8. Commonwealth Policy Responses

Commonwealth receptiveness to the claims of the women’s health movement has waxed and waned, depending on the political leanings of the party in power. Support under the Whitlam Government was replaced with withdrawal of funding and abnegation of policy responsibility under the Fraser Government. Renewed support during the period of the Hawke and Keating Governments (1983–96) saw women’s health again recognised as a legitimate national policy sphere. The next Commonwealth Government, the Liberal-National Coalition led by John Howard (1996–2007), was hostile to feminism and completely withdrew from a women’s health policy role in 1997. Labor returned under the leadership of Kevin Rudd in 2007 and brought with it a commitment to a second NWHP, following calls from the movement for revision and revival since 1995. Thus, the two major parties have displayed very different attitudes to women’s health. But while the contrasts are sharp, the case is not entirely black and white: non-Labor governments have supported occasional initiatives and Labor’s support has sometimes been less than wholehearted. Moreover, no matter which of the parties has held power, the women’s health sector has always been seriously under-funded. The launch of the NWHP in 1989 can be seen as the pinnacle of the movement’s policy achievements at the national level.

Women’s Health in a Changing Society

In September 1985, more than 700 women gathered in Adelaide for Australia’s Second National Conference on Women’s Health: Women’s Health in a Changing Society. There they resolved that a national women’s health policy should be developed, to be in accord with the World Health Organisation (WHO) strategy of ‘Health for All by the Year 2000’. In particular, the policy was to be based on the social view of health, recognising that population health is improved if individuals and communities are able to participate in health policy decision making (Kerby-Eaton and Davies 1985:47). The processes of policy development, the conference suggested, should be a shared enterprise between Commonwealth, State and Territory governments, the women’s health movement and community groups. The resolution called for the establishment of a working party to further the proposal. In passing this resolution, participants were returning to the first recommendation of the inaugural National Women’s Health Conference in 1975, which had resolved ‘that a separate policy be formulated on women’s health needs and services’ (Commonwealth Department of Health 1978:2).
The second resolution of the Adelaide conference called for the establishment of a parallel national women’s health program, which would give effect to the aims of the policy and operate within its guidelines. The Commonwealth was asked to commit to ongoing funding.

Four years later, the world’s first National Women’s Health Policy was endorsed in principle by all Australian health ministers in Burnie, Tasmania, on 21 March 1989. It was launched by the Prime Minister, Bob Hawke, the Health Minister, Neal Blewett, and NSW Health Minister, Peter Collins, at Westmead Hospital, Sydney, on 20 April 1989. Policy development had been a lengthy but participatory process. Both the policy and the program were broadly consistent with the principles articulated in Adelaide. State and Territory governments had been involved in formulation and there had been extensive participation in decision making. Estimates have it that the representatives of more than one million women from diverse backgrounds and all parts of the country were consulted.

The Adelaide women’s health movement members who organised the conference knew what they wanted from it: they wanted to put women’s health firmly on the national political agenda and they wanted endorsement for a national policy. With that endorsement in hand, they were then able to persuade the then Deputy Secretary of the Commonwealth Department of Health, Ann Kern, of the validity of the proposal. Health Minister, Neal Blewett, was supportive and was not averse to the Commonwealth taking a leading role. The Secretary of the Commonwealth Department at the time, Bernie Mackay, previously Director-General of Health in New South Wales, was interested in health promotion.

**The First National Women’s Health Policy**

In November 1985, two months after the conference, the Prime Minister announced that a national policy on women’s health would be developed, which would partly fulfil Australia’s international obligations following the Nairobi conference marking the end of the UN Decade for Women (Commonwealth of Australia 1989:1). At the same time, he outlined proposals for what later became known as the National Agenda for Women. As in so many previous consultative processes, women’s health had emerged from the agenda consultations as a top priority.

Liza Newby, who had been Director of the Women’s Interests Division of Premier and Cabinet in Western Australia, was appointed Special Adviser to Commonwealth Health Minister Blewett in 1987 to coordinate development
The following October, a subcommittee of the Australian Health Ministers Advisory Council (AHMAC) on Women and Health was created to assist with the process. The original subcommittee was broadly representative: Commonwealth representatives included the Medical Services Adviser, a representative from the office of the minister, a representative from the Office of the Status of Women (OSW) and a representative from the Australian Institute of Health and Welfare. Women’s health advisers or, in some cases, directors of medical services, represented the States and Territories. Non-governmental membership included representatives of Aboriginal and non-English-speaking background women, the Consumers Health Forum, the ACTU, the Royal College of General Practitioners, the Australian Nursing Federation (ANF) and the Australian Women’s Health Network. In policy machinery terms, a Commonwealth women’s health unit had been set up by the Fraser Government in 1978 but had been abolished a couple of years later by the Lynch razor gang, a ministerial cost-cutting team. The new Commonwealth Women’s Health Unit was set up in 1985.

Following informal discussions with a range of stakeholders, including service providers, women’s groups and government representatives, Newby, with the AHMAC Subcommittee, wrote a preliminary paper, Women’s health: a framework for change, a discussion paper for community comment and response. Minister Blewett, who had read a draft and contributed to the document, released it in February 1988. Commonwealth money was allocated for an extensive consultation process.

Responsibility for organising consultation meetings was delegated to women’s health advisers in the States and Territories. Pre-consultation forums were sponsored in those jurisdictions that had little or no women’s health infrastructure at the time—namely, the Northern Territory, Queensland and Tasmania. In some States, for example, South Australia, a coordinator, who worked with key groups and individuals, including femocrats, was employed to oversee consultation arrangements. Background papers were prepared for meetings so that when the Commonwealth team met with women, there was a level of familiarity with a range of issues. Consultations took place in both metropolitan and rural areas, including day-long workshops, and were well attended. More than 300 submissions were received from government and non-governmental agencies, unions, health professionals, professional organisations, groups of women and individuals (Commonwealth of Australia 1989:2–4).

A major effort was made to work with Aboriginal women’s groups to facilitate participation. Special meetings were organised and, in a few cases, individual appointments were made. Large numbers of Aboriginal women took part in

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1 The position had been advertised in 1986 but had not been filled.
the NT consultations. There was, however, a view that including Aboriginal women’s concerns and preferences in the NWHP might detract from the work being undertaken at the same time to develop the National Aboriginal Health Strategy. In any case, many women thought that a separate, dedicated process was needed to properly capture the views of Aboriginal women. Immigrant women (or, as they were called at the time, NESB women) participated strongly and wanted their concerns included.

Consultation organisers remember that the women who attended were constructive and positive and put forward practical suggestions. They saw health from a social perspective, they knew what they wanted from the health system and they knew what was missing from the services on offer. On the basis of the consultations and submissions, the first NWHP was written in the second half of 1988 and in early 1989, largely by Laurie Gilbert, Director of the Commonwealth Women’s Health Unit from 1987 until the end of 1989, in collaboration with the AHMAC Subcommittee. A steering committee was established to pilot the policy through departmental processes.

**Obstacles Confronting Commonwealth Femocrats**

A number of difficulties beset the femocrats charged with writing the policy and having it endorsed. The Women’s Health Unit had a very heavy workload and it was short of staff. Many staff members were on short-term appointments and on very steep learning curves. Some positions were approved but never filled; even at the Commonwealth level, women in the bureaucracy are reported to have been ‘very wary’ of moving to an area with a feminist label, fearing that career advancement would be jeopardised. The result was that the team writing the NWHP was smaller than intended. Moreover, the unit had to deal with ordinary departmental work as well, which included responsibility for producing input to the women’s budget statement, responding to ministerial questions and the requirements of interdepartmental committees and producing all the preliminary report documents that went to AHMAC.

