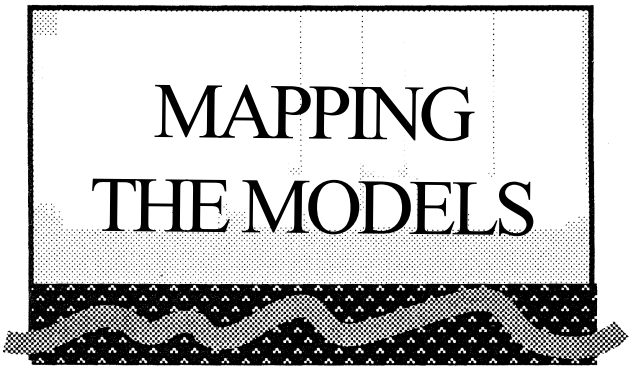
MAPPING THE MODELS

The Women's Health Services Program in Victoria

Produced by the Women's Health Resource Collective
on behalf of Women's Health Around Victoria and
Community Development in Health

David Legge



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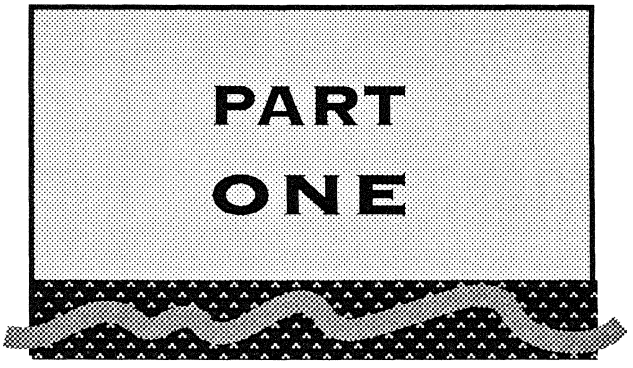


Introduction and overview

CHAPTER ONE

INTRODUCTION

In 1987 some three hundred and fifty women gathered together in the basementoftheFootscray Community Arts Centre in Melbourne's Western suburbs to celebrate the launch ofthe first programatically funded Women's Health Service in Victoria.

The launch involved women of many ages and from a diverse range of cultural and social backgrounds, from those prominent in public life to those making a quieter, though none the less important contribution, in the home, work place and community. A theme of participation was set which has continued to characterise the Victorian Women's Health Services Program (VWHSP).

Prior to this time, the particular health needs of women had attracted scant recognition in government health policy. Those few Women's Health Services which did exist survived in the absence of se.cure government funding, relying largely on the voluntary efforts of Victorian women. The Footscray celebration marked both the culmination of decades of hard work by many women and, it was hoped, the beginning of an era in which women's specific health needs would receive appropriate attention in government funding programs and in health policy.

By 1992 there were twelve publicly funded Women's Health Services across rural and metropolitan Victoria. Together, these Services comprise the Victorian Women's Health Services Program (VWHSP). Despite its relatively short existence, the program has worked with thousands of women and with health care providers developing new, innovative and sensitive approaches to women's health care. It has made particular advances in reaching women who have typically had poor access to mainstream and mixed gender services - namely women from a non-English speaking background, Koori women, low income women and women with disabilities.

While Victoria once lagged behind other Australian states in the development of women's health policy and Women's Health Services, it now shares with New South Wales and South Australia sound achievements in responding to the particular health concerns of women.

\VJ-IY A REPORT OF THE VICTORIAN WOMEN'S HEALTH SERVICES PROGRAM?

This report has been prepared by Women's Health Around Victoria (WHAV), the network of Women's Health Services, to record the development and first five years of operation of the VWHSP. It was produced with a number of purposes in mind.

First, it aims to record the approaches to service delivery that have been pioneered by the program as well as the practice, wisdom and skills which have been acquired along the way. In this way it will assist other health and related services wishing to better meet the needs of women, and serve as an educational resource for students and teaching staff involved in post secondary courses in the health and welfare sectors. The demand for such a resource is indicated by the many requests Women's Health Services receive for information from health care providers and tertiary institutions about the program.

Second, the document explains the ways in which the program works, why it exists, and what it does. This is of critical importance since Women's Health Services aim to work cooperatively with other services and organisations, and depend on charitable and government funding bodies for resources to deliver programs. The cooperation involved in these relationships requires a high level of mutual understanding.

It is also hoped that the document will be useful to people in the community who want to learn more about the program. This is important since Women's Health Services aim to encourage community participation and input. Moreover, they see access to information about their Services as a practical expression of their accountability for the expenditure of public and charitable funds.

Finally, it is hoped that this report will serve as an historical record of the development and early achievements of this important program and affirm the vital role dedicated Women's Health Services play in addressing the health concerns of women.

STRUCTURE AND CONTENT

This report uses case studies of particular projects undertaken by Women's Health Services to illustrate the program in a very tangible manner. The case studies have been selected to paint a picture of the program and describe some of its key themes and approaches (Chapter 6). Earlier chapters explore the need for a specific focus on the health concerns of women and for special Women's Health Services (Chapter 3), as well as the history of the program in Victoria (Chapter 2).

In Chapter 4, the women's health policy context is described. This Chapter is important as it outlines some of the key goals of the VWHSP and the ways in which it was intended these would be met.

Chapter 5 outlines the organisation of the program. It looks at its philosophy and overall planning as well as providing detail on the management and administration of individual Services.

by Debbie Milliganfrom 'Everything d Fine: Women d StorO of Cervical /)ydpfMi.a'
produced by the Women:, Health RMource Collective

CHAPTER TWO

THE HISTORY OF THE VICTORIAN WOMEN'S HEALTH SERVICES PROGRAM

Victoria was the first Australian state to have a health service run for and by women. The Queen Victoria Hospital (now the Monash Medical Centre) was established in 1896 by a group of women doctors who were concerned about the poor health of women and children in Melbourne's slums, the lack of services to meet their needs, and the lack of opportunities for women doctors to practice medicine.

Money was raised through the Shilling Fund with each Victorian woman being asked to donate one shilling towards the cost of establishment. Needless to say, the hospital grew to be a major provider of health services in Victoria. It was delivered by women, for women and their children for some sixty years. While the hospital was renamed and relocated in the 1980s, part of the old building will become the Queen Victoria Women's Centre, a tangible reminderto the people ofVictoriaofthe enormous potential in service provision 'for women by women'.[1]

The beginnings of contemporary Women's Health Services can be found in the mid seventies when a group of women in inner city Collingwood folmed the Melbourne Women's Health Collective. The Collective operated a Women's Health Service, initially from premises in East Melbourne and later from a shopfront in Johnston Street, Collingwood, providing medical and support services. Services were offered free of charge by women doctors and other women health workers. Women involved in the development of the Collective reported that 'from the first week of operation, there was persistent and overwhelming demand from women for the limited services offered'.[2]

Funding was allocated for the centre in 1974 through theFederalgovemment'sCommunityHealthProgram. However, the funds were never released despite the Collective's efforts to meet the requirements of the funding authority. Eventually the Collective was forced to close its doors and the funds intended for the Service were absorbed into general state revenue.[3]

