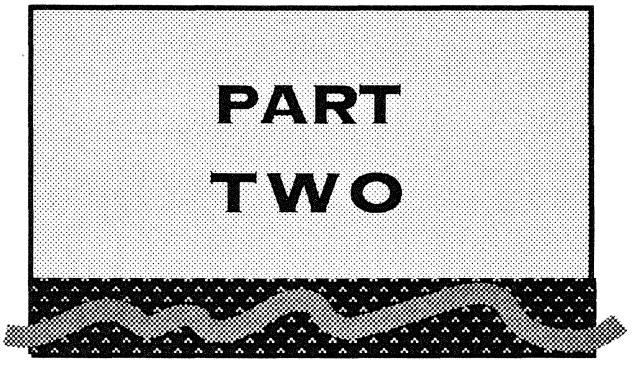


Case studies

CHAPTER SIX

WOMEN SHEALTH SERVICES ACHIEVING CHANGE:

CMe c1tud0fronz Victorian Women dHealth Serricu

Presenting case studies of the work of each of the services in the program, this chapter looks at how Women's Health Services implement National and Victorian policies and in particular the dual strategy.

WHAT STRATEGIES DO SER\1CES USE?

Each of the case studies illustrates the application of one or more of the following strategies used to implement the dual strategy (as indicated in the checklist accompanying each study).

by Debbie Milligan

1. Exploring and modelling improved ways of delivering services to women.

2. Monitoring issues emerging in direct service with a view to identifying trends and concerns and developing an informed base for the Service's work at other levels.

3. Making representations to government, health services and other bodies to advocate concerns of women.

4. Providing information which assists women to access and make better use of health services and resources; information and resource development.

5. Advice and consultation to mainstream services and other organisations regarding service provision to women.

6. Promoting women's participation in decision making within the health system.

7. Training of health professionals.

8. Joint ventures with other services with a view to encouraging services to allocate resources to address the specific concerns of women and to provide a focus for demonstrating service delivery approaches which are sensitive to women's needs.

TAKING THE HEALTH MESSAGE TO WOMEN

Women in lndU:Jtry and Community Health

CoNVENTIONAL MODELS FOR DELIVERING HEALTH INFORMATION OFTEN ASSUME COMPETENCE IN ENGLISH, A SHARED CULTURAL UNDERSTANDING OF HEALTH, AND AN ABILITY TO ACCESS HEALTH SERVICES FOR MORE THAN THE MOSTPRESSINGOFHEALTHCONCERNS. ITISDIFFICULTTOCONTEMPLATE HOW THE HEALTH NEEDS OF WOMEN FROM NON-ENGLISH SPEAKING BACKGROUNDS (NESB) WORKING IN FACTORIES COULD BE MET USING THESE MODELS. THIS CASE STUDY ILLUSTRATES HOW ONE WOMEN'S HEALTH SERVICE HAS DEVELOPED INNOVATIVE WAYS OF REACHING THESE WOMEN.

TIME AND ACCESS ARE SELF CARE BARRIERS

Women who bear the dual responsibility of paid employment and a family often find it difficult to get the time to look after their own health. This is doubly challenging for women working in industry where there is often not the flexibility to take time to visit a health service, especially for the purposes of illness prevention, a second opinion, or a health matter which has not yet become urgent. The problem is further compounded for women from NESB, who may lack familiarity with the Australian health care system and for whom there is a dearth of culturally sensitive services able to assist them in their own language.

Research shows us that while women from NESB have particularly poor access to health services, they are the very group of women who have pressing health needs. Migrant women tend to have very good health on their entry to Australia - due to the stringent health test applied as part of the process ofimmigration. However, their health deteriorates after arrival[47]. In part this is due to the fact that women from NESB are concentrated into poorly paid and physically taxing jobs, adding to the stresses they may already be experiencing as the consequence of the financial pressures and the cultural and social isolation often associated with settling into a new country48.

TAKING THE MOUNTAIN TO TOYOTA, HOLEPROOF AND FORD

Through its factory visits program, Women in Industry and Community Health (WICH) takes health information to women in the work place via a team of bilingual and bi-cultural workers speaking over 10 languages. Most of these women have themselves worked in factories at some time. The team are able to discuss health issues with women in their own language. In addition multi-lingual written and audio visual material is used as part of the program.

WICH gains entrance to the factories through negotiation with both management and unions. Sometimes workers are granted work time to attend the program, although women usually attend during their work breaks. The program is run at a venue most suited to the women at the work place concerned (for example, in the canteen, locker room, work station or rest room). The emphasis is on creating a friendly and informal atmosphere in which women can feel comfortable to discuss health issues of concern to them and to ask questions.

	STRATEGIES checkLut
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	*4.* Information & resource development
✓	5. Advice & consultation
	6. Promoting women's participation
	7. Training health professionals
✓	8. Joint ventures

Related Program Activities

Increasing NESB women's access to health information was the aim of the Women's Health Service for the West's Arabic Muslim Women's Project. Jointly conducted with the Altona and St. Albans Migrant Resource Centres, the project identified, provided and advocated for the women's needs.

An Occupational Health and Safety Project initiated by the North East Women's Health Service, included a number of information sessions in various community languages, the development of multilingual material, and consultation on a program for injured workers.

PROGRAM STRUCTURE

The program is run over four weekly sessions. The first is introductory; the second covers breast and cervical health; and the third, contraception and menopause. In the fourth, a summary of the issues is provided. Any outstanding matters raised in previous sessions, such as occupational health and safety issues, are followed up. Where necessary, referrals to other health and community services are arranged. WICH has developed an extensive directory of services which has a specific emphasis on those facilities which respond to the particular needs of women from NESB.

20,000 WOMEN HAVE BEEN DIRECTLY ASSISTED THROCGH THE WICH FACTORY VISITS PROGRfu'v'l SINCE ITS INCEPTION IN 1978.

IN 1992, 600 WOMEN ATTENDED WORKSHOPS RUN BY WICH IN COMMCNITY SETTINGS AIMED AT PROVIDING WOMEN WITH THE OPPORTUNITY TO EXPLORE HEALTH ISSUES IN THEIR OWN LANGUAGE.

The program is also able to use its day to day experience of working with NESB women to bring their needs to the attention of other health and community services and to government. In this way, it is hoped that existing services, policies and programs will be more responsive to the needs of women from NESB.

INGREDIENTS OF SUCCESS

There are a number of ingredients involved in this program's manifest and long standing success, other than its obvious benefits to the women who participate.

First, the program recognises the demands placed on women in the workplace and responds flexibly to these. Sessions are provided at times and in places which make it easy for women to attend, without losing valuable work time and money. This is critical given that in many factories women are paid piece work rates or risk losing pay if they return even minutes late to work. Second, the program makes efficient use of the time available to women in their meal breaks, getting across a lot of information in as short a time as possible, yet in a form and style which is acceptable to them. Third, it is provided by workers who share with the women both their status as a woman from NESB and their work place experience. The empathy and understanding which results from these common backgrounds enables the program to be finely tailored to the needs of migrant women working in industry.

A PARTNERSHIP WITH UNION AND MANAGEMENT

Finally and most importantly, the program has worked closely with both unions and management. These relationships have been critical to the Service gaining access to factories in the first instance and to the acceptance of the program at the factory floor level. The high regard in which WICH is held by a number of Melbourne's leading companies is indicated by the fact that the organisation is often invited to return to factories or, having visited one site, is referred to other plants owned by the same company. On this basis WICH has visited the Port Melbourne and Dandenong plants of the Toyota Company and the Box Hill, Deepdeene and Fitzroy sites of Holeproof.

MODELLING ALTERNATIVES

Management in a number of factories have consulted with WICH about their program with a view to adopting its approach in their own occupational health and safety programs. Factory visits have been an integral part of the Pap test programs offered by a number of Victoria's community health centres. WICH has clearly developed a model which is worth emulating.

DEVELOPING WOMEN-CENTRED RESOURCES

Women:, Health Ruource Collective

IT IS WIDELY AGREED THAT HEALTH PROMOTION AND ILLNESS PREVENTION STRATEGIES HAVE A MAJOR ROLE TO PLAY IN IMPROVING THE HEALTH STATUS OF THE COMMUNITY. HEALTH PROVIDERS AND WOMEN IN THE COMMUNITY HAVE REPEATEDLY POINTED TO THE ABSENCE OF ACCESSIBLE, RELEVANT AND APPROPRIATE INFORMATION ABOUT A BROAD RANGE OF WOMEN'S HEALTH ISSUES, A KEY ELEMENT IN HEALTH PROMOTION STRATEGIES. ONE OF THE FIRST WOMEN'S HEALTH GROUPS TO ADDRESS THIS WAS THE STATEWIDE WOMEN's HEALTH RESOURCE CoLLECTIVE (WHRC).

In *Health/or All Australians,* the report of the Health Targets and Implementation Committee,[49] it is argued thatexpenditureon carefully focused health promotion activities will substantially reduce health care costs in the longer term. From its earliest days, the WHRC aimed to develop information for women which would be:

- factually correct;
- meet women's information needs;
- facilitate informed decision making;
- increase both women's and provider's knowledge of the topic;
- validate and reflect womer.'s experiences;
- situate women's health in the context of women's lives;
- cover a range of broadly defined health issues;
- be based on thorough and up-to-date research.

These aims are reflected in the distinctive features of the resources produced by WHRC, as well as the processes used to generate them. These features are described in detail below. However, in summary, a resource produced by WHRC reflects a process which begins with women's health information needs, is centred on women's experiences and is accessible and relevant.
It meets the dual purpose of providing information to individual women in the community as well as to health professionals working in a range of institutions and services.

BEGINNING WITH WOMEN'S NEEDS

The resources produced by WHRC aim to fill gaps in the available health information material. Women's health information needs, as a starting point, can be identified in a number of ways. A gap in the available material can be initially identified by women, groups or organisations. Alternatively, after reviewing the currentliterature, WHRCstaffwillprioritiseanumber of unmet information needs. These needs reflect not only an absence of specific medical information about a condition, such as post-natal depression, but also a lack of information about a range of complex political and social factors which might cause, aggravate or otherwise impact on that condition. For example, women's mental and emotional health is greatly influenced by their life experiences and circumstances.

	STRATEGIES checkLut
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	4. Information & resource development
✓	5. Advice & consultation
✓	6. Promoting women's participation
	7. Training health professionals
✓	8. Joint ventures

Caring for young children without adequate support, coping with changing expectations about roles, working in low paid positions, or experiencing some form of violence may all contribute to stress, fatigue or depression, or more severe forms of mental illness. The relationship between stress and a woman's mental and emotional health was recently emphasised by a group of women associated with WHRC and subsequently led to the evolution of a new resource focused on that issue.

A MASSIVE 36,882 WOMEN'S HEALTH RESOURCES \VERE SOLD BY THE WOMEN'S HEALTH REsocRCE CoLLECTIVE IN THE FINANCIAL YEAR 1991-92.

DURING THE SAME PERIOD 7,813 RESOURCES WERE GIVEN TO INDIVIDUAL WOMEN.

WOMEN'S EXPERIENCE COUNTS

An important feature of all WHRC's resources is the central role women's experiences play in focusing and informing the resource. Critical to a thorough understanding of the nature of women's health issues are the various understandings and perspectives women have about causes, management and effects of illness.

When generating a new resource, women who have direct experience of the selected health issue and relevant support or self-help groups are located and involved in a consultation process. This allows WHRC to benefit from the women's understanding, knowledge and experiences of the issue. The various aspects of the health issue can be identified, clarified and explored from a number of different perspectives in order to build a comprehensive knowledge base.

When WHRC decided to produce a resource for older women caring for relatives or friends with chronic illness or disabilities, they consulted with the Alzheimers Association, the Older Person's Action Group, the Victorian Council of the Ageing and other older persons' organisations. Similarly, when developing *Women and Doctors: a Guide to Patient Rights* WHRC, in association with the Melton Community Health Centre and the Women's Health Service for the West, consulted with the women of Melton and Bacchus Marsh to identify the questions they most frequently wanted an answer to when vlslting their general practItlOners. This included information about medical terms, medical records, prescription drugs such as minor tranquillisers, and the costs of general practitioner consultations.

Consultation is not the only method WHRC employs to guarantee that women's knowledge, experiences and voices inform the development of health information resources. Another method for ensuring this, is the co-production of health information material with other agencies or groups. The booklet *Monsters Aren't Real: Women Talk About Incest* is an example. The stories and drawings in the booklet were produced by members of an incest survivors' group who wished to share their experiences of the nature and effects of sexual assault on their lives. WHRC assisted these women to feel so safe, confident and supported that they were able to publicly speak out about experiences which until then had been considered private and shameful. The importance of such personal experiences being publicly discussed was also emphasised by the many survivors of sexual assault who contacted WHRC to thank them for the publication. WHRC provided general resources and support to the group including technical skills (for example, typesetting and layout). The Collective also facilitated the printing and distribution of the booklet.

