting demographic characteristics, but where possible we infer trends in the gendered differences among different populations. Feldman and Radermacher's 2016 report into opportunities for economic and social participation of older women stresses that the gender inequality that women may have experienced at earlier stages in their lives becomes sharper and more pronounced as they age. They also point out that there is a need to understand the differences in the experiences of growing old

for women and men to ensure their unique needs are met (2016).

All older people are at increased risk of experiencing social exclusion. However, the drivers of exclusion vary between women and men, and what they need in order to be more socially included are distinct. These different experiences can impact on the choices that people make and the opportunities that they have in their lives, which in older age can lead to inequalities in health, lifestyle and inclusion. Social exclusion is a process rather than an outcome, and knowing what is causing the exclusion for an individual or group is essential to addressing it.

AS A STRUCTURAL DETERMINANT OF HEALTH, GENDER WILL IMPACT ON HEALTHY AGEING FOR OLDER WOMEN, CAUSING INEQUITY IN HEALTH OUTCOMES.

MEASURING SOCIAL INCLUSION

The lack of international consensus on the precise definition of social inclusion means that it has been difficult to establish commonly accepted indicators for measuring social inclusion and exclusion. Multiple frameworks have been developed and within these common themes emerge that seek to explain the influences on a person's ability to be socially included:

- Income: a person's capacity to access adequate goods and resources;
- Productivity/labour market participation: a person's capacity to participate in economically or socially valuable activities;
- Service engagement: services can include public transport, social and health services and basic services inside the home (e.g. gas, electricity, telephone);
- Social and civic interaction: the extent and quality of a person's social networks, support available in normal times and times of crisis and engagement with political and civic activities (Saunders et al., 2007; Burchardt et al., 2002).

These themes correlate closely with ASIB's defining elements of social inclusion: learn (linked to productivity, income capacity and access to services); work (labour and economic participation); engage (access to services, quality of social networks and supports); and have a voice (engagement with political and civic activities).

This paper uses the social inclusion indicators adopted by the ASIB to explore the different experiences of social inclusion for men and women. These are:

- Income
- Access to the job market
- Social supports and networks
- Effect of the local neighbourhood
- Access to services
- Health (Vinson, 2009)

The paper also looks at another predictor of social exclusion specific to older people – elder abuse.

GENDER ANALYSIS OF KEY SOCIAL INCLUSION INDICATORS

INCOME

Poverty can be a driver of social exclusion. Those living in poverty are likely to experience a lack of resources and have fewer opportunities to participate in society. This can result in people living in poverty being excluded from ordinary living patterns and social activities, and becoming marginalised (Public Health Information Development Unit, 2012). According to the ASIB (2009), poverty remains one of the most potent elements of social exclusion. The ASIB lists 'aged persons' as particularly vulnerable to social exclusion, due to their greater risk, higher incidence and more persistent rates of poverty (2009). However, the ASIB does not undertake any gendered analysis of this particular vulnerability.

Older women are more likely than older men to live in poverty and are more likely to experience entrenched poverty (Wilkins & Lass, 2018). The reason for this disparity is multifaceted and accumulated over a lifetime. During their working life, women are likely to have earned less, due to the persisting gender wage gap, and are likely to have taken time out from the paid workforce to have children and take on full-time caring roles. This lower wage and gaps in employment mean that on average, women in Australia retire with about half the superannuation of men (Hetherington & Smith, 2017).

Australian Bureau of Statistics (ABS) data shows that in 2016/17 similar numbers of women and men relied on a government pension/allowance as their main source of income in retirement (45% and 49% respectively) (2017a). However, men are twice as likely to report superannuation/annuity/allocated pension as their main source of income in retirement (33% compared to 17%) and women are more than three times as likely to report receiving 'no personal income' (7% for men, 29% for women) (ABS, 2017a). Other ABS data reveals the average weekly earnings for men in Australia aged 65 years and over is $1,263 and $834 for women (2016b).

> OLDER WOMEN ARE MORE LIKELY THAN OLDER MEN TO LIVE IN POVERTY AND ARE MORE LIKELY TO EXPERIENCE ENTRENCHED POVERTY (WILKINS & LASS, 2018)

Table 1: Total personal income (weekly) Eastern Metropolitan Region residents

Weekly personal income	Males 65 years and over	Females 65 years and over
Negative/Nil income	3,917	6,289
$1-$149	2,064	3,182
$150-$299	6,516	8,946
$300-$399	13,285	16,883
$400-$499	9,930	18,898
$500-$649	7,972	10,935
$650-$799	6,191	6,706
$800-$999	5,398	4,610
$1,000-$1,249	4,773	3,454
$1,250-$1,499	2,768	1,850
$1,500-$1,749	2,275	1,374
$1,750-$1,999	1,423	852
$2,000-$2,999	2,365	1,167
$3,000 or more	2,291	1,090
Personal income not stated	7,167	11,607
Total	**78,327**	**97,790**

Source: ABS Community Profiles, 2016a

Table 1 shows that the typical weekly income for men 65 years and older in the EMR is $300-399 and $400-499 for women. This suggests that older women are receiving a higher weekly income than men, however closer examination of the figures show that 46% of men 65 years and older have a weekly income of $500 or less compared to 62% of women 65 years and older. It is imperative, also, to look at the different living situations and how this would affect overall household income, with men more likely to be living in dual-income households than women. Sixty eight per cent of men in this age bracket are living with their partner compared to only 49% for women, whilst only 12% of men live alone compared to 26% of women. From the age of 85 years, women are twice as likely to be living on their own compared to men (40% and 20% respectively) (ABS, 2016a).

The average income of Aboriginal and Torres Strait Islander people is significantly lower than the non-Indigenous population. In 2016 the typical weekly equivalised household income (adjusted for household size and composition) was $300-399 for Indigenous people aged 15 years and over and $1,000-1,249 for non-Indigenous populations 15 years and over (ABS, 2017b). When broken down by sex, Indigenous women 15 years and over were more likely to report a personal income in the lowest income range of $1-799 compared to men (61% compared with 46%) (ABS, 2017b).

Indigenous people also experience almost double the rate of poverty than non-Indigenous Australians (25.4% and 13% respectively) (Tanton et al, 2018). People living with a disability are also more likely to be living in poverty than people without a disability. According to the Victorian Council of Social Services 14.8% of people with a disability in Victoria are living in poverty compared to 10.9% of those without a disability (Tanton et al, 2018). Limitations in the available data mean that we are unable to break these statistics down further by age or gender, however, Meekosha (2004) suggests that women with a disability are more likely to be living in poverty than men with a disability.

ABS data indicates that males accounted for 63% of older people who were homeless on

Census night in 2016 (2018). However, older single women are the fastest growing cohort of people experiencing housing stress and homelessness. There was a 31% increase in the number of older women experiencing homelessness between the 2011 and 2016 census nights (ABS, 2018a). The National Older Women's Housing and Homelessness Working Group (2018) also point out that older women without stable housing often don't self-identify as homeless and may refer to their situation as a 'housing crisis'.

McFerran (2010) asserts that older women living alone are less able than older men living alone to maintain homeownership and are less likely to be able to afford private rental accommodation. According to Australian Institute of Health Welfare (AIHW) (2017c) data, women account for 61.4% of social housing tenants, and people aged over 65 years make up the largest proportion of tenants by age group (31.4%). The AIHW states that a typical public housing and community housing tenant can be described as an older female living alone (2017c). The Brotherhood of St Laurence's *Social Exclusion Monitor* has found that 75% of public housing tenants are socially excluded (2015). This data suggests the increased prevalence of social exclusion among older women through their higher rates of public housing tenancy.

Another consideration of the risk of poverty in older age is the differing levels of financial literacy for older men and women. Many older women in heterosexual relationships have traditionally taken on the primary responsibility of child rearing and housekeeping and thus many have not had exposure to or responsibility for long-term financial planning (Feldman & Radermacher, 2016). A survey commissioned by ANZ found that from the age of 28 women have lower financial literacy knowledge and are not as good at staying informed about their finances (Social Research Centre, 2015). This can be a particular risk for older women who become single either due to marriage breakdown or widowhood. Women from culturally and linguistically diverse backgrounds may also be at significant risk of poor financial literacy, largely due to language barriers, education attainment levels and cultural expectations around financial management within the household.

ACCESS TO THE JOB MARKET

In 2007, Julia Gillard stated that '*workforce participation is a foundation of social inclusion; it creates opportunities for financial independence and personal fulfilment' (p. 3).* As well as 'financial independence and personal fulfilment', workforce participation provides social interaction, and access to networks and powerful institutions (ASIB, 2009). And regardless of age, paid work is linked to identity and being seen as a contributing member of society (Feldman & Radermacher, 2016).

Across the lifespan, men have greater workforce participation than women, with the exception of the 15-19 age group (ABS, 2017c). Over the age of 65, men are more likely to be in the labour force than women (18% compared to 10%) and are more likely to be working full-time (49% compared to 29%) (ABS, 2017d).

Due to greater life expectancy, both men and women increasingly need to work to an older age to ensure they have enough money to support them in the years they are unable to work. Unfortunately, age discrimination remains widespread in the workforce resulting in barriers to older people's job attainment, retainment and advancement (Australian Human Rights Commission, 2015).