HEALTH EDUCATION AND PROMOTION

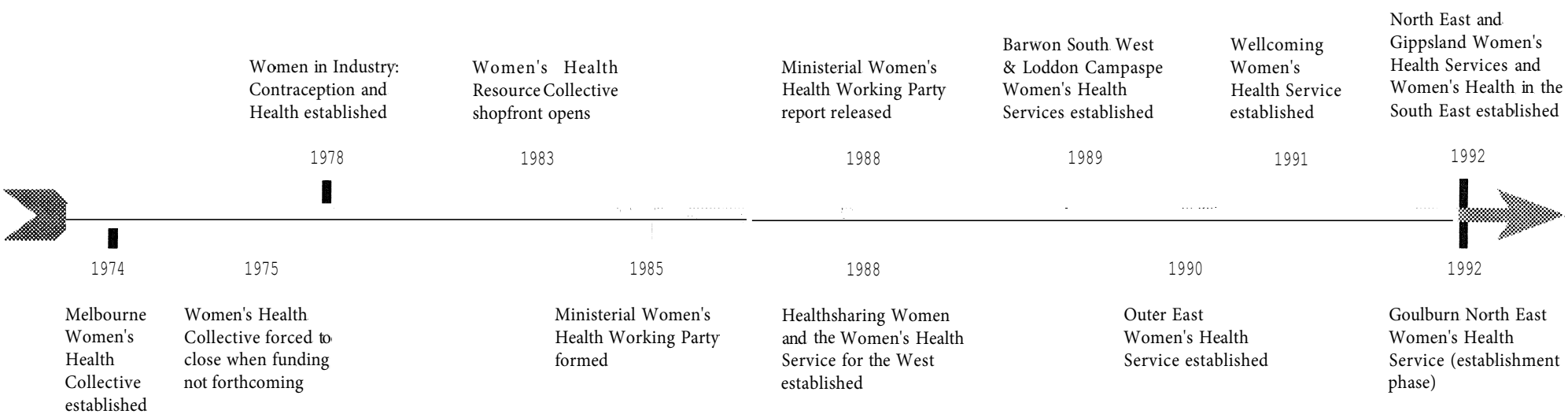
The difficulties the Melbourne Women's Health Collective experienced in establishing a Women's Health Service, although cause for considerable concern, encouraged Victorian women to devise alternative, and often more effective and creative, ways of responding to women's health issues. While Women's Health Services in other Australian states played a major role in the provision of direct clinical services, in Victoria the focus was on self-help and advocacy groups, women's health information and resources, community education, and promoting women's interests within the health system. These activities were aimed either at making the health system more responsive to the needs of women or at supporting women to care for their own health, including making better use of existing services. The 1970s and 1980s saw a proliferation of groups and services in Victoria supporting work of this nature. Examples include the Women's Health Resource Collective (WHRC) shopfront, Women in Industry: Contraception and Health (WICH) and groups such as the Endometriosis Self Help Group and the Depo Provera Action Group.

In part, these developments were a necessary response to the failure to attract funds to develop a women's health centre. They were also, to some extent, a product of efforts to tailor service activities to qualify for funding through other programs (for example, job creation schemes). Nonetheless they contributed to the development of a 'women's health' culture in Victoria which has a different emphasis from that of other states. This is a tradition which was ultimately to be 'written into' Victorian women's health policy in the form of the 'dual strategy' (for more information, see Chapters 3 and 4).

FIGURE 1

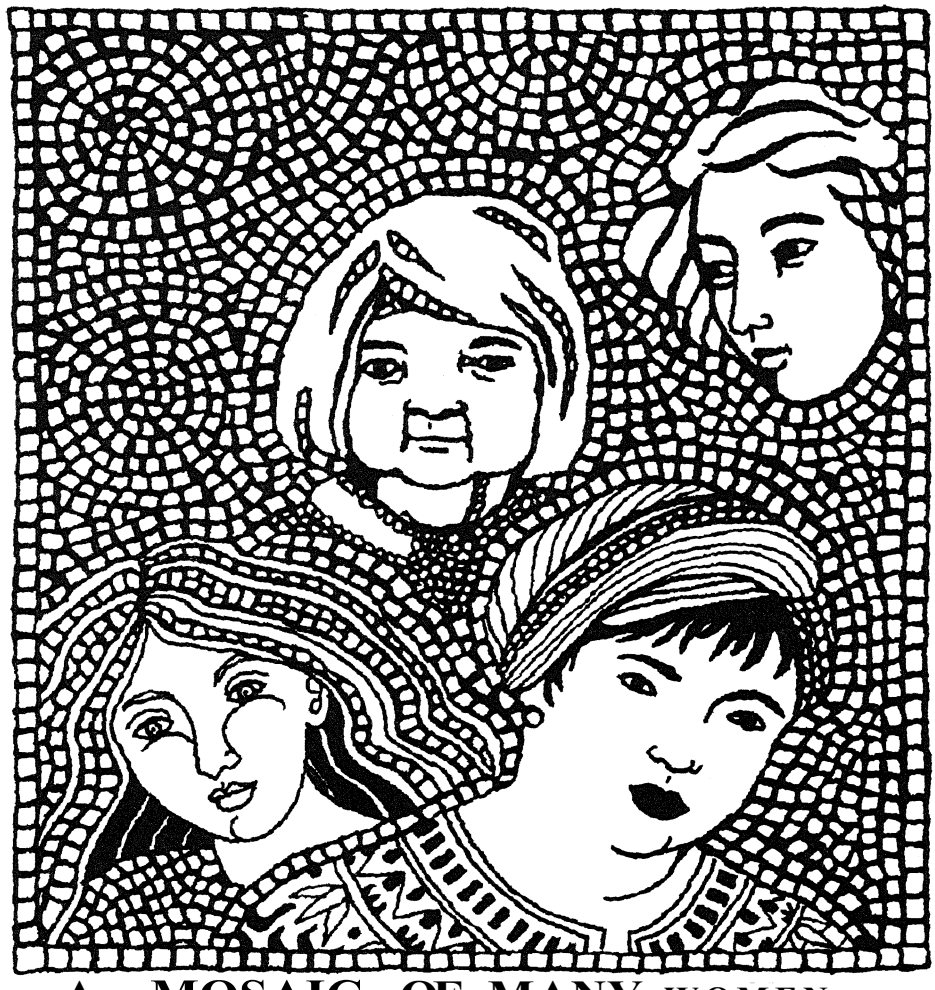
CONTEMPORARY WOMEN'S HEALTH SERVICES

A TimeLine



Victorian women's health groups struggled throughout the 1980s remaining, despite their constant funding uncertainties, remarkably productive (see in particular Appendix Two).

