4. Group Proliferation and Formal Networks

There are hundreds of community-based groups of women organised around particular health issues. (Dwyer 1992b:211)

Like the women’s movement, which has been described as ‘broad-based’ and ‘somewhat protean’, ‘loosely made up of many disparate parts’ (Dowse 1988:207), the women’s health movement has always encompassed groups with different views and priorities. From the 1980s onwards, however, it became even more diverse as groups proliferated and the movement took on the appearance of a variegated array of assemblages, some of them tiny. Most of the new health groups were concerned with specific issues, such as maternity services or breast cancer treatment, but some focused on the health of particular groups, such as women with disabilities or sex workers. Immigrant and refugee women continued to set up their own associations and services, as did Aboriginal women. Not all of the new groups were feminist but most undertook advocacy, provided support and facilitated information sharing and self-help. As new interests and needs emerged, existing centres and services modified their activities in response. In the academy, the proliferation of groups was reflected in feminist theory building, where attention moved from a focus on similarities to the importance of difference and different experiences, whereupon the notion of a ‘variety of feminisms’ gained currency.

In the 1980s, women in the movement turned their minds to the problem of how to improve the effectiveness of political action. One response was the formation of generalist networks and associations that were established in most jurisdictions, along with a national peak body: the Australian Women’s Health Network (AWHN). Specialist associations and peak bodies were also set up in the refuge and sexual assault sectors. Over time, most of the generalist State and Territory networks have been replaced with associations of service providers but AWHN and the Queensland Women’s Health Network (QWHN) continue.

Group proliferation can be seen as both a strength and a weakness. The formation of multiple organisations is one of the criteria that has been used to assess the strength of women’s movements: the more organisations and the more members, the stronger is the movement (Weldon 2002:80). The creation of so many groups demonstrates the importance that women attach to health and it facilitates the articulation of a much broader range of issues. On the other hand, movement members often no longer know each other, even at the local level. The capacity of the movement to speak with a single voice is reduced. The list below and the following survey of new groups are far from exhaustive.
Selected Specialist Women’s Health Groups Formed from the 1970s Onwards

- ACT Incest Centre
- AIDS Council of New South Wales
- Australian Lesbian Medical Association
- Australian Women’s Health Nurse Practitioners Association
- Australian Women’s Health Nurses Association
- Bonnie Babes Foundation
- Breast Cancer Network of Australia
- Centre for Women’s Action on Eating Issues
- Coalition against Depo-Provera
- Coalition of Activist Lesbians
- Collective of Australian Prostitutes
- Continence and Women’s Health Physiotherapy
- Council for the Single Mother and Her Child
- DES Action
- Eating Disorders Foundation of Victoria
- Eating Issues Centre
- Endometriosis Association of Victoria
- Female Doctors Group (Gender and Medicine)
- Feminist Therapists Group
- Girl2girl
- Incest Survivors’ Association of Western Australia
- Jean Hailes Foundation
- Medea
- Migrant Women against Incest Network
- National Breast Cancer Foundation
- National Council for the Single Mother and Her Child
- National Network against Trafficking in Women
- National Rural Female GP Network Steering Committee
- National Rural Women’s Coalition
- Older Women’s Network
- Older Women’s Network of New South Wales
- Older Women’s Wellness Forum
- Pelvic Instability Association of Victoria
4. Group Proliferation and Formal Networks

- Pink Links
- Polycystic Ovarian Syndrome Alliance
- Polycystic Ovarian Syndrome Association of Australia
- Positive Women
- Post and Antenatal Depression Association
- Post and Antenatal Support and Information Group
- Postnatal Depression Support Association
- Project Respect
- Project without a Name
- Real Rape Law Coalition
- RSI Group Canberra
- Scarlet Alliance
- SIDS Council of Australia
- Stillbirth and Neonatal Death Support
- Sydney Incest Survivors Collective
- Tenosynovitis Association
- Victorian Women with Disabilities Network
- Women against Incest
- Women and Addiction Group
- Women with Disabilities ACT
- Women with Disabilities Australia
- Women’s Addiction and Recovery Service
- Women’s Healing Centre
- Women’s Incest Survivors Network
- Women’s RSI Support Team

A Proliferation of Groups

Specialist and single-issue women’s health groups had already begun to emerge in the 1970s. One of the early specific concerns was use of the drug diethylstilboestrol (DES). DES Action was initiated by the Union of Australian Women in 1979 as a support and advocacy group for women exposed to synthetic hormones, which can have cancerous and other adverse reproductive side effects for mothers and daughters and possibly sons. Other groups followed in different parts of the country. Initially, pharmaceutical companies, health authorities, doctors and gynaecologists denied that the drug had been used in Australia but, in 1983, after a long campaign, a DES clinic was opened at the Royal Women’s
Hospital, Melbourne. Its existence, however, was not publicised and neither doctors nor the Victorian Government knew of its existence. It was eventually privatised (DES Action Australia website). A coalition against another drug, Depo-Provera, was arranged in Victoria in 1987, after a 10-year campaign by a number of organisations (National Women’s Health Centres Newsletter 1988).

Groups began to form around women’s mental health issues from the late 1970s onwards, partly in response to reluctance in the mainstream movement to address serious mental health issues. The Feminist Therapists Group began in Adelaide in 1981 to provide mental health care and facilitate the formation of support groups. The Project without a Name was set up in Sydney in 1982, with mental health among its several concerns. The Leichhardt Women’s Community Health Centre (LWCHC) collaborated with feminist therapists and others to establish Louisa Lawson House, which was opened in 1983, first to provide support for women in severe emotional crisis and, later, when more public funding became available, to provide emergency accommodation. In 1985, funding was received to operate a women’s mental health and therapy centre, including provision of counselling services and group programs. Later, a minor tranquilliser clinic was established to offer education and mental illness prevention programs. Obtaining funding was always a struggle (Shaw and Tilden 1990:94–5).

Meg Smith, one of the original workers at LWCHC, set up a mood-disorder support group in 1982, which grew rapidly. Many similar self-help and support groups were formed, some of which also undertook advocacy, concerned about the poor state of mental health services and the shortcomings of mental health legislation. Other issues were discrimination against people with mental illness and lack of rehabilitation services for people in the recovery stages (Smith n.d.). In the Australian Capital Territory, a group of friends who had experienced mental illness themselves formed a collective in 1984 and opened Medea in 1986 when funding was obtained. Medea was a holistic alternative to the limited mental illness management options that existed in the Territory at the time. Workshops, open to any member of the community, were held three days a week on issues such as anger release, unresolved childhood issues, child sexual abuse, resolving conflict and the like (Australian Women’s Health Network 1988:2–4).