Several key documents have looked at policies to improve participation, including workforce

participation, of older Australians. This includes the *Inquiry into Opportunities for Participation of Victorian Seniors* (Family and Community Development Committee, 2012), *Ageing is Everyone's Business: a report on isolation and loneliness among senior Victorians* (Commissioner for Senior Victorians, 2016) and *Social Inclusion for an Ageing Population* (International Federation on Ageing, 2010). Within these documents there is very little recognition of the gender inequality that women face throughout most of their working life and that workforce participation rates, capabilities and needs differ for men and women.

According to the Australian Human Rights Commission (AHRC) older women are more likely than older men to be perceived as having outdated skills, being too slow to learn new things or likely to deliver an unsatisfactory job (AHRC, 2015). Large gaps in employment history for child-rearing and caring responsibilities can mean that older women are seen as having fewer skills or experience by prospective employers (Feldman & Radermacher, 2016).

Whilst age discrimination is a significant issue, it is important to remember that Aboriginal and Torres Strait Islander people and people living with a disability are most likely to experience discrimination in the workplace. According to a survey undertaken by Diversity Council Australia, 38% of Indigenous Australians experienced workplace harassment or discrimination in 2016 and 34% of people with a disability experienced harassment or discrimination (Booth, 2017).

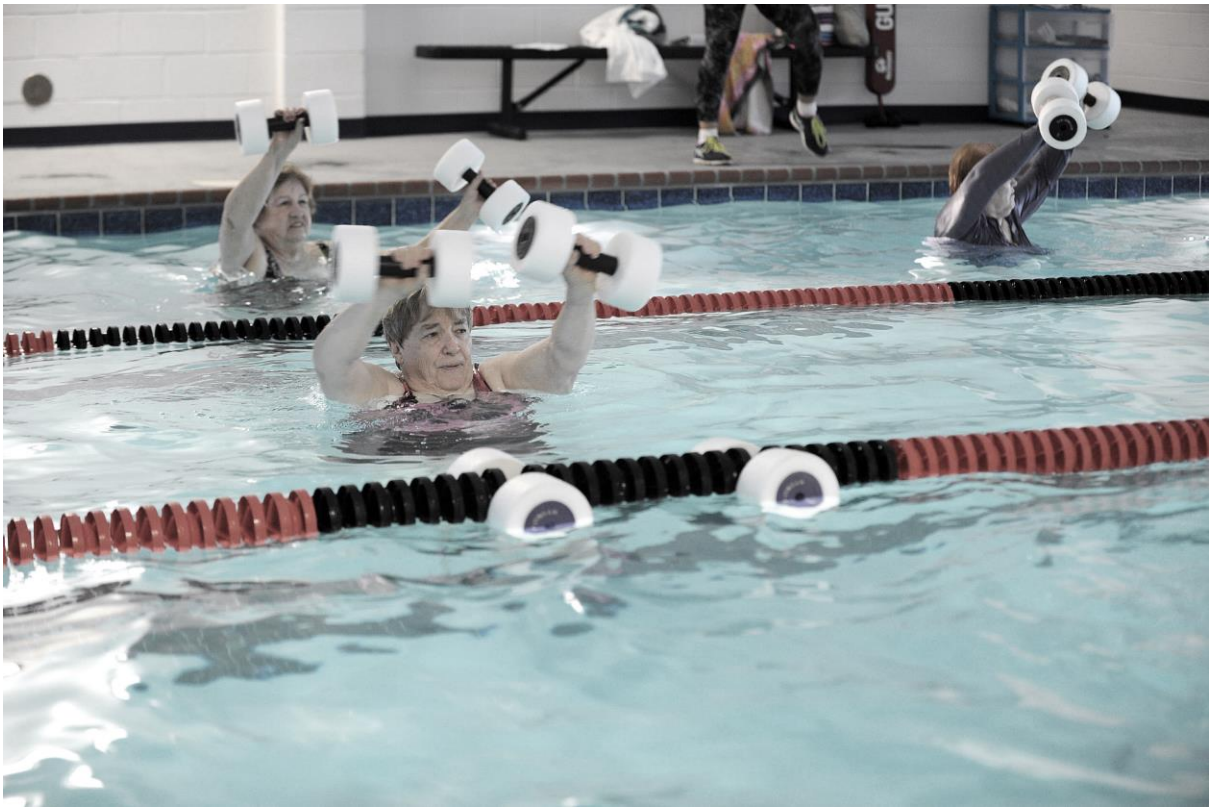
Aboriginal and Torres Strait Islander people face lower labour force participation rates than non-Indigenous Australians throughout their lives. For older Indigenous Australians, the proportion of women aged 60-64 who are employed is 32% and 40% for men, compared to 48% for non-Indigenous women and 61% for non-Indigenous men (ABS, 2017b and Vandenbroek, 2018).

For older people living with a disability, labour participation is also significantly lower than for those without a disability. According to the ABS, in 2015 the labour force participation rate for people aged 65 years and over was 20.9% for people without a disability and only 8.3% for those with a disability (ABS, 2017e).

The overwhelming emphasis placed on workforce participation is inherently sexist as it de-values and fails to recognise the huge contribution of unpaid care to our society. Unpaid care work is estimated to be worth the equivalent of 50% of Australia's GDP (Hoenig & Page, 2012). Though caring responsibilities are categorized as a form of productivity with regards to labour force participation, caring does not hold the same value within our society in terms of both the financial compensation, and community recognition that carers receive. Staying at home to care for family members may limit the connections, opportunities and other benefits that come with participating in the workforce.

Women make up the majority of informal care givers. About 17.5% of women aged 65-74 provide unpaid assistance to a person with a disability, compared to 12.6% of older men. Older women also provide more unpaid child care than older men (ABS, 2017d). Additionally, women make up 74% of informal carers of people with dementia (AIHW, 2016).

Caring responsibilities can negatively impact an older woman's capacity to remain engaged with paid work. The labour participation rates for carers are substantially lower than for all Australians (Tilly et al., 2013). Over 65% of carers of people with dementia provide more than 40 hours of care per week (AIHW, 2016). A lack of appropriate, flexible jobs and the poor mental and physical health outcomes of carers are cited as contributing to the low rates of employment among carers Feldman & Radermacher, 2016).



SOCIAL SUPPORTS AND NETWORKS

As Berkman and Glass (2000) point out, social networks can provide support, influence and meaningful roles (e.g. friend, confidante, community leader) as well as access to services. Some social networks help people to get by on a day-to-day basis (i.e. through emotional support, looking after someone when they are ill, feeling connected to one's community or celebrating important milestones). Other networks provide a person with opportunities for getting ahead (such as political and civic engagement, providing information on jobs and opportunities for advancing one's interests) (Wilson, 1987).

When a person lacks supportive social networks they are at risk of social isolation and loneliness. Multiple studies measuring the prevalence of social isolation have consistently shown that between seven and eight per cent of older people are socially isolated (Warburton & Lui, 2007). Much of the literature looking at social inclusion puts a strong focus on social isolation and how to improve participation for those who are socially isolated. A breakdown of data by sex is most commonly provided in social inclusion literature when emphasizing the risk of social isolation amongst older men.

Arber, Davidson and Ginn (2003) found that, compared to older women, older men have fewer friends, are more socially isolated and feel lonelier. While women tend to have stronger social networks, men are more likely to be at risk of social isolation (Arber, Davidson & Ginn, 2003). Conversely, Department of Health and Human Services (DHHS) (2017) found that men have a higher number of social contacts than women. The number of social contacts a person has decreases with age for both men and women however, across all age groups we still see more social contacts for men than women (DHHS, 2017). It is pertinent to note that this question did not measure the quality of the social contacts. The contacts ranged from family members, speaking to people on the

phone and speaking with people as a part of work. This data does not provide any clarity as to whether women experience fewer, but more meaningful social contacts. Other data from this survey showed that when it came to adults' ability to get help from family, friends or neighbours, there was little difference between men and women (DHHS, 2017).

As mentioned previously, Wilson (1987) explores the different types of social networks that a person can have, this being a network that either provides value on a day-to-day basis, or a network that provides political, civic or economic opportunities. It is likely that men's greater workforce participation throughout their life, provides access to networks of more political, civic and economic value, whilst women's networks are likely to be more supportive on a day-to-day basis. Even though men and women may have similar numbers of social networks, this means women are less likely to benefit from social networks that provide opportunities for 'getting ahead'.

In their paper *Isolation: the emerging crisis for older men,* Beach and Bamford (n.d.) examine the emerging crisis of social isolation for older men and point out how men and women experience social isolation and loneliness differently. They suggest that men: are less likely to seek out medical services, with many services developed specifically to address social isolation being used more by women than men; may be less willing to accept that they need support; and may prefer services that cater to their particular interests. They imply that men may be less likely to seek support than women due to ideologies, norms, and gender roles related to masculinity (Beach & Bamford, n.d.).

The Coalition of the Ageing's (COTA) *Social Isolation: Its impacts on the mental health and wellbeing of older Victorians* (Pate, 2014) report points out that specific groups of people at risk of social isolation include:

- The oldest old;
- Older men;
- Some people from a CALD background;
- LGBTI older people
- Carers;
- Older people who are socially excluded;
- Older people living in rural areas; and
- People in residential care.