In 1985, the then Minister for Health established the Ministerial Women's Health Working Party to investigate women's health issues and to recommend measures to improve health services for women in Victoria. The report of the Working Party, released in 1987, recommended that existing Women's Health Services funded by Health Department Victoria (HDV; now the Department of Health and Community Services) be programatically funded and that a number of new 'stand alone' Women's Health Services be established. These were to include at least one Women's Health Service in each of the health regions and two Women's Health Information Services, one of which would be targeted to women from non-English speaking backgrounds.[4]



by Debbie Mi!Liganfrom 'Women'l Health: Where do health projeMwnau .1tandl' produced by Healih.1hari.ng Women

In 1988, funding was allocated by the Victorian government for the development of one of the Women's Health Infonnation Services (Healthsharing Women) and the first Regional Women's Health Service (now the Women's Health Service for the West).

Following the release of its *National Women's Health Policy*[5] in 1989, the Federal government granted funding for the development of a four year program on acostshared (50:50) basis with the states and territories to include the establishment of special Women's Health Services. This funding program enabled the Victorian government to fulfil its commitment to establish a Women's Health Service in each of the health regions. WHRC and WICH received programatic funding in 1988/89 and 1990/91 respectively.

While their 01igins stretch back two decades (see Figure 1, page 10), it is only recently that Women's Health Services have attracted funding which is sufficient and secure enough to enable them to begin to make a real impact on service delivery to women. It is important to recognise this in appraising the achievements of the program.

Women's Health Services are a new concept in the Victorian health system. Services have had to establish themselves, attract skilled staff, develop an identity, seek acceptance by other services and HDV, form cooperative working relationships, and find the best ways of achieving change. These processes inevitably take time. However, the productivity and achievements of the longer established Services suggest that this is an investment well worth making.

CHAPTER THREE

WHY HAVE WOMEN'S HEALTH SERVICES IN VICTORIA?

Both Victorian and National women's health policies maintain that women have particular health needs and that if these are to be met, there is a need for reform and change within the health system. Each identifies separate Women's Health Services as playing a crucial role in the agenda for change.[6] The case for Women's Health Services which was outlined in the two policy documents, is presented briefly in this chapter.

The question 'Why have Women's Health Services?' is best answered in three parts: Are there any differences in women or in women's experiences which need to be given particular recognition in delivering services? If so, are existing services responding to these needs and, if they are not, how is reform best achieved?

WHAT'S DIFFERENT FOR WOMEN?

There are obvious biological differences between men and women that have an impact on women's interaction with the health care system. For example, it is women who bear and give birth to children. Less often recognised is the effect that women's social position has on their health.

While growing up, boys and girls are subject to very different influences in the family[7], the education system[8], and the media[9]. As adults, women's access to education, employment, income and to positions of power and influence is unequal (see box, page 13). Sex and gender differences and gender inequality have a significant impact on the health of women and their use of health services.

Patterns and experiences of health

- There are some issues which are primarily or exclusively of concern to women. For example 90% of the sufferers of anorexia and bulimia nervosa are women[10], a pattern thought to be due to the social pressures on women to be thin.[11]

- Women's experience of the same health issues may often be very different from the experiences of men. There may be different causal factors and different forms of support required. For example, young women are taking up smoking in greater numbers than young men, and women are giving up at a slower rate.[12] These differences have been attributed to women using nicotine as an appetite suppressant in the bid to be thin, or for relieving the stresses associated with the 'double day' of paid work outside or the home and unpaid work within it.[13]

- While women live longer than men, their lives are not necessarily healthier. Women report higher rates or recent illness and days of reduced activity than men.[14] This is due to women's unequal access to those resources required to be healthy (see box, page 13).

Women's frequent use of health services

- Women use health services more often than men.[15] This is due to a combination of factors including women's role in bearing children, the responsibility they assume for contraception, their greater longevity, and their higher rates of reported illness. Women often rely on the health system for assistance with social problems such as family violence, and interact with it (in their roles as carers of children, the aged and those with disabilities) on behalf of others.

Women's experiences of using health services

- The health system is oriented toward responding to the needs of the sick. However, women have a high rate of health service usage when they are well. For example, routine cervical screening, and birthing and contraceptive care. They are also more likely to turn to the health system for problems which are of a social, emotional or personal nature; for example, family violence, sexual harassment, stress and unhappiness.

- Women rely on the health system for issues which have profound personal significance and which have an impact on many other aspects of their lives (for example, assistance with family planning).

- Only 22% of doctors are women [16] and medicine is a profession which is held in very high regard in our society. This means that when women seek health care, it is likely that they will find themselves consulting with someone whose social experience is very different from their own and who is significantly more powerful than them. These dynamics affect the extent to which women can confidently act as equal partners in their own health care. [17]

ARE EXISTING HEALTH SERVICES MEETING WOMEN'S NEEDS?

This question has been answered in the last decade by Australian women themselves through two major consultations conducted by the Commonwealth and Victorian governments. [28] Involving over a million women, these consultations demonstrated that while women were very satisfied with many aspects of health care provision and believed that advances had been made, there was still some room for improvement.

Australian women: different but unequal

We know from research that there is a very close relationship between our health and our access to housing, social support, employment and income. In general, those with good access to these resources enjoy better health than those whose access is limited. [18] Despite many positive changes in the last three decades, women's access to basic social and economic resources remains demonstrably unequal.

- 90% of sole parent families (comprising nearly 15% of all families [19]) are women. [20] Sole parent families are more likely than couple families to be in receipt of a pension or benefit and their rates of poverty are some four times higher than that for all families. [21]

- Over 40% of women work part time [22] and women remain concentrated in positions requiring few formal skills, and providing poor remuneration and opportunities for advancement. [23]

- Women's rates of unemployment, when the hidden unemployed are included, have been consistently higher than men's. [24]

- Despite women's movement into paid work, they still undertake a disproportionate share of the responsibility for domestic work .[25]

- Women make up two thirds of those in receipt of a pension or benefit and receive on average between only 67% and 85% of men's average weekly earnings. [26]

- Only 4% of Australian women compared with 30% of young men undertake an apprenticeship. Women are under-represented in maths and science at secondary level and in engineering, the sciences, architecture and law in our universities and colleges. [27]

WOMEN WORKERS IN HEALTH OCCUPATIONS IN AUSTRALIA

Health Occupation	% Women Workers
General Medical Practitioners	25
Specialist Medical practitioners	16
Dental Practitioners	14
Pharmacists	39
Occupational Therapists	93
Optometrists	22
Physiotherapists	84
Speech Pathologists	96
Chiropractors and Osteopaths	16
Podiatrists	69
Radiographers	63
Nurses	93
Other	69
All Direct Care Health Workers	78

Source: ABS Cat No 4346.0 p15, 1986.

Specifically women wanted to:

- have a greater say in the management of health services and programs;
- have their health concerns taken more seriously (there was concern among women that many common and disabling health conditions were ignored or trivialised within the health system);
- have less medical intervention in their lives, preferring approaches which prevented problems from occurring in the first place and which give women greater control over their own health;
- be treated as 'whole' human beings rather than the focus being on specific diseases or injuries;
- have less sex role stereotyping within the health system;
- have the range of issues of relevance across the life cycle addressed (concerns were expressed that undue emphasis was placed on reproductive health and on women in their reproductive years);
- have the needs of particular groups of women recognised within the health system;
- have greater recognition within the health system of the reality of their lives and the impact that this has on their health and health care;
- have information and resources to help them make informed choices about their health care;
- have more of their health needs met through locally based primary health care services.

