7. Policy Responses: States and Territories


If setting up separate services for women was difficult, the objective of influencing public policy was probably even harder. Consider the circumstances: groups of feminists, easily dismissed as part of a lunatic fringe, spoke about taboo subjects in public and circulated a radical critique of an esteemed institution—namely, the medical-care system. Persuading people of the validity of their claims was not easy. First, issues and concerns had to be identified and articulated. Sometimes a new language had to be developed with which to discuss issues previously hidden from view. Explanations had to be developed about why things were as they were. Meetings had to be held, agreements forged, position papers written and arguments disseminated in public places. Coalitions of support had to be created and maintained. Bureaucratic hostility was common and often a majority of political party members opposed, did not understand or were not interested in women’s health perspectives. In some jurisdictions, women’s health was seen as synonymous with abortion, which could be counted on to raise intense opposition. The social health perspective was new and often not well understood so that many health bureaucrats tried to incorporate women’s health initiatives into the conventional medical paradigm. This came about partly because of familiarity with past practice and partly because bureaucracies do not like to establish organisations over which they have little control. Incorporating women’s health into the medical model would also maintain trouble-free relations with organised medicine and avoid political fallout. Influencing public policy was not achieved easily.

The advocacy of the women’s health movement, however, built up such momentum by the 1980s that political parties felt they could not afford to ignore it, especially as opinion polls were showing that the ‘women’s vote’ was a force to be reckoned with. The decade can be seen as a golden age in the development of women’s health policies, centres and services. As well as general women’s health policies, strategies to confront domestic violence were formulated and reforms implemented. Prior to and feeding into the development of the NWHP in the second half of the 1980s, most States and Territories had initiated inquiries into women’s health and/or developed their own policies. At the same time, women’s health policy machinery was introduced in all jurisdictions and at the Commonwealth level. These new institutional arrangements assisted policy and program advancement; women’s health advisers and the units they ran were
crucial in the many-pronged struggles for policy influence that followed. Sexual assault was the hardest issue to bring out of the wings and position on the policy stage.

New South Wales

The establishment of health policy machinery and the development of policy progressed steadily in New South Wales under the Wran Labor Government (1976–86), even if persuading it to make up the funding being withdrawn by the Commonwealth was a struggle. A Women's Coordination Unit was established in the Premier’s Department in 1977, followed by the establishment of women’s units in key departments to work with the Coordination Unit—a hub-and-spoke model as advocated by WEL. The Women’s Advisory Council, the main channel through which community views were fed into government, was established in the same year. The council consulted with women, paying special attention to rural areas. As in all consultations with Australian women, here, health emerged as a major concern and became an element of the reform agenda. The council recommended that more women’s health centres be established, more birthing choices be developed, better contraceptive information be made available and that participation in health decision making be facilitated.

New initiatives, however, took several years to develop, despite persistent lobbying by movement members. In June 1984, the Women’s Health Policy Review Committee was established. The Women’s Health Unit, with a staff of three to four, headed by the Women’s Health Advisor, Carla Cranny, was set up in 1985. Most staff members were experts in particular fields and had links with grassroots women’s groups. By the mid-1980s, the Wran Government had made a clear commitment to women’s health action.

The Policy Review Committee was charged with identifying the main women’s health issues, assessing the adequacy and accessibility of existing services and determining appropriate funding mechanisms. Its final report was presented in November 1985 and formed the basis of an approach termed ‘a policy in action’ in the absence of a formal policy. Extra funds were provided for rural and public hospital sexual assaults centres, and, as discussed, some unfunded health centres received funding for the first time. By 1986, 19 women’s health centres, including Jilimi (later renamed Waminda), were being funded by the State Government. Women’s health coordinators were installed in each of the health regions, along with women’s health educators and approximately 60 women’s health nurses, who were trained to provide sexual, reproductive and
breast health services. With increased capacity, women’s health centres were seeing more than 80,000 women each year (NSW Women’s Advisory Council to the Premier 1987:187–9).

Bureaucratic resistance to separate women’s health services remained, nevertheless, even in New South Wales, which has the longest experience and the most centres. One of the arguments against centres was that NGOs needed to deliver better services than the mainstream in order to justify a funded existence. The mix of services provided in the two sectors is too different to compare quality in any straightforward sense. During this time, NGOs were evaluated and measures put in place to ensure financial accountability. Some centres found the requirements of intricate record keeping and statistical collection onerous, particularly given the straitened financial circumstances in which they found themselves. Differences in the power of stakeholder groups were clear: women’s services were required to account in detail for the trivial funding they received whereas multimillion-dollar hospitals were able to report in broad-brush terms.

In 1988, the Labor Government was replaced with the neo-liberal-leaning Greiner Liberal Party Government, which quickly set in place a review of all NGOs funded by the Health Department. Although the women’s health sector feared it might lose support, it had established its legitimacy to the extent that the Premier endorsed the principles of the NWHP in a women’s policy statement in 1990. In 1995, the government changed hands again and the Carr Labor Government was elected. A women’s health discussion paper was produced in 1998, and a policy document, *A Strategic Framework to Advance Women’s Health*, indicating directions until 2003, was released in 2000. The document confirmed a commitment to a social view of health and other principles of the NWHP, including intersectorality. The four key strategic directions identified were adoption of a gendered approach to health, collaboration to address social determinants, advancement of women’s health research and the application of a health-outcomes approach, based on measurable indicators. In April of the same year, the Gender Equity in Health statement was released, which recognised gender as an important determinant of health. It presented an overarching framework for promoting women’s and men’s health (NSW Health Department 2000:1).

The Women’s Health Outcomes Framework was subsequently developed and released in 2002. It provided a guide to measuring and monitoring conventional health outcomes and prioritised mental health and the prevention of violence against women, as well as preventive health measures, such as smoking cessation. Influenced by the principles of the NWHP, it acknowledged the social health
perspective and the importance of health promotion, disease prevention, equity of access to appropriate and affordable services and a strengthened primary healthcare system (Women’s Health Unit 2003).

In January 2010, the interim Women’s Health Plan, 2009–2011, was released. Priority action areas include violence, the Aboriginal Family Health Strategy, the improvement of the health of pregnant women, and the health of immigrant and refugee women and women living in regional, rural and remote areas. Each Area Health Service is required to implement and monitor the plan. The plan suggested that 2010 was a time of transition because the Commonwealth would soon release a new NWHP. A full review of New South Wales policies for women is to be held in 2012 (NSW Department of Health 2010).

Queensland

The Bjelke-Petersen Government, including the Health Minister in the early 1980s, Brian Austin, was not interested in women’s health. Leisha Harvey, only the second woman in Queensland to hold a cabinet position, took the health portfolio in 1987 and, after intense lobbying, agreed to set up the Women’s Health Advisory Council. The Women’s Health Forum was held, attended by 400 women, as part of Queensland consultations for the NWHP; however, there had been no further policy progress when the Government lost office in 1989. By then, community consensus about the importance of women’s health had emerged. Nevertheless, the new Labor Government took time to act, partly because supporting women’s health apparently meant supporting access to abortion in the minds of some parliamentarians. Jude Abbs, first Interim Convenor of AWHN, was an ALP member and introduced women’s health as an issue. Because policy development on women’s issues lagged behind other jurisdictions, there was a sense that time had to be made up. Former Women’s Health Adviser Janet Ramsay describes her experience at Queensland Health as trying to do 20 years’ of policy development in two years.

The Queensland Labor Party had formed a women’s policy committee, which saw women’s health as a priority issue, with special emphasis on the needs of women in rural and remote areas. By this time, diverse groups of community women were well organised in Brisbane and in regional towns and were ready to assume responsibility for managing women’s health projects. Networks had been formed, meetings and forums were held and expectations were high.