During the co-production process a number of additional developments occurred. The women involved exchanged skills, benefited from knowledge gained, increased their networks and felt validated and valued for their contributions. Clearly, for the women involved, the process was as important as the final product.

/Jy Carol£ Grayfrom 'MonAer.1 Aren't Real: Women Tall:: About l n.ce"t 'producer) /Jy the Women 1 Health Ruource Collative

Related program activities

Wellcoming Women's Health Service published an *Infant Breastfeeding Protocol* for the Grampians region in association with the Nursing Mother's Association, general practitioners, specialists, midwives, and ante-natal educators.

Each issue of Healthsharing Women's newsletter contains a 3000 word feature on a women's health topic which combines information drawn from academic, medical, feminist and mainstream sources. The *Research Findings* section discusses the latest research on women's health, culled from international scientific, medical and women's journals.

APPROPRIATE, ACCESSIBLE AND RELEVANT

A further feature of a resource from WHRC is its accessibility and relevance to a range of women and providers. If user friendly resources are to be developed they must be framed with a view to their target audience. This is particularly crucial when developing resources for non-English speaking women, especially as word-for-word translations of existing material are generally not accurate and are unlikely to be culturally sensitive.

For example, WHRC researched and published *When a Pap Smear Isn't All Clear,* a comprehensive booklet on pap tests, abnormal cell changes, diagnosis, treatment and prevention. This booklet is in high demand from a range of health institutions as well as individuals. The booklet's reach was limited as it was aV,ailable in English only. Following various and extensive consultations to determine the appropriateness of the booklet for translation and to ascertain which languages would be selected, WHRC decided to produce it in Spanish and Italian. Community readers checked and adapted the translations. Partly as a result of this process, the translations were well received by Spanish and Italian speaking women and service providers.

by Debbie Milliganfrom 'Caregivin.g: Carefor Youue/f Too' pro'Juce'J by the Women d Heafth lk,ource Coll£ctive

The fonn in which the infonnation is communicated also influences the resources' accessibility and effectiveness. Accordingly, WHRC produces infonnation using a range of media, to ensure that the largest possible number of women receive information.

Recently WHRC addressed the difficulties involved in communicating health information to women who found written information inaccessible. The Women's Health on Tape (WHOT) project grew out of the search for an accessible fonnat. By collaborating with groups such as the Carlton Rental Housing Co-operative, the Council of Adult Education Health Issues Group and the Northcote Library Low Literacy Group, WHRC was able to meet this particular population group's needs.

Another example of maximising accessibility through the use of an appropriate medium is the colour poster, *Caregiving: Care for Yourself Too.* One of the difficulties in providing information for carers is that they often have little spare time. A poster is an effective way of communicating information to this target group. The colourful and striking screen printed poster has been widely distributed and displayed in doctors' surgeries, waiting rooms, shopping centres, health centres and senior citizens' organisations.

by Jo Watte from 'Women and Doctor,1: A Guwe to Patient Rigbt,1' produced by tbe Women Hea/ib RMource Coll.ective, Women Healih Service for the Wut and Mellon Community Health Centre

INFLUENCING CHANGE

A final feature of WHRC resources is their dual purpose. They are directed to health professionals working in a range of private practices, services and institutions, as well as to individual women. Information resources are generated in association with key organisations and agencies. As a result, these organisations often develop a degree of commitment to the resource and are therefore likely to be keen to participate in its distribution.

The provision of these resources to doctors, nurses, and other health professionals can, for example, influence a doctor's practice in a variety of ways. The presence of easily accessible information resources can encourage a doctor to provide information and accurate explanations for medical procedures as well as support and referral for patients. The provision of this information in relevant community languages is an additional advantage.

An indication of the value of WHRC resources is reflected in the number of repeat orders and frequent new orders received from doctors, nurses, hospitals, community health services and women's services. WHRC also distributes information to a wide range of agencies and locations including neighbourhood houses, local councils, church groups, bingo halls, community groups and many others.

Individual resources often receive publicity through radio programs, local newspaper and women's journals, such as *New Idea* and *Woman's Day.*

by Jo Watte from 'Women an'J Doctor,1: A Guwe to Patient Rigbld' produced by the Women:, Hea/J.h R.uource Coll.ective, Women d Healib Service for the Wui and Melton Community Healih Centre

RECLAIMING THE WOMB

HeaLthc1haring Women

WHETHER TO HAVE A HYSTERECTOMY IS A SIGNIFICANT DECISION IN THE LIVES OF MAi WOMEN. JT CONCERNS NOT ONLY THEIR PHYSICAL WELL BEING, BCT THEIR EMOTIONAL HEALTH, SEXUALITY AND SELF-IMAGE. THIS CASE STUDY DESCRIBES THE RANGE OF WAYS HEALTHSHARING WOMEN HAS SOUGHT TO IMPROVE THE SITUATION OF WOMEN FACI'NG A DIFFICCLT AND COMPLEX DECISION AND HOW THIS CONTRIBUTES TO SAVINGS WITHIN THE HEALTH SYSTEM.

HYSTERECTOMY - AN ALL TOO COMMON PROCEDURE

Australian research has shown that almost 17% of women between the ages of eighteen and sixty-nine years have had a hysterectomy. The prevalence of hysterectomy among women in their fifties is over 34%.[50] However, it is clear from the large number of enquires received by Healthsharing Women that this procedure is problematic for many women. The prospect of a hysterectomy is frequently emotionally as well as physically difficult, raising issues associated with sexuality, the end of the fertile years, and feminine self image. Many women report that their doctors have failed to deal with these concerns and in some cases have been openly insensitive at a time when they feel particularly vulnerable. Healthsharing Women provides support and information and offers referral to an appropriate counselling, support or medical service.

WOMEN AND INFOR.ivIBD DECISION MAKING

Others, keen to make an informed decision about this critical issue, report that they face difficulties in gaining accurate information about alternatives to hysterectomy, the advantages and disadvantages of the procedure, and the different forms of surgical and non-surgical intervention available (see box, page 38). The Service has a large, up-to-date collection of literature and audio visual material on hysterectomy and related subjects from both Australia and overseas which is open to the public. Women who are unable to come into the Service can be given information through the 008 telephone information line or by post. Healthsharing Women has the capacity to conduct literature searches of international and national publications- a facility of use to women considering the prospect of a hysterectomy as well as to students and researchers interested in the issue.

RESEARCH AND CLINICAL LITERATURE

Healthsharing Women regularly monitors research findings and where possible clinical practice, on women's health issues with the aim of identifying trends or issues to which women should be alerted. The Service has identified that hysterectomy is often performed without reference to protocols or practice standards, there being little consensus between practitioners concerning both the indications for hysterectomy and the efficacy of the different forms of the procedure (see box, page 38).

In particular, research indicates that there are marked regional differences in hysterectomy rates which can not be reasonably explained by variations in women's reproductive hcalth[51], suggesting that hysterectomy rates have much todo with individual practice stylcs.[52] Given this, it is critical that women are able to exercise informed choice about the procedure.

	STRATEGIES checkLut
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	4. Information & resource development
✓	5. Advice & consultation
✓	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

GETTING THE INFORMATION ACROSS

Consequent!y, Healthsharing Women has alerted women to the problems associated with hysterectomy in Victoria and made information available to assist them in decision making. This has taken place through avenues such as the Healthsharing Women newsletter, in which the findings of research or any new information emerging from the monitoring of clinical practice have been reported. Healthsharing Women also researched and produced an information sheet on the management of fibroids, a condition for which hysterectomy is often recommended. This publication included information on various approaches to dealing with fibroids and hysterectomy, from mutual support and naturopathy to the techniques offered by conventional medical practice.

SUPPORTING WOMEN TO SUPPORT WOlVlEN

Healthsharing Women has also supported the development of the Hysterectomy Support Group-· providing information, administrative support and acting as a source of referral. The group enables women to support one another and provides them with a forum through which they can take action on issues of concern. Healthsharing Women's relationship with the support group provides the agency with a valuable source of information regarding the experiences and needs of women facing or undergoing hysterectomy.

TAKING THE INITIATIVE FOR CHANGE

It soon became apparent to Healthsharing Women that, as well as reacting to women's immediate requirements for information and support, there was a need to take the initiative in the area of gynaecological care by attempting to address the causes of some of the problems experienced by women at their source; that is, in the attitudes and practices of health care providers. The Service has done this in a number of ways, some examples of which are described below.

MONITORING CURRENT PRACTICE

Documenting the experiences of women contacting the Service provided little known information about actual practice in the management of those conditions for which hysterectomy is often recommended, and about the efficacy of various treatments and approaches. In the Australian health care system, management is a matter between the woman and her practitioner, with very little overall monitoring, recording, research and evaluation taking place. The information collected by Healthsharing Women has been invaluable in alerting those involved in the delivery of gynaecology services to the problems women experience with hysterectomy.

IN THE MONTH OF OCTOBER, 1992 HEALTHSHARING WOMEN DIRECTLY ASSISTED 345 PEOPLE - 294 THROUGH ITS TELEPHONE INFORMATION AND LIBRARY RESOURCE SERVICE.

H S W ALSO PROVIDED HEALTH PROMOTION SERVICES TO *45* PEOPLE, AND RAN 19 TRAINING SESSIONS FOR OTHER HEALTH WORKERS I'VOLvTNG 169 INDIVIDUALS.

WO?vlEN FROM NON-ENGLISH SPEAKING BACKGROUNDS

Aware that very little was known about the experiences of women from non-English speaking backgrounds and hysterectomy, the Service commissioned a major piece of research exploring the issue of hysterectomy with women of Turkish, Vietnamese, Latin American and Greek origin. This research, *Non-English Speaking Background Women's Experience of Hysterectomy* is significant both for its findings and for its innovative approach to obtaining information about an issue

by JuJitb Rodriguafrom 'Women and Surgery 1990 Conference Proceeding.1 'produced by Health.1baring Women

ABOUT HYSTERECTOMY

WHY A HYSTERECTOMY?

Hysterectomy may be performed for a number of life threatening conditions such as invasive cancer of the reproductive organs, or severe and uncontrollable infection or bleeding. Hysterectomy may also be used to treat other conditions which place women at high risk of a life threatening disease (for example, pre-cancerous changes of the endometrium); or which are severe enough to be debilitating (for example, extensive fibroid tumours causing profuse bleeding).

Debate continues about the use of hysterectomy for a range of other disorders, many of which can often be treated with alternative therapies which are both cheaper and more effective. These conditions include small fibroids, pelvic congestion and mild dysfunctional uterine bleeding. American studies indicate that between 30 to 50% of hysterectomies performed in that country are unnecessary and a further 10% could be avoided by the use of alternative therapies[53].

WHAT DOES HYSTERECTOMY INVOLVE?

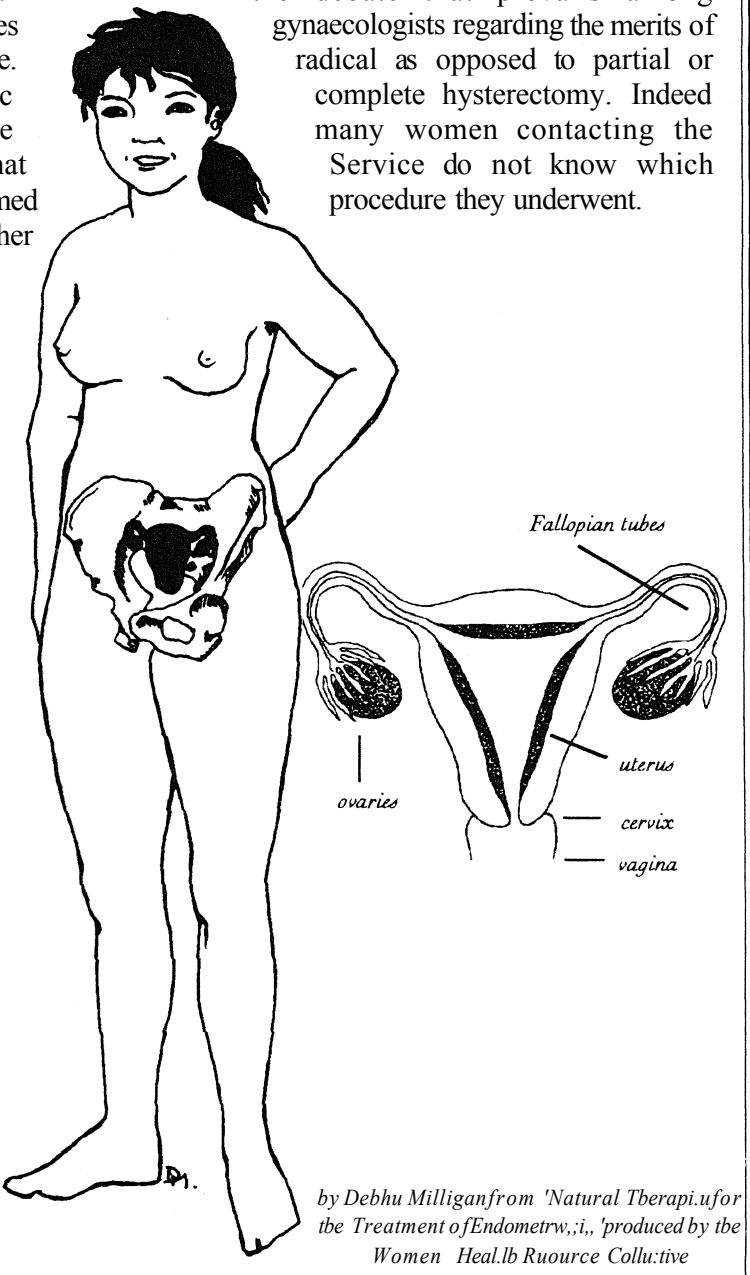
There are a number of different hysterectomy procedures including:

- total or complete hysterectomy, involving the removal of the uterus and cervix, leaving the Fallopian tubes and ovaries;
- partial hysterectomy, where the cervix and stump of the uterus remain; and
- radical hysterectomy, involving the removal of the uterus, cervix, Fallopian tubes and both ovaries (oophorectomy)

Many surgeons routinely perform oophorectomy (removal of the ovaries) for women over the age of 45 at the time of the hysterectomy, whether or not signs of disease are present. This has been done in the belief that it reduces women's ovarian cancer risk. Advocates of this approach argue that women can replace ovarian function by taking Hormone Replacement Therapy (HRT).

