

WOMEN'S HEALTH PROFILE & NEEDS ANALYSIS

OCTOBER 2010-2013

LIVERPOOL WOMEN'S HEALTH CENTRE

A guide to planning for services to women in the Liverpool LGA

The Liverpool Women's Health Centre has a strong commitment to providing high quality services to the women of Liverpool LGA. Planning is central to this commitment and good planning relies on relevant, accurate, up to date information.

This document draws on a range of key strategic plans national, state-wide and local. Most importantly this document records the voices of local women- women from the community and women service providers.

I wish to thank Kristen Dawson and Margaret Hickie for their work in developing what is a comprehensive and informative document that will guide the work of the Centre over the next 3 year period.

Betty Green

Manager

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WOMEN'S HEALTH ISSUES -2010

INTRODUCTION

This document outlines the major health issues identified for women in Australia, and then specifically for women in the Liverpool LGA. The document refers to the demographic and epidemiological information related to Liverpool, to National, State and Area Health policies and plans, local Government plans, statistical data and research. This information will be used to guide Liverpool Women's Health Centre in setting its key priorities and directions for the next three years, and to ensure that the proposed principles¹ of the new National Women's Health Policy guide this direction. These principles include: i. Gender Equity; ii. Health equity between women; iii. A focus on prevention; iv Evidenced based and v. Using a life course approach in addressing the needs of women and the social determinants of health in the Liverpool LGA. The following overview of Australian women's health is taken from the discussion paper in preparation for the development of a national women's health plan.

OVERVIEW OF AUSTRALIAN WOMEN'S HEALTH²

Life expectancy for Australian women is increasing and now ranks equal second in the world.³ However, there are worrying levels of risk factors causing chronic illness, injury and premature death, including:

- overweight and obesity – nearly half of Australian women are overweight or obese, with younger women gaining weight at a much higher rate than previous generations;⁴
- physical inactivity – about one third of women do not exercise;⁵
- poor diet – over consumption of high fat and sugar foods and inadequate intake of fruit (40% of women) and vegetables (80% of women);⁶
- stress – compensation claims for workplace stress almost doubled between 1996 and 2004);⁷and
- smoking, alcohol consumption, unprotected sex, and self harm in young women.⁸

In addition, much of the gain in women's life expectancy is being spent with disability (including significant levels of severe limitation) and disease, illness or hereditary conditions were the leading causes of female disability in 2003.⁹

¹ [Developing a women's health policy.pdf](#)

² [Developing a women's health policy.pdf](#)

³ WHO 2007. WHO statistical information system. Life tables for WHO member states. Geneva: WHO

⁴ ABS 2006. National Health Survey: Summary of Results 2004-05 Cat. No. 4364. Canberra: ABS. and, Adamson L. Brown W. Byles J. 2007. Women's weight: Findings from the ALSWH.

⁵ ABS 2006. National Health Survey: Summary of Results 2004-05 op. cit.

⁶ *ibid.*

⁷ Australian Safety and Compensation Council 2007, Compendium of Workers' Compensation Statistics Australia 2004-05.

⁸ Australian Institute of Health and Welfare (AIHW), 2008, Australia's Health 2008 Cat. no AUS 99 Canberra AIHW./ ALSWH 2008. Use and costs of medications and other health care resources. Department of Health and Ageing./ AIHW 2007 Young Australians: their health and wellbeing 2007 AIHW cat. no. PHE 87

⁹ AIHW 2006. Life expectancy and disability in Australia 1988 to 2003. Cat. No. DIS 47. Canberra: AIHW.

The top five causes of death for Australian females are:¹⁰

- ***Ischaemic (coronary) heart disease – a form of cardiovascular disease;***
- ***Stroke;***
- ***Dementia and Alzheimer's disease;***
- ***Trachea and lung cancer;***
- ***Breast cancer.***

Changes in the leading causes of death with increasing age reflect the ageing process and longer exposure to risk factors. For girls and young women, injury and poisoning are the major causes of death. Among women aged 25 to 64, cancer is the leading cause of death and for women aged 65 and over, cardiovascular disease is the leading cause.¹¹

In 2003, **the leading contributors to the burden of disease** (years of "healthy life" lost due to disease or injury) for females were:¹²

- ***Anxiety and depression (10 per cent);***
- ***Ischaemic (coronary) heart disease (8.9 per cent);***
- ***Stroke (5.1 per cent);***
- ***Type 2 diabetes (4.9 per cent);***
- ***Dementia (4.8 per cent).***

Asthma is the leading contributor to burden of disease for the 0–14 age group, anxiety and depression in the 15–44 age group, breast cancer in the 45–64 group, and ischaemic heart disease in the 65 and over group.¹³

The higher levels of risk factors and the poorer health status of groups, such as Aboriginal and Torres Strait Islander women, are discussed later in this document.

GUIDING RESOURCE DOCUMENTS

NATIONAL WOMEN'S HEALTH PLAN

A Women's Health Policy for Australia

The last National Women's Health Policy was released in 1989 and has determined priorities in service planning at both State and Local Levels for more than 20 years. The newly elected Federal Government (2007) resolved to develop a new National Women's Policy to be released in 2010 after a consultation period from 2008. Below are some excerpts from the plan for development, including the focus of the policy, an overview of women's health, gender related health issues, health issues for women from specific groups and the principles underlying the plan. [Developing a women's health policy.pdf](#)

¹⁰ ABS 2008. Causes of Death Australia 2006. ABS Cat. No. 3303.0. Canberra: ABS.

¹¹ Australian Institute of Health and Welfare. 2008. Australia's Health 2008. Cat. No. AUS 99 Canberra: AIHW.

¹² Begg S. Vos T. Barker B. Stevenson C. Stanley L. Lopez A.D. 2007. The Burden of Disease and Injury in Australia 2003.

¹³ *ibid.*

In line with international developments and the Government's social inclusion agenda, the National Women's Health Policy will emphasise prevention, health inequalities in our society, and the social determinants of those health inequalities. The women's policy will address the needs of:

- Aboriginal and Torres Strait Islander women;
- women in rural and remote areas;
- women from culturally and linguistically diverse backgrounds, including refugees; and
- women from disadvantaged backgrounds.

Gender as a determinant of health

The National Women's Health Plan, in accordance with the 2002 WHO Madrid Statement, will be based on a gendered approach to health. Examples are given of the gender differences in the leading causes of death and burden of disease in Australia for women in contrast to men.

Anxiety and depression is the first or second leading cause of burden of disease for females in the age groups spanning 0-64 years of age, more than double that of males in these groups. The most common claim on the Pharmaceutical Benefits Scheme for the youngest cohort (30-35 years is for antidepressants.)¹⁴

Other health issues that are more female than male related are Breast cancer¹⁵, Cardiovascular disease including stroke (women are 10 percent more likely to suffer from it than men)¹⁶, Dementia and Alzheimer's disease (fifth ranked contributor to the burden of disease in females, but does not appear in the top ten for males)¹⁷, and migraine – the second highest contributor to the burden of disease in the 15-44 age group but does not appear in the top 10 for males.¹⁸

Gender specific conditions – sexual and reproductive health

Conditions relating to women's sexual and reproductive health include:

Antenatal and postnatal depression¹⁹; Chlamydia- can lead to infertility and has almost tripled between 2000-2006;²⁰ Endometriosis,²¹ Gestational diabetes²²; menopause symptoms²³ and

¹⁴ ALSWH 2007 Use and costs of medications and other health care resources: Findings from the Australian Longitudinal Study on Women's Health Department of Health and Ageing

¹⁵ Begg et. al. 2007 op. cit.

¹⁶ AIHW 2008 Australia's Health 2008 op. cit.

¹⁷ Begg et. al. 2007 op. cit.

¹⁸ Begg et. al. 2007 op. cit.

¹⁹ www.beyondblue.org.au

²⁰ Carnie J Dr Chlamydia Forum http://www.health.vic.gov.au/vwhp/downloads/forum/john_carnie.pdf

²¹ jeanhailes.org.au

²² Di Cianni G. Volpe L. Lencioni C. Miccoli R. Cuccuru I. 2003. Prevalence and risk factors for gestational diabetes assessed by universal screening. Diabetes Research and Clinical Practice. 62:2

²³ <http://www.mayoclinic.com/health/belly-fat/WO00128>

Polycystic Ovary Syndrome with its increased risk of cardiovascular disease, diabetes and mental health issues²⁴.

Social Determinants of Health

Health inequities, "the avoidable inequalities in health between groups of people within countries and between countries",²⁵ are shaped by the social and economic conditions of people's lives. The AIHW has identified some of these as the broad features of society, eg culture, affluence, political and economic systems, and socioeconomic characteristics, eg education, employment and income.²⁶

Social Inclusion Agenda

The Australian Government is committed to reducing health inequalities by addressing the social exclusion of disadvantaged Australians – "the lack or denial of resources, rights, goods and services, and the inability to participate in the normal relationships and activities, available to the majority of people in a society, whether in economic, social, cultural or political arenas".²⁷

The new National Women's Health Policy will form part of the Government's social inclusion agenda²⁸ by addressing the health inequalities which exist between different groups of Australian women. Social exclusion is associated with high levels of risk behaviours, such as obesity and tobacco smoking, and much worse health outcomes, but good health enables women to be socially included and fully participate in community life.²⁹

NSW WOMEN'S HEALTH PLAN 2009-2011

"The Plan promotes actions to: advance health priorities for women in NSW; implement targeted early intervention and disease prevention services for disadvantaged population groups; and broaden the health system's understanding and appreciation of how gender and other social determinants of health influence the health needs of women. The Plan also aims to establish a baseline of information that will strengthen a future comprehensive review of NSW Women's Policy under the new national directions in women's health anticipated in 2010." [NSW Women's health Plan 2010.pdf](#) (p. 1-Policy Directive)³⁰

²⁴ Norman R.J. Wu R. Stankiewicz M.T. 2004. MJA Practice Essentials - Endocrinology 4: Polycystic ovary syndrome. Medical Journal of Australia, 180, 132-137.

Meyer C. McGrath B.P. Teede H.J. 2005. The effects of medical therapy on insulin resistance and the cardiovascular system in polycystic ovary syndrome. J Endocrinology & Metabolism, 90(10) 5711-6.

Coffey S. Mason H. 2003. The effect of polycystic ovary syndrome on health-related quality of life. Gynecology Endocrinology, 17, 379-386.

²⁵ World Health Organisation. 2008. Commission on the Social Determinant of Health, Key Concepts. Geneva: WHO.

²⁶ AIHW 2008 Australia's Health 2008 op. cit.

²⁷ Levitas R. Pantazis C. Fahmy E. Gordon D. Lloyd E. Patsios D. (2007) The multi dimensional analysis of social exclusion Bristol

²⁸ An Australian Social Inclusion Agenda 2007 ALP

http://labor.com.au/download/now/071122_social_inclusion.pdf

²⁹ Social Inclusion Unit, PM&C 2008 Social Inclusion – Origins, concepts and key themes

³⁰ [NSW Women's health Plan 2010.pdf](#)

The conceptual and evidence base for the Plan can be found in the **NSW Health and Equity Statement** and related NSW Health policies, including the **Strategic Framework to Advance the Health of Women** (2000), **NSW Gender Equity in Health** (2000) and **Women's Health Outcomes Framework** (2002). (p.1- Plan)³¹

The priorities established under the National and NSW Health Programs under the Public Health Outcomes Funding Agreement (PHOFA) programs continue to direct women's health strategies in NSW. They are: violence against women; reproductive health and sexuality; health of ageing women; women's emotional and mental health; health needs of women as carers; occupational health and safety; and the effects of sex role stereotyping.(page 6)³²

Priorities For Action- NSW Women's Health Plan 2009-2011

1. Improved health services for women, particularly those women with the poorest health status:
 - i. Women who experience violence
 - ii. Pregnant women
 - iii. Women with intellectual disability
 - iv. Migrant and refugee women
 - v. Women in rural, regional and remote areas
 - vi. Aboriginal Women
2. Build the health system's knowledge about gender and gender-based analysis
3. Measure and understand the achievements in women's health and the priorities for future action. (p.12-22)

SYDNEY SOUTH WEST AREA HEALTH PLANS

Community Health Strategic Plan 2007-2012

The Community Health vision is for "an integrated and coordinated primary and community health care system working in partnerships to promote the health and wellbeing of our community."³³

The following provides an overview of the structure of women's services in SSWAHS and the priorities and emerging issues identified in the strategic plan for women's health.

Women's Health Services (p.41)³⁴

Women's Health services across SSWAHS have recently been amalgamated into a single Area wide service. Work is currently underway to restructure these services, which have historically been provided through slightly different models of care. The role of Women's Health as a service has been to build on existing

The '**LOVEBITES**' and '**WEEO WISER**' programs recognize that **violence** is a significant risk factor for poor health for women, which is shaped by attitudes and social norms, gender inequalities and a wide variety of social factors. 'WEEO WISER' (Women Educating Each Other - Women in Safe and Equal Relationships) run by Liverpool Women's Health Centre is a gender sensitive approach to violence prevention for girls in Year 9. 'WEEO WISER' is a peer education program that involves a series of interactive workshops conducted by specially trained local young women from culturally and linguistically diverse (CALD) backgrounds and experienced local workers. (p.6 NSW Women's Health Plan 2009-2011)

³¹ [NSW Women's health Plan 2010.pdf](#)

³² [NSW Women's health Plan 2010.pdf](#)

³³ [CommunitHealthStrategicPlan.pdf](#)

³⁴ [CommunitHealthStrategicPlan.pdf](#)

intersectoral partnerships to improve women's health status, focussing on health issues which can be actioned by other services. Women's Health undertakes a range of policy, program, health promotion and community development work, as well as offering direct clinical services through women's health clinics.