The Women’s Health Unit was established in 1991, with between five and eight permanent, designated women’s health policy positions (Gray 1999:210). Between 1989 and 1995, Anne Warner, Minister for Family Services and Aboriginal and Islander Affairs, was the only woman in the Queensland cabinet. She was only
the second ALP woman to be elected to the Parliament and the first to hold a ministerial portfolio. So her office tended to operate as a centre of women’s issues.

A discussion paper, *Towards a Queensland women’s health policy*, was developed in 1992 followed by a consultation process across the State and in the Torres Strait Islands. The Royal College of General Practitioners, strongly opposed to the discussion paper, did its own survey to try to show that women did not really care about the sex of general practitioners or about women’s health issues. The Queensland Medical Women’s Society also voiced opposition. Members were upset, for example, about a proposal to train women’s health nurses. Within government, it was felt that the support of organised medical groups was necessary, so extensive negotiations were held.

Queensland Health received 138 written responses to the discussion paper, which was followed by a green paper with the same name. The Goss Government was committed to hearing from Queensland women about health priorities but some members counselled caution at this point, as it was realised that consultation creates expectations. The green paper provoked considerable controversy and the abortion issue was again raised. To get cabinet approval, which was extremely difficult in any case, the ‘A’ word had to be avoided at all costs. Even Family Planning Queensland felt it had to hold itself aloof from the abortion issue for self-protection. After a politically fraught passage during which the need for separate women’s health services was questioned extensively, the Queensland Women’s Health Policy was launched in November 1993.

The 1993 policy was never reviewed or updated, nor was it properly monitored. Despite the existence of a relatively well-staffed women’s health unit, little research or statistical collection was carried out. These omissions were put down to lack of central direction and coordination. Within government, there was talk about partnerships with the community sector but no real action was taken to develop connections or concrete programs. In 1996, the Women’s Health Unit was formally abolished.

In 2001, Queensland still had no access and equity policies and no bilingual health workers, except in women’s health centres and services. Women advocating for the employment of interpreters in health agencies were told that there were not enough migrant and refugee women to justify the effort. Although women’s health never had a high profile within government, members of the movement feel that it was gradually accepted as a legitimate area of public policy. Moreover, the principles of women’s health are thought to have influenced the direction of Queensland primary healthcare policy due to compatible principles and philosophies.
Reaching for Health

South Australia

The State health bureaucracy appears to have had an unfavourable view of the women’s health centre from the start. (Auer 2003)

In the late 1970s, women’s groups in South Australia had mobilised and were campaigning for separate women’s health services. The Liberal Party won government at the 1979 election and Jennifer Adamson (later Cashmore), a supporter of a feminist health perspective, became Minister for Health for the next three years. Gaining support within government and the bureaucracy, however, was not easy. It took until the middle of 1982 for the minister to be given authority to request the South Australian Health Commission to develop a women’s health policy. A working party was set up and consultations undertaken but the policy had not been written when the Government lost office.

Labor women had responded to grassroots agitation by establishing a women’s policy committee within the party in 1978. On gaining office in 1982, a major task was to finalise the women’s health policy. A philosophical framework supportive of women’s health was accepted within the party and the importance of opening channels of communication with women so that they could contribute to policy was emphasised.

The Adviser on Women’s Health, Liz Furler, who reported directly to the minister, was appointed in January 1984. Health Minister, John Cornwall, who supported separate women’s health services, proposed that she become a member of the Health Commission Executive, but ‘at least a dozen reasons were advanced over so many weeks by the existing members of the executive as to why such an appointment would not be “appropriate”. Most of them relied on the fact that her position did not carry Executive Director status’ (Cornwall 1989:45). At the time, there were no women in senior executive positions at the commission. When the minister insisted, the Adviser on Women’s Health was ‘grudgingly admitted’ but she was ‘never accepted into the inner sanctum. Nor was her “pushiness” ever forgiven’ (Cornwall 1989:44–5).

In August 1984, the Report of the Working Party on Women’s Health Policy was released, which was the first women’s health policy in Australia. Women’s health, however, had no natural home in the bureaucracy and it took time to decide where responsibility should be located. Indeed, it took four years to identify which area should take responsibility for immigrant women’s health. According to one femocrat involved in the processes, the South Australian Health Commission resisted all changes recommended in the policy because bureaucrats did not want to deal with an assortment of small agencies. Under
the circumstances, it was not hard to get the policy endorsed but it was very difficult to get a commitment to implementation, maintenance and proper funding.

In spite of the obstacles, a number of valuable projects were undertaken after the release of the report, including the establishment of new women’s health centres, as discussed in Chapter 3. The representative Women’s Health Consultative Committee to the Health Commission was appointed to advise on issues raised in the policy. Aboriginal, immigrant and older women, women with disabilities and single mothers were represented, together with women from general practice, nursing and the voluntary sector. A program of seminars on women and health was initiated in regional and rural areas. Abortion services were improved, along with responses to child sexual abuse. Equal opportunity for women within the health system became a central issue.

The new Social Health Unit was established in 1986, which was seen as integral to the Government’s social justice strategy. The Adviser on Women’s Health became the Director and her office was transferred. The new unit had a staff of eight, including an Aboriginal project officer. It was not directly responsible for women’s health and its creation gave rise to considerable controversy. Some members of the movement wanted a more direct focus on women’s health and discussion was rekindled about whether it had been a good idea to work with ‘the state’ after all. In the event, the major supporters of the Social Health Unit, Minister Cornwall and the Director, Liz Furler, both moved away before the unit had time to make an impact. After their departure, the staff and resources of the unit were slashed.

In 1988, the metropolitan women’s health centres worked together to produce a five-year strategic plan, developing strategies around key issues (Radoslovich 1994:62). Under the Brown Liberal Government, however, elected in 1993, the independence of women’s health centres was lost. Inspired by the neo-liberal objectives of increased efficiency and expenditure reductions, the regional centres were amalgamated with community health centres to form regional community health centres, while Adelaide Women’s was amalgamated with the Women’s and Children’s Hospital, as discussed above. Severe budgetary cuts were used to ‘encourage’ cooperation (Radoslovich 1994:104–5). The changes accorded with the longstanding Health Department position of strong opposition to separate women’s health centres.

The Olsen Liberal Government released a consultation paper in 2000, as the first part of a project to develop the Department of Human Services Policy and Planning Framework for Women’s Health and Well-Being. A key initiatives paper, *Women’s health and well-being*, setting out a snapshot of existing projects, was released in 2001. The Government changed hands in 2002. The
Women's Health Ministerial Advisory Council was established by incoming Health Minister, Lea Stevens, in 2003 and a new Women's Health Policy was launched in 2005. It describes itself as ‘a policy like no other’ because ‘it is about all of us—the whole health system and the South Australian community. It is about changing health for women, changing health for everyone—but it starts with women.’ The policy takes a social determinants perspective and suggests structural reform to achieve a focus on prevention and primary health care, aiming to achieve ‘health for all’ (Government of South Australia 2005). Based on the policy, the Women’s Health Action Plan was written and, in 2009, Women’s Health Statewide produced an evaluation, ‘Women’s Health Action Plan Report Card’. While a number of programs and strategies were introduced in key women’s health areas, the major reforms envisaged in the 2005 policy did not proceed.

Tasmania

In Tasmania, where hospitals have been the central health institution for decades, awareness of the importance of primary health care was slow to develop. Many people saw community health as an extension of hospital care into the home situation, with hospital staff providing the service (Shaw and Tilden 1990:29). The women’s health movement was therefore without an important band of community health allies and, while the movement was strong, those with authority in health policymaking took a long time to respond to the new ideas. As one femocrat has argued, the road to women’s health in Tasmania has been ‘a twisted and convoluted one: a step or two forwards, some backsliding and a few quantum leaps’ (Personal communication).