However oophorectomy as part of hysterectomy procedure has been a controversial practice because it upsets the hormonal balance of both menopausal and pre-menopausal women. This in turn exposes women to the risks of circulatory disease, premature osteoporosis and sudden menopause. Hormone therapy, it is argued, is a poor substitute for natural ovarian function as it carries its own health risks (for example, a possible increase in the breast cancer risk)[54].

Calls to Health.sharing Women suggest that many practitioners do not explain the different forms of hysterectomy to women nor draw their attention to the debate that prevails among gynaecologists regarding the merits of radical as opposed to partial or complete hysterectomy. Indeed many women contacting the Service do not know which procedure they underwent.



by Debhu Milliganfrom 'Natural Tberapi.ufor tbe Treatment ofEndometrw,;i,, 'produced by tbe Women Heal.lb Ruource Collu:tive

Related Program Activities

A Women's Informed Consent Action Group was established in association with the Women's Health Service for the West. The group addresses the issue of informed consent, particularly in relation to gynaecology and obstetrics.

The Outer East Women's Health Service has developed a workshop series on sexual and reproductive health which includes sessions on contraception, birthing choices, hysterectomy and menopause.

which for many women is highly sensitive and personal. The research, first presented in 1990 to gynaecologists and other health practitioners and subsequently published, is the first addressing the issues of hysterectomy and ethnicity in Australia.

WORKING WITH THE SCHOOLS OF MEDICINE

In 1990 the Monash University School of Medicine made a commitment to review and revise its curriculum for undergraduate medical students. Input from Healthsharing Women on those aspects of the curriculum relating to women's health was invited. Material is now included in the undergraduate medical curriculum to enhance practitioner's skills in promoting informed choice and in understanding and responding sensitively to women's health issues. Healthsharing Women anticipate that this will have a positive impact on the ways in which new medical graduates work with women facing the prospect of a hysterectomy.

THE WOMEN AND SURGERY CONFERENCE

Hysterectomy was addressed at the Women and Surgery Conference held by Healthsharing Women in 1990, in the Melbourne University's School of Medicine. The conference was attended by over 360 people from across Australia and overseas and provided an opportunity for women to raise their concerns in a forum that included general practitioners, nurses, gynaecologists, psychologists, academics, health activists, and policy makers. A paper on hysterectomy was presented by a group of women gynaecologists which, together with other papers, opened debate on the issues around which there is a lack of consensus.

BRINGING WOMEN AND HEALTH CARE PROVIDERS TOGETHER

Healthsharing Women holds regular research forums on women's health issues. The forums encourage people to look critically at issues arising in research, to give information to those involved in women's health care and to generate new knowledge, promote debate and mutual understanding and facilitate the cross fertilisation of ideas. They generally involve women from the community, policy makers, service providers, general and specialist practitioners. Specific research in relation to hysterectomy was presented at one such forum, provoking energetic discussion. The forum was organised in cooperation with the College of Obstetrics and Gynaecology and attended by College members, providing a link between the college and the experiences and concerns of women.

IMPACTS

It is apparent from both the Australian and international research that for a very large proportion of women for whom hysterectomy is recommended, a less invasive procedure and even no surgery at all, is actually required (see box, page 38). Unnecessary surgery occurs at great expense not only to the individual women who must cope with its physical and emotional consequences, but also to the health system.

Healthsharing Women has made a significant contribution to reducing these personal and economic costs, by facilitating a better understanding and a greater consensus between women and the various health care providers involved, and by promoting women's capacity to exercise informed choice in relation to hysterectomy.

PARTICIPATION AND EQUITY: THE KEY TO GOOD HEALTH

Women;, Health Servicefor the Weclt

ONE OF THE PARTICULAR ACHIEVEMENTS OF THE VICTORIAN WOMEN'S HEALTH SERVICES PROGRAM IS THE WORK IT HAS DONE WITH WOMEN OFTEN PERCEIVED BY MAJ;,JSTREA..'M HEALTH SERVICES AS 'HARD TO REACH' (FOR EXA.'MU'LE, YOUNG WOMEN, WOMEN FROM),'ON-ENGLISH SPEAKING BACKGROUNDS, AND WOMEN WITH DISABILITIES). THIS CASE STUDY LOOKS AT HOW ONE SERVICE WORKED WITH WOMEN WITH DISABILITIES TO ASSIST THEM IN ADDRESSING BARRIERS TO HAVING p AP TESTS.

MORE THAN A WORLD FIRST IN PAP TEST EDUCATION

TheWomen'sHealthServicefortheWest(WHSFTW) has supported the development of a support group for women with disabilities (see box, page 42). During 1991 members of the group approached WHSFTW staff and committee members about the difficulties they were experiencing in having Pap tests at local health services and in accessing information about cervical screening that was relevant to their particular needs.

The WHSFTW made a commitment to address this issue. However, it became apparent that there was no educational material which could be used by the Service that addressed the specific needs of women with disabilities. Members of the disability support group reported that while existing material tended to have an emphasis on the physiological aspects of the Pap test, they required information on how they could negotiate the process of having a test and about alternative positions in which the test could be taken. This was important for some women as their disability prevented them from assuming the conventional supine position (see box, page 43).

Women with intellectual disabilities suggested that existing information was presented in a way which could not be readily understood by them. This meant that these women were having Pap tests without comprehending what the test entailed (raising issues with regard to informed consent) or were not having tests because they were unaware of their importance.

DAlvL'JED IF YOC DO... DAMl'\ED IF YOC DON'T

Members of the support group also reported that their past attempts to have Pap tests had been problematic, with very few doctors being aware of the different techniques involved in taking tests for women with disabilities. Pap tests are particularly important for women once they have started having sexual intercourse (see box, page 43). While some doctors were more than keen to give disabled women Pap smears assuming them to be promiscuous, others resisted offering the test, believing that disabled women tended not to be sexually active. The reality is that the sexual practices of women with disabilities are as variable as those of other women.

	STRATEGIES check!ut
✓	I. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	4. Information & resource development
✓	5. Advice & consultation
✓	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

A CO-OPERATIVE VENTURE

Accordingly, it was agreed that the Service should make a video which would be of use to students of nursing and medicine, to service providers, and to women, particularly those with disabilities. A working group was fonned comprising representatives of the support group, the WHSFTW, the Melbourne University Department of Community Medicine, the Family Planning Centre, the Department of Health and Community Services Victoria and the Centre for Social Health.

Members of the support group were directly involved in researching, writing and editing the script and shared the task of acting in the video with professional actors. Their involvement in this capacity was important, since women in the group reported that they often found portrayals of disabled women in conventional media unrealistic and difficult to identify with.

USING WOMEN'S DAY-TO-DAY EXPERIENCE TO CHANGE MEDICAL EDUCATION

Through the involvement of women from the support group, the project was able to develop techniques for taking Pap tests from women with different forms of disability and documeflt these on the video. This new material will be incorporated into the undergraduate medical courses of both University Schools of Medicine and into the Family Planning Association's Nurse Practitioner Course.

Similarly, the video will be used by intellectual disability services to help increase understanding about Pap tests and to ensure that women make informed decisions about the procedure. Consequently, the project will have a positive impact for thousands of women who will have contact with service providers of the future.

THE WHSFTW's succESs IN TARGETING WOMEN MOST IN NEED OF HEALTH SERVICES IS ILLUSTRATED BY THE FACT THAT THREE QUARTERS OF WOMEN WHO USE RESOURCES AT THE CENTRE ARE WOMEN FROM NON-ENGLISH SPEAKING BACKGROUNDS AND 76% OF WOMEN ARE IN RECEIPT OF A PENSION OR BENEFIT.

91% OF THOSE WOMEN PARTICIPATING IN THE CENTRE'S HEALTH EDUCATION AND PROMOTION PROGRAMS IN THE COMMUNITY ARE WOMEN FROM A NESB AND 60% ARE IN RECEIPT OF A PENSION OR BENEFIT.

These achievements would not have been possible without the involvement of key organisations on the working group (for example, the Schools of Medicine). Members of the group were familiar with the processes of change in their own organisations and were able to advise the WHSFTW on approaches that would be relevant and acceptable to their respective professions. Importantly, the involvement of the various groups in the project and their commitment to it, meant that they had an investment in making sure that its impact was felt.

ADVOCACY

Through their involvement in the video the working group became aware that women who were housebound by their disability faced particular problems in having pap tests. Consequently, the Service negotiated with the Royal District Nursing Service to have several of its nurses undertake the WHSFTW's nurse practitioner course so they could provide Pap tests to women in their own homes.

Related Program Activities

Babies: It's Our Choice is a booklet produced by the Women's Health Resource Collective and the Family Planning Association for women with intellectual disabilities. It depicts a woman on a personal journey, reflecting on the possibility of having children.

The Loddon Campaspe Women's Health Service devised, with local community services, a workshop program entitled *Me, Myself a Woman* which explores the area of sexuality, self-esteem and relationships for disabled women. The Service is co-producing a training kit, with the Women's Health Resource Collective, based on the program.

It was also discovered that there was no medical service in the western region with the facilities to provide Pap tests to women whose disability is such that they are confined to a wheel chair (see box, page 43). This is an issue which the support group has asked its steering committee to raise as part of a new project involving working with services to promote their accessibility to women with disabilities.

members of the support group. Their involvement has contributed to improved self esteem and confidence and has enabled them to develop research and production skills. The pivotal role played by the group provided opportunities for the development of leadership skills. Significantly, this project serves as a positive model for other women with disabilities. The video was jointly funded by the WHSW, the

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Critical to the success of the video and peer support program was the existence of a group of women with the experience of a disability, a knowledge of its impact in the experience of using health services, and the skills and confidence to work with providers and other disabled women.

The support group's strength was due to the extensive ground work which had been undertaken by the Women's Health Service for the West (WHSFTW) since its inception. As part of an affirmative action strategy, which also targets other groups of women, a position is designated on the committee of management of the service for women with disabilities. The service's first representative of disabled women was also from a non- English speaking background. She served on the committee for its first four years of operation. Through her participation she acquired knowledge and skills which made her a confident advocate of the needs of women with disabilities in other service and community contexts. She ultimately gained employment in the ethnic disabilities field.

BROADENING THE INFLUENCE OF WOMEN WITH DISABILITIES

With the help of this individual, staff of the WHSFTW developed a broad consultative process to establish a support group for disabled women. The establishment of the group involved extensive negotiations with institutions and community based services who were sometimes reluctant to commit the resources needed to facilitate women's involvement (for example, by providing an attendant to travel to the group where required). The Service's effective negotiations and the subsequent success of the group will hopefully set a precedent for similar activities by other organisations.
While initially the group provided assertiveness training for women with disabilities, its role has now broadened to include health education and discussion, personal development, recreational activities and skills development. It is supported by a steering group involving representatives from the WHSFTW, the support group itself and a local disability rights agency. Its aim is to promote the group's skills in self-management and to acquire resources to ensure its ongoing survival.

As well as meeting the needs of its members, the group has played a critical role in ensuring that the WHSFTW's general activities include planning and attention to the special needs of women with disabilities. As the Pap test projects described in this case study indicate, the group has also been directly involved in developing programs specifically targeted to women with disabilities.