Of the non-clinical services provided by Women's Health, much of the focus is on coordinating, facilitating and managing the implementation of women's health policy and programs to respond to women's health needs, and establishing collaborative partnerships (in particular through the Women's Health Forum) to improve women's health status. In addition, significant investment has been made in a range of community development projects. The Bilingual Community Educator (BCE) Program specifically targets women from new and emerging migrant/refugee communities to improve their access to information and skills relating to health as well as education and employment opportunities.

The clinical role of the Women's Health service centres on the provision of Well Women's Clinics, targeting women who experience social disadvantage or who do not access mainstream health services. The Clinics are conducted by the Women's Health Nurses (WHN's) on an ongoing basis, in partnership with key stakeholders. These services include Pap test screening, pelvic examinations, breast examinations, counselling and education/information programs for women about contraception, menopause, sexually transmissible infections, gynaecological health and related matters. Women's Health services provided by SSWAHS complement a wide range of services available through NGOs.

Current and Emerging Issues (p.42)³⁵

- o **Domestic violence** - Limited availability of services to respond to the needs of women experiencing domestic violence, abuse and/or trauma;
- o **Prevention** - Need to strengthen participation in community development and prevention activities. Screening rates need to be increased including breast and cervical cancer screening and STIs;
- o **Partnerships** - Need to strengthen current partnerships with other government and non-government agencies and to participate in joint planning and development initiatives to improve the service system;
- o **Counselling services** - Need for additional counselling services, including in languages other than English;
- o **Service access** - Need for "one stop shop" facilities where women can access multiple services/resources. These services should be supported by outreach services to access women in appropriate locations;
- o **Refugees** - Women who are refugees have unique health issues and needs. Refugee groups are changing, with each group having unique prior experiences and needs.

Identified Clinical Needs and Priorities(p.43)

Clinical priorities have been identified through an analysis of need and an understanding of the effectiveness of intervention outcome. The highest priority clinical services in Women's Health are outlined below:

Priority One:

- o Cervical screening;
- o Pelvic examinations;
- o Breast examinations;
- o Postnatal checks;

³⁵ [CommunitHealthStrategicPlan.pdf](#)

- o Advice/information about contraception, menopause, sexually transmitted infections, gynaecological health and wider health and wellbeing issues

A significant proportion of the Women's Health service involves non-clinical work including community development, health education and promotion, policy development, consultation and partnerships with General Practitioners, other health services and external agencies.

SSWAHS Aboriginal Health Plan 2010-2014

With the amalgamation of the area health services, SSWAHS now has over 10% of the State's Aboriginal population, and just over 2,200 reside in the Liverpool LGA. Therefore SSWAHS has developed a health plan to promote the health and well being of the Aboriginal population in the area. Good practice in the planning processes is identified on page 1 of the plan,³⁶ and can be summarised in the statement in the text box opposite.

The health status of Aboriginal women in SSWAHS as outlined in this document is described in the next section together with the facts taken from the document: *Developing a Women's Health Policy for Australia- Setting the Scene*.

The Framework principles for service provision are also described in the SSWAHS Aboriginal Health Plan 2010-2014 (p7) and are documented below:

The principles are:

Provision of services within a **holistic health** paradigm;

Demonstrating **relationships** between SSWAHS clinical services and with the services provided by other public funded human service agencies that are consistent with an **integrated response** to holistic health principles;

Demonstrating **partnerships** with Aboriginal communities that reflect both involvement in the development of programs that reflect the **communities' views** of priority areas of need; and an intent to **empower communities** to increase their capacity to address health issues;

Providing services that are **complementary, supportive and non-duplicative** of services best provided through Aboriginal Medical Services.

These principles serve as a guide for Liverpool Women's Health Centre in the provision of services to Aboriginal women in the community.

HEALTH ISSUES OF WOMEN FROM POORER STATUS GROUPS

Health inequalities between groups of Australian women
Major inequalities in the health status of Australian women exist in relation to the groups of women outlined below. There is a degree of overlap between these groups as, for

Of necessity, the planning process needed to be comprehensive, complex and responsive to community need. Importantly it needed to be grounded in values and principles that are shared with the Aboriginal communities of SSWAHS and that recognise that joint action across services and within communities would be necessary to bring about improvements in health. (p.2)

³⁶ [2010-14 Aboriginal HP Summary & Strategies Overview.pdf](#)

example, socioeconomic disadvantage plays a significant role in the health status of all of the groups. The information about these specific groups are taken from the document: *Developing a Women's Health Policy for Australia- Setting the Scene*.³⁷(pages 7-9). It is acknowledged that women from rural, regional and remote areas also suffer disadvantage, but this group will not be considered in this document as the Centre does not provide services to this group.

Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women experience poorer health across almost all health areas compared to non-Indigenous women and life expectancy is 17 years less than for non-Indigenous women.³⁸ For example, Indigenous women have:

- higher rates of mental health conditions, and hospitalisation and mortality for those conditions;^{39, 40}
- hospitalisation as the victims of assault at a rate 33 times higher;⁴¹
- a higher proportion of deaths due to disadvantage, particularly for circulatory diseases, diabetes and kidney diseases;^{42 43 44} and more than four times the death rate for this cancer;⁴⁵ and
- higher rates of Chlamydia and hepatitis C in young Indigenous women.⁴⁶

High body mass and tobacco smoking are the most important risk factors contributing to the burden of disease in Aboriginal and Torres Strait Islander women.⁴⁷ In 2004–05, 34 per cent of Aboriginal and Torres Strait Islander women were obese, double the rate of non-Indigenous women, and 49 per cent were current daily smokers, more than twice the rate of non-Indigenous women.⁴⁸

In addition, over half of Indigenous women reported their level of physical activity as "sedentary" compared to a third of non-Indigenous women.⁴⁹ While Indigenous status is not collected for cervical screening, it is known that Aboriginal and Torres Strait Islander women access breast cancer screening (BreastScreen Australia) less than non-Indigenous women.⁵⁰

³⁷ [Developing a women's health policy.pdf](#)

³⁸ ABS 2007. Deaths Australia 2006. Cat. No. 3302.0 ABS: Canberra.

³⁹ AIHW, 2008, The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Population

⁴⁰ Australian Health Ministers' Advisory Council 2006. Aboriginal and Torres Strait Islander Health Performance Framework Report 2006. Canberra:AHMAC.

⁴¹ ABS, AIHW 2008. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander Peoples AIHW cat. no. IHW 21; ABS cat. no. 4704.0

⁴² Australian Health Ministers' Advisory Council 2006 op. cit.

⁴³ Australia's Health 2008. op. cit.

⁴⁴ AIHW 2008. Cervical screening in Australia 2005-2006. Cancer series no. 41 Cat. No. CAN 36. Canberra AIHW.

⁴⁵ ABS, AIHW 2008. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People. op. cit.

⁴⁶ ABS, AIHW 2008. The Health and Welfare of Australia's Aboriginal and Torres Strait Islander People. op. cit.

⁴⁷ Vos T. Barker B. Stanley L. Lopez AD. 2007. The Burden of Disease and Injury in Aboriginal and Torres Strait Islander Peoples 2003, University of Queensland.

⁴⁸ ABS, 2006, National Aboriginal and Torres Strait Islander Health Survey 2004–05, ABS Cat. No. 4715.0.

⁴⁹ *ibid.*

⁵⁰ Australia's Health 2008. p476 op. cit.

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009, may be an appropriate tool to guide the development of culturally relevant, gender based policies and service delivery, and thus contribute to improved health outcomes for Aboriginal and Torres Strait Islander women. Other frameworks could be developed to assist in addressing the specific needs of women from culturally and linguistically diverse backgrounds.

AHMAC (2004) The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 Dept of Health SA

Aboriginal and Torres Strait women experience poorer health across all health areas compared with non-Indigenous women [1]. There is the potential for significant health gains for Indigenous women through improved prevention, early detection and treatment to address the higher level of risk factors and the burden of disease with earlier onset and lower survival rates. Addressing their health needs will be included in a new national women's health policy, which is in the process of being developed. It takes into account that women have many responsibilities as mothers, grandmothers, sisters, daughters, wives and partners. Often it is the women in households who have the main responsibility for looking after the health of other family members. Many Indigenous women suffer health problems due to the context of their lives. To ensure better health outcomes, strategies need to include knowledge and awareness of their history, experience, culture and rights.

[womens health review may 2010.pdf](#)

The SSWAHS Aboriginal Health Plan 2010-2014 also affirms these statistics, but also adds other information relevant to the State and to this Area Health Service. (pages 6-7)⁵¹

- The health of Aboriginal mothers and babies remains of concern. It is known that the perinatal mortality rate is around 40% higher in Aboriginal communities across NSW and that rates of prematurity and low birth weight are higher. Risk factors for low birth weight and prematurity include smoking in the second half of pregnancy (55.2% of Aboriginal mothers report smoking in the second half of pregnancy, compared with 14.2% of non-Aboriginal mothers) and being a teenage mother (21.4% of Aboriginal mothers are teenagers, compared to 4% of non-Aboriginal mothers) or older mother (9.6% of Aboriginal mothers are aged >35 years, compared to 19.9% of non-Aboriginal mothers). In SSWAHS the proportion of Aboriginal mothers who attended their first antenatal visit before 20 weeks gestation (69.5%) is considerably less than that reported for non-Aboriginal mothers (81.9%).
- Childhood oral health remains of concern in SSWAHS, with 27.3% of Aboriginal children 5-12 years having no caries experience compared to 53.1% of non-Aboriginal children.
- There is a considerably lower prevalence of adequate physical exercise among females, compared to both their non-Aboriginal counterparts in SSWAHS and across NSW and other Aboriginal populations in NSW.
- Hospitalisation rates (in public hospitals) for vascular related conditions (cardiology, stroke, diabetes, renal etc.) among the adult Aboriginal populations of SSWAHS aged 40-65 that are in total, over double that of the comparable non-Aboriginal adult population.
- For SSWAHS residents 6.5% of Aboriginal people aged 16+ report having diabetes or high blood sugar, compared to an average figure of 6.1% of SSWAHS adults. In Sydney, it is estimated that incidence rates of treated end-stage kidney disease in Aboriginal populations, adjusted for age and sex, are double those of the non-Aboriginal population.
- Also, 23.3% of Aboriginal adults aged 16+ resident in SSWAHS report current asthma, with a much higher rate in females (29.4%) than males (17.6%), this being the highest reported of any AHS and well above the 7.3% reported for the whole population of SSWAHS.
- The rates for cervical cancer among Aboriginal women are more than double those for non-Aboriginal women. High incidence of cancers of the lung, mouth and throat are caused by high rates of smoking earlier in life, while high cervical cancer incidence is preventable by

early detection in Pap test screening. High incidence of cancer of unknown primary site is likely to be associated with late diagnosis.

⁵¹ [2010-14 Aboriginal HP Summary & Strategies Overview.pdf](#)

The NSW Women's Health Plan (2009-2011) also cites that: Aboriginal women are more than twice as likely as other women to be a victim of a sexual assault and four times more likely to be a victim of an assault, domestic violence-related or otherwise. (p16)⁵²

Women from culturally and linguistically diverse backgrounds, including refugees

While many migrant women arrive in Australia with better health than other Australian women, due to selective immigration policies, some ethnic groups may be at higher risk due to genetic predispositions to developing certain diseases.⁵³

The adoption of Western diets and lifestyles and changed environments can accelerate the development of diabetes and associated conditions in some groups. Particular cultural practices and beliefs can increase risk, for example, among Pacific Island populations; larger body sizes are traditionally associated with high status, power, authority and wealth.⁵⁴

Many migrant women also experience a double disadvantage due to lower levels of English proficiency than male migrants,⁵⁵ which impacts on the ability to access health related knowledge, health services, and more broadly, education, employment and income.

Migrant women and refugees may have experienced poverty, violence and discrimination in their countries of origin. Female Genital Mutilation (FGM) is also an issue for women from some countries and the *NSW Women's Health Plan 2009-2011* refers to the FGM Program overseen by Women's Health in NSW. (p.15) Refugee women may also experience long periods of abuse and neglect living in refugee camps before they arrive in Australia. These experiences are damaging to these women's physical health, including their sexual and reproductive health, as well as their mental health and emotional wellbeing. Once in Australia, numerous financial, cultural and language barriers can also hinder the ability of these women to receive treatment for often significant health conditions.

Refugees may often have little or no family support.⁵⁶ Common health issues include:

- mental health issues, e.g. anxiety, depression and post traumatic stress disorder;
- dental health;
- nutritional deficiencies;
- infectious and communicable disease; and
- chronic disease.

