1. Concepts, Concerns, Critiques

The driving ideas and principles underpinning the Australian women’s health movement have remained remarkably stable over time, which is counterintuitive given that the movement has always included women with a range of perspectives. As Stevens (1995:26) has argued, the context of the early years was not ‘quiet conformity to an overarching ideology’ but rather a time of ‘great turbulence in the development of new ideas, forms of organisation and in the ways in which women related to each other’. Ideas were developed, changed and reformulated in line with experience and changing circumstances. For example, among those setting up early centres and services the question of whether to accept government funding was contentious. While opinions were strong and feelings ran high, the issue was resolved relatively quickly because agencies could not survive without financial support. Similarly, aspects of the feminist critique of conventional medicine lost some of their relevance as appropriate responses were put in place. Other parts of the critique, such as questions of unnecessary medicalisation and criticising the inadequacy of pharmaceutical safety evaluation, are as relevant as they ever were.

Priorities sometimes differed even when agreement was strong. Among Anglo-Australian women, there was general agreement on a number of central issues, including the harmful effects of Western gender roles, the shortcomings of conventional hospital and medical services, the gaps in available services, the need for information to make informed decisions about health and treatment and women’s reproductive-health rights. In setting out to achieve change where it was vital, movement members were initially unaware that their concerns were not shared by all Australian women and that for some, racism and cultural insensitivity were higher priorities. Differences between women from divergent backgrounds gave rise to animosities and tensions, some of which remain but in working to improve women’s health through multiple avenues many groups have nevertheless developed successful collaborations.

The unifying set of ideas around which the movement revolves is that which underpins a social view of health. The social perspective developed early and took deep root, creating common ground between women from diverse backgrounds. There is wide agreement among feminists with its underlying principles, which include social justice, holism, respect, empowerment and participation. Immigrant women applied these principles in the services they established and Aboriginal women seem always to have known about the social determinants of health.
Women and Healthcare Provision through the Ages

Legislators, priests, philosophers, writers, and scientists have striven to show that the subordinate position of women is willed in heaven and advantageous on earth. (de Beauvoir 1972:22)

Second-wave women’s health activism, in Australia and elsewhere, was cast by many as radical in the early years. Throughout history, however, women have struggled to gain and retain a respected voice in healthcare decision making. Direct action in support of women’s health rights is recorded as early as the third century BC when Agnodice was arrested and tried for practising gynaecology and obstetrics, allegedly without formal training—a forerunner to modern accusations that some women’s health workers are not properly trained. The leading men of Athens found her guilty but her patients demonstrated in her support, forcing men to change the law and allow women to train and practice.\(^1\) Since then, women have struggled against repeated attempts made on religious and other grounds by churches, governments and male members of medical professions to exclude them from medical education and to preclude independent midwifery practice.

Women have provided health care for their families and community members as nurses, unlicensed doctors, pharmacists, herbalists, abortionists, counsellors and midwives since ancient times (Ehrenreich and English 1973:3; Willis 1983:94). Records have it that a midwife was present at the birth of the prophet Mohammed in 570 (Giladi 2010:190). Khaldun, a Muslim historiographer who died in 1406, dedicated a chapter of a large history to midwifery, arguing that midwives were better acquainted with obstetrics than others and better able to treat children’s ailments than male physicians (Giladi 2010:185). In Europe and the Middle East, women continued to practice both as midwives and as obstetricians, despite opposition and sometimes in contravention of the law. In England, the term ‘man-midwife’ first appeared in the seventeenth century but, until the twentieth century, childbirth was almost exclusively women’s business (Willis 1983:94–6).

Aboriginal women played an important role in Australian history as midwives in their own communities and for non-Aboriginal women in country areas. They also played a role in caring for non-Aboriginal women when they were ill. Women from the Wiradjuri tribe, whose country is central New South Wales, are reported to have delivered as many white babies as black babies (Gaff-Smith

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\(^1\) Whether Agnodice was a historical figure has been questioned; however, even if she were not, the recorded struggle was clearly part of ancient experience. The story is eerily similar to modern attempts to keep women out of medicine.
A settler’s wife has told an illuminating story of being called to assist at a premature birth. The distressed husband read from a medical book outside the room and shouted orders, while the Aboriginal midwife, Fanny, ignored him and the settler’s wife and quietly did what needed to be done. A premature baby girl ‘so tiny she would have fitted into a pint jug’ was safely born (Holthouse 1973:85–6). Childbirth is still women’s business for many Aboriginal women, with mothers passing knowledge from generation to generation and assisting daughters during birthing (Webb 1986:1–3). Similarly, a century ago in rural New South Wales, my own great-grandmother was midwife at my mother’s birth and the births of my uncles and aunts. She was midwife also for extended family members and anyone in surrounding communities who chose to call for her. I am not aware that she had any formal training, nor are there written records of her work; Australian midwives left very few accounts of what they did (Willis 1983:94).

**Women’s Health Reform Movements**

In the United States, Weisman (1998) has identified what she calls a women’s health ‘megamovement’ over the past two centuries, comprising several ‘episodes of intense public attention to women’s health’. Women were prominent in the social health movement of the 1830s and 1840s, which advocated what is now called primary health care and set up training and information sessions (Baldry 1992). Women physicians and social reformers took leading roles in a subsequent wave of women’s health action in the concluding decades of the nineteenth century—a struggle partly about reproductive rights. This period coincided with the women’s suffrage movement in North America and Europe, Australia and New Zealand. A later women’s health activity phase, between 1900 and the 1920s, focused on maternal and child health, sex education and birth-control rights. Margaret Sanger, a public health nurse and reproductive-rights activist, founded the American Birth Control League in 1921, after witnessing shocking loss of young life for want of appropriate information and care. The organisation became the Planned Parenthood Federation of America in 1942. It played a major role in the struggle for medical abortion in the United States, which was legalised in September 2000. The fourth stage of the women’s health ‘megamovement’ is the grassroots movement that began in the late 1960s (Weisman 1998:37–92).

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2 There is a distinct difference between primary health care and primary medical care. Whereas primary health care focuses on the provision of a comprehensive range of community-based services, including prevention, primary medical care is mainly concerned with the delivery of conventional treatment services to individuals. The distinction is important because, as Keleher (2001:57) argues, primary health care can make a difference to health inequalities in the population as a whole whereas primary medical care treats individual episodes of disease.
Australia, too, has seen several waves of women’s health activism. A women’s movement, at least partly concerned with health, has been present since the nineteenth century. Marilyn Lake (1999) has shown that the women’s movement did not disappear after that ‘first wave’ but that women remained active through the twentieth century, struggling for a range of rights and freedoms, including equal pay, reproductive rights and sex education. At the end of the nineteenth century, Australian women agitated for special women’s health services. Women-only hospitals run by and for women were established in capital cities. Demand for these services was overwhelming. For example, women are reported to have come ‘in droves from all over Victoria’ to the Victoria Hospital for Women, which was opened in a small church hall in 1896 (Robertson n.d.). In an early example of Australian women taking a social health perspective, the Women’s Progressive League, founded in 1900, initiated discussion groups and courses on matters that included health and diet, and they lobbied for reform of factory, health and prison legislation (Baldry 1992).

The contraception and abortion-rights movement developed late in Australia, however, hampered by elite concern about declining birth rates in an empty continent. Following a drop in the birth rate after 1890, a royal commission was established in New South Wales in 1903. Its report is said to have influenced Australian policy for half a century. It regarded the use of contraceptives as a national problem caused by the growing selfishness of women and a love of luxury and social pleasures. In the years that followed, all States extended their laws restricting the availability of contraceptives (Browne 1979:24–8). The birth rate fell again between 1928 and 1935, provoking another round of official concern and ‘invocation of the twin spectres of physical decline and national powerlessness’ (Hicks 1978:158). As Pringle (1973:19) has argued, the ideology that was imposed on everyone displayed ‘total contempt for actual attitudes and behaviour or for the rights of women to seek fulfilment outside narrowly defined roles’. Under these circumstances, family planning organisations were not formed until the 1930s and abortion-rights groups became active only after World War II (Siedlecky and Wyndham 1990:9–31).