The video *Paps I Should,* is the first of its kind in the world. It will have a market, and therefore an impact, both nationally and internationally. While it is the tangible product of this project, its legacy can be seen in the development of new techniques for taking Pap tests from disabled women; in the education of medical and nurse practitioners; and in the delivery of services to women who are housebound. It can also be seen in the sense of pride and achievement experienced by

Health Promotion Foundation and the Department of Health and Community Services.

WOMAN TO WOMAN: PEER EDUCATION IN PREVENTING CERVICAL CANCER

Broad-scale education programs aimed at encouraging Pap tests have had only limited success in reaching women with disabilities (see box, page 43).

Consequently, the WHSFTW saw the need to look at other ways of getting the message about Pap tests across to women with disabilities.

A targeted approach involving a peer education model appeared to offer some potential. Peer education, pioneered in the Third World, is based on the proven assumption that people are more likely to receive, understand and act on a health message if it is given to them by someone with whom they can identify. Peer educators are believed to have greater empathy with those they are working with and a better understanding of their needs.

In cooperation with the disabilities support group the WHSFTW has developed a six week training course for peer educators, involving material on adult learning methods as well as the technical aspects associated with cancer prevention and the taking of Pap tests. The material developed in the process of producing the video, *Paps I Should,* will be used both in the course for the peer educators and by the peer educators themselves, most of whom are from the support group.

The peer educators will form two teams, one to work with women with intellectual disabilities and the other to work with women with physical disabilities. Women will be coupled together to make the most of their different abilities. The teams will work with women in institutions, community based units and groups in the community. Appropriate arrangements will then be made by the WHSFTW for women who choose to have a Pap test.

At the time of writing, the first peer education training course was coming to an end and it is too early to assess the effectiveness of the model in terms of Pap test rates among disabled women. Nevertheless the indications are that the educators themselves have both the confidence and competence to play their new roles effectively.

What U a Pap t&1t?

The Pap test is a simple test used to detect the early signs of cancer of the cervix. The test, normally taken as part of a general pelvic (internal) examination, involves the insertion of a speculum into the vagina to obtain a small amount of tissue from the cervix. If done properly the test is normally painless, though it may involve some discomfort. The tissue is sent to a pathology laboratory where it is examined with a view to excluding early changes in cells which may lead to cancer of the cervix.

Screening with Pap tests every two years is recommended for all women who have ever been sexually active, generally commencing between the ages of 18 to 20 years and ceasing, in general, at age 70 years.[55] At present, only 50% of cases of cervical cancer are prevented. However, it is believed that this would increase to 90% if all women requiring Pap tests had them at recommended intervals.[56] Studies have shown that cervical screening is particularly poor among women over 50, and rural, Aboriginal and disabled women[57]. Since disabled women represent 15.2% of all women this is a significant concern.[58]

pAP TESTS :'\:\Tl DJSABLED \VO:v\E"\"

A Pap test is usually taken with the woman on her back (the supine position) with the pelvis raised and legs separated. Some women with physical disabili tics, particularly those involving the legs or spinal cords, are unable to assume this position. Women whose disability is such that they are confined to a wheelchair need access to a special hoist which enables them to be lifted from the wheelchair to the medical couch.

REACHING OUT TO WOMEN IN RURAL VICTORIA

Loddon CamptMpe Women d Health SerfJice

ONE OF THE MOST SIGNIFICANT CHALLENGES FACING RURAL WOMEN'S HEALTH SERVICES IS HOW THEY CAN HAVE A MEANINGFUL IMPACT ON THE LIVES OF WOMEN IN RURAL AND REMOTE COMMUNITIES WITHOUT SPREADING THEIR RESOURCES SO THINLY THAT THEY BECOME INEFFECTUAL. THIS CHALLENGE HAS BEEN SUCCESSFULLY MET BY THE LODDON CAMPASPE WOMEN'S HEALTH SERVICE (LCWHS) IN ITS CAREFULLY PLANNED RURAL OUTREACH PROGRAM.

THE RURAL CHALLENGE

While the LCWHS is located in Bendigo, one of Victoria's provincial cities, the region it serves is large and has many isolated rural towns. One of the first decisions of the committee of management of the Service was that it would commit at least 60% of its resources to working with women outside of the city of Bendigo. During its first years of operation the Service established itself and developed relationships with the region's major health and community services, most of which are located in Bendigo. However by 1991, it was ready to embark on the challenging task of providing programs to the region's outer-lying towns.

CONSTRAINTS

In its planning, the committee was conscious of a number of factors. First, the Service simply did not have the resources to reach every town in the region. Accordingly, there was a need to select a limited number of towns, work within these for a period of time, and then move on to other locations in the region. Second, any service delivery model needed to keep worker travel to a minimum, since this would be expensive to the Service in terms of staff time. The distances between the Service's Bendigo base and potential service locations were great. Finally, given that the Service could not afford to work indefinitely in any one town, it was important that it developed programs and ways of working that would have a lasting impact.

OUTREACH

The Service determined that the most resource-effective way of serving rural towns would be to appoint workers who resided in or near the towns themselves since they would have an existing knowledge of the town and its networks. Further, unlike workers employed at the LCWHS's Bendigo base, they would not need to spend large amounts of time, that could otherwise be spent developing programs, travelling to the communities they served.

	STRATEGIES checlcLiJt
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
	4. Information & resource development
	5. Advice & consultation
✓	6. Promoting women's participation
	7. Training health professionals
✓	8. Joint ventures

OVER *4000* WOMEN USED THE PROGRAMS AND SERVICES OF THE LODDON CAMPASPE WOMEN'S HEALTH SERVICE IN 1992.

OVER 750 WOMEN RECEIVE THE NEWSLETTER OF THE LODDON CAMPASPE WOMEN'S HEALTH SERVICE.

The role of the locally based workers would be to develop the foundations for the delivery of a women's health program. This would include raising the profile of women's health issues, establishing an advisory group of local women and developing links with local service providers. The worker would then have the task of working with local women to develop programs which could be provided either by workers from the LCWHS or by other health care providers in the region. The rural outreach workers would be supported by a worker at the LCWHS whose role it would be to coordinate the program.

The Service selected three towns to work in over a two year period, each for 19 hours (two and a half days) a week. These were Dunolly, Tarnagulla, Boort and Cohuna. Premises were negotiated in existing community service locations. For example in Dunolly the local Maternal and Child Health Service was used. Advisory groups, involving local women and service providers, were established in all three towns.

SKILLS FOR LOCAL WOMEN

While the work of the LCWHS has varied from town to town there has been an emphasis on projects with the potential for lasting effect. For example, in Cohuna women identified a particular need for relaxation classes. The Service provided an initial series of sessions and then offered a training program for women in the town keen to learn how to provide the classes themselves. The success of this approach has meant that Cohuna will have access to skilled relaxation instructors long after the LCWHS has moved to other towns in the region. In Boort, the program supported the development of a group aimed at sharing ideas on managing on a low income. Called *More Dash than Cash,* this group now has a life which is independent of the women's health project. The time devoted to the development of the advisory groups for each of the programs has paid similar dividends. Two of the three groups still exist and continue working toward maintaining the profile of women's health issues in their towns.

JOINT VENTURES

There has also been a particular emphasis on joint ventures with local health services. For example, the Dunolly hospital provided the booking service and some medical equipment for the women's health sessions in that town (see box, page 46). As well as being cost effective, this enabled the Service to establish links with the hospital and raise the profile of women's health issues within it. Each of the three programs has established close links with local health care providers (for example, General Practitioners) and has depended on these people for advice and support. Sound relationships have also been developed with local community networks, including schools and bowling clubs. These connections have proved invaluable in helping the programs to gain acceptance in rural towns.

ADVOCATING WOMEN'S NEEDS

The programs have played a significant role in working with women to resolve problems in the provision of local health services. For example, in one of the towns the program negotiated with the local medical practice to purchase a screen for its surgery, as women experienced embarrassment undressing in the presence of a male doctor.

THE FUTURE

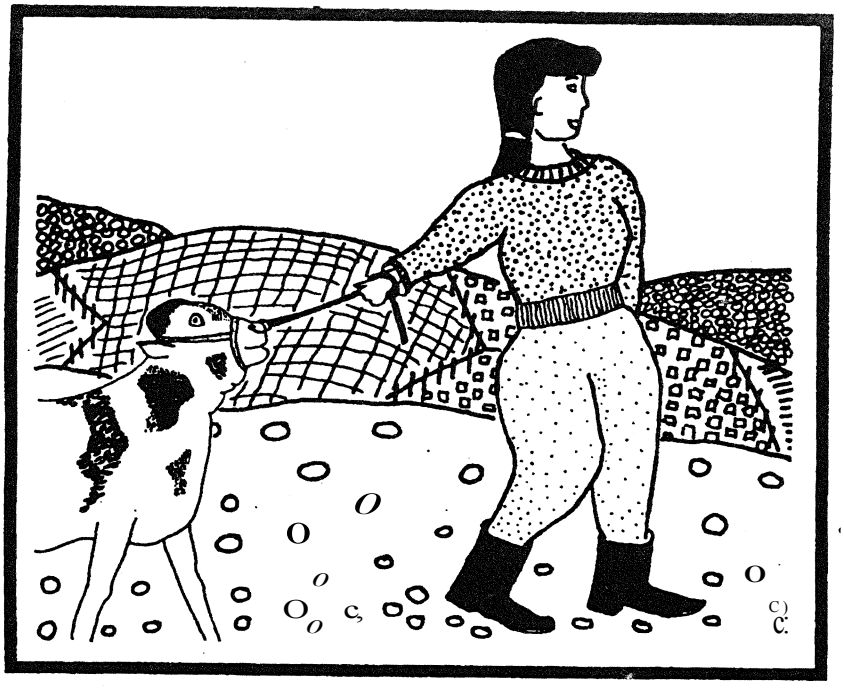
The rural outreach program will move to two new towns in the coming year: Rochester and Kyneton. These towns will benefit from the Service's past experience. For instance, workertime will be increased

Related service activities

An outreach service was provided by the Barwon and South Western Women's Health Service to meet the needs of women in the South Western sub-region. Advice, support and networking resulted in workshops on menopause, young women's health and older women's issues.

Wellcoming Women's Health Service, based in Horsham and Ballarat, facilitated a variety of programs for women living on farms in order to alleviate the women's isolation, reduced incomes and lack of access to services.

A COOPERATIVE SUCCESS IN DUNOLLY



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In the consultation to establish the Loddon Campaspe Women's Health Service (LCWHS), women identified a need for access to a service providing basic women's health care (for example, Breast Self Examination and Pap tests) and delivered by a doctor, preferably female, who does not reside locally. This confirmed research regarding Pap tests which indicates that rural women resist attending local doctors for gynaecological care because of the lack of anonymity. Consequently this group of women is poorly screened[59]. In abid to respond to this concern, the Dunolly women's health program entered ajoint venture with the local GP, a woman general practitioner in a neighbouring town, the Maryborough Community Health Centre (MCHC) and the Dunolly Hospital to run a series of women's health sessions in the town.

The sessions were promoted through local community networks (for example, schools and sporting clubs) and through the local newspaper. The local general practitioner also encouraged women to attend. The sessions were provided by community health nurses from the LCWHS and the MCHC and offered information and advice about a range of women's health issues. Pap tests and breast examination were provided, with women's choice of either a man or woman doctor. Women attending the sessions were given a 'Women's Health Package' developed by the LCWHS containing information on a range of issues from breast and cervical cancer to emotional health.

AN OBVIOUS IMPACT

The Hospital provided the booking service, while equipment and medical consumables were contributed jointly by the Hospital and LCWHS. The program was successful in attracting many women from Dunolly. Of those attending, 82% were over40 years, the age group in which women are typically under screened. 70% had not had a Pap test in the previous two years. Feedback on the service was overwhelmingly positive with 72 % of women reporting that they attended the service because it was provided by a woman doctor. 70% of the women said that they would prefer to have their next Pap test at a special clinic.

from two and a half to three days per week, there will be greater liaison between the rural workers and the LCWHS in Bendigo, and rural advisory committees will be established prior to the employment of workers to enhance local ownership of the project.

Health and community services have long been criticised by rural people for their half-hearted and piecemeal attempts to serve Victoria's rural and remote areas. The LCWHS has pioneered a model of service delivery which provides a meaningful service to rural communities without compromising the viability and identity of the Service as a whole. While the LCWHS rural outreach program will be moved to other locations in the region this year, the effects of its work in Dunolly! f arnagulla, Boo rt and Cohuna will be felt for some time to come.

MORE THAN A HEALTH AND SUPPORT SERVICE FOR WOMEN

Outer EMt Women d Health Serrice

IN THE CONSULTATION CONDUCTED TO ESTABLISH THE OUTER EAST WOMEN'S HEALTH SERVICE (QEWHS) THE LACK OF DIRECT MEDICAL, COUNSELLING AND SUPPORT SERVICES IN THE REGION EMERGED AS A lAJOR ISSUE. WOMEN REPORTED THAT THOSE SERVICES WHICH DID EXIST WERE OFTEN BEYOND THEIR LIMITED FINANCIAL MEAJ\S OR DID NOT RESPOND SENSITIVELY AND APPROPRIATELY TO THEIR NEEDS.

