

Needs Assessment Report

Liverpool
Women's Health Centre

2007



• **Acknowledgements**

This report was compiled by Margaret Hickie, LWHC Coordinator. The Health Profile was prepared by Kristin Dawson working as a consultant to Liverpool Women's Health Centre.

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Contents

Background, Aims, Methodology	5
Survey Findings	7
Focus Group Findings	15
Summary of Demographics for Liverpool LGA	21
Health Profile	23
Suggested Actions	41
Conclusion, General References	45
Appendices	47

List of Tables

<i>Table 1: Age of Respondents</i>	7
<i>Table 2: Cultural Background of Respondents</i>	8
<i>Table 3: Breakdown of Respondents</i>	8
<i>Table 4: Main Problems Facing Women in Society</i>	11
<i>Table 5: Main Health Problems for Women in Liverpool</i>	12
<i>Table 6: Type of Service Requested</i>	12
<i>Table 7: Groups Requested</i>	13
<i>Table 8: Age of Women in Liverpool 2006</i>	21
<i>Table 9: Language Other than English, Liverpool 2006</i>	22
<i>Table 10: 2003-04 SWSAHS Cervical Screening Rates</i>	29
<i>Table 11: Liverpool LGA Sexual Offences 2002-06</i>	31

Background

Liverpool Women's Health Centre (LWHC) undertakes a Needs Assessment process on a three yearly basis. The aim is to assess the views and needs of local women, to compile a health and community profile and where appropriate make adjustments to existing services and activities. The Needs Assessment document feeds into our planning processes and complements the development of the 3 year Centre Plan. While not intended as the sole source of information regarding client feedback on Centre services, opinions are sought from existing clients regarding the quality of services provided to them.

• Aims

Specifically the needs assessment is intended to:

- Identify areas of concern for local women in relation to social and health issues
- Nominate improvements for services and identify groups and information that women want
- Describe in general terms respondents opinions of the services of LWHC
- Describe the opinions of a number of groups of women around health and social issues including:
 - Existing clients
 - Young women through to older women
 - Indigenous women
 - Women from culturally and linguistically diverse backgrounds
 - Women who have not used centre
 - Lesbians
 - Differently abled women
 - Low income women
 - Women from outlying areas
- List up to date local regional state and / or national community and health demographics

Overall its aim is to stimulate discussion amongst consumers, staff and Management Committee regarding identified areas for change in service provision, to guide the work of the Centre in planning days and for the Centre to implement where possible suggested changes, services and projects based on what women tell us.

• Methodology

The needs assessment involved collection of information via a short 2 page survey and by conducting focus/ discussion groups. ABS Census data and DIMEA data was used to develop Liverpool community profile. The Health Profile combining national, state, area and occasionally LGA specific information drew on a range of sources including SSWAHS, NSW Health, ABS and other relevant bodies' epidemiological information.

Survey

A self administered written survey (Appendix 1) was used to collect information from women. Questionnaires were distributed to existing clients and via community events such as Day of Action against Sexual Assault. Some surveys were also provided to other services and stakeholders for distribution to women using their services and located in other parts of

Liverpool. Clients who were attending the Centre for appointments or were involved with Centre groups running either on site or as part of Outreach services were invited to complete a questionnaire. Some women completed surveys as part of staff presentations to groups visiting the Centre. For some clients assistance was provided to overcome English literacy difficulties. Many surveys were distributed to students attending classes at Liverpool TAFE. The survey included both open and closed questions. Women were offered the opportunity to receive one of 2 prizes if they completed the survey.

Focus groups

Focus groups/ informal discussions were conducted by Centre staff with a number of groups. Some groups contained women who have contact with the Centre and others had women unconnected with the Centre. These groups were selected as survey research is often traditionally ineffective with these women due to issues such as literacy, barriers related to access, distrust of questionnaires, low response rates. Participants were asked to share their ideas around eight questions. This allowed the discussion to be more free flowing and to promote a range of ideas across participants. About 96 women participated. See Appendix 2 for Focus Group Discussion questions.

Demographics/ Health Profile

This information complements the Centre's needs assessment giving a picture of the community profile of Liverpool women and the evidence of health issues affecting women.

Limitations/ Comments

The survey was not done using a randomised selection method. This suggests that responses towards quality of service questions will be more likely to be positive. However, the Centre did get input from many women who had no contact with the Centre. In addition, the survey was not translated into languages other than English which results in more limited responses to questions from women with limited English literacy. Focus groups were focussed on existing Centre contacts as opposed to women who had no contact with the Centre which limits perhaps a broader input into Centre directions.

Some of the responses to open ended survey questions were very general e.g. some women answered 'women's health' in response to what groups they would like the Centre to run. This is very hard to interpret.

Many of the limitations from the 2002 survey remain the same for 2006. It is therefore important to highlight the following recommendation: **use a predominantly closed option survey for groups and new services with room for open ended comments similar to the survey we use on an annual basis.** It would also be useful to collect demographics in a way that matched Census categories e.g. age ranges as this would make for clearer comparisons.

It was disappointing to be unsuccessful in organizing a focus group for lesbians. It is likely to be due to weaker connections with the local lesbian community on an organised basis. We will revisit this and organize a consultation later with a view to rebuilding our relationship.

Like all needs assessment this is a "living process" and communities like Liverpool rapidly change. This document is intended to complement our other work we do in consulting and engaging with communities of women on a regular basis.

Survey Findings

Profile of respondents

Number of respondents

Information was obtained from 104 women. 43% (45) women had previously used the services of the LWHC in the last three years. As such the survey provides a good insight into both the needs of existing and potential clients. It also suggests that the survey is a good promotional strategy for the Centre.

Age profile of respondents

Surveys were received from women across the age spectrum. The two largest groups represented were women in aged 50 – 59 years (26.9%) and women aged 30 –39 years (18.3%).

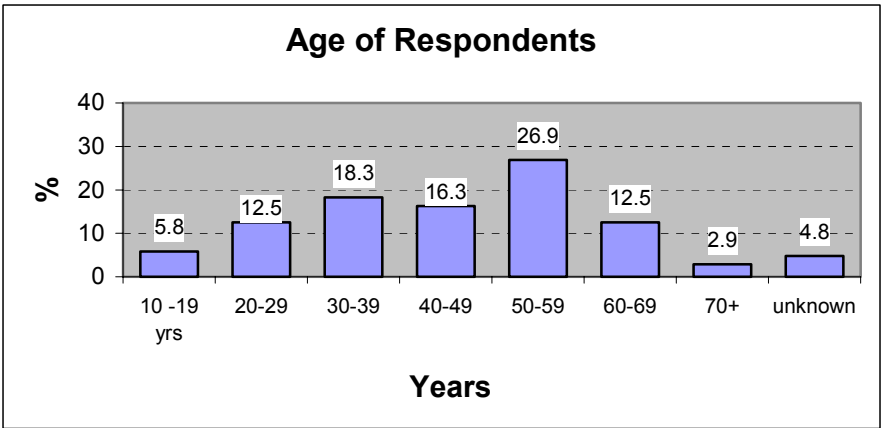


Table 1

Comparison with the ABS Census 2006 is difficult due to different age ranges used. However, for Liverpool Local Government Area the Census showed that 9.2% of women were over 65. 14.2% were between 15 – 24 years and 31.6% were between 25 –44 years. The median age in Liverpool was 32. It would appear that younger women are under-represented in the survey given that almost one quarter of women in Liverpool LGA are under 15 (ABS Census, 2006).

Cultural backgrounds

Aboriginal or Torres Strait Islander

7.7% of respondents were Aboriginal or Torres Strait Islander. This compares with 1.3% in the 2006 Census for Liverpool LGA and 1.1% for Sydney Statistical Division. This higher proportion is likely to reflect the ongoing work of the Centre in providing culturally appropriate services for Aboriginal women on and off site and the outstanding health and social issues which continue to affect Aboriginal community life.

CALD

24% of respondents were from English speaking backgrounds.

Those respondents from culturally and linguistically diverse (CALD) backgrounds (76%) nominated 31 different cultural backgrounds other than English speaking. 19.2% (20/104) of all respondents were from Latin American or Spanish speaking backgrounds. The next largest CALD background was Lao (12.5% or 13/104) This was followed by Chinese (8.7% or 9/104) and Vietnamese /Cambodian (8.7% or 9/104). This suggests culturally diverse women are over-represented among survey respondents providing an important opportunity to ensure services are responsive to these women’s needs. Women from an Arabic speaking background were again underrepresented in this survey at 3.8% of respondents. The top 2 responses are a reflection of the Centre’s longstanding work with Spanish speaking women and Lao women via the employment of workers from those backgrounds.

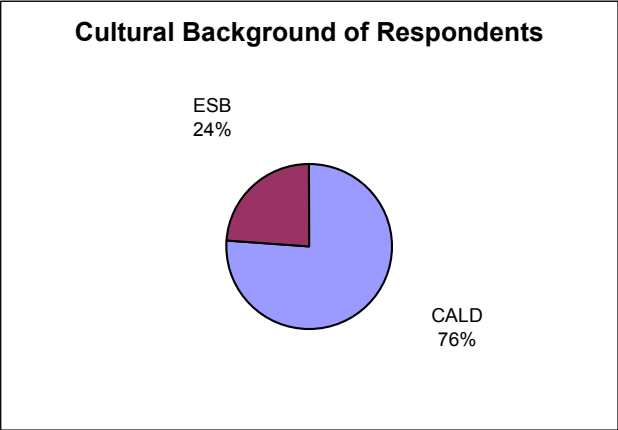


Table 2

Comparison with the 2006 Census shows that 37.6% of Liverpool residents were born overseas and 52.9% of residents spoke a language other than English at home. This suggests a higher level of cultural diversity among respondents than within the community. This is also confirmed by the language spoken at home figures.