Feminists brought incest out of the shadows and publicly identified it as a major, long-term women’s health issue. Women against Incest was formed in Sydney in 1983, and worked to attract funding for a community-based centre. Dympna House, Australia’s first feminist incest facility, was opened a year later, to undertake counselling, research, training, community education and accommodation provision. Its priorities were the protection of children, the empowerment of women and girls and the creation of a referral network for offenders. Women against Incest continued to work with Dympna House as a policy advice and advocacy group. Originating at Women’s Health Care House,
Perth, the Incest Survivors Association of Western Australia was incorporated in 1984. It deals specifically with child sexual abuse and post-traumatic stress disorder (PTSD) in later life, and produced a parenting manual in 2007. The Migrant Women against Incest Network was established in 1986, which broke new ground by conducting public awareness and education programs around this previously taboo issue (Jung 2003:111). The Women's Incest Survivors Network Incorporated (WISN), which still operates, was formed in Sydney in 1992 after the First National Confest for women survivors of incest and child sexual abuse, which was organised by the Sydney Incest Survivors Collective (Martin 2000). Women in the Australian Capital Territory set up an incest centre in the 1990s but it was forced to close when funding was withdrawn by a Liberal Party government.

Recognised as a major women’s health issue in the 1980s, eating disorders became a focus for program development work and research. A variety of community-based associations and foundations was established to support sufferers and undertake advocacy. Most were not women specific, which is perhaps surprising given that women are the main sufferers. Only about 10 per cent of the young adults diagnosed are males (Eating Disorders Foundation of Victoria web site). The new organisations provide services for women, of course, and there are one or two that are exclusively for women. Brisbane feminists set up the Centre for Women’s Action on Eating Issues in the 1990s, changing its name to the Eating Issues Centre in 2009. It provides services for women on Tuesdays and Thursdays and for men, women, transgender and intersex people during the rest of the week. The centre takes a holistic view and uses the term ‘eating issues’ in preference to ‘eating disorders’ to denote a social view rather than a medical, individual pathology perspective (Isis web site).

A number of specialist groups formed around issues related to pregnancy in addition to maternity care reform and pro-choice groups. Postnatal depression (PND), trauma and grief after miscarriage, stillbirth and neonatal death emerged as important women’s health issues from the 1980s onwards. The Post and Antenatal Depression Association (PANDA) is a Victorian community-based, self-help organisation formed to provide support, including telephone support, information and referral services, to women and their families. An average of 200 calls per month is received through the helpline. PANDA trains volunteers, undertakes advocacy, supports the establishment of new support groups and offers information, education and training seminars for professionals and community groups. In 2003, it established a network of postnatal depression group facilitators to bring health professionals and facilitators together. In the Australian Capital Territory, the Post and Antenatal Depression Support and Information group (PANDSI) and, in Perth, the Postnatal Depression Support Association (PNDSA) provide a similar set of services. Groups that formed in
the 1980s around miscarriage, stillbirth and neonatal death include Stillbirth and Neonatal Death Support (SANDS Australia), which has branches in several jurisdictions, and the National Sudden Infant Death Syndrome (SIDS) Council of Australia, with branches in all jurisdictions and the Hunter region of New South Wales. The Bonnie Babes Foundation, established in 1994, provides a range of services, including counselling, in cases of infertility, miscarriage, stillbirth, pregnancy loss, neonatal loss and premature birth.

Groups also sprang up around the ‘new’ malady repetitive strain injury (RSI) in the 1970s and 1980s. The problem was new only in the sense of having been recently brought to public attention: reports of its occurrence had appeared in journals for 100 years. The Workers Health Centre in Lidcombe, Sydney, ran support groups from 1979 onwards. Victorian women set up the Women’s Repetitive Injury Support Team (WRIST) in 1982. In the same year, Adelaide women set up RSI Campaign and in 1984 the Tenosynovitis Association was formed in Sydney and the RSI Support Group in Canberra. Most groups provided information in a number of languages. Doctors at Adelaide Women’s Community Health Centre discovered that women prefer support groups rather than individual counselling because it reassures them to know they are not alone. Moreover, groups were found to be an efficient way of disseminating information (Brown et al. 1986).

The advent of HIV/AIDS was the stimulus for the formation of yet another set of issue-specific groups when women felt that their concerns were not being fully recognised. By 1993, there were groups in most major cities providing support and information and conducting advocacy. Positive Women was established in Victoria in 1988, for example. The organisation obtained funding to develop a resource kit for women with HIV/AIDS and for service providers. It was also funded to facilitate support group formation and to develop a sense of community. Women had expressed a strong need to meet other HIV/AIDS-positive women to break down the sense of isolation they felt. To help meet these needs, a book and a video were produced.

There is a women’s health sub-movement around alcohol and other drugs but it has always been small. Most community-based associations and public agencies are mixed-sex services, and, in the early days, in particular, the focus was on the needs of men. High relapse rates were attributed to the inability of services to meet women’s needs. In 1989, an Australia-wide survey showed that there were no arrangements in place in 44 per cent of agencies to meet the needs of women with children. There were even fewer services for women with special needs, such as migrant women, Aboriginal women and lesbians (Crawford and Elliott 1994:143–53). The Royal Women’s Hospital, Melbourne, however, does
provide a voluntary, State-wide women’s alcohol and drug service for pregnant women with ongoing drug and alcohol issues, along with professional support and education programs.

Otherwise, nearly all women-specific drug and alcohol programs originated in women’s health centres. Most of the larger women’s health centres, such as Leichhardt, employ drug and alcohol workers. The Women and Addictions Group associated with the Leichhardt centre was formed in 1981. Women’s Health and Family Services (formerly Women’s Health Care House), Perth, offers a comprehensive set of services for women and those living with women who are experiencing drug and alcohol problems. As well as a general program, separate services have been fashioned for immigrant and refugee women, and for pregnant and parenting women and their families, and the Singing Up Project has been created for Aboriginal women and their families.

ACT initiatives include the establishment in 1985 of the feminist Women’s Addiction Recovery Service (WARs) by the Toora Single Wimmin’s collective. WARs was a community-based information, referral, education, training and counselling service for women and children; however, the service had only one paid worker and so could not provide effective support for more than a few individual clients. It therefore set about developing a broader approach, which included a critique of existing services. It attempted to counter negative attitudes towards drug-dependent women, redefined women’s dependence and developed new models to promote positive change. Experience showed that it is impossible to separate women’s experience of drug dependence from the conditions of their everyday lives, including past and present abuse, levels of self-esteem and motherhood roles (Morgain 1994). Focusing on both licit (pharmaceuticals, alcohol) and illicit drugs, a policy of resourcing communities to respond to their own needs and experiences was developed.

The ACT Women’s Health Network, of which more below, established a longstanding working group on alcohol and other drugs. One issue of concern was the provision of safe injecting equipment for the local remand centre. It successfully lobbied for a halfway house, opened in 1994, where women recovering from addiction could be with their children.

The availability of information about breast cancer and its treatment became a concern in the 1980s when survivors began to form support, advocacy and exercise groups around the country. The Breast Cancer Network of Australia (BCNA) was established in 1998, after public meetings in each State and Territory had brought women together to discuss their concerns. The network is supported by well-known people such as Olympian Raelene Boyle, a breast cancer survivor, and by donors with significant capacity, such as Baker’s Delight. After only two years, the organisation had 5100 members. At the time of writing, BCNA has
33 000 individual members and 200 member groups. It aims to ensure that all women diagnosed with breast cancer receive the best information, treatment, care and support available. In the first decade, it conducted public awareness campaigns, such as setting up (pink) ‘Fields of Women’ in various locations, and lobbied extensively on breast cancer treatment issues. It has established a free telephone information service, produces brochures and publishes a newsletter four times a year (Breast Cancer Network of Australia web site). The non-profit National Breast Cancer Foundation, which gathers support from both the corporate and the community sectors, was formed in 1994 to raise money for breast cancer research. In the Australian Capital Territory, Pink Links has been formed as a support group for younger women with breast cancer. These groups have lobbied successfully for improvements in treatment, gaining, among other things, the provision of more information, more supportive care and, in 2001, the establishment of a lymphoedema research network (Redman et al. 2003).

