3. Infrastructure Expansion: 1980s onwards

We bring women together to support each other and strengthen their sense of connection. Using a community development approach we involve women in a range of short or long-term health promotion activities within their own communities, including health festivals, support groups, resource production and more. (Women’s Health West web site)

The two decades after the fall of the Whitlam Government can be seen as the high point of the women’s health movement. A momentum had been generated that even unenthusiastic governments could not afford to ignore. The 1980s in particular was a period of intense policy development as the political advocacy of the previous decade began to bear fruit. Inquiries into women’s health were held in most States and Territories and all produced women’s health policies, plans or strategies. Similarly, in several jurisdictions, the first policies in relation to domestic violence and sexual assault were formulated. All governments set up women’s health policy machinery in their bureaucracies during this time, in the form of either a women’s health unit or a special women’s health adviser. As a result, channels of influence became more diverse. Grassroots activists were able to interact more readily with women in the bureaucracy and opportunities were created to serve on government advisory committees and inquiries. At the Commonwealth level, the development and launch of the groundbreaking National Women’s Health Policy (NWHP) was definitely the pinnacle of policy achievement.

Yet the movement faced a mixed policy environment, or series of environments, during the period. While no government after Whitlam’s would be as strongly committed to structural reform of the health system, especially at the level of community-based health care, policy opportunities did emerge. These were all the more visible because they were interspersed with periods of resistance, sometimes bordering on overt hostility. During these years, members of the movement carried on their work in both the political and the service-provision arenas. Women from diverse backgrounds continued to establish new services to meet needs, sometimes in collaboration with each other, and although some centres waited years, in almost all cases funding was eventually allocated by one level of government or the other and sometimes by both. Staff in women-led services received training, often for the first time, and training packages were developed for relevant professionals, such as the police and lawyers. For
mobilised groups in some States and the Australian Capital Territory, the NWH Program provided the funds with which to establish the health centres and services they had been planning for years.

By the end of the period, the Australian women’s health infrastructure was largely in place; very few new centres or services have been established since the mid-1990s. Given the lack of Commonwealth policy interest since that time (notwithstanding the introduction of a second national women’s health policy in 2010), the locus of action has largely moved to the sub-national level and sometimes involves local government as well. This chapter presents an overview of the movement’s advocacy and infrastructure-building activities over the two decades, which are summarised in the list below. The policy responses of the period are examined in Chapters 7 and 8.

Selected Women’s Health Centres and Services Established from 1980 Onwards

1980

• Adelaide Women’s Community Health Centre.
• Dawn House, providing accommodation and support services, Darwin.
• Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women’s Council, provider of health and human services, South Australia.

1981

• Blue Mountains Women’s Health Centre, New South Wales.
• Wirraway Women’s Housing Co-operative, Moree, New South Wales.
• Women’s Community House, Alice Springs, Northern Territory.
• Women’s Place, for homeless or intoxicated women, Sydney.

1982

• Brisbane Women’s Community Health Centre.
• Coffs Harbour Women’s Health Centre, New South Wales.
• Dympna House, Sydney.
• Louisa Lawson House, Sydney.
• Women’s Health Resource Collective, later Women’s Health Information Resource Collective, Melbourne.
• Yinganeh Aboriginal Women’s Refuge, Lismore, New South Wales.
3. Infrastructure Expansion: 1980s onwards

1983

- Elizabeth Women’s Community Health Centre, South Australia.
- Esther Refuge Collective, Sydney.
- Mookai Rosie Bi-Bayan, Aunty Rosie’s Place, services for rural and remote Aboriginal women and children, Cairns, Queensland.
- The Women’s Cottage, Hawkesbury District, Sydney.
- Toora Single Women’s Shelter, now Toora Women, Australian Capital Territory.

1984

- Dale Street Women’s Community Health Centre, South Australia.
- Illawarra Women’s Health Centre, New South Wales.
- Immigrant Women’s Support Service, Brisbane.
- Jilimi, now Waminda Aboriginal Women’s Health Centre, Nowra, New South Wales.
- Migrant Women’s Lobby Group, Adelaide.
- Refuge Ethnic Workers Program, Victoria.
- Southern Women’s Health and Community Centre, South Australia.

1985

- Darwin Counselling Group, providing sexual assault services.
- Immigrant Women’s Resource Centre, Sydney.
- Immigrant Women’s Speakout Association, Sydney.
- Migrant Women’s Support and Accommodation Service, Adelaide.
- Shoalhaven Women’s Health Centre, New South Wales.
- Southwest Women’s Child Sexual Assault Resource Centre, later Rosebank, Sydney.

1986

- Albury–Wodonga Women’s Health Centre, Albury, New South Wales.
- Central West Women’s Health Centre, Bathurst, New South Wales.
- Dympna Accommodation Program, Sydney.
- Goldfields Women’s Health Centre, Western Australia.
- Migrant Women against Incest Network, New South Wales.
- New South Wales Women’s Refuge Resource Centre.
- Sexual Assault Support Service, Hobart.
- Sexual Assault Referral Centre, Darwin.
- Women’s Centre, providing sexual assault crisis services, Cairns, Queensland.
1987

- Blacktown Women’s and Girls’ Health Centre, Sydney.
- Campbelltown Women’s Health Centre, also known as WILMA, Sydney.
- CASA House, Centre against Sexual Assault, Royal Women’s Hospital, Melbourne.
- Congress Alukura, women’s health, maternal and child health centre, Alice Springs, Northern Territory.
- Healthsharing Women, Victoria.
- Hobart Women’s Health Centre.
- Immigrant Women’s Health Service, Fairfield and Cabramatta, Sydney.
- Lismore and District Women’s Health Centre, New South Wales.
- Penrith Women’s Health Centre, Western Sydney.
- Ruby Gaea, providing sexual assault services, Darwin.

1988

- Domestic Violence Resource Centre, Queensland.
- Geraldton Sexual Assault Referral Centre, Western Australia.
- Gloria Brennan ATSI Women’s Centre, East Perth.
- Sexual Assault Counselling Service, Alice Springs, Northern Territory.
- Waratah Support Centre, sexual assault and domestic violence services, Bunbury, Western Australia.
- Women’s Health Service for the West, Victoria.

1989

- Laurel House, Launceston, Tasmania.
- Patricia Giles Centre, offering services for gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) people.
- Whitfords Women’s Health Centre, now Women’s Healthworks, Western Australia.

1990

- Canberra Women’s Health Centre, now Women’s Centre for Health Matters.
- Cumberland Women’s Health Centre, Sydney.
- Perth Women’s Centre.
- Townsville Women’s Community Health Centre, Queensland.

1991

- Geraldton Women’s Health Centre, Western Australia.
3. Infrastructure Expansion: 1980s onwards

- Rockhampton Women’s Health Centre, Queensland.
- Wide Bay Women’s Health Centre, Queensland.

1992
- Edith Edwards Women’s Centre, accommodation and support services, Bourke, New South Wales.
- Ipswich Women’s Health Service, Queensland.
- Logan Women’s Health Centre, Queensland.
- Mirrabooka Multicultural Women’s Health Centre, Western Australia.
- North-East Women’s Health Service, Victoria.

1993
- Eastern Goldfields Sexual Assault Resource Centre, Western Australia.
- Goulburn North-Eastern Victoria Women’s Health Service.
- Hedland Women’s Health Service, Western Australia.
- Rockingham Women’s Health Service, Western Australia.
- Women’s Health Victoria, formed from amalgamation of Healthsharing Women and the Women’s Health Information Resource Collective.
- Yarrow Place, incorporating the Adelaide Rape Crisis Centre.
- Yorgam Aboriginal Corporation, providing support services for people who have experienced violence, East Perth.

1994
- Gladstone Women’s Health Centre, Queensland.
- Gosnells Women’s Health Service, Western Australia.
- Gympie and District Women’s Health Centre, Queensland.

1997
- Immigrant and Refugee Women’s Coalition Victoria.

2002
- Aboriginal Family Violence Prevention and Legal Service, Victoria.

2005
- Women’s Health Services, formed from amalgamation of Women’s Health Care House and Women’s Health Services.
The Context: Mixed political opportunity structures

The 1980s and 1990s saw both high and low points for the women’s health movement, fluctuations that can be explained largely by the advent of favourable or unfavourable political opportunity structures. The defeat of the Whitlam Government ushered in a period of ‘depleted political opportunity’ for women’s health at the national level, which was the first of two inauspicious periods in the life of the movement so far. Political opportunity structure is a term used to denote the political context in which social movements try to influence governments, and is held to be a key element in determining whether advocacy succeeds or fails. Opportunity structures can help to explain the rise, fall and transformation of social movements and can go some way to explaining different outcomes at different times within one country or in different countries (Meyer 2004:125-131; Tarrow 1996:81–99). Political opportunity structure interacts with other factors that influence policy, among which institutional arrangements are considered important (Gray 2008:55).