Liverpool LGA has one of the highest proportions of new settlers in the State who have arrived on humanitarian grounds, with 3,180 settling in Liverpool between 1999 and 2004.⁵⁷ The *SSWAHS Community Health Strategic Plan 2007-2012* refers to the newly emerging groups in the area as documented:

⁵² NSW Bureau of Crime Statistics and Research, Fitzgerald and Weatherburn, Crime and Justice Statistics Bureau Brief: Aboriginal Victimisation And Offending: The Picture From Police Records 2001

⁵³ AIHW 2008. Australia's Health 2008. op. cit. p91

⁵⁴ Colagiuri R. Thomas M. Buckley A. 2007. Preventing Type 2 Diabetes in Culturally and Linguistically Diverse Communities in NSW. NSW Department of Health: Sydney.

⁵⁵ ABS 2008. Perspectives on Migrants, 2007 Cat. No. 3416.0 Canberra: ABS.

⁵⁶ Victorian Dept of Human Services 2005. Refugee Health Wellbeing Action Plan 2005–2008. Melbourne.

⁵⁷ Source: DIMIA Settlement Database 2005, Note: excludes City of Sydney

Across SSWAHS a number of new migrant/refugee communities are emerging. These new communities are predominantly African, with people coming from the Sudan, Sierra Leone, Ethiopia, Ghana, Nigeria, Somalia and Eritrea. People from the Asian nations of Burma and Bangladesh, as well as Pacific Islanders, are also settling in SSWAHS. Many people from these countries have poor health and have experienced trauma/torture. (p.37)⁵⁸

Women from disadvantaged backgrounds⁵⁹

Social and economic disadvantage, e.g. lower levels of income and education, unemployment, limited access to services and inadequate housing,⁶⁰ is directly associated with reduced life expectancy, premature mortality, injury and disease incidence and prevalence, and biological and behavioural risk factors.⁶¹

A recent study showed a 31.7 per cent greater burden of disease for the most disadvantaged population compared with the least disadvantaged,⁶² due to higher rates of burden for most causes, particularly mental health disorders, suicide, self-harm and cardiovascular disease. In 2000–02, women living in the most disadvantaged areas had a 29 per cent higher death rate from coronary heart disease than people living in the most advantaged areas.⁶³

Women from disadvantaged backgrounds report a greater use of doctors and hospital outpatient services, but are less likely to use preventive health services.⁶⁴ Participation in preventive health screening programs, eg breast, cervical and bowel screening, is lowest for the most disadvantaged women⁶⁵.

Socioeconomically disadvantaged women are more likely to have a higher rate of health risk factors, such as being overweight or obese, having fewer or no daily serves of fruit, smoking tobacco, and being exposed to violence.⁶⁶

As noted in the next section, Liverpool LGA has a population with a high level of disadvantage and the health issues described above would be prevalent in the community serviced by Liverpool Women's Health Centre.

⁵⁸ [CommunitHealthStrategicPlan.pdf](#)

⁵⁹ [Developing a women's health policy.pdf](#)

⁶⁰ Furler J. Young D. 2005. Prevention and socioeconomic disadvantage. *Australian Family Physician* 34(10): 822-824.

⁶¹ AIHW 2008. *Australia's Health 2008*. op. cit. p65

⁶² Begg et. al. 2007. op. cit.

⁶³ Australian Institute of Health and Welfare 2006. *Australia's Health 2006*. Canberra: AIHW.

⁶⁴ Australian Institute of Health and Welfare 2004. *Australia's Health 2004*. Canberra: AIHW.

⁶⁵ AIHW 2008. *Australia's Health 2008*. op. cit. p476

AIHW 2008. *National Bowel Cancer Screening Program 18 month monitoring report*

⁶⁶ AIHW 2008. *Australia's Health 2008*. op. cit.

Mouzos J. Makkai T (2004) *Women's experience of male violence Aust Institute of Criminology RPPS No. 56* p28

Lesbians

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. Mc Nair (2003).

“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 2000.⁶⁷

Lesbians were less likely to have had a sexual health check –up than their male counterparts. (Ryan (2005)

Younger lesbians are significantly more likely to report problematic alcohol use than heterosexual women and young gay men respectively. (Hillier 2004 and 2005)⁶⁸

Harland (2002) says that 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.⁶⁹ Research showed a widespread prevalence of depression and suicidal ideation (thoughts) amongst participants. (Pitts, Smith, Mitchell & Patel (2006)

Women with Disabilities ⁷⁰

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.

⁶⁷ “Lesbian Health Discussion Paper: Access to and Confidence in Health Services” by Amber Mc Bride and Jo Piggot for ACON 2006

⁶⁸ Mahamati for ACON: LESBIANS AND ALCOHOL DISCUSSION PAPER 2006

⁶⁹ (Lesbians and Mental Health- a Discussion Paper prepared for the ACON Lesbian Health Strategy Working Party 2006, Dr. Erin Cahill)

⁷⁰ Australian Bureau of Statistics; *Disability, Ageing and Carers: Summary of Findings*, Australia, (cat. no. 4430.0).Canberra, ABS 2003

-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

-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 of 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; that

Indigenous women are significantly over represented in the prison population; that many are victims of sexual abuse; and that 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.

-The level of, and growth in, the number of Aboriginal women¹¹ 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.⁷¹

Women as Carers

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.⁷²

–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.⁷³

–Almost 72% of primary carers are women.⁷⁴

–Carers tend to have lower incomes than the rest of the population. 71% of primary carers receive a pension or allowance.⁷⁵

⁷¹ Increase in Prisoner Population: Interim Report: Issues Relating to Women, the NSW Legislative Council Select Committee on the Increase in the Prisoner Population

⁷² Australian Bureau of Statistics, *Managing caring responsibilities and paid employment*, Cat. No. 4903.1, ABS Canberra, 2000.

⁷³ Australian Bureau of Statistics, *Disability, Ageing and Carers*, Cat. No. 4430.0, ABS Canberra, 1999.

⁷⁴ Australian Bureau of Statistics, *Disability, Ageing and Carers*, Cat. No. 4430.0, ABS Canberra, 1998.

⁷⁵ Australian Bureau of Statistics, *Disability, Ageing and Carers*, Cat. No. 4430.0, ABS Canberra, 1998.

–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.

A national survey (2009) is being prepared to gather information on disability, ageing and carers, and more up-to-date information will be provided when this survey has been completed.⁷⁶

Young women

Persons under the age of 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.⁷⁷

-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 12.⁷⁸

- In 2002/03, women accounted for 69.5% of all hospitalisations for attempted suicide amongst the 15-24 years age group.⁷⁹

- Depressive episode 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.⁸⁰

- 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.⁸¹

BARRIERS TO HEALTH CARE ACCESS⁸²

Australian women accounted for 56 per cent of visits to GPs in 2006–07, but the groups of women outlined above face significant barriers in accessing health care services and information. These

⁷⁶ [2009_SDisability Ageing Carers Discussion Paper.docx](#)

⁷⁷ Australian Institute of Health and Welfare, Australia's Young people – Their Health and Wellbeing 2003, Cat. No. PHE 50, AIHW Canberra 2003

⁷⁸ Australian Institute of Health and Welfare, Australia's Young people – Their Health and Wellbeing 2003, Cat. No. PHE 50, AIHW Canberra 2003

⁷⁹ Public Health Division, The Health of the People of New South Wales - Report of the Chief Health Officer, 2004. Sydney: NSW Department of Health, 2004

⁸⁰ Australian Bureau of Statistics 1995, National Nutrition Survey, Cat No. 4802.0, ABS, Canberra

⁸¹ Australian Institute of Health and Welfare, Australia's Young People - Their Health and Wellbeing 2003, Cat. no. PHE-50, AIHW, Canberra, 2003

⁸² [Developing a women's health policy.pdf](#)

barriers are part of the social and economic conditions of women's lives which lead to health inequalities, and include:⁸³

- a lack of affordable health care services;
- a lack of female doctors, including Indigenous service providers;
- distance to health care services and lack of affordable transport, particularly in rural and remote areas, but also an issue in the outskirts of cities;
- a lack of culturally appropriate services and information;
- a lack of services and information available in other languages;
- inaccessibility of buildings, services and information for people with disabilities; and
- health services being ill equipped to deal with the complexity of the health and social needs of women from these groups.

The National Women's Health Policy will form part of the Government's efforts to address these barriers.

HEALTH ISSUES OF WOMEN IN SSWAHS INCLUDING LIVERPOOL

Liverpool Council Community Strategy 2009 (Social Plan)⁸⁴

LIVERPOOL Local Government Area – DEMOGRAPHICS

The Sydney South West Area Health Service (SSWAHS) Community Health Strategic Plan (2007-2012), and the Liverpool Council Community Strategy 2009 (Social Plan) both detail information about the population, which is significant in planning for Liverpool Women's Health Centre.

As stated in the SSWAHS plan that in accord with the Metropolitan Strategy plans for a significant proportion of Sydney's population growth to be based in the South West Growth Centre (centred mainly on the local government areas of Liverpool, Campbelltown and Camden. This growth is expected to occur over the next 10 to 20 years,⁸⁵ with the majority growth to Liverpool.

Diversity of the Population in Liverpool

10% of the Aboriginal population of NSW live in South West Sydney with the highest proportion in Campbelltown, Liverpool and part of the Inner City. In 2006, 1.3% or just over 2200 people in Liverpool identified as Aboriginal/Torres Strait Islander.⁸⁶ Liverpool's people are younger with a median age of 32 in 2006, compared with 35 in Sydney. 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) - 38% of Liverpool's population were born overseas, with the majority from Fiji, Vietnam, Iraq and Lebanon, and with the major languages other than English spoken at home are Arabic, Vietnamese, Hindi and Italian. 72% of Liverpool

⁸³ Australian Institute of Health and Welfare 2007. Aboriginal and Torres Strait Islander Health Performance Framework, 2006 report: detailed analyses. AIHW cat. no. IHW 20. Canberra: AIHW.

Boustany J. 2000. Health access problems facing the Aboriginal community

<http://www.medicineau.net.au/clinical/abhealth/abhealt3504.html>.

Ansari Z. A review of literature on access to primary care health care. Australian Journal of Primary Health Vol 13 No 2 August 2007

⁸⁴ [LIVERPOOL COMMUNITY STRATEGY 2009 \(SOCIAL PLAN\) PDF Version \(2\).pdf](#)

⁸⁵ [CommunitHealthStrategicPlan.pdf](#) (p.6)

⁸⁶ [LIVERPOOL COMMUNITY STRATEGY 2009 \(SOCIAL PLAN\) PDF Version \(2\).pdf](#)

families are couples with children but with a slightly higher proportion of single parents than in Sydney.⁸⁷ Mean taxable income is lowest in Fairfield, Canterbury, Campbelltown and Liverpool.⁸⁸ The LGAs in SSWAHS with socio-economic disadvantage greater than the State median, in order of ranking, are Fairfield, Canterbury, Campbelltown, Liverpool, Bankstown and Marrickville.⁸⁹

Identified Health Needs for Women in SSWAHS – Liverpool

The NSW 2009 Health Survey⁹⁰ (HOIST) from the Centre for Epidemiology and Research, NSW Department of Health identifies some of the major health needs of women in SSWAHS including the Liverpool area. Risk drinking of alcohol was not significantly different than the NSW population of women, however 33.9% of younger women aged between 16-24 responded positively in the survey to engaging in risky drinking. Another area of significant difference was the response to the question whether there was or was not a smoke alarm/ fire detector in the home. The response was lower than was generally for females across NSW, and in the 75+ female age group there were 79.6% who responded positively to having an alarm compared with 94.9% of females in the same age group across NSW.

In regard to nutrition, females across all the age groups surveyed, generally ate less than the 2 serves of fruit per day than females in the NSW population, and overall there were 57.3% surveyed in SSWAHS who ate the two serves, but only 47.6% in the 16-24 age group. Females who ate the recommended 5 servings of vegetables per day were significantly less than females across NSW with a general total of 8% responding positively to this question as against 13.2% in the general population, and only 3% as against 4.8% of women aged between 16-24 years of age. The survey shows an increase in the number who eat three or more serves a day, but the number is still well below the NSW population, indicating an area for health promotion.

In the area of physical activity, females in the SSWAHS generally exercised less than females across NSW, and this is particularly less for those women in the 35-54 age ranges. Smoking for females generally mirrors the NSW level in the survey, with a total of 13.7% of women smoking, but a higher range of smoking in women aged 55-64 with 17.1% in SSWAHS compared with 13.3% across NSW.

Asthma rates were similar for females in SSWAHS to those in NSW with an average rate of 12.2% of females in the area being treated for asthma. Diabetes and high blood sugar rates were significantly higher for females in the SSWAHS across most age ranges and especially for women aged between 65-74 years who scored 31.6% of the surveyed population as against 17.1% of the NSW surveyed population. Women in SSWAHS were generally more overweight than women across NSW, with the more significant levels being in the age groups 25-54, with a 36.4% of women aged 45-54 overweight in SSWAHS compared with 31.3% in NSW. Those rated as obese in the SSWAHS survey that was significantly different than the NSW surveyed female population, were those in the 16-24 age range with 13.2% compared with 8.9% and those in the 65-74 age range with 33.9% compared with 25.4% of the NSW surveyed population.