New groups continued to form around violence against women, especially in response to notorious statements by members of the judiciary, mentioned above. For example, the Justice for Women Action Collective was formed at Melbourne University in response to comments by Justices Bollen and Bland in 1993. About the same time, the Victorian Police Service conducted a sexual assault phone in, called Operation Pegasus, which met with an overwhelming response. Ten extra phone lines had to be installed to cope with calls and the police who took the calls are reported to have wept openly. Another Victorian group, the Real Rape Law Coalition, was active in the 1990s, along with the Brisbane Rape Crisis Centre, which partnered with the Women’s Legal Service, the Domestic Violence Resource Centre and the Brisbane Women’s Health Centre to produce a critique of Queensland’s Criminal Code, entitled Rougher Than Usual Handling: Women in the criminal justice system (Fredericks 1993).

A variety of other issue-specific groups, too numerous to list, includes the Women’s Healing Centre, formed in Sydney in the early 1980s, which, like dozens of others, was concerned with promoting alternative therapies, including relaxation, meditation, acupuncture and herbal remedies. Menopause-awareness groups sprang up in many places and the self-help Endometriosis Association was formed in Victoria in 1984, following calls to the Women’s Health Resource Collective from more than 200 women seeking information. The Polycystic Ovary Association of Australia began in 1998 as an information-dissemination, awareness-raising and support group. In 2008 it established an alliance with the Jean Hailes Foundation and the Robinson Institute and in 2009 received Commonwealth funding support. The alliance lobbied for the development of a set of evidence-based guidelines for the assessment and management of polycystic ovarian syndrome, which was released in 2011. The Pelvic Instability Association was formed in Victoria in 2003. The Australian Physiotherapy
Association set up a subgroup, Continence and Women's Health Physio, which provides information and resources about back and pelvic-floor health during pregnancy. A national e-newsletter is produced four times a year and one of the aims is to provide resources for rural and remote-area physiotherapists who do not have access to specialist services (Australian Physiotherapy Association website).

As well as forming around specific health issues, women organised to promote the health of particular groups. The need for a specific focus on women prompted the formation of Women with Disabilities Australia (WWDA) as a national peak body in 1995. Founding women felt that their issues were not getting a full hearing either in the disability sector or in the women’s health movement. The organisation evolved from a women’s network within Disabled Peoples International Australia (DPIA), where it had operated as an unfunded subgroup for some years. WWDA is managed by women with disabilities and has a strong human rights focus. A large part of its work concentrates on health issues, including activism around enforced sterilisation, the facilitation of access to appropriate hospital and medical services and violence and sexual assault issues. Affiliated groups include the Victorian Women with Disabilities Network and an ACT group formed in 1995. Women with Disabilities ACT (WWD ACT) is a feminist collective that undertakes systematic advocacy on the impact of disability across all areas. It was funded by Disability ACT in 2011, allowing it to employ two part-time workers who are co-located with the local women’s health centre, the Women’s Centre for Health Matters.

Health is a priority for many same-sex-attracted women who have experienced having their sexuality overlooked in medical encounters. Homophobia, social isolation and discrimination often lead to mental and physical health conditions, which can result in other problems, such as substance misuse. Lesbians might also have special needs, such as those arising from a disability, for example (Women’s Health in the North 2009:6). While some Australian lesbians thought that the women’s health movement was not fully cognisant of their issues, they have, on the whole, been far less critical of it than their North American sisters, probably because so many have been involved as members. Sylvia Azzopardi (quoted in Robertson n.d.:Ch. 19) notes the importance of this contribution, which resulted in many women’s health centres developing specialised services.

As well as working with multipurpose women’s health groups, lesbians have also formed separate groups. In 1999, the Australian Lesbian Medical Association (ALMA) was founded to offer support and mentoring for lesbian doctors, medical students and their partners. It funds lesbian health research, lobbies to have lesbian health included in medical curricula and fosters links with like-

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1 For an excellent review of health problems faced by sexual-minority women, see McNair (2003, 2009).
minded organisations. The voluntary committee runs an annual conference and produces a newsletter. The Coalition of Activist Lesbians (COAL) is an advocacy and lobbying association formed in 1994 to campaign for an end to discrimination. It produced a major paper on lesbian health issues in 1997 (Myers and Lavender 1997) along with research papers on violence against lesbians, ‘lesbophobia’ and lesbian domestic violence. Girl2girl is a web site providing information for lesbians about safe sex and sexually transmitted infections. The AIDS Council of New South Wales (ACON) is a community-based Sydney group with 150 staff members and 700 volunteers that operates extensive programs to promote the health and wellbeing of the gay, lesbian, bisexual and transgender (GLBT) community and men and women with HIV. In Victoria, action by the gay and lesbian communities led to the introduction of the Gay and Lesbian Health Action Plan, announced by the Minister for Health in 2003. As part of the plan, a health resource unit was established for gay, lesbian, bisexual, transgender and intersex Victorians, which is jointly managed by the Australian Research Centre in Sex, Health and Society, the Victorian AIDS Council/Gay Men’s Health Centre and Women’s Health Victoria (WHV).

Many generalist women’s groups see health as one of their major concerns. Said to be the first of its kind in the world, the Council for the Single Mother and Her Child was formed in 1969 by a group of Victorian single and relinquishing mothers who had experienced prejudice and discrimination. From the beginning, the group worked within a self-help framework and its twin objectives were to support single mothers and at the same time work for social change and legal reform. The council aims to change practices and laws that have an adverse effect on women’s health. Early concerns were social and institutional pressures to relinquish babies for adoption, refusal of the right for mothers to see babies prior to adoption and adoption processes that were shrouded in secrecy. There was no reliable income support for single mothers at the time and such special benefits as might be available were discretionary. ‘Illegitimate’ children and their mothers were stigmatised and legally discriminated against in a variety of ways. Similar organisations were set up in other States soon afterwards and the National Council was established in 1973. The organisation has successfully fought for and achieved a range of important reforms.

Health is a central concern for many immigrant women’s organisations such as the Association of Non-English Speaking Background (NESB) Women of Queensland, formed in the early 1990s as a lobby group. The YWCA has advocated and worked for women’s health on its own and in collaboration

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2 There is a group with the same name in the United States.

3 ‘Non-English-speaking background’, a term that appeared to be widely accepted in the 1980s and 1990s, has largely fallen into disuse. It is sometimes replaced with ‘culturally and linguistically diverse’ (CALD), or, more simply, immigrant and refugee women.
with women’s health groups over many years. Older Women’s Network (OWN) groups have been established across Australia, including an Australian peak body, beginning with a group formed in New South Wales in 1985. Health has always been a major issue for OWN members. Betty Johnson, the first Convenor of OWN Australia, who regularly collaborates with AWHN and other women’s groups, was appointed an Officer of the General Division of the Order of Australia for her advocacy on aged care and health care. She serves on numerous health committees in New South Wales.