Another problem was simple disruption. There were three reorganisations of Commonwealth government departments during the development and implementation of the policy. Having been called the Department of Health since its foundation in 1921, the department had three different names in the second half of the 1980s, there were three different departmental heads and the Women’s Health Unit had four division heads and three different locations. These
changes made the job of Commonwealth femocrats difficult. The continuity necessary to drive reform processes was difficult to achieve in rapidly changing circumstances.

Two of the policy’s key supporters in the Commonwealth Department, the Secretary, Bernie McKay, and the Deputy Secretary, Ann Kern, both left in 1987, at the beginning of the development phase. As at the sub-national level, for many senior bureaucrats, women’s health was not a high priority and was a contentious issue for others. Moreover, policy changes were being made on the basis of what women said (during consultations), which was a departure from standard practice that was not widely accepted. Traditionally, experts made policy, in what they knew to be in everyone’s best interests, advised by organised medicine in processes that were generally secret. In addition, departmental officers were concerned about opposition from organised medicine and a real effort was made to get the support of medical unions. In this, Dr Cathy Mead, Chair of the Working Group of the AHMAC Subcommittee on Women and Health, played a crucial role. She is medically trained, understands the issues and, broadly, succeeded in containing medical opposition. Christine Giles, Manager of the Victorian Women’s Health Policy and Programs Unit and also a member of the AHMAC Subcommittee Working Group, is said to have been able to persuade key Commonwealth bureaucrats to support the project. That Health Minister Blewett offered positive support was crucial to the outcome. The whole process was timed around elections in order to gain maximum political mileage for the Commonwealth. Completion was scheduled to be in time for the budget cycle preceding the 1990 election.

It is reported to have been touch and go whether Australia’s health ministers would endorse the policy and there was uncertainty about whether meaningful sums of money would be allocated to the program. Budget decisions the previous year did not inspire confidence. Proposals had been made to fund projects identified as needed in NWHP consultations but none was successful (Szoke 1988:33). Femocrats and AHMAC Subcommittee members worked hard to generate support for funding. They held meetings with the Women’s Caucus Committee of the Federal Parliamentary Labor Party. Labor women could then inform women in their constituencies of progress, maintaining momentum. A great deal of lobbying was done, which included discussions with State and Territory health ministers and senior departmental officers. This laborious process eventually brought about a significant change in attitudes.

The change, however, was not enough to transform women’s health into a high-priority item; participants remember a budgetary allocation process that was completely ad hoc. The Women’s Health Unit was required to put up costing proposals for the 1988–89 Budget, on the understanding that initiatives in all five action areas would be funded. The cost was to be $100 million over five years, to
be shared between the Commonwealth and the States and Territories—a modest enough proposal. A women’s health branch of the Commonwealth department was also to be established to implement the program. In the event, only the first three action areas were funded. Combined Commonwealth, State and Territory funding totalled only $33.72 million over four years or just under $8.5 million per year (Commonwealth of Australia 1993:6). Given that Australian health expenditure between 1989 and 1993 averaged $32.09 billion per year (AIHW 1997:2), this was a tiny sum of money.

The proposed Women’s Health Branch was never established. An additional $6 million for alternative birthing services, $3 million for the provision of reproductive health services in rural areas and $1 million for breast and cervical screening programs were allocated. In States with relatively small populations, the amount of money for specific services was ridiculously small. For example, in Western Australia, the total Commonwealth funding for the alternative birthing services program was $35 000.

**Infrastructure Established under the NWH Program**

The NWH Program was initially funded for four years, following which funding of $59.512 million or just less than $15 million per year was approved for a second four years—a modest increase. The projects that were funded were enormously diverse and varied considerably from place to place, partly depending upon the infrastructure already established. As a cost-shared program, Commonwealth/State/Territory assessment committees were formed in each jurisdiction to recommend the funding of selected projects to ministers. Community support had to be demonstrated before funding would be approved. The terms of reference of the AHMAC Subcommittee were altered to allow it to take responsibility for monitoring and overseeing implementation.

A number of national projects were undertaken in the first four years, mainly in professional training and education. These included an education package for schools, focusing on the effects of sex-role stereotyping; an education kit for general practitioners, with fact sheets in 10 languages; a general practitioner education project, intended to improve knowledge of women’s health issues; a continuing education package for nurses, focusing especially on rural and remote area work; and a distance learning package for midwives (Commonwealth of Australia 1993:23–7). During the second four years, the national effort consisted of small projects, including continuing education for general practitioners, the
development of outcomes and performance indicators for women’s health and a collaborative services project for older and isolated women (Commonwealth of Australia 1997:109–17).

Of the States and Territories, New South Wales had the most extensive women’s health infrastructure. Instead of establishing new centres and services, a number of mainstream reforms were introduced, including the establishment of regional women’s health coordinators, ethnic obstetric liaison programs, Aboriginal antenatal outreach, multicultural family planning and health services for older women. Twenty-eight of the 89 projects were directed towards the needs of rural women (Commonwealth of Australia 1993:28–32). During the second four years, funding was mainly allocated to continue the innovations of the first four years; however, a small number of NGO services were funded, including family planning and rape crisis services, information for immigrant and refugee women and services for Aboriginal women (Commonwealth of Australia 1997:19–20). One of the programs was the Aboriginal Maternity Service, located in the northern NSW town of Tamworth, providing antenatal, intrapartum and postnatal services for Aboriginal women and non-Aboriginal women with Aboriginal partners. Among its health-promotion activities were support for breastfeeding and information about good nutrition, exercise and the benefits of smoking cessation. An infant immunisation rate of 100 per cent was achieved. In keeping with tradition and grandmothers’ stories, the message was that Aboriginal women are ‘the best nurturing mothers in the world’ (Nichols and Hurley 1999:24–8).

In Queensland, where the existing women’s health infrastructure was limited, the focus was on funding separate women’s health services, as discussed in Chapter 3. In addition, the Mobile Women’s Health Service was funded, staffed by 15 women’s health nurses trained to work as independent practitioners. Service provision included reproductive health services, together with counselling, stress management and preventive health education. A number of smaller projects were also funded (Commonwealth of Australia 1993:35–7). In the second four years, 97 per cent of the funding was allocated to Queensland’s eight community-based women’s health centres (Commonwealth of Australia 1997:22–3).

In South Australia, services for women living in non-metropolitan areas were identified as the top priority. The Country Women’s Health Services Advisory Group was set up in 1990, replaced with the broader State Steering Committee in 1991, which met monthly to oversee proposal development and implementation. Clinical and health promotion services for rural and remote women were funded, community women’s health nurses were employed and the Women’s Health Business Project for Aboriginal women was undertaken. A ‘008’ women’s health information line was introduced, along with a newsletter,
Stating Women’s Health (Commonwealth of Australia 1993:41–3). During the second four years, funding continued for services for women living in rural and remote areas, and, in all, 17 Country Women’s Health Services were set up, all of which were integrated into existing services. Each service was required to have a Women’s Health Advisory Committee, facilitating discussion and community participation. A number of respondents to the evaluation questionnaire rightly identified the low level of funding as a major obstacle to achieving program goals (Commonwealth of Australia 1997:23–5).

The first two years of the program in Tasmania focused on local research to identify needs, followed by seed funding for a range of one-off programs, intended to be innovative and participatory. A strategic planning document was produced, with identified priorities and plans for regional women’s health programs. The Health for Women in the Workplace project, the Flinders Island Women’s Health Project, the Centre for Excellence in the Middle Years Project and the Social Health Project were set up (Commonwealth of Australia 1993:43–6). Ongoing funding for the Hobart Women’s Health Centre was provided in the second phase, along with the employment of three Regional Women’s Health Coordinators whose responsibilities included service development, training, advocacy for mainstream sensitivity to women’s needs, information provision, consultation, initiation of best-practice models and policy advice. Each region of the State developed a Women’s Health Strategic Plan (Commonwealth of Australia 1997:26–8).