The most recent wave of women’s health activism emerged at roughly the same time in the United States, Australia, Britain, Canada and New Zealand and a little later in Ireland and South Africa. These are, of course, the major English-speaking industrial countries. There were, however, no comparable mobilisations in non-English-speaking capitalist democracies. Feminists in Norway, for example, were intrigued when I inquired about a Norwegian women’s health movement in the 1990s. They answered that they saw no need for a specific focus on women’s health, as the mainstream system could be influenced to respond appropriately. The reasons women’s health movements were formed in one set of countries and not in others are touched on in Chapter 7 but thorough analysis must wait for another study.
The Modern Women’s Health Movement in Australia

The second-wave women’s movement in Australia—at first called women’s liberation (WL)—emerged as feminist groups formed in capital cities and quickly proliferated. Sydney WL began in January 1970 and within a year groups had formed in every major town. Melbourne alone had 34 different groups by 1971 (Kaplan 1996:32). Although originating in ‘new left’ politics, WL groups encompassed a range of perspectives. At first, there was reliance on material heavily imbued with socialist ideas, primarily from the United States and Britain. In some States, the movement was initially a people’s liberation movement. In South Australia, for example, men participated in women’s meetings for the first several years (Kinder 1980:30–54). In other States, however, the movement was partly ‘a revolt against New Left men’ who, while concerned about imperialism, oppression in the Third World and against minority groups, were nevertheless happy to dominate and exploit new left women (Curthoys 1984:162). Groups in different parts of the country quickly communicated with each other which brought a level of consensus. As time went on, theoretical analyses of women’s oppression were developed. New left ties meant that socialist ideas were strong so that women’s oppression was often explained as a product of capitalism and patriarchy (Curthoys 1984:162).

Health, especially reproductive health, was a major issue from the beginning. Sex-role stereotyping and media exploitation of women were other early concerns (Kinder 1980:30–54). The more centrist Women’s Electoral Lobby (WEL) was formed in 1972. Initially, an uneasy tension characterised relations between the two: whereas WEL focused on working within state institutions (an approach called liberal or ‘reformist’ feminism), WL aimed to achieve a radically restructured society—a project some women thought would be scuttled by working through existing structures (Kinder 1980:104–8). Despite the differences, the two groups cooperated and marched together on International Women’s Day (IWD). In some settings, including Western Australia and the Australian Capital Territory, collaboration appeared to come easily and some women participated in both groups.

Initially, WEL adopted the six demands that WL had formulated: equal pay, equal employment opportunity, equal access to education, free contraception, abortion on demand and free twenty-four-hour child care. This list expanded to include other policy areas and soon recommendations were being made about taxation, the structure of work, paid maternity and parental leave, access to
justice and the public–private dichotomy. The notion that particular issues were women’s issues was abandoned and most Australian feminists soon argued that all areas of public and private life were important to women.³

By 1973, groups whose primary interest was health began to form. In Melbourne, for example, the Women’s Health Collective and Women against Rape were set up. In Adelaide, all segments of the women’s movement were concerned with aspects of health. A group called The Body Politic, largely comprising nurses and trainee doctors, was formed in 1972, absorbing an existing abortion-rights group. It was concerned with a wide range of women’s health issues and emphasised the need for sex education, producing an information sheet called ‘How not to get pregnant, how to find out if you are and what to do about it’, which was distributed widely and became the subject of vice-squad inquiries. A member of the group subsequently graduated in medicine and became one of the founders of Adelaide’s first women’s health centre. Even within feminist health reform groups, however, rape as a health issue was rarely mentioned (Kinder 1980:88–9), indicating the strong taboos around the subject. Sydney women celebrated IWD in 1973 by holding a commission over a weekend at which women shared their experiences. Health, especially the inadequacy of hospital and medical services, emerged as the main topic. At follow-up meetings, groups were formed to work on various issues and one was to focus on health services for women (Cooper 2003). Similar developments took place in Melbourne.

The Struggle for Health Information

Simone de Beauvoir helped to lay the philosophical foundations for modern women’s health activism when she argued in The Second Sex (first published in 1949) that women had limited control over their bodies, their minds, their lives and their destinies. ‘Woman is determined not by her hormones or by mysterious instincts’, she argued, ‘but by the manner in which her body and her relations to the world are modified through the action of others than herself’ (de Beauvoir 1972:734). While professionals monopolised health information, women could not participate equally in treatment and care decisions or attempt to control their own bodies.

The quest for knowledge and information emerged as a key issue in the consciousness-raising (CR) groups of the 1960s in the United States. Members of the pioneering Boston Women’s Health Collective, for example, realised in 1969 that they knew very little about how their bodies worked. They undertook to research topics, found they could understand medical and scientific writing and

³ Separatist feminists, whose ideas include the view that women need to live separately from men, do not necessarily share this opinion.
decided to put together an information course for women. These efforts resulted in the book *Our Bodies, Ourselves*, first published in 1971, later translated into a dozen languages, adapted to suit different countries and now in its sixth edition. From the late 1960s onwards, a feminist information-dissemination effort took place in the United States, particularly in the cities (Lipnack 1980; Ruzek 1978). At the same time, in Britain, a feminist health education movement emerged, in which women produced information materials and other resources, together with lists of speakers, to facilitate knowledge dissemination (Doyal 1983:22).

Information was a central issue at the first Australian national women's health conference, held in 1975. One major recommendation from the gathering was that ‘a federal commission be set up to investigate all aspects of health education’ (Commonwealth Department of Health 1978:3). Women reported finding it extremely difficult to get the information they needed from medical practitioners, particularly if there were additional obstacles, such as language barriers. For example, in the late 1970s, widespread misinformation was found among immigrant women in Melbourne by Women in Industry, Contraception and Health (WICH), a newly formed grassroots non-governmental organisation (NGO). WICH discovered women who were taking the contraceptive pill without knowing it was a contraceptive and others who had had intrauterine devices (IUDs) fitted that had not been changed for years (Caddick and Small 1982). Even where there were no language barriers, women often found it hard to find out what they wanted to know. A young woman, Susan Waide, told me about her unsuccessful efforts to extract information from her doctor during her first pregnancy in the 1970s. ‘Y’know how it is’, she told me, ‘Pat you on the head and kick you out the door’.

The early women's health centres aimed to fill some of these gaps, both inside and outside their walls. Activities included discussion sessions, coffee gatherings and self-help meetings. As in the CR movement, group meetings were recognised as valuable mechanisms for exchanging information, ideas and experiences. Women aimed to ‘get to know themselves, reinterpret their biological function, question their role in society’ and ‘regain control over their bodies. And their lives’ (Sandall 1974:89). Feelings of frustration and powerlessness associated with inadequate information were closely related to dissatisfaction with conventional hospital and medical services.

**The Feminist Critique of Conventional Medical Care**

At one end of a spectrum were straightforward expressions of anger about the attitudes of medical practitioners and the inappropriateness of many treatments.
At the other end, sociological and political analyses of modern medical care drew on social theory and the ‘limits to medicine’ perspective discussed above. As Dorothy Broom (1991:43) explains, women were dissatisfied with medical services, critical of many of the professionals who delivered them and had a vision of a radically different society, in which women would be no longer subordinate, would be proud of their bodies and would enjoy life conditions that would enable them to be responsible for their own health and health care.

Social institutions are a product of their time and place and, in medicine in the 1960s and 1970s, women were seen primarily as wives and mothers, rather fragile creatures (nevertheless capable of long hours of unpaid work, without recreation, and sick or weekend leave), who spent most of their lives in the recesses of the private sector taking care of others. Founding members of the Boston Women’s Health Collective identified four prevailing cultural notions of femininity that they found restrictive: woman as inferior, woman as passive, woman as beautiful object and woman as exclusively wife and mother (Boston Women’s Health Book Collective 1976:18). Such ideas were conveyed to medical students in gynaecology texts, which adhered tenaciously to views of women as frigid and sexually unresponsive, long after contrary scientific evidence was available (Broom 1991:38–9; Scully and Bart 1973). An Australian bureaucrat’s view of single, middle-aged women, as expressed in a Commonwealth Minute Paper in the 1960s, captures a perspective not uncommon at the time: ‘A spinster lady can, and very often does, turn into something of a battle axe with the passing years. A man usually mellows’ (Commonwealth of Australia 1963).

The Subordination of Women in Health Care

At a fundamental level, many women have a strong sense that health care really is women’s business, given the long history of involvement, and many were dissatisfied with a system in which women constituted the bulk of health professionals but medical system decision making was heavily dominated by men. In Australia, organised medicine had long worked to marginalise women providers. It had campaigned against the introduction of any service, such as baby health centres and school health services staffed by nurses, which might be a threat to the size of private medical markets. By the middle of the twentieth century, these campaigns had successfully sidelined female professionals, leaving hospital and medical systems dominated by men, with doctors filling most key positions (Gray 1991:60–2; Willis 1983; Wyndham 1983:28–30). The division of labour resembled that in wider society: women did the low-status, low-paid caring and support work while men in high-status, well-paid positions made the all-important decisions. Pringle and Game (1983:94) argue that ‘in no other workplace are power relations as highly sexualised as they are in hospitals.
Bureaucratic domination is directly reinforced by sexual power structures. They also found that increases in the number of male nurses and female doctors had not changed basic power relations. A similar situation prevailed in Britain (Doyal 1983:27).

