5. Working Together for Health

So much of what affects women also affects children and men, so many agencies have responsibilities…and our agenda is so large, that we need to work with and through others as much as possible. (Dwyer 1992a:25)

The value of a collaborative approach to health care, pioneered in the community sector,¹ is now widely accepted among public health experts. Collaboration between team members and with outside services and agencies is considered a foundational element of effective, comprehensive primary health care. Collaborative ventures are undertaken between governments and non-governmental agencies and between agencies in the health sector itself. Health workers collaborate with local governments and social and community services, including housing, income security, child services and services responsible for safety from violence (Keleher 2001:59). Partnerships between government, non-governmental agencies and communities are now considered indispensable when addressing health promotion. Community-based partnerships are a means through which local needs and capacities can be evaluated and appropriate projects and programs designed. National, State and Territory partnerships of various kinds are being put together in most jurisdictions.

Collaboration is an essential element of everyday work in women’s health centres and services. Within a few months of opening in 1975, Liverpool Women’s Health Centre was already working with local agencies. Referrals were coming in from local doctors, invitations to speak to local groups and organisations had been received and liaison with local agencies and government departments was under way (Cooper and Spencer 1978:151). Collaboration is so extensive that in South Australia a special project has been deemed necessary just to identify and document the ‘myriad activities’ of the Central Northern Adelaide Health Service’s Women’s Health and Safety Unit, which includes Dale Street Women’s Primary Health Service, Northern Women’s Primary Health Care Service and the Northern Violence Intervention Program (MacKenzie 2009:6).

¹ Much of the pioneering community health centre infrastructure established in the 1970s has now been disbanded. After the Fraser Government handed back responsibility, most State and Territory governments have presided over a dismantling process, as part of an exercise to shift costs to the Commonwealth. Without community health centres, citizens will primarily get their services from general practitioners in private practice, subsidised by the Commonwealth through Medicare. Queensland never established a comprehensive community health centre network, due mainly to the vehement opposition of organised medicine in cooperation with the conservative government that held power there until 1989. Victoria has retained the most extensive community health centre infrastructure, although centres have lost at least some of their independence. The Aboriginal community-controlled health sector, however, has been maintained and has managed to expand in some jurisdictions.
At the most fundamental and perhaps most important level, according to one of the principles of women’s health, health workers collaborate with clients and families in arrangements where power is shared. The ‘health worker as expert’ model is supplanted with one that aims to empower and enhance the self-esteem of those seeking advice and care. Both the expertise of professionals and the expertise of individuals and family members are recognised. As Radoslovich (1994:51) argues, ‘women’s health centres believe in empowering women to take control of their health…To achieve this, the services have adopted particular styles which differ from traditional service models’.

Women in centres and services support each other and work with agencies in the wider community. In the early days, they provided strong support for groups trying to establish new services. They share information and experiences, work together to address service problems and act politically to influence public policy. In collaborative partnerships, they produce a broad range of community health, outreach and education services designed to meet multifaceted needs, especially the multiple needs of disadvantaged groups. By working together at the local level with other service providers and agencies, the resources of the community are mobilised and appropriate community-development projects are generated. The teams of health professionals employed by most women’s health centres, including nurses, dieticians, counsellors and psychologists, for example, are generally well equipped through their training and their approach to health, to facilitate community participation and community development (Baum and Keleher 2002:36). Ongoing collaboration has, however, always been hampered by scarce resources and the pressure to respond to women’s immediate needs (Broom 1990:121). For many centres and services, demand is so heavy that the capacity to operate beyond day-to-day provision is limited. Nevertheless, an amazing array of informal interactions and collaborations characterises the work of the sector.

The move towards multi-agency cooperation and collaboration in health mirrors changes that are taking place in the way Organisation for Economic Cooperation and Development (OECD) countries are governed. Since World War II, the complexity of policymaking processes and the interdependence of the agencies have increased in Western countries in response to globalisation. A large literature has emerged on what is called ‘collaborative’ or multilevel governance (see, for example, Leo and Enns 2009; Sorensen 2004; Stein and Turkewitsch 2008). Growing international interaction has increased the number of intergovernmental actors and agencies involved in policy, as well as expanding their roles. At the same time, there has been a proliferation of NGOs, both national and international, so that governments now collaborate in decision making with a variety of agencies, public and private, including corporations, unions, NGOs, members of social movements and individuals (Gray
Collaborative governance has been defined as a ‘governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus oriented, and deliberative and that aims to make or implement public policy or manage public programs and assets’ (Ansell and Gash 2007:2).

Health sector partnerships, often complex and multilateral, can be seen as a form of collaborative governance. Acknowledging the importance and ubiquity of partnerships and the varied forms they take, VicHealth has attempted to develop a typology, producing a fact sheet and the Partnerships Analysis Tool to assist practitioners in their work. Partnerships, VicHealth argues, usually move along a continuum depending on the level of commitment and degree of joint action. At one end is networking, which involves exchange of information for mutual benefit but is not time consuming and does not necessarily involve further cooperation. Coordination is the next stage on the continuum. Here, information is exchanged and activities are altered for a common purpose, involving more time and requiring greater levels of trust than networking. Cooperation, the next point on the scale, involves a sharing of resources for common purposes as well as information exchange and a shift in activities. More time and higher levels of trust are needed, and perhaps detailed agreements. Collaboration is identified as the most complex and committed type of partnership. As well as having the features of the other three types, collaboration involves a willingness to increase the capacity of another organisation and to share turf. High levels of trust are needed because risks are involved but, offsetting this, there is a possibility of highly beneficial outcomes (VicHealth n.d.[a], n.d.[b]).