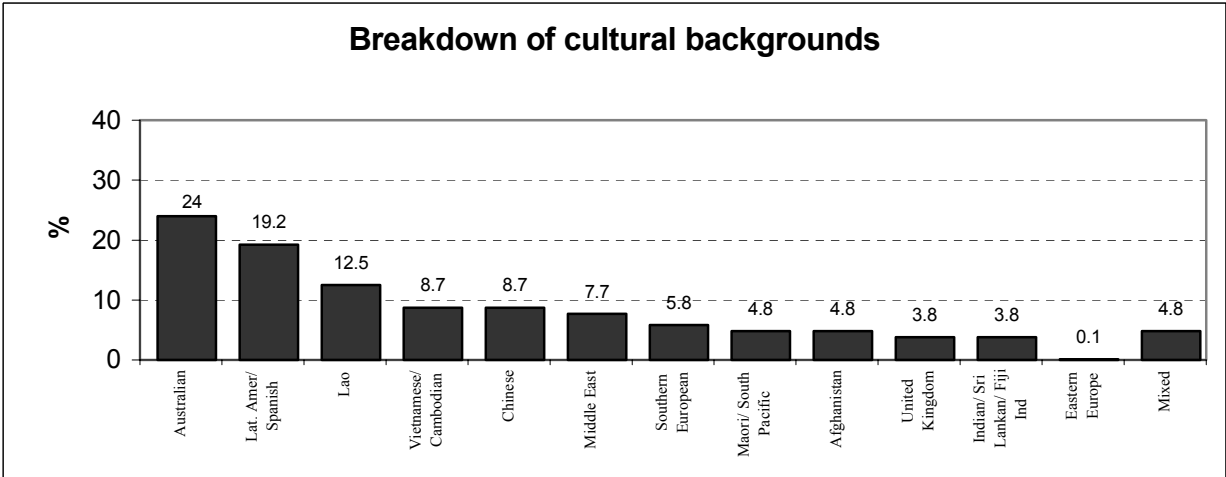


Table 3

Language Spoken at Home

When asked what language was spoken at home, 73.1% indicated they spoke a language other than English at home. This compares with 52.9% of Liverpool residents overall. Women from culturally and linguistically diverse backgrounds were over-represented in this survey. 25 languages other than English were nominated by respondents. The most common languages were Spanish (16.3%), Chinese languages including Cantonese, Mandarin, Chinese and Chow Chiu (12.5%), Lao (10.6%), Dari (4.8%), Vietnamese (3.8%), Italian (3.8%). Others included Hindi, Arabic, Kurdish, Cambodian, Greek, Macedonian, Persian, Cook Islander, Maori, Farsi, Baluchi, Tongan, Assyrian, French, Iranian.

The cultural diversity of respondents within the survey provides an important opportunity for the Centre to ensure its services are meeting those most disadvantaged within mainstream health services.

Lesbians

3.8% (4/104) of respondents identified as lesbian. This is a significant drop from the Centre's previous survey (12.5%) and represents a reduction in the Centre's active work within the local lesbian community. It is worth noting that 2 respondents expressed concern about the relevance of this question and its invasion of privacy. From the Centre's perspective it is important for us to understand the specific expressed needs of lesbians. The literature identifies specific health needs for lesbians which are overlaid by poor access to lesbian friendly services. All questionnaires were confidential.

Disability

16.3% of respondents indicated they had a disability. This compares with the 2006 ABS Census where 4% of Liverpool residents identified having a disability requiring assistance. This would suggest that LWHC is doing well in attracting women with disabilities to use the service and this is possibly a reflection of the accessibility of the service.

Services used and quality

As stated earlier, 43.3% (45/104) of respondents had previously used the services provided by the Centre in the last 3 years.. Respondents used a wide range of services , including: groups/ education sessions (22.1%); massage (8.7%) medical (7.7%); counselling (5.8%); naturopath (5.8%); acupuncture (2.9%) legal (2.9%). 8% of respondents had used multiple services. The broad spread of useage across the range of services suggests there was no or little bias in the sample of respondents experience of the Centre's services apart from perhaps those who regularly attend Centre groups such as Spanish speaking groups.

Those respondents who had previously used LWHC rated the service as either Excellent (70.7%) or Good (29.3%). No respondents rated the services as Poor or Fair. Comments made about the Centre included:

“Just love it cos it's women only”

“More groups and services for Spanish”

“Photography was a great course. I learnt a lot. Thank you.”

“Very friendly nice people”

“I first came here for a menopause workshop, it was extremely useful, followed by appointments with Alex (naturopath) which was excellent and helpful”

“I feel that I have taken a lot more care with my health”

“Very understanding and patient, works well together, very relaxed atmosphere. I feel like I will improve my wellbeing. Very happy with the attention and care I am receiving”

“Lots of colour and smiles”

“I really like the fact that it helps a lot of women with comfort in the centre because there’s no men”

“More counseling and massage”

“Very good support”

Knowledge of the Centre

The most common way women knew about Liverpool Women’s Health Centre was from an organization or a worker (42%). This is a significant change since our last survey suggesting our profile and standing with other organizations has improved. It also reflects our work with TAFE as many students mentioned learning about LWHC through TAFE teachers. Word of mouth via friends/ relatives played an important role in informing people about the Centre (25%). This suggests a strong level of community confidence in the quality of the Centre’s work.

The promotional activities of the Centre through talks, events, etc. were also important with 23.1% learning about LWHC in this way. 13.5% of respondents learnt about the Centre through the newspaper. Only 1% used the phone book which suggests that the Centre need not focus funds on any extra phone listings. 4.8% of respondents learnt of the Centre through other means including a Club, another group, walking or driving past.

Main Issues facing Women

Respondents were asked what they thought were the main issues facing women. A wide range of issues were identified, possibly reflecting the diversity of women who responded to the Survey.

The main issues identified are listed in the Table 4. Many of the same issues were identified with a similar priority as in the 2002 survey.

Violence, abuse and control of women including sexual assault was the most commonly identified issue at (29.8%). Interestingly this concern stands out amongst all of the issues identified – more than double the proportion of respondents identified violence than the next greatest area of concern. Financial issues were of concern for women (14.4%) and this was

matched by concern regarding women’s inequality (14.4%). This was expressed in a range of ways including lack of respect, recognition and support for women; power differences in relation to gender roles; stereotyping; women carrying too much of a burden. A number of these respondents also identified inequality especially affecting Aboriginal and migrant women.

Family issues at 13.5% related to problems with children, childcare, specific support for young mums and single parents. Unemployment and getting work when there are family responsibilities was also of concern (12.5%). Language barriers were identified by 11.5% of respondents which is not surprising given Liverpool’s cultural diversity and numbers of new arrivals. as a concern for women. The same proportion of women identified loneliness and isolation and this could also relate to language barriers, family responsibilities and being in a new country for some.

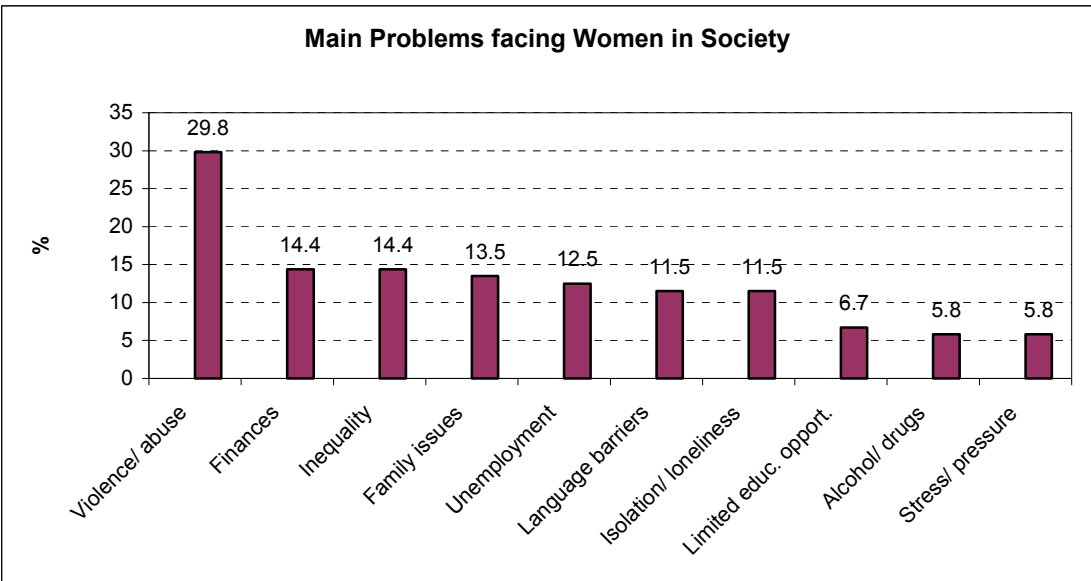


Table 4

Main Health Issues facing Women in Liverpool

Table 5 shows the main health issues that respondents thought faced Liverpool women .

This survey overwhelmingly identified depression and mental and emotional wellbeing (34.6%) as the main health problem for women in the Liverpool area. This is different to our last survey where the health problem of concern was cancer. Once again the level of difference between this issue and the next greatest concern is more than double.

Cancer (14.4%) was also identified strongly with particular focus on breast cancer. This survey identifies increased awareness of being overweight (13.5%) as a health problem for local women and also heart disease (11.5%) being an area of concern. The latter being the most common cause of mortality in Australian women and indeed Liverpool women.

Violence and abuse were identified as health problems by 9.6% of respondents. It is interesting that women do not appear to see this problem so strongly as a health issue.

A range of health problems were identified individually these related mostly to social issues and included lack of family support, limited education and employment opportunities, limited language skills, tiredness, poor body image. Surprisingly, low self esteem was in this category too.

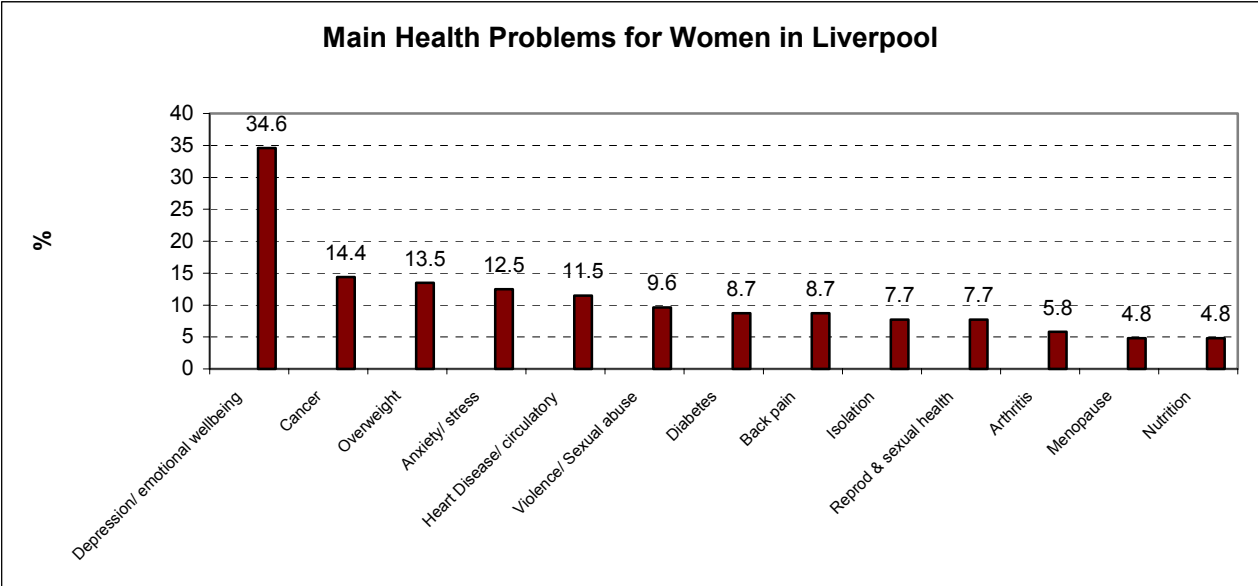


Table 5

Useful Services

Women were asked what services they would find useful for the Centre to provide and a vast range of suggestions were made. Some of these suggestions were services currently provided by LWHC. This could be an indicator of the number of respondents who prior to completing the Survey did not know about the Centre. It could also be a way of women indicating their support for the existing services LWHC provides or a way of saying ‘we want more’.