Women still make up a majority of the health workforce in Australia. More than 90 per cent of nurses were women in 2006 (AIHW 2009:31). Although women constitute an increasing proportion of doctors, at 33.7 per cent, only 21.6 per cent of specialists are women (AIHW 2006:8, 16). Male dominance in health system decision making has many untoward consequences. For example, unpaid care giving is rarely recognised as a women’s health issue. Primarily a cost-cutting exercise, policies promoting shorter acute hospital stays and de-institutionalisation in the mental health, disability and aged-care sectors have transferred responsibility to predominantly female carers, significantly increasing the burden of unpaid work and undermining women’s capacities to achieve economic and other forms of independence (Armstrong et al. 2002).

Medicine’s Role in the Subordination of Women

The male-dominated medical system of the 1970s, it was argued, not only reflected the views about women held in wider society but also played ‘a particularly strategic role in actively creating these stereotypes and in controlling women who may deviate from them’ (Doyal 1983:26). The views about women presented in medical textbooks, for example, masqueraded as scientific fact when, in fact, they were (male) socio-cultural interpretations. Feminists claim that unscientific medical discourse of this kind is really social and political action that helps to sustain the status quo (Braun 2003:5–10). In this and other versions of the narrative, medical personnel operate as agents of the establishment (reviewed in Broom 1991:44–7), constructing ‘deviance’ through interpretation and labelling processes and controlling it through medicalisation and other avenues, such as population policies. Men become experts on women’s bodies and medicine is involved in the construction of a particular view of the ‘nature’ of women, labelling and treating ‘normal’ and ‘abnormal’ femininities. Broom (1991:53–7) suggests that the word femininity itself conjures up notions of illness and disease because women and sick people share characteristics, such as weakness, passivity and dependency.4

4 Similarly, some semiologists argue that the word ‘woman’ is infused with inerasable meanings of weakness and subordination or even that it simply means reproductive capacity. Simone de Beauvoir (1972:35) wrote: ‘Woman? Very simple say the fanciers of simple formulas: she is a womb, an ovary; she is female—this word is sufficient to define her.’
Feminists argue that these influences are particularly apparent in mental health systems, where therapeutic models perpetuate gender stereotypes, pathologise women's anger and maintain their lack of power (Ussher 1991:209). From the beginning, women's emotional health and wellbeing were major issues in women's health centres (Schofield 1998:1–9). The view that women suffer more mental ill health than men because they are subjugated, distressed and unhappy was put forward in the early years. On entering the psychiatric system, women are confronted with a view of mental health that is inherently sexist: women's distress is pathologised rather than validated. The impact of violence and trauma is not given full weight, the social conditions of women's lives are not examined and women's control is further undermined because information about treatment choices is not readily available. Research on women's mental health remains sparse and there is insufficient recognition that women and men might experience conditions, such as stress, differently. An interactionist model, it is argued, needs to be developed, which examines social conditions and psychical factors as they occur together. In this view, the traditional therapy model of dominant professional and submissive client must be replaced with an egalitarian approach (Hodges 1997:22–30).

Superior–Subordinate Relations

The Women's Commission was told in Sydney in 1973 that doctors' attitudes towards women were often experienced as patronising and judgmental and sometimes as degrading and humiliating. The commission was a two-day gathering of some 500 women organised by WL as part of the 1973 IWD activities. Patronising doctor–patient interactions could occur in any setting: in the 1980s, a newly retired State Minister for Health, needing minor surgery, asked a question about the procedure, to which her doctor replied, not with an answer, but with the admonition: 'Now you are going to be a good girl, aren't you?'

Women reported especially distressing experiences when seeking abortion services. Jean Taylor (2003) remembers the concerns expressed in the early 1970s during her volunteer work with a new Melbourne WL information service:

Many women were looking for a sympathetic doctor so they could have an abortion and the Women's Abortion Action Campaign (WAAC) was set up in 1972 to campaign for the repeal of anti-abortion laws...We encouraged women to let us know what their experiences had been...so we could have a resource file of doctors who could do abortions or other medical procedures or consultations in a sympathetic way. In the same way we also had a file on doctors who were less than sympathetic
or downright incompetent and dangerous. We were challenging sexist attitudes and ways of looking at the world. Doctors and other professionals were often quite sexist and wouldn’t give women information, so we were encouraging women to ask their doctor questions and find out what was happening about treatment. From this, women started to be involved in their own health care.

Women also identified a lack of sympathy for victims of violence and a lack of concern about what women themselves wanted and needed (Siedlecky 1977:30). Many felt unable to discuss problems with their doctors. The tragic consequences that can result from ineffective communication and inadequate training to deal with issues such as domestic violence are illustrated in the case of Heather Osland, who was convicted for her part in the murder of her violent husband. Osland had attended her doctor regularly for 10 years prior to the killing, with recurrent cystitis, and vaginal and pelvic infection and inflammation, resulting from marital vaginal and anal rape. She had taken her children, who displayed serious behavioural problems and sometimes physical injuries, to the same doctor. Her husband also attended the practice. Osland was treated with antidepressants, tranquillisers and antibiotics and although there were discussions with her doctor about marriage problems, these discussions were not included in her records nor were the problems connected with her medical conditions (Taft 1999:64). This might be an extreme case, in terms of both the oversight and its consequences, but it illustrates the way non-medical and even medical problems, major and minor, can slip through the net in the absence of information and training.

Another major issue for 1970s women was that their health problems were frequently trivialised, regarded as exaggerations, not believed and/or passed off as emotional reactions or overreactions. Endometriosis, for example—a painful condition—often went undiagnosed for years. Women felt that menstrual problems, pelvic infections and the like were not given appropriate attention and were meant to be ‘suffered in silence’ (Broom 1991:37). Indeed, as late as 1990, the menstrual cycle had not been studied in depth (Doyal 1995:17). Chest pain, long-term chronic pain, headache and dizziness were other conditions women felt were often not taken seriously. Moreover, research shows the same symptoms were taken more seriously in men, who received quite different treatments. For example, chronic pain might be treated with painkilling drugs in men but with tranquillisers or even shock treatment in women. Other studies showed female prisoners were far less likely to receive conventional medical treatment, and women with heart disease were treated differently from men with the same condition (Wyndham 1983:29).
Unnecessary Medicalisation

Women complained and continue to complain about the unnecessary medicalisation of life events, such as menstruation, pregnancy, childbirth, menopause and mental ill health. Social and emotional problems, in particular, are often treated medically. The women’s health movement quickly identified the heavy prescribing of tranquillisers as highly inappropriate. In 1984–85, 70 per cent of the six million prescriptions written in Australia for benzodiazepines were for women. Estimates were that between 30 and 40 per cent of these women would become addicted both physically and psychologically. Women from non-English-speaking backgrounds were particularly likely to be prescribed tranquillisers (Crawford and Elliott 1994:143). The safety of many treatments was questioned. The untoward effects of drugs, such as Depo-Provera, and of devices such as the Dalkon Shield, were discovered and publicised. The use of the contraceptive pill came to be seen as a massive experiment on women: dosage levels were the subject of trial and error and use became widespread before longer-term effects could be known.

More recently, the use of hormones has become highly controversial (Boston Women’s Health Collective 2006). After millions of women had been prescribed hormone replacement therapy (HRT), evidence appeared that implicated it in either causing or exacerbating a range of cancers, including lung cancer, leading one researcher to question its use in medicine in any form (Ganti 2009:1218). Researchers argue that the HRT experience reaffirms the importance of mandatory randomised trials. Recent work to develop a ‘female Viagra’ for women with supposedly low libidos is seen as an attempt to create a new disease, called ‘female sexual dysfunction’, and so establish a new and potentially lucrative market. The work has been strongly criticised by feminists and others (Moynahan 2003).