OWN has developed a positive approach to older women’s wellbeing, based on the social perspective. Women are encouraged to define their own needs and to design and implement programs that will meet those needs. With public funding support from health departments, local councils and other places, OWN New South Wales supports groups that wish to establish wellness centres. The Older Women’s Wellness Forum in 1999 resulted from collaboration between OWN New South Wales, the Benevolent Society and the Departments of Health, Women, Sport and Recreation and Ageing and Disability. There are currently 14 regional groups in New South Wales, which aim to provide an inclusive, welcoming, drop-in environment for women from a diversity of cultures. At the time of writing, there are OWN Wellness Centres in The Rocks, Bankstown, Chatswood, Sutherland and in Coniston, in the Illawarra area.

Health is a major concern for women living in rural and remote areas where all services are in short supply. Some areas have access only to the Royal Flying Doctor Service and perhaps a clinic staffed by a remote-area nurse and an occasional doctor on a flying visit. Such circumstances reduce the likelihood of regular screening, for example, so it is not surprising that women in the bush have higher morbidity rates from cervical cancer. Domestic violence is a serious concern, partly because support services are few and partly because disclosure can create socially difficult situations. Problems of isolation from family and friends can be exacerbated because rural and remote mental health services are under resourced (National Rural Women’s Coalition 2008; Whittle and Williams 2001).

A number of organisations have been established to promote rural health. While only a few are women specific, all have women members. The National Rural Health Alliance is a mixed-sex, Commonwealth-funded coalition, with 27 member organisations. It was set up in the early 1990s as an advocacy and information-providing agency. The Rural Doctors Association of Australia was formed in 1991 and has a women’s special-interest group, the Female Doctors Group (Gender and Medicine), which keeps the organisation abreast of current research. In 1992, a group of rural women in Victoria met to discuss the possibility of a State-wide organisation, which resulted in the formation of Australian Women in Agriculture the following year. The National Rural
Women's Coalition, whose member organisations are mostly mixed-sex groups, is one of the six national women’s alliances funded by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA). It currently focuses on women’s health issues, including family violence. On the basis of extensive consultations, it produced a report on rural health infrastructure in 2008. The National Rural Female GP Network Steering Committee has also been formed for the purpose of encouraging other organisations to value and support female general practitioners.

Women set up groups in the 1980s to agitate for the rights, including the health rights, of sex workers, with policy reform as a major goal. The Collective of Australian Prostitutes was formed in Sydney in 1983, concerned with legal rights, policing and health issues. In 1989, Scarlet Alliance was established as the national body for State and Territory sex-worker associations with the aim of achieving optimal OHS and legislative provisions (Scarlet Alliance website). One of the key aims of sex-worker organisations is to develop effective responses to HIV. In 1998, a non-profit community-based organisation, Project Respect, was formed to support women in the sex industry, including women trafficked to Australia, and to prevent exploitation and enslavement. The organisation conducts outreach support and advocacy work in relation to law and policy reform. The National Network against Trafficking in Women has also been formed.

Unlike their Canadian counterparts, Australian nursing organisations have not mobilised strongly around access and equity issues in health, although a couple of ‘Keep Medicare Healthy’ campaigns were run in the 1980s. Nurses have, however, been active in relation to industrial issues, including remuneration, occupational health and conditions of work. From the 1970s onwards, several groups promoted the transfer of nursing education to the tertiary sector. An extended strike over inadequate staffing levels and pay was staged by Victorian nurses in 1986, following direct action in other jurisdictions (Ross 1987). OHS issues have been a major concern for the Australian Nurses Federation (ANF). The Australian Women’s Health Nurse Practitioner Association was formed in 1988, first in New South Wales, where the first women’s health nurse practitioners were trained. Its name was changed to the Australian Women’s Health Nurse Association in 1999—a peak body for women’s health nurses throughout Australia. The Community Health Nurses Association was formed in Victoria and groups have been active on environmental health issues. A ‘lead in the soil’ campaign, for example, was conducted in Port Pirie, South Australia, a lead-smelting town where, among other problems, citizens had high blood-lead levels.

A different type of women’s health organisation is the non-profit Jean Hailes Foundation, established in Victoria in 1992, in honour of the female doctor after
whom it is named. The foundation is Commonwealth funded and focuses on research and education. Meanwhile, partly in response to the fragmentation that came with the movement’s expansion, women decided to established specialist advocacy groups, generally called networks, in the mid-1980s.

**Generalist Women’s Health Networks**

Networking is a way of working that has been used extensively by women’s groups in Australia and overseas. It has been found to be an effective way of problem solving, exchanging views and information, building confidence, morale and professionalism, sharing resources and improving skills. Networks are also used to increase visibility, to access sponsors and mentors, to build alliances with like-minded organisations and engage in collaborative projects (Townsend 1994:12–13).

In the 1980s and 1990s, the women’s health movement established formal networks with the aims of strengthening capacity and creating advocacy arms that were independent of funded centres and services. During unfavourable political times, established agencies were in danger of becoming ‘activists on a leash’. In Victoria under the Kennett Government, for example, the threat of being de-funded had a ‘gagging effect’ on women’s health services and tended to subdue criticism of policy changes that were detrimental to the community sector (Horsley 1994:10). Independent networks, it was therefore thought, would allow women to speak out strongly. Moreover, women’s voices would be more unified and advocacy work could be planned. Intelligence about community perspectives was to be gained through the centres and services that are in daily contact with clients and other community agencies. At its best, this set of arrangements would work as a type of standing consultation process, which, under the right conditions, could feed ideas into policy on a regular basis. In addition to service providers, networks were open to all women who agreed with the aims and objectives.

**Establishing a National Women’s Health Network**

In the wake of momentum generated by the successful 1985 Adelaide women’s health conference and the subsequent announcement by the Prime Minister that a national women’s health policy would be developed, the Australian
Women’s Health Network (AWHN)\(^4\) was formed by women attending the inaugural Community Health Association Conference in September 1986. About 50 women from different States and Territories, mindful of the need for a feminist perspective to be represented in general health policy debates, agreed to form a national network. The new association was announced at the final conference plenary session, attended by Commonwealth Health Minister, Neal Blewett, and was greeted with a spontaneous ovation. Yoland Wadsworth, a sociologist, was the first convenor. Immediate expressions of interest and offers of assistance came from officers of the Commonwealth Health Department (Abbs 1994; National Women’s Health Centres Newsletter 1987a).

Jude Abbs, long-standing women’s health activist, became interim national convener in 1987. She and the State and Territory representatives of the new organisation generated interest across the country, assisted by a Commonwealth Women’s Health Development Program Grant. A funding submission for a secretariat was written to the Commonwealth setting out the long-term goals, proposed activities and a provisional organisational structure (Abbs 1987). Links were established with the Consumers Health Forum and maintained with the Australian Community Health Association. AWHN gained a place on the newly formed Australian Health Ministers Advisory Council (AHMAC) Subcommittee on Women and Health, a position that served the movement well (Abbs 1994:4–5). It allowed women’s views to be fed into policy processes while facilitating the dissemination of information about policy developments within government to the wider movement.