The NWH Program enabled Victoria’s network of women’s health services, set up under the Victorian Women’s Health Program, to be expanded. The network of sexual assault services was also extended to provide after-hours cover and to cater for the needs of rural areas. The Multicultural Centre for Women’s Health received additional funding for information services, along with Healthsharing Women. Other projects included support for Greek women who suffered mental illness, an older women’s housing project, a service mapping project, an access and equity program for immigrant and refugee women needing to use sexual assault services, a good practices in mental health project and statistics and evaluation framework projects (Commonwealth of Australia 1993:32–5). Support for this network of services continued in the second four years.

Western Australia, as we have seen, did not come into the program until 1991. All the State’s women’s health centres except Perth’s original centre and the Fremantle multicultural women’s health centre were established with NWH Program funding. New regional sexual assault centres were also established and existing ones expanded. Women’s health information services were set up and a variety of quality-assurance, research and data and service development and monitoring projects was introduced (Commonwealth of Australia 1993:38–40). In the second four years, support continued for women’s health infrastructure
so that by 1997 the program was funding five sexual assault referral centres in regional areas and 11 community-managed women’s health centres in both metropolitan and rural locations (Commonwealth of Australia 1997:25–6).

Effectively, only one project, a community-controlled women’s health centre, could be financed from the funding available to a small jurisdiction such as the Australian Capital Territory. Nevertheless, the opening of the centre was cause for jubilation among activists. Tiny amounts of money were provided for information provision, which included pamphlet and booklet production, translation of information material into languages other than English and a limited number of community workshops (Commonwealth of Australia 1993:49–50). Funding distribution in the second four years replicated that in the first. In the Northern Territory, there were few dedicated women’s health services before the program and this situation was maintained. Program grants were advertised in 1991 and projects funded include the Aboriginal and Torres Strait Islander Women’s Health Service in Darwin, with another in Tennant Creek, a cervical cancer screening program for Aboriginal women, the establishment of a carers’ network and a project supporting the development of culturally appropriate health-promotion services by Aboriginal health workers. Family Planning NT received money to provide reproductive and sexual health education forums for young people. The AIDS Council of Central Australia was funded to employ a women’s HIV/AIDS project officer, and the Wunara Aboriginal Corporation received money for the ‘Beat the Grog Signs’ project (Commonwealth of Australia 1993:9). In the second four years, a total of 39 projects were funded, approximately half of which were managed by community-based organisations and the other half by the Territory Health Service. As in the Australian Capital Territory, the amount of money available was small (Commonwealth of Australia 1997:28–30).

Criticisms of the Policy and Program

Apart from criticisms of the inadequacy of program funding, some women felt that the NWHP and the NWH Program reflected the concerns of Anglo-Australian, middle-class women. Whatever the validity of the view, projects for a diversity of cultural groups were funded. It is true, however, that the concerns of Aboriginal women were largely left aside, as discussed. Regrettably, the National Aboriginal Health Strategy, which was meant to address Aboriginal women’s health, was never sufficiently funded or effectively implemented. A 1994 evaluation found gross under-funding by all governments, lack of accountability and lack of political support for the National Council of Aboriginal Health, which had been established to oversee implementation. The evaluators recommended that the Commonwealth renew its commitment to
the principles underpinning the strategy, that it accept the holistic Aboriginal view of health and that it recognise the importance of local community control (Commonwealth of Australia 1994:2–3).

Immigrant and refugee women were positioned differently but the long-term outcome was no more satisfactory. As part of the National Agenda for Women, the Commonwealth–State Council on NESB Women’s Issues was established in 1989 (Commonwealth of Australia 1991:66). The council chose health as its first priority, not because the health of immigrant women was not addressed in the NWHP, but because it was felt that the special health problems faced by NESB women warranted a dedicated strategy. Thus, it produced the National Non-English Speaking Background Women’s Health Strategy (NESBWHS) in 1991. The main concerns identified were high rates of workplace-related illnesses and injuries and a higher than normal incidence of poor mental and emotional health. The strategy was intended to complement the NWHP (Commonwealth of Australia 1992:xi–xxxiii). Like the NWHP, the strategy took a social view of health, offered a strong critique of conventional medical care and advocated inter-sectorality.

This strategy, too, failed to attract resources and became essentially ‘an un-actioned information document’ (Schofield 1996: 30–5). On the basis of major presentations, the Third AWHN National Women’s Health Conference recommended that the strategy be updated and implemented (Davis et al. 1996:13–14). No action was taken, however, and soon afterwards, the Keating Labor Government lost office.

The Indirect Impact of the NWHP

The existence of a national policy, endorsed by all State and Territory health ministers, strengthened the position of local-level femocrats and the policymakers who supported them. They were able to argue that the principles and priorities of State and Territory women’s health policies and strategies should be in line with those of the NWHP. The national policy also provided protection for women’s health infrastructure. For example, one of the first acts of the newly elected, neo-liberal-leaning Greiner Government in New South Wales was to review Health Department-funded NGOs, which raised fears within the sector. Shortly afterwards, however, government statements endorsed the principles of the NWHP: national recognition of the claims of the women’s health movement produced a stronger level of legitimation than would otherwise have existed. Jennifer Cashmore, former SA Minister for Health, who overcame opposition and secured agreement to begin work on a women’s health policy, attested to
the importance of the national policy’s influence. In her view, her party’s policy developed for the December 1993 SA election would have been unthinkable had it not been for the NWHP.

Perversely, however, the existence of the NWHP could be used to justify inaction when the political climate was unfavourable. For example, in 1996–97, femocrats in Western Australia who had developed proposals for a State women’s health policy were told this was not a priority and, furthermore, that there was no need for a State policy since the national policy had been endorsed.

Domestic Violence and Sexual Assault Enter the Commonwealth Policy Agenda

The first Commonwealth policy directly addressing domestic violence was part of the National Agenda for Women. It was the three-year National Domestic Violence Education Campaign (NDVEC), run by OSW and judged ‘very successful’ by the Agenda Implementation Report. At the same time, a survey was run to plumb attitudes to domestic violence. A high level of social sanctioning was found: one in five people considered physical violence by a man against his wife to be acceptable sometimes, more than half thought it was okay to yell abuse and one-third still thought it a private matter (Laing 2000:4). The campaign raised community awareness of violence but because violence support services received no additional funding, service providers were ‘stretched to the limit’. One set of evaluators argued that action as well as rhetoric was needed from the Commonwealth (Earle et al. 1990:4–6).

In 1990, the National Committee on Violence against Women was established by the Keating Government, with a budget of $1.35 million over three years, or $45 000 a year. The committee was charged with covering all forms of violence against women, initiating research and undertaking education work, with special emphasis on the requirements of groups with special needs, all with a few thousand dollars a year. A position paper was produced in 1991 (Commonwealth of Australia 1991:63–4) and the National Strategy on Violence against Women was introduced in 1992. Its aims were to share information and coordinate the policies, programs, law enforcement and legislation in the different jurisdictions. It had no programs of its own nor did it provide funding for the States and Territories, which were expected to continue to support their own programs and any new initiatives that might be proposed. Heads of government were asked to deliver annual statements on eliminating violence against women. The strategy, which, with so little funding, was more of a public relations exercise, ran until the Government lost office in 1996. The Women’s Safety Survey conducted in
1996 by the Australian Bureau of Statistics (ABS) showed that 7.1 per cent of Australian women had experienced an act of violence in the previous 12 months (Commonwealth of Australia 1996).