HOW IS REFORi.\1. BEST ACHIEVED?

In recognition of the need for change in the health system, the National and Victorian women's health documents recommended a 'dual strategy' involving the establishment of special Women's Health Services and reform of mainstream health services and programs. This approach recognises that there will be some circumstances in which it is in the interests of appropriate health care for services to be provided f ᵽ and by women and that some women may prefer to use separate Women's Health Services. However, it is not envisaged lhat Women's Health Services will directly meet the needs of all Victorian women. Rather their primary objective is to achieve reform of mainstream health services and programs so that they are more responsive to women's needs. In this way it is anticipated that the benefits of Women's Health Services will accme not only to those women who have direct contact with them but to the thousands of women using mainstream health services.

WHY ARE SPECIAL WOlvIBN'S HEALTH SERVICES NECESSARY TO ACHIEVE REFORi.\11?

The dual strategy is based on the belief that owing to historical and contemporary gender inequality, the health system is not a 'level playing field' in which women can participate as equals to secure health services and programs that suit their needs. Rather, special measures are required to ensure that this occurs.

Women have had very little influence over the development of the contemporary health care system.

In earlier times, women healers played a significant role in health care. However, this role was gradually eroded from around the fourteenth century. The decline in women's influence over health care in Britain and America has been documented by Ehrenreich and English who comment:

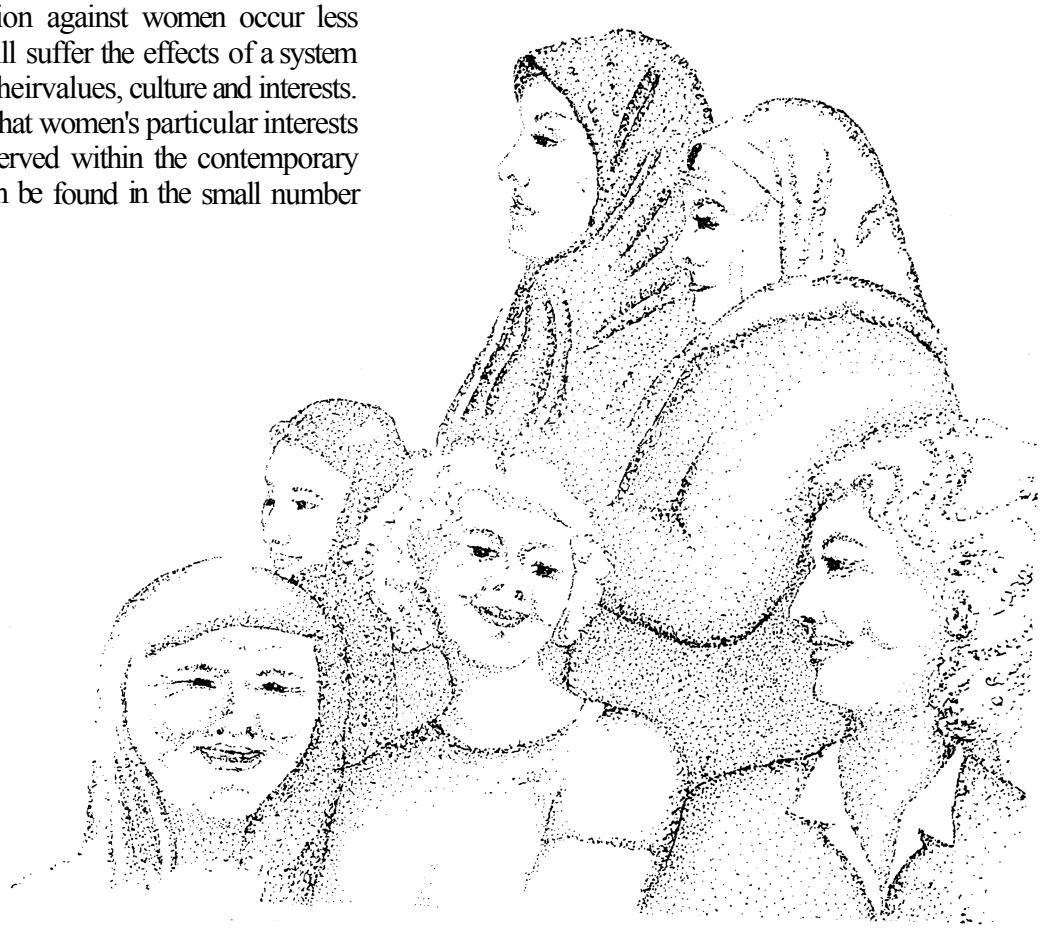
> "With the elimination of midwifery, all women fell under the biological hegemony of the medical profession. In the same stroke women lost their autonomous role as healers. The only roles left for women in the health system were as employees, customers or 'material'."[29]

It was not until the 1880s that women were accepted to study medicine in Victoria. In 1986 - the latest year for which data is publicly available - there were over 1600 hospital board members in Victoria. Only 339 of them were women.[30] The gender segmentation which exists in the work force generally is reproduced, arguably in an even more extreme form, in the health care system (see Table 1, page 14).

While much progress has been made in the last fifty years to eliminate gender inequality so that instances of active discrimination against women occur less frequently, women still suffer the effects of a system which often excludes their values, culture and interests. Evidence of the view that women's particular interests are less likely to be served within the contemporary health care system can be found in the small number of women entering the medical specialities. While women are no longer specifically excluded, specialist education is structured in such a way that entry for women (particularly those wanting to have children) is extremely difficult.[31]

American findings suggest that research studies use few, if any, female subjects.[32] Rather men are treated as the 'norm' for both men and women. This means that while research yields results which are directly relevant for men, they may not necessarily be applicable to women. The dangers inherent in this approach are evident in the studies used to establish the link between heart disease and cholesterol (see box, page 16).

In addition to hidden discrimination, there also continues to be instances where women's attempts to achieve change and reform have faced resistance or been ignored. This is evidenced by the intense opposition that nurses have faced in their attempts to provide cervical screening services to women,[35] despite evidence suggesting the acceptability of this approach to women and the demonstrated effectiveness of nurses in delivering these services.[36]



by Di Surgey from 'Women Talk... about AIDS, Sex and Sexual Health' produced by Women in Industry and Community Health for the Department of Health, Housing and Community Services

How easily are women left out of the health care equation?

For some years both men and women alike have been advised to reduce their cholesterol intake in the belief that there is a link between high blood cholesterol levels and heart disease. This link was established in two commonly cited studies. The first, the *Coronary Primary Prevention Trial* was carried out over a seven and a half year period and involved some 40,000 subjects. All were men. The second, the MRFIT study, followed up some 300,000 subjects - again all of them men - over a six year period. However a third and lesser known study conducted in Finland in 1972 which did involve female subjects found that lowering cholesterol levels in women did not bring about significant reductions in mortality associated with heart disease. [33] Indeed some nutritionists are now of the view that women changing their diets to reduce cholesterol intake may be doing more harm than good. [34]

It is also illustrated by a recent study which demonstrated that the relatively low level of funding allocated by the research granting bodies to the particular concerns of women between 1985 and 1989 remained stable, and in some cases fell, despite a focus on women in both Federal and State government health policy during those years. [37]

The establishment of special Women's Health Services represents an attempt by women and government to give voice to the experiences of women within the health care system and to support them to take action on issues of concern. Services in the Victorian Women's Health Services Program are distinguished from mixed gender services and from other health services which primarily serve women (for example, a major obstetric hospital) in the following ways.