Psychological Distress was rated higher in the survey for females in SSWAHS across most of the age ranges except for those aged 65-74 years, compared with females surveyed across NSW. A sense of safety with a level of trust was significantly different and lower for women in SSWAHS except for those aged between 25- 34 years, and very low for women aged 75+ with a report of 53.1%

⁸⁷ [LIVERPOOL COMMUNITY STRATEGY 2009 \(SOCIAL PLAN\) PDF Version \(2\).pdf](#)

⁸⁸ [CommunitHealthStrategicPlan.pdf](#)

⁸⁹ [CommunitHealthStrategicPlan.pdf](#)

⁹⁰ [hsa_09area_ssw.pdf](#)

indicating a level of trust compared with 76.1% of the NSW surveyed female population. **Social capital** in the form of closeness to neighbours was also significantly different in the SSWAHS population of women compared with the NSW surveyed population, with 51.7% against 59.8% of the NSW female population visiting or being visited by neighbours. This difference is across all age groups.

Screening for Cancers:

Pap Screen-

In NSW, the incidence and death rates for cervical cancer among women aged 20–69 years fell by 40% from 1990 to 2000.⁹¹ 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.⁷⁵

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.⁹²

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. In 2004-2008 there were 23 incidences of Cervical Cancer of women in the Liverpool LGA a rate of 2.6 per 100,000 of the population.⁹³

Breast Screening-

SSWAHS has one of the lowest rates (74%) in the state which averages 76.2%. (NSW Health Survey 2006). There were 358 incidences of breast cancer in women living in the Liverpool LGA between the years 2004-2008, a rate of 40.7 per 100,000 of the population.⁹⁴

VIOLENCE AGAINST WOMEN

Domestic Violence

The Liverpool Community Strategy 2009 (Social Plan) states that:

“Violence in the home continues to be of concern in Liverpool. According to the Liverpool and Green Valley Local Area Commands a significant proportion of their work is related to domestic violence.” (p13)⁹⁵

⁹¹ Tracey E, Roder D, Bishop J, Chen S, Chen W. *Cancer in NSW: Incidence and mortality 2003*. Sydney: Cancer Institute NSW, 2005

⁹² NSW Cancer Institute Aug 2007 Annual *Statistical Report 2004 NSW Cervical Screening Program*

⁹³ [NSW Central Cancer Registry.pdf](#)

⁹⁴ [Breast Cancer in LGA.pdf](#)

The best indicators available to date about the levels of violence against women in Australia are from the 1996 ABS publication Women's Safety Survey and the more recent ABS Personal Safety Survey 2005 that surveyed both men and 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.

A study by the AIC in 2002, Homicides Resulting from Domestic Altercations, found that the majority of female homicide victims were killed during domestic altercations. In a follow up AIC study, Family Homicide in Australia, 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).

A more recent study released in October 2009: Domestic Homicide in NSW, January 2003-June 2008 by Clare Ringland and Laura Rodwell,⁹⁶ came to the following conclusions:

The most important finding to emerge from this study was the low percentage of victims who had contact with the police as a victim of domestic violence where the eventual homicide offender was the person of interest. Only ten per cent of victims had contact with the police in the 12 months leading up to the homicide with involvements of this nature. This provides some indication that the majority of victims and offenders involved in domestic homicide do not come to the attention of the police in the 12 months leading up to the homicide.

⁹⁵ [LIVERPOOL COMMUNITY STRATEGY 2009 \(SOCIAL PLAN\) PDF Version \(2\).pdf](#)

⁹⁶ [Report on Domestic Homicides.pdf](#)

This highlights the difficulties that would be faced by the police in identifying offenders and victims who are likely to be at risk of being involved in a domestic homicide. One possibility is that these individuals are coming to the attention of other agencies and services, such as victim support services, counselling providers, mental health services, or hospitals.

Domestic Violence statistics in Liverpool LGA

2006			2007			2008			2009		
Total	Rate per 100 000 of population	Rank in NSW	Total	Rate per 100 000 of population	Rank in NSW	Total	Rate per 100 000 of population	Rank in NSW	Total	Rate per 100 000 of population	Rank in NSW
659	385.6	67	692	398.5	67	623	352.2	71	712	402.5	60
BREACH OF AVOS											
254	148.6	81	240	138.2	89	224	126.6	93	260	147.0	85

NSW Bureau of Crime Statistics 2009⁹⁷

The Australian Longitudinal Study on Women's Health- *Partner Violence and the Health of Australian Women* finds that partner violence has a serious impact on women's physical and mental health, including increased symptoms and medical conditions such as, sexually transmitted infections (including cervical cancer), and depressive illnesses.⁹⁸

Sexual Violence

On August 10, 2006 the ABS released the results of the first national Personal Safety Survey presenting information about women's and men's experiences of violence.

- 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 2005 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

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

⁹⁷ [Assault- Domestic Violence NSW.pdf](#) [Breach of AVO.pdf](#)

⁹⁸ [achievements-violence.pdf](#)

The most recent statistics indicate 198 incidences in 2007, 224 in 2008 and 231 in 2009. However, these are not divided into the type of sexual offence, but there appears to be an increase in sexual offences.⁹⁹

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.¹⁰⁰

Problem Gambling

The majority of known problem gamblers are men, but the number of women who are known to be problem gamblers are escalating;¹⁰¹

- 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).

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.¹⁰²
- In 2004, HIV prevalence among women in heterosexual relationships and female sex workers remained below 1%.¹⁰³
- 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.¹⁰⁴

⁹⁹ [Incidences of Sexual Offences.pdf](#)

¹⁰⁰ Australian Institute of Health and Welfare, Australia's young people- their health and wellbeing 1999, p 127-128

¹⁰¹ Productivity Commission Inquiry into Australia's Gambling Industries-AMA Submission

¹⁰² Public Health Division, The Health of the People of New South Wales- Report of the Chief Health Officer, 2004. Sydney: NSW Department of Health, 2004

¹⁰³ National Centre in HIV Epidemiology and Clinical Research, 2005, Annual Surveillance Report 2005

¹⁰⁴ National Centre in HIV Epidemiology and Clinical Research, 2005, Annual Surveillance Report 2005

- 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.¹⁰⁵

Pregnancy trends in NSW ¹⁰⁶

- 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.

CONCLUSION

Liverpool Women's Health Centre will be guided by the national, state, area and local government policies and plans as outlined in this document. These policies aim for equity in health provision, prevention and a gendered approach to health services. The Annual Report 2009¹⁰⁷ of the Australian Longitudinal Study of Women's Health contains the abstracts of major studies that have recently been completed on women's health and would also be a resource for the Centre in following up women's health issues. Major priority areas for women's health include prevention of cancer, especially breast and cervical cancers, cardiovascular disease and diabetes. Contributors to these diseases such as lack of adequate nutrition, low levels of physical exercise, obesity, violence against women, and other stressors are to be addressed in improving women's health. There are groups of women who have less equity in accessing health services and who are more vulnerable to poor health. These groups of women that include Aboriginal and Torres Strait Islander, migrant and refugee women and those who are socially disadvantaged represent a significant presence in the population in the Liverpool LGA. These groups of women and the health/social issues that arise from their situations are to be considered in priorities set by Liverpool Women's Health Centre.

¹⁰⁵ National Centre in HIV Epidemiology and Clinical Research, 2005, *Annual Surveillance Report 2005*

¹⁰⁶ NSW Department of Health, NSW Public Health Bulletin: New South Wales Mothers and Babies 2004, Vol. 16 No.S-4

¹⁰⁷ [Annual2009.pdf](#)

Section 2 Needs Analysis

Background

Liverpool Women's Health Centre (LWHC) undertakes a Needs Assessment process on a three yearly basis. The aim of this 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.

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

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 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 including recently arrived communities
 - Women who have not used centre
 - Lesbians
 - Low income women
 - Women from outlying areas
- List up to date local regional state and / or national community and health demographics
- Act as a resource document useful for planning, lobbying and funding applications.

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. This information was collated and analysed by Margaret Hickie working as

a contractor to the Centre. In addition, 2006 ABS Census data and DIAC Statistics (2009) Liverpool City Council Community Strategy (2009) were used to develop a brief community profile.

The Women's Health Profile combining national, state, area and occasionally LGA specific information was developed by Kristin Dawson as a consultant to Liverpool Women's Health Centre. This profile drew on a range of sources including SSWAHS, NSW Health, ABS and other relevant bodies' epidemiological information.

A discussion on limitations and suggestions for future needs assessments can be found in Appendix 3.

Survey

A self administered written survey (Appendix 1) was used to collect information from women. The survey is different from that used in 2006. Questionnaires were distributed to existing clients attending the Centre. 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 or education sessions running either on site or as part of Outreach services were invited to complete a questionnaire. For some clients assistance was provided to overcome English literacy difficulties. The survey included both open and closed questions.

Focus groups

16 focus/ discussion groups were conducted by Centre staff (and a management committee member) to get the perspective of a range of communities of women.

Some groups were conducted at the Centre with women familiar with the LWHC while the majority were conducted in other locations such as schools, community centers, TAFE classes. With at least two (Lao women and a group from Busby) the methodology was less of a focus group and more inclined to individual interviews / surveys responding to focus group questions with responses collated. Included in the focus group records are the outcomes of 4 discussions about health concerns and needs conducted by an LWHC management committee member with specific refugee communities. 2 of these related to the development of the Maternity Services Plan.

Focus group information is intended to complement information collected in the survey and to ensure the voices of specific groups are represented. The decision about who to run focus groups with was influenced by a combination of opportunity and ensuring that a diverse range of women were consulted including Aboriginal women, women of different ages, women from culturally diverse backgrounds, refugee women, lesbian women, parents, Centre users as well as those unfamiliar with the Centre and women who are living in newer areas of Liverpool.

Women were asked about their perceptions of main issues facing women in general, women in Liverpool and women in their own community. They were asked what they see as problems face women in their communities and what health issues they're concerned about . They were asked to discuss what groups, health education and projects the Centre should run and how else the Centre

can improve. Knowledge of other services in the Liverpool area was also explored. (See Appendix 2: Focus Group Questions.)

Demographics/ Health information

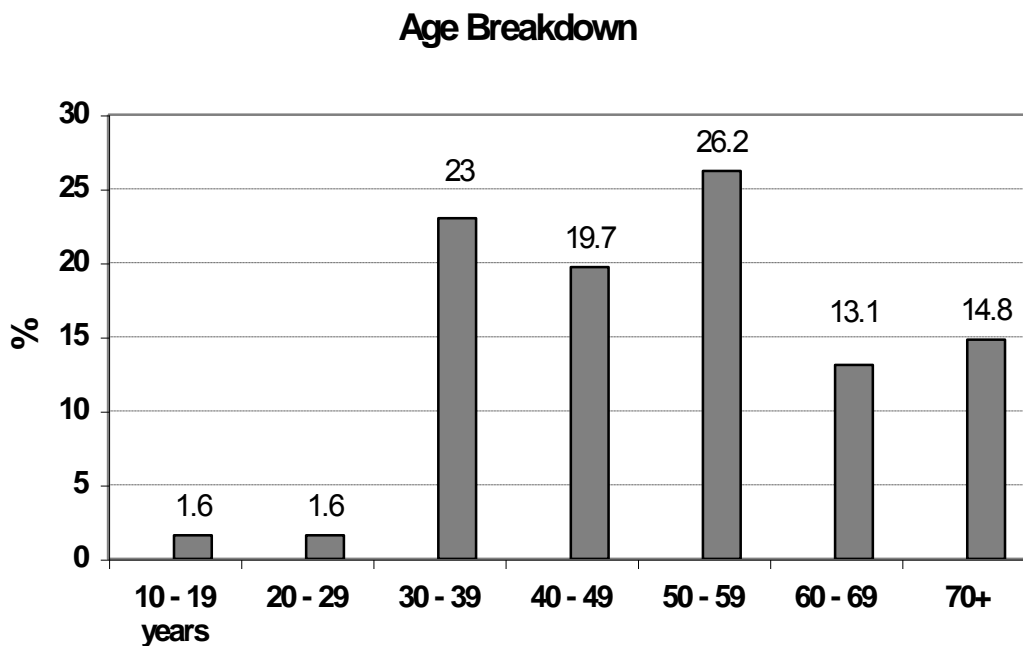
This information is used to provide a background to the Centre’s needs assessment and provide a picture of the community profile of Liverpool women as well as some of the evidence of documented health issues. The community profile is drawn from the last ABS Census conducted in 2006.

Survey

61 women completed the survey which sought their opinions on the services and groups the Centre should offer. 57.4 % of respondents had previously used the Centre. This gives a good balance of opinion between those who are familiar with the Centre and those who are not.