The election of a Labor government and the launch of the first NWHP in 1989 heralded a positive period for women’s health and brought renewed energy from community groups. Money was made available for a Women’s Health Forum, as a means of generating input to the NWHP, under which funding was provided for a women’s health senior policy officer position. Research on women’s health needs in regional areas was also funded, along with the Hobart Women’s Health Centre. In subsequent years, various small projects were supported and funding was directed towards the development of a Tasmanian women’s health policy, which was launched in 1994. In the mid to late-1990s, a discrete women’s health program was developed within the Department of Health and Human Services. Regional coordinators were appointed and an information service was established. A manager was appointed in 1999 to oversee the program and all positions were made permanent in the same year.
During the early 2000s, the Women’s Health Program became part of the Population and Health Priorities Unit within Population Health, alongside other priority areas, such as Aboriginal health, immigrant health, youth health and men’s health. Since that time, there has been a focus on health equity, diversity and gender mainstreaming. Although it works to improve mainstream services, the Women’s Health Program aims to achieve change at the level of population health and is structured around a regional outreach model.

According to the evaluation of the NWHP, the Tasmanian Women’s Health Program developed within a context where there had been a philosophical shift from traditional illness orientation towards a social view of health with a focus on primary health care (Commonwealth of Australia 1993:45). The program was maintained until 2011 when State finances became stressed. The budget announced funding cuts across portfolios, including a $100 million reduction in health funding. The implications for women’s health are not clear at the time of writing but it is anticipated that a leaner program will result.

Victoria

In Victoria, the Cain Labor Government was elected to office in 1982. Although the new Premier regarded the women’s policy machinery set up under the previous Liberal Government with suspicion (Sawer 1990:162), Mary Draper was appointed Women’s Adviser in 1983. One of the issues she discussed with the Premier was a women’s health policy. A group of women parliamentarians and femocrats, in response to grassroots activism, identified women’s health as a key issue and agreed that the development of a policy should be a priority.

A number of crosscutting forces operated. Within the Labor Party, support for separate women’s health services was weak and, even among female members, opinion was divided. The party’s Health and Welfare Policy Committee did not favour separate women’s services, arguing that community-based services were important but they did not have to be separate. Many officers within the Department of Health were hostile; the view that women’s health was a waste of time and money was strong. As in other States, in Victoria, health bureaucrats tended to oppose government funding for community groups on grounds of increased complexity and accountability problems. On the other hand, there was a commitment to community consultation and an awareness of lagging behind other jurisdictions on women’s issues. Victoria was certainly lagging behind New South Wales, perhaps rekindling ancient rivalries. Female politicians and femocrats were able to use these forces to advantage, assisted by
opinion polling that showed the electoral importance of attracting the women's vote. Kay Setches and her colleagues, who included Joan Kirner and Carolyn Hogg, are said to have been known as the feminist mafia.

The Labor Party’s health platform for the 1985 election was headed by policy for hospitals and made no mention of women’s health. Under these circumstances, many avenues had to be used to promote the development of a formal women’s health policy. An intense struggle ensued, which included women parliamentarians persistently lobbying the Premier. Senior bureaucrats, no matter how resistant, are likely to be responsive to the wishes of the minister and, in 1985, David White, who supported women’s health, became Health Minister. Jenny Macklin, later to become a Commonwealth minister and Deputy Leader of the Labor Party, was a member of the minister’s staff and her work is regarded as pivotal in the struggle for a positive outcome.

The strongest resistance to separate services was gradually eroded and an in-principle agreement was reached that the Health Department should develop a policy. Minister White announced the establishment of the Ministerial Women’s Health Working Party, under the leadership of Kay Setches, who later joined the cabinet. Before entering Parliament, she had been coordinator of the Maroondah Women’s Refuge. A discussion paper was distributed and consultation was undertaken with thousands of Victorian women.

Many senior parliamentarians, however, were not convinced that funding community-based women’s health services was a wise move, nor that electoral advantage would follow. A number of others were simply not interested. The Cain Government perceived itself as having inherited a poor financial situation and wanted to prove itself as a sound financial manager. This cannot, however, be considered a serious justification for inaction, since the amounts of money so far allocated to women’s health are too small to have a serious budgetary impact, irrespective of jurisdiction. After another intense struggle, it was agreed to set up the Victorian Women’s Health Program, as outlined in Chapter 3. In the event, funding was approved in 1987 prior to the release of the working party’s final report, *Why women’s health, Victorian women respond*.

The Women’s Health Policy and Program Unit was established in the Health Department to implement the changes. The two major policy directions were long-term structuring of general health services to reflect women’s health issues and the provision of separate services (Women’s Policy Coordination Unit 1987:68–9). A women’s health centre was established in each region, and specialist community-based women’s addiction services and services for young women were set up under the new program.
By 1990, the Cain Government was in crisis, the budget deficit was high and some financial institutions were deeply unstable. Divisions emerged within the ALP about an appropriate response. There were attempts to regenerate momentum and to identify important issues for the 1990s but energy was low and the party’s policy committees were in decline. Although a dynamic leader, Joan Kirner, took over in 1990, the Government was unable to regain its electoral strength and it lost office to the Liberal Party under Jeff Kennett in 1992.

Social policies and programs were not Kennett Government priorities but reigning in expenditure was. Shortly after the election, the health budget was cut by 12 per cent. The traditional bureaucratic distaste for separate women’s health services once again emerged in proposals to ‘integrate’ women’s health centres into primary care services. The number of people working on women’s health in the bureaucracy was reduced. In 1997, however, Health Minister, Rob Knowles, asked the Ministerial Advisory Committee on Women’s Health to begin the development of a women’s health plan for Victoria. A round of consultations followed and, in 1998, the Department of Human Services and the Ministerial Advisory Committee on Women’s Health jointly sponsored a women’s health conference as part of the policy development process. The conference met with an overwhelming response (Beaumont 1998:6–7.) A women’s health plan was written before the Government (unexpectedly) lost office, after which the plan was abandoned. Overall, the Kennett Government era has been described as a ‘policy vacuum’ for women’s health (Johnstone and Bachowski 2000:4).

The incoming Bracks Labor Government was elected on a platform of commitment to women’s issues. The Ministerial Advisory Committee on Women’s Health and Wellbeing was established, chaired by Caroline Hogg. After a discussion paper and further consultations, the four-year Women’s Health and Wellbeing Strategy was launched in 2002. The strategy focused on the needs of women with the most disadvantages, particularly in the areas of safety and security, mental and emotional health and participation. Upon the expiry of the strategy, a group of women’s health providers collaborated to write a new policy proposal, Women’s Health Matters: From policy to practice, 10 point plan for Victorian women’s health, 2006–2010. The plan was endorsed by 30 women’s health and community groups. The aim was to attract the attention of political parties in the lead-up to the 2006 election. The document successfully influenced priority setting.

In 2009, WHV released a second 10-point plan for the period 2010–14, which builds upon the 2006 document and suggests policy directions, including increased funding for women’s services (WHV web site). In Victoria, the women’s health movement has had considerable success in building a positive partnership with the State Government in recent years.
Western Australia

The Burke Labor Government came to power in Western Australia in 1983 with a clear agenda to promote the status of women. Deborah McCulloch, former women’s adviser to the Premier of South Australia, was employed as a consultant to help develop women’s policy machinery. The Women’s Advisory Council, which had a strong women’s health focus, was set up in the first year. It is said that the Government initially listened carefully to the council’s advice. Liza Newby, who later led the national consultation for the NWHP, was appointed Director of Women’s Interests in the Division of the Department of Premier and Cabinet. In 1986, the small Women’s Health Unit was established within the Health Commission, headed by Thea Mendelsohn.