Type of Service Requested	No
Groups/education workshops (inc 57 specific ideas)	64
Counselling/ mental health support/ crisis support	27
Massage	19
Doctors/ health checks/ pap smears/family planning	17
Naturopath	7
Solicitor	5
Acupuncture	4
Volunteer visits to ease loneliness	4
DV Support	3
Stuff for young women	2
Physiotherapist	2

Table 6

Individual suggestions included: DV court support, out of hours service, noticeboard for out of hours groups, help with Centrelink problems, financial advice, dietitian/ nutritionist, information on pregnancy and children, food vouchers and other practical support, support for young pregnant women, more things for young women, literacy and numeracy support, more Aboriginal resources, women's sports centre with pool, promotion of activities in languages other than English, support for children from DV situations.

At 64, groups were the highest service requested although this could be a reflection of the way this category was collated as suggestions for specific groups were included with the broad suggestion for groups. The second service women thought that the Centre should provide was counselling/ mental health and crisis support (27). This was followed by massage (19) and reproductive and sexual health medical consultations (17).

Requested Groups/ Health Education Sessions

A number of the suggested groups and health education sessions are already provided by the Centre which confirms the Centre's work in meeting perceived needs. This section has included respondents answers at Question 11 when asked what groups/ health education sessions the Centre should run as well as the specific suggestions made for groups in Question 10.

Groups Requested	No.
Diet/ healthy eating/ nutrition/ weight management/ managing cholesterol	34
Self esteem/ confidence/ mental health	12
Meditation/ relaxation	12
Arthritis management	9
Women's health/ preventive health/ lifestyle	9
Groups in Spanish	8
Parenting (without put downs)	8
Yoga	7
Managing Depression	6
Menopause	6
Social/ recreational activities	6
Stress	5
Women's discussion/ women's business	5
Feminism/ overcoming male power/ being a woman/ women's rights	4
Exercise/ physical activities/ boxing	4
Return to work including maintaining balance	4
Tai Chi	4
Assertiveness	3
Sex education/ sexual health/ STDs	3
Conflict management	3
Craft	3
Domestic violence group	3

Table 7

Other suggestions included: self defence, motivation and self help, workshops in schools, managing pain, Fijian Indian group, managing finances, pregnancy support groups for young women, safe dating, music, first aid, antenatal classes, drumming, medical language/terminology, more Aboriginal groups, more naturopathic/ acupuncture workshops, cross cultural sharing.

Suggestions for Improvement

The most common suggestion for improvement was that more people should know about it/ advertise more widely (12). Here there were specific suggestions for promoting the Centre through playgroups, preschools, schools, refuges, newspapers, radio, TV, language specific newspapers, distributing the newsletter more widely especially through new estates. The next most common suggestion was to open after hours and on weekends (7). The same number of respondents felt the Centre did not need improvement. Parenting classes were suggested by 4 respondents. More multicultural communication and more doctors were suggested (3).

Other Comments

“Great place +++”

“My husband had a stroke 6 weeks ago and I can’t drive”

“This Centre has a lot to offer women we are lucky to have this service with all the services under one roof I’m sure it helps the majority of women in their everyday lives.”

“I think you need more advertising of the Centre not many people know where the Centre is or what they offer.”

“Teach women you can do everything on your own feet rather than husband and family”

“Staff are very friendly – good atmosphere”

“Thank heaven for such places”

“It was helpful to attend the Kurdish menopause group and parenting classes”

Focus Group Findings

9 focus groups were conducted by Centre staff to get the perspective of a range of communities of women. Some were conducted at the Centre with women familiar with the LWHC while the majority were conducted in other locations such as schools, community centers, the Lao temple.

Focus groups were conducted with some groups that use Centre services, groups who may have literacy difficulties or prefer to express their opinions verbally or with specific groups whose opinions we wanted to further explore and finally with community/ health workers. See Appendix 2: Focus Group Questions.

Main Findings from Focus Groups

- *Aboriginal women*

20 women attended this focus group which was conducted as part of a breast awareness workshop for Aboriginal women. The group felt that problems facing women related to a lack of respect and not being treated with dignity. Specifically for women in Liverpool there needs to be more empowerment with services like the Women's Health Centre. Problems nominated as a concern for Aboriginal women were drugs and domestic violence and a lack of resources, services and specifically Aboriginal workers to respond. Depression was identified as a major health problem for women. The women indicated that bringing women together in groups to mix was important. The group identified that giving more information to the Aboriginal community would be helpful.

- *Farsi speaking women & Arabic speaking women from Iraq*

6 women participated in the Farsi group and 4 women in the Arabic speaking group. The Farsi women had previous contact with the Centre through our Arts project.

They identified the main problems facing women in their community as the lack of information available in Farsi and lack of access to Farsi speaking doctors or doctors willing to use an interpreter. The women also identified that even subsidized complementary / alternative therapies can still be expensive for women on low incomes. Social isolation was identified as an issue and the need for culturally specific 'pensioner' social groups and outings as many have few relatives here.

Depression was a specific issue and related to the trauma and settlement experiences as well as social dislocation. This was especially so for Iraqi women. Some women identified problems advocating with Centrelink and the Dept of Immigration and feeling harassed and intimidated a worrying situation for women who have come sought refuge from state sponsored harassment, intimidation and torture.

Suggested activities for the Centre to undertake were to provide access to counselors as groups are not always appropriate, conduct language specific menopause groups and stress management groups, organize social activities, as well as information in Farsi.

- ***Women caring for young children (parents or grandparents)***

2 focus groups were run with women from diverse cultural backgrounds including Vietnamese, Macedonian & Anglo Australian who were parents/ grandparents of children at a Green Valley primary school and attending playgroups.

Issues facing women generally were identified as:

Mental health, isolation, lack of support for women after child birth and lack of support for young mothers. Stress and anxiety often associated with their roles of mothering and holding key responsibilities within the home was highlighted here as well as balancing return to work, financial pressures related to interest rate rises and managing conflicting information about parenting. Access to information about HPV vaccine was mentioned here.

Specific issues affecting women in the Liverpool area were:

Not enough in Liverpool for women to do apart from shopping which is hard for those on low incomes, concern about lack of free parking in Liverpool, lack of affordable childcare especially for those wanting/ needing to return to the workforce, domestic violence, access to medical services was especially an issue for women with children – long waiting times with kids was a barrier to seeking preventive health care.

Specific health problems identified by these women were:

Stress, post natal depression and changes in emotional and physical health for mothers of babies and young children, weight and body image . Media representations of women were considered to play a role here.

Suggestions for groups/ activities for Centre to run focused on more support for young mums, access to counselling and “Something for Green Valley” as no parking in Liverpool – this could be groups, information sessions or outreach women’s health clinics. Promoting the service was clearly an issue as only one woman knew of the Centre.

- ***Young women***

Approximately 12 young women aged 14 –15 from a local high school in attended this focus group.

Issues facing women were identified as violence and sexual assault; sexism and stereotyping that affects labeling of women’s behaviour and areas like sports participation and availability; inequality exists in the workplace and is reinforced by religion, and illustrated by for example the amount of attention they’re given when going through puberty. This reinforcing of inequality strengthens boys attitudes of superiority and gives permission for them to put girls down.

Issues specifically affecting women in Liverpool included: women judged by what they look like and how they dress; specific cultures are targeted; lack of safety in particular locations s e.g. Miller , day and night because of drug use reputation, or known areas where there are fights between nationalities or schools, women only go out during the day for safety reasons; sexual harassment on the street. The group felt that there is a lack of awareness of services available for women in Liverpool.

Problems facing young women were:

- *lack of access to sport/ recreation* especially non traditional sports like rugby and limits on women to reach/ play at representative level – different cultural views and conservative views re girls role identified here; limited availability of women only gyms where most young women are allowed to go as other gyms are male dominated; lack of other facilities that are not male dominated e.g. basketball courts; some girls are more limited by parents in joining out of school activities and when others are allowed its hard to understand; girls social development feels secondary to boys for example no school camp for girls due to lack of female teacher supervision. All of this lower participation feels like missed opportunities.
- *Self image/ self esteem* was considered a huge problem for girls and this is fuelled by name calling, constant negative communication, labeling, being judged by what you wear by guys and girls.
- *Relationships/ Abuse/ Bullying* – being used and abused by young men and when they're rejected they spread rumours, being sexually assaulted by boyfriends or guys they meet; boyfriends limiting your friends because of jealousy; boyfriends yelling and embarrassing you in front of others and treating it as a joke; lack of support from other young women who bitch about about you and telling teachers makes it worse as they don't know how to handle it.
- *Exploitation* in selling of products, various societal and school rules and by how they're treated by boys, exploited by pedophiles on internet asking invasive questions.
- *Lack of Information about services* available.
- *Education/ work* – girls can be put down for doing well or being smart, girls can experience abuse while working related to how they do things; some employers looking for stereotypical girls.

Health problems facing young women were:

PMS and period pain, weight issues/ eating disorders and the social pressure to be thin, STIs, cervical cancer, managing stress especially during HSC, working out relationships and conflicts especially with parents; depression; pregnancy; addictions –drugs, alcohol, piercings, communication problems, mental health problems.

Useful groups/ interventions for LWHC to consider running included:

debriefing sessions like counselling and anything that provides an outlet, WEEO WISER & more education on date rape, working with PCYC, more assertiveness programs, communication workshops, mental health, creative stuff like arts & crafts, education and written information on STIs run by young people, information from a mix of people – young people, experts and those who have experienced it, girls sports teams e.g. football, a place to play female sports, cool place to talk about female issues, relax days for girls with day spas, information available where girls are – schools, toilets etc, days where females can talk about female questions and have discussions led by someone who knows the answer, learning how to deal with sexual harassment from guys.

Suggestions for improving our work with young women included: keep coming into schools, upgrade workshops to cater for different ages, provide someone who women can talk to and advertise this, continue young people working with young people it works well, better advertising, follow up WEEO WISER programs, tour of the Centre with groups of friends or the school so can get to know and the staff and what you do.

Ideas about how to change women's lives were:
making women more equal to men, increasing women's opportunities, allowing women to wear things without being judged, give boys similar programs so they understand better, equality in work, more women's programs.

Lao women

Approximately 10 women participated in this group at the Temple in Edensor Park.

The main problems facing women were seen to be family issues including children not listening to parents, drugs and alcohol, domestic violence, divorce, poverty and homelessness. For women in the Liverpool area issues for women included gambling, poverty, homelessness, sickness and loss of work. Problems for Lao women were isolation, gambling, sickness, communication problems with children. Specific health problems identified were low self esteem, depression and arthritis.