The next Commonwealth initiative was the Howard Government’s Partnerships against Domestic Violence (PADV), introduced in 1997; $50.3 million was committed over the six years to 2004. Again, one of the objectives was to encourage Commonwealth, State and Territory coordination, not that the Commonwealth had many activities of its own at this point. New project funding was provided, which was intended to be seed money for prevention research. An additional $25 million was committed, primarily to set up the Australian Domestic and Family Violence Clearinghouse, which publishes newsletters and papers on key issues and new initiatives. PADV was criticised both for its location within a conservative discourse and for the paucity of its funding (Chappell 2001:66–7). Ruth Phillips (2006) argues that the results of the 1996 Women’s Safety Survey ‘compelled’ the Howard Government to maintain a policy on violence against women but that the terminology was changed to ‘family violence’, ‘family dysfunction’ and ‘family breakdown’, suggesting that violence was not primarily ‘against women’, thereby obscuring the links between gender and power. This shift in terminology can be seen as an example of what Howe (2009:28) calls the act of ‘disappearing’ men’s violence, in a context where ‘it’s still not permissible to name it as such’. Men and women, outside feminist forums, she argues, still engage in denials and disavowals. Nevertheless, funds were provided, including for projects in Aboriginal communities and for early intervention for children at risk. After three years, PADV is said to have run out of political steam and no major Commonwealth announcements were made between 1999 and 2003.

The next Commonwealth initiative was a community awareness campaign, ‘Violence against Women, Australia Says No’, launched in 2004, after delays during which the Prime Minister is reported to have altered the language. The campaign operated through TV, cinema and magazines. It provided a 24-hour helpline and resources in secondary schools (Carrington and Phillips 2006). Community education materials were also made available through the PADV web site. Phillips concludes that, while PADV acknowledged violence as a problem and funded some worthwhile projects, ‘both the discourse and the practice’ undermined the potential for the long-term structural and attitudinal change that is necessary to reduce violence against women (Phillips 2006:214).

Previous Commonwealth anti-violence strategies had included sexual assault but the Howard Government moved to address the two separately. It launched

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2 Many Aboriginal women prefer the term ‘family violence’ because it covers the full range of traumas that individuals and families suffer, including domestic violence, rape, child abuse and spiritual and cultural abuse (Lester 1992:38).
the National Initiative to Combat Sexual Assault in 2001, under which the OSW commissioned consultants to undertake research on the criminal justice system and sexual assault, with a view to developing a framework for sexual assault prevention. An international literature review on assaults against females sixteen years of age and older was followed by analyses of existing research in Australia, the United Kingdom, Canada, New Zealand and the United States. The Australian Centre for the Study of Sexual Assault (ACSSA) was set up under this initiative. ACSSA provides information to assist policymakers and develops evidence-based, prevention-oriented strategies. All forms of sexual assault are investigated but there is a focus on women and girls over fifteen years of age and adult survivors of child sexual assault (Commonwealth of Australia 2004a; Carrington and Phillips 2006).

In 2005, the Commonwealth announced that PADV had concluded and would be replaced with the Women’s Safety Agenda, which was to include both domestic violence and sexual assault. The program would have $75.7 million over four years and would build on the groundwork of PADV and the National Initiative to Combat Sexual Assault. Under the agenda, funding was continued for the Australian Domestic and Family Violence Clearinghouse (Carrington and Phillips 2006). Towards the end of its term of office, the Howard Government introduced significant changes to the *Family Law Act* that have implications for women and children experiencing violence. Said to be the result of lobbying by fathers’ rights groups, the changes introduced shared parenting after separation and mandatory participation in dispute resolution. The changes have been heavily criticised for putting parental rights, particularly fathers’ rights, ahead of the rights of children. Mediation is not required in cases involving violence or child abuse. However, because violence and abuse are often difficult to prove and the consequences of unproven accusations can be heavy, there is concern that many women refrain from speaking out (DVRCV 2008).

The Rudd Labor Government, elected in 2007, appointed the National Council to Reduce Violence against Women and their Children (hereinafter called the National Council), in May 2008, thereby fulfilling an election promise. The then Prime Minister, who had been involved in domestic violence policy development in Queensland in the early 1990s, was committed to action and in the early 2000s, he became a White Ribbon Ambassador. The Minister for the Status of Women, Tanya Plibersek, was equally committed, and the White Ribbon campaign had close ties with her office. The National Council was appointed for a year to provide advice on the development of an evidence-based national plan. It undertook research and consultations with approximately 2000 stakeholders. A five-part report, *Time for Action: The National Council’s plans for Australia to reduce violence against women and their children, 2009–2021*, was released in April 2009. On the release of the report, the Government agreed
to act on 18 of the 20 priority recommendations. It also agreed to develop a national plan through the Council of Australian Governments (COAG) because many of the council’s recommendations require cooperative action between levels of government.

The new funding commitments were $12.5 million for a 24-hour, seven-day-a-week telephone and online crisis service, $26 million for primary prevention projects, including $9.1 million over five years for the respectful relationships program and $17 million for a public information campaign. Some $3 million was allocated for research on nationally consistent laws and perpetrator programs. These are not large funding commitments and WWDA has requested clarification about possible overlaps with previously announced funding (Parkinson 2009:6). The Australian Law Reform Commission has been asked to work with State and Territory law reform commissions to examine the interrelationship of relevant laws. The Violence against Women Advisory Group was appointed for two years from September 2009, to advise on issues raised in the council’s report and to oversee the establishment of the National Centre of Excellence, which will evaluate the effectiveness of strategies, improve best practice and support workforce development.

The National Council’s report and the Commonwealth’s commitment to action have been welcomed by women’s movement spokeswomen, who are cautiously optimistic about the potential for valuable outcomes. The council has been commended for the quality of its work. The personal commitment and statement of zero tolerance made by then Prime Minister Rudd were both well received. The reform project is seen as ambitious but Commonwealth leadership on violence against women and girls, including sexual assault, is regarded as well overdue. According to Julie Oberin, longstanding movement activist and Chair of WESNET, the Rudd Government’s approach to domestic and family violence and homelessness ‘has for the first time in history, the capacity to radically address decades of neglect in these fields’ (Oberin 2009:2). She acknowledges, however, the enormity of the problems and the huge obstacles to be overcome.

In February 2011, the National Plan to Reduce Violence against Women and their Children was launched. It is intended to be a framework for a single, unified strategy for the next 12 years (Commonwealth of Australia 2011d). Six national outcomes have been formulated, which are that communities are safe from violence, that relationships are respectful, that Indigenous communities are strengthened, that services meet the needs of women and their children experiencing violence, that justice responses are effective and that perpetrators stop the violence and be held to account. The document incorporates the first three-year plan, which will focus on prevention. Proposed actions are support for local community work to reduce violence against women, commitment to the continuation of the respectful relationships education program in schools,
telephone support for frontline workers, perpetrator programs with their own national standards, a national centre of excellence that will focus on evaluation, the continuation of Personal Safety and Community Attitudes Surveys to track the effectiveness of policies and an Australian Law Reform Commission inquiry into the impact of Commonwealth laws. There is also to be a national recognition scheme for domestic and family violence orders, including a national database. Outcome six proposed by the National Council—that systems be made to work together effectively, through coordinated, evidence-based responses—has been dropped from the national plan. It is much too early to evaluate the impact of the Plan which will depend on levels of political commitment and resources.

Responses to Violence in Aboriginal Communities

Violence in Aboriginal communities and the destructive impact of colonisation are well documented. Aboriginal women and members of their communities have continued to work in their own ways on what many, but not all, call ‘family violence’. Larissa Behrendt has compared the characteristics of Aboriginal dispute-resolution mechanisms with those of the British legal system. She explains that Aboriginal approaches encourage the participation of all community members who feel they have an interest in either a dispute or its outcome and that resolution processes take place before the family and/or the community, acknowledging the social context of dispute resolution (Behrendt 2002). Thus, even if Aboriginal people trusted the criminal justice system, many would approach family violence quite differently. In general, the facilitation of community responses is preferred, with a focus on healing families, rather than punishing individuals. In some approaches, male perpetrators are integrated back into their communities after punishment, treatment and healing (Keel 2004; Memmott et al. 2006).