The Working Party on Women’s Health was set up, which produced a report in 1986. At the time, Ian Taylor, an ally of women’s health, was Health Minister. A women’s health conference was held to which Liz Furler was brought from Adelaide as a keynote speaker. Hundreds of women from all over the State attended, demonstrating the high priority women placed on health. Regional forums and workshops were held, which were also well attended. Minister Taylor attended all the forums and took time to talk with women about their health needs, sometimes for a whole morning. In the meantime, the Women’s Advisory Council pressed hard to get the recommendations of the working party accepted; however, the 1986 draft policy was never endorsed.

Infrastructure gains were made in 1988–89, when funding was approved for rural sexual assault centres in Bunbury and Geraldton, and the embryonic women’s health centres in Fremantle and Kalgoorlie were provided with small amounts of funding; however, progress was slow. The Women’s Health Unit had only one permanent position, supported by a continuous flow of temporary staff. The situation was exacerbated because the unit could not get information about the availability of finance. Over time, the influence of the Women’s Advisory Council waned.

Keith Wilson, no friend of women’s health, took over as Health Minister in 1988 when grassroots women were highly mobilised and were campaigning for a network of women’s health centres. The minister strongly opposed separate services and did not support reproductive choice. His early actions included cuts to the core funding for the WA Family Planning Association. About this time, Women’s Health Care House was given three months’ notice to quit its premises, which were earmarked to be bulldozed. Requests that the minister provide a building were ignored until centre staff wrote an article for the Western Australian Sunday Times. Premises were offered the following day.
Within the Labor Party, Minister Wilson is said to have been a ‘majority of one’, who regularly threatened to resign if the health portfolio were taken from him. Carmen Lawrence, as Premier, supported her Health Minister publicly in what is reported to have been an extremely difficult time within the party. Under the circumstances, Labor women could do little to influence the Government’s approach.

Within the Department of Health, women’s health became known as ‘the poisoned chalice’ because association might end a public servant’s career. The result was that few women in the bureaucracy were willing to be advocates. By 1990, it appeared that Western Australia alone might not join the NWH Program. The Women’s Health Adviser was told to develop a new set of reference groups and to focus on introducing changes to the mainstream health system, rather than plan separate services.

A number of alternatives to separate women’s health services were considered, including well women’s clinics that would be run from general practitioners’ offices—doubtless a suggestion from medical unions. Another proposal was to use the NWH Program money to employ women’s health coordinators. In 1990, the matched funding requirement was used to oppose acceptance of the program, transforming it into a ‘States’ rights’ issue in an effort to gain political traction.

The Women’s Advisory Council continued to press the Government to join the NWH Program, supported by community groups. A well-attended meeting, addressed by Premier Lawrence, was called by WEL to increase the pressure. Staff in the Commonwealth Women’s Health Unit exercised discretion, keeping open the opportunity for Western Australia to join after it could have been closed. Eventually, in March 1991, more than a year late, Western Australia joined the program, after which most of the State’s women’s health infrastructure was established. Observers are of the view that if it were not for Commonwealth money, Western Australia would have a very small women’s health infrastructure.

Any attitudinal changes within government or the bureaucracy at the time of joining were ephemeral. Participants reported a quick reversion to a policy of ‘what the Government thought women’s health should be’. In summary, after an initial burst of positive action under the newly elected Burke Government and Health Minister Taylor, women’s health initiatives were resisted in government circles, despite strong pressure from parliamentary women, women in the bureaucracy and women in the community. Moreover, absurdities appeared regularly. For example, male doctors were given responsibility for managing the Alternative Birthing Services Program, funded under the NWH Program. King Edward Hospital for Women henceforth became known informally as King Edward Men’s Hospital for Women. Under the circumstances, struggling to infuse
the primary care system with women’s health principles was thought to be much too hard, given the massive groundswell of support that is needed to support structural change, and movement members selected their goals strategically. In the middle of the 1990s, the Women’s Health Policy Unit was reduced to two bookcases. While the claim is colourful, it is only a slight exaggeration. In 1995–96, a senior manager had responsibility for women’s health, in addition to five other portfolio areas. She was able to spend on average only one-sixth of her time on women’s health (Gray 1999:210).

The Australian Capital Territory

The process of developing a women’s health policy in the Australian Capital Territory was stimulated by the announcement of the forthcoming NWHP but interrupted by the introduction of self-government in 1989. Some of the regular opponents, who feared a policy would legitimate an abortion service, were active. At the time, the Australian Capital Territory had a relatively extensive network of community health centres—a legacy of the Whitlam Government’s constitutional authority in the jurisdiction. Some people held the view that community health centres could adequately meet the needs of women. This is not an entirely unreasonable view, given appropriate women-focused arrangements. (Broom 1991:80–1). A women’s health adviser position was established in the mid-1980s by the then ACT Health Authority. Marilyn Hatton was appointed and work began on a women’s health directory and a formal policy. At the same time, a small women’s health service was set up by the Health Department. The distribution of the draft policy was delayed, pending expected initiatives to be outlined in the NWHP. Women’s Health Development in the ACT was released in November 1990 in draft form but the document was never finalised or formalised.

The first ACT Government was headed by the first Australian female head of government, Rosemary Follett, who set up the Women’s Health Advisory Committee (WHAC) in 1989. The ACT Women’s Health Network (ACTWHN) was represented on the committee through its six-year existence. WHAC regularly consulted with ACT women about their health needs and monitored policy developments and changes, including the controversial alternative birthing services program. Under the Follett Government, legislation was changed to allow abortions to occur in facilities other than a public hospital, as discussed in the previous chapter. Under the Carnell Liberal Government (1995–2000), the importance of women’s health was downgraded. Meetings of the WHAC ceased and, more seriously, Canberra’s relatively extensive network of community health centres was progressively dismantled.
Labor was re-elected in 2001, under the leadership of Jon Stanhope, who remained in power until 2011. A five-year women's plan was produced, with an excellent health section setting out key principles. Substantial investment has been made in transitional housing for families in crisis, for example, including designated properties for women and children escaping domestic violence. But, as elsewhere, a serious shortage of low-cost housing remains. In 2008, the Government embarked on a consultative review of the Women's Health Services Plan—a process assisted by a widely representative steering group. A paper, *Health status of women in the ACT*, was released in 2008 as a guide to the review. The 2008–09 Budget announced that $1 billion would be spent on an overhaul of the ACT public health system, including $200 million to be spent specifically on women's services. The $90 million Women's and Children's Hospital is under construction in 2011, along with a new community health centre in a newly settled, densely populated suburb. Existing community health centres are being expanded and refurbished.

The Northern Territory

Despite the small population of the Northern Territory, a strong women’s movement emerged from the 1970s onwards that tended to be involved in all women’s issues. The Family Planning Association was set up in 1973 by Jo Parish, Lyn Reid and members of WEL. At the time, key people in the Northern Territory Government supported women's health and money was made available to support interstate training for family planning staff. In 1974, legislation, which passed by one vote, made abortion in a public hospital lawful up to 14 weeks’ gestation if there was a danger to the health of the mother or if there was a danger of serious deformity. Early government support for women's health faded, however, and, as we have seen, funding was withdrawn in 1980 from the centres that women had established in Darwin and Alice Springs.