Gender Bias in Medical Research and Practice

The priorities and methods of medical research have attracted criticism since the early 1980s. Even within the biomedical model, research on women was the exception rather than the rule. Until the 1970s, ‘women’s health’ was thought of as comprising reproductive issues and gynaecological diseases but even these were seriously under-researched (Doyal 1995:17–18). Women were heavily under-represented in clinical studies, which primarily studied men and then applied the findings to both sexes (Keville 1994). In Australia, funding for women’s health research constituted a ‘tiny fraction’ of the total until 1990 (Broom 1991:38). Inquiries of the National Health and Medical Research Council
(NHMRC) and the Australian Institute of Health and Welfare (AIHW) in 2010 failed to establish what proportion of total health research was specifically devoted to women. The NHMRC collects data only on the research it funds itself, not on the total Australian research effort. In 2010, however, $82.3 million of a total of $730.1 million, or approximately 11 per cent, was identified as being for ‘women’s health’ (NHMRC Research Funding Dataset 2000–2010). Inquiries of the AIHW were less satisfactory. In reply to my questions and follow-up questions, I received the following reply by email: ‘I passed your enquiry around to colleagues specialising in areas that your questions were around. The general consensus was that we are unable to answer the questions, this is due largely to [the fact] that we try not to differentiate between sexes in our reports.’

Given that the importance of collecting sex disaggregated data and the need for gender analysis has been acknowledged for many years, it is astonishing AIHW staff seem unaware of the arguments.

By the 1990s, it was acknowledged in overseas medical research circles that clinical trials on diseases that affect both men and women should include both men and women as subjects (Cohen and Sinding 1996; Keville 1994). US responses include the establishment by the Institutes of Medicine of a committee to consider ethical and legal issues surrounding the inclusion of women in clinical studies, which recommended that women be included ‘wherever possible’ (Mastroianni et al 1994). The US Congress passed legislation in 1993 stipulating that women must be included in clinical trials in sufficient numbers to obtain ‘a valid analysis’ of differences in the way women and men respond to drugs, therapies and treatments. Later research, however, suggested that companies were disregarding aspects of the legislation (Pear 2000).

Similarly, the Medical Research Council of Canada issued a paper in 1994 drawing attention to the need for gender balance in research. In Australia, the NHMRC’s National Statement on Ethical Conduct in Human Research (2007) does not reflect these concerns, referring only to ‘women who are pregnant’. Its recently revised National Ethics Application Form, however, which researchers must use to apply for ethics clearance, asks applicants about the ratio of males to females that will be recruited and whether the ratio accurately reflects the distribution of the disease, issue or condition within the general community. Research published in a high-profile international journal in 2010 showed continuing gender bias and prompted leading women’s health NGO Women’s Health Victoria (WHV)

5 The questions asked were: 1) What proportion of total Australian health research funding is devoted to studying women’s health? 2) What proportion of women’s health research is devoted to areas other than reproductive and sexual health? 3) What are the rules about the inclusion of women in clinical trials for diseases that affect both men and women, such as cardiac disease? 4) What proportion of research on cardiac disease is conducted specifically on women?
to issue a media release calling on the Australian Government to develop and enforce a set of national guidelines to ensure that medical research takes account of gender differences (WHV 2010).

Biased research results in biased approaches to care. Until recently at least, drug and alcohol rehabilitation policies and services in Australia centred on the needs of men with little recognition that these differed from the needs of women. Almost all the research that had been undertaken investigated men’s experiences (Morgain 1994:175–6). There were few women-only alcohol and substance-abuse centres where women who, because of past experiences, were afraid to use mixed-sex services could go, and there was virtually no provision for women with children. Similarly, few professionals were trained to deal with the effects of abuse and violence on women and children. Moreover, awareness of the need for cultural sensitivity was low.

Gender Bias in Treatment

Biased medical research leads to biased treatment, with women less likely to receive ‘accurate diagnosis and appropriate treatment’ (Bönte et al. 2008; Keville 1994:129). We do not know whether inappropriate treatment is less common than it once was but we do know that serious problems remain. Rosenberg and Allard (2007) found ‘a pattern of overestimation of benefit and underestimation of harm’ for women being prescribed statin therapy. A large study in the United States found that women are 30 per cent less likely than men to receive the kind of stroke care that limits brain damage (RedOrbit News 2009). A number of studies show that women with cardiac disease are treated less appropriately than men, even after accurate diagnosis and hospitalisation. For example, research in Germany, the United Kingdom and the United States found that ‘primary care doctors’ behaviour differed by patients’ gender in all three countries’. In Australia, recent research by the AIHW found that although cardiovascular diseases (CVDs) are a major health threat for Australian women, awareness of this threat is low. Both the severity and the number of episodes per woman can be reduced, the report argues. An ‘enormous potential’ exists, according to the AIHW ‘to improve the risk profile of Australian women and therefore reduce the numbers of women and families affected by CVD’ (AIHW 2010b).

To summarise the feminist critique, in the male-dominated medical system, men are not only experts on women’s bodies, they are also experts on women’s healthcare needs and make crucial decisions on services and treatments. Women have been subordinated as health professionals and, in many other respects, medical practice perpetuates the inferior status of women. Unnecessary medicalisation and gender bias in research and practice result in suboptimal
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health outcomes. From the social health perspective, a wide range of primary health and community services is seriously undersupplied. Like Aboriginal Medical Service (AMS) workers, women identify the need for more holistic, preventive, community-based services.

The Integrity of Medical Research

Concerns have emerged about the scientific integrity of medical research, following changes in the way it is funded. Whereas in the 1960s most research was publicly funded, by 2006 approximately three-quarters was funded privately. Moreover, until the 1990s, most drug company-funded research was undertaken in universities; however, research has moved to for-profit locations, where fewer checks and balances operate. Pharmaceutical companies can now select the research designs most likely to produce the results they want, they can terminate studies if the findings contravene their interests and they can fail to publish results altogether. The fear is that private research is ‘far more likely to produce results that support the sponsor’s interests’ (Boston Women’s Health Collective 2006). Three Australian oncologists caused something of a stir in 2010 when they pointed out that 27 of 32 authors of research published in *The Lancet* had declared financial links to the drug company that had funded the research. The authors, it was argued, had a potential conflict of interest (Medew 2011).

In recent years, the pharmaceutical company practice of employing ghost writers to write reports for medical journals has raised concerns about skewed findings. Experience validates such concerns. A study of court documents in the United States, for example, showed that 26 medical journal articles between 1998 and 2005 ‘emphasised the benefits and deemphasised the risks’ of HRT. All had been drafted by a medical communications firm paid by a major pharmaceutical company (Singer 2009:A1). Allegations have also been made about biased reports on antidepressants and diet drugs and, more recently, about cancer and haematology drugs. A recent analysis of reviews of a new drug for type-two diabetes found that experts who were paid by the drug’s manufacturer were more likely to report favourably on efficacy and safety. Investigation was prompted by sharply conflicting conclusions in published scientific work, some of which had warned about significant risks (Bakalar 2010). Medical journals have been forced to abandon the honour system of disclosure and introduce ‘ghostbusting’ measures in an effort to reduce industry-financed writing assistance (Singer and Wilson 2009:B1).
A Social View of Health

A person’s physical health is like a frozen moment taken from the social and economic environment.

— Stephanie Bell, 2001, Director, Central Australian Aboriginal Congress

Australian women did not need epidemiologists to tell them that the conditions of their lives had important ramifications for their health. According to Laurie Gilbert, Director of the Women’s Health Unit in the then Commonwealth Department of Health in the 1980s, Australian women understood and subscribed to a social view of health before they had heard the term. Laurie Gilbert was a member of the team, headed by Liza Newby, which consulted with women about their health needs for the 1989 NWHP. As the NWHP argues, a ‘major reason for the acceptance by so many women of the social health perspective is their understanding, often from personal experience, of the links between poverty, type of employment, education, access to housing, and health’ (Commonwealth of Australia 1989:10).

Another reason so many women take a social view, it has been suggested, is that they are more likely to use, or want to use, the health system for health reasons, whereas men use it mostly for illness. Aboriginal women have been keenly aware that life conditions affect health outcomes for a very long time. And although Aboriginal, immigrant and Anglo women often had different priorities, they were in agreement on most aspects of the social perspective. As Broom (2001:98) argues, ‘women of all racial and ethnic backgrounds were united…in their call for a voice in personal health care decisions and in the formulation of health policy’.

A social health perspective is an extension of the feminist critique of conventional medicine in the sense that it argues that a treatment focus is narrow and misses a great deal that is crucial for human health. When women talk about gaps in services, some of the things they are noticing are the paucity of prevention advice, counselling and support.