- Services play a role in service provision to individual women and other strategic activities including public advocacy and professional education.

- All aspects of service delivery are carried out with strategic goals in mind; for example direct services are delivered with the aim of pioneering new models.

- Services do not address health issues of a general nature but rather confine themselves to issues which exclusively or primarily concern women (forexample, family violence) or which effect women differently as the result of their different position in Australian society (for example, occupational health and safety).

- Services are managed for and by women. This is important since it ensures that reform is driven by women and that women gain experience in management (see Chapter 5, page 19).

- Services 'stand alone'; that is, they are located separately from mainstream health services. This is important since, while the Service's reform role requires a high level ofinteraction with them ainstream health system, Women's Health Services need to be independent of existing services.

- Services place a particular emphasis on reaching women who have traditionally been disadvantaged in their access to health care.

CONCLUSION

In this chapter it has been suggested that women have different needs which require recognition within the healthcare system. Theexperienceofwomen, together with a body of research, demonstrates that these needs are not being met adequately or appropriately within the existing system.

The women's health policies of both the Victorian and Federal governments are based on the understanding that while reform is necessary, it will not occur unless specific steps are taken. Accordingly, both see special 'stand alone' Women's Health Services as crucial to the reform endeavour. Their role is seen not simply as duplicating what is being provided by existing health services, but rather as working toward reform of mainstream health services, programs and policies.

CHAPTER FOUR

THE WOMEN 'S HEALTH POLICY CONTEXT

Women's Health Services in Victoria work within a government policy context. While general health policies apply to Women's Health Services, health policies and other documents of particular relevance to the Services include:

- the report of the Ministerial Women's Health Working Party *Why Women's Health? Victorian Women Respond* (1987);
- *The National Women's Health Policy: Advancing Women's Health in Australia* (1989);
- *The National Non-English Speaking Background Women's Health Strategy* (1991)[38].

These documents were developed following extensive consultation with women. Over 7000 women were involved in the consultations of the Victorian Ministerial Women's Health Working Party and over one million women participated in the consultation conducted nationally. Significant aspects of these policies arc summarised below.

THE DUAL STRATEGY

Both the National and Victorian documents propose that reform will best be achieved by a dual strategy involving:

- reform of mainstream health services, and
- the establishment of special health services for women.

Further detail on the rationale for the dual strategy can be found in Chapter 3, page 12.

WOMEN'S HEALTH SERVICES IN A REGIONALISED HEALTH CONTEXT

Since 1983, Victoria has had a regionalised health system, with health regions being the basic unit for planning and administration of health services and programs.[39]

In recognition of the fact that the capacity to achieve change would depend on the new Women's Health Services being able to influence regional planning and service delivery, the Victorian Ministerial Women's Health Working Party recommended that at least one Women's Health Service be established within each of the eight Victorian health regions. It was envisaged Services would work with women and with community and service networks within each region to ensure that service provision and health planning processes were relevant.

By being regionally- ratherthan centrally- located and managed, it was also anticipated that Women's Health Services would be betterequipped to understand and respond to local conditions and needs.

At the same time, the working party recognised that there were some tasks involved in improving women's health status which are most efficiently and cost effectively carried out by statewide services rather than at the local level. Examples include the development and production of health information resources and addressing broader health policy or research questions. Accordingly, it recommended the establishment (or continued support) of a smaller number of statewide Women's Health Information Services.

POLICY DIRECTIONS

The *National Women's Health Policy* was based on an understanding of health developed by the World Health Organisation and endorsed by the Australian government in its national policy on *'Health for All Australians'*. Both it and the Victorian report reflect a commitment to:

- increasing the participation of women in the delivery and management of health services as well as in decision making about their own health care;
- illness prevention and health promotion;
- the importance of a social view of health, involving recognition of factors in women's social, family and physical environments which effect their health and their capacity to use health services;
- reducing sexism and sex role stereotyping in the delivery and management of health services;
- strengthening the primary care network as an appropriate sector to meet many of women's needs;
- principles of equity and access.

PRIORITY ISSUES

The *National Women's Health Policy* outlines seven priority issues as follows:

- Reproductive health and sexuality
- Occupational health and safety
- Health of ageing women
- The health needs of women as carers
- Violence against women
- Women's emotional and mental health
- The health effects of sex role stereotyping on women

As can be seen these issues reflect the concerns of women throughout the life cycle and are of relevance in the range of roles they play. While the National Policy identifies particular health issues of concern to women, it also notes that:

'Women's health concerns extend beyond specific health problems to include the structures that deliver health care and information, and the processes which influence women's interactions with the health system. These structures and processes affect the quality of care women receive, their access to appropriate and acceptable services and their health outcomes.'[40]

Structural issues identified within the policy include:

- improvements in health services for women;
- the provision of health information for women;
- research and data collection on women's health;
- participation in decision making; and
- the training of health care providers.

RESPONDING TO THE NEEDS OF WOMEN FROM NON-ENGLISH SPEAKING BACKGROUNDS

The *National Non-English Speaking Background Women's Health Strategy* was prepared by the Commonwealth/State Council on Non-English Speaking Background Women's Issues. It complements the *National Women's Health Policy,* examining in depth the particular health concerns of women from non-English speaking backgrounds (NESB). The strategy presents a number of recommendations aimed at both improving NESB women's access to health services as well as addressing the underlying causes of the health problems experienced by NESB women.

The strategy provides a context for Women's Health Services which applies both to the way Women's Health Services work with women from NESB and to defining priorities for their work in addressing the concerns of NESB women. It identifies the issues of mental health and of occupational health and safety as of particular concern to women from NESB.

CHAPTER FIVE

PUTTING HEALTH POLICY INTO PRACTICE: An Overview of the Victorian Women Health Services Program

From its inception, the culture of the Victorian Women's Health Setvices Program (VWHSP) has emphasised the active participation of a range of women. This was apparent from the program's formal b ginnings in the broad based consultation held by the Victorian Ministerial Women's Health Working Party and was to continue through to the participatory and inclusive processes used to establish Services, and the management models adopted by Services. In the Service's day to day operation, this emphasis can be seen in the involvement of users in the initiation, planning and delivery of projects.

THE SERVICES

The VWHSP comprises nine Regional Women's Health Services (RWHS) and three Statewide Women's Health Information Services. (see map, page 20). A brief description of each Service in the VWHSPcan be found in Appendix 1, page 72. Specific projects carried out by each Service since its inception are listed in Appendix 2, page 77.