The first national meeting of AWHN was funded by the Commonwealth Department of Health and took place in the Board Room of the Royal Women’s Hospital, Melbourne, in October 1987. Women worked strenuously for two days to develop a set of aims and objectives and work out a structure. It was decided the organisation would be feminist, with as broad a base as possible. The main purpose was ‘to present a well-articulated set of demands to Commonwealth and State Governments’ (Donovan 1987:9). Liza Newby, who headed the consultation team for the first NWHP, attended, outlining the main issues that would be canvassed in a forthcoming discussion paper. Participants reported on the state of play in each jurisdiction, which varied considerably from place to place. At the time, it was expected that AWHN would soon receive funding. The plan was to become incorporated and ‘advertise for a national coordinator as soon as possible’ (Donovan 1987:9). In the event, AWHN was to wait 25 years for the funds to employ a coordinator.

At the same time, enthusiasm for connection prompted women’s health centres to produce a newsletter—a process assisted by Senator Patricia Giles, Labor

\(^4\) It was at first called the National Women’s Health Association; the name was not settled for a year.
Senator for Western Australia, a founder of WEL and women’s health activist. ‘At last! A thousand welcomes, sisters; we’ve needed you so much’, wrote the Hunter Region Working Women’s Centre in a letter to the editor of the first issue. Issue 2 came out in October and flagged that the newsletter might become a vehicle for the distribution of information from AWHN, as the network became further established (National Women’s Health Centres Newsletter 1987b). And so it was. The decision was taken to rename the newsletter and to make its receipt an AWHN membership benefit. Issue 4, produced in April 1988, became the first Australian Women’s Health Network Newsletter. Two further newsletters were produced before production ceased in early 1989. The 1987 funding application had not succeeded. AWHN continued to participate in the work of the AHMAC Subcommittee on Women and Health and that of the Consumers Health Forum but, by 1990, it had not been incorporated, it no longer communicated with members and was effectively in recess.

Three years later, ACTWHN, whose financial management system consisted of collecting money in a polystyrene cup to cover meeting expenses, held a women’s health festival outside Old Parliament House. The festival, organised by a committee led by Jenny Lyons, made a profit! With a few hundred dollars to spend, members decided to pay someone to write a funding application for AWHN. At the time, Leanne Webster, the first coordinator of the Canberra Women’s Health Centre, was on maternity leave and was available to do the work. The 1993 application to the Commonwealth Department of Health was successful and AWHN received seed funding of $61,180.

The Interim Steering Committee of ACTWHN members—Convenor, Manoa Renwick, Dorothy Broom, Jenny Lyons and Gwen Gray—was formed. A project officer, Julie McCarron Benson, was employed and the first (and so far the only) AWHN office was established in Kingston, ACT, complete with office equipment, including a computer and a photocopier. A teleconference of State network representatives was called and arrangements made for a two-day face-to-face meeting in February 1994. Representatives from all jurisdictions attended, the aims and objectives were clarified and the structure and constitution agreed. AWHN was incorporated in the Australian Capital Territory on 3 March 1994. During the funded 12 months, strong communication channels were established across the country, not only with AWHN members but also with like-minded organisations. The 1994 submission for continued funding, however, was not successful. The photocopier was sold, the national office disbanded and newsletter production once again ceased.

During the years until the end of 1998, the position of convenor remained in the Australian Capital Territory, with Gwen Gray filling the position. AWHN worked closely with QWHN members, especially with Carol Low and Marybeth Sarran, who took the role of secretary for several years. These were frustrating years
of repeated, unsuccessful funding submissions. Communicating with members was difficult, with fax the main method. Telephone calls and teleconferences were expensive and mostly outside the capacity of the tiny budget. Non-governmental sources of funding, such as foundations, were explored without success. In 1994, AWHN was told that the Commonwealth Department of Health would no longer provide operational funding. Henceforth, one-off project grants would be all that were available—a development influenced by encroaching neo-liberal ideas. A funding application was made to the National Agenda for Women Grants Program in 1995, but it, too, failed. In 1996, however, AWHN was chosen by the Office of the Status of Women (OSW) to be one of four national organisations to be assisted by a consultancy firm to develop strategic and business plans. The plans were duly developed but could not be used effectively by an organisation that could scarcely afford a teleconference.

Undaunted, the 1996 AWHN AGM agreed that efforts to gain funding should be the top priority in the next year. At the time, the network was fortunate to have Carolyn Frohmader to assist with submission writing and other AWHN work. An unsuccessful application was made to the Rural Health Education Support and Training Grants Program ‘to improve access to women’s health information, education, training and support in rural and remote areas’. In early 1997, office-holders met once more with officials in the Commonwealth Department of Health and Family Services to consider possibilities. Extensive discussions took place about an expanded role for AWHN, the outcome of which was another major funding submission. After a protracted process, that application, too, was eventually rejected. In June 1997, a repeat application to OSW for operational funding resulted in a grant of $25,000. The organisation was able to develop a web site, arrange for information and membership pamphlets to be printed, pay for a post office box, hold teleconferences and continue to research and write submissions to a range of grant programs and funding bodies. A third submission to OSW for the 1998–99 year was turned down.

At the end of 1998, Helen Keleher was elected convenor and the centre of gravity shifted to Victoria until 2005. During that period, the enormous job of organising two successful national women’s health conferences, one in Adelaide and the other in Melbourne, was undertaken. Small profits from the conferences allowed the web site to be upgraded and maintained and regular newsletters produced. In 1995, the position of convenor moved to South Australia under Anne-Marie Hayes and, subsequently, Celia Karpfen. As the costs of communication fell, it became possible to hold regular teleconferences and was easier to have office-

5 Carolyn Frohmader has been Executive Director of Women with Disabilities Australia (WWDA) since the second half of the 1990s.

6 Rumours had it that when the proposal came to the notice of staff in the office of the Minister for Health, it was swiftly conveyed to the ‘no’ tray.
bearers located far from each other. In 2008, the position of convenor moved back to the Australian Capital Territory, with the convenor, program convenor, secretary and treasurer of the 2010 Sixth AWHN National Women’s Health Conference Organising Committee all living in different States.

Since incorporation in 1994, AWHN has financed operations from membership fees, small conference profits and a handful of small project grants. It has responded to relevant political issues as they emerge, as resources allow. It has participated in ‘Defend Medicare’ and right-to-choose/reproductive rights campaigns. In 2002, it was one of seven original members of the National Medicare Alliance—a group that met frequently by teleconference and lobbied to try to persuade the Commonwealth to preserve the universality of Medicare, on the grounds that universal access to hospital and medical services is essential for women’s health. It is a member of the Australian Health Care Reform Alliance, formed in 2003, a coalition of some 53 health organisations and associations advocating structural health reform.

AWHN has written submissions to government commissions and inquiries. It has written letters and otherwise lobbied on a range of issues, providing support for State women’s health services when they seemed to be under threat. It was instrumental in warding off a Commonwealth attempt to discontinue its funding for women’s health centres through the Public Health Funding Outcome Agreements (PHOFAs) in 2004. It campaigned for an update of the first NWHP from 1995 onwards and influenced the Labor Party’s commitment to develop a second national women’s health policy, launched in 2010. It has increased its membership, communicates with them weekly, maintains a web site and produces regular newsletters. Successful national women’s health conferences have been staged every five years since 1995, when the Third National Women’s Conference was organised jointly by ACTWHN and WEL ACT. Generous Commonwealth subsidisation facilitated the participation of more than 160 Aboriginal women in the 1995 conference, which laid the foundation for the later development of an Aboriginal women’s subgroup, the AWHN Talking Circle, of which more below.