In a social view of health, the focus is on population rather than individual health. It is concerned with ‘the causes of the causes’. Outcomes emerge from complex interactions between social, economic, cultural, environmental and biomedical factors rather than arising from biological determinants alone. Furthermore, feminists argue that biology is not given and unchangeable, as it tends to be in the medical scientific view, but is influenced by multiple factors. Therefore, biomedical processes cannot be understood out of context. In this view, as Hammarstrom (1999:243) argues, ‘there is a close interplay between social and biological factors, which means that biology must be problematised’.
There is no clearer association in the epidemiological evidence than that between poverty and inferior health outcomes; however, the poor are not the only ones who are affected. There is a definite social gradient in health, which shows that everyone’s health is less robust than it might be, perhaps affecting even those at the top of the socioeconomic scale. Health outcomes consistently improve as socioeconomic status improves, with the biggest differences obviously found between those at the top and those at the bottom. It follows therefore that comfortable, middle-income people, for example, have poorer health outcomes than they might have (WHO 2003:10–11). Recent research suggests that levels of inequality, material and social, can explain the social gradient. Countries with the largest gaps between rich and poor experience more mental illness, more drug and alcohol-related problems, more obesity, higher rates of teenage pregnancy, poorer educational performance and literacy scores and higher rates of homicide (Wilkinson and Pickett 2009).

Inequality works to undermine health, it is suggested, by increasing stress right across society. Stress, medical research shows, produces a range of diseases and behavioural problems. In heavily unequal societies, the rich fear the poor and the poor suffer from status anxiety and shame, making everyone’s health poorer than it might be. In more equal societies there are higher levels of trust and lower levels of stress. Low status, low levels of respect and feelings of low self-esteem, rather than material deprivation per se, contribute most to poor health and help explain the social gradient (Wilkinson and Pickett 2009). Such arguments fit with the findings of earlier studies. For example, Kawachi et al. (1999) studied men and women across the 50 American States and found that both smaller wage gaps between the sexes and higher levels of women’s political participation were ‘strikingly correlated’ with lower female and male morbidity and mortality. Status, the authors conclude, reflects ‘more general underlying structural processes associated with material deprivation and income inequality’. Such findings corroborate the arguments of Aboriginal people who point to the devastating health consequences of colonisation and racism.

Returning to the health of the most disadvantaged, the close association between poverty and very poor health outcomes holds both between countries—some rich, some poor—and within countries, whether they are OECD countries or those that are less well off (WHO 2008a). Women are everywhere over-represented amongst the poor.6 Australia’s gender pay gap, for example, contributes to economic insecurity, increasing the number of low-income families, especially female-headed families, with a negative impact on health, including that of

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6 This is not generally the case for Aboriginal women, who point out that they often have better jobs and higher education levels than Aboriginal men.
children. It also contributes to financial vulnerability for women, especially women in retirement. The effects of the pay gap are exacerbated by socially prescribed caring responsibilities.

Violence is another major ‘cause of the causes’ of poor health. While the underpinnings of violence are complex, there is wide agreement that intimate partner violence, in particular, is firmly embedded in gender inequality. Violence is detrimental to women’s health in many ways. A major WHO study found that violence had a negative impact on women’s physical, sexual, reproductive, psychological and behavioural health, as well as having fatal consequences in cases of AIDS-related mortality, maternal mortality, homicide and suicide (Krug et al. 2002).

Post-traumatic stress disorder (PTSD) is more prevalent among women who have experienced violence, along with neurological disorders as a result of head injuries and attempted strangulation. Women who have experienced violence have more sexually transmitted and urinary tract infections, more migraine headaches, more chronic pain and poorer reproductive health outcomes (Coker 2005:1; Taft et al. 2003). Moreover, studies show that the health consequences of abuse can persist for years and that the more severe the abuse, the greater is the detrimental impact on health, with multiple episodes having a cumulative impact.

Workplace conditions can give rise, directly and indirectly, to poor health outcomes. Discrimination or harassment in the workplace, for example, might lead to anxiety, depression and other mental health problems and economic insecurity—all closely associated with reduced life chances and poorer health. The Canadian Women’s Health Strategy (Health Canada 1999) identified 12 key social determinants of women’s health: income and social status; employment status; education; social environment, including social support and social exclusion; physical environment, including access to food, housing, transport, clean air and the like; healthy child development; personal health practices and coping skills; access to health services; social support networks; biology and genetic endowment; gender; and culture. Indeed, each of these categories is an umbrella for more specific determinants.

A biomedical perspective of health, in contrast, is narrower. It focuses on the immediate or direct causes of ill health, which are seen as located in individual bodies in interaction with outside causal factors, such as germs, toxins and injuries. The human body is seen as a set of interdependent but contained systems, and ill health is treated as a failure of one of the parts. Disease unfolds within individuals. Day-to-day interactions with broader social and physical environments are outside the scope of inquiry (Doyal 1995:15–16).
Very different views of appropriate public policies flow from these distinct perspectives. If the causes of ill health are predominantly biomedical and largely outside human control, the role of public policy is limited. In an ‘old’ public health framework (as discussed in the Introduction), the range of responsibilities is relatively narrow but includes provision of clean water, sewage disposal and health regulations. Public authorities might also provide relevant health information and enact legislation to restrict the activities of commercial enterprises if health concerns are at stake. Importantly, people in wealthy countries now agree that good-quality hospital and medical services should be made accessible to citizens, and public policies are required to regulate access.

In contrast, where a social determinants view of health is taken, extensive public intervention is the rational response, both inside and outside health systems. If the ‘causes of the causes’ can be known and understood, it follows that health and public policy should focus on prevention as well as cure. A social determinants perspective requires substantial investment in primary, community-based health care to complement medical and hospital services, as well as investment in economic security, physical security, affordable housing, accessible education, food security and so on.

While the women’s health movement has championed a social view of health and illness, this is equally relevant to men’s health. Gender, which is one of the social determinants, helps shape the conditions of men’s lives, just as it does those of women. Male gender roles might work to undermine health by encouraging physical risk taking and, perhaps, the denial of emotions, physical discomfort and pain. The expectations held about what is required of breadwinners might induce men to work in stressful, dangerous occupations or to work unhealthily long hours. Risk-taking behaviour can have untoward effects on the health of both men and women, particularly in relation to sexual activity. We might not be able to tell for sure whether women suffer more morbidity than men (Broom 1991:47–52), but a social health perspective tells us for certain that many men and women suffer high levels of avoidable ill health as a consequence of the constraints and requirements of masculine and feminine gender roles.

A Peculiarly Australian Debate: To accept or reject state funding?

The question of whether women should collaborate with ‘the state’ (or government) was a strongly contested issue in the early Australian women’s health movement. The problem arose when the movement established its own services and public funding support was a real possibility. Conflict and bitter disagreements ensued and in some cases permanent ruptures followed.
Demand for the services women’s health centres provided was strong and placed a heavy load on volunteer and low-paid service providers. Some workers felt frustrated, wishing to devote more of their time to broader, change-seeking action, but often found their energies consumed by day-to-day service provision (Broom 1991:120–2). Thus, some found the prospect of financial support attractive. Whereas social liberal (social democratic) feminists were generally comfortable working through government institutions, women oriented towards socialist, anarchist, radical, cultural and lesbian-separatist feminist perspectives generally held reservations. Divergent perspectives are nicely illustrated in a letter written by Beatrice Faust, the founder of Melbourne WEL, to Biff Ward, convenor of Canberra WL in 1972. ‘Does Canberra Women’s Lib plan to establish a second branch of WEL?’ Beatrice asked. She went on to suggest: ‘If you believe the democratic process is useless, perhaps you could pass this on to someone who still has hopes of it’ (reproduced in McCarron Benson 1991).

In the 1960s and 1970s, many feminists were preoccupied with analysing the nature of ‘the state’, which was a reflection of the strength of socialist feminist thinking at that time. In the Marxist tradition, the institutional apparatus—which includes government, the economic system, the legal system, the education system, the military, the police and so on—is referred to as ‘the state’. The state is regarded as an instrument of oppression, used by the ruling class to prevent a revolution from below that would benefit the more numerous working class. Socialist feminists, therefore, work within a tradition that is highly suspicious of the state. Distrust of public-sector institutions also emanated from women’s lived experiences. Because there was relatively low female participation in the public sphere, the state could be seen as male in character, with institutional arrangements, practices and processes that were alien to women.