However, the report does not recognise the disproportionate representation of women in many of these specific groups. For example:

- **The oldest old**: With women having a greater life expectancy than men, women make up the majority of the oldest population. ABS data shows that there are 59 men for every 100 women in the over 85 age group (2017d).
- **Carers**: Women make up the majority of carers across most age groups. They are more likely to provide unpaid childcare and to care for a person with a disability (ABS, 2017d). Though it should be noted that from the age 80, men are more likely to care for someone with a disability than women (ABS, 2017d).
- **Older people who are socially excluded**: Older women are more likely to be socially excluded than older men. Focusing on seven key areas, and 30 key components, the Brotherhood of St Laurence have created a composite measure that allows measurement of an individual's overall level of social exclusion. Their results showed that in 2016 28% of women were socially excluded, compared to 23% of men and that people over the age of 65 experience exclusion at twice the rate of other age groups (2015).
- **People living in residential care**: According to the Australian Institute of Health and Welfare women make up 60% of aged care residents (2018).

It is clear then, that to suggest that older men are more likely to be socially isolated fails to take into consideration the particular complexities for women, the nature and number of social connections people can have and the different levels of risk for diverse populations.

As COTA points out LGBTIQ and some people of CALD background are at particular risk of social isolation (Pate, 2014). Many older LGBTIQ people may have experienced violence, isolation and stigma throughout their lives. As they start to engage with the aged care system, they may be reluctant to disclose their identities or histories for fear of judgment from their peers or discrimination from services. Older LGBTIQ people may also be less likely to have had children, and so may have fewer familial supports. This is an emerging issue that has not yet been looked at in depth; as such there is little data available looking at the particular issues faced by older LGBTIQ women and men. Some of the key issues that can place CALD older people at risk of social isolation include language barriers, cultural expectations around family and caring responsibilities (particularly for older CALD women), poor understanding of the foreign environment, and a loss of connection to their country of origin and friends and family (Department of Health, 2019).

EFFECT OF THE LOCAL NEIGHBOURHOOD

The social connectedness of a geographical area can greatly influence individual and household wellbeing. Limited identification with their local area and perceptions of safety and sense of trust can greatly impact on a community's ability to form strong connections and collective resilience (Sampson et al, 2002).

ABS data found that there are certain marginalised groups who are more likely to live in socio-economically disadvantaged areas. On average, 18.2% of people who speak only English at home lived in socio-economically disadvantaged areas in 2016, compared to 30.8% of people who spoke Arabic, 42.5% of people who spoke Vietnamese and 86% of people who spoke Australian Indigenous languages (ABS, 2018b).

Older men are more likely than older women to agree that most people can be trusted. Additionally men are significantly more likely than women to feel safe walking down their street alone after dark (77.1% and 45.4% respectively) (DHHS, 2017). Perceptions of safety and sense of trust in others can have very strong impacts on people's physical and mental health as it can affect their willingness to physically move within their neighborhood and socially engage with their community (DHHS 2017).

Volunteering has been shown in many studies to be associated with better health. Research has found that some of the health benefits of volunteering include lower morbidity, longer survival, less depressive symptoms and higher quality of life (Gottlieb & Gillespie, 2008). According to DHHS, among Victorian men aged 65 years and above, 27% often volunteer for a local group, compared to

24.1% of older women (2017). Conversely, older women are more likely than older men to volunteer never or not often (68.5 % compared to 62.3%) (DHHS, 2017). ABS data around volunteering gave different results, showing that for most age groups women are more likely to volunteer. In the older age groups the rates of volunteering are similar between women and men, and from the age of 80 the gender balance reverses, and a greater proportion of men volunteer than women (Glenn, 2019).

These two sets of data therefore question the common perception that women are more likely to participate in volunteering, and thus benefit from its positive health impacts. And if we consider the higher rates of volunteering in the oldest age groups among men, this could suggest that though fewer men are included in the oldest age groups, those that are have greater capacity, whether physically, financially or transport wise, to engage with community and volunteer organisations.

Men and women over the age of 75 are less likely to feel valued by society compared with other Victorian adults, and there is little difference between men and women (DHHS, 2017). Interestingly, older Victorians (aged 45-84 years) are more likely to feel there are opportunities to have a real say on matters that are important to them and again, there is little difference between men and women (2017).

Age discrimination and perceptions of invisibility are very common experiences for older Australians. Older people can experience feelings of invisibility:

- When accessing services - providers may not see the value in spending time with an older person;
- As product consumers - older people may not be viewed as a profitable customer;
- In relationships - older people may feel like a burden on family and friends; and
- In popular culture, where there is very little representation of ageing (AHRC, 2013).

Older women can experience further invisibility and gendered ageism, due to societal pressures which link a woman's value to her physical appearance, and society's messaging that as women age, their looks fade, and their place in society is degraded. Research by Halliwell and Dittmar found that aging is commonly seen as negative for women's appearance, as opposed to neutral or positive for men's appearance (2003). Our society also places little value on carers and mothers. Our self-worth often correlates with career and financial success, and women who spend their lives caring for loved ones are often not seen as valuable contributors (Jordan, 2016). Feeling undervalued and invisible would have a significant impact on older women's ability to feel connected and safe in their local community.

ACCESS TO SERVICES

From the age of 45 years health literacy levels have been shown to steadily decline, with adults over the age of 65 having the lowest literacy levels of all adults (ABS, 2009). ABS data shows that in early adulthood, women have higher rates of adequate or better health literacy, however from the age of 45 this inverts and for older people, men have better rates of health literacy than women (2009). These results challenge common understandings of men and women's level of health literacy and health-seeking behaviours. The ABS report also found that people with higher levels of income, and those who were employed had better health literacy levels (2009). Considering that older men

typically have higher average incomes, education levels and are more likely to be employed, this could help us to understand the findings that older men have higher health literacy levels than older women.

Poor health and digital literacy can both greatly impact on a person's ability to access services. Literacy levels can impact a person's ability to seek appropriate services, navigate the service system, and then understand the information provided by the service, especially given the shift to online health platforms. Older women are more likely to be digitally disengaged (63%) and have low digital literacy (69%) compared to men (37% and 40% respectively), and a lower proportion of women (46%) compared to men (54%) have high digital literacy (Office of the eSafety Commissioner, 2018).

Losing a driver's licence is recognised by the Commissioner for Senior Victorians as a major life event that can greatly exacerbate isolation (2016). However, the Commissioner fails to look at the gendered nature of this particular life event. The Household, Income and Labour Dynamics (HILDA) Survey data highlights to us that rates of a driver's licence possession begin to decrease for women from the age of 65 (Wilkins & Lass, 2018). The proportion of women holding a driver's license between the ages of 65-69 is 85.1%, which significantly drops to 42.7% at 85 years. Whilst for men, the rate of driver's licence possession does not begin to decrease until age 70. Eighty nine per cent of men aged 70-74 hold a driver's license and this sees a much smaller drop during the older years, with 73.8% of men 85 years and older still possessing a driver's license (2018). Women are therefore far more likely than men to experience the loss of independence and ability to access services, as well as the impact on social participation, that comes with losing a driver's licence.

For community members of CALD backgrounds English literacy levels have been shown to reduce with age, with a decline seen from the ages of 45-49 years (ABS, 2013a). Across most adult age groups women have lower rates of high English literacy than men, with the gap increasing with age (ABS, 2013b). CALD older people can face specific and serious barriers to accessing services including a lack of knowledge of available services, ability to navigate complex service systems, language barriers and a lack of culturally and linguistically appropriate services. They may also experience racism or discrimination from service providers (Department of Health, 2019).

HEALTH

Experiences of health vary between women and men. Though women typically live longer than men, they also live more years with chronic illness and disability and rely more heavily on health services. Despite the fact that older women are more likely to be diagnosed with a chronic illness, multiple studies have found that women typically wait longer from the onset of symptoms to diagnosis, and usually have to visit a doctor more times before receiving a diagnosis, for a number of chronic illnesses (Din et al, 2015). A growing body of evidence is highlighting the existence of unconsciously held prejudiced attitudes within the medical profession. Women's pain is more likely to be perceived as 'exaggerated', their symptoms labeled as being 'all in their head', and they are more likely to be misdiagnosed with a psychological disorder as the cause of their symptoms (Dunsberg, 2018).

Older women have higher incidences of anxiety and depression, which can in part be explained by poor physical health, experiencing a delay in diagnosis of illness,

reduced functioning, economic insecurity and bereavement (McCredie, 2009; Bowling, 2007). Additionally, older women are more likely than men to live with two or more chronic diseases, due in part to longer average life expectancies (AIHW, 2016). Delay in chronic illness diagnosis and management can also place women at greater risk of developing other chronic illnesses. Dementia has unique implications for older women. Across all age groups from the age of 65, women experience higher rates of dementia than men. Significantly, around 33% of women aged 85 years and above are living with dementia, compared to 25% of men (AIHW, 2016). As mentioned previously, women make up 74% of informal carers of people with dementia. Sixty five per cent of informal carers are aged 65 or older, 65% provide 40 hours or more of care per week and 46% are living with a disability themselves (AIHW, 2016).

Older women experience a higher prevalence of disability than older men. This is attributable to both a higher incidence of disability and more years living with a disability. According to the ABS, in 2016, 15% of men and 22% of women aged 65 and over were living with a severe or profound core activity limitation (2017e). Women with Disabilities Australia points out that women are more likely to be classified as 'disabled' in Australia (Meekosha, 2004). Compared to men living with a disability, women with a disability are less likely to receive support services, more likely to be living in poverty, less likely to be in the paid workforce and more likely to experience violence both within and outside of the home (AIHW, 2009; Meekosha, 2004; Women With Disabilities Australia, 2008; UN General Assembly, 2007).