Suggestions for groups and health education sessions were women's health, nutrition and arthritis. Suggestions for improving the Centre were for the staff to show kindness and friendliness, improve the appointment system by reminding women of their appointments, for practitioners to do breast checks at each health check. Suggestions for improving women's lives were for them to be happy, peaceful, with good self esteem, no suffering and good health.

Spanish speaking Women

16 women participated in this group conducted at LWHC.

Participants saw the issues facing women as loneliness and isolation, depression, language barriers, job seeking skills, lack of knowledge of support services and poor public transport with limited frequency.

For Liverpool women the issues identified were related to Centrelink and pensions, safety on the streets especially on Sundays and at night where poor maintenance and lighting means streets are very dark. Access to education has been limited due to TAFE fees.

Problems facing Spanish speaking women were language barriers and lack of interpreters, affordable dental care, limited availability of groups and domestic violence.

The group identified the following as health problems for women depression, self esteem, diabetes, menopause, cholesterol, arthritis, gastroenteritis, osteoporosis, breast cancer and cancer in general.

When asked what groups and other initiatives LWHC should do women suggested workshops on the abovementioned health issues, grief and loss groups, outings with bus provided and groups and more groups.

Other comments expressed a desire for the Centre to receive more funding to undertake more work to improve women's lives.

When asked what they would change to improve women's lives women suggested men and also giving women enough information to feel secure to speak on their own.

Service Providers

12 women participated in this discussion from a range of organizations representing Council, Aboriginal health, refugee health, women's health, employment, Violence against Women strategy, youth health. The group was conducted at LWHC.

The main problems identified for women included childcare, safety – both domestic violence and in public places, affordable housing, accessing Aboriginal workers, discrimination against Muslim women, lack of women in leadership and inequality in the workplace eg. Maternity leave, literacy issues, job seeking skills, access to health care including pregnancy options and preventive health, places to go for young women to learn about and discuss issues affecting them.

Issues identified for Liverpool women were all of the above with specific elements such as lack of childcare in Liverpool CBD, lack of Aboriginal workers in services, safety issues around the station, Additionally mental health problems and poor service responses, health issues relating to low income and or drug and alcohol problems, health of refugee women and their kids with little support, isolation especially for migrant women with limited English

Workers were asked what were concerns for those groups they worked with. These included: social isolation in CALD communities especially for those with language barriers; lack of after hours services especially domestic violence services for working women seeking assistance; transport in outer suburbs especially where trying to get to work in industrial estates; lack of money; inflexible boundaries of health services result in poor access; sexual harassment and bullying young girls by SMS.

Main health problems for women were identified as poor access for CALD women due to long waits for interpreters and lack of willingness by GPs to use telephone interpreters; low cervical and breast screening rates; information/ education on nutrition; living in a new country for teenagers from new and emerging communities; need for awareness of right to say no to sex in marriage for CALD women; parenting including hygiene for children and also for CALD communities with no family support; inability to access dental care; invisibility of carers either of parents, family members or in a grandparenting role.

Suggestions for addressing these issues included: information evenings, groups run after hours with transport home using Council bus; self defence classes; LWHC operate a dental service; operate a child care service; operate a young women's drop-in centre; self esteem courses; work in partnerships; outreach programs to outer areas for isolated women; skills for workplace programs for women falling through gaps could offer first aid; green/ white card course for getting onto worksites; computer skills courses; legal advice including tenancy; legal information sessions; mentoring; leadership skills; financial management including budgeting, saving, managing credit; financial counseling; celebrations involving mixed communities; diabetes workshops esp. for Koori community; funding for doctors; early intervention/ prevention of violence with young women; run a low cost loans scheme (NILS)

The following strengths and opportunities were identified: partnerships and networking due to range of NGOs and developing partnerships with non-traditional organizations eg businesses like Westfields; working with Karitane to provide parenting classes; keeping directories up to date; seek partnership with Council for funding for women's issues to be addressed through crime prevention plan; LWHC needs to keep pace with Liverpool's growth plans and opportunities as they arise; BBQ or Fair with organizations on the women's card having a stall; do more with employers re their role when staff are victims of DV.

When asked what was one thing to change to improve women's lives this ranged from broad, for example equality and easier access to education, to more individualized focus such as improve women's self belief, to opening a one stop shop for women 8am – 8pm to quite specific such as organize a big fun IWD event.

■ Summary of Demographics for Liverpool LGA

(Source: ABS Census 2006 Liverpool Basic Community Profile, Liverpool Time Series Profile, Sydney SD Basic Community Profile & Dept of Immigration and Citizenship)

At the time of the 2006 Census Liverpool Local Government Area's population was 164602. 82727 of these are women. There was a 6.9% increase in population since the last census in 2001. This compares with a 28% increase in the population between 1996 and 2001. However, with the upcoming land release in Bringelly population growth in the LGA is set to rapidly grow again in coming years.

1.3% of the population identified as indigenous and this has remained steady since the last census. In absolute numbers it has grown slightly This is slightly higher than the proportion for all of Sydney which is 1.1%. 1165 Liverpool residents who identified as indigenous were female. In absolute terms the indigenous population has slowly grown over the last 3 census.

The median age in Liverpool was 32. This suggests a more youthful population than Sydney as a whole where the median age is 35. Almost a quarter of Liverpool's female population are under 15 years of age.

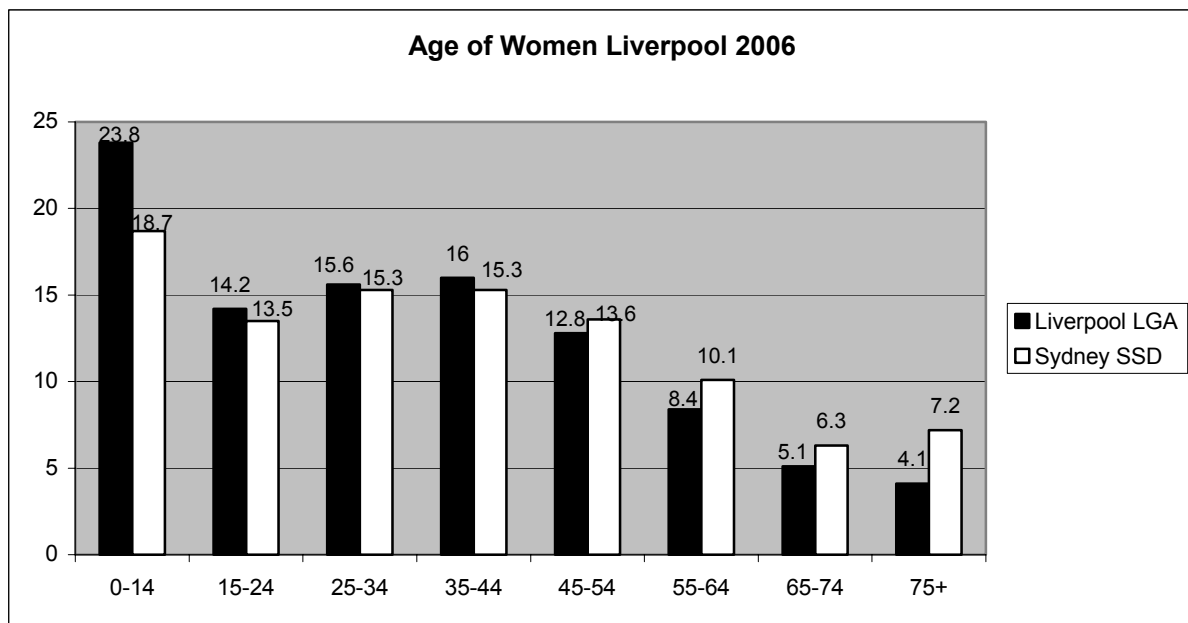


Table 8

53.6% of residents were *born in Australia* and 37.6% were *born overseas*. This compares with the Sydney Statistical Division where 31.7% were born overseas. This shows Liverpool is more likely to be a place of residence for those migrating to Australia. Of those born overseas, the top countries of birth were Fiji (8.5%), Vietnam (7.3%), Iraq (5.4%), Lebanon (5.3%) and Philippines (5.1%).

47.1% of residents spoke only English at home compared with 64% for the Sydney Statistical Division. Of those who specified a *language other than English spoken at home*, the top languages were Arabic (16.7%), Vietnamese (8.8%), Hindi (8.3%), Italian (7.1%), Spanish (6.7%), Serbian (6.3%), Chinese languages (6.2%).

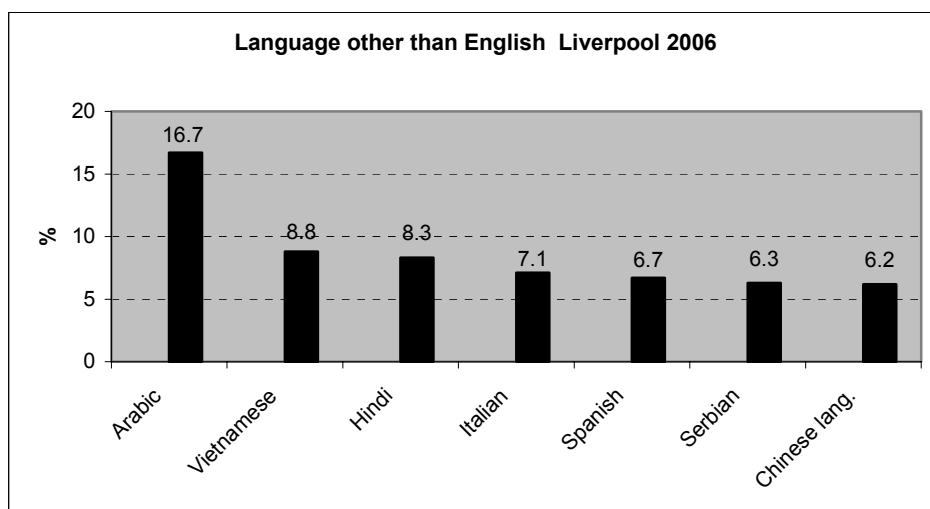


Table 9

24.5% of women who spoke a language other than English had poor or no English proficiency while 18.2% of men indicated this.

According to DIAC figures from January 2005 – June 2007 83.4% (412) of humanitarian female arrivals were from Iraq followed by 6.5% (32) females from Sudan. The top languages other than English spoken for all new female settlers ie. in all migration streams during this period was Arabic (45.9%), Vietnamese (6.1%), Hindi (3.3%), Serbian (3.2%), Mandarin (2.5%) and Spanish (2.3%).

The Census shows that 41.8% of Liverpool women over 15 *completed Year 12 or its equivalent* the rate for men is similar. This is lower than the rate for Sydney which is 48.6%.

The median *weekly income* for those aged 15 and over was \$440 with the median for Sydney being somewhat higher at \$518.

4% of Liverpool residents indicated they had a *disability* that required some assistance with life activities compared with 3.8% for Sydney. 12% of women over 15 indicated they provided unpaid assistance to a person with a disability while 7.7% of Liverpool men indicated they provided assistance. There was little difference for Sydney SD.

17.4% of family households were single parent families. 56% of these were families with children under 15. This is slightly higher than the rate for single parent families in Sydney which was 15.6% with 50% having children under 15.