Another strand of thinking analysed the state as male dominated or patriarchal. In Kate Millett’s view, for example, patriarchy is a universal phenomenon and patriarchal government is an institution under which ‘half of the populace which is female is controlled by that half which is male’ (Millett 1977:25). Patriarchy is deeply entrenched and runs through all the political, social and economic institutions of all societies. In this perspective, as Randall (1988:10–11) argues, ‘the state has remained a bastion of male power’, controlling women’s freedom, restricting creativeness, denying autonomy and ‘withholding from women large areas of society’s knowledge, power, opportunity and resources’. Government, some feminists suggested, was conducted as if men’s interests were the only ones that counted (Pringle and Watson 1992:57).

Theorists also developed critiques of government bureaucracy—an arm of the state—which went beyond conventional complaints about red tape, goal displacement and empire building. Whereas behaviour, attitudes, structures and processes are seen as gender neutral in conventional organisation theory,
feminist theorists argue that masculine values and assumptions underpin and reinforce the systems of sex stratification typically found in organisations. According to Ferguson (1984:4), the bureaucratic organisation of public life directly controls the work of most women employed outside the home. Further, because of its hierarchical nature, bureaucracy affects the entire society in a way that is antithetical to the goals of feminist theory and practice and antithetical to democracy. Clearly, such structures are not appropriate channels through which to pursue the liberation of women.

With these ideas in mind, some women searched for new ways of working, inspired by visions of a society based on empowerment rather than domination. In alternative structures, it is argued, women can work towards their own emancipation through processes in which they support and value each other and where the conditions for empowerment and skill development are present. In Australia, as elsewhere, feminist collectives were set up and were the chosen management form for many health centres, rape crisis, domestic violence, sexual assault and abortion counselling services (Outhwaite 1989:203–5). Non-hierarchical power structures in women’s health were felt to benefit both workers and clients. In keeping with a radical democratic focus, Jocelyn Auer (2003:7) argues that hierarchical decision making in women’s health reduces the power and information that workers have and this deficit is felt by clients.

As it developed in Australia, feminist theorising about the state produced different positions, with some accounts suggesting the possibility of meaningful improvement in the status of women through collaboration (see, for example, Allen 1990; Yeatman 1994). One strand of the ‘reformist’ view was that while seeking equality through the state might offer only limited prospects, the alternative of purchasing equality in the marketplace offered even less cause for optimism (Dowse 1984:143). Women were aware that accepting government funding would involve, at the very least, keeping records, writing reports and possibly complying with unacceptable conditions, such as restrictions on modes of operation and/or on the selection of clients. In practice, such restrictions quickly became reality. Marian Sawer (1990:50) notes the tensions created when women’s health-sector workers became ‘caught up in bureaucratic procedures’, requiring them to produce business plans, job descriptions, policies and procedures. Collective-management models had to be modified and sometimes abandoned.

Controversy over state funding appears to have been stronger in the women’s health movement than in the mainstream women’s movement. It has been argued that there was scarcely a debate in the wider women’s movement (Dowse 1984:146). An alternative view is put by Dorothy Broom (1991), who documents vigorous and sometimes bitter debates and irreconcilable conflicts. For example, differences between radicals and reformists in Brisbane’s Women’s House
Health Centre ‘broke out into open warfare’ in the mid-1970s, resulting in the centre losing its funding (Broom 1991:16). According to Broom’s central thesis, working with the state in women’s health involves women in a fundamental contradiction—the contradiction of ‘using the system to change the system’. In this view, very briefly, both medicine and the state are patriarchal institutions that prop up a social order that makes women sick. These institutions must be reformed if the underlying social conditions that give rise to avoidable illness amongst women are to be eliminated. The dilemma was expressed very clearly by the Women’s Liberation Halfway House Collective just after accepting government funding in 1975:

> Whether we can threaten the relations of power and control that form the basis of this society while being financed by the system which maintains them, and how far we can use government funding to develop the potential of the Halfway House as a political weapon are the most important questions. (Quoted in Alley et al. 1980:10)

The movement has always been very clear that the relations of power and control need to be changed, both inside and outside the health system; disagreement centred upon the best way forward. Both Broom’s work and my own research for this book suggest that opposition to cooperation with the state was much stronger among women’s health advocates than in the mainstream women’s movement. In interviewing activists from the 1970s and 1980s in the 1990s, I more than once heard the view that the kinds of policy changes that women were pursuing were insufficient to make even a dent in power relations.

Two points might help to explain the divergence between the women’s health movement and the women’s movement more broadly. First, it has been argued that radical feminists, rather than liberal or reformist feminists, have been a particularly important force in the women’s health movement (Kenway 1992:111; Outhwaite 1989:202). Radical feminists are especially concerned about sexual subordination and violence against women and have been highly active in the refuge movement. A second point of explanation is that in keeping with the feminist critique of medicine, the state is heavily implicated in supporting the mainstream medical system. Therefore many activists thought that collaboration would ineluctably lead to being asked to work within the conventional medical framework, with the accompanying displacement of goals. At Hindmarsh, in Adelaide, for example, the area providing medical services was organisationally cordoned off from the rest of the centre because feminists feared contagion from a medical hierarchy in their midst.

Whatever the reasons, diametrically opposed attitudes to cooperation with the state were a reality and a destructive force in several women’s health centres. In a number of settings, the issue was not resolved, even if compromises were
found. Joyce Stevens (1995:17) describes differing perspectives at the Leichhardt Women’s Community Health Centre (LWCHC), Australia’s first women’s health centre:

[S]ome thought that they should take advantage of the more favourable situation to try to build some permanent outposts for women, such as women’s services controlled by women. Others thought that the movement needed to maintain its radical and oppositional stance without the support of government funding or interference. The tensions between these positions were not resolved and they often coexisted in a type of unhappy marriage within projects, including LWCHC, where defiance and acquiescence were twin progeny.

In South Australia, tensions over how far to go in engaging with the state continued into the 1980s, along with concerns about losing touch with the grassroots feminist movement (Auer 2003:8). Most groups providing services, however, wherever they were located, accepted government funding from necessity, which created very real difficulties for many movement members interviewed for this book. Women reported that relationships with the state were ‘always fraught’. Many thought that a level of separation was necessary to retain critical independence and pursue feminist goals; securing survival through the state risked submerging the reform agenda.

With the passage of time, the ‘revolution–reform dilemma’ that Broom (1991:128) noted became less apparent. Today, women’s health workers are far more likely to be concerned about the sufficiency, indexation and security of public funding. Awareness of threats to independence is still keen, however, and radical health reform is still a major objective. In the early days, the decision to accept government funding undoubtedly weakened the movement by costing it members. Sarah Maddison has argued that an ‘unintended consequence of state engagement’ was the exclusion of many radical, socialist and anarchist feminists from the women’s movement, with a subsequent decline in energy and activity (Maddison 2001). State engagement certainly alienated many radical feminists who distanced themselves from reformist activity. Moreover, antagonisms were such that continued cooperation would have been very nearly impossible. The decision of some to accept public funding, however, did not prevent radical, socialist and anarchist feminists from continuing their own preferred forms of activism and there is no clear causal link between engagement with the state and the decline of the women’s movement as a whole.
An Anglocentric Women’s Movement

The Australian women’s movement, like sister movements elsewhere, has been described as centred upon the dominant group, or, in the Australian case, centred upon Anglo-Australian women. It has also been criticised consistently by women with disabilities for neglecting their issues. Early second-wave feminism is said to have taken a ‘coherent, fixed, singular and unitary’ view of the position of women. In this reading, women are everywhere subjugated to patriarchy—a condition that gives rise to similar experiences for all women everywhere. An all-inclusive feminism of this kind, as postmodern analyses point out, ignores differences between and within groups of women and ignores differences in preferences and priorities. By ignoring differences, positions outside the mainstream are marginalised: a unitary, single-perspective feminism cannot take into account the experiences of black women, immigrant women, refugee women, women with disabilities or lesbian women, to name just a few. Second-wave feminism, critics argue, is dominated by white, middle-class women, whose focus on their own issues marginalises the concerns of ‘others’ (Larbalestier 1998:150).

This is not the place to discuss Australian feminist discourses (see, for example, Bulbeck 1997; Larbalestier 1998), but portrayal as fixed and singular overstates the case. A diversity of views was always present, acknowledging a variety of ‘feminisms’ and cultural differences. Mary Kalantzis (1990:40–1), for example, has described Sydney meetings of an ethnic women’s network, which included women as different from each other as Muslim women in purdah who wished to reform working conditions to allow traditional prayer sessions, and women from South American backgrounds who saw Australian women’s organisations as politically backward.