While the VicHealth categorisation is helpful in terms of conceptualising different partnership forms, in practice, many women’s health activities cannot be neatly classified. Political action, for instance, can be rather one-sided at least initially but might develop into a cooperative endeavour. For example, Victorian women’s health centres engaged in a local-government capacity-building project in 2008. First, efforts were made to ensure that candidates standing for election had information about women’s health. Next, candidates were asked to commit to an action plan, called Safe, Well and Connected: Victorian Local Government Action Plan for Women’s Health 2008–2012. Endorsement of the plan entailed commitment to the development of local women’s health strategies, addressing issues such as mental illness, disability, intellectual disability, violence, family friendly workplace practices and the concerns of women carers, lesbians and culturally diverse women (Hudson 2010; Women’s Health in the North website). As well as not fitting into any one type of partnership, joint endeavours often change over time. An interaction might begin as networking, for example,
but develop into committed collaborative activity as linkages are established and trust deepens. Nevertheless, the VicHealth framework is a useful organising tool for a discussion of the way women work together and with other agencies for health.

**Networking**

Information sharing—the purpose of networking according to the VicHealth typology—is a basic aspect of women’s health work. Aboriginal women find that value and empowerment flow from networking together to share health information. Gatherings also enable them to address difficult issues, such as violence, meet health providers, extend their networks and affirm their cultural and spiritual values (Adams et al 2002; Pearse 2002). Centres and services develop networks, partly to fulfil the needs of their own clients but sometimes to assist with service provision for clients from other organisations, often in a two-way information exchange. For example, Women in Industry Contraception and Health (WICH), Victoria (now the Multicultural Centre for Women’s Health), shared information with Adelaide Women’s Community Health Centre in the late 1980s, when Adelaide was interested in introducing programs based on WICH models. It also checked translations for the Victorian Domestic Violence Education Task Force and for the Prostitutes Collective. It has been consulted about curriculum development by the Broadmeadows TAFE and about migrant women’s information needs by the National Women and AIDS Campaign. In addition, organisations visit the centre to learn about its work and from its experience. In 1989, WICH was a member of the Victorian Women’s Health Services Providers Group, Non-English Speaking Background (NESB) Women’s Health Services Funding Group, the Women’s Health Forum, the Coalition against Depo-Provera and the Occupational Health and Safety Commission’s NESB Workers Advisory Committee (WICH Annual Report 1989).

Sometimes what is nominally called a network operates more as a system of coordination or cooperation in VicHealth’s terms. For example, Western Australian alcohol and drug agencies formed Wanada, a network that spreads across that State. Member agencies provide education, advocacy, community development, prevention, treatment and support services. Members include women’s health centres and Aboriginal health services and corporations. Wanada is a member of Community Sector Services and provides services for its member organisations, including child care for clients and interpreter services—a much larger role than suggested for a network in the typology (Wanada web site). In another example, the Government of Victoria took the lead in developing integrated family violence networks in 1989. Community groups, including women’s health centres and sexual assault and domestic violence services,
formed regional networks under the program. Other network members include representatives from criminal justice, housing and community health. The main aim is to provide a more coordinated system, geared towards the protection of victims. In 2006, there were 20 partnerships, funded to provide integrated services, involving 70 organisations. Clearly, such activity involves more than an exchange of information. Similarly, the Alice Springs Women’s Shelter convenes the Central Australian Family Violence and Sexual Assault Network, which comprises 26 government and non-governmental agencies. As well as sharing information, the network is involved in planning and advocacy (Commonwealth of Australia 2008b).

Cooperation

According to the VicHealth typology, cooperative activity includes information sharing, alteration of activities for common purposes and resource sharing. A great deal of women’s health action fits into this category. From the early days, activists shared information and worked together for common benefit. The collective that later set up the Leichhardt Women’s Community Health Centre (LWCHC) gave assistance to similar groups in Adelaide and Canberra, as well as others in Sydney, and produced the controversial booklet What Every Woman Should Know (Broom 1991:2). As mentioned, women in other States travelled to Leichhardt, the flagship centre, to learn from experiences there and, for their part, Leichhardt women travelled locally and interstate, as requested, to assist new centres. In the process of planning for a refuge and a women’s health centre, Western Australian women had regular contact with, and support from, Leichhardt. Adelaide women had similar support (Radoslovich 1994:14). Leichhardt became a model for the health centre movement and cooperation was a hallmark of its operations.

Similarly, when the Hobart Women’s Health Centre opened with precarious, short-term funding in 1987, women from Liverpool Women’s Health Centre visited to provide training. HealthSharing Women in Victoria and Women’s Health Statewide, Adelaide, supported the new centre by providing health information leaflets. There were also links with women in WICH, through which advice on appropriate services for immigrant and refugee women was channelled. A similar set of cooperative interactions took place between women establishing new refuges, who were able to learn from services already in place. The pattern of supporting new initiatives sometimes attracted the support of outside groups. In establishing Ngalawa Wingara in Liverpool, many different groups worked together in what became a full-scale collaboration. Ngalawa Wingara means ‘to sit and think’ and is an Aboriginal women’s healing space, a beautifully landscaped area beside the health centre, with stones, plants, mosaic
decorations and a rock pool. Clients and community women use the space for quiet time or to meet and talk. A steering committee of local women worked with health workers and the South Western Sydney Area Health Service, using the talents of a local artist, to set up the space. Assistance was supplied by local businesses, including nurseries. The artist worked closely with the steering group and received support from a group of Hoxton Park elders.