During the years of the Fraser Commonwealth Government, from the end of 1975 until 1983, opportunities for policy expansion, which had been wide open, all but closed. Moreover, most of Labor’s health system reforms, which were of so much benefit to women and low-income earners, were steadily dismantled. The Fraser Government came to power promising to retain both the national health insurance scheme, Medibank, and the Community Health Program. Within months, it set up an informal interdepartmental committee to review the operation of national health insurance. No public consultation was ever undertaken nor was any report published, but over the next five years Medibank was steadily abolished.

In addition, Commonwealth funding for the Community Health Program, through which women’s health centres and refuges were funded, was progressively slashed each year. In 1981, community health centre funding was completely absorbed into the general federal tax-sharing grants, absolving the Commonwealth of all policy responsibility. The previous grant conditions requiring that the remaining funds be used for the Community Health Program were lifted and Commonwealth monitoring ceased. Funding for the Aboriginal housing program was also drastically cut back (Dowse 1984:151). The one area where funding was not reduced in total was refuges, of which more below.

On the other side of the coin, as often happens in federations, political opportunities were relatively open in several sub-national jurisdictions. While there was sporadic support for women’s health within the Liberal Party, particularly among women members, it was almost entirely under
Labor governments, national and sub-national, that significant reforms were implemented. Under National-Liberal Coalition or National Party governments, as in Queensland up to 1989, support for women’s health was entirely absent. In jurisdictions where Labor had a significant share of office, reforms were introduced earlier. The South Australian Dunstan Labor Government, for example, passed Australia’s first legislation making rape within marriage a crime, in 1976. In New South Wales, the Wran Labor Government, which supported women’s health, came to power in 1976 and was not defeated until 1989. Labor was elected in Victoria in 1982, re-elected in South Australia in the same year and elected in Western Australia in 1983, after being out of office for 11 years. In Tasmania, Labor lost power in 1982 and was not returned again until 1989, after which policy development moved ahead.

**Opposition—and some support**

All governments operated in a context where opposition emanated from the key player in health politics: the organised medical profession. The main doctor’s union, the Australian Medical Association (AMA) has steadfastly opposed separate women’s health services. Historically, it has taken a stand against all publicly funded services, such as baby health centres and venereal disease clinics in public hospitals because it feared such services might attract clients away from the private medical market. The President of one State branch of the AMA put the general case that separate women’s health services are ‘illogical’. Women are a majority of the population and consume a majority of the services. If they are not happy with the services, the services should be modified rather than supplied separately. The solution, the President suggested—missing the point that women would like more comprehensive services supplied by teams of providers—is to increase remuneration for general practitioners so they can afford longer consultations. Under the Medicare payment schedule, the 19-minute consultation is an economic disaster for doctors, the President told me. Publicly funded services are always unfair competition for the private sector, he argued, especially in the face of what was seen as an oversupply of general practitioners in the 1980s and 1990s. In some States, AMA members actively campaigned against the establishment of separate women’s health services. In Western Australia, where medical unions appear to be especially powerful, obstetricians from the King Edward Memorial Hospital for Women threatened to go on strike if the Government funded salaried midwives. For similar reasons, country general

---

1 Reform-minded governments are sometimes constrained by reform-resisting bureaucracies, as in South Australia in the 1970s and 1980s. This is discussed further in Chapter 9.

2 The claim to be part of ‘the private sector’ ignores the fact that approximately 80 per cent of ‘private’ medical incomes is drawn directly from the Commonwealth Treasury. It also ignores the reality that without a conduit to the public purse, the medical profession would be much smaller and its remuneration much lower.
practitioners and radiologists resented the introduction of mobile screening services. Indeed, Stefania Siedlecky, general practitioner, founding member of family planning, adviser to the Leichhardt Women's Community Health Centre (LWCHC) Collective and later Commonwealth women's health bureaucrat, remembers that some of the bitterest opposition to women's health centres came from female doctors, who asked that funding be withdrawn.

At the level of practice, however, general practitioners, even those who were initially suspicious, often found that there was little or no encroachment upon their markets. Indeed, many found that the work of the centres complemented their own. From the early days, LWCHC saw many women whose doctors had been unable to help them. At the Liverpool centre, acceptance was such that one gynaecologist developed the practice of having his female medical students spend time at the centre (Edwards 1984:22).

Although organised medicine was strongly opposed, many individual women doctors worked hard over long periods as part of the general women’s health movement, providing services in many of the early centres, usually on a voluntary basis. The contribution of Dr Janet Irwin from Brisbane is an example of dedication and hard work. Irwin, a long-time human rights advocate, campaigned strenuously on abortion issues, supporting C by C and early family planning initiatives in Queensland. She was director of student health services at the University of Queensland from 1974 to 1988, where she promoted student health and identified sexual harassment as a women’s health issue. In 1982, the university was one of the first in Australia to establish procedures to deal with sexual harassment complaints. In 1996, Janet Irwin was appointed the university’s first Sexual Harassment Committee conciliator. Among many other health-related activities, she served on the university’s Status of Women Committee, where she fought for the rights of general staff members, almost all of whom were women, especially on OHS issues. She was also active in medical women’s groups and is co-author of two books on raising female daughters, *Mom, I Got a Tattoo* and *Parenting Girls*. For her work in human rights and women’s health, she was made a Member of the Order of Australia and awarded a Centenary Medal. Many other women were similarly dedicated.

Opposition sometimes came from unexpected quarters: in Sydney, it was suggested that a sexual assault counselling service should be set up at Rachel Forster Hospital for Women but the board decided that such a service was unnecessary. Another possibly unlikely opponent was the Parramatta Council, which objected to the establishment of a local women’s health centre. In South Australia, the hospitals, as well as organised medicine and the bureaucracy, opposed both women’s health and community health centres. Across the country,  

---

3 Perhaps some men did also, although I have not uncovered written records.
general practitioner organisations opposed the appointment of women’s health nurses. Finally, in some places, women opposed each other. In Tasmania, for example, some women consider that opposing positions within the movement in the 1980s and into the 1990s were at least as much of a problem as external opposition.

**Women’s Health Centres: Continuing expansion**

Despite the forces standing against them and the scarcity of resources, community women continued to set up their own services. Aboriginal women worked together and through Aboriginal community health centres and Aboriginal resource centres, making their voices heard in a range of ways. Similarly, immigrant and refugee women continued to respond to expressed need.

**Aboriginal Women’s Initiatives**

To us, health is about so much more than simply not being sick. It’s about getting a balance between physical, mental, emotional, cultural and spiritual health. Health and healing are interwoven.

— Dr Tamara Mackean, Australian Indigenous Doctors’ Association

A few examples of the various centres and services set up in different parts of the country by Aboriginal women are presented here by way of illustration. An impressive centre was established in Alice Springs under the auspices of the Central Australian Aboriginal Congress (CAAC). The major focus of the congress was health service provision from the beginning and the model adopted was comprehensive and community controlled, in keeping with the social health perspective. At the time, the NT Government was unsympathetic so Commonwealth support was sought, which enabled a general health service to be opened in 1974 (Rosewarne et al. 2007).

In the early 1980s, Central Australian Aboriginal women approached the congress about the need to respect traditional birthing practices and other concerns. As a result, the Birthright Research project was established in 1984 with financial support from the Commonwealth. The research team visited 60 communities and met with women from 11 language groups who were spread over 78 000 sq km. The research was followed up with the Women’s Birthrights Conference, where the aims and objectives of a proposed new centre were worked out. A primary healthcare model was selected, to be based on traditional grandmothers’ law, under which ‘law, languages and culture’ were
to be incorporated into ‘a women’s health and birthing service’ (Carter et al. 1987; Stuart 1995). The conference established the Congress Alukura Women’s Council, which set up the Alukura Women’s Health Program in 1985. Alukura means ‘a woman’s camp’ in Arrernte, the language of the traditional owners of the Alice Springs area. The women’s council is a subcommittee of the CAAC and has representative, advisory and decision-making roles in relation to women’s law and practices. It set about the task of obtaining funding and was eventually successful. Congress Alukura opened as a pilot project with a midwife, a health worker and a liaison worker in June 1987 (Carter et al. 1987).

Alukura provides a range of health services for the city and surrounding regions, including comprehensive antenatal and postnatal care, shared maternity care, gynaecological services, a well women’s clinic, sexual assault and domestic violence counselling and examinations, health education, transportation, health worker training and a bush mobile clinic. In 1994, Alukura was awarded a UN Human Rights Award for the development of its community health and birthing service. After 10 years of operation, the Acting Director was able to claim that ‘we are one of the most experienced organisations in the country in Aboriginal women’s health, a national leader in primary health care and a strong political voice for the health of our people’ (Stuart 1995:179).

In the 1990s, some women were able to give birth at Alukura. In 2002, however, an agreement was signed under which Alukura midwives had visiting rights at the Alice Springs Hospital. For three years, babies were delivered at the hospital by Alukura midwives but in November 2005, due to staffing shortages and other issues, birthing services were suspended. Some of the special projects carried out by Alukura include a three-day Women’s Health Conference in 1997, attended by more than 700 women, the production of a grandmothers’ law video, which preserves cultural information, a cooperative research project on antenatal health, the development of the Women’s Business Manual and the Young Women’s Community Health Education Project (CAAC 2004–05, 2006–07; Carter et al. 2004).