DIRECT SERVICE A MAJOR ISSUE IN THE EASTERN SUBURBS

While access to affordable and responsive direct services was an issue which the Service had to address as its first priority, certain factors required consideration. First, limited resources were available. The OEWHS serves a very large and populous region in which women have different and often competing demands. These range from those of women in the suburbs of Ringwood and Croydon to the needs of women residing in the semi-rural towns of Sherbrooke, Upper Yarra and Healesville. Limited staffing meant that it was important the Service developed programs designed to have the maximum impact for the largest number of women. Second, the Service was aware that resource limitations would prevent the provision of direct medical, counselling and support services to all women in the region. Accordingly, strategies for ensuring that existing services become more responsive to the health needs of women were needed. Finally, while women in the consultation identified a range of legitimate needs (for example, financial and marital counselling), the Service was aware of the need to maintain its focus on the particular health concerns of women[1].

MEETING THE CHALLENGE

The Service has attempted to meet these challenges in a number of ways. In addition to working with individual women, the OEWHS has placed an emphasis on developing group programs. This has included the establishment of support groups around specific issues such as anger management, self-esteem, mid-life and family violence. It has also involved delivering health education programs concerned with issues including breast and cervical health, menopause, sexually transmitted diseases, and osteoporosis. Group work is a resource-effective way of reaching a large number of women, and can reap benefits by promoting supportive relationships between women which persist well beyond the life of the group itself.

GROUPS

Some of the groups have been established by, and sometimes at, the Service while others have been delivered on organisation's requests such as the Young Women's Christian Association and at venues such as neighbourhood houses, schools, Technical and Further Education (TAFE) colleges and community health centres. An outreach service operates one day a week from the Upper Yarra Community House.

Many of the groups are run cooperatively with health and support services in the region so that other workers

	STRATEGIES checlcLi:Jt
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
	4. Information & resource development
	5. Advice & consultation
	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

Related Program Activities

Direct service provision which includes counselling, medical care, massage and a well women's clinic is also provided by the Barwon Women's Health Service.

The Women's Health Care Delivery In General Practice Project is overseen by Healthsharing Women and auspiced by the Royal Australasian College of General Practitioners. It aims to improve the level of health care delivered to women by general practitioners.

involved in the programs will acquire skills and ideas that will enable them to continue to offer the program on an ongoing basis from their own agencies. In this way the impact of the Service is ongoing and reaches a large number of women.

WOMEN'S HEALTH INFORMATION SERVICE

The Service provides a counselling, information and referral facility which is staffed during business hours and provides assistance to women visiting the Service and over the phone. The Service's experience in the region is such that it has extensive knowledge of counsellors and health care providers with particular skills in delivering services to women. Consequently it is able to make informed and appropriate referral to a range of organisations.

A problem identified by local women is lack of access to information to assist in making informed choices and to take some responsibility for their health. The Service has an extensive library containing up-to-date information on a wide range of health issues. Women from the region are welcome to 'drop in' to use the library and to consult with workers at the Service.

COUNSELLING

The Women's Health Service initially responded to the demand for counselling services by researching and developing a comprehensive list of counsellors skilled in and committed to working with women so that, where appropriate, women could be referred to their nearest provider. However, it soon became apparent that in many localities there were simply no suitably qualified counsellors. Accordingly, the Service has taken steps to attract skilled counsellors to rent rooms and work from the Service's premises.

Counselling is also provided by the Service itself to women who are unable to meet the cost of a private counsellor or who, for other reasons, cannot access counselling services in the region. Counselling is provided around a range of women's health issues including domestic violence, eating disorders, sexual health and incest.

WELL WOMEN'S CLINIC

More recently, the Service has established a 'well women's clinic' provided on a sessional basis. The clinic is not a general medical practice, but rather specialises in women's health issues such as menopause, reproductive health and sexuality. The Service receives referrals from general practices in the community and, with the consent of women, liaises with and ultimately refers back to the family doctor. A number of features of this service distinguish it from many mainstream medical practices.

Significantly it has a holistic view of health, taking account of the range of factors contributing to a woman's sense of well-being including her physiology, her emotions, her material well being, her work and social life, and her family and personal relationships. This view pervades all other aspects of the Service.

Many of the issues women bring involve not only their physical health, but also those associated with their personal relationships, sexuality or emotional well-being. The Service's experience is that a standard consultation is seldom long enough to deal adequately with these complex issues. Therefore extended appointment times are scheduled where appropriate.

Women are able to consult with either a doctor or community health nurse or both. This means that they have access to the counselling and support skills of the community health nurse as well as to the doctor's medical skills and knowledge. The Service has found that often women feel comfortable talking to nurses, particularly about issues involving relationships, sexuality and gynaecological health. Further, the doctor/nurse team represents a cost effective way of delivering the service.

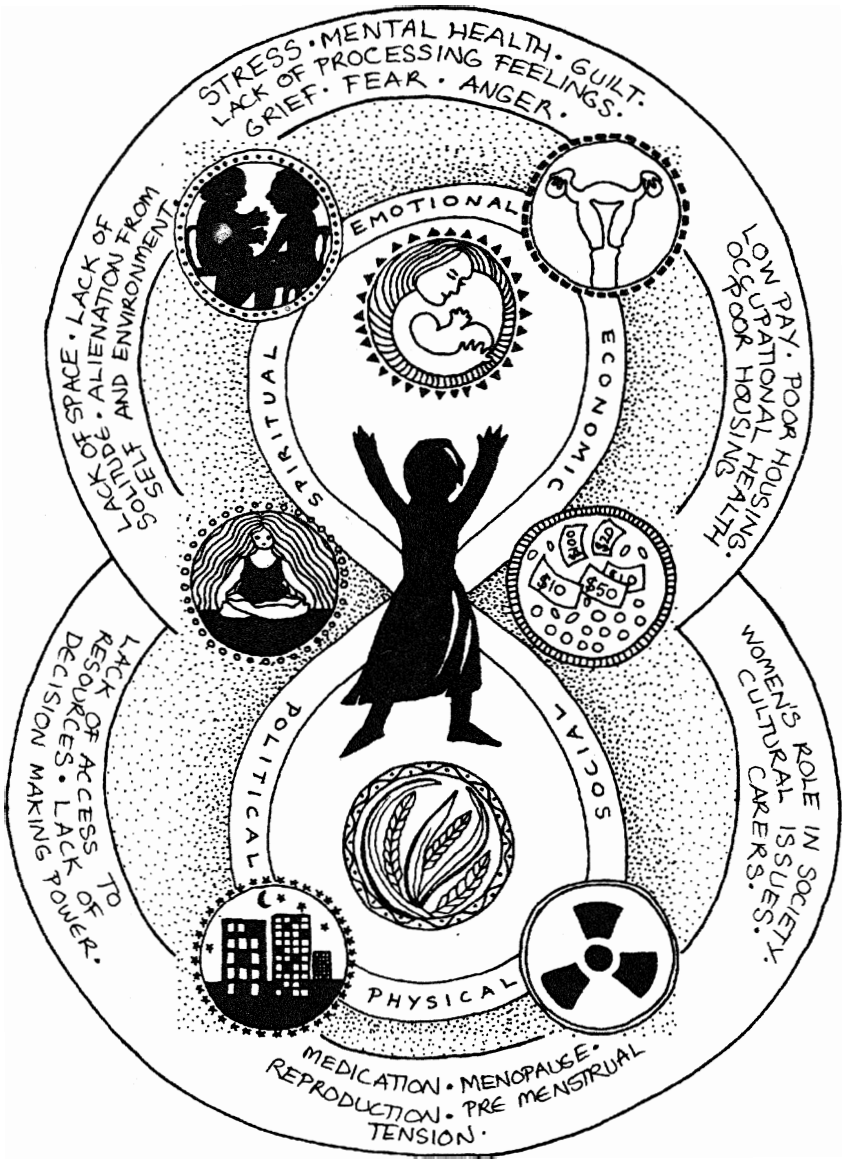
Women attending the clinic can also gain access to other resources available at the OEWHS including a referral network specifically attuned to their needs, the extensive resource library, and groups and health education programs offered by the Service. Where required, women can also be referred for counselling for more complex issues to Service staff. This team approach ensures that continuity of care is maintained.

Most importantly women who use the Service can be sure that they will be consulting with women medical and nursing staff who have a keen interest in women's health, who have undertaken relevant further study, and who are primarily committed to working with women to address their health needs.

FINDING BROADER SOLUTIONS

The Service's experience in working with women has meant that it has gained a wealth of practical wisdom and developed new and different ways of responding to women's needs. This experience is carefully documented and forms the basis of in-service programs run by the Service for other health workers in the region. This in turn enhances the capacity of these services to respond sensitively and appropriately to women's health needs, again broadening the impact of the Service.

The Service's day to day experience in working with women has enabled it to monitor trends and issues in women's health care and to use this knowledge to influence government regional planning



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processes. This is illustrated by the Service's part1Cipation in the development of the *Discussion Strategy Paper: Health Services for Women in the North Eastern Metropolitan Region, 1992* (Health Department Victoria). The paper identifies key issues of concern to women in the region and recommends strategies to address these.

In some instances the problems brought to the Service by women require action beyond the regional level. For instance there may be a lack of written material on an issue or women's concerns may need to be raised with a government department, regulatory body, or professional association. In instances where these issues could be better addressed at a statewide level, the Service brings them to the attention of the Women's Health Resource Collective and Healthsharing Women for their consideration.

SHARING THE LOAD OF CARING

WeLlco,ning Women d Health SerJJice

THE HEALTH NEEDS OF WOMEN AS CARERS IS ONE OF THE SEVEN PRIORITY ISSUES IDENTIFIED IN THE NATIONAL WOMEN'S HEALTH POLICY. T m s CASE STUDY SHOWS HOW ONE WOMEN'S HEALTH SERVICE IS WORKING WITH A GROUP OF WOMEN WHOSE ISOLATIO:'\ AS CARERS IS COMPOUNDED BY THE FACT THAT THEY L N E IN OUTLYING RURAL AREAS.

The responsibility of caring for someone who is aged or who has a disability can be a 'labour oflove' in the best of circumstances. Carers often report that they gain a great deal of satisfaction from having their loved ones at home where they are able to maintain a relationship and give the best possible care in a familiar environment At the same time, caring can be a stressful and isolating experience, particularly if the person being cared for requires intensive 'around the clock' support.[61] In some cases carers have not made the choice to care, but have had the responsibility thrust upon them. Many carers provide single-handedly, and on an unpaid basis in theirown homes, what would otherwise be provided by a number of paid staff in an institution or community residential unit

CARJNG: A WOMEN'S HEALTH ISSUE

The stresses of caring are evident in research which indicates that carers suffer relatively poor health.[62] The National Women's Health Policy argues that caring is essentially a women's issue, with women continuing to bear the major responsibility for this task.[63] The health needs of women as carers is identified as one of the seven priority health issues in the policy.

In the consultation conducted to establish the Wellcoming Women's Health Service in the Central Highlands Wimmera region, the health needs of women as carers similarly emerged as a significant issue of concern. Women in the region argued that for them, the isolation often associated with caring was compounded by geographic isolation. Neighbours do not live close enough to be relied upon for social contact, support and relief, and the lack of public transport in rural Victoria limits mobility to access support from distant friends and relatives or from services in the provincial cities. For many women, their caring responsibilities exacerbate the pressures already involved in running a farm and household. Added to these problems is the lack of community suppon services available in rural areas.

RURAL CONCERNS

Accordingly, Wellcoming Women's Health Service committed itself to a project addressing the health needs of women as carers. Like the Loddon Campaspe Women's Health Service, Wellcoming was aware of the disenchantment many rural communities felt with health and community services that served the provincial cities, at the expense of outer-lying areas. It was agreed that the project would be targeted to residents outside of Ballarat. An area comprising the localities of Avoca, Ballan, Beaufort, Bungaree, Creswick, Clunes, Daylesford, Glenlyon, Learmonth, Lexton, Linton, Smythesdale, Scarsdale and Waubra was chosen.

	STRATEGIES check!ic1t
	1. Exploring & modelling new approaches
✓	2. .I\'lonitoring women's health issues
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	.5. Advice & consultation
✓	6. Promoting women's participation
	7. Training health professionals
✓	8. Joint ventures

6100 WOMEN HAVE USED THE WELLCOMING WOMEN'S HEALTH SERVICE SINCE IT OPENED IN 1991.

THE NUMBER OF WOMEN USING THE WELLCOMING WOMEN'S HEALTH SERVICE IS INCREASING AS THE SERVICE BECOMES ESTABLISHED AND BETTER KNOWN IN THE REGION. IN 1991, WELLCOMING ASSISTED AN AVERAGE OF 300 WOMEN EACH MONTH. BY 1992 THIS HAD INCREASED TO 500 WOMEN PER MONTH.