Among the initiatives that women have had a part in developing are night patrols, initiated in the Northern Territory as a self-policing mechanism and later adapted and modified in other places. Night patrols assist in ensuring social order, preventing potentially violent situations and assisting the vulnerable. By 2003, they were described as ‘a distinctive feature of the community landscape in Indigenous Australia’ (Blagg 2002:200; Blagg and Valuri 2003:7).

Other women-led responses include constructing family healing centres instead of refuges, establishing shelters on women’s law principles, which render them out of bounds for men, and using sacred objects in women’s spaces as a deterrent to male violence. Traditional women’s business has been reinstated in some
settings as a dynamic factor in community life, along with the reinforcement of grandmother law, under which senior women become involved in dispute resolution, sometimes through mediation (Blagg 2002:4).

While some projects are women-only initiatives, others involve both men and women. The *Aboriginal and Islander Health Worker Journal* has published annotated indexes of Indigenous health information, which provide an overview of health projects up to 2008. Other responses include mentoring schemes, worker gatherings for networking and sharing knowledge, theatre projects around family violence and community-controlled counselling projects oriented towards social and emotional health (Memmott et al. 2006).

All Australian governments have funded projects intended to address violence in Aboriginal communities. The main Commonwealth initiatives in recent years include the Family Violence Prevention Legal Service (FVPLS) program, first established as a pilot project and an initiative of the Aboriginal and Torres Strait Islander Commission (ATSIC) in 1998. The initial aim was to meet the legal needs of victims of family violence. The program provides assistance predominantly to women and children. In 2004–05, on the abolition of ATSIC, control passed to the Commonwealth Attorney-General’s Department, after which the program was expanded, both in services and in functions. It was extended again in 2006–07, and since that time 31 community-controlled services have been funded. The Early Intervention and Prevention Program was added and the program now provides counselling, practical support and assistance, information regarding support services and referrals. Educational and community-awareness projects and early identification and prevention strategies have also been developed. In 2006, 5717 clients presented themselves to the Family Violence Prevention Legal Service (FVPLS) (Commonwealth of Australia n.d.).

Under PADV, there were new initiatives for Aboriginal people. The first was the National Indigenous Family Violence Grants Program (NIFVGP), which ran between 1999 and 2004 and provided funding for 74 community-based projects. The principles of cultural appropriateness, holism, intersectorality, local community control and leadership and community development were embedded in the design. Following this, FaHCSIA funded a number of programs including the Family Violence Partnership Program (FVPP) and the Family Violence Regional Activities Program (FVRAP). Under the FVPP, the Commonwealth contributed $37.3 million over four years, and through agreements with the States and Territories family violence and child-protection initiatives were put in place. Under FVRAP, support was provided for grassroots projects that had been identified in communities and operated through centres called Indigenous Coordination Centres. FaHCSIA also ran a number of other programs, including
the Stronger Families and Communities Strategy and the Family and Community Networks Initiative. In addition, COAG ran trials in eight community locations in 2002 and 2003 (Memmott et al. 2006).

This is not the place to discuss the contentious NT National Emergency Response introduced by the Howard Government in 2007 and continued by the Rudd and Gillard Governments. As a top-down policy, however, there is wide concern that it ignores the demonstrated principles of best practice. Experts argue that the program flies in the face of evidence that successful programs are built from the ground up in collaboration with communities (Kelleher 2009:13–14). Evaluation of the NIFVGP, for example, showed that projects to address family violence are best developed, driven and nurtured by Aboriginal people at the community level (Memmott et al. 2006:22).

According to Hannah McGlade, a Perth-based Aboriginal human rights lawyer, the new national plan needs to go much further than the recommendations made in the council’s report. She recommends three specific strategies: the establishment of a national research and capacity-building agency, specifically addressing violence against Aboriginal women, to be located within the proposed National Centre of Excellence; the placement of the victims of violence at the centre of proposed healing centres; and the funding of Aboriginal women’s legal services in all Australian jurisdictions rather than relying on the erroneous notion that mainstream services can serve the needs of Aboriginal women and children. McGlade argues that the new national plan ‘must unequivocally recognise and affirm that Aboriginal women play a central role in ending the violence’ (McGlade 2010:4–5).

The national plan does recognise the centrality of Aboriginal women in reducing violence:

The National Plan is focused on supporting Indigenous communities to develop local solutions to preventing violence. This includes encouraging Indigenous women to have a stronger voice as community leaders and supporting Indigenous men to reject violence. Improving economic outcomes and opportunities for Indigenous women are critical to reducing violence. (Commonwealth of Australia 2011d:20)

As mentioned, the third national outcome of the plan is that Indigenous communities are to be strengthened; however, as in so many other cases, results will hinge largely upon whether resources are made available to pursue these objectives.

The women’s health movement has been able to influence a number of other Commonwealth policies, the most important of which are reviewed briefly below.
Better Health Policy

The movement succeeded in having the terms of reference of the 1985 Better Health Commission expanded. The commission was established to examine the health status of Australians and to recommend national goals for improvement. Originally, its terms of reference asked it to report on ‘the major preventable health problems of women in their reproductive years’; however, the minister agreed to extend the terms of reference to include the ‘health problems of women of all ages’, after the 1985 National Women’s Health Conference. Women on the commission, including Dr Janet Irwin, argued for a comprehensive, social view of women’s (people’s) health and women at the grassroots level were able to make contributions. Ultimately, the commission, which reported in 1986, endorsed the WHO ‘Health for All by the Year 2000’ initiative. When it came to addressing the question of ‘why women’s health should be given more consideration than men’s health’, it decided, however, that women’s illnesses were not different from those of men but that women’s health needed attention because it did not get proper consideration from a ‘male dominated health care system’ that excluded humane and caring values (Commonwealth of Australia 1986a:147–8).

Women’s Health Research

Research and data collection formed one of the five priority areas of the NWHP but, initially, no funding was provided. In 1989, however, the Commonwealth Department of Community Services and Health funded a workshop, which was asked to develop a list of research priorities as a guide to funding under the Health and Community Services Research and Development Grants (Broom 1990). Subsequently, and just before the 1993 election, Prime Minister, Paul Keating, announced that the Commonwealth would fund a major longitudinal study on women’s health. Submissions were called and a contract awarded for the project, later renamed Women’s Health Australia. It received its first resources in 1995 and is managed by a multidisciplinary team of researchers from the Research Centre for Gender, Health and Ageing at the University of Newcastle and from the University of Queensland (Lee et al. 2005). The aim is to collect data and evidence that can be used to inform policy.

The study involves three age cohorts and includes more than 40 000 women over 20 years. It examines attitudes and lifestyles, together with the biological, psychological, social, economic and lifestyle factors that influence health outcomes. Women’s use of time is studied, including the impact of paid and unpaid work, family roles and leisure. It also identifies women’s health-service needs and evaluates the adequacy of the services on offer. Findings are released
regularly. The only new funding announced with the 2010 NWHP is $5.3 million to enable the project to recruit a cohort of younger women—an extension that AWHN and the movement had supported for some time.

Policy Responses to Trafficking

In 1999, the Howard Government introduced legislation amending criminal code provisions on slavery. The new legislation imposes penalties on people responsible for bringing women into Australia under ‘slavery-like’ conditions. Prosecutions under the new law were slow but, in 2008, the High Court found a brothel owner guilty of slavery. Further prosecutions followed in Victoria. The Howard Government replaced deportation with the offer of temporary visas for women willing to help police and made provision for some support services. Significant problems with the visa system remained, however, and, in 2009, the Commonwealth introduced further reforms. Project Respect has worked for all these changes and now advocates legislative reform that will allow trafficked women to receive compensation. It wants to see programs introduced to alter attitudes and for sex slavery to be incorporated into violence-prevention policies (Maltzahn 2009). The Victorian Parliament’s Drug and Crime Prevention Committee held an inquiry into People Trafficking for Sex Work and tabled its final report in June 2010. It made some 30 recommendations, including that a whole-of-government Sex Industry Regulation, Policy and Coordination Unit be established in the Department of Justice.