Poor health and disability affect older Aboriginal and Torres Strait people significantly more than the non-Indigenous population. According to the ABS, 88% of Indigenous people over the age of 55 years are affected by a chronic health condition (ABS, 2016c). Older Indigenous people are also more likely to be living with a disability, with 27% of Aboriginal and Torres Strait Islander people over the age of 65 reporting a need for assistance with core activities compared with 19% of non-Indigenous people (ABS, 2017b).

ELDER ABUSE

Elder abuse can be a powerful driver of social exclusion. Conversely, older people who are socially excluded and isolated are at greater risk of experiencing elder abuse. The many different forms of abuse that an older person may experience can infiltrate all facets of their life. Their abuser may control or deny them access to their money, affecting their ability to participate in the normal personal and social activities available to other people. An older person may be denied access to services (through denial of transport or finances), medical care and their medicine, which all have an impact on their health and ability to take part in activities of daily living. The deliberate isolation of the older person will negatively influence their ability to maintain social connections and meaningful relationships. Psychological abuse may impact greatly on an older person's perception of safety, both inside and outside the home, their sense of trust in their community and their self-worth. All of these factors can impinge on a person's confidence to move around their community and engage with community networks.

It is estimated that between 2-10% of older people in Australia experience elder abuse, with neglect likely to be occurring at higher rates (Joosten et al, 2017). According to Senior Rights Victoria 72.5% of older people

who reported abuse were women and 27.5% were men (Joosten et al, 2015). Ninety two per cent of alleged perpetrators are a relative of the older person, 60% of perpetrators are male and 40% female (2015).

Hayes, Matthew and Edwards (2008) state that family violence (including elder abuse), sexual assault and sexual abuse are significant contributors to social exclusion; either pushing people into social exclusion, or worsening social exclusion for those already vulnerable to it. They also describe a strong relationship between family violence and homelessness, with 20% of those who are homeless having experienced family violence (2008). In exploring the links between social exclusion and family violence, including elder abuse, it is imperative to acknowledge the disproportionate burden of family and sexual violence experienced by women. One in six women have experienced actual or threatened physical or sexual violence by a partner and Aboriginal women are 3 to 5 times more likely to experience family violence than other Australian women (ABS, 2017f; Our Watch, 2014). According to the Australian Institute of Health and Welfare domestic and family violence was cited as the reason for 55% of women with children seeking accommodation support (2012).

Whilst statistics in Australia indicate that the proportion of older women experiencing family violence is low, international research suggests that older women experience physical, sexual, emotional and financial abuse, and neglect at a similar extent to younger women (Women's Aid, n.d). It is suggested that older women are less likely to report violence for a range of reasons including shame, lack of financial resources, difficulty leaving their home, caring responsibilities, fear of estrangement from family, a different understanding of 'abuse', and lack of knowledge of services and the law (Tually et al, 2008). If all violence against older women is categorised as elder abuse the gender inequality that is a reality for older women is lost when age alone is considered the major driver of abuse (Mears, 2002). It is therefore imperative to acknowledge the impact of gender on the lived experiences of older women and the intersections of discrimination that can put them at risk of abuse.

IMPLICATIONS FOR HEALTHY AGEING OF OLDER WOMEN

Reflecting on the WHO's definition of healthy ageing - 'developing and maintaining the functional ability that enables wellbeing in older age' - and the influence of both intrinsic capacity and environmental factors on an older person's 'functional ability', it is clear that the various disadvantages and inequalities that women experience throughout their lives has significant implications on their health and wellbeing in older age.

Through consultation with older women, Feldman and Radermacher (2016) found that housing and financial insecurity are significant contributors to poor physical and mental health. It is likely we are seeing the impact of the chronic stress of insecure housing and income reflected in the higher rates of anxiety and depression, and more years of chronic illness experienced by older women.

Older women are less likely to feel safe walking alone, and to believe that most people can be trusted, impacting on their ability to maintain an active lifestyle, both physically and socially in maintaining social connections. The perception of living in a safe neighbourhood fosters community connectedness, encourages physical activity, and helps to improve health and wellbeing. Optimising public safety involves the consideration of the built environment, neighbourhood design and availability of transport options. Fear of violence can significantly limit the participation of women in community life. This can contribute to disparities in the health outcomes and social exclusion of older community members (Women's Health Victoria, 2019).

Having a role or identity, autonomy and the ability to contribute are all imperative to older women's ability to achieve good health and wellbeing. The age discrimination and sense of invisibility that many older people experience can create strong negative emotional responses and a feeling of not being heard. Ageism can cause a sense of shame, anger and sadness and can directly impact a person's self-worth and their experience of ageing. Older women's lives are significantly impacted by gender inequality and the experience of ageism only compounds this. Though older men can also experience ageism, the systemic and cultural sexism that women face put them at particular risk of a number of poor health and wellbeing outcomes in older age.

Disparities in healthy ageing for older women are also likely experienced due to low levels of digital and financial literacy, which has the potential to impact on their ability to access, navigate, and afford health and other services. With older women more likely to be the primary carers of loved ones, they would also be disproportionately affected by the health impacts of caring for others, including the physical and mental toll, and the ability to maintain social connections. Additionally, elder abuse can take many forms and can impact on older women's health and wellbeing in numerous ways, including their ability to maintain a healthy lifestyle, access health services and medical treatments, maintain social connections, and on their mental health and identity.

When reflecting on healthy ageing for our oldest community members, we must look beyond the difference in life expectancy between men and women, and consider the ways in which gender impacts across so many

of the extrinsic factors that influence a person's 'functional ability'. Older women may only enjoy the benefits of longer life if those extra years are lived in relatively good health, and with meaningful social connections and a sense of belonging.

FOCUS GROUPS

To gain insights into practitioners' knowledge of the impact that gender has in shaping older women's social inclusion and how these unique needs are addressed at a service delivery level, Women's Health East undertook two focus groups with practitioners working in the EMR.

RECRUITMENT

Women's Health East recruited practitioners working in the Eastern Metropolitan Region of Melbourne whose role would include work to improve social inclusion of older people. A flyer with information about the focus groups (see appendix 2) was developed by Women's Health East and distributed to the Women Ageing and Social Inclusion (WASI) steering group (led by Women's Health East with 10 other organisations represented), the Social Inclusion Community of Practice (convened by the Inner East Primary Care Partnership), neighbourhood house networks, and aged-care practitioner networks. WHE and IEPCP staff also directly contacted other organisations and practitioners, such as local government positive ageing officers, via phone and/or email to encourage promotion of the flyer.

Practitioners from the following sectors were invited to attend:

- Health promotion (particularly those working in healthy ageing);
- Community health;
- Aged care;
- Gender equity; and
- Social inclusion/social planning.

PARTICIPANTS

Two focus groups were conducted in March 2019 with a total of 10 participants.

Focus group participant workplace breakdown

Focus Group 1

Workplace	Number
Community-based organisation	2
Volunteer organisation	1
Local Government	2
Community Health	1
TOTAL	6

Focus Group 2

Workplace	Number
Community-based organisation	1
Volunteer organisation	0
Local Government	2
Community Health	1
TOTAL	4

The three participants who worked in community-based organisations represented neighbourhood houses and other community services, participants at councils worked in areas including positive/healthy ageing and community development, one participant worked in a volunteer-placement organisation, and two participants worked in community health, including palliative care coordination. All participants identified as women.

DATA COLLECTION AND ANALYSIS

Two focus groups were held in the EMR, one in Box Hill and one in Balwyn North. The focus groups ran for 1 hour and 15 minutes, preceded by 15 minutes for facilitators to introduce the topic and aim of the focus groups. The aim was to establish the baseline knowledge level of practitioners regarding the interplay of gender, social inclusion and healthy ageing, and determine how best to meet the needs of practitioners to improve understanding and practice. Participants were informed that the focus groups were designed to answer the question: *Do social inclusion and healthy ageing practitioners recognise gender as an impacting factor on older people's capacity for social inclusion?*

Each focus group had a facilitator and additional support to take notes and record the session. The first session was facilitated by a WHE staff member, the second by a staff member from IEPCP. A run sheet that included an overview of the aims, key activities and discussion points was used to guide the focus groups (see Appendix 3). Each participant signed a consent form about the recording, storage and usage of information collected during the focus groups.

The discussions were broken up into two parts:

1. The aspects of an older person's life that impact on their capacity to be socially included, and how gender fits within this.
2. How practitioners can be supported to build their capacity to improve social inclusion for older women.

The discussions were transcribed from the notes taken during the sessions and review of the audio recordings to ensure accuracy. WHE staff used thematic analysis to code the transcriptions and identify the key themes.

LIMITATIONS

Only a small number of participants took part in the focus groups, and all participants identified as women, thus the discussions that took place may not be representative of the broader health and community sectors. Despite this, the discussions provided rich data which brought to life the awareness and experiences of practitioners, both personal and professional. Additionally, the results of the focus groups aligned with the findings of the existing literature, and thus help to form and reinforce the recommendations provided.

RESULTS AND DISCUSSION

The focus group discussions indicated there is great diversity among practitioners' understanding of how gender can impact on older women's experience of social inclusion. The two sessions produced quite different responses. This may be explained by the difference in the work settings of the practitioners in the two groups, with the first group including more practitioners working in organisations that provide community and volunteer services. The participants in the first session showed quite a broad understanding of the ways in which gender and inequality impact women across all life stages and ultimately leads to increased exclusion for women in older age. This suggested that what some practitioners would benefit from the most is support in addressing the causes of exclusion that their community is experiencing. The second group on the other hand showed a much narrower awareness of the role of gender on social inclusion, indicating that there are gaps in practitioners knowledge that need to be addressed. It is also important to note that as much of the community-based workforce is made up of older women, the responses shared during the discussions were a combination of both workers' reflections of their clients' experiences, as well as their own experiences of ageing as a woman.