Profile of Survey Respondents

Age of Respondents

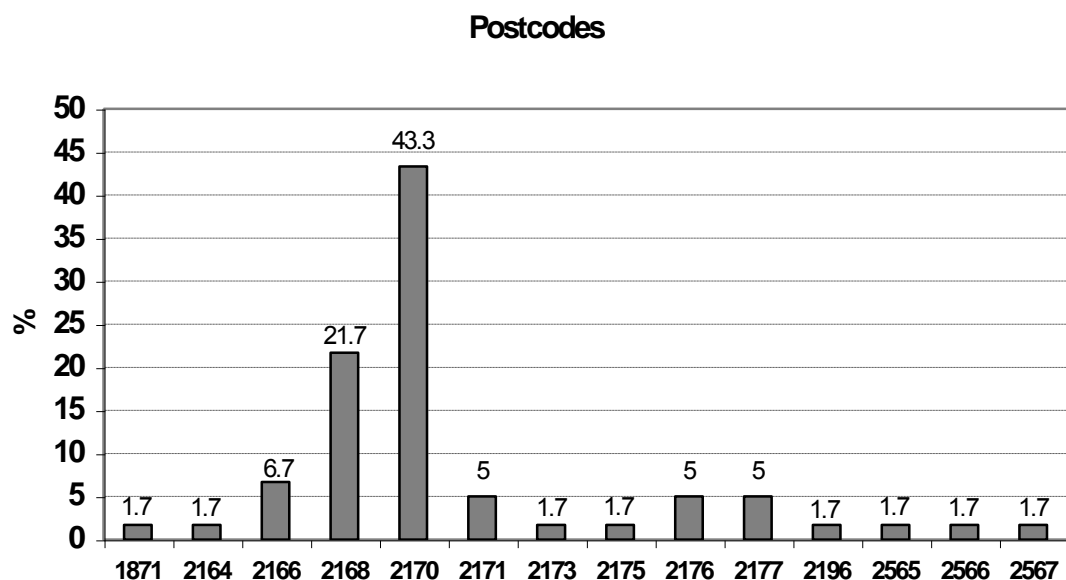


There is a strong representation of middle aged and older women from 30+ years. 68.9% of respondents are between 30 – 69 years. There is very low representation of women under 30 (3.2%).

For Liverpool LGA 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 38% of women in Liverpool LGA are under 25 (ABS Census, 2006).

Where Do Respondents Live

Two thirds of respondents live in the inner suburbs of Liverpool or suburbs of Green Valley. There is much lower representation of women from the outer areas of Liverpool LGA. However the SEIFA Index of Disadvantage shows that the greatest levels of disadvantage are within the Green Valley suburbs of 2168 and some of the inner Liverpool suburbs of 2170. This means that the survey has good representation of the group it aims to work most with.



2170=

Casula, Liverpool, Chipping Norton, Liverpool South, Hammondville, Lurnea, Moorebank, Mt Pritchard, Prestons, Warwick Farm. 2168 = Ashcroft, Busby, Cartwright, Green Valley, Heckenberg, Hinchinbrook, Miller, Sadleir. 2166=Cabramatta, Cabramatta West, Canley Hts, Canley Vale, Lansvale. 2171= Cecil Hills, Horningsea Park, Hoxton Park, Middleton Grange, West Hoxton. 2176 = Abbotsbury, Bossley Park, Edensor Park, Greenfield Park, Prairiewood, St John's Park, Wakely. 2177 = Bonnyrigg, Bonnyrigg Hts; 2164=Smithfield, Wetherill Park & Wood Park; 2173 = Wattlegrove, Holsworthy; 2175 = Horsley Park ; 2196 = Punchbowl, Roselands ; 2565 = Denham Court, Ingleburn, Macquarie Links; 2566 =Minto, Minto Hts, Bow Bowing, Raby, St. Andrews, Varroville ; 2567 = ; 1871= Liverpool Post Office.

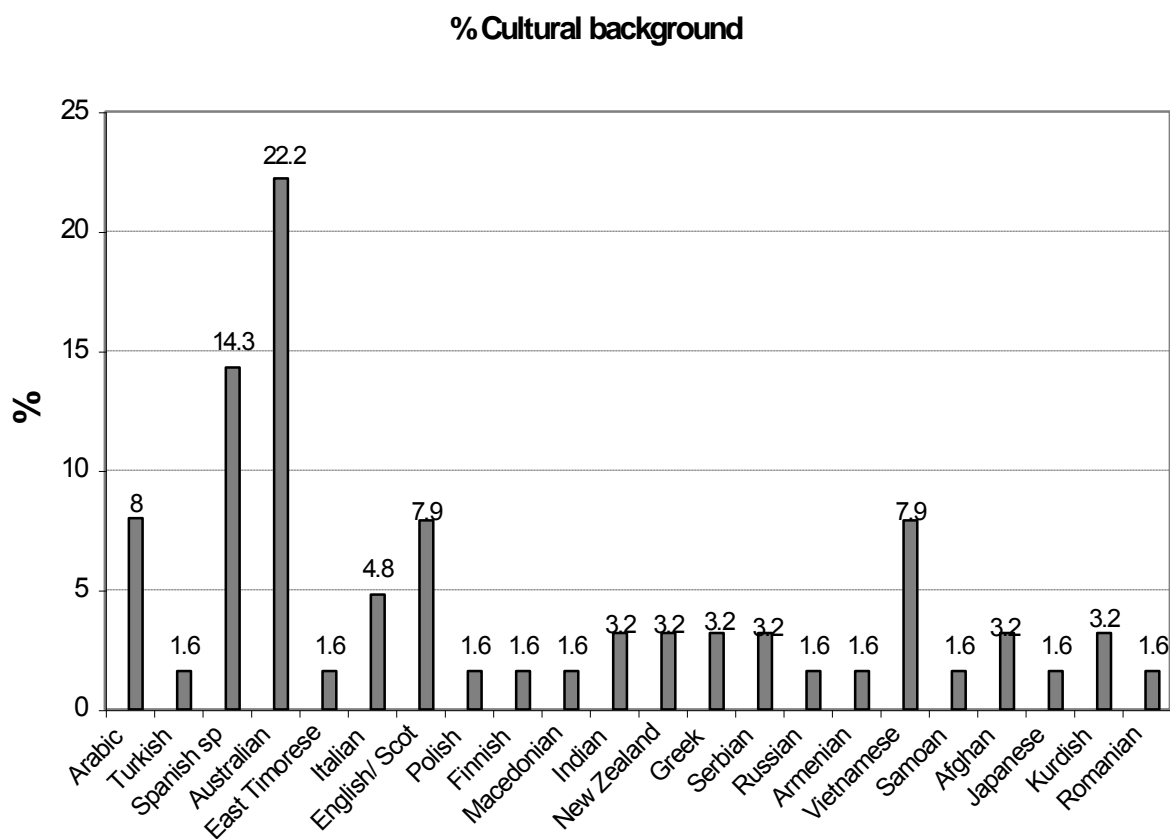
Cultural Backgrounds

Aboriginality

1 respondent was from an Aboriginal background (1.6%). This compares with 1.3% in the 2006 Census for Liverpool LGA and 1.1% for Sydney Statistical Division.

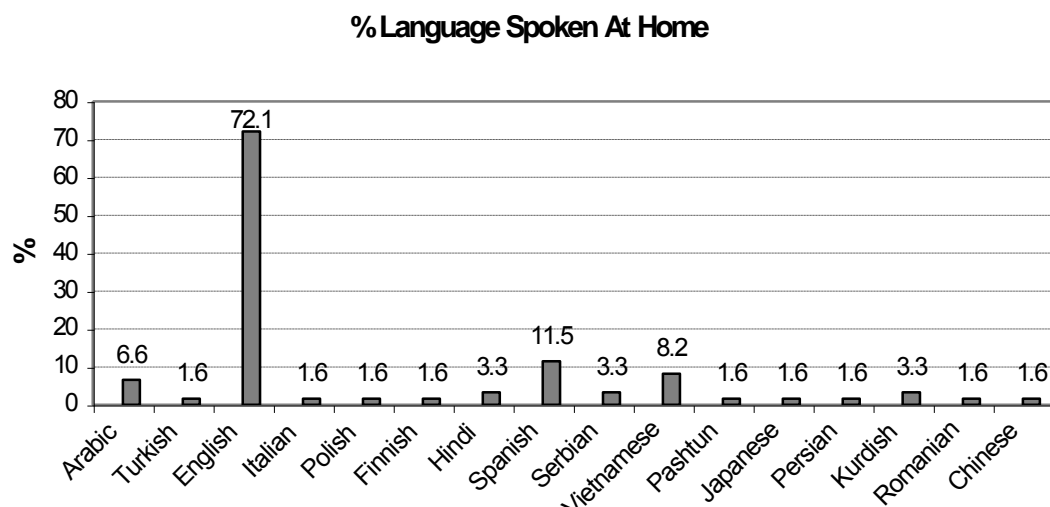
CALD

65.7% of respondents were from culturally and linguistically diverse backgrounds.



Respondents represent a broad range of cultural backgrounds which are representative of the diversity of the Liverpool LGA. Those from non English speaking cultural backgrounds include Spanish speaking (14.3%), Arabic speaking (8%), Vietnamese (7.9%) and Italian (4.8%). 22.2% of respondents described themselves as from an Australian background.

Language Spoken At Home



*Some respondents spoke more than 1 language at home.

27.9% of respondents spoke a community language at home. The most common language other than English spoken at home was Spanish (11.5%), followed by Vietnamese (8.2%), Arabic (6.6%), Hindi (3.3%), Kurdish (3.3%) and Serbian (3.3%). 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.

There is a high level of cultural diversity within respondents backgrounds and a comparatively lower level of languages other than English spoken at home. This suggests that many of the survey respondents may be second generation or long settled migrants.

What Did Women Want

Suggestions for Services and Groups (Questions 7 and 8)

22 women (36.1%) answered question 7 and 34 (55.7%) answered question 8 asking about suggestions for services and groups. Note that for some questionnaires the format for question 7 was changed listing detailed needs groups and this clearly influenced some responses. There was some overlap in responses between the two questions.

These **open ended questions are of limited value and as previously recommended should be excluded in future** especially as the questionnaire is complemented by focus groups. Closed questions appear to be easier for respondents to complete.

Suggestions for other services and groups included:

- services and groups for NESB women and newly arrived refugees (9) with sessions in Arabic specifically mentioned.
- groups about looking after your health (6); nutrition (2)
- natural therapies groups and services (6); massage (2); chiropractor (1)
- tai chi (6); yoga (5) ; exercise & fitness (4); self defense (1)

- groups on self development, mindfulness, anxiety management, confidence building, self esteem, stress management (5)
- counselling (3) with one suggesting for young women
- services and groups for older women (3)
- craft, ceramics and hobbies (3)
- social groups, outings, discussion groups, current affairs (4)
- legal advice (2)

Other suggestions included: weight management, general women's health services, mothers and daughters informal group round puberty, support groups, Pilates, single parents groups, diabetes education, play group, schools information sessions, dental information, immunizations.

2 people suggested there was already a good range of services with good support.

Suggestions for specific needs groups (Question 10):

54.8% of respondents indicated a need for activities targeted to specific communities (ie. 23 out of 42) 28.6% of respondents expressed interest in groups for older women, 16.7% were interested in groups for women from non English speaking backgrounds and newly arrived migrants and refugees. Groups for the differently abled and lesbian women had 1 woman each express interest.

7 women made suggestions for specific needs groups

- Older women: maintaining optimism, dancing, yoga, dealing with loneliness
- Younger women: social get togethers
- Differently abled women: dealing with disabilities
- NESB: Healthy lifestyle, parenting in different languages, cultural activities and festivals, Australian culture and ways
- Newly arrived: health education sessions, English lessons.

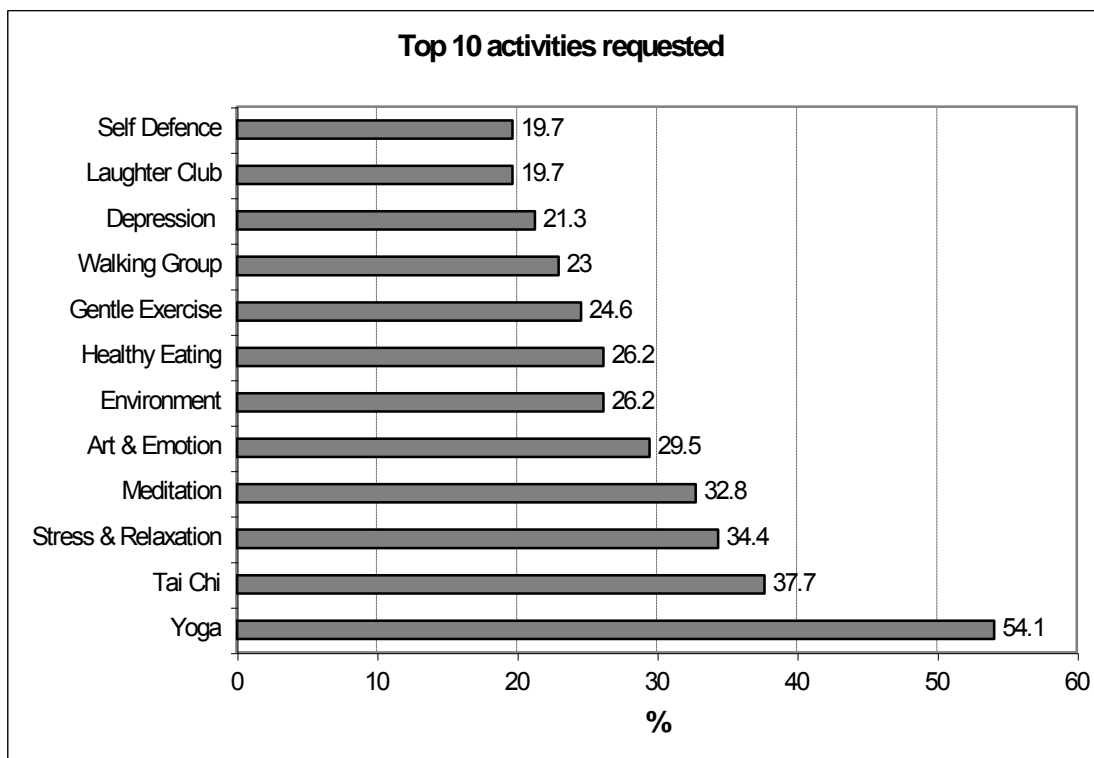
Most Frequently Chosen Activities (Question 9)

Women were asked to select up to 5 groups they would be interested in attending. 56 women chose at least 1 activity. A number of women chose many more than 5 activities. 5 women did not complete this question. This may mean they were not interested in any of the listed activities or they did not turn the questionnaire over.