Women’s health centres and services continue to cooperate in the establishment of new groups and services, as in the early days. Women’s Health Victoria (WHV), the Breast Cancer Action Group and other Victorian women’s health services established BreaCan in 2003. Originally funded as a pilot by the Victorian Department of Human Services, the service provides holistic support, information sessions, library resources, exercise programs, complementary therapies and opportunities for women to interact with trained peer-support volunteers, all of whom have themselves experienced cancer or cared for someone with cancer. The service is State-wide, confidential and provided without charge. In 2007, BreaCan expanded its activities to include women with gynaecological cancers. It subscribes to the philosophy that the best services are delivered in collaboration with partners and has formed a research partnership with the Key Centre for Women’s Health in Society at Melbourne University (now the Centre for Women’s Health, Gender and Society). BreaCan is community managed and receives operational funding from the Victorian Department of Health (BreaCan 2009).

Cooperation in the sense of sharing or creating resources for mutual benefit takes place when State-wide services provide a range of resources for the sector. For example, Women’s Health NSW has produced a non-governmental women’s health service training program that can serve as an orientation tool for new workers and aims to increase knowledge and skills about outcomes-based planning. Women’s Health Queenslandwide provides comprehensive web-based health information, a library service and a range of education courses for professionals. Education courses have also been developed for schools, corporate-sector women and community members. Like its sister organisations, WHV produces extensive resources. All these agencies undertake advocacy for the whole sector. In South Australia, the Family Medicine Program at the Royal Adelaide Hospital established a women’s health training module, in cooperation with femocrat women’s advisers and community-level women’s health groups.

A recent cooperative venture in Melbourne took the form of an Indigenous Women’s Health Day, organised by Women’s Health West and a number of mainstream health services, including the Western Melbourne Division of General Practice and North West BreastScreen. Held at the Western Suburbs Indigenous Gathering Place, a two-way exchange of information took place, during which Aboriginal women discussed their health concerns. Community
women were able to meet healthcare providers, helping to build a sense of trust. Women’s Health West continues to collaborate with the Gathering Place. The service also works with African women, Bosnian women, young women and women with disabilities, and has programs addressing emotional wellbeing, violence prevention and mental health, to name a few. All of these endeavours involve cooperation with a range of local agencies (Women’s Health West web site).

Cooperation also takes place between Aboriginal community health services and other agencies. For example, in Victoria, the Gunditjmara Aboriginal Cooperative and the South Western Centre against Sexual Assault (CASA) worked together on a successful project to raise awareness about family violence and sexual assault. An evaluation of the project found it had produced ‘increased and more relevant community education’ and that the mutual learning from informal liaison among the workers in both organisations had been ‘most fruitful’. Moreover, cooperation continued after funding ran out (South Western Centre against Sexual Assault 2003–04:49–50).

Cooperation is also strong among domestic violence agencies. The North Queensland Domestic Violence Resource Service (NQDVRS), itself a product of joint endeavour, and the Coalition on Criminal Assault in the Home North Queensland applied to the Queensland Government for funding to establish the Domestic Violence Resource Service for Townsville and Mount Isa in 1993. The service works closely with the Women’s Centre and Sera’s Women’s Shelter and provides student places for James Cook University, TAFE and students from overseas. It has also established a partnership with the Queensland Police Service, which aims to provide better responses to domestic violence (NQDVRS 2009:1). The NQDVRS, the Sunshine Coast Domestic Violence Service and the Gold Coast Domestic Violence Service recently ran a one-year pilot to trial a support program for women and children staying in their homes after perpetrators had been required to vacate.

Sometimes women’s health centres join forces with other agencies to help meet the health needs of rural women. For example, Women’s Health Statewide in South Australia identified rural women’s health as a priority and attended major country events, such as field days, to raise awareness of issues and provide information. It worked with groups such as the Women’s Information Service, Women’s Legal Services and the Working Women’s Centre in these ventures. Country visits were coordinated with the work of local health workers. Ways of enhancing rural health work were explored, which often involved maintaining extensive relationships with country personnel over a period of years. The Women’s Shed Project in Oodnadatta, near the Simpson Desert, is a partnership
between the Northern and Far Western Regional Health Service, Dunjiba Council and Oodnadatta Health Service. A preventive health program, it uses the arts as a medium of communication.

Women’s health groups regularly take up one another’s issues, especially when a threat to existing rights or infrastructure is perceived. As an example, women concerned with violence took up the abortion issue towards the end of the Howard Government period (1996–2007), when the preservation of existing services came under threat, as represented in statements by the Health Minister, Tony Abbott, and the Prime Minister. In response, Issue 19 (2007) of the journal Women against Violence focused almost entirely on issues of pregnancy counselling and abortion, naming government pronouncements as ‘the violence of misinformation’.

**Collaboration**

Collaboration sits at the complex end of the partnership continuum in the VicHealth framework. As well as information and resource sharing, collaborators must be willing to increase the capacity of one or more outside organisations to achieve common purposes. Again, much of the activity of the women’s health movement falls into this category. Groups have worked together extensively to enhance mutual capacity building, often with outside agencies, including trade unions, family planning associations and political parties.