PART 1.

The first part of the focus groups explored the aspects of an older person's life that impact on their capacity to be socially included, and how gender fits within this.

The group was presented with a drawing of a non-specific person with four circles around them (see images below).

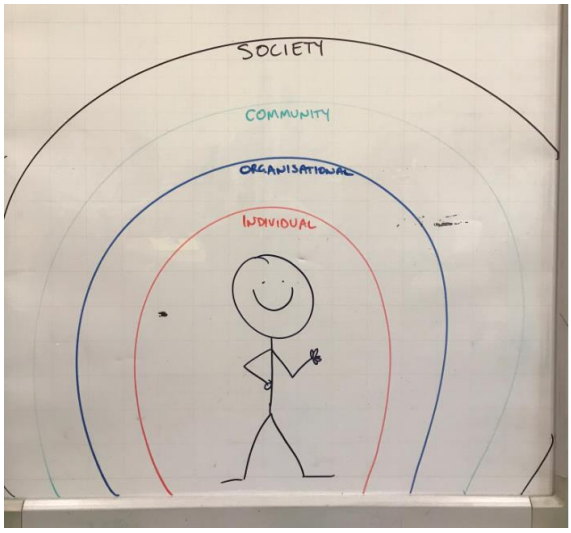


Image 1

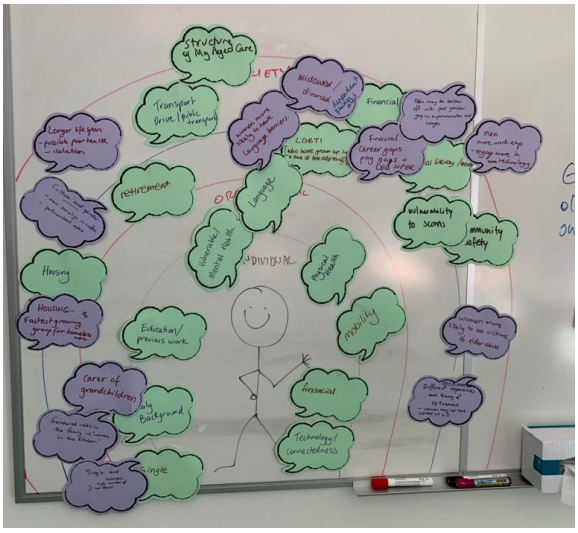


Image 2

These circles represented the 'Socio-Ecological Model of Health' to assist participants to consider the interrelationships between various personal and environmental factors that impact on a person's ability to achieve optimal health (Golden & Earp, 2012).

Participants were asked: *What are the experiences and aspects of an older person's life that could impact on their social inclusion?*

First asked to work in pairs to answer the question in individual bubbles, the group came together to decide which circle the responses should be placed within.

Participants were then asked: *How do you see gender impacting on the experiences of older people in your work?*

Once again, the group decided as a whole which of the circles the response corresponded with.

Analysis of this data generated several key themes:

1. Mental health
2. Inequality across the lifespan
3. Declining physical health
4. Unmet needs

THEME 1: MENTAL HEALTH

Participants in the first group spoke about several barriers regarding mental health that impact on older people's – particularly older women's – inclusion. These included grief and trauma, feelings of invisibility/not mattering and the mental toll of caring. These issues did not come up in the other focus group.

Participants felt strongly that there was little recognition within the workforce of the effect that lived experience has on people's mental health, and how over a lifetime people experience grief and trauma, which ultimately shapes their reality in older age. This may include traumatic experiences for migrant or refugee populations, or the loss of family and loved ones as people age. Participants also stressed that dealing with these feelings whilst having to care for 'everyone else' has a big impact, and as a result of this they see a lot of isolation and depression in their clients. It was felt there needs to be greater understanding and value placed on these experiences in order to know how best to support the ageing community.

Feelings of invisibility were highlighted as a common issue for older women. It was felt that in many areas of society, such as in the workforce and in public places; women become invisible as they age and their contribution, potential and ability are undervalued. This invisibility and undervaluing can include being ignored by customer service workers, struggling to find work, and strangers assuming women require assistance when they are still physically able. This strong message from society can impact on the individual's self-perception and they can start questioning their own value in society and finding meaning in their life.

"Finding meaning is very hard. I think it's society's message that feeds the individual. It's taken me three years to get a job; I came second all the time. I've coloured my hair now. Ageing is really tricky, you know. Society dismisses you a lot." Focus group 1 participant

In the first group participants felt that in some ways women's greater ability to 'band together' in older age served as a protective factor for poor mental health, particularly because collaboration has been a significant part of their working lives. This is in comparison to men, who participants felt are more likely to have worked 'in silos', working only for their own success. For this reason participants believed that older men could be at risk of mental health issues in older age, as they are less likely to seek support and 'have the vocabulary for these conversations'.

Interestingly, one participant in the second focus group stated that men are at greater risk of isolation than women in older age and questioned why the research was focused on older women. This again demonstrated a narrower awareness among the second group of the compounded effects of gender inequality across a life span, beyond social isolation.

THEME 2: INEQUALITY ACROSS THE LIFESPAN

Participants in both groups spoke extensively about the gender inequality that women experience across their lifespan and how this can accumulate and become more pronounced in older age. Some of the areas of women's lives that they mentioned included: education, jobs, caring, income, elder abuse, driving and literacy.

Lack of education and opportunity was seen as a generational issue for older women, with participants mentioning how their mothers and women of their own generation were far less likely to have higher levels of education. They stated that a lot of their older female clients have never been to university and with that comes a lack of power. They stated that in some of the diverse communities they work with there continues to be less importance placed on women's education than men's in younger generations.

"In my family my mother had six brothers and four sisters, only the boys went to school past primary school." Focus group 1 participant

Several participants in the first group spoke from personal experience about the inequality that women experience throughout their working lives. Their commitment to their work was questioned at various points in their career, from when they chose to begin having children, to caring for children and/or older parents later in their career. They spoke of the 'devaluing' of women professionally and a lack of recognition and respect from male colleagues.

"I landed my first CEO role when I was 38 and I would go to regional meetings and all men were sitting there and whatever you said was de-valued... I was the CEO and they were mostly retired men who had never been to university… all you would get is comments about my clothing and appearance…." Focus Group 1 participant

The 'devaluing' of women in the workforce, and women bearing the disproportionate burden of caring were brought up as key factors that influence women experiencing high rates of financial stress in older age. Participants mentioned low incomes, less superannuation and fewer assets as contributing factors. They saw many older women who had worked for much of their lives but still retired with very little superannuation. A lack of stable and secure housing was seen as a big issue for women.

Single or widowed women may own their home but don't have the financial means to maintain it. There can be pressure to downsize, either due to financial stressors, or from family. Participants pointed out that they hear a lot about financial abuse against elderly parents – especially older mothers – from children pressuring them to downsize to free up money. This downsizing can mean moving to a new community, losing past connections and experiences of isolation.

"I think a lot of women are angry. Angry about the way they were treated, angry about the husbands that left, the fight they have had to fight through divorce and family issues, anger that they've been a single parent and had to cope with no financial support from social support or ex-husbands." Focus group 1 participant

There was discussion around other forms of family violence within this group. One participant stated that "Family violence doesn't have an age limit". They spoke of seeing women developing dementia and then reliving the trauma of past abuse, or the continuation of violence into older years. One participant spoke of the unique experience for older women where the perpetrator of violence can become their carer, and they become dependent on that person.

"The perpetrator could end up being the person you rely on in older age… The carer, the person you have to rely on for transport, income etc... But locked together as they don't have anyone else. Tied till end of life... in this isolated bubble." Focus Group 1 participant

The second focus group discussed the differences in the experiences of retirement for men and women. For men, generally, retirement was seen as a clear line: they would stop working and then have more free time. People would ask them "What are you going to do next?" But if a woman is at home, her retirement is not as clear. There may be an expectation that she continues to fulfil the caring duties and housework whilst he is now out in the community more. This group also mentioned that retirement could be both an

enabler and a barrier to social connection. One participant pointed out that many people rely on their workplace to build connections, which they can lose after retirement. Conversely, retirement can provide people with the time to build new connections.

Participants in the first group mentioned that they saw higher levels of digital literacy among older men, as they were more likely to have worked with digital technology as part of their job. They also saw language barriers as more of an issue for their female clients. Highlighting that for couples that had migrated to Australia in the past, the men were more likely to have entered the workforce, providing them with greater opportunities to learn English.

Participants in both groups pointed out that isolation caused by lack of transport was more pronounced among their female clients. In their work they saw far few older women driving, and this wasn't just in the very advanced ages, this included women who were just entering the service at 65. They found that more of their male clients were still driving at 75-80 years of age. Several reasons for this were mentioned, such as the common occurrence of the husband taking on the responsibility of driving in younger years, impacting on women's ability and confidence in driving later in life. It could be that older women may lose their confidence to drive or experience health issues that prevent them from driving. Interestingly, it was also pointed out by participants that because women, generally, tend to visit the GP more often, they are more likely to have their capacity to drive questioned by their doctor, and that older men may avoid going to the GP so as not to risk losing their license.