Concern about the lack of appropriate health services for Aboriginal women and their families emerged on the South Coast of New South Wales in the early 1980s. There were financial barriers to accessing mainstream services, which, in any case, could be insensitive to cultural needs. In 1984, the Aboriginal Women’s Health Centre was set up under the auspices of Jilimi, the Shoalhaven Women’s Health and Resource Corporation. A change of incorporation brought into being the South Coast Women’s Health and Welfare Aboriginal Corporation and a change of centre name to Waminda in 1990. Understanding and valuing Aboriginal culture are fundamental at Waminda. Other principles are a holistic, family and community-as-a-whole approach to health and respect for women’s agency and participation in decision making. Primary healthcare programs
include the Women’s Health Program, providing a health and sexual health clinic, screening services, support groups for grief and loss, physical activity groups, health promotion and information. A domestic violence support program is responsible for education, awareness and community-development projects, healing camps and court support. There is a drug and alcohol support program and a Koori Girls School Program, which aims to empower girls and young women and help them make informed, healthy lifestyle choices. A Koori Women’s Playgroup supports mothers in relation to health, welfare, housing, finances and social and emotional wellbeing. An early childhood nurse and a dietician are employed, along with other children’s service providers. The Family Support Program operates workshops for women and their children in skill development and strength building and identifies family needs in relation to housing, finances, social and emotional wellbeing and health. A parenting program aims to build stronger families and the Aboriginal Women Artist Cooperative promotes personal growth and empowerment through art and craft, as well as the development of business and information technology (IT) skills.

Aboriginal women in Cairns set up a women’s and children’s health centre in the early 1980s. An Aboriginal welfare worker from the Cairns Hospital, Rose Richards, aware that Aboriginal children from rural and remote areas were returned home before they had fully recovered because there was no appropriate Cairns accommodation, began to take children to her own home. With help from other women, including registered nurse and midwife Jilpia Nappaljari Jones, she eventually obtained funding to set up a halfway house. Later relocated, it became known as ‘Rosie’s Farm’. It was also apparent that transitional accommodation was needed for women who came from remote locations before the births of their babies. Secure funding was obtained and Rosie’s Farm moved to its present location, where it is known as Mookai Rosie Bi-Bayan, or Aunty Rosie’s Place. It provides services for women and children, including accommodation, transport, recreational activities, health support and advocacy, access to counselling, cultural and emotional support, reproductive health care, pre and postnatal care, nutrition and environmental health education, a playgroup and other educational activities. Anecdotal evidence from Mookai Rosie health workers suggests a reduction in the number of children who fail to thrive, an increase in breastfeeding, a drop in premature births and an improvement in infant health (Mookai Rosie Bi-Bayan web site).

Another Aboriginal women’s centre, the Gloria Brennan Aboriginal and Torres Strait Islander Women’s Centre, was established in 1988 by the Aboriginal and Torres Strait Islander Women’s Congress of Western Australia to provide health and childcare information. Located in eastern Perth, it is a multipurpose centre. As well as health information, it provides assertiveness training and conducts courses in problem solving, conflict resolution, letter writing, management
and communication skills and meeting procedures. It runs cultural education programs and provides support, counselling and referral services. Among its political projects has been the ‘Stop the Abuse’ campaign against sexual assault (Weeks 1994:86, 99).

The Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women’s Council, which covers parts of Western Australia, South Australia and the Northern Territory, was formed in 1980 when women felt that their needs were not being addressed in relation to land rights. The council, incorporated in 1994, soon became a major provider of human services, juggling advocacy work with casework. It takes a holistic approach to issues such as domestic violence, aged care, emotional and social wellbeing, nutrition and disability needs. The Cross Borders Domestic Violence Service covers 350 000 sq km across the three jurisdictions (NPY Women’s Council web site).

In other places, Aboriginal women work for health through local Aboriginal Controlled Community Health Services (ACCHS), or in cooperation with government-employed health workers. The Aboriginal and Islander Health Worker Journal provides a record of multiple health-improvement projects undertaken by Aboriginal women over three decades. For example, Lajamanu women, who live in an outback area of the Northern Territory, participated in a project designed to address alcohol and violence issues in their community in the late 1990s. The women painted their stories on calico, which was made into wall hangings and displayed in various public places, conveying their messages to their community. A banner, in English on one side and Warlpiri on the other, and a video were also made. The Lajamanu women insisted on involving men in discussions. Evaluation showed that alcohol and violence issues and strategies to overcome problems were more openly discussed in both family and women’s groups. The principles on which the project was based demonstrate traditional views about the importance of community:

Mobilising communities or even groups within communities has long been acknowledged as the most successful method of empowering people to take responsibility for their own health and well-being. Ensuring that the client group has ownership and direction of the program, in cooperation with an outside agency to support and help resource the activities is a virtual guarantee of a positive outcome for the community. (Clarence and McDonald 1998:2)

Storytelling has also been used by Aboriginal women as a method of health promotion. Drawing on the tradition of oral narratives and on aunty/niece and grandmother/granddaughter relationships, information about female sexual and reproductive roles and practices has been disseminated in several Sydney communities. In 1993, a group of Koori women elders, in cooperation with
Aboriginal academics and other women, made video recordings, in which the need for healthy lifestyles was stressed and information was provided about cervical cancer and coronary heart disease—two of the big illness issues for Aboriginal women. The Aboriginal women involved were empowered and affirmed in their roles as carers and health-promotion information was made available to be passed on to others (Newman et al. 1999:18). Other projects have used art to help women dealing with social and emotional issues and mental illness to feel safer and to bring women together for mutual support (Aboriginal and Islander Health Worker Journal 2002:12). These examples serve to illustrate the keen interest Aboriginal women take in improving the health of their communities.

Immigrant and Refugee Women’s Initiatives

Similarly, immigrant and refugee women continued to set up their own centres and services, within the limits of the resources available to them. Gradually, collaboration with the Anglo-Australian women’s movement grew. In most places, immigrant and refugee women sought to work with government departments and to gain representation on relevant boards and committees. Like the rest of the women’s movement, the immigrant women’s community lost human resources to bureaucracies, as women moved into newly created positions.

In most jurisdictions, from the early 1980s onwards, immigrant and refugee women were active around issues of health, culturally appropriate services, language barriers, isolation, the scarcity of interpreters and issues concerning overseas qualifications. Activism was easier in some States than in others. In Queensland, women had to work extremely hard to gain support for health issues. They tried to get appointments with relevant ministers, attempted to get representatives onto relevant advisory committees and tried to persuade the government to take responsibility for interpreting services. Progress was slow, however, under the National and National-Liberal governments that held power through the 1980s.

Brisbane women established the Immigrant Women’s Support Service in 1984 with Commonwealth SAAP funding. The centre is multipurpose and community based and adheres to feminist principles. In 2004, it was providing services for women from 72 different countries through its two main programs, which focus on domestic violence and sexual assault. The service is now funded jointly by the Commonwealth and Queensland governments.

The Multicultural Women’s Health Centre was established in Fremantle, Western Australia, by a group of women in 1985, spearheaded by the extraordinary efforts of one woman, Ronelle Brossard (Broom 1991). As well as providing for
the needs of immigrant women, the centre was soon also providing services for local Aboriginal women. Also in Perth, the community-based Ishar Multicultural Centre for Women’s Health, formerly the Mirrabooka Multicultural Women’s Health Centre, began operation in 1992. Its philosophy is grounded in a social model of health and, as well as core staff, it is supported by a band of volunteers. In 2009, Ishar collaborated with a neighbouring women’s health centre, Women’s Healthworks, supported by the Western Australia Department for Communities, to consult with more than 100 women on their views about issues of concern for the new national women’s health policy. The centres wrote a combined submission to the Commonwealth.

In 1987, the Immigrant Women’s Health Service was established in western Sydney, with centres in Fairfield and Cabramatta. It provides a comprehensive range of preventive and clinical services and information and referral services for women from diverse backgrounds and it adjusts its programs to changes in cultural demography. Special events are staged regularly, including cooking demonstrations, food sharing and well-known feast days.

Multipurpose immigrant women’s centres and associations generally feature health as one of their priorities. The Immigrant Women’s Speakout Association, community based and managed, was formed in New South Wales in 1985, following a successful speak-out gathering in 1982. The NSW Immigrant Women’s Resource Centre was established at the same time. The association’s priorities include health, domestic violence, child care, education, and workplace, legal and equity issues. It undertakes community-development projects and is particularly concerned about the needs of disadvantaged women. Speak-out gatherings were also organised in Brisbane and Adelaide in 1983.