A total of 423 selections were made at this question.

The most popular request was for yoga (54.1%) with more than half of the respondents choosing it. (This has been popular in previous years when brief Annual Needs Assessments were conducted). This was followed by Tai Chi, Stress Management and Relaxation and Meditation.

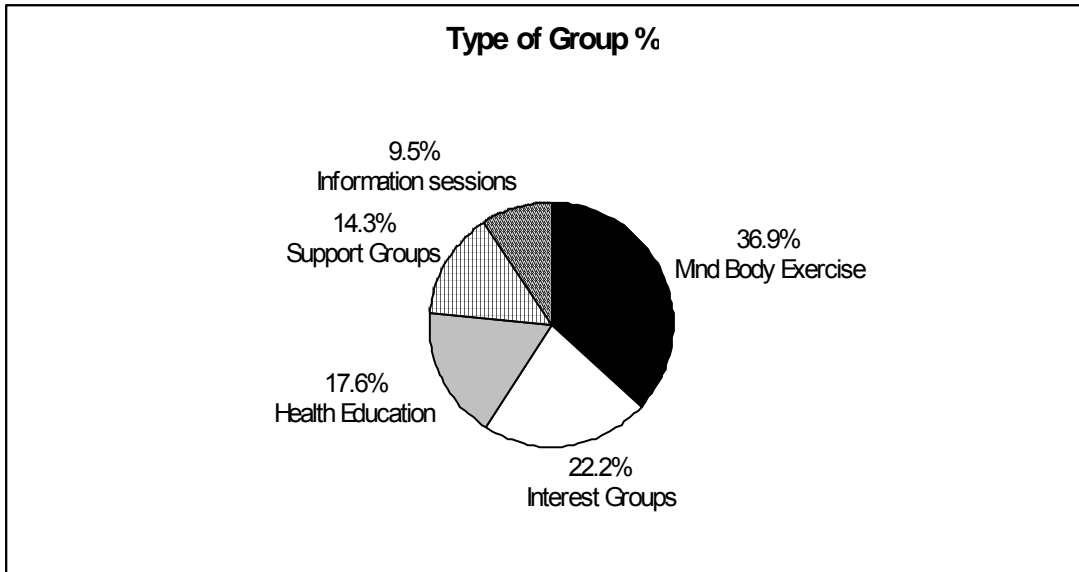
The popularity of the options in the Mind Body Exercise category was striking.



The highest proportion of selections went to the health education grouping. However, it offered the most options. When we take this into account (by reweighting responses by giving them an average value) the most popular category of activities by far are Mind, Body and Exercise (36.9%), followed by Interest Groups (22.2%) and then Health Education (17.6%). This is also clearly shown in that 6 of the 8 options listed for Mind Body Exercise were ranked in the top 10.

Proportion of Interest by Type of Activity (Reweighted)

Type of Activity	Original Proportion (%)	Calculation	Reweighted (%)
Mind Body Exercise	31.4	$9.4/8 \times 133/423$	36.9
Interest Groups	18.9	$9.4/8 \times 80/423$	22.2
Health Education	31.9	$9.4/17 \times 135/423$	17.6
Support Groups	10.6	$9.4/7 \times 45/423$	14.3
Information Sessions	7.1	$9.4/7 \times 30/423$	9.5



Most Popular Choices Ranked from Highest to Lowest Across All Types

(Question 9)

Ranking	Activity	No. selected	% (n = 61)
1	Yoga	33	54.1
2	Tai Chi	23	37.7
3	Stress Management & Relaxation	21	34.4
4	Meditation	20	32.8
5	Art & Emotion	18	29.5
6	Taking Care of the Environment	16	26.2
6	Healthy Eating	16	26.2
7	Gentle Exercise	15	24.6
8	Walking Group	14	23
9	Depression	13	21.3
10	Laughter Club	12	19.7
10	Self Defense	12	19.7
11	Back Care	11	18
11	Coffee/ Tea Morning	11	18
12	Managing Anxiety	10	16.4

12	Get Moving: Building Fitness	10	16.4
12	Managing Health Naturally	10	16.4
13	Love Lust & Sexuality	9	14.8
13	Exploring Feminism	9	14.8
13	Family Law	9	14.8
13	Managing Arthritis	9	14.8
13	Menopause	9	14.8
13	Socially isolated	9	14.8
14	Osteoporosis	8	13.1
15	Personal Development	7	11.5
15	Communication Skills	7	11.5
15	Parenting Children	7	11.5
16	Drumming	6	9.8
16	Domestic Violence	6	9.8
16	Breast cancer	6	9.8
16	Safe Cycling	6	9.8
16	Managing Pain	6	9.8
16	Relationships	6	9.8
17	Women's Choir	5	8.2
17	Wellbeing	5	8.2
17	Adult Survivors of CSA	5	8.2
18	Good Bladder Health	4	6.6
18	Young mum's	4	6.6
18	Young women's drop in	4	6.6
19	Parenting Adolescents	3	4.9
20	Managing Premenstrual Tension	2	4.9
20	Post Natal Distress	2	4.9
20	Quit Smoking	2	4.9

21	Gambling	1	1.6
21	Contraception	1	1.6
21	Lesbian Health	1	1.6

Most Popular Choices Ranked Highest to Lowest within each Category

(Question 9)

Interest Groups (Total Response: 80)	No.	% (n = 61)
• Art & Emotion	18	29.5
• Taking Care of the Environment	16	26.2
• Laughter Club	12	19.7
• Love Lust & Sexuality	9	14.8
• Exploring Feminism	9	14.8
• Drumming	6	9.8
• Women's Choir	5	8.2
• Wellbeing	5	8.2
Support Groups (Total Response: 45)		
• Coffee/ tea mornings	11	18
• Socially isolated	9	14.8
• Domestic Violence	6	9.8
• Breast cancer	6	9.8
• Adult Survivors of CSA	5	8.2
• Young mum's	4	6.6
• Young women's drop in	4	6.6
Mind Body & Exercise (Total Response: 133)		
• Yoga	33	54.1
• Tai Chi	23	37.7
• Meditation	20	32.8
• Gentle Exercise	15	24.6

• Walking group	14	23
• Self Defence	12	19.7
• Get Moving: Building Fitness	10	16.4
• Safe Cycling	6	9.8
Health Education (Total Response: 135)		
• Stress Management & Relaxation	21	34.4
• Healthy Eating	16	24.6
• Depression	13	21.3
• Managing Health Naturally	10	16.4
• Managing Anxiety	10	16.4
• Managing Arthritis	9	14.8
• Menopause	9	14.8
• Osteoporosis	8	13.1
• Personal Development	7	11.5
• Communication Skills	7	11.5
• Parenting Children	7	11.5
• Managing Pain	6	9.8
• Relationships	6	9.8
• Parenting Adolescents	3	4.9
• Managing Premenstrual Tension	2	4.9
• Lesbian Health	1	1.6
• Sexual Health	0	0
Information Sessions (Total Response: 30)		
• Back Care	11	18
• Family Law	9	14.8
• Good Bladder Health	4	6.6
• Post Natal Distress	2	4.9
• Quit Smoking	2	4.9

• Gambling	1	1.6
• Contraception	1	1.6

Focus Groups

A total of 151 women participated 16 focus/ discussion groups (This does not include women in the 4 discussion groups conducted by a management committee member where attendance numbers were not provided).

Record of Focus Groups

▪ *Aboriginal women*

4 women attended this group held at Miller Aboriginal Women’s Clinic. They identified mental health, lack of equal pay and family friendly working conditions as issues facing women. For Liverpool they saw transport, mental health and access to women doctors and women’s services as important. These were issues important for Aboriginal women as well and housing and the need for dental services was also identified. The need for an Aboriginal specific medical service for Liverpool was highlighted. The women identified financial issues, mental health and isolation as health issues of concern. Aboriginal specific groups for relaxation skills and laughter club were requested to be located at the Women’s Resource Centre at Ashcroft. It was suggested that the Women’s Health Centre should work more in partnership with mental health services. The group was looking forward to improved services when the Centre’s extensions are complete. Specifically more doctors full time in the Centre was mentioned. Knowledge of other services included: Joan’s Refuge and DV Service, Hoxton Park CHC.

▪ *Women attending TAFE to re-enter workforce (2 groups)*

Group 1

18 women participated in this group conducted at Ashcroft High School.

In the discussion of issues facing women in society this group identified parenting issues related to raising teenagers including need for money, conflict and stress within the family and concerns regarding being compared to other parents. They also identified discrimination and harassment as issues facing women. For women in Liverpool related to the parenting of teenagers issues came concerns that there was nothing in Liverpool for teenagers to do to get them out of the house or places they could go that were safe and not run down or old. The women identified a general concern with safety and concerns for their children’s safety and concerns about gangs were raised.

Caring for sick parents and a lack of services and information related to this was seen as one of the problems facing these women. A range of health issues were identified including stress, depression , asthma, heart problems, caring for parents, dementia, cancer (breast and uterus).

Suggestions for groups the Centre could run including support group for raising teenagers with solution based focus and debriefing opportunities, carers group, friendship groups, budgeting and managing tight finances, nutrition, self esteem, exercise/ walking group, support group for parents of children with ADHD (Attention Deficit Hyperactivity Disorder).

The women suggested the Centre should better advertise itself and specifically suggested promoting its services through school newsletters as an effective strategy. They also suggested working in partnership with TAFE to inform more women of Centre services.

Group 2

20 women participated in this group conducted at Liverpool TAFE

The group felt that the key issues facing women including those in Liverpool were language barriers, lack of understanding of cultural differences, lack of skills and qualifications to get work, lack of confidence and communication skills. This group felt that women have less power at home to make decisions about their future especially in relation to employment. When asked about health problems the women discussed unhappiness with their situation and feeling 'lost' when they reach middle age. The women suggested putting more specialised health workers into all suburbs. Letting more women know of Centre services and improving their availability to working women would improve the Centre. Women being financially independent was put forward as a way to improve women's lives.

The TAFE teacher's feedback about the Centre commented that the Centre has helped many women, and guest speakers promote the services of the Centre but it takes too long to get an appointment.

Iraqi women who are parents

4 women participated in this focus group. They were attending a group at Fairfield Parent Support.

The women identified language issues, family problems specifically domestic violence, gambling, financial issues and smoking as of concern for them and women in general. They also identified drugs and alcohol as a concern for women in the Liverpool area. Stress and depression were the health issues mentioned. They felt the Centre should conduct women's health groups. In discussing what could improve women's lives the women's responses focussed on having happy healthy family and children and having good mental health. The women did not know of any women's services in the area.

Young mothers (2 groups)

Group 1

7 women participated in the focus group they were attending a play group at Prairievale Primary School.

Domestic violence and financial problems were identified as key issues facing women and for local women financial problems were important. For women in their own communities they felt lack of education, lack of workplace support for women with children and the difficulty of getting skills and

qualifications when you have children were of concern. They also mentioned isolation. When asked about health issues the women felt there was a lack of information about health issues, and that the overload of work and family responsibilities impacted on health. The women identified stress management groups and general women's health groups as something the Centre could run. Things that could improve women's lives were financial security, good mental health and job seeker support. The women did not know of any women's services.

Group 2

10 women were in this group attending a play group held in Busby.

The issues identified for women in general were relationship issues, lack of family support, self esteem, financial problems, when women get more work they face demands from their families too. For women in Liverpool this group identified isolation as a factor. They felt all of these problems were relevant to their lives and added that everyone is self centred and a lack of parenting knowledge was also an issue for them.

When discussing health issues the women talked about stress and depression, lack of health services, being overweight. Suggestions for groups the Centre could run were self esteem, stress management groups, fitness classes, parenting skills. The Centre could improve by offering more outreach programs and better promoting their services as well as having more ethnic workers and providing childcare. Women's lives could be improved by having greater support including free counselling services to improve their confidence.

The women did not know of any other ethnic services in the area.

Older women (2 groups)

Group 1

8 women participated in this focus group they attend LWHC's Laughter Club.

The issues identified as facing women in society were financial, concerns about parking and safety and security at night, depression and anxiety, isolation, family issues, child care and lack of support. The women identified that specifically for women in their community the issues of concern were isolation, transport, drugs, health and the lack of support for sole parents. When asked about health issues the group especially highlighted lack of transport and lack of childcare. Other health concerns were those related to immigration, loneliness and diabetes. Women identified a range of groups and health education activities that the Centre could run. Suggested topic areas were heart problems, diabetes, eye problems, cancer, stress related illness, arthritis, loneliness, osteoporosis, menopause. They also mentioned counselling and support as important. When asked how the Centre could improve many in this group felt the Centre was doing well as it was. Other suggestions were to work with children, to do anything that brings people together, focus on wellbeing. Things that could improve women's lives were free psychology services through Medicare, laughter club, communication and self esteem groups, tai chi classes, good relationships, providing support to women with children, availability of different groups. Many women in this group knew of no other women's services, some mentioned BreastScreen.