THEME 3: DECLINING PHYSICAL HEALTH

The two groups spoke of different issues surrounding declining health and how it could impact on older people's capacity for inclusion. The first group spoke about the effect declining health has on an individual's confidence and self-perception. The body no longer functions how it used to, and losing physical ability can be a 'terrible' experience. They also spoke about how difficult it is for older people living with dementia to stay connected to services. That even though they have increased need to stay connected with community and services, they are the least likely to be able to do this.

"I feel at a loss because I don't have the knowledge on understanding dementia, how to work with it organisationally. You shouldn't not come to a class because you have dementia. We should be making things easier to be included, while you're going through that."
Focus group 1 participant

One participant spoke of discontinuing computer tutoring for older clients as she felt it was exploitative to take money from clients who were displaying early signs of dementia and were not retaining any of the information she was providing regarding their computer each week.

The other group highlighted the different experiences between men and women regarding health in older age. Participants pointed out that though women have a longer life expectancy they live more years in poor health and with chronic illness. One participant mentioned a 'new study done in Denmark' which showed that women are diagnosed up to 5 years later than men for similar health conditions, meaning by the time it is diagnosed the condition is likely to be more advanced and have greater impact on their quality of life and prognosis (Westergaard et al, 2019).

THEME 4: UNMET NEEDS

Both groups spoke about specific barriers that prevent people from accessing services, and one group spoke extensively about particular population groups for whom services were unable to provide adequate support.

A participant in the first group spoke about their concerns of services meeting the needs of the ageing LGBTIQ community. Highlighting that there may be a need for individuals to go 'back into the closet' when they enter the aged care system, either out of fear of bullying from their peers or discrimination from staff. The participant highlighted multiple levels at which issues with the service system can occur. This included accessing preventative health, using gynaecological health as an example, when a doctor may make an assumption about what gynaecological care a non-heterosexual woman may need. Ageing LGBTIQ individuals are less likely to have children and so may have fewer family support structures whilst trying to navigate the aged care system. Additionally, it was also mentioned that, though this is an issue for all elderly couples, the possibility of elderly LGBTIQ couples finding aged care places together is 'nearly non-existent'. The particular experiences of LGBTIQ older women were not mentioned during these discussions, missing an opportunity to explore how the intersection of ageism, sexism and heterosexism may be impacting on the wellbeing of this marginalised group.

People with an intellectual disability were identified in the first focus group as a population who may face particular challenges when accessing services in older age. A participant pointed out that ageing in place might not be a realistic option for older people living with an intellectual disability. Particularly if an individual has lived in supported accommodation – these services may not be designed or have the capacity to meet the increased needs of someone who is ageing. With increased health issues frequently occurring with older age – accessing preventative health services can present issues for those with an intellectual disability. With people with an intellectual disability experiencing very high rates of sexual/physical abuse at the hands of staff - individuals can often be very reluctant to engage with services. The participant also pointed out that communication could be a huge issue.

"You may not be able to verbalise your symptoms and people may not recognise your signs. Someone might put down pain as a behavioural issue. You can't communicate what it is. People may not realise you have a physical health need. You just get 'behaviourally adjusted'." Focus group 1 participant

Again, there was little consideration of the impact of gender in this discussion. Research shows that, though men with an intellectual disability are at higher risk of experiencing sexual abuse than men in the general population, the gendered pattern of sexual violence persists across diverse abilities and across the lifespan (Australian Institute of Family Studies, 2008). In fact, it is estimated that 90% of Australian women living with an intellectual disability have been sexually abused (Australian Law Reform Commission, 2010).

A participant who works with volunteers pointed out the difficulty they face in trying to place volunteers with a disability in a community agency. Agencies often refused to accept volunteers with a disability, as they had neither the knowledge nor the capacity to support them. It was pointed out that older people with a disability – any kind of disability – face challenges to social participation, and isolation is a big problem. Another participant remarked on the difficulty they have in placing volunteers from

a diverse cultural background. They stated that it is particularly problematic if the person is a refugee or asylum seeker, hesitantly stating that community agencies were especially unwilling to take volunteers from Ethiopia, Somalia or South Sudan. Practitioners' perceptions of a potential volunteer's competence and language skills presenting as particular barriers for CALD women were not brought up by participants in this discussion.

All these discussions around unmet needs came from only the first focus groups. The other group, apart from commenting on ageing LGBTIQ community members facing discrimination from their peers, did not recognise any of these specific issues and increased exclusion risks faced by marginalised groups.

Other barriers to accessing services, discussed by both groups, which would be significant to the ageing population, included the reliance of many government services on online platforms, accessibility of public transport, and financial barriers. It was pointed out that so many services, such as My Aged Care, Centrelink, banking and GP appointments, use online platforms and require a level of digital literacy, which has already been identified as having a gendered difference, with older women having lower digital literacy levels than older men. There were also discussions highlighting that older people may lack confidence in using public transport, for multiple reasons: poor understanding of how it works, safety concerns, and a lack of support staff. Rates of driver's license possession explored earlier in this paper has highlighted the significant difference in license possession between older women and men and thus the increased reliance of older women on modes of transport other than driving. The gendered nature of this issue was not brought up during the focus group discussion. Financial barriers were also briefly mentioned – with one participant pointing out that joining clubs, buying books and generally engaging all carry financial costs. Considering that older women are at greater risk of financial insecurity, we can assume these financial barriers would have a more significant impact on older women.

PART 2

The second part of the focus group discussions explored how practitioners can be supported to build their capacity to improve social inclusion for older women. Participants were asked:

1. *How do you feel overall the sector is recognising the impact of gender on people's capacity to be socially included? /*

   How can we promote and improve social inclusion for older women, as a whole?

2. *How do you feel you and your organisation could be supported to improve social inclusion for older women to address these issues that we have brought up?*

The main themes that came through in the discussion included:

1. Societal attitudes
2. Advocacy
3. Data
4. Policy to practice

1. SOCIETAL ATTITUDES

The two groups spoke about the need to change attitudes from both a long term, prevention perspective, as well as a response, service delivery level. The first group spoke about the need for society to begin valuing older women more. One participant felt that rather than thinking about what older women take, in terms of services, society needs to recognise the significant social capital that older women contribute, such as volunteering, caring for family and loved-ones, and fulfilling household duties.

"Respect the strength of women. Respect and honouring who women are, what they've been through, and what they have to offer." Focus group 1 participant

Participants spoke about prevailing gender stereotypes within community organisations. As the majority of the staff and volunteers are older community members there is a general acceptance of the division of roles and responsibilities. They spoke of women generally preparing the meals whilst the men socialise, and even high level female staff being expected to arrange tea and coffee for meetings when male volunteers are present.

The ways in which services could help to change ideas about gendered roles were also discussed. Suggestions included positive grandfathering classes to help normalise the idea of male carers and expanding the classes offered at Men's Sheds and the RSL to include activities traditionally viewed as female-oriented. Activities that enable different generations to engage and learn from each other were also suggested; examples of activities already in place were mentioned, such as young people going to nursing homes to connect with the older residents, and 'homeshare' programs that create opportunities for international students to board with an older person living in their own home. Both were viewed as potential ways to address ageism and to change the younger generations' perceptions of older community members.

2. ADVOCACY

Participants highlighted two areas of advocacy that would be beneficial in improving social inclusion for older women. These were funding and support for neighbourhood houses, and giving older women a voice.

Participants in the first group spoke about the work of neighbourhood houses being significant to the community and society. They reported that these services are chronically underfunded, and therefore have few paid staff and have to rely heavily on the goodwill of their volunteers – which are mostly women. They pointed out that many volunteers and paid staff often go above and beyond their designated role in order to keep the service functioning. Their severe underfunding drastically impacts on their capacity to support their majority female clients. The crucial role neighbourhood houses play in the community is also greatly underappreciated. Participants felt that if neighbourhood houses had increased funding and structural support they would then be able to more effectively address some of the issues that were mentioned in the first part of the discussions.

It was suggested multiple times that consultation with women is vital to understanding their needs. Women need to have a voice; they need to be asked what the issues and barriers are that are preventing them from being more included, feeling valued and building their confidence. It was stated that women need more opportunities to be involved in decision-making and practitioners need to look at how we ensure women have a voice in making community decisions.

3. DATA

Participants in both groups spoke about the value of more localised data, and more disaggregated data, in order to improve the services they offer. With many participants working for organisations offering services to local communities and neighbourhoods, they felt that having access to localised data disaggregated by gender, age, and other demographic characteristics could allow them to identify where the greatest need for services are, and the major issues for their neighbourhoods. Participants use sources of larger scale data, such as NARI and COTA, regularly, however, these data sources are not disaggregated. Having disaggregated data would assist participants when applying for funding as it allows them to highlight disparities in need among different groups.

Some participants stated that within their services there is a reluctance to disaggregate data, and that they regularly have to justify their reason for collecting this information. They stated that being able to provide a rationale for disaggregating data would be helpful, such as evidence of how disaggregating data can assist with identifying who is, and isn't, using their service, targeting specific groups, and undertaking evaluation and future planning.

4. POLICY INTO PRACTICE

Participants in the first group felt that generally there was a good awareness of the particular barriers that older women face to being socially included, and that funders and government agencies working to improve social inclusion show an understanding, but no willingness to address these needs meaningfully and practically. They pointed out that often 'older women' are listed as a target group, as well as 'men', when applying for funding for community participation and support. However, there are often occasions when funders require services to prioritise other minority groups, such as CALD, Indigenous or LGBTIQ communities. Participants stressed that these groups do have high needs, but they point out that women make up half the population, and they are often ignored by funding bodies.