The Migrant Women’s Lobby Group, established in Adelaide in 1984, is a peak body for immigrant women’s groups. Health issues are a major focus. Another such group is the Australian Vietnamese Women’s Association, formed in Victoria in 1983. More recent groups include the Filipino Women’s Support Group, New South Wales, formed in 1998, and the Victorian Immigrant and Refugee Women’s Coalition, set up in 1997. The Migrant Women’s Support & Accommodation Service (MWSAS) is a not-for-profit, community-based organisation, established in 1985 in Adelaide. It is a specialist provider of emergency and short-term accommodation and crisis and support services for women and children escaping violence. It operates an outreach service and conducts community education workshops. The organisation aims to promote the basic human rights of women and children from non-English-speaking backgrounds ‘so they may live free of domestic violence’ (MWSAS web site).
Anglo-Australian Initiatives

The second half of the 1970s was a period of serious funding insecurity for established women’s health centres, while there were few financial opportunities for those that were trying to set themselves up. State and Territory governments were being asked to shoulder the costs of the Community Health Program and other programs as the Commonwealth withdrew its funding. Thus, even where sub-national governments actively supported women’s health, money became scarce as the Whitlam Government’s largesse came to an end. At the best of times, Australian federalism is characterised by severe financial imbalance, as discussed. This general situation was exacerbated by the balance-of-payments problems of the late 1980s and the recession of the early 1990s. At that time, the Commonwealth Labor Government drastically and unilaterally cut its grants to the States and Territories in order to curtail public spending, resulting in straitened financial circumstances at the sub-national level (Summers 2006:142–3).

In the late 1970s in New South Wales, where most of the women’s health centres were located, women waged a time-consuming and discouraging battle for several years to maintain funding. They were assisted by femocrats and women in the ALP. Under the new arrangements, funding levels were reduced so that, for example, the workers at LWCHC received no pay increases during the first eight years.

Survival on minimal funding was one thing but the new centres that were trying to establish themselves from the mid-1970s onwards had an even more difficult time. Most opened and survived on a mix of volunteer labour, donations, the proceeds of fundraising and small, short-term grants. The Central Coast Women’s Health Centre in Gosford began in 1976, staffed by volunteers. After two years, it succeeded in obtaining minimal funding but, until the mid-1980s, it relied heavily on donations and volunteers (Broom 1991:18–19). In 2011 it has satellite services in Woy Woy and Wyong. The establishment committee for the Bankstown centre in south-western Sydney was involved in four years of intense work before it received a small grant in 1978. The Wran State Government ‘firmly refused’ to fund it fully, in what was believed to be a strategy to discourage the formation of new centres (Smith 1984:5). Eventually, it received enough funding to allow it to expand in the mid-1980s (Broom 1991:23).

The Wagga Women’s Health and Support Centre (New South Wales) was opened in 1979 after a long period of activism. The centre enjoyed relatively high levels of material support from the local community, despite the founders having to endure a deal of disparagement (Roberts and Stewart 1999). The feminist, community-based Women’s Community Health Centre in the Blue Mountains was set up in 1982. In the Coffs Harbour area of New South Wales, the local branch of WEL researched women’s health needs in 1973. Priorities were a
refuge, opened in 1978, and family planning services. The Women's Resources Centre was opened in 1982, providing information and support and, later, family planning services. When funded in 1986, it became the Coffs Harbour Women's Health Centre. At that time there were health fears about the use of agricultural chemicals. Within hours of opening, appointments were booked out for three months.

The Illawarra Women's Health Centre (New South Wales), a feminist, community-based organisation, was opened in 1984. It houses a lesbian safe place, the Illawarra Lesbian Health Project, which provides health information and services for lesbians. Shoalhaven Women's Health Centre was opened in 1985. Another organisation, The Women's Cottage—not strictly a women's health centre—opened in the Hawkesbury district in 1983, funded by the Department of Community Services to be a resource centre. The cottage now functions primarily as a feminist women's health centre, helping to address considerable unmet need in its local area.

In 1985–86, women's health centres in Wollongong, Wagga Wagga, Campbelltown, Penrith and Blacktown received funding for the first time, as a result of the recommendations of the NSW Women's Health Policy Review Committee. In Bathurst, the Central West Women's Health Centre was opened in 1986. A feminist, community-based organisation, funded by the NSW Department of Health and the Department of Community Services, it aims to make its community safer, fairer and more supportive for women and children. Blacktown Women's and Girls' Health Centre was opened in 1987, after years of lobbying by a group of feminists. Initially funded by the Commonwealth, it works from a social determinants framework and is cognisant that many of its clients have low incomes. In the same year, Penrith Women's Health Centre and Lismore and District Women's Health Centre were opened. In 1990, the feminist Cumberland Women's Health Centre began to operate, with a particular focus on combating violence against women. It employs complementary health practitioners and an Aboriginal women's health worker. The Women's Health Centre in Albury–Wodonga is very unusual in that, instead of having to work long and hard for funding, it happened that money became available before women had fully mobilised (Broom 1991:143–4).

Other States have fewer women's health centres than New South Wales. Between the closure of the Brisbane Women's House Health Centre in 1977 and when the next centre was funded in 1990, a group of volunteers struggled to provide a rudimentary service. Over the years, hundreds of women belonged to the group and many came, left and joined again. By the early 1980s, the volunteers were despondent and their energies depleted. They had been unable to secure meetings with Health Minister, Brian Austin, and, indeed, he is said to have ridiculed and trivialised women's issues in public statements. Only three of the
original group remained committed and such funding as they had derived mainly from a pledge system and from performing street theatre! A women’s health centre group in Hervey Bay was mobilised and, in Rockhampton, a women’s information centre was run by volunteers from donated premises in a shopping centre. Despite efforts across the State, there were limits to the community effort and interest that could be maintained in the face of a staunchly conservative government.

In 1982, however, a new collective formed in Brisbane, which opened Brisbane Women’s Community Health Centre in Woollongabba in early 1983. The centre was supported by project funding from the Commonwealth Community Employment Program (CEP). At the end of 1983, enough money was raised to employ Carol Low as a fundraiser and submission writer. Workgroups and subcommittees were formed and fundraising included staging a women’s health day. A submission to CEP in 1984 produced funds to employ seven full-time and two part-time workers but when the funding finished, staff were reduced to three and survival again became dependent on a pledge system and small amounts of temporary funding. About this time, another group of women, sensitive to trade union issues without being trade unionists, began to meet in the Union of Australian Women offices. A Queensland branch of the Australian Community Health Association was formed and energy for a women’s health centre was mobilised again, supported by the newly established Workers Health Centre and the Migrant Women’s Speakout. A way was found to have Commonwealth money channelled through the Australian Community Health Association to the Queensland branch and then to the Brisbane Women’s Health Centre, which received Commonwealth funding in this way for three and a half years. Hard work and strong commitment brought a modicum of success: Helen Abrahams, then a participant, now a Brisbane City Councillor, is of the view that anything that survived in Queensland during the years of government hostility is strong, like a desert flower.

The Goss Government came to power in 1989 with a policy on women’s health that it is said was written by a male party member. Jude Abbs, women’s health activist, is credited with having brought women’s health to the Queensland branch of the ALP and then into government when she became head of the new Women’s Health Unit. From this time on, women’s health in Queensland received more stable funding, jointly supplied by the Commonwealth and Queensland under the NWH Program. In the next two years, six new community-based centres were funded from the same source: Townsville in 1990, Rockhampton and Wide Bay in 1991, Logan and Ipswich in 1992 and Gympie and District Women’s Health Centre in 1994. Gladstone nurses had campaigned for a centre, which was opened in 1994. In 2011, there are nine women’s health centres in
Queensland, all women controlled and community based, except for the Ipswich centre, now called West Moreton Women’s Health, which ran into financial difficulties in 2003 and became part of Queensland Health in 2004.

The general situation in South Australia in the key early 1980s was one of strong community and ministerial support for women’s health, on one hand, and determined bureaucratic opposition on the other. The story of the closure of Hindmarsh and its reopening as Adelaide Women’s Community Health Centre has been discussed. Soon after, Labor replaced the Liberal Government and the new Minister for Health, John Cornwall, was strongly interventionist. He was persuaded to support a social determinants and community-development approach to health and was aware that, despite Australia’s relatively good average life expectancy, there were serious inequalities in health outcomes and significant levels of preventable death, disease and injury, especially among low-income groups (Cornwall 1989:157–62). Liz Furler was appointed Women’s Adviser on Health at the beginning of 1984, with a brief to increase women’s influence in health policy. During his tenure, Cornwall approved funding for three new women’s health centres to complement Adelaide Women’s Community Health Centre as a State-wide service.

The first was Elizabeth Women’s Health Centre (later Northern Women’s Primary Health Care Centre), which began providing services in 1983 and officially opened in 1984 after five years of lobbying and preparation by a sponsoring group. In a clear instance of party difference, the centre had been approved by the Labor Government in 1979 but was abandoned by the incoming Liberal Government (Radoslovich 1994:31–7). In the southern part of Adelaide, women mobilised in response to the enormous health and social problems and service gaps that were evident in the area. A formal group was established in 1983 and, supported by the local community health centre, it wrote a submission for a women’s health centre. Approval to proceed was announced at the opening of the Elizabeth centre, and Southern Women’s Health and Community Centre was officially opened in September, 1984 (Radoslovich 1994:39–44).