The Immigrant Women’s Speakout Association in New South Wales provides a good example. It has established connections with other agencies, including the NSW Domestic Violence Network. Staff serve on a number of outside advisory and steering committees, including the Violence against Women Regional Reference Group, Family Planning Australia, Women’s Health in Industry Program Steering Committee and the Australian Domestic and Family Violence Clearinghouse Advisory Committee. Similarly, Women’s Health NSW, formerly Women’s Health and Information Resource and Crisis Centres Association (WHIRRCA), has long experience working in collaboration with other NGOs to enhance capacity. In 2008–09, the Female Genital Mutilation Advisory Committee, the NSW Council of Social Services and the Primary and Community Health Working Group of NSW Health were among the committees on which it served. Other groups with which it is linked include the Multicultural Disability Advocacy Association of New South Wales, the NSW Police Domestic and Family Violence Stakeholder Forum, Reproductive Choice Australia (RCA) and the Royal Australian College of Physicians Health Consumers and Community Partnerships Forum (Women’s Health NSW web site).
A recent example of a multi-partner project intended to produce information for mutual benefit is the Gender, Workplace Injury and Return to Work Research Project conducted in South Australia in 2003–04. The steering committee was drawn from a range of stakeholders and researchers. The aim was to explore people’s experiences following workplace injury and return to work, to shed light on obstacles and to find out whether men’s and women’s experiences are the same or different. Project initiators included the Working Women’s Centre, the Office for Women, the Australian Manufacturing Workers Union, the Equal Opportunity Commission, Dale Street Women’s Health Service, the Migrant Women’s Lobby Group and a community representative. During the research process, views were canvassed among employers, managers, OHS/rehabilitation coordinators, unions, health and safety representatives and trainers, claims agents and case managers (WorkCover Corporation and the Working Women’s Centre 2005).

The promotion of cultural sensitivity has been furthered through collaboration. In 1981, LWCHC joined with refuges, Family Planning NSW and government agencies to organise a conference to promote the employment of immigrant women in established services and to encourage ongoing interaction between groups providing services in immigrant communities. In addition, it worked with Annandale Neighbourhood Centre and the Leichhardt Council to produce a 10-week health project for immigrant girls at the local high school (Stevens 1995:49). A Queensland example of intercultural collaboration is the formation in 1993 of the non-English cultural background (NECB) Women’s Health Reference Group, to provide information and to advance the health of immigrant women in the Logan and North Albert areas. Members of the reference group were the Logan Migrant Neighbourhood Centre, Logan Women’s Health Centre, Logan Hospital and the South Regional Health Forum. The reference group lobbied successfully for a NECB health worker for the Logan Women’s Health Centre and held cultural awareness workshops and seminars.

Major collaborations have also been undertaken in the sexual assault field. Recently, the Australian Research Council funded a joint project between the NSW Rape Crisis Centre and the University of Western Sydney, which investigated the possibility of promoting ethical, non-violent relationships between young men and young women (Carmody and Willis 2006). From this research, a six-week education program for young people was piloted and developed, with the aim of creating opportunities for learning new ways of negotiating sexual intimacy and promoting ethical, non-violent skills. In 2009, funding provided by the Commonwealth’s Respectful Relationships Program was used to train educators and run groups with young people in New South Wales and Queensland. Collaborators include the AIDS Council of New South
Wales (ACON) and the National Rugby League in Queensland. Influence has crossed the Tasman: the New Zealand Ministry of Justice provided funding in 2010–11 for the program to be run in New Zealand.

Collaboration with Communities

Community-development projects are a standard part of the work of women’s health centres. Meeting complex needs involves day-to-day collaboration with other service providers and agencies to try to ensure that a full range of services is available. Women’s health workers recognise that no one agency can effectively meet more than a fraction of a community’s health needs. For example, domestic violence services must interact with local doctors, local hospitals, mental health services and so on, when clients need medical assistance. Similarly, cooperation with housing authorities, local councils, social service agencies and possibly local charities might be necessary. The Immigrant Women’s Health Service (IWHS) in the western suburbs of Sydney works with multiple agencies to help meet the needs of its clients. It has facilitated the establishment of support groups for women from 19 cultural groups, which meet regularly at the centre. Other community-development projects include the Ethnic Communities Sustainable Living Project and a support group for Vietnamese working women. Among the agencies with which it collaborates are Women’s Health NSW, the Smith Family, the Serbian Orthodox Welfare Association, Playgroup Australia, Miller TAFE Outreach, Granville TAFE, the Multicultural Respite Network, Fairfield City Council, Liverpool City Council, Fairfield Division of General Practice, the Benevolent Society, Australian Quarantine Inspection Service, Fairfield Hospital, Liverpool Hospital, Fairfield Migrant Resource and the Wetherill Park Police, to name only some (Immigrant Women’s Health Service web site).

Women’s health centres also participate in community efforts to rectify environmental degradation. From the early 1980s onwards, for example, in the Dale Street area, concerned residents mobilised in response to problems such as dust, noise, factory emissions and spills of copper chromium arsenate and chlorine gas. Centre workers had noticed increases in the incidence of bronchial disease and ear, nose and throat problems. Dale Street thereupon employed local women to document the health problems being experienced and develop strategies to deal with them. The report was presented to a large public meeting, which included representatives of government and industry. Subsequently, a favourable public policy response emerged.

Dale Street Women’s Health Centre has been involved in a number of other community-development projects (Radoslovich 1994:68–70). For example, it was noticed that many local women worked at home as piece workers. The centre responded with a support project called ‘Outwork: Reaching an Invisible
Workforce’ in the second half of the 1990s. Information was assembled and distributed about OHS issues, rights and entitlements under safety legislation and workers’ compensation arrangements (Tassie 1997:185). As part of the project, the centre worked extensively with individuals and organisations, including employers, doctors, community workers and community groups representing women from different cultural backgrounds.