After pressure from WEL, the Office of Women’s Affairs and Women’s Adviser position were introduced in 1983. The office was a policy coordination unit, located in the Chief Minister’s Department, and it works across government. The Women’s Advisory Council was later established. There was only one woman in the Legislative Assembly at the time and no women in cabinet, so that these institutions, which were relatively well resourced, played important roles.

As word about the possibility of the NWHP circulated, Northern Territory community women began to mobilise more strongly. A submission was written to the National Agenda for Women requesting funding for a women’s health conference, as a mechanism to begin formulating a Territory position. The application was successful and small working groups were formed. The
conference was held in 1989 and attracted a large contingent of Aboriginal women. The proceedings were published and distributed to key players, including the Chief Minister and senior bureaucrats. Widespread ignorance about women’s health was revealed when, after the proceedings were circulated, the Women’s Adviser received numerous calls asking what women’s health was all about.

When the Territory began to implement the NWH Program, there was no infrastructure in place, apart from Congress Alukura and family planning clinics in Darwin and Alice Springs (Commonwealth of Australia 1993:46). A struggle ensued between the Government and the women’s health movement about how the program money would be spent. The Government wanted to spend most of the money on consultations, whereas the movement wanted a Northern Territory women’s health policy and the establishment of a women’s health adviser position. Staff at the Office of Women’s Affairs felt pressured by colleagues, who did not understand the notion of a separate focus on women’s health or did not see value in such a perspective. Nevertheless, members of AWHN Top End Branch felt they had been able to influence decision making. At the time, Carmel O’Loughlin, Director of the South Australian Office for Women, was employed as a consultant. She raised issues at senior levels of the Health Department and managed to have these concerns accepted—testimony to the centrality of the femocrat role in the right circumstances.

An advisory committee, consisting of one Commonwealth officer, one Northern Territory officer and two NGO members, including an Aboriginal woman, was set up in September 1991 to oversee the implementation of the program. The women’s health movement proposal for a women’s health adviser position was rejected outright at first but a change of chief minister and a turnover of senior bureaucratic staff brought a change of direction. The Women’s Health Adviser was appointed in 1992 and the Women’s Health Strategy Unit (WHSU), with one funded position, was created. The Women’s Health Policy was released later the same year. The policy has eight objectives, which include the reorientation of mainstream health and welfare services to enable them to be more responsive to the needs of women. One of the aims is to provide ‘direction for the development of specialised women’s health services’ but there is no mention of community-based women’s health centres (Government of the Northern Territory 1992).

The mobilisation of community women and the influence of the NWHP are reported to have been the springboards for action that resulted in a Territory policy. In turn, the policy provided a framework within which women employed in the Government could work. Community women also found it a useful tool for keeping pressure on political representatives, allowing them to argue for
action on the issues that the policy enunciated. In the event, most of the NWH Program money in the Northern Territory was used to provide sexual and reproductive health information.

The WHSU, with its single women’s health advisor, now manager, position, has been retained. In 2001, in response to the increasing incidence of heterosexually acquired HIV infections by young women, the unit conducted a pilot project, in partnership with the AIDS/STD Program of the Centre for Disease Control. The aim was to increase awareness of the dangers of HIV among young heterosexual women. Evaluation of the project was positive, except that the target group thought the campaign could have been more effective had it been targeted at young men as well (WHSU 2003). In 2004, the Health Department embarked on a large project to assemble in one place all available information on the health and wellbeing of Northern Territory women, with the aim of providing a resource for policymakers, researchers and health professionals. The result was a report, The Health and Well-Being of Northern Territory Women: From the desert to the sea, released in 2005. The report is set within a social determinants framework. The WHSU envisaged that the report would form the basis for a revised Northern Territory women’s health policy (Department of Health and Community Services 2005:2). In 2008, Building on Our Strengths, A Framework for Action for Women in the Northern Territory, was released. Overall, however, Northern Territory support for women’s health centres and programs has been comparatively weak.

Violence against Women Becomes a Policy Issue

Significant changes have been achieved in public policy and the law in relation to violence against women since the 1970s, when domestic violence was a private matter, apprehended violence orders (AVOs) were almost unheard of and ‘good wives’ suffered in silence. Even among professionals, including marriage guidance counsellors, the existence of violence in marriage was not acknowledged and scarcely appeared in the professional literature (Mugford 1989). Under the circumstances, feminists had to identify the most pressing issues and draw attention to basic but unrecognised anomalies, such as the plight of women and children trying to escape violence who were ineligible for public housing because the ‘family’ already had a public tenancy.

All States and Territories, where primary responsibility for criminal justice is located, have taken policy action, as activism made violence against women ‘one of the rediscovered crimes of the 20th century’ (McFerran 2007:1). The survey below is indicative only, capturing a few of the main policies, papers, programs,
projects and statements of intent that have been produced over the past 30 years. A review of the main policies and programs currently in operation across Australia can be found in the background paper *Time for action*, produced by the National Council to Reduce Violence against Women and their Children (Commonwealth of Australia 2009a).

The Wran/Unsworth Labor Government in New South Wales (1976–88) supported refuges by filling the funding gap left by the Commonwealth and funding new refuges from its own resources (McFerran 1990:1). New South Wales was the first State to introduce legal reform intended to improve the remedies available to women experiencing violence. The Task Force on Domestic Violence was set up, which reported to the Premier in 1981, and was followed by the *Crimes (Domestic Violence) Amendment Act 1982*, which implemented many of the task force’s recommendations. All States and Territories in Queensland and the Northern Territory action was slower. Subsequently enacted similar legislation, the main thrust of which was to define the range of offences that constitutes domestic violence and to make AVOs available in cases of violence or where violence is feared. The onus of proof was changed to the civil standard of the ‘balance of probabilities’, breach of a protection order became a civil offence, rules were made to provide for the compelling of witnesses, police were encouraged to lay charges and their powers of entry to a dwelling were extended. This round of legislation was influenced by US, Canadian and British reforms (Mugford 1989).

Further legislative reform took place in New South Wales in 1987, extending the definition of domestic violence. In 1991, the NSW Domestic Violence Strategic Plan was developed, as an attempt to coordinate government services. Reports in the first half of the 1990s drew attention to the uncoordinated nature of the response and, in 1996, another report, *New Directions in Reducing Violence Against Women*, was released by the Department for Women and the Premier’s Council for Women. This was followed in the same year by the NSW Strategy to Reduce Violence Against Women (VAW Strategy), the objective of which again was to try to provide a coordinated, whole-of-government response, focusing on prevention. A new set of central and regional State structures was put in place. Actions under the VAW Strategy include the Staying Home Leaving Violence pilot project in Bega and eastern Sydney, which was extended in 2009 to six other locations. In 2008, the Government produced a discussion paper, *NSW domestic and family violence strategic framework*, as a step in the development of a new strategic framework (NSW Department of Premier and Cabinet 2008).

Queensland women, organised as the Queensland Domestic Violence Action Group, lobbied for government action in the 1980s. Subsequently, the Task Force on Domestic Violence was established. It produced a report, *Beyond These Walls*, in 1988, which led to the *Domestic Violence (Family Protection) Act 1989*,
now the *Domestic and Family Violence Protection Act*. The Domestic Violence Council was established in 1990. The 1989 Act was amended in 2003 to extend coverage to a broad range of non-spousal relationships, including informal care relationships, intimate personal relationships and family relationships. Service providers were given training to equip them for the changes and were encouraged to develop networks and share knowledge and experiences. The Stop Violence against Women Campaign was launched in 1992 and, since then, Domestic and Family Violence Prevention Month has been an annual event.

Concern about violence against women during pregnancy led to the development of a domestic violence initiative in 1998 as a screening aid in antenatal clinics and emergency departments. In 2003, the Queensland Centre for the Prevention of Domestic and Family Violence was established to conduct research, provide education and evaluate initiatives. A domestic and family violence strategy, *For Our Sons and Daughters, 2009–2014*, was launched in 2009. Initiatives take place under an annual program of action (Government of Queensland 2009).