DEFINING AND DOCUMENTING NEEDS

The Service decided that it was critical to establish an accurate understanding of the issues, particularly as experienced by carers themselves. Although there has been some recent research on the issues of caring generally, very litte is known about the specific concerns of women carers in rural and isolated areas. The Service began conducting research involving interviews with both carers and other health workers. The findings will be presented in a report which will assist the Service in planning future stages of the project and will be an important piece of Australian research. It will provide a resource for health planners and policy makers and for other service providers.

INVOLVING WOMEN CARERS

The Service identified the need to establish contact with carers and to bring them together. It was decided to form a support network to provide women with opportunities for mutual support and a means for women carers themselves to determine how issues should be addressed. This is a similar process to that used by the Women's Health Service for the West in its work with women with disabilities - an approach which was ultimately to pay healthy dividends in the form of innovative and meaningful outcomes for women using that service (see page 40).

Establishing a support network has been a particular chalenge for Wellcoming as potential members arc, by definition, isolated and often do not have connections in the community. To contact women, the S e rĭce has had to make extensive use oflocal media and informal community networks.

The support network is well established, having a membership of some 52 carers who have been meeting regularly for over six months. The research is near completion. Through the project, Wellcoming aims to ensure that women carers have information about community supports and entitlements; to provide support and training to rural health care providers who work with carers; to address any problems carers have in accessing community supports (for example, respite care); and to raise the status of women as carers. A number of ways of achieving these aims are currently being considered by the Service including:

- meetings by 'tele-link' i.e. meetings of the network held over the telephone;
- a carers weekend camp;
- a travelling 'expo' or show taking health services and information to the outlying towns; and
- coffee mornings.

Related Program Activities

WOMEN'S HEALTH IN THE SOUTH EAST AND THE WOMEN'S HEALTH RESOURCE COLLECTIVE ARE GENERATING A *WOMEN AS CARERS* RESOURCE WITH THE DUAL PURPOSE OF PROVIDING INFORMATION TO CARERS AND PROVIDERS.

While it is too early to assess the effectiveness of the project in meeting all ofits aims, staffhave established sound contacts with local health care providers and with statewide carers networks. As project staff have made contact with women, in the process ofconducting their research and forming the support group, they have provided information to them about services and other community supports. The high profile of the project in the community and local media to date has had a positive impact in raising awareness of the issues of concern to women in their roles as carers.

hy Shannon &rriganfrom Lo'J'Jon Campa,,pe Women!, Heali.h Service New,1/.eller, 1992

UNCOVERING WOMEN'S NEEDS

North Ealt Womend Health Serrice

ADDRESSING THE HEALTH NEEDS OF WOMEN FROM NON-ENGLISH SPEAKING BACKGROUNDS (NESB) IS THE SPECIAL FOCUS OF THE NORTH EAST WOMEN'S HEALTH SERVICE (NEWHS). THE SERVICE WAS ESTABLISHED AS PART OF THE VICTORIAN WOMEN'S HEALTH PROGRAM AND IN RESPONSE TO NUMEROUS RESEARCH AND CONSULTATION REPORTS WHICH HIGHLIGHTED THE SHORTCOMINGS OF MAINSTREAM HEALTH SERVICE DELIVERY TO WOMEN FROM ETHNIC COMMUNITIES. IN PARTICULAR, NESB WOMEN'S MENTAL AND EMOTIONAL NEEDS WERE FREQUENTLY UNRECOGNISED AND INADEQUATELY PROVIDED FOR.

NESB WOMEN AND MENTAL HEALTH

Data reveals that a disproportionately high number of people from a NESB are admitted to psychiatric institutions. Further examination of admission details shows that a relative! y high number of these admissions involve NESB women who reside in the north east sector. This is especially the case for Greek women. It is also apparent that women caring for psychiatrically ill people are at risk of mental and emotional ill-health due to the inevitable stress and strain resulting from their role as carers.

Given this situation, North East Metropolitan Psychiatric Services and NEWHS prepared a submission for funding to undertake a number of projects to address these issues at two levels. First, they would aim to identify NESB women's needs and, second, they would attempt to increase the responsiveness of a range of mental health and generalist services to NESB women.

A FOCUS ON SPECIAL NEEDS

Accordingly, NEWHS now auspices the following three projects: an Italian Women Carers project; a Greek Women Mental Health Consumers project; and a research study to identify issues related to NESB women's use of community based mental health services.

The Italian Women Carers project targets Italian women caring for people with psychiatric disabilities. The women are either older women responsible for sons or daughters or younger women caring for older relatives. The project aims to identify carers' information and support needs, and develop strategies to meet these needs. The strategies include providing culturally relevant information to the women, linking them to appropriate services and working to increase the responsiveness of staff within mental health agencies.

The Greek Women Mental Health Consumers project aims to enable Greek women suffering from psychiatric disorders, and at risk of re-hospitalisation, to more effectively utilise local community based support services. To achieve this the project will interview approximately twenty consumers to identify key issues related to limited access to services, develop an information kit for providers which addresses the key issues, and advocate for programs within community based services which are appropriate for Greek women.

The third project, a research study, aims to identify the community support services used by women from diverse eth ic communities following hospitalisation for psychiatric illness, and any barriers these women experience when accessing services.

	STRATEGIES checkLic1t
	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	4. Information & resource development
✓	5. Advice & consultation
	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

Recommendations outlining strategies to deal with current barriers will be included in the research report. At the time of writing this project was about to commence.

REFLECTING CURRENT POLICY

The implementation of these projects is concurrent with major policy shifts related to the provision of psychiatric services. Government policies at both the Federal and State level support an approach to service provision which maximises the opportunities for those with psychiatric disabilities to reside in the community. A number of strategies have been identified to implement this general policy direction.

Given this current policy direction and the associated re-orientation of services, the three NEWHS projects are well placed to assist in building networks between agencies to facilitate integration, identify issues related to mainstreaming psychiatric services for NESB women, and to provide recommendations to improve the quality and continuity of care for NESB women.

PRELIMINARY OUTCOMES

Although in their early stages, the projects show signs of achieving these outcomes. An Advisory Group, established to guide the three projects, has brought together workers from ethno-specific, generalist health, specialist psychiatric and community based mental health agencies in the north east area. Many of the staff representing these agencies had not met before and have benefited from the opportunity to network and develop links with each other and their organisations. In addition, participation in the Advisory Group has provided a forum for discussion about the most effective strategies for working with NESB women within mainstream and community based services.

Information from the intensive contact with Greek women who are consumers of psychiatric services and Italian women carers has assisted a range of services to identify ways to improve their accessibility to women from these communities.

It is anticipated that these projects will continue to provide valuable insights into appropriate work practices for psychiatric and related support services working with NESB women and will thus facilitate the effective devolution of psychiatric services in Melbourne's north east.

Related Program Activities

The Women's Health Resource Collective has produced a leaflet which discusses the causes and definitions of mental illness. It also addresses the social and medical responses to mental illness in our society.

Healthsharing Women, in consultation with the Women and Mental Health Network, received funding for the Good Practices in Mental Health Project. The project will provide training to mental health workers on women-sensitive practice and women's sexuality. In addition, a training package will be produced.

They are known as mainstreaming, integration and coordination.

Mainstreaming involves the delivery of psychiatric services with other general health services rather than through specialised psychiatric services. This initiative is promoted to reduce the stigma associated with mental illness in the community and to ensure quality service provision.

The second strategy, integration, aims to integrate a network of specialist services that encompass in-patient and community care agencies.

Finally, the coordination of specialist psychiatric services, generalist health services and those located in the community, is encouraged to ensure that appropriate supportforpsychiatrically disabled people is provided. Integration also provides opportunities for generalist services and specialist services to play a complementary role.

WOMEN'S HEALTH AWARENESS IN HOSPITALS

Women J Health in the South EMt

WOMEN HAD STATED, DURING CONSULTATIONS AROU);D VICTORIA, THAT THE TRAINING OF HEALTH CARE PROVIDERS SHOULD INCLUDE THE RANGE OF ISSCES \\'HICH AFFECT WOMEN'S LIVES. REsPONDING TO THIS CHALLENGE, THE \VoMEN'S HEALTH SERVICE IN THE SOUTH EAST (WHISE) HAS ESTABLISHED A TRAINING PROGRAM FOR HEALTH PROFESSIONALS EMPLOYED IN A HOSPITAL SETTING.

GAPS IN HEALTH PROFESSIONAL EDUCATION

Curriculum for general practitioner education inadequately prepares doctors to deal with the breadth of health and life issues they encounter in practice. Recent reports have emphasised that programs and curricula for health care practitioners frequently place a disproportionate emphasis on specialised, curative approaches to the care of individuals rather than balancing this with a range of preventative approaches and a recognition of the impact of a person's whole life on their health.[64]

These views are confirmed by women in contact with large hospital systems who have felt that practitioners have trivialised their health concerns or not taken them seriously. Many women have also commented on the way in which they were stereotyped by health professionals concerned primarily with their reproductive health. This can often mean that other significant women's health issues and concerns, such as the effects of poverty or family violence, are overlooked.

Given these inadequacies, primary health care providers have requested continuing education programs which

> "relate to a specific issue or problem of significance to the practitioner; provide opportunities for application or practice of new knowledge or skills; and provide opportunities for peer support, sharing of experiences and the development of networks."[65]

TheNationalWomen'sHealthPolicyandthe Victorian report *Why Women's Health? Victorian Women Respond* emphasise that training of health care providers should include the range of issues which affect women's lives, the health needs of particular groups of women, practices which enhance women's dignity and privacy, specific clinical skills, and methods to ensure women's participation in their health care.

A NE\V TRAINING PROGRAM

It is in this context that WHISE determined to undertake a Hospital Awareness Program. This initiative set out to raise the awareness of women's health issues in a social health context among health professionals working in a hospital setting.

	STRATEGIES check!ut
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
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✓	6. Promoting women's participation
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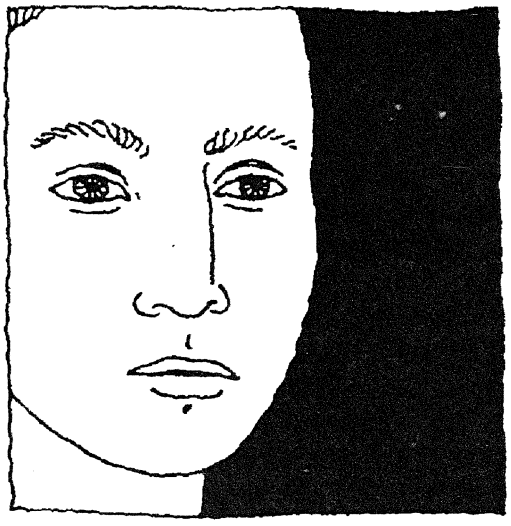


Specifically it was hoped that after participating in the program hospital staff would:

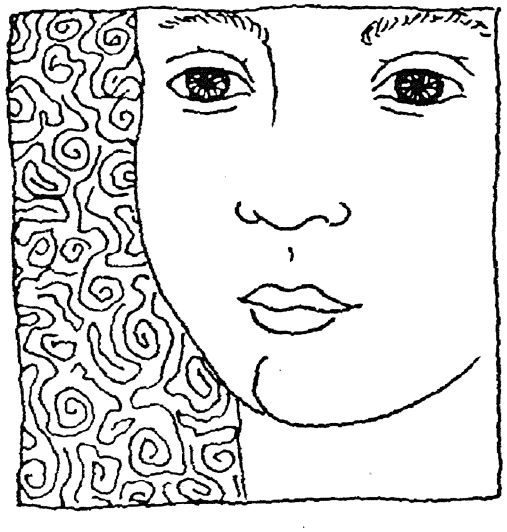
- have a greater understanding of the social, economic and political contexts of women's health issues;
- more readily identify the special needs of particular groups of women;
- be familiar with the rationale for placing a special emphasis on women's health;
- be willing to consider the role of advocate; and
- be prepared to develop guidelines for advocacy in relation to women's health requirements in hospital settings and develop strategies to improve women's health services within the hospitals.

UTILISING EXPERIENCE AND KNOWLEDGE

Although WHISE has only recently been established and the Hospital Awareness Program is one of its first initiatives, it is well placed to conduct such a program. As part of the Victorian Women's Health Program, it is able to draw on a sophisticated and extensive knowledge base regarding women's health issues. This includes a considerable level of expertise in professional training and education that has been developed by women working in various Women's Health Services. Much of this training has been focused on the education needs of health professionals working in a range of health institutions. Training manuals have been generated and refined to address a number of specific health issues and practices. One example of this, *Women's Health: Where Do Health Professionals Stand?* was co-written by the Co-ordinator of WHISE while she was working at Healthsharing Women. In addition to their own understanding of women's health and training expertise, the staff at WHISE drew on their thorough knowledge of local connections. They also utilised their networks with hospital staff, community health workers and other community based health organisations.