Group 2

28 women attended this group conducted at Casula Community Centre.

The women discussed the following as issues facing women in society: 'unruly kids', alcohol and drugs, violence in streets including knives and drugs; stress and anxiety; breast and cervical 'downstairs' cancer; problematic drivers; young people in family taking belongings. Issues for women in Liverpool were seen to be: 'unruly kids'; difficulties with transport and access to health including inaccessible transport for the elderly (buses without ramps) and the advertising of the timetable for those buses with ramps, illegal parking in bus stops is also a problem for access on to buses; lack of parking at hospital; noise at night from rowdy parties, drinking, fireworks; build up of rubbish.

Access to health care was a major problem for older women: they discussed concern that breast screening reminders for mammograms stopped at age 70 nor did their GPs perform breast checks. This was a worry as many women over 70 were diagnosed with breast cancer. Many Liverpool GPs were unwilling to undertake the paperwork involved in putting them on a care plan unless you were seeing a specialist; GP home visits only occur in emergencies and without a full medical history they are unwilling to prescribe medications. The cost of medical services was increasing especially the gap between the rebate and specialist fees. This was particularly difficult for women not on a pension or without a health care card.

Health issues identified were: breast and cervical cancer, diabetes, heart problems, blood pressure, strokes, obesity, menstrual problems, eyesight, arthritis and joint problems, hearing, depression, confidence and self esteem, isolation.

The groups and education programs that would be of use to these women were Tai chi (maybe even chair based), services in Liverpool, naturopathic, acupuncture and massage services especially for blood pressure and joint pain, self esteem groups, self defence and personal safety, friendship groups to meet new people, memory classes, laughter sessions, home handy person skills e.g. changing washers, opening jars independently. In discussing how the Centre could improve only 5 knew of the Centre so clearly better promotion of the Centre is important. The women suggested doing talks with community groups was useful. Improving access to massage appointments was a priority. The women also emphasised the importance of outreach services at Casula to improve their participation and providing transport to the Centre as important for older women.

When discussing what would improve women's lives the key response was good health. Other suggestions were: safety at home and on the streets, home handyperson skills to be independent, reliable finances, less house work and fewer men would also help. When asked about other local services the women could name local Aged Care Services and the University of the Third Age. Few knew of LWHC.

Young women

13 young women aged 14 –17 participated in this discussion at Ashcroft High School.

Being judged by external factors such as clothes, your looks and who "you hang out with" were considered key issues facing women. This group also identified cyberspace issues such as people

exposing themselves via webcam without consent. These issues were also relevant to Liverpool women as well as exposure to abuse and violence especially round Westfields and experiencing shouted insults and sexual harassment from cars.

Problems facing young women included backstabbing, rumour mongering at school, both online and face to face stalking and harassment, being threatened by people both known and unknown, feeling unsafe especially at night around Liverpool CBD, sexual pressure from peers and young men, pressure to fit in regarding their behaviour (e.g. drinking alcohol, cigarette smoking and using other drugs such as marijuana). Dealing with bad relationships was also seen as a problem and issues here included violence, possessive, jealous and overprotective boyfriends controlling who you talk to and checking up on you via mobile or MySpace. When asked about what health issues faced them they discussed anorexia and bulimia, depression, pregnancy, HIV, sexually transmitted infections and being overweight.

The young women expressed interest in accessing a women's health nurse for Pap smears and responded positively to the idea of classes of girls visiting the health centre with school. They felt the Centre could improve by letting people know about the service and having brochures available at school e.g. on the notice board outside the Careers Advisors office. Their impression was that the Centre was more for older women and that the Centre hours only left 2 hours after school for girls to use it. They suggested more youth friendly services such as a youth space at the school.

Suggestions for improving women's lives included foolproof methods for preventing unwanted pregnancies, having good non abusive boyfriends. Another suggestion was changing the way the world sees women so they were not judged and discriminated against at work and school.

Other services they were aware of included local GPs, counselling at Bigge Park Centre, Police Citizens Youth Centre, Centrelink. No specific women's services were known of .

NB The wording and the concepts behind the question regarding community strengths and opportunities in Liverpool was unable to be answered and may require review at the next needs assessment round.

Spanish speaking women

20 women attended this group conducted at LWHC

The issues facing women in society were seen to be domestic violence, stress, multiple roles, pay inequity, discrimination, educating children about dangers of drugs, climate change. More specifically for women in Liverpool the group discussed the following issues: cultural differences and tolerance, poor public transport, violence and abuse, crime and theft. Problems facing women in their community were related to immigration, settlement and adaptation to life in Australia, communication and language barriers, public transport and maintaining cultural traditions. A range of health problems were identified including isolation, lack of tolerance and discrimination, panic attacks, fears and phobias, managing diabetes, high cholesterol, varicose veins, arthritis, migraines, hearing problems and spinal and back pain. Women named the following groups as useful gentle exercise, self esteem, nutrition and groups in Spanish was a strong request. All women in the group felt the new extension would be a great improvement. They felt that having women's opinions on any theme respected by men would improve women's lives. These women knew of a number of

local services including the Migrant Resource Centre, Immigrant Women's Health Service and Family Planning in Fairfield.

Lao women

7 women participated in individual interviews (phone and face to face) which followed the focus group questions.

The problems facing women were seen to be domestic violence, sexual assault and family problems. Women do not feel safe. These were all seen to be relevant to the women of Liverpool. Problems facing women in the Lao community were unemployment, financial problems, gambling and isolation. When thinking about health problems, the women talked about family issues and working too hard. The groups they felt would be useful were: stress management, relaxation, parenting workshops. The Centre would improve by having more space. When asked what would improve women's lives the suggestions were financial support and good health.

Refugee women (4 groups)

The following information came from discussions facilitated by the women's projects worker from the NSW Refugee Health Service with specific refugee women's groups around their health needs. The consultations with the Sudanese and Serbian women were part of the development of the Area Health Service Maternity Services Plan. They do not follow the same format as other focus group discussions however the information was included as it is useful in guiding the planning of the Centre. The number of participants is unknown.

Mandaeen Women's Group

Health problems affecting them were: aches and pains – back neck and shoulder and stomach pains; stress and depression including sleeplessness, nightmares from war experiences, family dying in Iraq. Useful services and activities to assist were massage and swimming classes.

Afghan Women's Group (with some Iranian women)

The women identified the following health problems: stress and sleeplessness; depression including getting upset over simple things, lacking motivation, no relatives in Australia; aches and pains (back, knee, chest, migraines); arthritis; stomach problems (heart burn and acid); dental problems (including long waits for appointment); irregular periods; anger management problems with children; low self esteem; unable to stand up to husband in arguments; liver problems and Hepatitis C; anaemia; difficulties getting family to Australia.

Groups and strategies they thought would be useful were: nutrition and diabetes education, social groups to break isolation, cooking classes; managing heart disease, anger management; exercise program (must be in a covered area) and exercise that accounts for those with joint problems; swimming classes (women only) information on contraception; weight management; healthy eating; sewing group; beauty tips; anything that keeps you busy helps with depression.

Serbian women

This group identified the need for information on support services available after giving birth and for language support at antenatal clinics.

Sudanese women

The following issues were identified by the women: lack of awareness of the range of birthing services including antenatal classes and postnatal services; there was a lack of advice from doctors and midwives re circumcision and the effects of FGM on birth. The services and groups that were seen to be useful breastfeeding support; information on the birthing procedure; postnatal care for babies; programs for looking after your baby e.g. settling, feeding and postnatal depression.

Service providers

12 people participated in this discussion at LWHC representing Liverpool Council, Area Health Service – the Hub, 2168 and health promotion, South West Women’s Housing, Liverpool and District Neighbourhood Centres, Liverpool Youth Accommodation Association.

Issues identified as facing women were:

- Financial insecurity: lack of finances leaves women trapped in poverty;
- Employment issues – women are over represented in part time, casual and contract work, workplaces need to be flexible.
- Lack of affordable community based child care especially difficult for single mothers
- Gender pay inequity where women dominated work is not valued as highly.
- Women and volunteering- expectations that some services can function effectively with volunteers this falls mostly to women and thus women’s work is again undervalued. Also discussed was that level of volunteering is seen as a measure of a community’s social cohesion and what this might mean for women.
- Education – access to education is also about flexibility re women’s family responsibilities. TAFE Outreach was seen as a flexible form of education especially useful to disadvantaged women. Concern expressed re cost cutting of these programs. Welfare to Work requirements of Centrelink had put burdens on disadvantaged women – concerns re type of courses available and the limited employment opportunities – welfare and human services.
- Isolation – lack of family support and networks available especially for refugee women;
- Lack of safe affordable secure housing especially crisis housing;
- Mental health was a major issue for women as carers of people with mental illness and women with mental health problems themselves – there is a lack of resources and support for women;
- Information – concern about how accessible is information about services and how do women find out about them, is information available in community languages;
- Access to affordable legal representation is limited e.g. Legal Aid.

- The full spectrum of Violence against Women – including sexism, racism, discrimination, domestic violence, sexual assault.
- Language can be a barrier to accessing services
- Older women – there are growing needs in this group who are still often invisible and overlooked in planning in spite of their growing numbers.
- Young women – the WEEO WISER program was identified as critical in working with young women to seek safe and healthy intimate relationships.
- Lack of investment in women at all levels of infrastructure and service development
- Portrayal of women in the media – this discussion covered the increasing objectification of women and the sexualisation of young female children; media reinforces gender roles and stereotypes in relationships especially pertinent to young women exploring sexuality and what is expected of them i.e. sexual favours and acts.
- Decision making and power: Women are not adequately represented in positions of power. Men are still making decisions about women and the issues that affect them.

Specific problems for women in Liverpool were identified as:

- Access to safe affordable accommodation is a huge local issue of special comment was the lack of crisis accommodation for women leaving domestic violence. Housing traumatised and vulnerable women at the Grandstand Hotel in Warwick Farm is completely inappropriate.
- Lack of resources for CALD women in Liverpool given 46% of households do not speak English at home. Especially of concern were refugee and newly arrived migrant women and those on a humanitarian visa deemed 'at risk'.
- New land release areas – ensuring decent infrastructure and services in those areas and planned
- Car reliance was a huge cost from driving lessons, purchasing and maintaining a car. Relying on poor public transport creates isolation and barriers to employment.
- Mortgage stress was mentioned as an issue for women in the Hinchinbrook, Carnes Hill and Cecil Hills areas.
- Lack of support for social enterprise projects where women could gain skills and start their own business. Work providers will not support women to participate in these projects as client payments are linked to a more strict definition of employment placement.

Health problems identified by the group were:

- Mental health issues including depression and anxiety.
- Increased experience of ill health and violence among Aboriginal women
- Obesity related diseases

- Lack of access to fresh fruit and vegetables and ease of access to processed high fat fast food.
- Lack of access to healthy lifestyle opportunities: gym membership, exercise options, swimming, tai chi, stress management, yoga.
- Access to nutrition information especially for newly arrived women where traditional foods give way to processed Western diet; access to information about low cost nutritious foods
- Poor investment in preventive health promotion strategies.
- Groups and strategies discussed were: more outreach services, more clinics, free affordable groups and programs, creating practice forums which bring together local women and service providers would build on the Centre's recognised role in being a leader in providing a voice for women. A focus of this discussion was the lack of recognition of the huge growth in population for the area and the lack of funding to meet growing demand.

When discussing partnerships and opportunities the participants felt the Centre could build its partnership work with refugee and migrant services and the Police.

The group was very excited about the opportunities that the Centre's extension could bring.

When asked what would improve women's lives responses were: safe affordable housing, access to information, equality and equitable opportunities, women not being relied on to be everything to everyone, making healthy choices the easy choices.

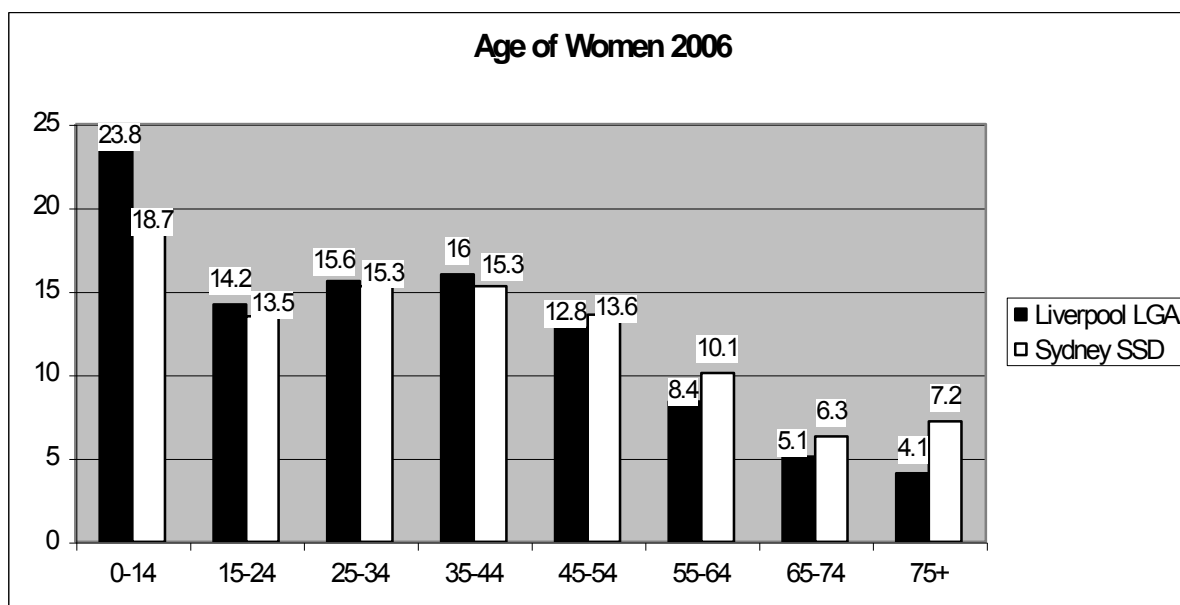
Summary of Demographics for Liverpool LGA

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

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. The Estimated Residential Population is 182,261 at 30 June 2009.