The Domestic Violence Council was established in South Australia in 1985. It produced a report in 1987 after which the Domestic Violence Prevention Unit was set up in the Office of the Women’s Adviser to the Premier. Its purpose was to implement the reforms suggested by the council. In the early 1990s, South Australia promoted the formation of a network of domestic violence action groups across the State. The groups involve representatives of agencies and organisations working in domestic violence at the local level, including the police, housing authorities, community corrections, charity groups, regional health authorities and women’s health agencies (Riverland Domestic Violence Action Group web site). Action groups include a non-English-speaking background domestic violence group and a lesbian domestic violence group. The Women’s Safety Strategy, which is ongoing, was released in 2005. The Whole of Government Reference Group, involving eight departments, operates and has convened a number of working parties, including an Aboriginal family violence group, a culturally and linguistically diverse women’s group and a women with disabilities group.

The Gray Liberal Government in Tasmania commissioned a report into domestic violence in 1984, prompted by the murder by her husband of Maureen Thompson, who had been beaten repeatedly and had eventually obtained a restraining order, which the police had refused to accept. The subsequent *Report on Domestic Violence in Tasmania* made a number of recommendations, some of which were implemented after intense campaigning by women. The Crisis Intervention Unit was established in the Department of Community Services in 1985. The *Family Violence Act* was passed in 2004, and, in the same year, the Safe at Home strategy began, as a whole-of-government response. The program, considered groundbreaking in terms of its focus on coordination, was introduced.
by then Attorney-General, Judy Jackson, who was passionately committed to reform (Australian Domestic and Family Violence Clearinghouse 2006:5–8). It combines 16 separate initiatives across four government departments. The aims are to improve safety for those experiencing violence, change the behaviour of offenders and focus on prevention. A consultant’s review in 2009 found that these objectives were being partially achieved (Department of Justice 2009).

In Victoria, a domestic violence committee was convened by the Premier’s Department in 1981, followed by a major report published by the Women’s Policy Coordination Unit in 1985. The following year, a discussion paper on child sexual assault was released and the Domestic Violence Incest Resource Centre established. The Crimes (Family Violence) Act was passed in 1987, which initiated intervention orders. At the same time, Aboriginal and Torres Strait Islander and migrant and refugee women took action against violence in their communities (Weeks and Gilmore 1996:144–5). In 2002, the Victorian Law Reform Commission was asked to review the 1987 legislation. The Government responded with the Women’s Safety Strategy (Government of Victoria 2002). A central aim was to develop a coordinated, integrated response. To this end, the Statewide Steering Committee was formed and it launched a report in 2005. Endorsed by 11 ministers, the strategy focused on four areas: protection and justice, options for women, violence prevention and education, and community action and coordination.

In 2004, then Police Commissioner, Christine Nixon, took the lead in developing the Code of Practice for the Investigation of Family Violence, one of the aims of which was to provide support for aggrieved family members to stay in their own homes. The new code resulted in a significant increase in the police issuance of intervention orders. It also encouraged partnerships between the police and the community. The following year, the Statewide Steering Committee to Reduce Family Violence produced a major reform framework, entitled Reforming the Family Violence System in Victoria. The Law Reform Commission reported on the 1987 legislation in 2006 and recommended new legislation, focusing on the safety of victims, with various measures to support those experiencing violence to stay in their own homes (McFerran 2007). The Family Violence Protection Act came into effect at the end of 2008 and replaces the 1987 legislation. The definition of family violence has been broadened to include economic and emotional abuse, police powers have been extended, tenancy arrangements have been made easier to adjust and measures to encourage increased reporting have been introduced (DVRCV 2009).

In Western Australia, awareness about the magnitude of violence against women began to emerge in government circles in the 1980s (Murray 1999:9). The first action in response to feminist claims was to set up the Task Force on Domestic Violence in 1985. The task force’s report, Break the Silence (1986), made 103
recommendations. The Domestic Violence Coordinating Committee, representing key departments, was established to develop appropriate legislation. The ensuing policy changes included training projects and financial assistance for women escaping violence. In 1988, a community education campaign, *Freedom from Fear*, was launched, which challenged perpetrators to take responsibility for their actions.

The Domestic Violence Prevention Council was established by legislative means in the Australian Capital Territory in 1986, along with the office of Domestic Violence Project Coordinator. From that time onwards, the expectation has been that a person acting violently would be removed from the family home. The Domestic Violence Crisis Service (DVCS), with a 24-hour crisis line, began operation in 1988 and was subject to major review in 1997–98. In response to review findings that women wanted the service to support partners as well and did not necessarily want their relationships to end, the service changed the way it worked and the language it used, and found ways of ‘engaging respectfully’ with partners, piloting a DVCS Men’s Line (Simpson 2003:6–8).

ACT community-based services have been leaders in developing coordinated responses to domestic violence, the value of which is now widely recognised. The Family Violence Intervention Program (FVIP) was established to facilitate cooperation between agencies in 1998, partly in response to perceptions that domestic violence was not being taken seriously in the criminal justice system. It relies on cooperation between 12 agencies, including police, the Office of the Director of Public Prosecutions, DVCS, Legal Aid and the Office of Family, Youth and Children’s Services. The scheme is facilitated by a steering committee, data and evidence are presented to regular weekly meetings and protocols and practice principles are developed, along with support systems and perpetrator education programs. Evaluation shows the program to be highly successful and a national leader (Australian Domestic and Family Violence Clearinghouse 2007; McFerran 2007; Mulrony 2003b).

In response to pressure from activist women’s groups, the Northern Territory Government produced the Northern Territory Domestic Violence Strategy in 1994, which was described as ‘all paper, no infrastructure’ (Edwards 1998:46) because few programs were put in place and those that were, were poorly resourced. Like other jurisdictions, the Northern Territory has legislated to specify conduct that constitutes domestic violence, the relationships covered and to regulate the issuance of domestic violence protection orders. The principal piece of legislation is the *Domestic and Family Violence Act 2007*, amended in 2009 to provide for mandatory reporting of serious physical harm by health workers—a requirement that is highly controversial. The Government’s rationale is that a message is sent to the community that violence against women and children is unacceptable. Mandatory reporting has been criticised, however,
on grounds that there is no evidence that it improves safety, that police lack the capacity to investigate all reported cases and that health workers might lack the expertise to meet their obligations. A significant number of women who experience violence oppose mandatory reporting and might therefore be deterred from seeking medical treatment (Marcus 2008).

In sum, despite differences in policies and programs, Australian jurisdictions have produced sets of legislative arrangements with shared features. In all jurisdictions, courts are empowered to make AVOs and to exclude from a shared residence the person against whom the order is made. The types of conduct that constitute domestic violence, the relationships covered and the penalties for breaching an AVO are all regulated and are all broadly similar. In all jurisdictions, temporary orders can be obtained quickly and stalking is now a criminal offence everywhere (Commonwealth of Australia 2009a). There are, however, still significant differences in the discourses in different jurisdictions, variations in levels of penalty and, in some places, differences in issue coverage. For example, emotional and financial abuse and forced social isolation are not offences in every jurisdiction (Murray and Powell 2009).

As in other areas of public policy, here, ideas frequently spread from jurisdiction to jurisdiction. In the 2000s, for example, the importance of coordinated, integrated responses, based on multidisciplinarity, has been recognised in most jurisdictions. Progress has not been striking and evidence suggests there are no easy solutions but shared approaches and frameworks do seem to be producing results (Mulrony 2003b; Willcox 2008:4–6). Another key focus in most jurisdictions in recent years has been on prevention (discussed further below), where work with young people is intended to foster respectful and non-coercive relationships (Mulrony 2003a).