Between 2007 and 2011, efforts to secure operational funding were stepped up. The matter was discussed with relevant departmental officers and ministerial staff. Applications were written variously to the Women’s Development Grants Program of the Commonwealth Office for Women, the Department of Health and Ageing and to the office of Health Minister, Nicola Roxon. AWHN’s submission to the new NWHP stressed the need for funding support if the organisation was to be able to represent its membership and provide good policy advice to the Commonwealth. In 2009, on the basis that it was already an alliance with 64 organisational members at that time, AWHN applied to become one of the six National Women’s Alliances funded by FaHCSIA. In a review of the alliances
the previous year, there had been strong support for a national alliance focusing on women’s health. That application was also unsuccessful. Quite unexpectedly, however, in September 2011, Minister Roxon endorsed a proposal that AWHN had put to her office several months earlier and the organisation received secretariat funding for 2011-2012 from the Community Sector Support Scheme. At the time of writing, negotiations are taking place about the details of the contract with officers from the Department of Health and Ageing.

State and Territory Networks

The first general State and Territory-based networks were formed in the mid-1980s, as branches of the newly formed national network. Formal networks operated in every State and Territory by 1988, most focusing on lobbying for the development of sub-national women’s health policies and plans and the establishment of more women’s health services, especially women’s health centres. The Victorian network held bimonthly meetings and produced a bimonthly newsletter, named Hot Goss, while the New South Wales network aimed to link a large number of informal networks that had already been established (Community Development in Health 1988:3–12). Several of the early sub-national networks did not survive as the level of voluntary contribution needed to keep them going was too heavy. Others fell into abeyance and were revived from time to time.

Among the earliest and most active was the ACTWHN, which began with informal meetings, followed by the establishment of a formal network in 1986, at much the same time that AWHN was formed. It held well-attended monthly meetings and carried out advocacy work for more than a decade. At the height of its strength in the early 1990s, a number of standing working groups managed their own meetings and their own agendas. The working parties included those on reproductive technology, the health centre working party, alcohol and drugs, information and resources, alternative therapies, the national women’s health policy, assertiveness/self-esteem and a party working party (planning an end-of-year celebration).

In 1991 and 1992, ACTWHN members, especially Dorothy Broom and the staff of the Canberra Women’s Health Centre, which was still only in the planning stages, were distracted by a challenge to the legality of the centre. Indeed, the case, which was ‘full of outrages, ironies and contradictions’ (Broom 1992:62), challenged the legality of all separate women’s health centres, including those being established under the NWH Program. Three men, led by a Canberra doctor, claimed that the centre breached the Sex Discrimination Act because it excluded men from taxpayer-funded services. The case involved much that was
abhorrent. During the hearings, women were asked to provide evidence that the women’s health movement was not ‘special pleading by a lunatic fringe’ and that women’s needs were real rather than merely perceived by women themselves. The reality and integrity of the claims that the women’s health movement had made over the previous 20 years were ‘distorted, demeaned and discarded’ (Broom 1992:63–4). In the event, the President of the Human Rights and Equal Opportunity Commission, Sir Roland Wilson, decided that it is not unlawful under the provisions of the Act to ensure that persons of a particular sex have equal opportunities with other persons. He argued that because women are disadvantaged, measures that promote equal opportunity between women and men in the health field are lawful. Mounting a defence, however, which included a not inconsiderable nationwide fundraising effort, was extremely stressful and time consuming for the women involved.

Reviewing operations in May 1994, a meeting of ACTWHN listed among its achievements the establishment of the Canberra Women’s Health Centre, a birthing centre and a halfway house for women with alcohol and other drug problems. It had organised the incorporation of AWHN, provided support for key defendants in the Canberra Women’s Health Centre case, contributed to surrogacy legislation, influenced alcohol and drug policy and participated in the consultation processes for the NWHP. It had lobbied for the establishment of an abortion service, which was opened the same year by Sexual Health and Family Planning ACT, and lobbied against the Hawke Government’s ‘New Federalism’. As mentioned, it had jointly with ACTWEL organised the 1995 AWHN National Women’s Health Conference. This event was so popular that women had to be turned away after 760 registrations were received because of the capacity of the venue.

The AWHN Top End Branch, NT, was established in 1987, at the prompting of Pip Duncan, a member of the Central Australian Aboriginal Congress (CAAC) who had heard about AWHN. At first energy was low because women were already overwhelmed with meetings in a small jurisdiction (the saying was that the same five women often attended the same five meetings). Enthusiasm was stimulated, however, by the news that there was to be a national women’s health policy, and regular monthly meetings soon became the pattern. The first major project was to plan a women’s health conference. An Alice Springs branch was formed and the two groups kept in touch by exchanging minutes of meetings. Both supported the establishment of the Alukura Birthing Centre (Australian Women’s Health Network 1988:8–9). In April 1989, the first AWHN women’s health conference was held in Darwin and was well attended by both Aboriginal and non-Aboriginal women.

The Queensland Women’s Health Network (QWHN), the most enduring of the sub-national bodies, was formed at a public meeting in 1986, after which
volunteers worked at home to progress establishment. A State-wide survey led to a publication, *The Health Needs of Queensland Women*. Without funds, the network went into abeyance but was revived when the State Government changed and the NWHP was launched in 1989. Funding submissions were written and the first grant of $21,000 was received from Queensland Health in 1993 (QWHN 1995).

Once funded, the network was able to produce communication bulletins, organise planning days and teleconferences, link groups in Brisbane with regional centres, gather and disseminate information and increase its membership. The management group met monthly by teleconference and a members’ gathering was held every three months (QWHN 1995). The network carried out advocacy in relation to the implementation of the NWH Program in Queensland and, later, worked with Queensland Health’s Women’s Health Policy Unit. A longstanding tradition is the organisation of regional women’s health forums (QWHN 2003). A linked rural women’s health network operated for a time, as did local network groups that worked with regional health authorities.

Queensland is currently the only jurisdiction with both a formal Women’s Health Network and a providers’ alliance. In 2009, when funding insecurity was restricting the work of women’s health centres, the coordinators gathered in Gladstone to share ideas and discuss strategies. From the meeting, the Women’s Health Services Alliance was formed. QWHN provides secretariat services, acts as a contact point, assists with communication and correspondence and provides a direct link with AWHN (QWHN 2009:7).

The South Australian Women’s Health Network was formed in the mid-1980s and survived into the 1990s. It received funding support for two years from the NWH Program, which enabled it to employ a part-time worker, and was responsible, with Adelaide Women’s Community Health Centre, for the newsletter *Stating Women’s Health*. Country women’s health service providers joined, along with women from the community health movement. Members served on a number of key women’s health committees. An application to the South Australian Government for funding for a permanent part-time executive officer, which had been promised at one time, was unsuccessful.