Regional Women's Health Services
Each RWHS offers a different range and mix of services. These may include:

- direct counselling and medical services;
- the provision of health information and referral (which informs planning and assists the Service to identify gaps and issues);
- support and information to women considering options for treatment;
- support for the development of self help groups;
- professional education and development;
- health promotion;
- community health education;
- representation of the interests of women in local and regional health planning and policy forums;
- participation in the development of services and resources of particular relevance for women;
- raising awareness of the particular health concerns of women in the community and among health service providers;
- project work to address specific health issues and to develop innovative models for working with women.

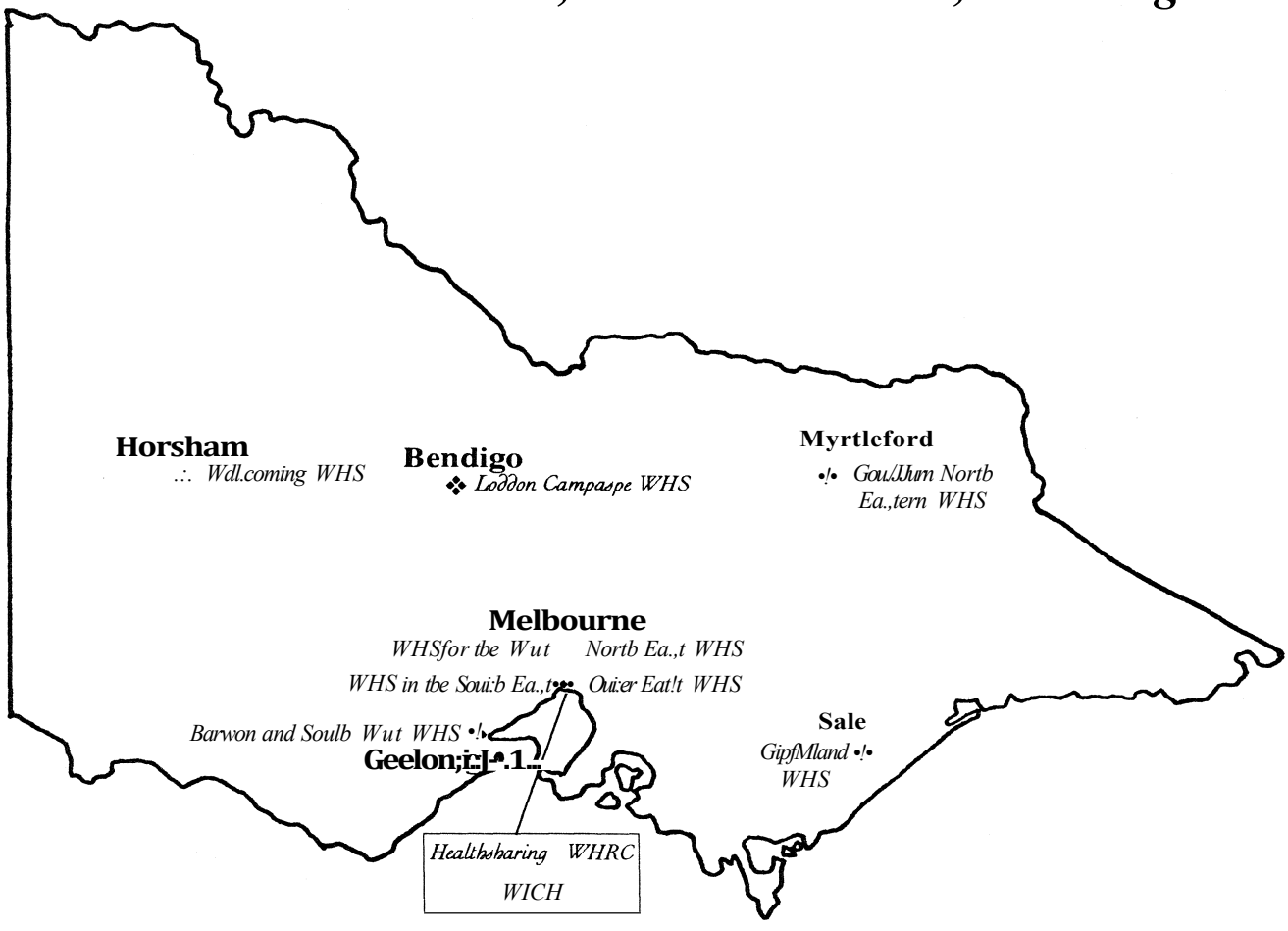
Each Service provides a resource library of books, pamphlets, journals, videos, audio tapes and kits, and offers health information and referral to local agencies.

Statewide Women's Health Information Services
Each of the three statewide Services has a different role and emphasis. Broadly speaking:

- Women In Industry and Community Health is a migrant women's health organisation that plays a fundamental role in meeting the information needs of women from non-English speaking backgrounds (NESB);
- the Women's Health Resource Collective develops and distributes resources on women's health issues and provides advice to other agencies who wish to produce health resources;
- Healthsharing Women operates a Women's Health Information Service, supports the development of women's health groups, has input into policy and service development at statewide and national levels, plays a significant role in health care provider training, and initiates research.

FIGURE 2: LOCATIONS

Victorian l,l!omen d Health Se,vtce1 Program



Legend

Region One - Barwon South West Women's Health Service (established 1989)

Region T w o - Wellcoming Women's Health Service (established 1991)

Region Three - Loddon Campaspe Women's Health Service (established 1989)

RegionFour-GoulburnNorthEastern Women's Health Project (in establishment phase)

Region Five - Gippsland Women's Health Service (established 1992)

Region Six - Women's Health Service for the West (established 1988)

Region Seven - Outer East Women's Health Service (established 1990) and
North East Women's Health Service (established 1992)

Region Eight - Women's Health in the South East (established 1992)

Women in Industry and Community Health (WICH), formerly Women in Industry: Contraception and Health (established 1978)

The Women's Health Resource Collective (WHRC) (established 1982)

Healthsharing Women (established 1988)

The regional and statewide Services work together to provide a coordinated and cohesive approach to the implementation of Victorian and National women's health policy objectives. This is illustrated in the case study *Working together across Victoria* (seepage 62).

HOW ARE WOMEN'S HEALTH SERVICES MANAGED?

While there are differences in emphasis in the management models of Services, most are incorporated associations under the Incorporation's Act 1981 and are managed by committees of management elected annually from the membership of the association. Membership of the association of a Women's Health Service is open to any woman living or working within the Service's 'catchment area' providing that she is committed to the aims, objectives and philosophy of the Service concerned.

This management structure helps to ensure that those responsible for managing Women's Health Services are drawn from as broad a base as possible. Women's Health S e r ice committees of management are comprised only of women. There are a number of reasons for this.

- The program was established to assist women to achieve positive change in the health system. It is crucial that women maintain control over, and inform the direction of, whatisessentiallytheirreform agenda.

- Many women have had very little experience in public participation and in the management of services. Through their involvement in a 'woman only' environment women can gain skills and confidence which equips them to participate and to advocate on behalf of women in other areas of the health system and in other aspects of community life.