Women with Disabilities and Public Policy

The influence of women with disabilities on Australian policy has been disappointing, despite the tenacity and professionalism of members of Women with Disabilities Australia (WWDA), which received one of four National Violence Prevention Awards in 1999. The association campaigns on an expanse of issues and produces valuable resources. It has worked extensively on violence against women with disabilities, for example, and has produced reports, action plans, model processes and national information kits. Spokeswomen draw attention to the fact that their concerns are regularly overlooked by the disability movement, the women’s movement, the women’s health movement and by governments at all levels (Howe 1999; Meekosha 1990, 2001; Tilley 2000). Meekosha (1990:36–7) argues that the uncritical acceptance of physical strength and self-reliance by feminism has had the effect of excluding some women while, at the same time, many doctors and others hold a view that women with severe disabilities should not be mothers. Margaret Cooper and Diane Temby (1995) point out that even under the first NWHP and Program, women with disabilities were ‘relatively marginalised’.
Some commentators explain this situation by pointing to the low status generally accorded women with disabilities. Chenoweth (1997:26) has argued that this group of women is so devalued that they are denied even a sexual identity and exist in a state of ‘extreme marginalisation’. WWDA works to undermine the multiple surrounding myths, many of which controvert basic human rights. Myths include the claim that women with intellectual disabilities are promiscuous, that they should not have children because they are not fit mothers and that sterilising women with disabilities will protect them from rape (Chenoweth 1993:4).

Recent research confirms that there are still major knowledge gaps about the experiences of women with disabilities, including the experiences of Aboriginal and immigrant and refugee women, and major gaps in policies and available services (Healey 2009:8). In terms of public policy responses, Tilley (2000) points out that although women with disabilities are often mentioned in the preambles of policy documents, they are nevertheless almost entirely ignored when it comes to developing and funding appropriate programs. Certainly, disability policies in Australia have consistently failed to apply a gender lens. Most have proceeded on the assumption that men and women experience disability in the same way and that there is therefore a common set of issues.

Governments have enacted legislation with the aim of benefiting people with disabilities. The national Disability Discrimination Act was passed in 1992, which provides protection for men and women against discrimination on the basis of disability. A set of standards specifying rights and responsibilities about equal access and opportunities for people with a disability accompanies the Act. Successive Commonwealth, State and Territory disability agreements have been hammered out, the first of which was signed in 1991. It provides a framework for the development, delivery and funding of specialised services. Through the agreements, governments share responsibility for the provision of programs and support services.

In 1994, the Commonwealth developed the 10-year Disability Strategy, which helped to meet its obligations under the Disability Discrimination Act 1992. The strategy aimed to enhance equal opportunity for Australians with disabilities and improve the accessibility of services, such as transport, telecommunications, education, health, housing and so on. Among a number of other national projects are the National Disability Advocacy Program, National Auslan Interpreter Booking and Payment Service, National Print Disability Services Program and the National Disability Conference Initiative. Australia ratified the UN Convention on the Rights of Persons with Disabilities in July 2008. The convention contains a stand-alone article on women with disabilities and the text is cognisant of gender throughout. Governments are therefore obliged to
prioritise women with disabilities as a group warranting specific attention and to take positive action to ensure that women and girls with disabilities enjoy the full gamut of human rights and freedoms.

After advocacy by WWDA, the National Partnerships Against Domestic Violence Taskforce agreed to fund a national project to develop information resources for women with disabilities who experience violence. This was the first Commonwealth-funded project on women with disabilities and violence, and WWDA members participated on various committees. The national plan recognises that ‘policy solutions to address domestic violence and sexual assault must take into account the diverse backgrounds and needs of women and their children’ (Commonwealth of Australia 2011d:11). It argues that

new perspectives and strategies are required by all Australian governments in the delivery of best responses, as early as possible to victims of violence. Women may require specialised support based on individual needs in recognition of issues such as age, English language proficiency, disability, sexuality and prior victimisation.

The plan does not, however, explore the way policy solutions might need to differ to respond appropriately to women with diverse needs.

Following on from the National Disability Agreement in 2008, the National Disability Strategy (Commonwealth of Australia 2011b) was developed and written by the Commonwealth, States and Territories, under the auspices of COAG. It will help to fulfil the country’s obligations under the UN convention. The strategy is based on extensive consultations and 750 written submissions and was endorsed by COAG in February 2011. It sets out a national plan with the stated aim of improving life for Australians with a disability, their families and carers for a decade. In theory, at least, all Australian governments are now committed to a unified national approach. Implementation and evaluation plans are to be worked out in the first year, in what is envisaged as a participatory process. As part of the strategy, the Productivity Commission is undertaking a study of the costs, benefits and feasibility of a national long-term care and support scheme, including a national disability social insurance scheme. The commission is being assisted by an associate commissioner, an expert in disability issues and an independent panel of experts.

The influence of the women’s movement is apparent in that this strategy which, unlike previous documents, employs a gender lens. It recognises that women and men have different needs, priorities and perspectives and that some experience multiple problems. It draws attention in several places to the disadvantages experienced by women with disabilities, such as high levels of violence, including sexual violence, lower levels of participation in paid work
and poorer economic outcomes and discriminatory attitudes in relation to parenting. It discusses the need for a coordinated and comprehensive approach, in which governments work together and with the wider community, stressing that ‘the views of people with disability are central to the design, funding, delivery and evaluation of policies, programs and services’ (Commonwealth of Australia 2011b)—all familiar ideas for those who take a social perspective of health. This document argues explicitly that ‘the Strategy is based on a social model of disability and recognises that attitudes, practices and structures are disabling and can prevent people from enjoying economic participation, social inclusion and equality’ (p. 16).

It remains to be seen whether funds will be allocated to put appropriate policies and programs in place.

**Neo-Liberalism Comes to Women’s Health**

Since the 1990s, a set of political ideas very different from that of the 1970s has increasingly dominated political discourse. As neo-liberalism gradually supplanted social liberalism,³ health and social policy expansion gave way to attacks on the authority of government and attempts to dismantle and de-fund as many programs as politically possible. It is true that the Commonwealth committed itself to a further four years of funding for the NWH Program in 1992 and later to funding for the longitudinal study of women’s health. Otherwise, however, little of an expansionary nature took place, even though Labor held office until 1996. At the State level, too, funding was tightened and the women’s health policy machinery began to be dismantled.

The health and social policies of the Kennett Liberal Government (1992–99) in Victoria illustrate the influence of neo-liberalism and demonstrate the hardship and distress that follow the withdrawal of support from services that were under-funded and oversubscribed in the first place. Between 1992 and 1994, Victorian Government spending on health and community services was cut by 27 per cent. After 1994, instructions were given that 54 per cent of required government budget savings were to be found from the sector. The accommodation support program was cut by $7.5 million or 12 per cent. Large numbers of residential care units were closed, including refuges, respite care centres, centres for disabled people and drug and alcohol rehabilitation centres. Researcher Olga Bursian interviewed workers from family support,

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³ Neo-liberalism can briefly (if not very accurately) be described as a view that envisages a small role for governments and a large role for markets in the distribution of material resources. An expanded role for government, such as that attempted by the social liberal Whitlam Government, is seen as an illegitimate foray into realms that should remain in private hands.
foster care, maternal and child health and residential care programs to find out about workloads, stress factors, morale, worker’s relations with management, training opportunities, job security and the general impact on women’s lives. She found that the cuts resulted in heavier workloads, more complex demands on workers, fewer services to refer people to and fewer preventive services. In foster care, workloads were found to be unmanageable. Autistic, violent and psychiatrically disturbed children were housed inappropriately with children with fewer problems. High to intolerable stress levels were reported among staff and management alike. Professionals found themselves acting against their best judgments, volunteers were asked to carry out complex tasks for which they had insufficient training and uncertainty about funding led to anxiety because positions could be de-funded without notice. Occupational health and safety problems emerged and pay and conditions were eroded (Bursian 1995).