Participants agreed that there was understanding of the intersection of inequality and ageing on their older female clients by community and health service management, and even within organisational policies, but again, there was little drive to translate this into practice. Participants felt what is needed is for policies around inequality and the intersecting needs of different population groups to be embedded across all areas of services, such as accreditation processes, performance appraisals and training for management and staff. Many participants felt training on issues such as healthy ageing, dementia, inequality and mental health would assist services to build their capacity to tailor their services to meet the intersecting needs of their clients. One participant suggested the adaptation of inclusive frameworks used in other community organisations, such as sporting clubs, which work to strengthen the inclusion of women at all levels of organisational functioning, could assist the community services sector to implement good practice.

CONCLUSION

A review of guiding social inclusion literature in Australia highlights inadequate application of a gender lens to the issue of social inclusion and ageing. Gender is often absent from considerations of contributing factors for social exclusion risk, or, if gender is taken into account, it is focused on the risks for men. These documents will often identify those within the population who are at greater risk of exclusion, such as people living in poverty, carers, or people not engaged with the labour force; but will fail to explore further how women, and specifically older women, can be overrepresented in these high risk groups.

Results from the focus group discussions indicate that awareness of the impact of gender inequality on older women's social inclusion varies greatly among practitioners. Some practitioners were able to recognise the inequality that women may experience in multiple facets of their life, such as in education, employment, pay and caring responsibilities. Of concern is that others showed very little recognition, and instead expressed their understanding that because women had greater rates of participation in their community they were at reduced risk of social exclusion and poor health compared to older men. Some participants were able to identify particular marginalised groups at risk of being excluded from services, including older people with a disability, LGBTIQ individuals and CALD community members. They were unable, however, to see how gender intersects with these identities and can create greater vulnerability for older women within with these groups in certain areas or their lives.

It is interesting that the participants who indicated greater understanding of the impact of gender and ageing for women were those who had extensive experience in community services and were older women themselves. Their understanding of the issues came from both their professional experience of working with older female clients and seeing the inequality and barriers that they face, as well as their personal experience of ageing as a woman. These participants spoke of the invisibility and de-valuing that older women experience, and that there needs to be a shift within society to recognize and respect the lives of women, the experiences that they've had and the contribution they have made.

Regardless of awareness, it is clear that practitioners need greater support in order to better address the needs of older women to be socially included. Many practitioners spoke of a need to change attitudes towards women and ageing on a societal level, however knowledge of how to do this appears limited. Participants spoke of the ways in which advocacy can support services to be better recognized and funded for their important work in the community, and also to create greater opportunities for older women to be heard. At a practical level, practitioners recognised a need for greater collection and disaggregation of data in order for services to better identify community members' differing needs. Moreover, services need to be supported to better address inequality and other intersecting vulnerabilities at all organisational levels.

Women face unique challenges, risks and barriers to healthy ageing and social inclusion. The combined and intersecting impacts of gender inequality and ageism, result in women facing distinct challenges to maintaining optimal health and wellbeing in their later years. It is imperative that policy and program planning reflect the varied lives of our ageing populations in order to achieve greater equity in later life.

RECOMMENDATIONS

In order to provide more inclusive services and address the particular needs of older women and other vulnerable groups to be more socially included, organisations, groups and practitioners should:

Look beyond participation rates as indicative of improved social inclusion for clients.
Organisations and groups should measure their clients' risk of social exclusion beyond participation in community programs. Clients should be assessed against social exclusion risk factors and connected with specific services and programs.

Undertake internal audits of current services, and client and volunteer experiences.
Organisations and groups must ensure they are not perpetuating inequalities within the community and are not creating unintentional financial, physical or lifestyle burden. I.e. perpetuating gender stereotypes through the delegation of duties among volunteers, or creating barriers to participation in activities such as day trips or book clubs that may carry significant financial costs for participants.

Improve data collection practices.
Ensure client data can be disaggregated by sex and other risk factors. Improved data should be used to assess current client demographics, identify groups excluded from services, the effectiveness of services, specific needs of the client base and service improvement.

Ensure older women are involved in the design and delivery of services.
Identify pathways for older women to have greater decision-making power in the functioning of services and programs. Services should implement policies that ensure more diverse and inclusive representation of a broad range of clients and community members across all levels of service management and governance.

Ensure older women have a voice within services and the community.
Create more opportunities for diverse older women to be heard, for them to share their experiences of ageing as a vulnerable community member, and what they need in order to be feel more included and valued within society.

To better support organisations, groups and practitioners to improve social inclusion for older women, Women's Health East will continue to contribute to the outcomes of the Inner East Integrated Health Promotion Plan by:

- Building sector capacity to recognise and address the specific risk factors for older women to social exclusion through workshops and other engagement opportunities presenting the findings of this paper.

- Supporting interested stakeholders to develop more robust data collection practices that allow for improved disaggregation, identification of excluded groups and service improvement.

- Supporting interested stakeholders to develop and embed inclusive frameworks within their organisation to improve equity, diversity, representation and advocacy.

Additionally, WHE will investigate funding opportunities to:

- Undertake qualitative research, collecting rich data from older female community members regarding their experiences of ageing as women and the particular challenges and barriers they face in older age. So as to provide greater understanding for providers and practitioners around how to better support older women.

- Collect stories from older women of their lived-experiences using varying storytelling platforms, using the stories to tackle both sexism and ageism, and allowing organisations to use the stories to promote their own services and advocate for greater recognition and funding.

- Build the capacity of the older women who take part in the qualitative research or storytelling to advocate for their own and other older women's needs, and identify civic engagement and advocacy opportunities for interested women.

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APPENDICES

APPENDIX ONE: SOCIAL INCLUSION AND HEALTHY AGEING

Once a concept of sociological and economic theory, social inclusion is now recognised as both a key driver and consequence of health and wellbeing.

As the Victorian Public Health and Wellbeing Plan points out:

'Feeling connected to others, being able to cope with the usual stresses of life, having the opportunity and capacity to contribute to community and being productive are all critical to mental health.' (Department of Health and Human Services, 2019, p.26)

The Victorian Department of Health and Human Services (DHHS) explored the concept of social capital and its strong causal link with both physical and mental health (2017). Evidence has shown consistently that high levels of social capital are associated with lower incidence of cardiovascular disease and cognitive decline (DHHS, 2017). Holt-Lunstad & Smith et al. (2010) state that social capital is as strong a risk factor for mortality as many other commonly recognised risk factors such as smoking, physical exercise and obesity.

DHHS's exploration of inequalities in the social determinants of health looks at the link between social and civil trust and mental and physical health. They found that adults who do not feel safe walking alone after dark and/or do not believe that most people can be trusted are more likely to have high or very high levels of psychological distress and are more likely to rate their overall health status as only fair or poor. Similarly, poor mental and physical health were more likely to be seen amongst adults who do not feel valued by society and/or do not feel that there are opportunities to have a say on matters that are important to them (DHHS, 2017). Referring back to the Australian Social Inclusion Board's (ASIB) definition of social inclusion, these concepts of social and civic trust, and the importance of social relationships, are key components of a person's ability and capacity to 'engage' and 'have a voice'.

There are two main theoretical models that can explain the ways in which social relationships may influence health: the 'main effects' model and the 'stress buffering' model (Cohen et al., 2000). The main effects model proposes that social relationships can have a protective effect on health through emotional, cognitive, behavioural and biological influences. Social relationships can encourage healthy behaviours and can provide individuals with meaningful roles, self-esteem and purpose in life (Cohen, 2004 and Thoits, 1983). The stress buffering model suggests that social relationships can moderate or buffer the negative effects of stressors on health. This buffering occurs when a person's social connections provide emotional, informational and tangible (i.e. financial opportunities) resources that can mitigate the negative effects of ill health (Cohen et al, 2001).

A combination of factors can play a role in increasing the risk of social exclusion as people age. As people move into retirement they experience a drop in their income, and lose important social connections associated with their work. Disconnection from other social networks can also occur for older people when they live alone for the first time, either through adult children moving out, relationship breakdown or death of a partner. Accessing services can become more

challenging as people age, largely due to decreasing driver's licence ownership, difficulties in navigating the public transport system and a broader reliance of services on digital platforms, which many older people can find prohibitive. Prevailing ageist attitudes within our society lead to ongoing discrimination for many older people, with many expressing a sense of being 'de-valued', 'invisible' and 'ignored' by society. With advancing age, there can also come a decline in health status and increased disability, and a reduced ability to stay connected with the community. Additionally, older people face unique barriers to social inclusion separate to other age groups; including large proportions of older people caring for partners or other family members, and vulnerability to elder abuse.

All of these drivers of social exclusion that older people may experience can fall into ASIB's four main themes of social inclusion: learn, work, engage and have a voice. It is clear that an older person's ability and capacity to be socially included can be impacted across all facets of their life.

Healthy ageing and social inclusion are intimately related. Maintaining wellbeing and quality of life in older age can be supported through providing people with opportunities for healthy behaviours and active lifestyles, participation and security. Conversely, optimising health in older age drives an individual's experience of social inclusion, allowing them to engage with their community, and feel connected and valued.

In Australia, overall life expectancy has increased due to public health advances, medical science and economic prosperity. Though, reaping the benefits of a longer life relies on good health and wellbeing.