OHS Meets a Social View of Health

Extended collaboration took place between feminists in different agencies with the ultimate aim of overhauling OHS regimes that had been in a state of neglect for decades (Irving 1979; Pearse and Refshauge 1987:646). Until the 1970s, OHS was not seen as a health issue. Rather, it consisted of a narrow, prescriptive regulatory regime, focusing largely on particular industries, such as mining, manufacturing and construction. Just as medical research had focused on male bodies, investigations into safety and conditions of employment concentrated on the safety of men. At the time, women were seen as a low-risk, part-time or temporary workforce. The occupations considered appropriate for women were supposed to be safe and were therefore seen as outside the ambit of OHS. One of the views of the day was that there was no need to include women in OHS discussions because they could always avoid health problems by staying at home or working in another industry. For example, the report of the Williams Inquiry into OHS in New South Wales in the early 1980s failed to discuss the problems of either migrants or women, dismissing each with a one-line mention (Dimech 1982:18). It was not until 1985 that women’s occupations were included in the industrial death registration system (Skues and Kirby 1996; Shoebridge and Shoebridge 2002:7). Immigrant women were in a particularly vulnerable position. Their representation in union structures was virtually non-existent yet as a group they were severely affected by work-related injuries and they constituted the majority of those suffering from RSI, for example.

Workers’ health action groups were formed in most jurisdictions from 1977 onwards. Many women unionists saw health from a social perspective and worked to broaden the meaning of OHS, arguing that it should be much more than a set of minimum safety standards. Rather, employers should have a ‘duty of care’ to provide a safe, healthy place of work, one that would not only prevent the high incidence of industrial injuries but would also contribute to physical, mental and emotional wellbeing. The notion of a healthy workplace was influenced by ideas from industrial democracy and included the establishment and resourcing of participatory structures where workers would exercise responsibility and discretion.
Women unionists also worked to increase their representation in union structures, trying to ensure their election as union officials—a process assisted by funding grants from the Whitlam Government. A critical mass of female officials meant being able to raise and pursue issues not previously raised inside a union and being able to establish collaborative links with women's organisations, community organisations, political parties and other relevant agencies outside (Shoebridge and Shoebridge 2002:10). Working women's centres and women's health centres were collaborators in the many coalitions that were formed in the 1980s and 1990s around OHS issues.

After the main health issues were identified, women pressed for OHS provisions to be incorporated in industrial awards. A preventive focus required that hazards are eliminated 'at the source' rather than compensation being provided after the event. Seeing OHS as an industrial democracy issue, an argument was made that union-elected health and safety representatives should have powers to inspect workplaces, draw attention to conditions needing improvement and stop work if conditions were considered dangerous (Pearse and Refshauge 1987:636–42).

Women unionists argue that working life affects the rest of life and is therefore crucial to health. They raised problem issues, such as the availability of flexible working arrangements to fit with family responsibilities and union provision of child care, arguing that child care is an industrial issue. Other specific problems are working with chemicals, stress, sexual harassment, RSI and compensation in the case of injury. Violence in the workplace is identified as a problem, especially in nursing homes and hostels, where staff care for people with dementia and intellectual disabilities. Stress became a more urgent issue in the 1990s, when job insecurity increased and many women and men did not know whether they would have a job the following week.

The women's health movement in most States and Territories had good working links with women in the union movement. In many cases they knew each other through overlapping memberships of political parties and unions and a few sat on policy committees. So while women in trade unions played a crucial role in advancing women's OHS, in turn, the broader women's health movement supported workers' health and was a force in shaping a context conducive to workplace reform.

Liverpool Women's Health Centre was a pioneer in recognising OHS as a women's health issue. In 1975, the Industrial Health Group was formed on the discovery of a high incidence of musculoskeletal workplace injuries particularly among immigrant women. About the same time, the trade union arm of the women's movement lobbied for federal funding for the Melbourne Working Women's Centre, which was set up in 1976. Through the centre, OHS issues were advanced, along with issues around equal pay and conditions of work (Pearse and Refshauge 1987:639). The musculoskeletal and RSI conditions that
disproportionately affected immigrant women workers had previously been put into the ‘too hard basket’, participants remember. Through collaboration between members of advocacy networks, however, information about injuries was publicised and changes in conditions of work were slowly achieved.

In Western Australia, women unionists championed the principle that employers are responsible for providing safe working environments. They had close ties with women's health centres, academics, health policy professionals, workers' health centres in other jurisdictions, including the Lidcombe Workers' Health Centre, and with international organisations. They felt that they had good access to policymakers under Labor governments and succeeded in getting improved OHS arrangements written into policy. Union representatives sat on the health policy committees of the ALP, which was an opportunity not available under Liberal governments. A women's OHS committee was established in the Trades and Labour Council in the early 1980s and the first paid female officer was appointed in 1983. The incumbent Labor Government met the costs of the position. The committee was wound up in 1988 but the principles it promoted found their way into Australian Council of Trade Unions (ACTU) policy and then into the policies of Work Safe Australia. One Western Australian union instituted an immigrant workers' health project in the 1980s, which consisted of a team of five to six women who visited workplaces over a period of six months to talk about health and health rights to women in their own languages. A shortage of resources, however, limited the extent to which such work could be undertaken.

OHS was a major issue for Queensland women in the 1980s. The Brisbane Women's Health Centre shared premises with the Union of Australian Women which contributed to a cross-fertilisation of ideas. The Women in Trade Unions Network was formed in 1985 and it became the centre of a large, diverse, feminist network, which included the Queensland Workers' Health Centre. Membership was restricted to unionists but there was close collaboration with domestic violence and rape crisis networks and other relevant agencies. Helen Abrahams, a medical practitioner with specialist qualifications in occupational health and long experience in women's health in Adelaide and later in rural New South Wales, was Director of the Workers' Health Centre from 1982 to 1991.