Aboriginal women have continued to form their own organisations, such as Aboriginal women's councils (Flick 1990:66), and have continued to set up their own, often unique, services. Aboriginal Legal Services often provide specially tailored services in relation to violence. In addition, most jurisdictions have made some attempt to consult with Aboriginal women about their needs. For example, following consultations in New South Wales in the early 1990s, the Women Out West Project and the Aboriginal Women and the Law Project were put in place (Thomas and Selfe 1992). Similarly, some efforts have been made to better respond to the needs of women with disabilities who are at least twice as likely to be assaulted, raped and abused as women without a disability. In response to research undertaken by the Victorian Women with Disabilities Network in 2008, the Government funded a policy officer position for the network and Victorian Police have sought to use the evidence in their review of the Police Code of Practice (Healey 2009:8–9). For an indication of the multiplicity and variety of such programs, see the Australian Domestic and

Australia has been slow to act in relation to domestic homicide—an area where policy responses began more than a decade ago overseas. Fatality reviews were established in the United States in the 1990s, for example, with a view to finding patterns and commonalities. In Australia, intimate partner homicides have not declined and might be increasing (Oberin 2009:4). In response to the death toll, Victoria established Australia’s first domestic violence review panel in 2008, led by the Coroner’s Court. In May 2009, the Queensland Premier announced the establishment of the Domestic Violence Death Review Panel, following a four-year campaign by women. The panel will oversee research and provide advice to the Government. Towards the end of 2009, the New South Wales Government set up a permanent expert panel, chaired by the Coroner, to investigate all domestic violence-related deaths (Barrett Meyering 2010:9–11; Pollard 2009).

Sexual Assault Enters Public Policy

Persistent efforts over the last 30 years (especially by feminists in western contexts) have aimed to render sexual violence a visible concern by challenging the idea that it is a private matter. (Carmody 2009:3).

After an early start and three decades of activism, sexual assault remained a marginalised issue (Carmody and Carrington 2000:142–3). Amanda Goldrick-Jones (2002:123) argues that Australian feminists began to campaign for rape law reform long before well-known American analyses of rape, such as Susan Brownmiller’s book Against Our Will (1975), were written. Activism has included lobbying for law reform, public shaming, developing support services, mounting campaigns involving videos, films, pamphlets, stickers, posters and billboards, writing books, journal articles and conference papers, doing radio and television interviews, making community education announcements, training professional staff and students and direct action, including street marches and tree-planting ceremonies (Carmody 2009:3).

There are a number of reasons that feminists found it hard to keep this policy issue on the public agenda. First, service provision and legislation are State and Territory responsibilities, so there has been no national overview of the sector or the problems it faces. Further, victim-blaming justifications are strong and have persisted. Moira Carmody argues that the radical feminist analysis of the causes of rape had to be modified before governments were prepared to act; piecemeal reform was manageable, whereas structural transformation was not (Carmody 1990:304). Even in professional circles, rape was often left
off agendas of crime-prevention conferences, for example, despite knowledge about the severe health and other problems caused. Similarly, rape is still left off homelessness agendas, although it is known to be a major reason for young women’s, and possibly young men’s, homelessness. It was also left off drug and alcohol agendas, although the majority of women clients at drug and alcohol agencies identified as sexual assault survivors (Doyle 1996:44).

Slowly and painstakingly, however, feminist activism produced policy responses. South Australia took the lead in establishing the first review of rape law and procedures in the mid-1970s. As a result, rape within marriage became an offence and the definition of rape was extended. In response to feminist agitation in New South Wales, the Premier set up a task force to inquire into sexual violence in 1978. WEL had put forward a draft Bill, Rape and Other Sexual Offences, written by Dr Jocelynne Scutt in 1976. The draft Bill eventually influenced legislation in New South Wales, the Australian Capital Territory, Tasmania, the Northern Territory, Victoria and New Zealand (WEL NSW 2005). A child sexual abuse task force was set up in Queensland in the mid-1980s. In Victoria, a regional network of sexual assault services is part of the women’s health program initiated in 1987. At that time, seven centres were already operating and an additional three were approved (Women’s Policy Coordination Unit 1987:69). By the 1990s, policy responses in the States and Territories included the provision of counselling servicesCounselling services are always in heavy demand and there are generally long queues, and medical services within hospitals (instead of being delivered by police surgeons), the development of protocols and guidelines for providing support to survivors and the development of training packages for professionals, including the police and court personnel. Legislative reforms included removal of the rape-in-marriage immunity and reform of the rules governing the conduct of trials, including a bar on cross-examination in relation to sexual history (Carmody 1990:305; Carmody and Carrington 2000:341; Australian Capital Territory 2005:4–6).

Persistent advocacy saw government efforts stepped up in the 1990s. The Queensland Government launched the Women’s Health Sexual Assault Program, a pilot, in 1991, which provided rape crisis and sexual assault support services. Additional funding for existing and new support services was made available in 1993–94 through the Women’s Health Prevention of Violence against Women Program. In New South Wales, the Department of Women commissioned a study of sexual assault trials in 1996; the ACT Law Reform Commission released a discussion paper on sexual assault in 1997 and produced a report in 2001; the 1998 Task Force on Sexual Assault and Rape reviewed Tasmanian policies; the Victorian Law Reform Commission completed a reference on sexual offences in 2004; and the Western Australian Government introduced reform legislation in the same year (Australian Capital Territory 2005:6).
While no jurisdiction has a specific policy on sexual assault and the issue is usually considered under violence and safety agendas (Keel 2005b:4), legislation has resulted in significant advances. Evidence about the complainant’s sexual history is not allowed anywhere, except in the Northern Territory, where it is allowed with the permission of the court. There are exceptions, however, depending on relevance. Corroborative evidence is not required in any jurisdiction—that is, a conviction may be made on the evidence of a single witness. In practice, however, it is lawful for juries to be warned that witnesses might not be reliable. The power of a court to subpoena documents, including those that might have been produced in a confidential relationship between a complainant and a counsellor, has been restricted, except in Queensland. Provisions vary from State to State, however, and exceptions are made in particular circumstances. In terms of defining sexual intercourse, all jurisdictions have expanded 1970s definitions with considerable variation. Similarly, determinations of the meaning of ‘consent’ have been brought into law everywhere but provisions are not uniform. In some jurisdictions, the prosecution is not required to prove that the accused knew that the complainant was not, or might not be, consenting, whereas, in others, awareness and intention must be proven. In Victoria and New South Wales, accused persons must now demonstrate that consent was actively and consistently obtained. Provisions also vary in relation to incest but in every State and Territory, sexual intercourse between close relatives is a criminal offence (Carmody 2009:12; Heath 2005).

In terms of support for women and girls who have experienced sexual violence, a tapestry of services—some government, some non-government—is spread across the land. In New South Wales, major hospitals have sexual assault units, with trained personnel who provide forensic, support and counselling services. Evidence may be given to the police only with the complainant’s consent. The work of the NSW Rape Crisis Centre has been discussed. There are 29 publicly funded sexual assault services in Queensland, 20 of which are NGOs, along with a State-wide helpline. Yarrow Place Rape and Sexual Assault Service in Adelaide offers a full range of crisis services for adults but, as it is the only agency in the State, country areas have limited services. Yarrow Place collaborates with other agencies in the criminal justice system, such as the Office of the Director of Public Prosecutions, and works in partnership with such agencies as the Victim Support Service. Tasmania’s sexual assault support services (SASS) are community based and informed by feminist principles. They cover the three health system regions, offering comprehensive services, including support services for men. All engage in advocacy and lobbying. Galileo House offers services for children and young people up to the age of eighteen years. Victoria’s network of 16 sexual assault centres (CASA), offers free, 24-hour emergency
support services, including medical, legal and court support. The CASA Forum is a State-wide agency, providing training, community education and legal information. CASA also undertake advocacy work.