The Hospital Awareness program aimed to implement the training package, *Women's Health: Where Do Health Professionals Stand?* in a number of mainstream health institutions in the Department of Health and Community Services region wherein WHISE is situated, Region 8. This package is a guide for tratners and provides a comprehensive program which offers sessions on 'why women's health?', using ourown experiences, the causes of ill health, the health professional as advocate, case studies on hospital experiences, and strategies for action. Through the program, WHISE offered to introduce these key health institutions to this package, provide trainers to conduct the workshops with their staff, and train hospital staff to conduct 'women's health' workshops.

In order to gain widespread support for this program, WHISE targeted key hospitals in the region, set out to gain support and backing for the project from the Department of Health and Community Services, and conducted facilitator training sessions with staff from a variety of local health services.



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Related Program Activities

Women's Health: a Continuing Education Package for Nurses is a project auspiced by the Australian Nursing Federation, in association with Healthsharing Women. The project aims to develop an educational package which will increase nurses' awareness of women's health issues, assess the training of nurse teachers and generate a distance education package.

The North East Women's Health Service represents local women on the Community Advisory Committee of the Austin

'wonli co opyrative'lywiditheliospital staff on a r,e o f women's he-aldi issues.

INITIAL RESPONSES

Important early support for the project came from the Assistant Regional Planning Director. She wrote to all hospital Chief Executive Officers, introducing WHISE and suggesting a meeting with the Coordinator in order to discuss the hospital's staff training needs. Following this early support the Hospital Awareness Program has resulted in a productive partnership between major hospitals and WHISE.

Mr Peter Paterson and Hilary Critchley, a surgeon, of the Monash Medical Centre have strongly supported the program, endorsed the training package and encouraged staff to attend the sessions. They were adamant that the training sessions were relevant and recognised WHISE staff's expertise in women's health issues. Accordingly, an internal organising group was established at the Monash Medical Centre to co-ordinate the training session. Twenty-four senior staff enrolled for the program including staff from the hospital's women's health clinic.

To assist with ongoing support for the training program and the continuation of the Monash Medical Centre's organising group, a midwife from the Monash Medical Centre attended the facilitator training sessions also offered by WHISE.

In addition the Caroline Chisholm School of Nursing at Monash University has incorporated the *Women's Health: Where Do Health Professionals Stand?* training package into their nurse educator curriculum.

Monash Medical Centre and the Caroline Chisholm School of Nursing were not alone in responding to the training offer. Dandenong and District Hospital has welcomed the training package as part of its in-service training. A worker from WHISE conducted the session which was well attended by doctors, nurses, midwives and other staff of the hospital's health unit.

The amalgamated Alfred, Caulfield and Royal Southern Memorial Hospitals have also agreed to establish an internal hospital committee to oversee the implementation of the training program. Both the Planning Manager and the staff of the Nurse Educator Unit are keen to proceed.

FACILITATOR TRAINING

In addition to the hospital committees and training sessions, WHISE has successfully conducted a facilitator training program. Women from the local hospitals, community health services, Women's Health Services and other agencies have completed this training, thus maximising the possibility of on-going sessions within their organisations as well as continued discussion and debate about women's health issues in the hospital context.

In summary, although the Hospital Awareness Program has only recently commenced, support has been forthcoming from key hospitals within the region. This support increases the opportunity for further collaboration and joint programs between the Women's Health Service and major hospitals. New links and networks between large health institutions and local services have been established with the promise of information exchange. A new women's health information training package has been added to health professional's continuing education programs, thus increasing the possibility that there will be changes in health practices and health care received by women in some of our major hospitals.

TAKING A NATIONWIDE PROGRAM TO THE COUNTRY

Gippc1fand Women d Health Serrice

IT IS OFTEN SAID THAT IF A PROGRA.t'1. IS TO BE SCCCESSFUL IN A RURAL SETTING IT MUST REFLECT LOCAL PRIORITIES, BE ASSOCIATED \\'ITH FAMILIAR ORGA.t"JISATIONS, AND BE SUITED TO THE DISTINCTIVE FEATURES OF A RURAL COMMUNITY. WHEN PAP TEST VICTORIA \\'ISHED TO CONDUCT A PROGRAM IN REGIO:-J 5, THE GIPPSLAND WOMEN'S HEALTH SERVICE (GWHS), \\'ITH THEIR THOROUGH KNOWLEDGE OF LOCAL COMMUNITIES, NETWORKS AND ORGANISATIONS, WAS AN OBVIOUS PARTNER.

AN IDENTIFIED NEED

During the consultation and planning phase which preceded the establislunent of the GWHS local women had identified the need for better Pap screening services. They had commented that access to such services was problematic, particularly for women living some distance from regional centres and for women who were unable to travel far due to responsibilities such as farm and family-related tasks. Women also said that they were uncomfortable asking for a Pap test from their well known, local General Practitioner (GP). Some women, of course, didn't have a local GP due to the characteristic shortage of medical officers in many rural areas.

A PRODUCTIVE PARTNERSHIP

Given this very real need, the GWHS responded to Pap Test Victoria's program and decided to work jointly to establish a sustainable region-wide Pap test service for Gippsland.

Pap Test Victoria's statewide screening program aims to decrease the incidence of, and mortality from, cervical cancer by encouraging women in the 50 to 69 age group and women from low income groups, non-English speaking women and rural women to have regular Pap tests. Letters are sent to women in these various groups inviting them to have a Pap test, and including a list of local GPs or relevant health services. In addition, a professional education program trains nurses to conduct Pap tests and provides quality assurance mechanisms.

The involvement of the GWHS at the local level ensured that the Melbourne based initiative would be co-ordinated and supported in order to maximise its reach and effectiveness.

THE RURAL CONTEXT

Staff at GWHS felt that rural women would not readily respond solely to a letter inviting them to have a Pap test from Pap Test Victoria. Women in the community, they argued, would participate in the campaign if they perceived it to be related to familiar organisations and agencies. This was particularly necessary if underscreened and previous! y unscreened women were to be encouraged to access services.

The GWHS accordingly utilised a number of local events and the media to publicise the regional campaign. This also led to discussion of the campaign among various community groups, and in newsletters and bulletins. In addition the GWHS used their networks to increase the number of agencies that

	STRATEGIES checkLidt
	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
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✓	5. Advice & consultation
✓	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

would potentially offer Pap tests. Locally based bush nursing hospitals, community health centres and other health services were asked to participate in the program.

Related Program Activities

With Women's Health in the South East, Pap Test Victoria is focusing on isolated women in the Peninsular region. They are particularly keen to reach women living in caravan parks who may be unfamiliar with local services.

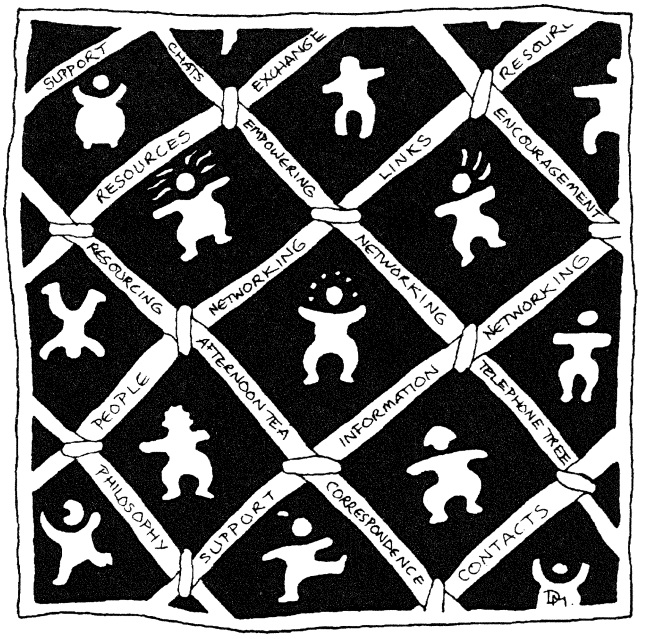
NURSE EDUCATION AND TRAINING

Another aspect of Pap Test Victoria's program is nurse education and training. GWHS encouraged a number of nurses from various locations in the region to participate in the nurse education program. This was to ensure that Pap test services would be available across the region, not only in the large provincial centres. Following the proposed training, the Women's Health Service could support the nurses in planning, networking, monitoring and implementing pap test services. Information and referrals could be readily provided to the nurses. By encouraging a network of nurse practitioners across the region and building on existing ones, the GWHS could maximise the likelihood of a local infrastructure continuing to support the ongoing provision of a quality service.

MORE THAN JUST A PAP TEST

The Pap test itself focuses on only one aspect of women's health and takes very little time to accomplish. Frequently women require a longer consultation in order to discuss other health matters. With this in mind, the GWHS intends to work with and encourage nurse practitioners to offer Pap tests as part of women's health days and well women's clinics. This will be done in collaboration with neighbourhood houses, community health centres and other community organisations to ensure that women receive information about a wide range of health issues, as well as appropriate advice and referral. The network of nurse practitioners and the involvement of many services in the region facilitates women's access to broader services and maximises follow up support where necessary.

The joint Pap Test Victoria and GWHS program is a good example of a productive relationship between a Melbourne based, statewide agency and a rural community based service. The GWHS's local knowledge, links, and commitment to a holistic approach to women's health will ensure that the program aims of professional education and a quality service to geographically isolated women will be successfully achieved.



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NEVV VVOMEN

Goul/Jurn North Ea<'ltern lVomen ;_„Health Service

THE CONSULTATION AND DEVELOPMENTAL PHASE OF A NEW WOMEN'S HEALTH SERVICE ESTABLISHED THE BLUEPRINT FOR ITS EVOLUTION INTO A FULLY FUNCTIONAL SERVICE. THIS CASE STUDY OUTLINES THE CONSULTATION AND NEEDS STUDY UNDERTAKEN BY THE GouLBURN NORTH EASTERN WOMEN'S HEALTH SERVICE

A NEW SERVICE

> "I live on a farm near a small town. I have three children under five. I am lucky to get into town to shop. There is nowhere in that town except the doctor's surgery where I can get any information. There is no child-care for me to even go to the library, which only visits, and I cannot afford phone calls to Melbourne. I feel I can't find out anything."
>
> *AresidentoftheGoulburnNorthEastRegion*

Historically, the centralisation of health services and resources in Melbourne's metropolitan areas has had serious consequences for rural women. The relative absence in rural locations of generalist health services is compounded by the lack of more specialised services which could address particular gynaecological conditions, family planning needs and other women's health issues. In addition a lack of choice in health services may prevent access to early treatment for a condition often resulting in unnecessary pain and discomfort -and leading to the development of more critical conditions.

In response to these realities, a group of women from Shepparton decided that a first step towards improving the health of women in the region was to establish a Women's Health Service. Whilst it was clear that a small s e r'ice would not be able to meet all the needs of women in the area, it would nevertheless be able to increase the awareness of women's health issues among mainstream providers, provide much needed information and referrals, and institute preventative programs.

This case study outlines one stage, the Consultation and Needs Study, in the developmental phase of the Goulburn North Eastern Women's Health Service.

FIRST STEPS

Funding was received for the developmental stage of the Service, with the Kiewa and Ovens Valley Community Health Centre providing a location for the project staff. As future funding for a fully fledged regional Women's Health Service was uncertain, it was decided that this stage of the developmental phase should be valuable in its own right and achieve more than identifying the health needs of country women. The consultation was therefore designed with a number of strategic aims including:

- the identification of specific health needs of women living in the various shires;
- an increase in isolated women's awareness of services available in their own and adjoining shires;

	STRATEGIES checkLut
✓	1. Exploring & modelling new approaches
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✓	6. Promoting women's participation
	7. Training health professionals
✓	8. Joint ventures

- a consolidation and extension of networks between a range of groups and services as well as between women and communities;
- an identification of service gaps in existing mainstream health services;
- the provision of health and related information to those participating in the consultation;
- the identification of a low cost service model capable of adapting to variations in funding.

CONSOLIDATING AND EXTENDING NETWORKS

In order to consolidate and extend existing networks amongst women interested or involved in women's health, a number of women were recruited to form a steering committee to manage the needs study. These women represented a diversity of organisations and health services, and geographical locations. The members of the steering committee were familiar with women's health issues and it was hoped that they would continue to support the Women's Health Service once it was established, develop joint programs with the Service and possibly initiate other women's health programs within their own agencies. The detailed knowledge of women's health needs that would result from the study could assist them to advocate for mainstream health service reform in the shires in which they lived.