The network, more resembling a full-scale collaboration in VicHealth terms, saw its major task as persuading the trade union movement to take more interest in women's issues. The Queensland Nurses Union used OHS issues as a vehicle to further this aim. The network met monthly, inviting expert speakers to talk on issues such as rape and domestic violence. Both the Workers' Health Centre, which had outreach services in workplaces, and the Brisbane Women's Health
Centre worked together extensively in relation to immigrant women's health. A drive was undertaken to increase union membership of the Workers’ Health Centre.

Another agency that collaborated to pursue women's health issues was the Trade Union Training Authority (TUTA). TUTA provided training in representation and negotiation skills for unionists at all levels. It also ran education courses about industrial relations systems and sessions on working women's issues, including sexual harassment, which was a notoriously difficult issue to pursue either in the workplace or in the courts (Thornton 1984; Working Women's Centre 1980). Workers from the Brisbane Women’s Health Centre participated in teaching and women from community organisations availed themselves of TUTA courses in order to learn negotiation and meeting skills.

Bernadette Callaghan, Queensland Secretary of the Federated Clerks Union in 1983, was the first woman elected to the Queensland Trades and Labour Council after which women's health became one of the areas of the council’s work. For example, it lobbied the Queensland Government to fund the Brisbane Women's Health Centre in the mid-1980s. The Federated Clerks Union participated strongly in the Women in Trade Unions Network but officially it never differentiated between men’s and women’s health; however, because women constituted a majority of members, OHS issues were able to be raised.

The Queensland Workers’ Health Centre was heavily involved with other agencies in OHS campaigns in the 1980s, including campaigns against RSI. An aggressive educational campaign was undertaken and brochures developed. An unsuccessful RSI test case was mounted but, eventually, the campaign to bring about safer processes of work was successful. Noise was identified as a safety issue and the centre backed a union campaign against it. Action was also taken concerning the problems facing women outworkers.

A major campaign identified sexual harassment as a serious workplace issue. Women unionists had posters and brochures produced, forums were held, meetings organised and resolutions passed. Despite opposition from the national body of the clerks union, which banned the posters, the campaigns were successful in articulating and gaining a level of acceptance of the problem as a women’s health issue. At the time, there was no anti-discrimination legislation in Queensland.

Because the Queensland union movement was generally conservative, opportunities for women to generate debate about access to abortion were limited; however, after the Bjelke-Petersen Government authorised a police raid on the Greenslopes Fertility Control Clinic in 1985, union members were persuaded to participate in a protest rally at City Hall.
In South Australia, there were cooperation and collaboration between the women’s health movement, the community health movement, trade unions and the Working Women’s Centre, which was established in 1979. In a relatively small community where people knew each other, the union movement enjoyed a particularly good relationship with the women’s movement. There were both formal links, through organisations such as the SA Coalition for Workers Health Action, and informal links—for example, overlapping memberships of political parties and other organisations.

The SA Coalition for Workers Health Action, established in 1984 to promote a preventive approach to OSH, had a membership drawn from trade unions, the women’s health movement, the Working Women’s Centre, the community health and welfare sectors, allied health workers and others. It was a member of the Australian Coalition for Workers Health Action, which lobbied for legislative change, changes to workers’ compensation arrangements and for a workers’ health centre. It did not get the centre but it did get the legislative reform. As in other States, in South Australia, RSI became a major issue. Word-processing pools had been introduced into the public sector without consultation with unions. There were no guidelines for use; there was no ergonomic furniture and no awareness of the health implications of overuse. Women providing word-processing services were required to have a keystroke rate of 18,000 words per hour, which was monitored by a machine. At the end of the week, those who had under-performed were counselled. The result was what was described as an ‘epidemic of RSI’, which especially affected immigrant women. The unions, in close cooperation with women’s health centres and the Working Women’s Centre, demanded 10-minute rest breaks, a reduction of the key stroke rate to 12,000 words per hour and ergonomic equipment. Sympathetic practitioners were needed for referral but were difficult to find, so women were referred to Adelaide Women’s Community Health Centre where staff became expert in the intricacies of RSI. Similarly, in other States and Territories, women in unions worked with the women’s health movement and other groups to promote a more expansive view of OHS.

Meanwhile, women unionists were working to increase their voice at the national level. In 1975, they demonstrated outside the ACTU Congress, demanding that working women’s issues be put on the agenda, which was part of a major campaign to press the council to adopt a Working Women’s Charter. A charter was adopted two years later, followed by the council-sponsored Working Women’s Charter Conference in 1978. The Women’s Committee of the ACTU was established in 1977. It focused on issues such as child care, RSI, flexible working hours and parental leave. After an intense struggle, the 1981 ACTU Congress made a historic decision to support women’s right to free, safe, legal abortion (Hague and Milson 1982:15). The first woman was elected to the executive in 1983 and, shortly afterwards, the Working Women’s Policy was produced and endorsed.
The ACTU now campaigns regularly on issues of importance to women workers, including pay equity, paid parental leave and sexual harassment, and supports strategies to promote compliance with the *Equal Opportunity for Women in the Workplace Act 1999* (ACTU 2009; Burrow 2008).