Again in 1983, Minister Cornwall gave approval for a steering committee of local women to investigate the feasibility of establishing a centre in the Port Adelaide area. Dale Street Women’s Community Health Centre was opened for business the following year. From the beginning, 180 people per month attended group and other sessions and waiting times for appointments with doctors, counsellors and nurses soon extended to several weeks (Radoslovich 1994:45–50).

In keeping with the longstanding bureaucratic preference for government (or health department) control, the SA women’s health centres have now lost their independence, although refuges have been allowed to maintain independent management committees. An early amalgamation attempt in 1986–87 by the
Health Commission was staved off by extensive grassroots action (Auer 2003:8). In 1995, however, in a move with the stated aim of achieving ‘efficiencies’, Adelaide Women’s Health Centre was de-incorporated and merged with the Women’s and Children’s Hospital. A memorandum of understanding was written that outlined the responsibilities of the two agencies and the name, Adelaide Women’s, was changed to Women’s Health Statewide. The three other women’s health centres were amalgamated into the community health services of their regions. In 2004, the Women’s and Children’s Hospital and Women’s Health Statewide were amalgamated to form the Children, Youth and Women’s Health Service. According to Jocelyn Auer, a member of the movement from the early days, the SA women’s health centres are now clearly part of the health service and can no longer be said to be run ‘by women, for women’. They now work for change within the health system (Auer 2003:8, 12).

Various groups interested in setting up a women’s health centre formed in Hobart in 1974 but their efforts to get support were unsuccessful and they finally disbanded. In 1984, another group, the Women’s Health Foundation, was established. Members were especially concerned that low-income women could not access abortion services because they could not afford to travel to Melbourne. At this time it was estimated that between 75 and 90 per cent of Tasmanian women wanting an abortion were forced to go interstate. Moreover, virtually no counselling services were available in Tasmania. The foundation raised some $33 000 over two years, with which they bought a building at 9 Pearce Street, Hobart. It was renovated and approved as a medical centre; however, medical practitioners willing to do abortions and general practitioners to provide back-up could not be found.

After this setback, it was decided that the house could be leased to the Hobart Women’s Health Centre group, to be used as a women’s health centre; however, operational funding was not available from the Tasmanian Government. Eventually, 18 months’ funding was allocated by the Commonwealth and the centre opened in 1987. A doctor who was able to bill Medicare for consultations was found. Lobbying for expansion continued and, in 1989, in the lead-up to the State election, the Labor Party promised that it would support three women’s health centres. Once in government, however, it announced that there was only enough money for one. And so it is that Tasmania, to this day, has one (precariously funded) women’s health centre.

After the closure of Collingwood Women’s Health Centre in the late 1970s, Victorian activists focused their attention on supporting women to care for their own health and trying to influence mainstream services to be more responsive to women’s needs. Information and community education resources were produced, as a variety of health-focused groups began to form, such as an endometriosis
self-help group and a DES\textsuperscript{4} action group. A Women’s Health Resource Collective (later Women’s Health Information Resource Collective) was formed in 1982 by a small group of women, some of whom had belonged to the original collective. The group survived on bits and pieces of short-term funding. It focused on information provision, community development, advocacy and lobbying and the development of written health-promotion material. In its first five years, it produced 14 information leaflets and booklets on a range of issues and printed, in total, 95 300 copies. Workers collaborated with other community groups and gave talks and addresses. The centre also operated as a drop-in place (Women’s Health Information Resource Collective 1987).

The Ministerial Women’s Health Policy Working Party was established in 1985. It reported in 1987, giving rise to a serious struggle that resulted in a period of expansion for Victorian women’s health services. The report recommended that at least one women’s health service be set up in each of the health regions and that there should be two women’s health information services, one of which would focus on the needs of immigrant women. A group called Healthsharing Women was formed, which successfully tendered to run a State-wide information service, opened in 1988. The Women’s Health Service for the West, the first regional women’s health centre, was initiated by two groups, one a coalition from the northern and the western suburbs and the other the Western Women’s Health Network. Under the cost-shared NWH Program, women’s health centres were set up in each of the regions between 1989 and 1992, following initiatives by groups of community women, most of which had been mobilised for years.

In 1993, the Women’s Health Information Resource Collective and Healthsharing Women amalgamated to form a single State-wide agency. The service changed its name to Women’s Health Victoria (WHV) in 1996. It provides health promotion, information and advocacy services, with a focus on informing and influencing health policy and service delivery. Currently there are nine independent regional services and three State-wide services funded under the Victorian Women’s Health Program.

The political climate in Western Australia was not strongly conducive to the establishment of separate women’s health services, although small windows of political opportunity opened at different times. The network of women’s health services that is in place, therefore, testifies to the dedication of grassroots groups and the women in bureaucracies, political parties and other places who support them. Grassroots action continued in the late 1970s and through the 1980s in efforts to get State support for new centres. The establishment of the Goldfields Women’s Health Centre resulted from action by community women and nurses over a period of years, for example. Initially, the director of community nursing,

\textsuperscript{4} Diethylstilboestrol, which is discussed in Chapter 4.
Margarita Paul, sent out a questionnaire asking women to identify the services that were important to them. A public meeting was held and the Goldfields Women's Health Care Association formed, followed by fundraising drives and lobbying. A group of volunteers began to provide skeleton services in 1986. The following year, services were expanded, supported by donations and more fundraising. The then Health Minister, Ian Taylor (minister from 1986 to 1988), was sympathetic but the women were required to prove they could run a centre efficiently on a volunteer basis before government funding would be considered. Money for a house was obtained from the Lotteries Commission in 1988 and funds were raised to employ a counsellor. Operational funding was secured from the Health Department in 1989 but had to be supplemented with other grants and community donations.

A similar process took place in the Geraldton area where a group wishing to establish a centre had been organised for several years. A regional planning study had been undertaken and submissions written. Despite supportive government statements, only $5000 had been allocated by 1989, when Labor promised support in its election campaign. Once in government, however, they refused to provide further funding. The centre, initially called the Midwest Women's Health Resource Centre, was eventually funded under the NWH Program in 1991.

Whitfords Women's Health Centre, now Women's Healthworks, was set up under the auspices of the Women's Health Care House in 1989, but the following year it developed its own constitution and became independent. Mirrabooka Multicultural Women's Health Information Centre, now Ishar Multicultural Centre for Women's Health, opened in 1992. Rockingham Women's Health Service was established in 1993, funded by the NWH Program, along with Hedland Well Women's Centre. Gosnells Women's Health Service opened in 1994. By 1997, 11 community-managed women's health centres, metropolitan and regional, were being jointly funded by the Commonwealth and WA governments under the NWH Program (Commonwealth of Australia 1997:26).

Throughout this period, Perth's original women's health centre, Women's Health Care House, continued to operate and expand. At the end of the 1980s, a decision was taken to try to better meet the needs of the significant numbers of clients with alcohol and other drug problems. To this end, Perth Women's Centre was established a block away the following year. In 2005, Women's Health Care House and Perth Women's Centre were amalgamated and now operate as Women's Health Services. The organisation manages numerous community and outreach projects and provides services for more than 45 000 families each year from more than 60 nationalities and from city, rural and remote areas of the State.
In the Australian Capital Territory, efforts to establish a women’s health centre go back to 1974 when the first unsuccessful funding submission was made. The ACT Women’s Health Network (ACTWHN) established a women’s health centre working party in preparation for the NWHP in 1987. The ACT Department of Health suggested a workshop in early 1990 to discuss the implications of the NWHP for local services. The workshop was convened by Dorothy Broom, then Convenor of ACTWHN. There was unanimous agreement that the NWH Program money should be used to establish a women’s health centre. The draft recommendations of the meeting were circulated for comment and a special general meeting of the network was called to refine the draft proposals. A subcommittee was formed to progress the decision. The ACT Government and the Commonwealth accepted the recommendations and the Canberra Women’s Health Centre, later renamed the Women’s Centre for Health Matters, was opened in 1990. Networkers became members at the next ACTWHN meeting and stuck gold stars on their foreheads to celebrate!

The Work of Women’s Health Centres

Women’s health centres provide a broad range of community-based services. The service mix varies from centre to centre and from time to time, depending on resources and local needs but whatever is offered is highly valued, judging by the queues of women who line up to use them. As well as medical services in some locations, counselling and preventive health advice might be on offer, alongside referral, naturopathic and massage services, for example. Counselling for emotional and mental health issues, sometimes related to abuse and domestic violence, is nearly always in high demand. Centres provide information on countless topics, often in many languages, facilitate the formation of support and self-help groups and hold a variety of workshops and classes in response to changing needs. Most centres provide outreach services. Service provision for individuals and groups involves interaction and cooperation with a wide range of local and State agencies, from individual health professionals to housing departments.