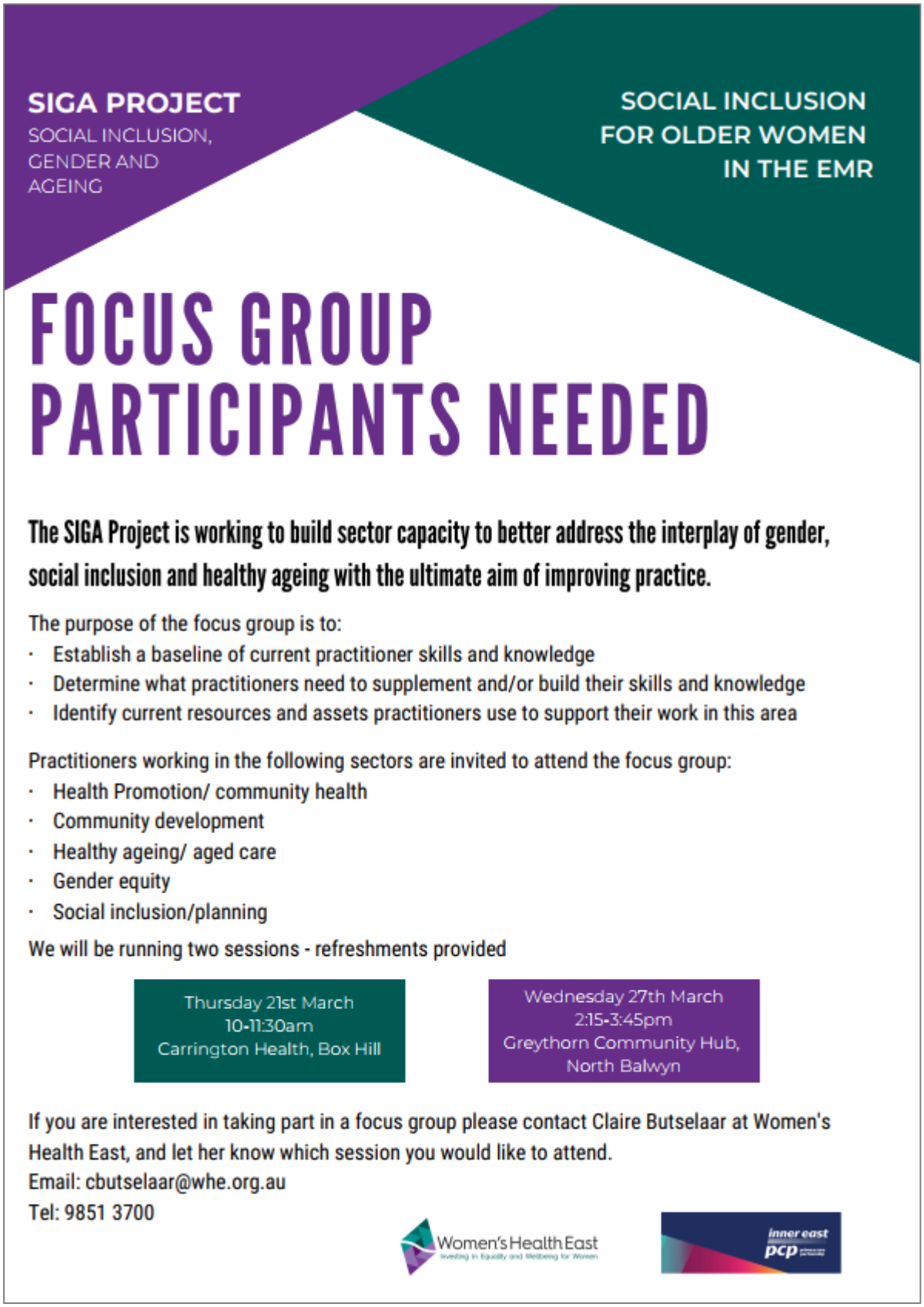
"A focus on healthy ageing can reduce the prevalence of chronic disease, improve health outcomes, and reduce pressures on the health care system, as well as maximise the many contributions older people make to their communities and increase the social capital of the community" (Brijnath et al, 2018, p.4).

A person's capacity to age healthily is impacted by both intrinsic and environmental factors. Intrinsic factors include our genetic makeup, personal characteristics and lifestyle factors. Whilst the context in which we live, the environmental influences, include:

- health and social policies;
- systems and services;
- economic situation;
- culture;
- community attitudes, norms, and values;
- the physical environment;
- social networks and relationships; and
- technology

Healthy ageing depends on the interaction between these intrinsic factors and the environment in which we live. The environment influences the choices that individuals can make throughout their life, in turn creating life circumstances that may limit opportunities for healthy lifestyles and exacerbate health inequalities (Brijnath et al, 2018).

APPENDIX TWO: PARTICIPANT RECRUITMENT FLYER



Facilitation Guide – WASI Focus groups

MORNING TEA ON ARRIVAL/THROUGH OUT AS REQUIRED

10:00am	Welcome and Introductions	

1. **INTRODUCTIONS**
- Welcome/acknowledgement of country
- WHE – who we are, what we do – Claire – *Health promotion agency, we work to improve health outcomes for women in the EMR.*
- IEPCP – who we are, what we do - Sharon
- Participants – introduce themselves, which organisation they work in and what their work role is
- Something to break the ice? *If you could have one super power, what would it be?*

10:10am	Purpose of today The focus group will identify and document practitioner understanding and needs on the intersection of women, ageing and social inclusion	

2. **PURPOSE OF THE FOCUS GROUP –**
- What is the problem we are trying to address – *Do social inclusion and healthy ageing practitioners recognise gender as an impacting factor on older people's capacity for social inclusion?*
- What is the desired output – *To establish the baseline knowledge of practitioners regarding the interplay of gender, social inclusion and healthy ageing and determine how best to meet the needs of practitioners to improve understanding and practice.*

3. **AGENDA FOR TODAY**
- Copies of agenda given out on arrival – run through briefly

4. **CONSENT FORMS**

5. **GROUND RULES/CONSENSUS – suggest and get agreement**
- Mobile phones on silent
- Respect for people who are speaking
- Allow time for all to contribute – want to hear from everyone

10:15am	Overview and context – ask if there are any questions and provide quick summary only?	

- Social inclusion
  - What is it: *Social inclusion refers to the extent that people are able to participate in key areas of the economic, social and cultural life of their community.*
  - Links to health - ***Maintaining wellbeing and quality of life in older age can be supported through providing people with optimised opportunities for healthy behaviours and active lifestyles, participation and security. Conversely, optimising health in older age drives an individual's experience of social inclusion, allowing them to engage with their community, and feel connected and valued.***
  - Project Aim - *Build sector capacity to better address the impact of gender on social inclusion and healthy ageing for older women with the ultimate aim of improving practice.*
  - What is Healthy Ageing – WHO definition SHARON
  - Questions/comments?

10.30 am	What is current practitioner understanding of the intersection of women, ageing and social inclusion? Current practitioner awareness and knowledge around impacts of gender on social inclusion for older people?	

1. Go around the group - *What work do you do in social inclusion and healthy ageing?* **(5 mins)**

2. Break into pairs
   Provide thought bubbles to each pair to write on and textas
   Draw person on whiteboard (or stick one on) draw circles around person (individual, organisational, community and society): *This model allows us to think about the interplay between the various personal and environmental factors that can influence our health and our capacity for social inclusion.*
   Thinking about the social inclusion indicators mentioned earlier (refer to write up of these) – discuss together and write down the experiences and aspects of an older persons life that could impact on their social inclusion. Put one idea on one thought bubble. At this stage don't spend too much time thinking about where they fit in the circles. We can do that later as a group.
   Stick the thought bubbles around the person (add arrows??) **(6 mins pair work, 6 mins group discussion)**
   NOTE: try to elicit some discussion/input at a more primary prevention level – comments about the nature of the world older women interact with and how we might change this?

   Discuss what has been added with whole group – any more to add? Expand on what's there? Anything surprising?

3. Discuss in different pair
   How do you see gender impacting on the experiences of older people in your work? (on social inclusion and healthy ageing)? **(6 mins pair work, 6 mins group discussion)**
   Note down your thoughts on different bubbles
   Discuss as whole group – pass bubbles to facilitator who will place them on the board to corresponding barrier, circle.
   Any more to add? Expand on what's there? Anything surprising?

11:00 am	What resources and assets do practitioners use to support their work in this area? What other resources or skills are needed by practitioners to supplement and/or build their skills and knowledge?	

4. *How do you think social inclusion can be improved for older women?*
   Think about the indicators and think about the different levels of working – individual, organisation, community, society **(10 mins)**
   Whole group. Write answers on butcher's paper

5. *How could you and your organisation be supported to improve social inclusion for older women?*

- Work in pairs and using the paper to write down thoughts to add what you would need to support the individual, organisation, community, society to improve social inclusion for older women. Then bring back to group. Facilitator to write on butcher's paper. (**5 mins pair work, 5 mins group discussion)**

6. **SUMMARISE THE RESULT/FINAL WORD (5 mins)**

- What came out of the activities – what are we seeing

11.25am	Next steps	

7. **COMMITMENT TO WHAT HAPPENS NEXT**

- We will write up, summarise, send out for any late additions/thinking
- Will contribute to our overall desired output/problem solving

11.30am	Thank you and Close	

ITEMS TO BRING

- Thought bubbles (two different colours, shapes)
- Box textas/pens
- Blue tack
- Butchers paper
- Paper
- Post it notes

Women's Health East acknowledges the support of the Victorian Government