In summary, a long collaboration, played out differently in different settings, took place between groups concerned with women’s health at work. Problems were articulated, the meaning of OHS was expanded and it was given a place on Australian political agendas. Legislative reform has been achieved in all jurisdictions. In South Australia, both major political parties made OHS election promises before the 1983 election. Reform legislation was introduced in that State in 1986 and the Occupational Health and Safety Commission was established, with the Women’s Advisory Committee and provision for women’s representation on all other committees. The Labor Government in Western Australia took reform action from 1983 onwards, in response to women’s advocacy, producing a discussion document that suggested that the focus of OHS be changed from safety to health. Legislative change was subsequently developed through a tripartite process and became law in 1987. When Labor lost office in 1993, however, much of the reform was overturned.

Australian OHS legislation now provides for worker-elected health and safety representatives—one of the demands of women in the 1970s and 1980s. Representatives have been given broad powers in most jurisdictions, including the right to order that work be stopped if conditions are considered unsafe. All State and Territory legislation provides for the establishment of health and safety committees, on which both employees and employers are represented, and everywhere inspectors have wide powers. Arrangements, however, still vary from jurisdiction to jurisdiction (National Research Centre for OHS Regulation web site) due to differences in political culture and the incumbency of governments (Pearse and Refshauge 1987:640).

Occupational health and safety was officially recognised as a priority women’s health issue in the first NWHP—a tribute to women unionists and their collaborators who worked hard to bring hidden problems to public attention and to have appropriate responses embedded in legislation and public policy.

**A Note on Working Women’s Centres**

Several Working Women’s Centres were established in the 1970s and 1980s to provide work-related support for women, including those from diverse cultural backgrounds and those disadvantaged in regard to workplace bargaining. All formed strong partnerships with other community organisations, government agencies, universities and unions and are experts on women and industrial
relations issues’ (Queensland Working Women’s Service 2007–08:9). In 1975, the first two Working Women’s Centres were established, one in Melbourne and the other in an industrial suburb of Newcastle, NSW: the Hunter Region Working Women’s Centre. The former was the first trade union women’s research and advisory centre in Australia, set up under the auspices of the Australian Council of Salaried Professional Associations. It campaigned for women to take a more active part in trade union and political life and for women’s issues in employment, including family friendly policies. It also advocated for reproductive health rights, including abortion and general women’s health issues (The Australian Women’s Register, Working Women’s Centre at Melbourne 1975–84). The Hunter region centre was a multipurpose centre but health has always been the major focus of its work. From the beginning, it was funded from disparate sources, including the Commonwealth Health and Hospitals Services Commission (HHSC) (Broom 1990:15–16).

The Working Women’s Centre was established in South Australia in 1979 by bureaucratic process. It has always received State funding but is managed by a community board. It collaborated closely with women’s health activists. Working Women’s Centres were established in 1994 and 1995 in Queensland, Tasmania and the Northern Territory, with combined Commonwealth/State funding. All collaborated extensively with the women’s health movement, as discussed, and all were primarily concerned with the interests of women who were not represented by a union. They provided advice, information and support. Among the range of OHS issues dealt with are RSI, outwork, family friendly practices, workplace bullying and sexual harassment.

The Workers’ Health Centre was established in Lidcombe, Sydney, in 1977 with the support of progressive trade unions and Leichhardt Women’s Community Health Centre but with no government funding. While not exclusively a women’s centre, it campaigned regularly on key women’s health issues as part of its core work to raise the profile of workers’ health issues. It was able to organise migrant women to take action on RSI and made a detailed submission to the Williams Inquiry into OHS in New South Wales in the early 1980s (Dimech 1982:16). Working Women’s Centres and Workers’ Health Centres have regularly worked with the women’s health movement on an ‘as needed’ basis.

Working Women’s Centres came under funding threat and were forced to curtail the services they provided when they opposed the Howard Government’s industrial relations policies, especially the WorkChoices legislation of 2005. The New South Wales centre closed towards the end of that year, after a long and unsuccessful struggle to retain Commonwealth funding without curtailing its services. The Tasmanian centre closed in August 2006, when the funding contract it was offered by the Commonwealth stipulated that the money was for ‘the provision of information on WorkChoices only’. Women in the Australian
Services Union were unable to persuade the Tasmanian Government to meet the Commonwealth funding shortfall. Three centres, however—those in the Northern Territory, Queensland and South Australia—survived the Howard years, only to be told in 2008, under a Labor government, that Commonwealth funding might be terminated. Months of time-consuming campaigning, letter writing and meetings with departmental officials took place before short-term funding was again secured.

Partnerships

Partnerships are located at the complex collaboration end of the VicHealth continuum. They are often a blend of hierarchy, and market and network forms of participation and are generally thought of as voluntary. The concept of partnerships, suggesting that participants are in relatively equal positions, appears regularly in recent government reports, reflecting its acknowledgment as an intrinsic element of preventive health care (Baum and Keleher 2002:36). The National Preventive Health Taskforce discussion paper *Australia: The healthiest country by 2020* envisages partnerships as a key element of almost every type of preventive healthcare strategy (Commonwealth of Australia 2008a).

Because one of the principles of women’s health is empowerment, building and promoting strong, collaborative partnerships is a favoured way of working (Women’s Health in the North web site). Since 2000, health partnerships have been established in Victoria where there are now 31 Primary Care Partnerships (PCPs). More than 800 agencies, including women’s health centres, are involved. A central aim is to ‘facilitate coordination of the provision of a broad range of services between GPs, community nurses and therapists, youth workers, home carers and people in numerous agencies’ (Government of Victoria 2002). Victoria has instituted the Aboriginal Health Promotion and Chronic Care Partnership, in which government agencies and Aboriginal community health centres work together on multiple projects.