The cluster of services provided is not readily available from primary medical care facilities, such as general practitioners’ offices. Moreover, services are provided in a sympathetic manner with time taken to listen, provide information and consider a woman’s overall life situation. Waminda Aboriginal Women’s Health Centre serves as an example. As well as conventional reproductive health and screening services and childhood health programs, there are domestic violence prevention and support programs, healing camps, grief and loss support systems, social and emotional wellbeing projects and health-promotion activities. Personal growth and empowerment are major goals. This work includes school
programs for girls alongside parenting programs and family support workshops for women and their children, involving the development of skills in relation to everyday needs and activities, such as housing, finance, business and IT use. Like other women’s health centres, Waminda aims to offer integrated, culturally appropriate, holistic primary health care, with a focus on health promotion and illness prevention.

Political advocacy is a major component of work. Women’s health workers write letters and position papers, make submissions to inquiries, and lobby and liaise with governments at all levels, including the local level. They lend their support to other groups, such as unions, during campaigns for equal pay, for example. Typically, a centre will be involved in a number of community-development activities, which can range from sexuality education for young people to the elimination of toxic waste. In facilitating participation in its decision making, a centre contributes to the personal development, health and wellbeing of local women (Broom 1998a:7). The bigger centres undertake research into local needs and conditions and publish and disseminate the findings.

Women’s health centres have been able to influence the way things are done in mainstream hospital and medical systems by expanding the scope of debate and developing best-practice models of primary health care, although their influence is less than activists would wish. Centres and the wider movement bring up new issues and suggest new approaches and new ways of working that raise mainstream awareness about what might be involved in women’s health care. More opportunities are thereby created for mainstream innovation than would have otherwise been possible (Dwyer 1992a:26–7). Centres influence both by example and through training: staff members are regularly invited to contribute to the education of medical students and centres provide training placements for medical students and students from other disciplines, such as nursing and social work (Broom 1998b:10–11). Information about women’s health, both hardcopy and online, finds its way into the nooks and crannies of health systems. It also contributes to the formation of bands of health consumers who expect to be well informed and to participate in decisions about their health and health care. And the day-to-day activities of centres support and reinforce political activism. As Dwyer (1992b:25) has argued, the two arms of the dual strategy reinforce each other: ‘the delivery of services legitimates the advocacy and the advocacy disseminates the lessons learned from the people being served and advances their interests.’

Women’s health centres are highly valued by the women who use them. Research undertaken in the 1990s by Dorothy Broom probed the reasons. Broom found that many women felt safer in an all-women environment and many were more comfortable with a woman doctor and therefore more willing to discuss problems. Women appreciated the sympathetic hearing they received, the time
taken to provide explanations and information and the responsiveness to their health, broadly defined, and their life situations. Women gained empowerment through their participation in groups organised around a range of healing and health-promoting activities, such as education, living skills development, exercise and self-defence. When asked, women wanted other health agencies to replicate features of women’s health centres: they wanted more informal environments, more supportive staff, more information and counselling, the availability of more groups, a more holistic approach to health and they wanted more women’s health centres, closer to home (Broom 1996, 1998). In summary, the appeal of women’s health centres was found to be based in best-practice models of care, including the time taken to deal sympathetically and holistically with complex problems and to provide information. Women felt empowered by their participation in groups and by opportunities made available for health development (Broom 1998b:5).

Refuges, Shelters and Houses

The one women’s health issue that the Fraser Commonwealth Government supported was shelter for women escaping domestic violence. At the time, new refuges were being established by churches and welfare-oriented groups, as well as by feminists. In 1975–76, 19 refuges were funded under the Community Health Program and one under the Homeless Persons Assistance Program; however, one year later, there were 40 refuges, with more than 100 in operation by 1979 (Dowse 1984:149–50). As discussed in Chapter 2, in the absence of agreement in the Commonwealth bureaucracy about the appropriate locus of responsibility, refuge funding had been provided through the Community Health Program under the Whitlam Government. The Fraser Government continued to use the same channel but it simultaneously slashed the funding, leaving the Community Health Program to fight for its life (Dowse 1984:151). One result, among others, was reduced refuge funding.

Prime Minister, Malcolm Fraser, seemingly supported refuges: he had personally intervened to ensure that Queensland refuges were funded directly after Premier Bjelke-Petersen refused to pass on Commonwealth money on the grounds that ‘Marxist lesbians’ were involved in the Brisbane refuge. In 1977, it was decided that the Commonwealth would put refuge financing on a secure basis and the Minister for Social Security, Senator Margaret Guilfoyle, was requested to prepare a submission for the budget that year. The minister was, however, reluctant to take on the new responsibility and the budget approached without a satisfactory proposal. Facing the possibility that funding would cease, the Office of Women’s Affairs sent out an alert. Strong community action followed, including a high-profile media campaign. In response, cabinet decided that
existing arrangements should continue and that the money allocated would be doubled to $2 million (Sawer 1990:38). At the same time, however, the Commonwealth continued to cut funding for the Community Health Program and called on the States and Territories to take up the slack (McFerran 1990:194). The outcome of this extraordinary situation was that while there was more money for refuges, existing (that is, feminist) refuges, which by this time comprised about one-third of the total, suffered funding cuts. Moreover, newly established refuges received ‘only shoestring assistance’ (Dowse 1984:151–2).

The entry of private institutions and organisations into the field gave rise to debates and disputes about the legitimacy of ‘feminist’ refuges. Workers continued to endure poor wages and conditions in feminist establishments, often donating their own money by splitting available salaries among a greater number of workers. Conservative sub-national governments did not support the refuge movement, at least initially, whereas reasonable support, albeit infused with electoral expediency, came from Labor governments. Overall, ‘new refuges were set up with ridiculously poor funding and funding for existing refuges stagnated’ (McFerran 1990:194).

A funding crisis was created in 1981 when the Commonwealth passed responsibility to the States and Territories for what remained of the Community Health Program, women’s health centres, refuges and rape crisis centres. A strong reaction followed from feminist organisations, supported by the National Women’s Advisory Council, which issued a media release censuring the Commonwealth for abrogating its responsibility to women and children. A tent embassy was set up outside Parliament House but the decision stood (McFerran 1990:198–9; Sawer 1990:54–5). Refuges limped along on grossly inadequate funding, unable to pay standard wages, until 1984, when a Commonwealth Labor government set up the Women’s Emergency Services Program (WESP), which brought with it funding increases. In 1985, WESP, jointly funded by the Commonwealth, States and Territories, was incorporated into SAAP—a move that was initially resisted by feminists on the grounds that refuges were not about homelessness but about domestic violence. The advent of SAAP funding brought a measure of stability, in the form of five-year funding agreements. Perversely, perhaps, the end of the ‘annual scramble for bitterly contested money’ rendered the refuges invisible in a political sense. No longer forced to draw attention to themselves and to make their arguments public, there was less debate about domestic violence and the homelessness it caused (McFerran 1990:200–2).

The proliferation of refuges did not solve women’s emergency accommodation problems. For example, only 19 per cent of women seeking emergency shelter were able to gain a place in Victoria in 1992 (Fredericks 1993). Thus, women from different backgrounds continued to set up new services. For example,
Cawarra Women’s Refuge Aboriginal Corporation was established in 1977 and has provided services for Aboriginal and non-Aboriginal women since that time. Wirraway Women’s Housing Co-Operative in Moree, New South Wales, was established in the early 1980s to provide Aboriginal women with emergency as well as permanent accommodation. More recently, the Aboriginal Family Violence Prevention and Legal Service Victoria was established to assist people affected by family violence and sexual assault. It has three branches in country Victoria and among its activities are programs for young Koori women. The Yinganeh Aboriginal women’s refuge was set up in Lismore, New South Wales, in 2005.

Immigrant women in Victoria set up the feminist Refuge Ethnic Workers Program (REWP) in 1984, which conducted education projects and worked to challenge negative stereotypes, both inside and outside immigrant communities. It adopted a new name and a new mission in 1994 as the Immigrant Women’s Domestic Violence Service. Run by a community-based collective, it provides an exceptionally comprehensive range of services. Women of Different Ethnic Backgrounds (WODEB), a subgroup of Women in Health around Melbourne (WHAM), was also formed to explore different ways of dealing with immigrant and refugee health issues. In South Australia, a number of services for women escaping violence were established, including the Non-English Speaking Background Domestic Violence Action Group.

New Anglo-Australian feminist refuges include the Women’s Place for homeless or intoxicated women without children, opened in Sydney in 1981 after considerable difficulty finding suitable accommodation. Louisa Lawson House was set up in Sydney in 1982, in response to concerns that women escaping physical and sexual violence were becoming ‘mental health statistics’ for want of appropriate services (Grahame and Prichard 1996:71). Its founders marched on the Premier’s office to demand funding. Coffs Harbour Women’s Support Group, formed in 1984, had a turbulent beginning, with serious disagreements in the first year (Grahame and Prichard 1996:34). The Esther Refuge Collective was formed in 1983 to establish a feminist refuge in the Hornsby–Ku-ring-gai area of northern Sydney.