IDENTIFYING GAPS IN MAINSTREAJ"vl SERVICE DELNERY

Although the primary focus of the consultation was to identify women's health needs from the service user's perspective, it was recognised that health service providers were often aware of gaps in the provision of services and were therefore likely to be a valuable source of information. If a health professional was unfamiliar with women's health issues, their participation in the consultation would provide an opportunity for them to consider the special case for women's health programs and services. For these reasons, 470 questionnaires were sent to health providers, with a 28 %response rate including 50 from general practitioners.

The consultation process precipitated much thought amongst health professionals. One general practitioner, upon receiving information about the needs study and a questionnaire, initially responded with a short curt reply. However, some days later he contacted the project worker to inform her that he had given further thought to the questionnaire, discussed it with his wife, and now believed that women had very specific health needs which were not always able to be encompassed by his medical practice. He went on to say that he would welcome a Women's Health Service which provided women's health information, illness prevention programs and support groups for women in the Shire.

CASTING A WIDE NET

In order to maximise the number of women participating in the consultation and to broaden the range of views offered, a variety of information-gathering approaches were used. This process began by identifying who would need to be contacted if the sample was to be representative of women in the region. This was based on demographic information and included age, interest, geographic location, socio-economic status, disability, health status, religious background, women in paid work, women as carers, Koori women and women from non-English speaking backgrounds .

To reach women, well known existing groups such as the Nursing Mothers Association, Country Women's Association, community services groups, sporting groups, women on farms, senior citizens, and garden clubs were asked to participate in the consultation.

The project staff also worked through educational institutions such as Rutherglen High School, Tallangatta High School, Wangaratta High School and various parents clubs.

Women contacted through these groups were asked to either attend a group discussion or to answer a questionnaire. A 'snowball sampling' method was then used to contact women who were not members of groups such as these. This meant that women who were known by others who did have contact with the project, were asked by them to attend a discussion group or, if that was not possible, they were sent a questionnaire.

As a result of these strategies, 500 individual women were sent questionnaires and 687 attended group discussions. Many of these women were informed about the agencies, groups and networks which participated in.the project, and received information about women's health issues and their local services. Some of them made specific requests for health information and subsequently received leaflets, references and other resources. As a consequence knowledge and awareness of available services and information was increased.

FINDINGS

Not surprisingly, the overall findings of the needs study are consistent with studies conducted in other regions and those recorded in the report of the statewide consultation *Why Women's Health?: Victorian Women Respond.* However, many issues raised in the final report are specific to a large rural region.

Access to services emerged as a key issue. Women observed that access was limited by the cost of services and treatments, lack of transport or, when it was available, its cost, shortages in the availability of child care and respite care, the limited hours of service, and the lack of interpreters. As one woman succinctly explained:

> "My son was too embarrassed to translate the details of my gynaecological problems, for months. Now it is too late; my cancer has progressed too far."

The study found that many information needs were simply unmet. The women who were consulted identified a variety of information needs. These included material about tre.atments and interventions, available services, women's bodies ahd how they work, and women's rights.

The narrow range of services available in rural areas was also felt to be a significant problem. As one woman remarked:

> "There is only a male doctor in our town, so I never have Pap tests. You see, we were brought up not to even look 'down there', let alone touch it. That was our generation. Ijust get so embarrassed when I think of him seeing me, then having to face him at the school concert."

The attitude of health practitioners to patients and aspects of their practice were frequently mentioned during the consultation. Women reported:

- being treated without respect;
- a lack of confidentiality;
- out of date information;
- poor referrals; and even
- authoritarian attitudes. For example, one woman said:

> "I went to see my male doctor to discuss menopause symptoms. He said, 'Look, don't talk to me. I'm sure it's all in your head. I can't help you."

A lack of cooperation between health services and a lack of planning and evaluation of service delivery were also commented on. In particular, it was noted that in some areas coordination between voluntary and government agencies was poor.

A MODEL WOMEN'S HEALTH SERVICE

The findings from the consultation were used to develop a model for a Women's Health Service. It was decided that a philosophy, developed in response to many of the comments made by women during the consultation, would underpin the Service. This philosophy begins with the assumption that women should be treated with respect and dignity, have freedom of choice and be ensured confidentiality.

In recognition of the size of the region, the importance of outreach strategies to reach isolated rural women, and the uncertainty of future funding, the steering committee and the project staff developed an innovative organisational and management structure. This included provision for a service base, initially situated at Myrtle ford, with key workers being located in other services in outlying communities. This dispersed structure would enable a strategic coverage of the area as well as an efficient use of resources.

The committee defined a number of stages for the development of the Service which would be implemented as funds became available. Stage 1 would be the provision of women's health information throughout the region. This could include the development of a Resource Directory and the employment of community-based information workers. Stage 2 would involve the development of support groups and Stage 3 the development of a Regional Women's Health Plan.

Stage 4 would include action to develop improved birthing services, domestic violence support, counselling services, access to women GPs and access to bulk-billing. This stage would also involve the provision of training for health professionals and an evaluation of health services.

A thorough report on the Goulburn North East Women's Health Needs Project was well received by many of the women and service providers who participated in the consultation.

WORKING TOGETHER ACROSS VICTORIA

The Women d Health Ser"icu Program

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BIRTHING SERVICES: A MAJOR CONCERN FOR W01VIBN AND THEIR FAJ'vllLIES

In the consultation conducted by the Victorian Ministerial Women's Health Working Party, Victorian women identified birthing services as a major issue of concern. Women reported that they found it difficult to find accurate information on options about where they could give birth and who could be involved in their care. Particular concerns were expressed about the level of medical intervention in childbirth and the lack of information available to women about birthing interventions. Women were dissatisfied with the fact that they had to give birth in the clinical environment of a hospital, when in the majority of instances birth was a natural and uncomplicated process.

The attitudes of professionals toward pregnant and labouring women were also the subject of some criticism. Women reported trouble getting accurate information from caregivers and were sometimes treated with a lack of dignity and respect. They identified the inadequate attention given to the emotional aspects of birthing, in particular the experiences of women with complications. Miscarriage was frequently cited as an example of this.

The Working Party recommended that a major review of birthing services be conducted in Victoria and in 1988 the then Minister for Health appointed a ten person Study Group comprising members of various professional backgrounds and community associations.

MAKING SURE THAT WOMEN HAD A SAY

The Study Group made a commitment to base its deliberations on extensive consultations with women and service providers. Concerned that traditional methods of consultation often failed to reach women, Women's Health Services were particularly keen to work with the Study Group to ensure that women in general, and 'hard to reach' women in particular, had a say in the consultation. Several services assisted in the development and implementation of regional consultative processes. The Loddon Campaspe Women's Health Service, in cooperation with the Loddon Campaspe District Health Council, conducted extensive consultation with rural women. The Women's Health Service for the West (WHSFTW), worked with local women's groups to facilitate the participation of women with disabilities, low income women, young women and women from non-English speaking backgrounds. The findings of the two consultations were submitted to the review. Both used innovative approaches to involve women. For example,

	STRATEGIES checlcLut
✓	1. Exploring & modelling new approaches
✓	2. Monitoring women's health issues
✓	3. Representing women's concerns
✓	4. Information & resource development
✓	5. Advice & consultation
✓	6. Promoting women's participation
✓	7. Training health professionals
✓	8. Joint ventures

INCREASING ACCESS TO INFORMATION

The Women's Health Resource Collective (WHRC), aware of the Birthing Service Review finding that women need more information about their birthing options and about birth, identified the production of birthing information as a major priority for the agency in 1991-92. WHRC co-produced a pamphlet with the Loddon Campaspe Women's Health Service (LCWHS), *Pain ReliefDuring Labour* and has worked closely with LCWHS on the production of two further materials *Making Birth Plans* and *Being Active in Labour.* As the products of a cooperative relationship between a Regional Women's Health Se1vice and a Statewide Women's Health Information Service, these pamphlets draw on the resource production skills ofWHRC and the understanding of women's day to day needs and experiences held by the LCWHS.

WHRC also began a promotional campaign of two of its existing resources, *Care of Stitches After Birth* and *Women's Health and Miscarriage* and is currently producing another birthing resource in response to demand, *Vaginal Birth After Ceasarian.*

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rather than relying on the traditional public meeting or questionnaire for eliciting women's opinions, the WHSFTW worked with small groups of women using a technique known as creative visualisation. This involved presenting women with pictures of a conventional birthing room and asking them to visualise what could be changed to improve the birthing experience.

By working in small and familiar groups and by using techniques which did not require a high level of English language competence, the Service was able to bring to the review the experiences of women whose voices would not otherwise have been heard.

STATEWIDE FOCUS

At the same time Healthsharing Women supported a number of statewide advocacy groups to raise awareness of the issues relating to birthing from the perspective of women and to ensure that the profile of these issues was maintained. This was important since women often found themselves competing with powerful ptofessional associations and large hospitals to have their views heard. Healthsharing Women provided administrative and research support to the groups as well as assistance in negotiating the review p r tess and working with the media.

In 1990, the final report of the review *Having a B a b^{y} in Victoria* was released. Shortly afterward, the Women and Surgery Conference was held by Hcalthsharing Women (sec also page 39). A number of papers and workshops on surgical procedures involved in pregnancy and birth were presented at the Conference.

In the report of the Birthing Services Review it was proposed that responsibility for implementation of the recommendations be devolved to each of Health Department Victoria's eight health regions. Since the release of the report, Women's Health Services have played a significant role in working with women and service providers to implement the findings of the review (see boxes, pages 63 to 65).

IN MELBOURNE S WESTERN SUBURBS

In 1992/3 the Women's Health Service for the West (WHSFTW) was involved in a cooperative venture with the Western Hospital aimed at improving the delivery of birthing services for women from non-English speaking backgrounds (NESB). The project addressed care in the antenatal and post natal periods and during labour. It was of particular significance to women in the Western suburbs where over 35% of the population is from a NESB.[66]

The project was overseen by a steering committee comprising senior hospital personnel, WHSFTW staff and committee members, and staff from the Footscray Migrant Resource Centre, and the Braybrook/ Maidstone Community Health Centre. The project worked with the Arabic, Vietnamese and Spanish communities to gather information from women who have given birth in the hospital in the past and those using the hospital during the life of the project. A decision was made to work with both of these groups so that solutions to problems which were identified throughout the process could be tested in the course of the project. Using this approach a number of tangible changes have been made.

Materials on birthing options have been translated into the major community languages and arrangements have been made to 'block book' interpreters for attendance at hospital antenatal clinics on designated days. Appointments for women requiring an interpreter are made at these times. Negotiations have been held with Outer Western community health centres to conduct antenatal classes in Spanish and Vietnamese. This will enable women to take classes in their own language and in a familiar and geographically accessible location. These classes will also be held at the hospital. A video will be made in Vietnamese to inform women about what to expect at the hospital.

With the aim of providing women from NESB the option of having antenatal care in their own communities with a service provider able to speak their language, the project also negotiated a number of' shared care' arrangements with local bilingual medical practitioners whereby women have most of their antenatal care in the community. The women need only attend the hospital for a small number of key visits and to give birth. Similar arrangements have been made with local community health centres. Interpreters have been arranged for those services that do not employ a medical practitioner able to speak a relevant language.

In response to women's concerns about lengthy waiting times, the hospital has overhauled its appointment system and has provided a play area for children. Women attending antenatal appointments are charged a flat fee for parking rather than an hourly rate. To achieve continuity of care, women are scheduled to see the same doctor at each hospital visit wherever possible.

Multilingual signs are being produced for the hospital and it is anticipated that in the near future, menus will be translated into the major community languages.

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IN RURAL VICTORIA

The Loddon Campaspe Women's Health Service (LCWHS) carried out a birthing services project in cooperation with local hospitals and consumer and community groups. The project aimed to ensure that some of the reforms proposed in the review were indeed implemented in the region. The project achieved this in a number of ways.

Information sessions were held for local medical practitioners, midwives and other health care professionals to inform them of the review and its implications for birthing practices in the region.

Sessions were also held with local women and their partners to discuss the recommendations of the review and to identify particular issues of concern. Where relevant, the project worked with local groups to facilitate communication with hospitals, with a view to resolving any issues which had been identified. Aware that women in the region were concerned about the lack of access to information about birthing and birthing options, the project also ran a series of information sessions in cooperation with local midwives. Using the information gathered in its contact with women the LCWHS, in cooperation with the Women's Health Resource Collective, developed a number of information pamphlets about birthing (see box, page 63).

This project has had a number of tangible results. In response to concerns expressed by local women, one of the hospitals made a decision to refurbish its birthing facilities to create a more homely environment in which women could give birth. Committees to implement the recommendations of the statewide Birthing Services Review were established by a number of hospitals and decisions were made by several facilities to routinely provide women with more information about birthing options. The demand for the birthing information produced by the service is so great that it is continually being reprinted.

In addition to the provision of direct info1mation and support to women, this project was able to serve as a focus for health care providers and women to work together to achieve long lasting and positive changes in birthing services.

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