After a recess, a women’s health network was re-established in Tasmania in the mid-1990s and a branch was formed in the north of the State in 1997. A website was developed that carried a comprehensive range of health information for clients and providers. The Women’s Health Forum was staged in Launceston in 2002, along with a hysterectomy awareness forum. In the same year, a domestic violence symposium was organised in Hobart. Neither branch, however, has met since 2006. The Independent Women’s Organisations of Tasmania (IWOT), which represented women’s services, including shelters, support and information
services, was a peak body formed by the Hobart Women’s Health Centre and others, to provide a stronger voice when negotiating with government. It, too, lost momentum and has not met since 2006; however, the Women’s Emergency Service Providers (WESP) group continues to meet.

Several network groups were formed in Victoria at different times, including Women in Health around Melbourne (WHAM) and the Women’s Services Coalition, developed with the assistance of the Victorian Council of Social Services in 1991. The coalition’s membership included refuges, housing services, domestic violence and rape crisis centres, drug and alcohol and women’s information services. It was disbanded because the broad-based membership could not agree on principles and objectives. According to one participant, a ‘heavy, restrictive feminism’ was embraced by some members but not others.

After a period of dormancy, the Victorian network reactivated in 1998 in response to interest from women who were not service providers but wanted to participate in the movement. It was incorporated the following year. It aimed to enhance communication about women’s health, create a coalition of like-minded organisations, provide a forum for debate and consultation and undertake advocacy. It organised forums on the Victorian Women’s Health Plan, women’s access to reproductive information and services and a rural forum. After a couple of years, energy fell and the network again ceased to meet; however, women’s health services and agencies are networked with each other through the Women’s Health Association of Victoria (WHAV), the peak body, which has nine regional and two State-wide member services. WHAV now encourages organisations with compatible goals to join as associate members. It is a central point of contact for policy consultations.

Network organisation has an uneven history of recess and revival in Western Australia as well. The Australian Women’s Health Network (WA) was revived in Perth in 1992 in response to threats to women’s health centres. At the time, the centres, most of which were newly established, had had their counselling positions abolished. The network made public statements and organised a media campaign. At its peak, it had a membership of approximately 180 women, many of whom had worked in women’s health centres, plus miscellaneous supporters, including women from environmental and consumer groups. There have also been various manifestations of a peak service provider body, including the WA Women’s Health Organisation (WAWHO), which operated from 1998 until 2003. At the time of writing, however, only the managers of the women’s health centres meet regularly.

In New South Wales, the original network did not survive, which is partly explained by the prior formation of a strong service providers’ network. In 1981, when the Commonwealth was handing responsibility for the Community
Health Program back to the States and Territories, the Women’s Health and Information Resource and Crisis Centres Association (WHIRCCA) was formed. It aimed to support centres, create regular connections between them and to advocate and lobby on behalf of communities trying to establish new centres. The association met quarterly and developed a list of some 26 policy guidelines, major and minor, in the early 1980s, which included establishment of a women’s health service for each administrative region of NSW Health. Another priority was the provision of broad preventive health care for the most economically disadvantaged women. In the first half of the 1980s, it engaged in regular consultative meetings with NSW Health.

Partial success came in 1985 when three new centres in the western suburbs of Sydney—Blacktown, Penrith and Campbelltown—were opened, along with others in rural areas. Funding, however, has always been seen as inadequate. In 2000, WHIRCCA changed its name to Women’s Health NSW and now represents 23 centres across the State. It assists members where appropriate, undertakes advocacy and policy development work, develops training modules and other resources, gathers and disseminates information, assists with infrastructure and standards, organises State-wide meetings three times a year, provides facilitation and mediation services and participates in the work of AWHN. The management board is elected and is representative of the different services and regions (Women’s Health NSW web site).

The AWHN Aboriginal Women’s Talking Circle

The major recommendations formulated by the Aboriginal contingent at the Third National Conference and endorsed by the full conference were the establishment of a National Indigenous Women’s Coalition, the staging of an Indigenous women’s health conference and the development of a national Aboriginal and Torres Strait Islander Women’s Health Policy. Within its limited resources, AWHN attempted to further the recommendations. In 1997 the organisation wrote to the Council for Aboriginal Reconciliation, informing it of the resolutions. AWHN’s proposal was endorsed by the council and discussed in its 1997 report (Australian Institute for Women’s Research and Policy 1997:20). Subsequently, a delegation from AWHN attended a meeting with the then head of OSW, Pru Goward, to discuss the proposals, but Commonwealth support was not secured.

The original name of the association appears to have been Women’s Health and Information and Rape Crisis Centres Association; however, Rape Crisis Centres resigned in 1985 when WHIRCCA agreed to be part of a government working party to develop service guidelines for NGOs.
In 2004, an Aboriginal woman from Perth, Dot Henry, joined the AWHN committee. As one of AWHN’s representatives on Womenspeak, Henry was able to use that forum to draw attention to Aboriginal women’s health problems. AWHN obtained funding from the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in 1997 to bring Aboriginal women from each State and Territory to Canberra for a national summit staged in September, of which more below. The Aboriginal women met the day before, developed an initial position paper and decided to form an Aboriginal women’s talking circle as a subgroup of AWHN. A further grant was obtained from Womenspeak in 2008, which enabled the group to meet again, in Adelaide in 2009. At approximately the same time, AWHN obtained a grant from the Women’s Development Program of FaHCSIA to manage a consultation process with Aboriginal women and write a submission to the proposed new NWHP. The contract also required the development of an Aboriginal women’s health strategy and the strengthening of the Talking Circle. A working group to oversee the project was formed at the Adelaide meeting.

Sandra Angus took leave from her position at Queensland Health to become the project officer and undertake the consultations, which were held in every jurisdiction. Unfortunately, time constraints prevented consultation with women living in the Torres Strait Islands. The Talking Circle Working Group met regularly by teleconference to steer the project and to comment on various drafts of the submission, which was written by Sandra Angus and delivered to the Commonwealth Department of Health and Ageing in September 2009. The working group continued to meet by teleconference, with one face-to-face meeting, to work on an Aboriginal women’s health strategy. The writing process was ably assisted by Dr Bronwyn Fredericks and Dr Karen Adams, and the strategy was launched at the Sixth AWHN National Women’s Health Conference in 2010. It received considerable press attention. At the time of writing, advocacy is continuing to try to progress implementation of the recommendations but the political response is disappointing.

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8 WomenSpeak was one of four National Women’s Alliances that were funded by the Commonwealth Office for Women to undertake consultations on issues affecting women. The alliances were introduced by the Howard Government and replaced the Hawke Government’s National Women’s Non-Government Organisations’ Funding Program, under which operational funding had been made available to a number of women’s NGOs. In 2009, the number of alliances was expanded to six.

9 Such work requires a long lead time, as women are scattered and transport between islands is often infrequent.
Domestic Violence and Sexual Assault Networks

A variety of networks and coalitions has been set up in the domestic violence and sexual assault sectors. As the number of refuges increased in New South Wales, the need for unified action led to the formation of a State-wide organisation in 1979. The feminist Women’s Refuge Movement Resource Centre, established in 1986, is the central contact for the movement in the State, where there are currently 57 member refuges. It aims to promote community awareness and provides information, resources and advocacy. A longstanding commitment to facilitating participation in decision making is maintained, and, to this end, regional and State conferences where major policy decisions are made are held quarterly. The NSW Women’s Refuge Working Party is a smaller management body with authority to make decisions between conferences, in line with endorsed policies and philosophies. Within the movement, Koori, immigrant and lesbian women have formed their own support groups and there is also a child-support group. The Stop Violence against Women Network has also been established in New South Wales.