While single-perspective feminism never existed, the theoretical position that dominated in the early years did not take account of the perspectives of all women, including Aboriginal, Torres Strait Islander, immigrant and refugee women. Goodall and Huggins (1992), for example, identify key differences between Aboriginal and non-Aboriginal women. They point out that, in many ways, Aboriginal women are in a better position than Aboriginal men, holding positions of power within their own communities—the reverse of the general situation for Anglo-Australian women. Moreover, Aboriginal women are generally better educated than Aboriginal men and often have higher-status jobs. Whereas Anglo-Australian women were demanding rights to abortion and contraception, Aboriginal women were fighting against unwanted sterilisation and the loss of children to various agencies. Thus, many of the demands of non-Aboriginal women were irrelevant to Aboriginal women and some were contrary to their wishes (Burgmann 1984:37). The major issue for Aboriginal
women has been the white feminist movement’s refusal to acknowledge the extent and depth of racism and the priority many Aboriginal women give to supporting Aboriginal men and to building healthy families and communities. Without recognising ‘the full horror of racism in Australia’, ‘white women simply invited Aboriginal women to join the movement’ (Goodall and Huggins 1992:401–2).

Feminists have also been guilty of attempting to speak ‘for’ Aboriginal women, rather than inviting Aboriginal women to speak for themselves. Perera (1985) recounts the story of a women’s housing conference where Anglo women told Aboriginal women about their housing needs. The Aboriginal women present walked out in protest, giving rise to consternation and feelings of guilt. In the process of ‘reconciliation’ that followed, Anglo women learned something about the requirements of effective consultation and inclusion. Bronwyn Fredericks (2010) discusses the many barriers that still preclude effective cooperation between Aboriginal and non-Aboriginal Australian women.

Immigrant women, too, have charged the movement with racism and with relegating immigrant women’s activism to the sidelines (Larbalestier 1998:148–58; Murdolo 1996). As with Aboriginal women, here, the main issues are often different and include problems of racism, poverty, language barriers, isolation, discrimination by supervisors at work, unfamiliarity with workplace rights and cultural disadvantage. Also, even though refugee women often find themselves with ‘the dirtiest and most dangerous jobs on the factory floor’ (Fraser 2008), unions have been slow to recognise their problems. As Kaplan (1996:125) argues, ‘the right of participation was questioned even in the workplace’. Access to services was also fraught with problems. For example, immigrant women returned to violent relationships more frequently than Anglo women, leading refuge workers to believe this pattern constituted a safety risk for workers and other residents. According to Fraser (2008), the predominantly Anglo-Australian workers lacked ‘the knowledge—or sometimes the desire—to help women from other cultures’. Another obstacle to identifying with the Anglo-Australian feminist movement was ‘a pervasive stereotype’ of immigrant women as ‘uneducated, unskilled, under the thumb of a dominating father or husband, and uncomplaining’ (Fraser 2008).

Immigrant and Aboriginal women have pointed out that they were politically aware, active in campaigns and active in setting up organisations and services to meet the problems they experienced. As Burgmann argued in 1982, ‘there is a black women’s movement—it is just that white women know virtually nothing about it’ (1982:37, original emphasis). There is also an Aboriginal women’s health movement, as the activism described in the following chapters demonstrates.
Consequently, the work of Aboriginal and immigrant and refugee women has often been left out of ‘mainstream’ accounts of what is erroneously labelled ‘the’ Australian women’s movement (Murdolo 1996). Despite limited opportunities and heavy oppression, Aboriginal, Torres Strait Islander, refugee and immigrant women have certainly been part of an Australian movement to improve the conditions of women’s lives. Immigrant women set up a number of their own associations and services from the 1970s onwards. For example, the Migrant Women’s Association was set up in 1973 in Sydney and the Migrant Women’s Refuge was established in Melbourne in 1978. The new centre could not meet demand so a way around the problem was found by setting up the Refuge Ethnic Workers Program (REWP) in 1981. This service provided language and advocacy services for immigrant and refugee women in Anglo-Australian refuges and became a model for service provision. In its current form as the Immigrant Women’s Domestic Violence Service (IWDVS), it is funded by the Victorian Government. It offers services in many languages and engages in prevention work, training and community education (Fraser 2008; IWDVS web site).

At the same time, Aboriginal women were establishing their own separate services. Aboriginal women’s work in the founding of community-based health services has been mentioned and, in the early 1980s in Perth, a woman headed the AMS. The Council for Aboriginal Women of South Australia was set up in 1966 and, while not focusing specifically on health issues, it was concerned with women’s and children’s services, welfare and race issues (Grahame and Prichard 1996:37). The National Council of Aboriginal and Island Women was founded in 1970, concerned with health, race, welfare, children’s issues and legal rights. The Victorian Council of Aboriginal and Island Women was active in the 1970s and the 1980s (Grahame and Prichard 1996:122). Among the council’s activities was supporting the establishment of the Aboriginal Health Service, Fitzroy, in 1973 and an Aboriginal girl’s hostel in Melbourne. Murawina Aboriginal Preschool and Women’s Hostel was established in Chippendale, Sydney, in 1972. Mimbingal Violet (Vai) McGinness Stanton, of Kungarakany and Gurindji descent, was one of the founders and later coordinator of the Foundation of Rehabilitation with Aboriginal Alcohol Related Difficulties (FORWAARD) in 1976 (Grahame and Prichard 1996:42).

The Aboriginal Women’s Centre was set up in Darwin in the second half of the 1970s and refuges were established in many places, including Melbourne and Moree, New South Wales. The last provided services for non-Aboriginal women as well. The founders of Cawarra Aboriginal Refuge, established in

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7 According to Kaplan (1996:124–5), as well as experiencing racism, immigrant women were not helped by ethnic organisations. She points out that the first national conference held by the Federation of Ethnic Communities Councils of Australia in 1979 had one female delegate and no women on the executive. ‘Neither ethnic community organisations nor the government gave enough weight to migrant women’s concerns’, she argues. See also Sawer (1990:107–39).
Sydney in 1979, had originally tried to locate it in the suburb of Penshurst but lost council approval due to racist reaction. (Grahame and Prichard 1996:28). The Western Women’s Council was formed in Wilcannia, New South Wales, in 1984, concerned with caring for the land ‘in the broadest sense’ and opposing the establishment of an army base on ‘fragile desert land east of Wilcannia’. Health was a concern, along with racism, imprisonment, police harassment and violence. The Federation for Aboriginal Women was formed in Victoria in 1982, with a number of aims including ‘consolidating and strengthening of Aboriginal women’ and promoting ‘universal cooperation and friendship with all women’s organisations’ (Grahame and Prichard 1996:45).

Early Cooperative Ventures

For all the understandable distrust that many Aboriginal, Torres Strait Islander, refugee and immigrant women felt and still feel towards Anglo-Australian women, there are examples of collaboration and evidence of a slow coming together. A group called Joint Women’s Action began in Canberra in 1972. It focused on ‘justice for blacks and whites’ and put together a leaflet dealing with the interracial rape of Aboriginal women and girls, which was co-authored by black and white women (Grahame and Prichard 1996:63). In Alice Springs, WL helped to campaign to protect a women’s sacred site from being flooded to create a recreational lake (Grahame and Prichard 1996:9). The Alice Springs Women’s Centre—part refuge, part health centre—provided services for both Aboriginal and non-Aboriginal women, and women from different backgrounds participated in management.

Living in small communities seems to be conducive to breaking down barriers between women of difference. Women in Broken Hill, New South Wales, founded the Multicultural Women’s Resource Centre in 1986. Originally an initiative of the Filipino Women’s Association, it received early funding from the Commonwealth Department of Immigration and Ethnic Affairs. The centre is managed by a committee of women from several ethnic groups, including Aboriginal and Anglo-Australian women, and it provides services, including health information and outreach, for all women in the area.

The cooperative effort that went into founding a women’s refuge at Bourke, New South Wales, demonstrates that cultural differences do not necessarily prevent women from different backgrounds working together. Over more than a decade, work by Aboriginal, Anglo and Indian women, with the help of some men, enabled a centre to become established without government funding. This story of cooperation and perseverance has been summarised as follows: ‘In an
otherwise racially divided community, we have managed to have Aboriginal and non-Aboriginal women work together for the common good. Many women who would have never met have come together and made friends’ (Alvares 1992:183).