It was in this atmosphere that the Howard Government set about formulating a range of health policies that had a deleterious impact on low-income groups, particularly women (Gray 1999, 2004). It divested itself of policy responsibility for women’s health through the introduction in 1997–98 of the National Public Health Partnership, although it continued to provide Commonwealth funds. Under the so-called partnerships, funding was broadened into eight public health programs: the NWH Program, the Alternative Birthing Services Program, the National Education Program on Female Genital Mutilation, Breast Screen Australia, the National Cervical Screening Program, the National Childhood Immunisation Program and the National Drug Strategy. The women’s health movement, through the AHMAC Subcommittee on Women and Health, resisted this change for a number of reasons, not least because the language of the discussion papers was the language of commodification, elitism and social control (Broom 1998c).

During the development of the bilateral Public Health Outcomes Funding Agreements (PHOFAs), it was suggested that a number of standards and safeguards should be incorporated but, in the event, few performance measures were developed and none related to women’s health programs. There was no longer any legal requirement that the States and Territories should spend any proportion of the money that was channelled through the agreements on women’s health. Initially, Commonwealth funding was guaranteed only until 1999, when the first set of agreements expired. The implementation of the Public Health Partnerships was a major defeat for the women’s health movement.

A second set of agreements, negotiated in 1999, this time for a five-year period, did include certain outcome measures in relation to women’s health, including that health departments should maintain community-based services for women
and that they should foster partnership and collaborative arrangements between gender-specific health services and mainstream services. The sub-national jurisdictions were required to report yearly against the criteria.

In keeping with intentions to reduce the size of government, the AHMAC Subcommittee on Women and Health was disbanded in 1998. The chief reason cited was cost saving. The capacity of the women’s health movement to contribute to policy and to obtain information from policymakers was thereby significantly weakened. Under the partnership, a steering group of chief health officers was established, with a representative from the Australian Institute of Health and Welfare (AIHW) and the National Health and Medical Research Council (NHMRC). There were no longer channels through which the views of consumers, trade unions, general practitioners, nurses and the women’s health movement could flow.

The Commonwealth seemingly took no further interest in women’s health until 2004 when the PHOFAs came up for renegotiation. During the process, information circulated that the draft agreements for the period 2004–09 contained no reference to women’s health. Rumour had it that a draft clause explicitly stated that Commonwealth money was not to be spent on any program not stipulated in the new agreements.

The AWHN Management Committee went into crisis mode. Representatives from all States and Territories met in Melbourne to discuss and decide upon strategy. Press releases were written and released, a background paper was put together and disseminated and an explanatory letter was written, which was sent to all relevant parliamentarians in every jurisdiction. A lobbying strategy was worked out that would involve Commonwealth, State and Territory governments, because all would sign the new agreements. Members made appointments to meet with State and Territory politicians, especially women. At the national level, as Deputy Convenor of AWHN, I unsuccessfully sought an appointment with Health Minister, Tony Abbott. Instead, I met several times with ministerial staff in June 2004 and was assured that there was ‘no hidden agenda’ and that the Commonwealth was willing to consider an extra category to be included in the new agreements, called ‘promoting women’s health’. This category was a possibility, I was told, if it did not restrict the Government’s aim of promoting as much ‘flexibility’ as possible in service delivery.

At the same time, small delegations of AWHN Committee members met with senators from the two minor parties, the Australian Democrats and the Greens, where the point was made that without intelligence from community groups, such as AWHN, they did not get to hear about proposed policy changes. As a result of discussions, Senator Lyn Allison asked a series of relevant questions on notice in the Parliament. These included asking whether a 2003 review had
recommended a stronger Commonwealth role in women’s health, whether the absence of mention of women’s health in the draft PHOFAs indicated reduced Commonwealth commitment and whether the Commonwealth had any plans to review the NWHP. She also requested that a copy of the review of the previous year be made public. Senator Allison’s questions brought the Commonwealth’s attempt to deliver a deadly blow to women’s health into the light of day whereas previously it had lurked in the mists of hearsay.

At the time, speculation about the date of the 2004 national election was being fuelled by the Prime Minister’s refusal to comment (Bennett et al. 2005). Women’s groups thus began to prepare, making arrangements to talk with key parliamentarians. WEL made several deputations, in which AWHN participated, including one to Shadow Health Minister, Nicola Roxon. At these meetings, the threat to women’s health under the proposed PHOFAs and the need to review the NWHP were both discussed. An AWHN delegation made a presentation to the Labor Women’s Caucus Committee in July 2004 where the same issues were raised. The delegation asked for an election commitment from the Labor Party to review and renew the NWHP. Although no commitments were given, support was promised and the view was expressed that review of the policy was a project to which Labor women might be able to secure agreement. When the 2004–09 agreements were finally signed, they retained reference to all existing women’s health programs—a major achievement for the movement.

The Second National Women’s Health Policy, 2010

The Third AWHN National Women’s Health Conference passed a resolution that the NWHP should ‘be updated and extended to take account of issues of increasing importance to women in the late 1990s’ (Davis et al. 1996:14). Similarly, the Fourth AWHN National Women’s Health Conference, in Adelaide in 2001, argued that Commonwealth leadership was necessary to ensure that funding and commitment for women’s health were maintained across the nation (AWHN 2001:9).

During the PHOFA period, the States and Territories continued to support the existing women’s health infrastructure and sometimes small advances were made. Nevertheless, after 10 years of neo-liberal Commonwealth government, the participants who met at the Fifth AWHN National Women’s Health Conference, in Melbourne in 2005, were pessimistic about the prospects of a women’s health revival. The only glimmer of light was the support for AWHN’s proposals expressed by members of the Labor Women’s Caucus Committee. At the conference, an inspiring address was delivered by Ilona Kickbusch, well
known internationally as an innovator in public health, women’s health, health promotion and global health. She suggested that women’s health groups needed to build coalitions with like-minded groups, identify possible funding sources, stage women’s health summits in all jurisdictions and develop an assemblage of strategies, including internet strategies, media strategies and ‘get out the vote’ strategies.

While such an agenda was daunting for the movement and the almost penniless AWHN, the speech was inspirational and ideas from it found their way onto AWHN planning agendas. Improved electronic communication strategies were developed, coalitions were built and the membership base was strengthened. Women’s health summits were held in three States and in 2006 AWHN began planning a national summit. The first step was the development of a draft discussion paper, which set out a new national agenda for women’s health. The paper was circulated widely for comment and feedback. In September 2007, a national summit was held at Parliament House, Canberra, to which approximately 120 representatives of national organisations with like interests were invited, along with Commonwealth parliamentarians. The AWHN position paper was presented, further feedback was requested and, after incorporation of the final contributions, the paper was published in March 2008 as Women’s Health: The new national agenda. Hundreds of copies were distributed across the country to parliamentarians, key stakeholders and all relevant health and women’s organisations.

Shortly after the summit, as part of a health policy package for the 2007 election, Shadow Health spokeswoman, Nicola Roxon, announced that, if elected, her party would develop a new national policy on women’s health that would encourage specific services for women and would promote women’s participation in health decision making and management. She also pledged that the focus of the health system would be shifted to achieve more preventive health care, enhanced health promotion and greater attention to managing and monitoring chronic disease. The women’s health movement greeted the announcement with excitement; women’s health had been missing from the national policy agenda for more than a decade.