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.

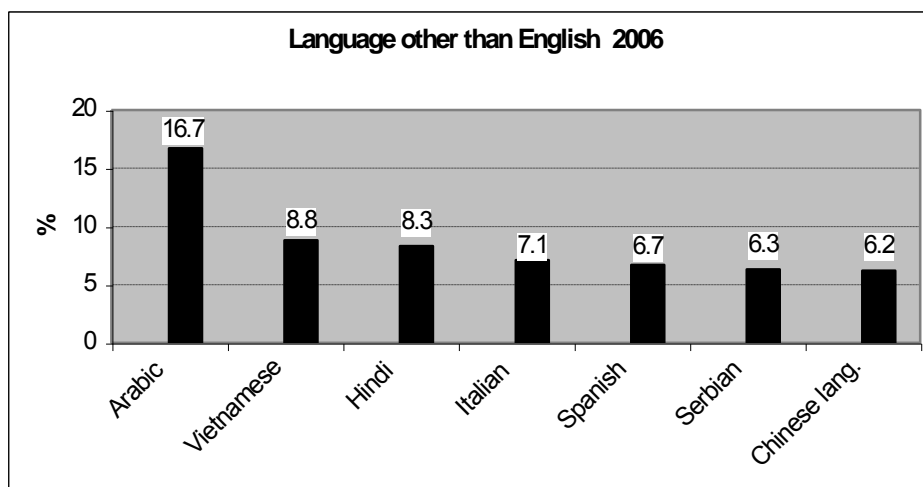
The median age in Liverpool was 32. This suggests a more youthful population than Sydney as a whole where the median age is 35. Almost a quarter of Liverpool's female population are under 15 years of age.



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%).



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 i.e. 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%).

SEIFA Index of Disadvantage for Liverpool LGA is 966.4. It is ranked 7th most disadvantaged LGA in the Sydney Statistical Division.

SEIFA Index of Disadvantage for Small Areas of Liverpool

Area	Postcode	SEIFA Index
Cartwright	2168	735.4
Miller	2168	737.5
Sadleir	2168	766.9
Warwick Farm	2168	773.6
Busby	2168	801.3
Heckenberg	2168	804.4
Ashcroft	2168	807.3
Lurnea	2170	874.7
Liverpool	2170	881.1
Green Valley	2168	947
<i>Liverpool LGA</i>		<i>966.4</i>
Austral	2179	976
Hinchinbrook	2168	990.1

Area	Postcode	SEIFA Index
Hoxton Park	2171	997.3
Casula	2170	1003.6
Moorebank	2170	1008.9
Western Rural	Not Available	1016.6
Edmondson Park – Leppington- Ingleburn Village – Denham Court	2174, 2179, 2565, 2565	1043.8
West Hoxton	2171	1045.6
Prestons	2170	1046.6
Hammondville – Voyager Point – Pleasure Point	2170, 2172, 2172	1048.6
Cecil Hills	2171	1051.5
Chipping Norton	2170	1062.9
Horningsea Park	2171	1067.7
Holsworthy	2173	1081.2
Wattlegrove	2173	1097.5

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.

Key Findings / Recommendations

Given the large number of focus groups conducted it is difficult to single out particular findings. However, there are some common themes to some of the groups and it is well worth ensuring that those focus groups who are under-represented in the survey such as young women and Aboriginal women are given particular attention.

The survey also shows women want to attend groups which provide *physical activity, flexibility and a balanced mind*.

1. Service Promotion

Many women did not know about Liverpool Women's Health Centre.

1. The Centre should develop and implement a *promotional plan* that emphasises building its profile with women outside of Liverpool CBD and Ashcroft and with identified key priority groups. This may be through: brochure deliveries in community organizations, high schools, placing ads in school newsletters targeting outlying Liverpool suburbs, talks with groups etc. Such a project could be *planned during the Centre building works*.
2. The Centre clearly needs to develop specific strategies for *promoting itself in new release areas, in newly arrived communities and with young women*.
3. Its greatest emphasis however should always remain with more disadvantaged, poorly resourced and newly arrived migrant communities who continue to reside in the suburbs of Green Valley and inner Liverpool.

2. Aboriginal women

The need for specific Aboriginal service provision was identified as a need as well as *providing activities on an outreach basis* closer to where Aboriginal women live e.g. in the Ashcroft area.

- The Centre should continue its outreach services at Miller and investigate offering Aboriginal specific groups that *build mental health and wellbeing* such as relaxation and laughter club in the Ashcroft area.

3. Women from Culturally and Linguistically Diverse Backgrounds

- Conduct *language specific groups with an emphasis on more recently arrived communities and refugee communities* who have fewer community networks and resources e.g. Iraqi, Afghani, Sudanese. Such groups could focus on women's health, stress management, parenting, self esteem. Such groups should be a continual focus of the Centre's work.
- Continue to *build on partnerships with the BCE program, Refugee Health, Liverpool Migrant Resource Centre and other relevant ethno-specific organizations and workers*. Many women identified isolation and making friends, language barriers, needing information about how things work, and information about health as important.
- *Employ more ethnic workers* who can work with newly arrived communities.

- Initiate *activities which increase cross cultural understanding across communities.*
- Organise *Dealing with Problem Gambling in Your Family* workshops
- Investigate *organising Pain Management workshops.* Managing pain (back, neck, shoulders, headache) were raised in a number of CALD communities.
- Develop *information workshop on Getting a Better Night's Sleep.* This should incorporate the needs of women from war torn countries. Networking with Blue Mountains Women's Health Centre and STTARTS might assist.
- Organise *swimming classes* in a women only covered setting.
- Organise *Anger Management* workshops for women especially related to parenting.
- Ensure availability of *language specific information* on post natal support services, looking after your baby for women from recently arrived communities.
- Advise women as appropriate on *impact of circumcision and FGM on childbirth* (e.g. would be valued by Sudanese women).

Groups in Spanish were strongly supported by Spanish speaking women.

4. Older Women

Public safety and security is an area of concern for some women.

- Maintain a relationship with Liverpool Council and lobby on issues regarding community safety initiatives that are relevant to women.
- Investigate feasibility of *conducting outreach workshops* for older women in targeted areas such as Casula.
- Offer information sessions and workshops for older women on:
 - *home handy person skills*
 - *health information sessions* on heart problems, diabetes, eye problems, cancer, stress related illness, arthritis, osteoporosis, menopause
 - *maintaining your memory*
 - *self defence and personal safety*

5. Young Women

The loss of the WEEO WISER program is likely to result in a decreasing engagement with young women.

- *Build stronger relationships with young women* e.g. by initiating high school class visits to LWHC or young women's open days or a drop-in project.
- Continue to seek funding for a *young women's health promotion officer*.
- Investigate ways of *continuing to conduct WEEO WISER programs* in schools.
- Continue to *conduct education sessions in high schools* and youth services.
- Offer *outreach young women's clinics* (e.g. for Pap smears, safe sex advice) around Liverpool LGA in places and times that girls can get to.
- Organise workshops for young women on *Protecting Yourself in Cyberspace*

6. Lobbying, Advocacy and Campaigns

Many of these issues were identified by the service providers.

Affordable housing especially for women in crisis was seen as a key issue for women in Liverpool.

- The Centre should continue to lobby for more in partnership with other service providers.

Population growth will continue to increase demands on services.

- The Centre should continue to be active in lobbying for more funding for a range of community and health services for women and particularly those that focus on preventive health and building wellbeing.

Maintaining *accessible and affordable health services* is important for all and was discussed in some way by most groups e.g. older women, young women, Aboriginal women and CALD women.

- Centre should participate in relevant health planning consultations to ensure health service accessibility in terms of availability, transport, cost and targeting decisions. Poor availability of GPs and dental services were identified.

Transport issues were identified by a number of groups including service providers and older women. There is a strong demand for more comprehensive, flexible, cheap and accessible transport. Cars cost money to buy and maintain. Getting to health appointments was identified as a problem by older women.

- The Centre should support initiatives which address transport issues and give them consideration when planning services and groups.
- The Centre should continue its strong work in advocating on all issues related to the full spectrum of *violence against women* and continue to look for opportunities to reinstate the WEEO WISER program.

Women's *financial independence* and the ability to *access education* to gain *meaningful employment* with a *decent income* was important to women.

- The Centre should continue working in partnership with TAFE and other education providers to support women and to lobby for continued women friendly education programs and workplaces.
- The Centre could be active in lobbying around policy *initiatives that impact on women's income* e.g. pensions, superannuation, equal pay campaigns, Centrelink policies.

A number of groups commented on the lack of respect and value placed on women.

- The Centre should support *public campaigns which aim to build the status of women and our rights in society*.

General

- Investigate multiple strategies and partnerships including running groups that aim to build women's *fitness, physical activity and flexibility* appropriate to their age and needs e.g. yoga, Tai Chi classes, gentle exercise, walking groups
- Continue conducting *groups that increase women's mental health, wellbeing and resilience*. Such groups would include:
 - Stress management and relaxation
 - Meditation
 - Art and emotion
 - Laughter club
 - Managing depression and anxiety
 - Self esteem and personal development
- Conduct *workshops* on:
 - Your rights: Responding to Discrimination and Harassment
 - Nutrition and Healthy Eating
 - Back Care
 - Taking Care of the Environment
 - Managing Health Naturally
 - Exploring Feminism
 - Managing Arthritis
 - Love Lust and Sexuality
 - Managing your Weight
- Investigate ways to increase/ streamline *access to massage services*.

Women's role as carers of children with disabilities, those with mental illness, aging and parents was discussed in a number of groups.

- The Centre could consider applying for funding for a project focussed on *supporting and resourcing carers*.

- Support and information for those *parenting teenagers* and *parenting children* was raised as an issue.
- The Centre could investigate the availability of such groups with relevant organisations and promote them.
- Organise a support group for *women in the middle years* which combined both some information and support around menopause and changing life roles and maintaining optimism for the future.
- Support initiatives for *women in domestic violence*.
- Continue to offer *childminding* as required alongside its group programs provision.
- Continue to provide *free counselling services* which were identified as important by a number of the groups.
- Organise activities which bring women together and *reduce social isolation* and *build friendship networks* were important and relevant especially to older women, young mothers and migrant women. Opportunities for making social connections should be incorporated into all group activities. *Coffee/ tea mornings* were also supported. Groups that incorporated crafts and cooking might be useful here.
- A number of groups found *low finances* a problem.
- The Centre may wish to offer *managing on tight finances workshops*. However, many women could run this workshop themselves. The problem is generally not money management but high costs, low income and family size.

Limitations/ Comments

All research comes with its limitations. This discussion is provided with a view to improving and building on the needs assessment process as well as alerting readers to some of the shortcomings of the process and methodology.

The survey was not done using a randomised selection method which may skew responses towards those women who have contact with community services. The low number of surveys collected lowers the validity of the information collected and limits the ability to draw strong conclusions.

The survey was not translated into languages other than English which may result in more limited responses to questions from women with limited English literacy.

The survey design varied between surveys 1- 42 and 43 – 61 with question 10 being excluded and slight variation in group options at Question 9.

Open ended survey responses are hard to interpret and code especially with the low response rate it is difficult to get anything meaningful from responses and gauge the strength of the response. **It is therefore important to re –emphasise the following recommendation: use a predominantly closed option survey with limited room for open ended comments.**

It would be useful to collect demographics in a way that matched Census categories e.g. age ranges as this would make for clearer comparisons.

The survey should be pre-tested prior to formal use to ensure the instructions are clear e.g. limit of 5 selections. Having said this, the compliance with completion of the front section of the form was impressive.

Many more women (151) participated in focus groups than completed the survey (61). Generally, this would be the reverse where focus group information complements and gives a voice to information collected in the survey. The substantial number of focus groups and participants and the variations in the depth of information recorded made analysis cumbersome and comparisons difficult. In future it would be useful to develop focus group questions/ areas for further exploration after having analysed the survey results so that areas requiring further clarification could be explored.

The low representation in the survey of young women, Aboriginal women and recently arrived migrants and refugees reaffirms the use of focus groups for these communities. However, it would be worth making extra efforts to gain greater participation in the survey.

It may be useful for the Centre to review its needs assessment processes in conjunction with other women services and a social researcher and develop tools which better suit long term planning requirements, are user friendly for women, applicable to the information required of a range of women's services and easily lend themselves to data analysis.