A number of writers acknowledge the ‘well-meaning concern’ of many Anglo-Australian feminists towards non-Anglo groups (Fraser 2008; Goodall and Huggins 1992; Kalantzis 1990). Goodall and Huggins (1992:402) argue that the Australian women's movement learned about difference ‘slowly and somewhat painfully’ over the first two decades. Tensions continued, however, because both the way that ‘racism shapes sexism’ and the needs of Aboriginal women to strengthen their communities were not sufficiently understood. Goodall and Huggins note, however, that supportive and productive relationships did sometimes develop.

In summary, Anglo-Australian concerns dominated the early women's movement but, gradually, feminists established links with women from different cultural backgrounds and learned more about their issues. For their part, some immigrant and refugee women, as well as some Aboriginal women, began to find value in working with some Anglo-Australian women. The collaboration that became possible is illustrated by the work of two immigrant women living in Queensland in the 1980s. Raquel Aldunate and Gladys Revelo both worked at the Brisbane Migrant Resource Centre but, as well, they belonged to the Women's Health Centre, the Community Health Association of Queensland, the Migrant Women's Network, the Australian Social Welfare Union, the Women in Trade Unions Network, Radio 4EB, the Chile Solidarity Committee, the Latin American Centre and others (Aldunate and Revelo 1987:40).

**Women’s Health Services and the Needs of Non-Anglo Women**

This discussion of difference and exclusion would be incomplete without taking into consideration the efforts made by women's health centres, refuges and sexual assault centres to meet the needs of the non-Anglo women who live in surrounding communities. From the beginning, despite ignorance and racism, many workers in women's health centres sought to discover what local women needed and wanted. They attempted to provide culturally appropriate services and, where possible, assisted groups to set up their own services. Most women's health centres were deliberately established in areas of high need, where low-income, immigrant, refugee and sometimes Aboriginal women lived (Auer et al. 1987:77; Broom 1991:3). They aimed to be accessible to disadvantaged women and some focused specifically on the needs of migrant and/or Aboriginal women (Broom 2001:101). The work of LWCHC serves as an example.
LWCHC, like most sister centres, was located in the midst of a large working-class and immigrant population. From the beginning, ‘before the concept of multiculturalism had been invented’ (Stevens 1995:48), almost one-third of the women using the centre were immigrants. Ways of delivering appropriate services were explored and, within a year, information and services were being provided in three languages. In the second year, bilingual and multilingual workers were employed. Visits were arranged to factories and hostels and a publicity campaign on immigrant radio and in the press elicited an ‘overwhelming response’. Italian women became members of the collective.

Throughout its 38 years, LWCHC has continued to provide services for immigrant women, altering direction and focus in response to demographic changes. The factory-visits program was expanded towards the end of the 1970s and became an established Factory Project in the 1980s. Information brochures were translated. In 1983, LWCHC and the similarly located Liverpool Women’s Health Centre, which had been doing its own research into women’s industrial health problems, set up the Health in the Workforce Factory Project, which operated for more than a decade. The project employed women from Yugoslav, Chilean, Greek, Turkish and Vietnamese backgrounds. Between them, members of the group spoke 16 languages.

Outreach work uncovered the stressful lives of women working at home. In addition, immigrant women, it was found, often had little information about their health. Many had never had a pap smear and, as a group, they were frequently prescribed tranquillisers. Outreach work in factories and shopping precincts became a standard part of LWCHC’s work. By the mid-1980s, the managing collective included South American, Italian, Thai, Turkish and Polish women. Information brochures in Italian, Spanish, Polish, Turkish, Greek, Arabic and Vietnamese were produced. In the early 1990s, Vietnamese and Chinese women joined the staff, and services were developed for newly arriving Pacific Island women. LWCHC continues to provide a range of services for the immigrant women who live nearby.

Mary Dimech, writing in 1982, recognised the efforts that many Anglo feminists had made to address the problems of immigrant women, pointing to the activities of workers’ health centres, women’s health centres and some refuges. She argued that women’s movement campaigns for equal pay, the right to work,
child care and abortion were all of benefit to immigrant women as were the efforts of teachers’ unions to promote appropriate language-teaching services for migrants, particularly women (Dimech 1982:16).

Working with and for women from different cultural backgrounds was not, however, achieved without tensions and difficulties. LWCHC programs did not (and probably could not) provide for the needs of all clients, leading some immigrant women to feel ‘that they were outside the real experience and discussions of the collective’ (Stevens 1995:53). Anglo women struggled to understand the problems immigrant women faced and many wrestled with the fact that some immigrant workers had little knowledge of feminism and were not committed to its principles. For example, one worker is reported to have had problems with the collective mode of organisation and with the propagation of the ‘Women’s Libbers’ creed’. As Stevens (1995:53) has recorded, ‘it was often difficult to decide how and if it was possible for feminism to incorporate an understanding of all these experiences’. Most members of the collective, however, were strongly committed to providing services for all women who lived locally.

Many other women’s health centres made similar efforts. Loddon Campaspe Women’s Health Service and North-East Women’s Health Service in Victoria developed factory projects soon after opening in the 1980s. Although the board was Anglo-Australian, women from non-English-speaking backgrounds were employed at the Hindmarsh Women’s Health Centre, Adelaide, from the early days. The staff of Liverpool Women’s Health Centre came from diverse cultural backgrounds, including three Aboriginal staff members employed in 1984. Funding limitations, however, prevented Liverpool from reaching all the groups that were known to have needs (Edwards 1984:22). In 2008, staff members of Women’s Health Care House, Perth, spoke 14 different languages and arrangements were in place for interpreters in other languages to be present at appointments or to speak with clients on the phone. In some centres, lesbian-focused programs have been developed (Cameron and Velthuys 2005). This list is far from exhaustive.

In summary, racism, ignorance and lack of understanding, along with a heavy focus on the priorities of Anglo-Australian women, were, and possibly still are, part of the women’s health movement experience. Some successful joint ventures have, however, been developed and women’s health movement workers, within the resources available to them, have made efforts to respond to diverse health needs. The value of collaboration, where it proved possible, was recognised by Raquel Aldunate and Gladys Revelo, when, at a community and environmental health conference in 1986, they acknowledged ‘the support of our friends,
companeras, mainly Anglos, who cared enough to get beyond their guilt, and or ignorance, and therefore beyond their own racism’ (Aldunate and Revelo 1987:41).

Conclusion

Women with divergent views and from many cultural backgrounds have been part of the Australian women’s health movement and while there have been disagreements and differing priorities, a core set of ideas, around which there is considerable agreement, serves as a guide for action. The question of whether community-based service-providing groups should accept public funding has long been settled, not to everyone’s satisfaction, and for many years the task has been to acquire sufficient resources to be able to respond to women’s expressed needs and pay workers decent wages. A great deal of learning has taken place as Anglo-Australian movement members realised that not all women shared their concerns, priorities and ways of doing things. While it is as misleading to talk about the Anglo-Australian women’s health movement as one homogenous whole as it is to talk about ‘all Aboriginal women’ or ‘all immigrant women’, understanding has been developed between these different groupings and collaborative and fulfilling working partnerships have been formed.

The critique of curative medicine, developed in Australia and other English-speaking countries, was a crystallising force in the early years and continues to be relevant. Unsatisfactory encounters with the medical system were common enough for large numbers of women to identify with the critique. Some modification of medical practice has taken place, particularly in relation to the provision of information as a basis for effective informed consent. Serious concerns remain, however, including continuing medicalisation, gender bias in medical research and treatment, questions about the safety and appropriateness of pharmaceuticals and the paucity of prevention advice and support services.

The social view of health, which is an elaboration of feminist criticism of the undue focus on treatment in conventional medical care, takes into account the impact of life circumstances on health outcomes. Developed from everyday experience in a context of support for structural health reform, it forms the centrepiece of the movement’s ideas. Outside the movement, the concept has gained legitimacy, as supporting evidence of its validity accrues. Within the movement and in the public health and Aboriginal health movements, it is strongly endorsed. Achieving structural change in the health system and in the unequal conditions of people’s lives is the task that the Australian women’s health movement set for itself.

Photo: Property of WEL History Project

Opening Warrina Women’s Refuge, Coffs Harbour, New South Wales, July 1978. From left: Salvation Army Capt. Gail Rogers, Betty Craft, Director, Jan Ireland, Mary Curran, Joan Dunkley, Bel Weise, Patricia Degens, Shirley Jones, Valerie Furniss.

Photo: Pat Degens

Photo: The Search Foundation, Mitchell Library of New South Wales


Photo: Manoa Renwick
The National Women’s Health Policy, 1989.