Early in 2008, the AWHN committee met to devise a plan to influence the shape of the second NWHP. The strategy had two major elements. The first was to contact relevant Commonwealth, State and Territory politicians and bureaucrats to keep them informed of the movement’s views and priorities. The second was to maintain regular communications with members and interested organisations, to let them know about developments and to gather views and contributions.

After Labor came to office, more than a year passed before the policy development process was launched with the publication of a background paper, Developing a
women’s health policy for Australia: setting the scene. The first consultation was held at Parliament House, Canberra, in March 2009. The meeting was chaired by Professor Sally Redman, Director of the Sax Institute. At the meeting, a consultation discussion paper, Development of a new national women’s health policy, was launched, which was an expansion of the earlier document. Both recognised a social view of health as central and both recognised that there are significant health inequalities between different groups of women. The new policy, it was argued, needed to focus on those groups with the highest risk of poor health, including Aboriginal and Torres Strait Islander women.

The invited participants were from 14 groups, including AWHN. A woman from Congress Alukura was invited but was unable to attend. Minister Roxon was present in the morning. She said the Commonwealth was not afraid to make decisions that would not have a major impact for 10 to 20 years and was not afraid to work across Commonwealth, State and Territory boundaries. The minister acknowledged that many factors affecting women’s health, such as economic and physical security, are located outside the health portfolio but she envisaged that the main thrust of the new policy would be within the portfolio. Among the issues raised in discussion were the paucity of services for rural women, the need for a greater understanding of difference and different patterns of health and illness, the OHS problems faced by immigrant and refugee women, violence against women, economic security, personal security and the need for a national sexual and reproductive health strategy. The importance of health education to teach practitioners about cultural and gender competence was stressed, together with the need for prevention and health-promotion programs.

In the second phase of the consultation process, March to June 2009, the organisations present at the round table were asked to consult with their constituencies and then make submissions to the Department of Health and Ageing (DOHA) by July 2009. The submission process was open to any group in Australia and AWHN developed a template to facilitate contributions. DOHA received almost 100 submissions by the middle of the year.

As discussed, AWHN and the Aboriginal Women’s Talking Circle managed a project through which Aboriginal women were consulted and an Aboriginal women’s submission was written, with funding support from FaHCSIA. From September to December 2009, DOHA held consultation forums in all capital cities, six regional cities and in Fitzroy Crossing in north-west Western Australia. The policy was released on 29 December 2010. There was no official launch.

The new policy covers key women’s health issues, including many of the views and experiences put forward in consultations and submissions. Its stated purpose is to continue to improve the health and wellbeing of all Australian women, especially those at greatest risk of poor health. It is framed within a
social health perspective and identifies the need to promote equity between groups of women through a focus on the social determinants. It acknowledges that women’s access to resources, such as income, education, employment, social connections and safety and security, including freedom from violence, influences their health outcomes and their ability to access services. The policy recognises health inequities between groups, with certain groups, particularly Aboriginal and Torres Strait Islander women, having poorer outcomes (Commonwealth of Australia 2010b:7–8).

The social determinants of health are to be addressed through five policy goals: highlighting the significance of gender as a key determinant; acknowledging that women’s health needs differ throughout their lives; prioritising the needs of women with the highest risk of poor health; ensuring that the health system responds to all women with a clear focus on illness prevention; and health promotion. Effective, collaborative research, data collection, monitoring and evaluation and knowledge transfer are to be supported. The short-term focus, however, is on the burden of disease in four priority areas: prevention of chronic disease and control of risk factors, mental health and wellbeing, sexual and reproductive health, and healthy ageing.

While the new policy expresses much that the movement endorses, it is extremely disappointing in a number of ways. First, the contribution of women’s health centres and services over decades is not acknowledged which is also, in effect, a refusal to acknowledge the crucial importance of strong primary health care. Second, chronic disease is to be addressed through the control of risk factors, such as obesity, unhealthy eating and physical inactivity. Disappointingly, however, the policy does not explore the risk factors in the light of their social determinants. Third, and most importantly, any actions that are to be undertaken to address either social determinants or the burden of disease are vague and unclear. It is extremely important that the social determinants of illness be linked to specific actions that will reduce the impact of those determinants. Such actions, of course, require resources and it is disappointing that the only funding announced with the policy is for Women’s Health Australia, a laudable project and one strongly endorsed by the movement but in itself insufficient as a national effort to address the social determinants of women’s health.

**Conclusion**

On the whole, Commonwealth Labor governments have responded positively to the women’s health movement, formulating a broad array of policies, strategies, programs, plans and initiatives. The high point of the movement’s influence was in the 1980s and early 1990s when, as one commentator argued, feminist
thought and action to improve women’s health had a strong influence on reform debates (Dwyer 1992b:211). The NWHP was an international first and influenced policy overseas as well as in the various Australian jurisdictions. The NWH Program expanded specialised women’s health centres and services and funded a variety of new projects. The separate women’s health sector has produced best-practice models of service delivery, especially in the area of preventive health care, which have had an influence on mainstream discourse and practice. Physical and sexual violence against women and girls, OHS, the health needs of Aboriginal women and women with disabilities and immigrant women, best-practice cancer treatment, maternity-care reform, strong primary, preventive health care and a social view of health are all issues that the movement has succeeded in drawing to public attention.

It can be argued that viewed from one angle, the women’s health movement has changed the face of national health policy discourse. We have a new national women’s health policy, which captures many of the arguments feminists have made, a national plan against violence against women and the National Disability Strategy that recognises social determinants and employs a gender lens. The large and avoidable differences in health outcomes for people situated differently are recognised in public policy documents for everyone to read. It is unlikely that a commission set up to focus on better population health would now claim, as the Better Health Commission did in 1986, that the diseases suffered by men and women are the same. Moreover, it is no longer so easy to claim, brightly, that Australia has some of the best average health outcomes in the world while ignoring serious disparities between groups.

From another angle, however, much of the changed focus and language can be seen as symbolic. Symbolic politics, in the simple sense, is a surrogate for substantive political action. The symbols used carry political meaning that is an end in itself and distract from the reality that policies and programs are not being developed. In this case, the use of the language of the social determinants of health, preventive health care and gender analysis gives the impression of an appropriate policy response to contemporary evidence. At the level of actual decision making, however, the focus is still squarely on hospitals and medical services, and new investment in primary health care, for women or anyone else, is small. The second NWHP is an action-free zone at the time of writing, a classic attempt to appease the women’s health movement without spending any money. Even at the pinnacle of achievement, the obstacles that femocrats and the movement encountered during the development of the first NWHP and the small amount of funding eventually allocated show that politicians perceived the need to be seen to be taking appropriate action while in reality making only a minimal investment.
Elaine Lomas, Operations Manager, NACCHO, supported by Irene Peachey, entertains the Sixth AWHN National Women’s Health Conference with an address entitled ‘Cooperation and collaboration between NACCHO and AWHN and the Talking Circle’—not a hilarious topic in anyone else’s hands!

Photo: Tracey Wing

Photo: Tracey Wing
Raquel Kerdel and Bessie Rigney (SA Aboriginal Women’s Committee), Carla Vicary (Murray Mallee Community Health Service) and Edie Carter (SA Aboriginal Women’s Committee) at the Sixth National AWHN Women’s Health Conference Party, Hobart, 2010.


Photo: Tracey Wing

Photo: Tracey Wing

Women’s Health West board members and staff at the Sixth AWHN National Women’s Health Conference Party. From left: Karen Passey, Linda Memery, Georgie Hill, Sally Camileri and Dr Robyn Gregory, Executive Officer.

Photo: Tracey Wing