As part of the Victorian Primary Care Partnership strategy, all women’s health and community health centres have health-promotion plans for 2009–12. Victoria has also established partnerships in violence prevention. Lauded as the first whole-of-government approach in Australia, Partners in Prevention is a network of Victorian professionals who work with young people. Established in 2007, the network is funded by VicHealth and managed by the Domestic Violence Resource Centre Victoria (DVRCV). Members meet four times a year to share resources and information and are involved in a variety of programs, including Relationships Education and Awareness for Life, a schools program aimed at supporting young people to experience positive, rewarding relationships. Feeling Safe Being Strong is a primary-school prevention project run by Bethany Community Support,
and Respect Protect Connect is a secondary-school peer-education program run by Women’s Health in the South-East in partnership with the South Eastern Centre against Sexual Assault. Other projects include performance pieces and online information and resources (Partners in Prevention web site).

Part of the Victorian Government’s aim in pursuing partnerships appears to be to save money through better management of the rising incidence of chronic disease in an ageing population and less use of expensive hospital, medical and residential care. Such an overriding objective is likely to undermine the autonomy of partners. And so a study has found: one evaluation of the Primary Care Partnerships detected a reasonable level of collaboration but there was limited capacity for agencies to follow their own priorities at the local level (Lewis 2009). At the same time, early evaluation has suggested that better health outcomes will follow (Hahn 2002).

Partnerships in violence prevention have also been established in South Australia. The Western Collaborative Approach (WCA) is a partnership developed in 2005 among 21 key agencies in the area of the Central Northern Adelaide Health Service. Among the groups involved is Dale Street Women’s Primary Health Service. The project, which includes Aboriginal people and organisations, makes use of ‘Change Champions’—men who are prepared to actively oppose violence against women and disrespectful ways of speaking. It has a reference group, a leadership group and key area focus groups (Johns 2009:7).

The Hobart Women’s Health Centre has been involved in a recent partnership with government and other agencies, which examined the health needs of women from diverse cultural backgrounds. The aim was to improve access to quality services through the establishment of permanent regional migrant and refugee women’s health worker positions. Existing State-wide networks were used to facilitate consultation and to provide support and feedback on completion. Project steering committee members were drawn from relevant branches of government, women’s health and rural health services, multicultural organisations, the Royal Hobart Hospital, TAFE Tasmania, the University of Tasmania and Devonport City Council (Valencia 2007).

In New South Wales, the Aboriginal Health and Medical Research Council (AH&MRC), while mindful of the principles of Aboriginal self-determination, supports partnerships with government, along with collaboration between relevant governmental departments with responsibility for Aboriginal health. Formal partnerships with the NSW Government, under which the parties were to enjoy equal status, were struck in 1995, 1997 and 2001. The aim was to ensure that the health expertise of Aboriginal communities was channelled into health policymaking processes. As part of the strategy, partnerships were put in
place at regional and local levels where health plans were developed. AH&MRC also participates in formal and informal partnerships with peak organisations involved in the delivery of health care for Aboriginal people.

Conclusion

So many and varied are the forms of collaboration that it is impossible to differentiate between types with precision, although VicHealth makes a valiant attempt. In community-based health care, cooperation and collaboration are central parts of everyday operations, and women’s health groups have found strength in working together, supporting each other wherever possible. They have formed networks, associations, coalitions and service-provider groups and have worked at all levels of political systems to try to change policies and so improve women’s health. Women unionists worked collaboratively to revolutionise the meaning of occupational health and safety and to put the new version on political agendas. Expectations about what constituted decent working conditions were raised and women’s rights to control their bodies eventually became ACTU policy.

One of the distinguishing features of the joint ventures, partnerships and collaborations being developed in the different health systems is that they have a population-health focus rather than a focus on individual treatment. Evidence shows that interventions at the level of community care improve population health; however, only a very small proportion of Australia’s total health budget is spent on population-focused programs. In 2008–09, 3.2 per cent of total Australian health spending was devoted to community health (some of which is not population focused since individual services are also provided). Another 2.1 per cent was spent on public health, defined by the Australian Institute of Health and Welfare (AIHW) as activities that ‘focus on prevention, promotion and protection rather than on treatment, on population rather than on individuals, and on the factors and behaviours that cause illness and injury rather than the illness and injury itself’ (AIHW 2011:2). Total spending on community health and public health combined therefore was 7.3 per cent of the total health budget and has been stable over the past decade (AIHW 2010c:119). Although health promotion and prevention have been on the Commonwealth policy agenda since 2007, no major investment in health has so far been made.

The next chapter presents case studies of two issue-specific sections of the movement: the maternity-care reform movement and the abortion rights movement. In the first, there has been less collaboration with other parts of the movement than we might expect. In the second, collaboration bubbles forth almost spontaneously when a threat is perceived or an opportunity presents itself, such is the centrality of reproductive health rights in the women’s health movement.
Women hang their health concerns out to dry at the Women on Top Health Forum, Launceston, June 2008.

Photo: Tracey Wing


Photo: Queensland Women’s Health Network
The ‘Mother of All Rallies’, organised by Maternity Coalition. Approximately 3000 women demonstrate in support of expanded maternity-care choices outside Parliament House, Canberra, 7 September 2009.

Photo: Maternity Coalition


Photo: Tracey Wing
Marilyn Beaumont, formerly Executive Director, Women’s Health Victoria, with Professor Karen Grant, University of Manitoba, at the pre-conference reception, Government House, Hobart, 2010.

Photo: Tracey Wing


Photo: Tracey Wing