In South Australia, Anne Women’s Shelter, Elizabeth, opened in 1978 and Hope Haven Women’s Shelter, Adelaide, Port Adelaide Women’s Shelter, Port Augusta Women’s Shelter and Whyalla Women’s Shelter all operated in the 1970s and 1980s. Annie Kenney Young Women’s Refuge was set up in Hobart, Matilda Women’s Refuge and Woorarra Women’s Refuge were established in Melbourne, along with others in country Victoria. In the Australian Capital Territory, the Single Women’s Shelter Collective was formed in 1981, in response to problems that emerged when women with different needs were housed in the same place. The group struggled to obtain funding for three years but Toora Single Women’s
Shelter, now called Toora Women, opened its doors in August 1983. Demand for services has always been high and, like so many others, it has survived on minimal funding, and, on occasion, even that has been under threat. The organisation has expanded and changed during its 28 years: there are now eight separate Toora services, employing more than 50 women (Rosenman 2003). In Western Australia by 1990, there were eight metropolitan refuges, five country refuges, an immigrant women’s service and an Aboriginal women’s refuge. One of these, the Patricia Giles Centre, which was opened in 1989 and expanded in 2006, offers programs specifically tailored for Aboriginal women and gay, lesbian, bisexual, transgender, intersex and queer (GLBTIQ) people.

The Women’s Health Network in the Northern Territory took the lead in lobbying for a refuge and wrote several unsuccessful funding submissions. Eventually, an application for Commonwealth SAAP funding succeeded and Dawn House, which is about to celebrate its thirtieth birthday, was established.

The remarkable story of how a country refuge, Edith Edwards Women’s Centre, in Bourke, New South Wales, was set up is worth recounting in detail because it illustrates the extraordinary efforts women undertook to set up basic services and demonstrates that women from different cultural backgrounds can work together successfully. Its establishment took a series of community meetings, stretching over a decade, and dedicated collaborative action by Aboriginal women, non-Aboriginal women and other members of the Bourke community. In response to high rates of violence, the first public meeting was held in the early 1980s, followed by the formation of a committee, a succession of further meetings and several unsuccessful funding submissions. In 1987–88, the District Manager of the then Department of Youth and Community Services supported the committee, making strong representations to her department and documenting the need for a facility in this isolated town. Her efforts also failed but the committee persevered.

In the meantime, Mygunyah Aboriginal Corporation, formed by Dubbo women, had obtained funding for a number of domestic violence workers to be located in western towns. The Commonwealth Department of Family and Community Services proposed that a support worker be provided through Mygunyah. Bourke women protested strongly because women and children would need to be transported to the nearest refuge in Parkes, about 500 km away. A support worker nevertheless arrived.

The Bourke committee continued to agitate for separate funding. It was assisted by a nun from Cobar who had helped set up another country refuge. In 1991, another public meeting was held. The result was an offer from the Historical Buildings Cooperative of a heritage-listed ‘Grand Mansion’ with a large garden in the centre of town, on condition that the group take responsibility for
maintenance. An added attraction was that it was only half a block from the police station. The group became incorporated, applied for charitable status and decided to wait no longer for government funding.

A mammoth community fundraising effort ensued. The solicitor employed by the Aboriginal Legal Service cooked curries to sell in the main street, helped by others making salads and rice. A radio auction was organised, with donated goods and services from surrounding towns. There were cake stalls, bingo games and the like, a small bequest and a local businessman who, facing a court appearance, donated $2000 to show he was of good character. The council agreed to waive water, sewerage and land rates. During the preparatory phase, informal community consultations were held, which included talking to older women about expectations, needs and concerns. Given that renovations, building maintenance and insurance had to be paid for, the committee was fortunate in finding a qualified, highly respected Aboriginal woman who agreed to live in, rent free, as unpaid manager.

The refuge opened on International Women’s Day, 1992. The first clients had arrived two weeks beforehand and in the first month 100 bed nights were occupied. Donations from religious organisations allowed the employment of two casual employees; otherwise all work was voluntary. Fundraising continued: donations included half a sheep a week from a fundamentalist Christian community and a towel service supplied by the Country Women’s Association. Aboriginal and non-Aboriginal women worked together and volunteers were included in decision-making processes, fostering feelings of ownership. By 1992, the refuge was providing a 24-hour, seven-day-a-week service without public financial support. In 2011, Edith Edwards Women’s Centre is a publicly funded, community-controlled service, with the capacity to house three families. Additional accommodation options are available in private homes, if needed (Alvares 1992; Personal communication with refuge staff).

A variety of other services to support women experiencing domestic violence has been set up over the years. To give just a few examples, the NSW Women’s Refuge Resource Centre has operated since 1986 as a referral, information and awareness-raising service. In Queensland, a State-wide domestic violence service offered counselling, community education and produced resources until 2002, after which it became an advocacy and outreach service. A domestic violence crisis service was set up in the Australian Capital Territory in 1988 to provide crisis intervention at the scene of the incident alongside the police and a 24-hour, seven-day-a-week crisis telephone service. Aboriginal women have devised various projects, using art and storytelling traditions for therapeutic purposes. Community arts projects are also used in multicultural settings (Cazalet and Lane 2000). In Townsville, in the late 1990s, a women’s collective established a community garden in the grounds of the North Queensland Combined Women’s
3. Infrastructure Expansion: 1980s onwards

Services Centre, as a symbolic project to work for peace and against violence (Lynn and Perkins 2000). Another creative project is the collection of stories by workers in a north Queensland women's shelter, published as Dragonfly Whispers (Sera Women's Shelter et al. 2006).

Like women’s health centres, refuges, shelters and houses operate with dual aims: they try to meet the immediate support and accommodation needs of women and children escaping violence while engaging in political action. Intensive case-management services for diverse groups of women and children are provided and some agencies have special programs for children. Refuges advocate on behalf of clients, produce information and research and conduct community education, aiming to generate awareness of domestic violence and promote the rights of women who have suffered from it. Training packages are developed for relevant professionals, along with a full range of information production and dissemination activities.

**Sexual Assault Services**

Despite campaigns against sexual violence in the 1980s and 1990s, the issue has been difficult to keep on political agendas. A couple of well-reported pronouncements helped the cause. In South Australia, Supreme Court Judge Justice Bollen said in 1993 that a husband may use ‘a measure of rougher than usual handling’ to persuade a wife to consent to sex. In the same year, Justice Bland told a Victorian County Court in a rape case that ‘no often subsequently means yes’. Such statements prompted public debate and intensified feminist campaigns.

As with domestic violence, in relation to rape and sexual assault the importance of considering cultural factors gradually became more widely recognised. In communities where shame was attached to victims and their families, sexual crimes were rarely discussed (Yarrow Place web site). Despite the establishment of services such as the Migrant Women against Incest Network in New South Wales in 1986, immigrant and refugee women usually maintained silence about sexual assault (Jung 2003). Regardless of these barriers, sexual assault became a major issue in many multipurpose centres set up by immigrant women.

As far as I have been able to discover, only a few sexual assault services along white feminist lines have been established by Aboriginal women.⁵ One such is the Yorgam Aboriginal Corporation, set up in 1993 in East Perth to overcome the

---

⁵ Aboriginal women have their own ways of meeting community needs.
problem that available services were inappropriate. Yorgam supports spiritual, physical, emotional and mental health needs and provides a range of counselling services to address violence and sexual abuse affecting Aboriginal people.

Anglo-Australian women set up many new services. In New South Wales, the Dympna House incest service secured funding for the Dympna Accommodation Program in 1986, which was incorporated as the Stepping Out Housing Program in 1987. Dympna staff recognised that clients who were homeless would benefit from more stability in their lives. The Stepping Out Housing Program provides supported accommodation for women (with or without dependent children) who have experienced childhood sexual abuse. Many such women fled to the streets at a young age. Another New South Wales service is the Southwest Women’s Child Sexual Assault Resource Centre, set up by women with CEP funding in 1985. Later called Rosebank, the service struggled to locate appropriate accommodation but, in 2006, premises were secured until 2011.

Women’s House, Brisbane, which began as a rape crisis centre in 1975, had to wait until 1983 to receive temporary funding and until 1991 to obtain secure funding. The following year, it added the word ‘incest’ to its title, to better acknowledge the scale of sexual violence, becoming the Brisbane Rape and Incest Survivors Support Centre. A multipurpose women’s centre was established in Cairns in 1986, providing a sexual assault crisis service. Similar services have been established on the Gold Coast and the Sunshine Coast.

In South Australia, the feminist Adelaide Rape Crisis Centre was still struggling financially in the 1980s, although it received some government funding. In 1993, the Government decided to amalgamate the service with the sexual assault service run by Queen Elizabeth Hospital. Feminists campaigned against the ‘amalgamation’, which meant disestablishment of the management collective, but the merger went ahead. The service, called Yarrow Place, has a strong preventive focus. It challenges attitudes and beliefs and works towards ‘a society free of sexual violence’. Two Aboriginal health workers are employed.