24.2% of dwellings were fully owned. 41.4% were being purchased. 30.6% were being rented. 26.9% of rental properties were Dept of Housing. For Sydney SD 31.9% of dwellings were fully owned, 33.1% were being purchased and 31.3% were being rented. For Liverpool the main difference here is that more dwellings are in the process of being purchased and this may reflect a more youthful population as well as lower incomes. 15.4% of Sydney's rental dwellings were Dept of Housing which is significantly less than Liverpool. 0.02% of Liverpool's residents were homeless or in improvised dwellings on Census night. This is much lower than for Sydney which had 0.25% of residents homeless.

60.7% of Liverpool households had an internet connection and 66.4% of these were connected to broadband. This is slightly lower than Sydney where 65.9% of residents had an internet connection and 72.4% of those were connected to broadband.

■ Health Profile

This section is a summary of major health issues, risk factors and at risk populations as identified in national, state & local plans, epidemiological studies and current research. A reference list follows this profile.

Currently, new State and Area Women's Health Plans are still in development phase, so that a State and Local Area set of priorities and plan are not available for service planning or drawing out epidemiological information. The Liverpool Local Government Social Plan focuses on themes rather than on target groups, and contains no information about women or actions to address their issues and needs. Information was also gained from SWSAHS Strategic Framework for Women's Health 2000 – 2005.

National Agenda for Women's Health - Australian Women's Health Network

In 2007, the Australian Women's Health Network has proposed a new national agenda for women's health in Australia, building on the first Australian National Women's Health Policy released in 1989. Their discussion paper outlines the criteria to be used for the development of policy as well as the priority areas for action in women's health.

The Network identifies the criteria to be used in the development of a new national women's health policy as:

- Using a social model of health- *“a broad range of environmental, socioeconomic, psychological, and biological factors impact on health, and that, to large extent, it is the settings, conditions and experiences of everyday life that determine good or poor health outcomes for women at all ages.” –NSW Women's Health Outcomes Framework*
- Incorporating a diversity analysis to ensure that the needs of all groups in the community, including indigenous women, are taken into account. The network recognises that within the diversity of women there are some that face even greater disadvantage, including:
 - indigenous women
 - women in rural and remote areas
 - women of culturally and linguistically diverse backgrounds, including refugees
 - women with disabilities
 - women as carers (both of children and elderly relatives)
 - lesbians, bi-sexual women, transgender and intersex people
 - women in prison or detention.

Developing priority areas for women's health

Suggested national priority areas the network considers are:

- Women's economic health and wellbeing
- Women's mental health and wellbeing
- Preventing violence against women (in all its forms)
- Women's sexual and reproductive health
- Improving women's access to publicly funded health services.

Within these priority areas, the network identifies critical issues to be incorporated, such as improving *indigenous health and life expectancy*, health care for our rapidly ageing population, and addressing the harms of health issues such as *obesity* and *drug and alcohol abuse*. (p.6)

- The benefits of adopting a gendered approach to the already agreed national health priorities
- Using an inclusive and accountable process for further development and implementation of the new women's health policy. (p.5)

Major Health Issues For Women

The National Chronic Disease Strategy (*Commonwealth Department of Health and Aging Factbook 2006, website*) identifies five of the most prevalent diseases that account for use of health resources and mortality in the Australian population. The diseases are: asthma, cardiovascular disease, cancer, diabetes mellitus, injuries and poisoning (including suicide), mental health problems and arthritis and musculo-skeletal problems.

In Sydney South West Area Health, as in NSW, these diseases comprised 80% the major cause of all deaths between 1998-2002. It is acknowledged that the prevalence and rates of these diseases vary between men and women, and require a gendered approach in their analysis. In Sydney South West Area Health there was a higher rate of cancer, respiratory illness and poisoning/injury in males and a higher rate of cardiovascular disease in women.

Cardiovascular Disease

This disease accounts for 36.9% of all deaths nationally in 2003. (*National Chronic Disease Strategy*) Circulatory conditions are more common among females (20%) than males (16%) but more males than females reported these conditions (1). Research shows that there are problems of delayed diagnosis of women with heart disease, in particular those women presenting with heart attacks. Most women in the mid-age group, who were the focus of this research, considered heart disease to be a gendered disease, primarily a disease of men (2). Cardiovascular disease is the number one cause of death in the Aboriginal and Torres Strait Islander population.

Cancer

The most common cancers in Australia (after non-melanoma skin cancer) are prostate, colorectal (bowel), breast, melanoma and lung cancer. These five cancers accounted for 60% of all new cancers. Lung cancer is the most common cause of cancer death in Australia, followed by colorectal, breast, cancer of unknown primary site and prostate cancer. These five cancers accounted for 53% of all deaths from cancer (3). Aboriginal women have higher levels of cervical and kidney cancer.

Breast cancer is the most common form for women and makes up 28% of all cancers. The average age at diagnosis of breast cancer is 60 years of age. 11.6 % of cases are 35–44 years with the incidence increasing with age, peaking at 26.5% in the 55-64 year age group. In NSW, between 1990 and 2000 the breast cancer incidence increased by 19% for women 50–69 years, but mortality fell 24%. The increased incidence is probably due to earlier detection. (4)

In Liverpool, the rate of death from breast cancer between 1998-2002 was 28.2% of death from all cancers in women in Liverpool in this period. The other more common cancers in women in SSWAHS and NSW are **colorectal** (12.9% of cancer in women in Liverpool) ; **lung** (7.8% of cancer in women in Liverpool) ; **melanoma-** (6.1% of cancer in women in Liverpool) **Cervical-** (2.1% of cancer in women in Liverpool) **Other cancers-** (42.8% of cancer in women in Liverpool) (5).

Major Health Risk and Preventative Actions for Cardiovascular Disease and Cancer

Both the Cancer Council of Australia and the National Heart Foundation identify similar risks to these diseases. These will be identified with a profile of risk for women in the Liverpool Area.

The major risks to the development of these diseases, aside from a genetic history, are identified as: lack of exercise, unhealthy body weight, lack of adequate nutrition, smoking, unhealthy levels of drinking alcohol, poor mental health-stress/ depression/ social isolation, and in recent years poor dental health is seen as a risk factor particularly in heart disease. Given these risks, it is recognised that women living in poverty, experiencing violence and abuse, being isolated, overburdened with carer's duties as well as household and employment tasks, having poor education, lack of access to services because of poverty, lack of English language skills, disabilities or deprivation through status such as being a refugee, a woman in prison or an Aboriginal/Torres Strait Islander are more at risk. Women are also at risk when they, for a variety of reasons are unable to access other preventative measures for early intervention such as screening for cancers and treatment from a GP.

The NSW Population Health Survey 2006 (HOIST) from the Centre for Epidemiology and Research, NSW Department of Health provides the following information in relation to women living in SSWAHS in regard to the above risk factors for cardiovascular disease and cancer.

Physical activity

Men are more likely to be physically active than women. Women's physical and sporting activity peaks in the 25-34 year age group at 67.7%. A 2003 NSW Health survey revealed that 40.7% of women aged 16 years and over reported taking adequate levels of physical activity.

Levels of physical activity tend to decrease with age, with 54.3% of 16-24 year olds engaging in adequate levels, compared to 23.3% of women 65 years and over. (6)

On the sample taken by NSW Health in 2006: 49.7% of women in the area who engage in an adequate 150 minutes of medium-intensive level of physical activity per week. This is against the State average of 49.6%. In the same survey it showed that there is a lower use of local neighbourhood facilities being 43.3% in SSWAHS and 45.8% in the State. Also, women in SSWAHS have the lowest rate of ability to swim 35.5% as against the NSW State average of 47.1%. (7)

Body weight

According to a NSW study of weight over time, women of all ages were heavier in 2000 than in 1990. The study also noticed that different generations experience different patterns of weight gain, because of the unique set of experiences presenting throughout their lifetimes:

- Women of the pre-war generation are much less likely to be obese than later generations.
- Women born after 1980 are in the highest 'obesogenic' generation. (8)
- Generation X women (born between 1963 and 1978) have the highest rising Body Mass Indexes (BMIs) of all generations. The greatest rise in obesity rates has been in 25–34 year olds. For this age group rates have more than doubled in men in the last 20 years and quadrupled in women. (9) This trend is higher in NSW than the nation as a whole. (8)

The 2006 NSW Health Survey showed that:

39.7% of women in SSWAHS are overweight with NSW averaging 43.3%

16.6% of women rate at levels of obesity whilst NSW averages 17.4%

Nutrition

Recent research has shown that a balanced diet is essential for the prevention both of heart disease and a number of cancers. The 2006 NSW Health Department (7) survey indicates a low level of knowledge and practice in recommended foods intake.

89.3% of surveyed women in SSWAHS had knowledge of the recommended fruit serves per day (NSW 90.3%) only 28.8% of women surveyed in SSWAHS knew the recommended servings of vegetables per day, (NSW 37.7%)

Only 8.1% of women actually consumed the recommended servings of vegetables (NSW-12.4%). 43.5% of women in SSWAHS had 3 serves or more of vegetables a day (NSW 50.8%). 6.5% of women experienced 'food insecurity', i.e. if they ran out of food and couldn't buy anymore. This contrasts with an area such as North Sydney/Central Coast where there is 2% and with the State at 6%.

Tobacco use

In 2003, 20% of females in NSW were current 'daily' or 'occasional' smokers. This represents a 10% decline from 1977. The highest rate of smoking in women is in the 25-34 age group (25.8%), closely followed by the 16-24 age group (25.3%). 14.9% of girls 12-17 years reported smoking in 2002. Since 1984 smoking for all young women in this age group fell significantly except for girls aged 12 years. (10)

The smoking rates for indigenous women are substantially higher than non-indigenous women. The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey revealed that in the age range of 18-54 around 50% of indigenous women are current daily smokers. This figure drops post-55; however this reflects the earlier mortality rates of indigenous women. (11)

Cigarette smoking causes around 10% of all deaths in women, and 20% of female deaths before the age of 65. In 2003, 2302 females died from smoking-related illness. (12)

Two per cent of all female hospitalisations are smoking related. Such hospitalisations for women increased 16% from 1989/90 to 2002/2003, compared to a 3% decrease in men in the same period. (11)

In the 10 years between 1995 and 2004, the incidence of female lung cancer rose by 11% while the female death rate remained stable. Men experienced 18% and 22% respective declines in the same period. (13)

The NSW Mothers and Babies 2003 Report (2004) reported that 14.6% of mothers were smoking in the second half of pregnancy. However, between 1998 and 2003, there was a trend towards smoking fewer cigarettes per day during the second half of pregnancy. (14)

The 2006 NSW Health Survey found that:

-in SSWAHS 18.5% of women smoke, 12.4% on a daily basis, and contrasts with North Sydney which has 8.3% daily smokers. Recent research has indicated a socio-economic factor in the tobacco industry's marketing to those who are more disadvantaged and vulnerable to nicotine use. This risk factor in disadvantaged populations will be outlined in the next section.