Women's Health Services: Principles

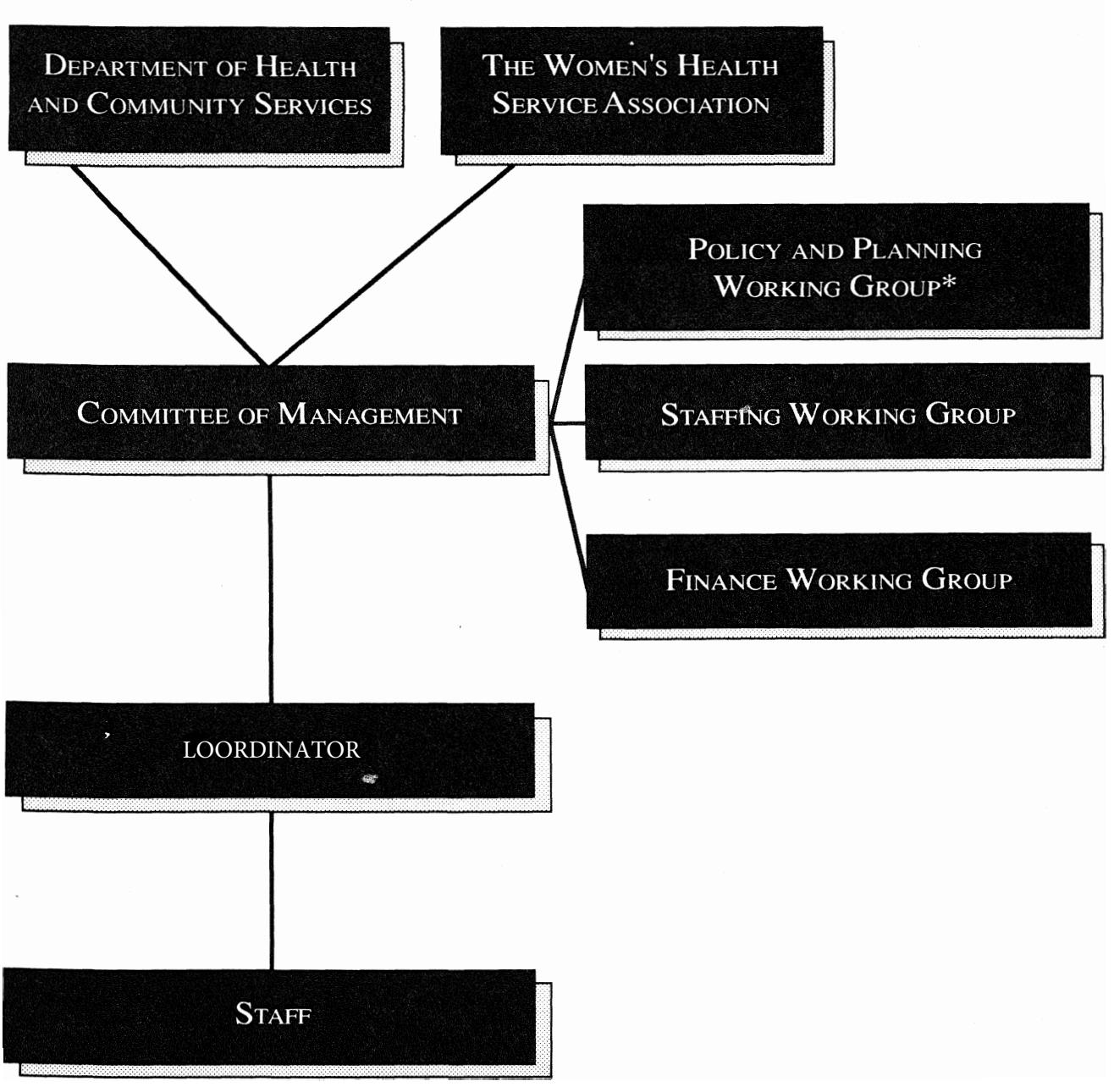
Women's Health Services have a commitment to:

- addressing power imbalances which arise as the result of the effects of gender, physical, intellectual and psychiatric disability, sexuality, social class, race or geographical location;
- recognising the importance of women having timely, appropriate, and accessible health information;
- an approach which recognises that not all groups in society start from equal positions; therefore, some will require special and additional resources to ensure that their needs are met;
- a social model of health (see Glossary, page 89);
- recognising, validating and promoting women's own experiences of health and health care;
- women having greater control over their own health and over their health services;
- promoting the important role Services provided 'for women, by women' play in the health system;
- engaging with the health system at a number oflevels and using a range of strategies (for example, community education, clinical services, health promotion);
- a woman-centred approach;
- a team approach involving positive working relationships between Services within the program, as well as between these Services and mainstream services and programs;
- a developmental approach; that is, one which involves people in the process of change, with the aim not only of achieving a desired outcome but of enabling people to gain power, skills and knowledge along the way;
- promoting the involvement of women in decision making within the health system.

FIGURE 3

A TYPICAL WOMEN'S HEALTH SERVICE:

Management Model



*Working groups normally comprise staff, commitee of management members and relevant co-opted members

These objectives may not necessarily be met within a mixed gender environment since research shows that men often dominate in such settings, even when they are not in the majority.[41]

The management structures aim to foster the participation of those groups of women who have traditionally had poor access to health services and who have suffered relatively poor health status. This includes women from NESB, low income women, young women, older women and women with disabilities. Participation of these groups of women is encouraged to enable women to gain skills, to have a say in the management of the Service and, most importantly, to ensure that programs are relevant to the needs of these women. The value of this participatory approach for both the individuals concerned and for innovative service delivery is illustrated in the case study *Participation and equity: the key to good health* (see page 40).

The importance of women being actively involved in the management, planning and implementation of Women's Health Services is stressed in both National[42] and State[43] funding guidelines.

At the same time, Women's Health Services recognise the need for committees of management to include members who have links with mainstream health services and statewide networks, who have an understanding of the regional context, and who have formal skills in service management and development. The involvement of women with knowledge and skills of this nature is critical if Women's Health Services arc to play an effective strategic role. In this way, many Victorian women have contributed thousands of voluntary hours to the VWHSP.

ORGANISATIONAL STRUCTURES

Most Services in the program employ a coordinator who usually acts as the executive officer of the committee of management. In general, staff are accountable to the committee of management via the coordinator (see Figure 3, page 22).

LEGISLATIVE FRAl'vlEWORK AND ACCOUNTABILITY

Services are bound by the *Victorian Health Services Act* 1988 and the *Associations Incorporation Act* 1981. They must adhere to the Department of Health and Community Services Standard Conditions of Funding for Registered Funded Agencies and are required to submit an annual Health Service Agreement. In this way the accountability mechanisms for Women's Health Services are consistent with those of other government funded health services such as community health centres and hospitals.

The *Sex Discrimination Act* 1984 (Commonwealth) and the *Equal Opportunity Act* 1984 (Victoria) also have a bearing on the employment, management and service delivery activities of Women's Health Services. In general these Acts prohibit the provision of services to one sex or another on the grounds that to do so would be discriminatory. Both, however, provide general exemptions.