The Women Against Rape group formed in Tasmania in the 1970s and worked towards law reform but was hampered by internal divisions. Roughly, one group of professional women favoured workers with professional qualifications while another thought that experience was the most important qualification and that cooperation with government would lead to cooption. Another issue was whether the service would participate in police training. Complicating matters was the position taken by male gynaecologists, who wanted a hospital-based, medically oriented service. In the event, women were able to cooperate sufficiently to set up a service in 1986.
As mentioned in the previous chapter, the publicly funded Sexual Assault Centre was established at the Queen Victoria Medical Centre, Melbourne, in 1977. The centre developed within a feminist framework and part of its early work was to undertake community and professional education. In 1982, the Cain State Labor Government was elected on a promise to establish a sexual assault service in each of the State’s health regions. By 1985, six Centres Against Sexual Assault (CASA) had been put in place. In response to the recommendations of the inquiry into women’s health, which reported in 1986 (of which more below), another seven centres were established by the end of the 1980s, followed by two more in 1992 and 1995 respectively, completing a network of 15 services. The centres have a variety of management models. Although government controlled and funded, some are community based and some have mixed boards, which include hospital administrators and community members—a structure designed to facilitate community input and accountability. According to Hewitt and Worth (n.d.), it is something of an open question whether CASA are an expression of the feminist struggle against patriarchy or ‘whether they had been co-opted to create a well serviced class of victims’.

Western Australia’s original Sexual Assault Resource Centre (SARC) was relocated in a house close to the King Edward Memorial Hospital in 1985. The aim was to provide a confidential, non-hospital environment, with hospital backup nearby. Workers enjoyed a considerable degree of autonomy, were organised as a collective and able to operate from a feminist perspective, although tensions existed ‘vis-a-vis the bureaucracy of a large teaching hospital’ (Farr 1987). A number of regional services also operate in Western Australia, including Waratah Support Centre, in Bunbury, which is a combined sexual assault and domestic violence service, set up in 1988. It runs the Mooditj Healing Program, which originally provided healing services for Aboriginal women and children but now also supports Aboriginal men. The Eastern Goldfields Sexual Assault Resource Centre is a community-based, government-funded centre, with a voluntary board of management, established in 1993 as part of the NWH Program. New sexual assault resource centres were set up in Port Hedland and Albany using NWH Program money.

In the Northern Territory, a group of women volunteers who saw an urgent need for a feminist service set up the Darwin Counselling Group in 1985 to provide support for women and children who had experienced sexual assault. The women lobbied for funding and, after two years, were successful. Ruby Gaea was opened in 1987 and is still managed by a collective today. Decision making is done on the basis of consensus and women from a variety of ethnicities have served on the collective.

In summary, what has emerged after almost 40 years is a variegated patchwork of government and non-governmental sexual assault services across the States.
and Territories. All provide services as well as engaging in advocacy and other political activities. Preventive programs are devised to challenge attitudes and beliefs, along with training programs for police, lawyers, doctors, nurses, social workers, youth workers and others. Two services, the NSW Rape Crisis Service and the Canberra Rape Crisis Service, have a continuous history back to the 1970s. Both provide 24-hour, seven-day-a-week telephone or online access to experienced counsellors. In Victoria, the services can be described as ‘arm’s-length’ government services, as each of the 16 CASA has its own community-based board and has been heavily influenced by feminist principles. In Queensland there are 16 services, all of them non-governmental organisations (NGOs). In Tasmania there are three services, one in each of the health regions, and all three are NGOs. All States and Territories provide 24-hour services but not all provide access to specialist counsellors. In some States, after-hours calls are referred to nurses or mental health workers. In other locations, only recent assaults are dealt with at the time of a call, with less recent assaults referred to daytime services.

Direct Activism in Relation to Sexual Violence

Following Italy and the United Kingdom, in Australia the first ‘Reclaim the Night’ marches were organised in 1978. The aim is to draw attention to sexual violence against women and to protest against the virtual curfew imposed on women because walking on the streets at night can be dangerous.

Direct action has included drawing attention to rape during war. One of the most publicised activities of the early 1980s was women marching on Anzac Day in memory of women who were raped in war. The Sydney Women Against Rape Collective was formed in 1980. In 1981, approximately 300 women joined the end of the Anzac Day march in Canberra, resulting in 65 arrests. The magistrate who heard the case used the language of terrorism and mutiny and sentenced three women to a month in jail for coming within 400 m of the march (Elder 2007:251). The Rape Action Group for Every Woman, established in Perth, was involved in Anzac Day activism in 1983, which resulted in 168 women being arrested when they marched, after having been refused a permit. The emphasis was, nevertheless, on non-violent protest (Grahame and Prichard 1996:111). Reclaim the Night marches are held annually in cities around Australia, as they are overseas. These attempts to decentre the dominant narrative of military heroism were met with outrage in many sections of society and they also sparked controversy and debate within the women’s movement about appropriate strategy (Howe 1984:22).
In recent years, Reclaim the Night activism has been partly overshadowed by the more male-oriented White Ribbon Campaign. Initiated by a small group of Canadian men in the early 1990s, it was a response to the massacre of 14 young women in Montreal. The United Nations followed up in 1999, declaring 25 November the International Day for the Elimination of Violence against Women, to be symbolised by the White Ribbon. Generally led by prominent men acting as White Ribbon Ambassadors, the international campaign asks men and boys to speak out and take an oath, swearing never to commit, excuse or remain silent about violence against women.

Conclusion

Members of the women’s health movement from a variety of backgrounds worked tirelessly to build an institutional infrastructure that would provide urgently needed services, giving generously of their time and energy and often their own money. Most of the services that were set up are not available elsewhere and are highly valued and strongly sought. The work of the movement has given rise to significant opinion shifts: taboo subjects that were not spoken about in public are now inscribed in government policies and many people now consider that access to appropriate services is a basic right. Moreover, although considered highly unconventional in the early years, separate women’s health services now enjoy a level of legitimacy in most jurisdictions.

The network of centres and services across the country provides an institutional base for the movement from which political action in all its forms can more readily be undertaken. Since the 1980s, those women working in women’s centres and services, both government and non-government, have constituted a core network of women’s health advocates. Surrounded by a growing constellation of funded and unfunded advocacy groups—some tiny, some large—a strong foundation is in place for continuing work.

In keeping with these developments, advocacy work took on a steadier, more predictable character from the 1980s onwards. After the heady days of the 1970s, when direct action was common, new institutional structures, set up in response to the earlier activism, created opportunities for new ways of working. A wider range of avenues through which governments might be approached and policy might be influenced was put in place. These included the channels opened through women’s health policy machinery in all jurisdictions and the extensive consultation processes that formed an important part of government inquiries into women’s health and aspects of women’s health in the 1980s. Inquiries, task forces and advisory bodies created representative roles and movement members were able to serve in the new positions and present a feminist perspective.
The possibility of working effectively through institutionalised structures is, however, strongly influenced by the political orientation of the government in power. Governments with no interest in women’s health have held power both nationally and sub-nationally at different times. The commitment and perseverance of movement members has been such, however, that advantage has been taken of political opportunities as they became available. In some cases, such as when Brisbane activists devised a means of having Commonwealth money for their centre channelled through national and State community health associations, women opened up opportunities for themselves. The institutional base that the movement has built for itself is small but strong.
3. Infrastructure Expansion: 1980s onwards

Women with Disabilities Australia (WWDA) Management Committee and staff, Hobart, 2010. Executive Director, Carolyn Frohmader, centre back; Convenor of WWDACT, Sue Salthouse, far right.

Photo: Women with Disabilities Australia

Members of the AWHN management committee at the Women’s Health Summit held at Parliament House, Canberra in 2007 to draw attention to the need for a review and update of the National Women’s Health Policy. From left: Vicki Lambert (WA), Denele Crozier (NSW), Cobi van der Es (Qld), Marilyn Beaumont (Vic), Marian Hale (Tas), Morven Andrews (Tas), Tracey Wing (Tas), Gwen Gray (ACT) Dot Henry (WA) and Celia Karfpen (SA).

Photo: Gill Wann
Members of the Queensland Women’s Health Network voluntary management committee facilitate Women’s Health Forums in the Torres Strait Islands, 2010. Pictured: Dr Betty McLellan, Chair of Queensland Women’s Health Network (centre), with local women and children on Hammond Island.

Photo: Queensland Women's Health Network

Hobart Women’s Health Centre.

Photo: Tracey Wing

Photo: Tracey Wing

Dorothy Broom, inaugural convener of the ACT Women’s Health Network, who has written extensively on the Australian Movement, in front of the AWHN stand at the Sixth National Women’s Health Conference. Dorothy had attended all six national conferences, 1975-2010.

Photo: Tracey Wing