-GPs-(46%) in SSWAHS are less likely to discuss with patients and advise against smoking in contrast with 51.6% of GPs across NSW.

Alcohol Use

In a 2003 NSW Health Survey, 30% of all females reported 'risky drinking behaviour'. This is to be compared to 41% in males. Women in the 16-34 year age group were most likely to report risky drinking (40.5%). (15)

32.2% of rural women reported risky drinking behaviour compared to 28% of urban women. (16)

'Short-term high risk drinking' (defined as 7 or more drinks in one day) declined progressively with age, peaking at 16-24 in females (27%). (17)

29.6% of women had 5 or more alcoholic drinks at least one day in the previous 12 months. (18)

In the 1999 Australian Schools Students' Alcohol and Drugs Survey, 20% of 15 year old girls and 30% of 16 year old girls reported having had five or more drinks on one occasion (19).

The overall rate of increase in hospitalisations due to alcohol was 36% for women, compared to 6% for men in the 11 year period from 1989/90 to 1999/00. (20)

Data from the 2001 National Health Survey show that indigenous adults aged 18 years and over were less likely to consume alcohol than non-indigenous adults (62%). Of those who consume alcohol, however, Indigenous adults were more likely to consume alcohol at risky or high risk levels (29%) compared with non-Indigenous adults (17%). (21)

The 2006 NSW Health Survey showed that there were 7.6% of women in SSWAHS who consumed over 7 drinks a day. This was the second highest in the State (6.4%-state average) after Greater Western with 7.9%

Oral Health

In SSWAHS 56.9% of women over the age of 16 years visited the dentist in the last 12 months. This contrasts with 59.8% in NSW and 68.2% in North Sydney/Central Coast. (7)

Medical attention

There were 10.5% of women in SSWAHS who avoided seeing a doctor because of the cost of medicine. This is one of the highest levels in the State which averages 8.6%. 12.2% of women also cut down or stopped using prescriptions because of cost. This contrasts with 10.8% in NSW. Only 55.6% of women have private health insurance in SSWAHS as against 55.9% in NSW which also contrasts with North Sydney/Central Coast where there is 71.5% with private health insurance (7)

Mental health

In NSW, the overall prevalence of mental disorders for men and women is similar (17.9% vs 16.9%), but the conditions vary. (22)

Women are more likely than men to be diagnosed with anxiety or affective disorders (12.8% and 6.8% of women with mental disorders respectively), whereas men are more likely to be diagnosed with substance abuse and psychotic disorders.

There are approximately 800 suicides in NSW each year. In general, death rates from suicide are about three to four times greater in males than in females. Yet, of around 3,500 hospitalisations each year for suicide attempts, 55% are women. (23) This difference is thought to be due mostly to males using more lethal methods than females, as there is less difference in suicide attempts between sexes. (24)

The 2006 NSW Health Survey showed that after testing using the Kessler 10, 15.4% women in SSWAHS experienced high and very high levels of psychological distress, the highest in the State. This contrasted with 11.9% in NSW and 7.8% in North Sydney.

Screening for Cancers:

Pap Smears

In NSW, the incidence and death rates for cervical cancer among women aged 20–69 years fell by 40% from 1990 to 2000. Between 1985 and 2000 the incidence of cervical cancer was almost halved from 15 new cases per 100,000 women to 8. By 2005, cervical cancers dropped from the fourth most common cancer in females (1972) to the fourteenth most common. (25).

This outcome is likely to have been assisted by national cervical screening programs introduced in the early 1990s, as up to 90% of cases can be prevented if cell changes are detected and treated early.

In 2000 to 2004 the rate of screening was the highest in the North Coast Area Health Service (at 63.2%) and the lowest in the Sydney South West Area Health Service (at 52.6%). In the 2003-2004 Statistical Screening Report (2007), Liverpool was the lowest at 52.5% after Campbelltown in Sydney South West Area Health.

2003-2004 Screening Rates:						
Biennial Cervical screening rates (%) by Age- AHS and LGA in NSW						
SOUTH WESTERN SYDNEY AREA HEALTH SERVICE						
LGA	20-49	(%)	50-69	(%)	20-69	(%)
Bankstown	18,783	53.8 (53.2 – 54.3)	6,333	56.6 (55.7 – 57.5)	25,116	54.5 (54.0 – 54.9)
Camden	6,427	60.0 (59.1 – 61.0)	1,598	61.1 (59.2 – 62.9)	8,025	60.2 (59.4 – 61.1)
Campbelltown	16,472	50.9 (50.3 – 51.4)	4,469	50.6 (49.6 – 51.6)	20,941	50.8 (50.3 – 51.3)
Fairfield	21,625	53.9 (53.4 – 54.3)	6,826	57.6 (56.7 – 58.5)	28,451	54.7 (54.3 – 55.1)
Liverpool	19,257	52.4 (51.9 – 52.9)	4,692	52.7 (51.6 – 53.7)	23,949	52.5 (52.0 – 52.9)
Wingecarribee	4,700	62.7 (61.6 – 63.8)	2,267	63.1 (61.5 – 64.7)	6,967	62.8 (61.9 – 63.7)
Wollondilly	4,592	57.1 (56.1 – 58.2)	1,283	52.2 (50.2 – 54.1)	5,875	56.0 (55.0 – 56.9)

Table 10: Taken from: NSW Cancer Institute Aug 2007 *Annual Statistical Report 2004 NSW Cervical Screening Program*

The NSW 2006 Health Survey showed that there was a 69.7% screening rate of women aged 20-69 years in SSWAHS as against the state average of 72.8% across the State. This screening rate is lower in some groups of women within the area.

Breast Screening

SSWAHS has one of the lowest rates (74%) in the state which averages 76.2%. (NSW Health Survey 2006)

Social Isolation/ Social Capital/ Safety

The NSW Health Survey, 2006 showed a high level of isolation of women in this area, and fear for safety in their community. Those women who had attended a community event in the last 6 months were 57.9% as against 63.6% across NSW. Only 31.9% had helped out in some community organisation in the last 3 months, as against 37.7% across NSW. 35.7% of women were active members of a club or some organisation as against 41.9% in NSW.

Women in SSWAHS had the lowest rating in the state for the question that “most people can be trusted- 64% in contrast to 72.7% in the State. They also had the least sense of safety walking down the street after dark across the State, with only 50% of SSWAHS in contrast with 58% in the State. 59.7% of Sydney South West women saw their area as having a reputation for being safe. This contrasted with 74.9% across NSW, and the next lowest was Sydney West with 69.3%. Finally, they also ranked lowest in the State for visiting neighbours, with 62.8% in SSWAHS as against 66.9% in NSW. They were also less likely to run into friends/acquaintances in the local area with 78.6 women who did, as against the state average of 83.2%. Males rated much higher on their sense of safety and connections in the community.

Violence Against Women

The best indicators available to date about the levels of violence against women in Australia are from the 1996 ABS Women's Safety Survey (26) and the more recent ABS Personal Safety Survey 2006 (27) that surveyed both men and women and the International Violence Against Women Survey 2004 (28) which included an Australian component involving 6000 Australian women.

The surveys asked women about their experiences of violence and found that:

- 5.8 per cent of women had experienced violence in the 12 month period preceding the survey in 2005 compared with 7.1 per cent in 1996
- 4.7 per cent of these women had experienced physical violence (this includes physical assault and threat of physical assault) in 2005 compared with 5.9 per cent in 1996, and 1.6 per cent had experienced sexual violence (this includes sexual assault and threat of sexual assault) compared to 1.5 per cent in 1996
- Of the women who experienced sexual violence during the 12 months prior to the 2005 survey 21 per cent had experienced sexual assault by a previous partner in the most recent incident, and 39 per cent by a family member or friend
- The 2005 survey also showed that of those women who were physically assaulted in the 12 months prior to the survey, 38 per cent were physically assaulted by their male current or previous partner. Of the women who had experienced violence by a current partner, 10 per cent had a violence order issued against their current partner and of those women who had violence orders issued, 20 per cent reported that violence still occurred.
- The Australian component of the IVAWS found that of women who had ever had an intimate partner, 34% reported experiencing at least one form of violence from a current or former partner. (28)

A study by the AIC in 2002, *Homicides Resulting from Domestic Altercations* (29) found that the majority of female homicide victims were killed during domestic altercations.

In a follow up AIC study, [Family Homicide in Australia](#), (30) Jenny Mouzos and Catherine Rushforth analysed the victim-offender relationships for almost 4500 homicides that occurred in Australia over a 13 year period from 1989 to 2002. The study found that:

- on average there were 129 family homicides each year, 77 related to domestic disputes
- that killings between partners/spouses accounted for 60 per cent of all family homicides in Australia, with women accounting for 75 per cent of the victims, and men comprising the majority of the killers
- that a quarter of the intimate homicides occurred after the partners had separated or divorced.

The 1996 ABS Women's Safety Survey also found that younger women were more at risk of violence than older women: in the previous 12 month period, 38 per cent of women aged 18–24 had experienced an incident of violence, compared to 15 per cent for women aged 45 and over. In the 2005 Personal Safety Survey this gap seemed to have narrowed—though the percentage of younger women experiencing violence had gone down, the percentage of older

women had gone up (26 per cent of women aged 18–24 had experienced an incident of violence, compared to 25 per cent for women aged 45 and over).

According to NSW Bureau of Crime Statistics Apprehend Violence Orders (AVOs) issued through the Fairfield Liverpool Local Courts has slightly dropped from 1106 (311.1 per 100,000) in 2004 to 1032 (286.6 per 100,000) in 2006. The NSW rate is 289 per 100,000 however the Fairfield Liverpool rate is third highest for Sydney courts preceded by Outer South Western Sydney and Blacktown. (31)

Sexual Violence

The 2006 Personal Safety Survey showed:

- Women in Australia still experience high rates of sexual violence.
- Since the age of 15, 32.5% of women have experienced inappropriate comments about their body or sex life, compared to 11.7% of men. 25.1% of women experienced unwanted sexual touching compared to 9.9% of men.
- Since the age of 15, people were more likely to have experienced violence from a previous partner than from a current partner.
- There was a small decrease in the overall incidence of sexual violence over the 12 months preceding the 1996 and 2006 surveys, but an increase over the course of women's life times.

The following statistics report recorded sexual offences, of which the major percentage would be females, in the Liverpool LGA, over the period 2002-2006.

Liverpool Local Government Area Sexual offences					
	2002	2003	2004	2005	2006
Sexual assault	81	127	87	90	94
Indecent assault, act of indecency	88	99	102	72	57
Other sexual offences	21	37	29	37	37

Table 11: From: NSW Bureau of Crime Statistics (NSW Recorded Crime Statistics 2002 – 2006) (32)

However, it must be noted that few women report sexual violence to police. Statistics show that in 2005, 19% of women who experienced sexual violence by a male perpetrator reported the incident to police (33).