The incorporated Coalition of Women’s Domestic Violence Services was established in South Australia in 2003. It works to raise the profile of violence against women and children in the public domain and to broaden the focus of discussion. It has explored the possibility of coordinated relationships with sexual assault and women’s health services and, to this end, has developed a multi-agency working party. It produces policy documents, collects and analyses statistics, collaborates in awareness campaigns and writes submissions to inquiries and consultations, drawing attention to a range of unmet needs, particularly the health problems of children who have experienced violent situations. Among such children, PTSD, developmental delays and behavioural problems are more common.

A women’s refuge group was established and incorporated in Western Australia in 1977. Now called the Women’s Council for Domestic and Family Violence Services (WA), it is a peak organisation that operates within a feminist framework, representing 54 refuges and other domestic and family violence services. It makes referrals and carries out a range of capacity-development, representation, advocacy, information dissemination, community education, research and training functions. In 2009, it conducted a State-wide survey of services, which found unacceptably low pay levels for workers and disparities between services. It found that the non-governmental not-for-profit community sector is underpaid by up to 30 per cent, compared with other sectors in the State, creating serious staff and recruiting problems (Hartwig 2009).
Nationally, the Women’s Emergency Services Network (WESNET) was established in 1992, as a peak advocacy body for SAAP-funded women’s services. The impetus for action was an identified need to bring representatives from all jurisdictions together to address issues of common concern. Members at early meetings unanimously agreed that the advancement and recognition of the essential nature of the work required better organisation at the national level. Funding was obtained to employ a consultant to develop a national structure and gather information for incorporation. The first National Joint Forum of SAAP-funded organisations was held in Canberra in 1994 (Townsend 1994:9–11).

WESNET works within a feminist framework and recognises that women’s and children’s experiences are shaped by their ethnicity, ability, age, sexuality and class. It collaborates with member organisations to identify unmet needs and emerging issues. Like other peak groups, it provides policy advice and lobbies for legislative and program reform. At the time of writing, WESNET has almost 400 members across the country. It has developed a comprehensive domestic violence policy, which includes recommendations for law reform. Changes proposed include the strengthening of mechanisms to remove a violent partner from the family home and the training, including cross-cultural training, of police, court staff, legal representatives and magistrates. The full provision of interpretative services, the compilation of comprehensive statistics in relation to sole-occupancy and exclusion orders and the development of model domestic violence and related legislation through Commonwealth, State, Territory and community-sector collaboration are all objectives. WESNET facilitates national debate, stages national conferences and sector forums and lobbies on all relevant issues (WESNET web site).

The Victorian Centres against Sexual Assault Forum was formally established in 1992 and was incorporated in 1994. It is a peak body for 15 sexual assault services in the State and is committed to addressing all inequalities that result from sexual violence against women, children and men. It takes the view that the occurrence, consequences and elimination of sexual violence should be the responsibility of the whole community and all tiers of government.

The National Association of Services against Sexual Violence (NASASV) has been established nationally to facilitate information exchange, undertake policy and advocacy work and promote the development of a national response to sexual violence within a feminist framework. It aims to challenge and change the attitudes that underpin the perpetuation of sexual violence and, eventually, to see it eliminated. An initial meeting was held in Sydney in 1989, attended by representatives from all States and the Australian Capital Territory. The association was incorporated in 1997 with assistance from the Office of the Status of Women but has no secure funding. NASASV coordinates information, skills and resource sharing between services, lobbies and negotiates with governments,
provides policy advice, promotes community awareness, undertakes research, promotes quality training and skills development, monitors innovative service models and organises national meetings, conferences and seminars. In 2002, it released a major report, Cultural diversity and services against sexual violence (Weeks 2002). The National Standards of Practice Manual has been produced and work on the development of a national data set has been undertaken. In 2009, Framing best practice: national standards for the primary prevention of sexual assault through education was produced by a small research team in partnership with other groups, including the Commonwealth and VicHealth.

Conclusion

The Australian women’s health movement expanded and grew more diverse as groups multiplied from the early 1980s onwards. A decade later, there were literally ‘hundreds of community-based groups of women organised around particular health issues’ (Dwyer 1992:211). A panoply of networks and associations was established that facilitated the articulation of women’s health issues despite the restrictions imposed by unfunded operation in most cases. The movement established a number of formal networks over the years but public funding to support them was difficult to obtain and many fell into abeyance or were dissolved. Clearly, the movement does not have the political clout that other health provider groups enjoy.

It was thought in the 1980s that the political arms of the movement—the State, Territory and national networks—needed to be one step removed from funded services in order to protect funding and independence. And certainly there have been unfavourable political times when this consideration was important. In 2011, however, most service-provider organisations are independent but part of the institutional apparatus. They work constructively with governments, pressing strongly for the sector’s interests and for changes that will improve the conditions of women’s lives. In most cases, they refrain from public criticism of the government in power. This way of working demonstrates the significant level of legitimacy that the movement has gained at the State and Territory level.

Growth and diversification within the movement seem to have had both costs and benefits. Expansion is generally considered to be a sign of strength and it certainly facilitated the public discussion of a broader range of women’s health issues. In addition, it facilitated the generation and sharing of more and more detailed health information. The capacity of the movement to lobby on specific issues was increased and its ability to provide support to women was enhanced. Self-help groups make a vital contribution to women’s health.
But proliferation has contributed to a fragmentation of the movement, at least since the very early days. As time passed, groups developed considerable expertise in their own areas and tended to undertake advocacy separately. More opportunities to address and articulate a wider range of issues have thus been offset by an increasing lack of cohesion, undermining the extent to which the movement can be seen, or can see itself, as a coherent entity. We will see in Chapter 6, for example, that the maternity-care reform movement has tended to work separately from other movement groups. In some areas, fragmentation can be a very real problem. Multiple groups lobby on specific disability issues, for example, and provide valuable support and information to their own client groups. It can be, however, that no group is working at the level of the broad picture where it is necessary to advocate for the general rights of all people with disabilities.¹⁰

Other processes were at work at the same time that groups were proliferating. Neo-liberalism and managerialism were gaining strength and these ideas influenced the way governments responded to community organisations. Many women who had previously worked at the grassroots level were taking paid positions in the newly created services, in the bureaucracy and in other places. According to Carmody (1990:307), these changes resulted in fewer opportunities for advocacy and collective action and a diminution in the quality of feminist political analysis, all of which was exacerbated by the demands of service provision in poorly funded services. Compared with the 1970s, feminists were becoming separated from each other in different spheres of activity, she argues.

Clearly, many forces were important in changing the way the 1970s women’s health movement operated, including changing political opportunity structures. Fragmentation seems to be an unavoidable consequence of expansion, which as we have seen brought benefits as well. While it is hard to isolate the impact of each of the impinging forces, the evidence suggests that the movement has been able to make progress towards its goals, no matter what the changes, when governments sympathetic to its objectives have held power.

¹⁰ I owe this insight to Sue Salthouse, Convenor of WWDACT.