In the case of the Commonwealth Act a general exemption applies if the service concerned is provided with the aim of relieving continuing disadvantage or where the services are of a nature that they can only be provided to members of one sex. Services exempt from the provisions of the Victorian Act are those established to prevent or reduce disadvantage. These general exemptions make it lawful for Women's Health Services to recruit only women to their boards of management and to provide their services only to women. Women's Health Services wishing to specifically recruit women staff must apply for an exemption from the Equal Opportunity Board. A number of Services in the program have done so successfully.

The question of whether Women's Health Services are eligible for a general exemption under the *Sex Discrimination Act* was the subject of a recent complaint brought before the President of the Human Rights and Equal Opportunity Commission, Sir Ronald Wilson, regarding the services provided by two Canberra Women's Health Services. In deciding in favour of granting the exemptions to the Women's Health Services, Sir Ronald Wilson stated:

> 'Their primary orientation to the distinctive concerns of women renders the services of a nature which can only be provided for women ... The distinctive health concerns of women extend beyond conditions suffered exclusively by women. The special sensitivity needed in treating the physical injuries inflicted by domestic violence and the desirability of complimentary counselling services are obvious examples of distinctive needs ... Furthermore, the evidence satisfies me that existing generalist services are more likely to provide the sensitive responses that some men's health needs sometimes require because the male model is dominant both in education and in practice.'[44]

STAFFING

Women's Health Services employ workers from a range of professional backgrounds and with diverse life experiences. Some bring to the program experience in delivering services in the mainstream of the health system as doctors, nurses, social workers or other health workers. Others, however, may not come from a traditional health background but have experience and skills in adult education, resource development and publications, community and professional education, health promotion, service development and organisational change. Staffing profiles encompassing a broad range of skills are compatible with health policies which recognise the importance of seeing health in its social context and the role of Women's Health Services in achieving positive change for women in the mainstream of the health system.

Some Women's Health Services have sought an exemption from the Equal Opportunity Board so that they can specifically recruit women staff. There are a number of reasons for this.

- Women have life skills and experiences which enable them to deliver services to women with sensitivity and understanding. This is well illustrated in *Taking the health message to women* (see page 30).

- Research has shown that a significant proportion of women prefer to be assisted by a woman healthcare provider, especially in matters involving gender relations (such as family violence or sexual assault).[45]

- As noted elsewhere in this report, Women's Health Services were established to address the disadvantages women experience in accessing mainstream health services. Since staff are influential in the implementation of that agenda, it is important that they be women.

- Many women health care providers have much to offer the endeavour to reform health care provision in the form of their knowledge, skills and experience. However, they often encounter difficulties having their voice heard or in securing positions within the health system where they are able to bring this experience to bear. The VWHSP provides a forum for women seeking to make positive changes in health care provision for women.

STAFFING LEVELS

The Ministerial Women's Health Working Party, in its report, anticipated that RWHSs would have a funded staffing establishment of at least 10 health workers. In practice no RWHS has been funded to this level. The maximum number of effective full time health worker positions in any of the Services in the program is 8.3 and the minimum is one. The average number of effective full time health worker positions for Services in the program is four (excluding temporary project staff). The working party also envisaged that eventually, there would be a number of Women's Health Services within each region.[46]

Given that Women's Health Services have either a statewide role or a role within an entire region, the relatively small actual staffing must be taken into account in appraising the achievements of the program.

THE RANGE OF PROGRAMS PROVIDED

The Ministerial Women's Health Working Party envisaged that Women's Health Services would play a significant role in the provision of direct medical and counselling services, and use this experience to help make the mainstream health system more responsive to the needs of women. In practice, Women's Health Services have faced considerable dilemmas with regard to the provision of direct clinical services, including:

- the fact that there is only one Service funded in each of the health regions, each of which has a large population;

- the large salary and operational costs associated with providing a clinical service, leaving few resources to undertake the work involved in mainstream reform. This is particularly the case given the difficulties involved in attracting staff who have the range of skills required to implement both direct service and broader reform;

- the relatively low rates of utilisation of direct counselling and medical services among groups of women whose health status is poor and whose access to mainstream services is limited (for example, women from NESB). This has been considered problematic by some Services given the emphasis on equity (see, for example, the description of the Women's Health Service for the West in Appendix 1, page 74); and

- the difficulties in ensuring that counselling and medical services do not duplicate what is being provided effectively by existing services but rather confine themselves to 'women's health issues' (see Glossary, page 89). For example, many women have the expectation that Services will provide an alternative to their general practitioner.

Different Services in the program have addressed these dilemmas in a number of ways including:

- offering 'clinics', sessions or programs around specific issues (for example, a pap test program, or counselling for women with eating disorders);
- providing direct service in a form which assists women in accessing and making better use of existing health services (for example, information and referral);
- providing assistance to groups (for example, an incest survivors support group); and
- directing resources towards working with service providers to resource improved service delivery to women.

PROGRAM LINKS

The success of the VWHSP in implementing the dual strategy depends on the extent to which Services are able to form links with women's and community networks, agencies and programs within the mainstream of the health system. As can be seen from Appendix 3, the program has been highly successful in developing links of this nature.

LINKS BETWEEN SERVICES I THE PROGRAM

Services work closely together enabling:

- the experience ofRWHS to infom1 the activities of the statewide Women's Health Infomrntion Services;
- Services to learn from the experience of one another;
- quality assurance and accountability through peer review;
- proper planning to ensure elimination of gaps and overlaps;
- the Services to act at different levels as a program on certain issues. This is illustrated in *Working together across rural Victoria* (see page 62).

Formal opportunities for links within the program include regular meetings of Women's Health Around Victoria (WHAV) and a forum of Women's Health Services sponsored by the Department of Health and Community Services. A number of Services are also involved in joint ventures.

THE ESTABLISrL\1.ENT OF NEW SERVICES

It was recognised by those involved in the implementation of the VWHSP that processes for establishing Services would need to be developed which recognised:

- the importance of informing the community of the role of Women's Health S e rices in the dual strategy;
- the need for Services to have developed sound links with relevant community and health services and networks prior to commencing operation;
- the need for Services to involve local women and women's networks in their development and, ultimately, in their management.

Consequently each of the Services developed according to a number of broad stages.

Stage One: Interest is expressed in the development of a Women's Health Service. A local group (usually made up of a coalition of local service and community networks) forms to submit for project funding.

Stage Two: Funding is allocated to develop a project usually involving research into the specific health needs in the region. The project also builds on the momentum of support for the Service, fosters participation of local women, establishes links with relevant service and community networks, and determines the most appropriate location for the Service within the region. This stage is usually auspiced by an existing agency such as a community health centre and is managed by an interim committee or steering group. At the completion of this stage a formal proposal for funding is developed and submitted.

Stage Three: Funding is approved, a committee of management formed and premises secured. Staff are appointed and the process of incorporation is commenced enabling the move from auspiced project to a self-managed Service.

Stage Four: The Women's Health Service commences operation.

The program has been developed progressively across Victoria with the result that each Service in the program is at a different stage of its development.