Problem Gambling

The majority of known problem gamblers are men, but the number of women who are known to be problem gamblers are escalating;

- Males and females have different preferences for the type of gambling in which they participate.
- In general, males prefer to bet on sporting events and games of skill while women prefer to bet on games of chance such as lottery tickets and electronic gaming machines;

- Females report boredom and loneliness as their primary reasons for gambling while males report non-emotional motivators or positive emotional motivators such as excitement as their primary reasons for gambling;
- Problem gambling is often frequently found in individuals from a lower socio-economic spectrum including the unemployed and retired people;
- Problem gamblers have been known to turn to illegal activities, particularly white collar crime, to alleviate their gambling-related financial burdens;
- Problem gambling is associated with marital disruption, family breakdown, and domestic violence;
- It has been suggested that historically females who experienced gambling-related problems may not have reported such problems because of the stigma associated with it (American Psychiatric Association 1995; Volberg 1994).

(Productivity Commission Inquiry into Australia's Gambling Industries-AMA Submission)

During the twelve months- July 2006-June 2007 there were 15 women from Liverpool, who attended for problem gambling counselling at Sydney Women's Counselling Centre, Campsie. *(Sydney Women's Counselling Centre Statistical report 2007)*

HIV/AIDS and Hepatitis C

- All diagnosed cases of HIV in NSW must be reported to the NSW Department of Health. In 2003, 10% of all notified diagnoses of HIV were women. (34)
- In 2004, HIV prevalence among women in heterosexual relationships and female sex workers remained below 1%. (35)
- A third (33%) of HIV-positive Aboriginal and Torres Strait Islander (ATSI) women acquired the virus during unsafe injecting drug use. This is to be compared to 10.8% of HIV-positive women in the non-Indigenous community. (35)
- Between 1995 and 2003 the percentage of females presenting to needle and syringe programmes with Hepatitis C infection decreased from 82% to 70%. Nationally 43% of people infected with Hepatitis C through injecting drugs were aged 20-24 years. (36)

Pregnancy trends in NSW (37)

- In 2004, 85,626 births were recorded to 84,288 women in NSW.
- The number of teenage mothers is in slow decline, falling from 4.4% of all mothers in 2000 to 4% in 2004. During the same period, the proportion of births to women aged 35 years and over increased from 17.7% to 19%.
- About 28 per cent mothers in 2004 were born overseas, most commonly in the United Kingdom (2.6 per cent), New Zealand (2.4 per cent), Vietnam (2.0 per cent), and China (2.0 per cent).
- Between 2000 and 2004, the rate of normal vaginal birth fell from 67.1% to 62.1%. Over the same 5 years, the rate of caesarean birth rose from 21.3% to 27.2%. Caesarean delivery continues to be more common among privately insured mothers than those using the public system.
- In the period 1990–2003, 100 deaths were reported which were directly or indirectly associated with the pregnant state or childbirth.
- About one in 5 Aboriginal and Torres Strait Islander mothers were teenagers.
- Since 2000, the rates of low birth weight (less than 2,500 grams) and prematurity (less than 37 weeks gestation) in Aboriginal and Torres Strait Islander babies have been one and a half times to 2 times higher than the rates for NSW overall.

- In 2004 the peri natal mortality rate among babies born to Aboriginal and Torres Strait Islander mothers was 11.6 per 1,000, higher than the rate of 9.0 per 1,000 of babies born to non-Aboriginal or Torres Strait Islander.
- Births in mothers with the drug-related diagnoses (opioid, stimulant, cannabis) were more likely in women who were younger (particularly in the cannabis group), who were not married, who were Australian-born, and who were indigenous.

Population Groups With Higher Health Risks

Aboriginal and Torres Strait Islander Women

Violence Against ATSI Women

The rate of family violence victimisation for indigenous women may be 40 times the rate for non-indigenous women and that despite representing just over two per cent of the total Australian population, indigenous women accounted for 15 per cent of homicide victims in Australia in 2002–03. However, the survey goes on to state that the current literature on the incidence and prevalence of family violence for indigenous women is limited, making it difficult to draw accurate conclusions. (28)

Health and Life Expectancy

Life expectancy for Aboriginal women in NSW is 63.6 years. (38)

An Aboriginal person born today can expect to live approximately 20 years less than their non-Aboriginal counterparts.

The smoking rates for indigenous women are substantially higher than non-indigenous women. The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey revealed that in the age range of 18-54 around 50% of indigenous women are current daily smokers. This figure drops post-55; however this reflects the earlier mortality rates of indigenous women. (11)

In 2001-2002 in NSW:

- the rate of hospitalisation attributable to alcohol was over three times higher in indigenous people compared to non-indigenous people;
- the current rate of involvement of indigenous people in drug and alcohol treatment is over three times more likely than for the non-indigenous population. (39)
- Based on BMI, 28% of indigenous females aged 18 or more could be classified as obese. This compares unfavourably with 19% of all females aged 18 or more. (40)

Incarceration of ATSI Women

-The level of, and growth in, the number of Aboriginal women in custody remains of grave concern. Considering that Aboriginal women represent about one percent of the NSW population, they are grossly over-represented in the NSW corrective services system. Between 1994 and 1999, the number of Aboriginal women in fulltime custody rose from 18.4 percent to 23.2 percent of the total female inmate population. (41)

Women from Culturally and Linguistically Diverse Groups

CALD women share the double disadvantage of cultural diversity and gender that can result in their needs and issues either not being adequately recognised or not addressed.

Some key issues for CALD women:

Violent Relationships

There may be social, cultural and community pressures on women to remain in violent relationships. Many factors actually prevent these women from taking action.

For instance, a history of oppression, racism, entrenched poverty, lack of awareness of the laws relating to violence against women and concerns of further disadvantage. Evidently, such multi-causal factors also consistently impact upon their ability to access both the law and support services and may underlie the higher rates of violence, especially within specific communities. (33,42)

Health Issues (43)

Mortality rates among migrants from the United Kingdom and Ireland are closest to the rates for Australian-born people. In comparison, migrants from Asia have much lower standardised mortality ratios, with mortality rates 35% lower among males and 20% lower among females than their Australian-born counterparts. This is dependent on length of time in Australia.

All migrant groups have lower levels of *cardiovascular mortality* compared with the Australian-born population.

Australian-born persons have a higher prevalence of *overweight and obesity* than their overseas-born counterparts, this being an important risk factor for the development of a number of health problems including cardiovascular disease (AIHW: O'Brien & Webbie 2003).

Persons born in Southern and Eastern Europe, Asia, North Africa and the Middle East report lower levels of *physical activity*. (ABS 2002b).

Death rates from *lung cancer* for both males and females born in the United Kingdom and Ireland, and for males born in Other Europe, were higher than for their Australian-born counterparts.

Females born in the United Kingdom and Ireland had higher death rates for *breast cancer*.

Cervical cancer mortality rates among women born in Asia and Other countries were higher than among Australian-born women generally. Hospitalisation for cancer of the cervix among females born in Asia and Other countries is higher than for Australian-born females. Women born in these regions also report lower rates of regular Pap smear testing (ABS 2002b).

Mortality rates for *diabetes* are higher for those born in Other Europe, Asia and Other countries relative to the Australian-born population. Proportionally more overseas-born people than Australian-born also report having diabetes; approximately 35% of people of all ages who reported having diabetes in 2001 were born overseas, whereas they comprise 23% of the population (AIHW: Holdenson et al. 2003). In particular, diabetes incidence, hospitalisation and mortality are more common among people born in the South Pacific Islands, Southern Europe, the Middle East and North Africa, and Southern Asia.

Hospitalisation rates for *tuberculosis* and *cataract removal* are higher for females born in Asia and Other countries than for Australian-born females.

Hospitalisation for *gastritis and duodenitis* among persons born in Other Europe, Asia and Other countries, as well as for calculus of the kidney and ureter among persons born in Other Europe and Other countries was higher than for Australian-born persons—these diseases may reflect specific dietary patterns. On the other hand, persons born overseas were less likely to be hospitalised for a number of *mental disorders*, such as schizophrenia, depressive episodes and sleep disorders.

Another notable difference was for *skin cancer*, where the hospitalisation rate for the overseas-born population was less than half that of the Australian-born. In particular, Asian-born males and females had less than one-tenth of the skin cancer hospitalisation rate of their

Australian-born counterparts.

Refugee Women

The south west of SSWAHS has historically been a preferred area of settlement for both migrants and refugees arriving in NSW (Community Relations Commission for a Multicultural NSW, 2006).

According to the Department of Immigration Multicultural and Indigenous Affairs (DIMIA) between January 1999 and October 2004, over 50,000 new arrivals settled in SSW. Of these, approximately 19% (over 9,000) were humanitarian arrivals, or refugees.

Refugees have a range of health issues, including presence of vaccine preventable diseases, poor oral health, poor nutrition, delayed development, sexual health issues, experiences of trauma or torture, poor mental health, potential for alcohol and drug dependence and difficulties in understanding and accessing the complex health system in NSW and Australia. (44)

Lesbians (45, 46, 47)

The 2006 Census indicates that 0.2% of NSW females are co-habiting in a same sex relationship. This figure is considered quite an under-estimate due to both under reporting and it only accounts for those in a co-habiting de facto relationship. The figure is growing with each Census.

Health inequalities continue to exist for lesbian, bisexual and same sex attracted women (LBSSAW), largely related to experiences of discrimination (insurance legislation), homophobia and heterosexism (assumption leading to invisibility of LBSSAW). These issues can lead to avoidance of routine healthcare and screening and reduced disclosure of sexual orientation within consultations.

“Fundamentally, lesbians need access to the same high quality health screening and preventive care that is appropriate for all women throughout the life cycle. Lesbians and their providers often remain uninformed about important health issues, including the need for: cervical and breast cancer screening, reducing the risk of sexually transmitted diseases and HIV; caring for mental health issues including depression; diagnosing and treating substance abuse; pregnancy and parenting assistance; and understanding domestic/intimate violence.

Extract from: ‘*Lesbian Health Fact Sheet: Health Status and Health Risks of Lesbians*’, November 2000.

Lesbians were less likely to have had a *sexual health check –up* than their male counterparts.

Younger lesbians are significantly more likely to report *problematic alcohol use* than heterosexual women and young gay men respectively. (46)

However, while less is known about alcohol misuse among lesbians aged 30 years and over, it is probable that problematic use of alcohol extends beyond young age due to a range of associated factors being experienced by many lesbians across age groups including sexuality confusion, social isolation, stress and low self esteem.

GLBT populations experience a higher rate of *mental health symptoms* and diagnoses as well as a generally poorer state of mental health than the general population. Depression and

anxiety rated very highly whilst ‘other psychological problems’ rated relatively lowly in comparison.⁵⁵ Research showed a widespread prevalence of depression and suicidal ideation (thoughts) amongst participants.

Women with Disabilities (48)

NSW Health Survey 2006 indicates that there is a higher than the state average of people living with a disability 44 years and younger residing in the Liverpool area.