In Western Australia, the Sexual Assault Resource Centre (SARC) provides 24-hour crisis services for adults in the metropolitan area who have been affected by sexual violence within the previous two weeks. It has a State-wide mandate, and provides referrals, a telephone consultation service for regional professionals and education and training, including training to provide forensic services. It chairs the Sexual Assault Services Advisory Group, on which relevant agencies are represented. Regional services are located in the Goldfields, Albany, Geraldton, South Hedland and in the Kimberley. A number of regional hospitals also provide sexual assault services.

The community-based Canberra Rape Crisis Centre offers a 24-hour crisis line and comprehensive, culturally sensitive support services, including legal services. It meets regularly with a range of relevant agencies and engages in advocacy work. Its executive officer at the time, Veronica Wensing, was awarded the 2009 Telstra ACT Businesswoman of the Year. Finally, in the Northern Territory, SARC Darwin is a government centre that provides 24-hour medical services by female doctors. There are regional offices in Katherine, Tennant Creek and Alice Springs. Ruby Gaea Centre against Rape is run by a feminist collective and provides extensive support and referral services for women and children.

**Sexual Assault Prevention**

Sexual assault prevention is a complex and challenging area for policymakers, educators, researchers and service providers (Carmody 2009:1), but recent research and debate have produced ‘a conceptually rich and empirically robust’ set of ideas (Clark et al. 2009:7) that are now finding a place on policy agendas. Primary prevention aims to change the underlying causes of violence, modify attitudes, undermine myths and create new standards of acceptability. The notions of primary, secondary and tertiary prevention are similar to those used in primary healthcare discourse. Primary prevention takes place before problems occur; secondary prevention addresses groups at elevated risk or provides early intervention in the face of early signs of violent or victim behaviour; tertiary prevention aims to prevent a recurrence of sexual violence and/or alleviate ongoing effects (Carmody 2009:5).

A number of prevention research and pilot projects have been initiated recently. A sex and ethics research and violence prevention project was jointly undertaken by the University of Western Sydney and the NSW Rape Crisis Centre between 2005 and 2008. Young people from metropolitan and rural New South Wales
were interviewed to find out what they thought about sexuality and sexual assault prevention education and how they negotiated sexual relationships. Findings were that education had not prepared them for the complexity of intimate relationships or given them positive skills. Subsequently, a sex and ethics education program was developed to help young people navigate relationships and develop non-violent skills. At the same time, the Violence Prevention, Intervention and Respectful Relationships Education in Victoria Secondary Schools Project was being conducted by VicHealth. The project mapped the prevention programs already in operation, identified and explored best practice in violence prevention and developed a capacity to contribute to policy making and program design. Its 2009 report, *Respectful Relationships Education*, found that some very good violence-prevention programs were operating in Victorian secondary schools but that most were short term, did not engage the whole school and had not been properly evaluated. An exception is the Sexual Assault Prevention Program for Secondary Schools, developed by CASA House. It involves a whole-of-school approach, delivers staff training, and peer education and programs are offered to all levels, rather than to selected groups. The aim is to promote sustainable, school-owned change (Government of Victoria 2009b:5, 59–71).

Various primary prevention programs are now being piloted with funding support from the Commonwealth, under its Respectful Relationships Program. The Sex and Ethics Program, which has been developed to operate in other settings as well as schools, has received funding to train educators and to run groups in three non-metropolitan New South Wales locations and through the AIDS Council of New South Wales. In Queensland, educators are being trained through the National Rugby League to run groups with young men. Pilot projects include the implementation of a prevention program in three ACT secondary schools by the Melbourne Royal Women’s Hospital CASA and Canberra Rape Crisis Centre. Provisions include professional development for school staff, train-the-trainer peer education programs and a theatre production. The Northern Territory Department of Education and Training provides teacher-training programs, based on South Australia’s Keeping Safe program. The Western Australian Departments of Health and Education are developing respectful relationships education programs for remote-area schools in partnership with SHine South Australia. In Victoria and Tasmania, La Trobe University is trialling and evaluating a Respectful Relationships program for people with intellectual and other cognitive disabilities. A variety of other State and Territory-funded preventive programs also operates (ACSSA web site). Another significant Commonwealth-funded project has been commissioned by the National Association of Services against Sexual Violence (NASASV) to
develop standards for best practice in sexual assault prevention education. Six principles, regarded as ‘relevant, achievable and inspirational’, were produced as a set of guidelines (Evans et al. 2009:2–3).

The primary prevention programs aiming to reduce and eventually eliminate violence against women and girls are in their early stages and results from pilots are not yet available; however, the distance travelled is significant when we remember that an issue that could not be spoken about in public 40 years ago is now ‘part of young people’s education’ (Keel 2005a:24).

**Conclusion**

The Australian women’s health movement has succeeded in influencing policy in the States and Territories in many ways. Over the years, particularly in the ‘golden’ 1980s, all jurisdictions developed and adopted women’s health policies or strategies. Women’s health centres have continued to operate even when Commonwealth support has been withdrawn. Services for women and children experiencing violence have been publicly supported, although intense and time-consuming struggles have often been required to maintain funding. Measures to address the problems created by domestic and sexual violence have been developed and adopted. Whereas in the 1970s there was almost no support for women and children trying to escape from violence, many services, well coordinated in some jurisdictions, are now available, although there are never enough to meet demand. All jurisdictions have modernised their laws in a number of ways. Service providers in public agencies, such as the police force and the courts, have been trained in feminist approaches through feminist-devised training modules. Surveys show that community attitudes have changed positively in response to feminist arguments. Whereas women were once required to ensure their own safety, men are now increasingly expected to take responsibility for violence, including sexual violence. More recently, primary prevention initiatives have been expanded with the aim of promoting healthy attitudes and behaviours among the young—a project that has real prospects for reduced violence in the future.

On the negative side, discussed more fully in Chapter 10, women’s health centres and services are not sufficiently resourced to meet demand. In the violence field, many projects have been one-off pilot programs, too localised to have a significant general impact. Moreover, they often raise expectations that cannot be fulfilled and leave a significant void when terminated. And a number of policies can be classified as symbolic gestures, giving the impression that action is under way but with no funded implementation plan and no follow-up.
In the 1970s, both domestic violence and sexual assault were buried in the private sector from whence they were extracted by feminist crusades. Yet, of the two issues, it has been much more difficult to keep sexual violence on policy agendas and to change attitudes towards it, even among professionals. A recent review of sentencing and judicial comments in 2008 Victorian judgments found that stranger rape and rape with violence were regarded as more serious than known-offender rape and attracted heavier sentences. There was also a disconnect between judicial comments about the enduring effects of rape by a known assailant and the sentences applied, leading researchers to suggest that ‘judges are subject to influence by rape and sexual assault mythology’ (Kennedy et al. 2009:19). In searching for explanations about why these myths are so strongly held, Australia’s heavily masculinist culture, discussed in Chapter 2, comes to mind. So, too, do the infamous statements of certain judges in relation to acceptable sexual behaviour. Anecdotal evidence suggests that many Australian boys are taught that ‘real men’ do not hit women whereas less, if anything, is said about sexual violence. Perhaps part of the explanation is that ‘rougher than usual handling’ is tacitly accepted and has its roots deeply embedded in Australian culture.