Women with disabilities are more likely to be institutionalised, less likely to own their own home, less likely to be employed and less likely to receive appropriate services than men with similar disabilities or women without a disability.

Women with a disability are 2 to 12 times more likely to experience *violence* than their peers without a disability and about 50 per cent of women with a disability will be sexually assaulted in their lifetime.

In 1998, an estimated 19 per cent (606,500 people) of women in NSW had a disability, which is equivalent to the overall Australian rate. This was an increase from 15 per cent in 1988.

More than 50 per cent of people with disabilities are women. The number of older women with a disability living in accommodation where care was provided was more than double the number of older men, 42,300 women compared with 17,600 men. Over 50 per cent of women with disabilities in Australia live on less than \$200 per week.

Men with disabilities are almost twice as likely to have jobs as women with disabilities.

Women with disabilities pay the highest level of their gross income on housing, yet are in the lowest income earning bracket. Some women with disabilities pay almost 50 per cent of their gross income on housing and housing related costs.

In 1998, 92 per cent of people with a disability in NSW lived in private dwellings. 41 87 per cent of people with a disability living in households received care from informal sources.

85 per cent of the total disabilities in NSW were caused by physical conditions and mental and behavioural disorders accounted for the remaining 15 per cent.

Women in/ from Prison (41)

The female inmate population has increased by 101% between 1994 and 2004, in comparison to a 40% increase in the male prison population.

Despite representing only a small proportion of the overall imprisoned population, women experience higher levels of *substance abuse* and drug related offending than males; higher rates of *infection with blood borne viruses*; higher rates of *mental illness* and *self harm*; and higher reported rates of past *childhood and adulthood abuse*. Women also face unique needs in the area of motherhood, often being the *primary carers* for their children. There is a general consensus that the needs of women in the criminal justice system are different from, greater than, and more complex than those of men.

Co-occurring disorders, or dual diagnoses, have come to be recognised as a significant issue for correctional systems as the prevalence of *mental disorders* has been found to be higher in the prison population than the general population. This is especially so for women offenders.

In a paper *Increase in Prisoner Population: Interim Report: Issues Relating to Women*, the NSW Legislative Council Select Committee on the Increase in the Prisoner Population found that *“The demographic information on female inmates overwhelmingly reveals backgrounds of serious economic and social disadvantage, mental health problems, violence and abuse and chronic drug and/or alcohol abuse.”*

In addition it found

- that many women are the primary carers of children before incarceration;
- indigenous women are significantly over represented in the prison population;
- many are victims of sexual abuse;
- there are a high proportion of ex-state wards
- The increase in women prisoners combined with the complex needs and vulnerability of many mean that specific consideration should be given to the housing and support needs of women exiting prisons, including women with children.

Women as Carers (49)

In 2000 an estimated 1,994,400 persons aged 18 years or over provided care for another adult or child, representing 42% of all persons aged 18 years and over in NSW. Of these 84% provided care on an ongoing or continual basis.

A higher proportion of women provided care (46%) than men (37%).

Half of all carers (996,200) were employees in paid employment. Women were more likely to use work arrangements (48%) than men (33%) in order to meet their caring responsibilities. For women these arrangements included part time work, paid leave or an informal arrangement with an employer, while men were more likely to use paid leave, an informal arrangement or rostered days off.

A higher proportion of women than men in the government and public service sector wanted to make more use of working arrangements (18% compared to 11%).

Almost 800,000 people in NSW provided care to a person, usually a family member, who was ageing or had a disability, representing 13% of the population.

Of this group 162,200 (20%) were primary carers, that is, they provide more assistance than anyone else, on an ongoing basis, to the person receiving care. (50)

Almost 72% of primary carers are women. (51)

Carers tend to have lower incomes than the rest of the population. 71% of primary carers receive a pension or allowance. (50)

In 1999, in NSW from a total of 1 056 300 children, 49.3% were in some form of formal or informal child care.65 Of this group, 22.6% used formal care and 26.7% used informal.

Young women

Persons between 12- 24 are considered to be young people for statistical purposes.

The major health issues among young women in NSW in 2003 were *anxiety* (affecting 14% of young women), *depression* (11%) and *attempted suicide, eating disorders, tobacco use and reproductive and sexual health*. (52)

Young women were more likely to report 'high' to 'very high' levels of *psychological distress* than young men with the 'very high' rate almost tripling from 1.9% in 1997 to 5.4% in 2001 amongst young women. The highest levels of distress were found amongst those whose highest education was Year 9, and lowest among those who had completed Year 12. (52)

In 2002/03, women accounted for 69.5% of all hospitalisations for *attempted suicide* amongst the 15-24 years age group.(6)

Depressive episodes and *eating disorders* (mainly anorexia nervosa) showed the highest hospitalisation rates amongst girls and young women aged 12-24 years accounting for 17% and 16% respectively. While the prevalence of anorexia nervosa and bulimia nervosa in Australia is relatively low, disordered eating, restrained eating, binge eating, fear of fatness, purging and distortion of body image are common among young people.(53)

Notifications of Chlamydia, one of the most common sexually transmitted diseases amongst young people, have tripled between 1991 and 2001. Young women account for 69% of Chlamydia notifications.(54)

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Suggested Actions

The following are suggested actions to take developed from an analysis of the needs assessment results. They are intended as a guide for Centre planning.

- Centre continue its focus on all forms of *violence against women* both at a prevention and intervention level and with a range of affected groups:
 - Continue WEEO WISER peer education project with further funding and investigate development of strategies for working with specific communities
 - Assisting with WDVCS
 - Providing advocacy for women in DV seeking information and assistance
 - Group work e.g. DV support groups, groups for adult survivors of child sexual assault
 - Community action and lobbying
 - Participating in relevant productive partnerships which further a feminist response eg. With JHSSW
 - Focusing on efforts to improve the perception and reality of public safety in the Liverpool LGA
 - Investigating violence prevention projects with an emphasis on young women with a disability.

- Continue to build connections with the *Arabic speaking community* through conducting language specific projects and groups

- Rebuild relationship with local *lesbian* women through undertaking specific projects and groups and working in partnership with other providers e.g. ACON.

- Given the youthful population in Liverpool to look at continuing to investigate and undertake work with *young women* in a proactive way for example:
 - conducting education programs in schools including sex education, puberty, managing body and life changes through adolescence.
 - investigate practicalities of offering *open days for school girls* – with classes doing Centre visits.

- Continue to provide a core emphasis on improving the health of *Aboriginal women* both through health promotion, community development, service interventions, working in partnerships, lobbying and funded projects
 - increase use of Centre's Aboriginal Women's Healing Space and also outreach to the community.
 - investigate ways of working in partnership with NSW *Aboriginal midwifery* project.

- Use all sorts of *creative arts* as a way of building dialogue about women's experiences especially as a method of engaging with women from *new and emerging communities* and to continue the Centre's work building relationships with newly settling communities.

- *Publicity*
 - Centre brochure to be translated into Chinese and distributed to Chinese organisations.
 - Translations of Centre's brochure to be updated with a priority on Arabic and Serbian
 - Centre improve it's advertising by:

-placing advertisements in school newsletters, in areas where there is low client representation.

-doing a mailout of updated Centre brochure

-promoting the Centre's websites

- LWHC continue its role in *advocating for social change* that challenges patriarchy and improves women's status in society as well as focusing on change that is about specific groups of women who experience discrimination e.g. Aboriginal women.
- Centre undertake work that aims to build social connections between *isolated women* e.g. open-ended groups, coffee mornings, walking groups, monthly lunches etc.
- Conduct groups and provide counselling which aim to provide skills for *managing depression and building emotional wellbeing*.
- Centre foster *access to women friendly counselling* through the Medicare funded schemes and investigate appropriate after hours private counselling at LWHC.
- Continue to provide a key emphasis on conducting *groups and education workshops*. They are both underpinned by our feminist philosophy and are the most requested service by survey respondents. Such groups are to focus on key topics identified by women including but not limited to:
 - healthy eating/ nutrition/ healthy weight.
 - self esteem and confidence building
 - meditation/ relaxation/ yoga and like activities
 - managing arthritis

Such groups should be underpinned by a clear *feminist gender based philosophy* and also reflect our *holistic approach* and draw on both complementary/ alternative medicines as well as a more traditional approach.

- Run a range of *groups in community languages* for example by using BCEs or interpreters with a focus on *refugee women from newly emerging communities* eg. Iraq and Sudan.
- Maintain a watching brief on the demographics and needs of *newly arrived refugee women* by working in partnership with Refugee Health.
- Build women's access to *physical activities* by undertaking a physical activity project which aims to overcome some of the barriers women face in doing exercise.
 - Investigate doing a directory of women/ girl friendly gyms and sports activities.
 - Organise walking clubs to provide physical activity and and build social connections.
 - Organise *learn to swim* classes for women which address some of the barriers to learning to swim.
 - Centre consider *sponsoring a women's/ girls sports* team in a less traditional sports area.
- Investigate ways of increasing *access to massage* through the use of students.

- Investigate conducting *outreach women's health clinics* in targeted parts of Liverpool LGA and liaise with Liverpool Council about permanent outreach opportunities in Liverpool's outlying areas.
- Investigate creating a relationship between Sydney Women's Counselling Centre *Gambling Project* and the Lao community and possible partnership with SWCC Counsellor for on-site *gambling counselling*.
- organise *financial management* workshops including managing credit in partnership with a suitable financial counsellor.
- Investigate strategies for supporting *women who are affected by breast cancer* e.g. YWCA Encore program.
- Distribute information on recognizing early signs of *heart attack*
- Run *quit smoking classes* for women with a gender perspective that target more marginalized groups.
- Continue *recruitment for doctors* and building access to other Medicare funded services such as *dental*.
- Conduct *breast screening and cervical screening recruitment* programs with identified underscreened groups.
- Continue to conduct *diabetes* education
- Investigate offering *routine chlamydia testing* to young women together with regular Pap smears.
- Undertake programs aimed at supporting *women exiting prison* and supporting *women whose family members are in prison*

Conclusion

The services currently provided by Liverpool Women's Health Centre are highly valued by clients and are tailored to the needs of women in Liverpool. The services provided by the Centre were rated by most Centre users as Excellent and the remainder rated them as Good. From the comments at the end of the Survey it was clear that the Centre plays an important role in the lives of many women.

From the survey, violence stood out as the main concern for women, followed to a lesser extent by finances, inequality and unemployment. More than a third of respondents listed depression and emotional wellbeing as a health issue for women in Liverpool. This was followed by cancer and being overweight.

Both those who were aware of the Centre and those with little or no knowledge of the Centre made suggestions for new services and groups in line with existing service provision. Groups were a high priority followed by counseling and mental health support. The most requested type of group or workshop related broadly to nutrition.

Generally the findings suggest, a number of potential targeted programs, in terms of age, cultural diversity and sexuality. In addition, there are strong opportunities to continue to work in conjunction with other local services especially women's services.

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Appendices

- 1. Needs Assessment Survey**
- 2. Focus Group Discussion Questions**

