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1. Organisational framework

Vision

Women in south west Sydney will live free of violence, have equal rights and optimum health and be recognised and valued for our essential and visible role in society.

Mission

Liverpool Women's Health Centre strives to achieve better health for women and enhance our status in society.

Core values

Liverpool Women's Health Centre is committed to empowering women and valuing and giving voice to women's life experiences.

We work with:

- compassion
- unity
- mutual respect

In addition we strive to incorporate into our work:

- on-going development and support for staff in their work roles
- accountability in providing quality health care services
- integrity in maintaining ethical standards in the provision of services
- the right of women to a valued place in society

Organisational goals

1. To promote the operation of a free, feminist, community oriented health care centre, run by and for women, in a supportive, non-judgemental environment. To ensure such a service will offer a range of medical, alternative/ complementary health care, counselling, information and referral services with an emphasis on preventative health care measures.

   To pursue this aim within the context and with an understanding of the life experiences and realities of women living in the south western suburbs of Sydney.

2. To provide health information, education programs, group activities and resources designed to promote the physical, emotional, psychological and social well-being of women and enable women to take more control over their own health care.

3. To set priorities in service and program provision based on need, with special attention being given to the following women: Aboriginal, culturally and linguistically diverse, refugee, lesbian, differently-abled, economically and socially disadvantaged women.

4. To identify, investigate and promote an understanding of women's health needs and the social, economic and cultural factors affecting women's health.

5. To inform and impact existing health and welfare services so as to make them more responsive to the needs of women.

6. To promote and support initiatives and actions for change that will improve the health and status of women in our society,

7. To employ women with a broad range of relevant life experiences, skills and cultural backgrounds to staff the centre. Such staff to work as a team, promoting skills and information sharing amongst its members.

8. To do anything incidental to, and conducive to, the furtherance of these objectives.

(*Source: Articles of Association Liverpool Women's Health Centre Inc with minor amendments made during Annual Planning Days 2006)*

Specific goals

1. To ensure the provision of a quality feminist women's health service to the women of Liverpool

2. To work in partnership with other service providers and women in the community to address women's health issues.

3. To promote access of disadvantaged women and those most in need to the services of the Centre.

4. To advocate on health and social issues with a view to improving the lives of women.

5. To publicise and promote the work and philosophy of the women's health centre and the broader women's health movement.

6. To promote a supportive and productive workplace that has effective administrative systems and resources that enables the organisation to achieve its goals.

Centre philosophy & principles of health care

Liverpool Women's Health Centre operates from a feminist perspective that views health within a social context, as endorsed by governments throughout Australia, through the endorsement of the National Women's Health Policy (1988).

This view recognises that:

- health is determined by a broad range of social, environmental, economic and biological factors;
- differences in health status and health objectives are linked to gender, age, socio-economic status, ethnicity, differences in ability, location and environment, racism, sex-role stereotyping, gender inequality and discrimination, ageism, sexuality and sexual preference;
- health promotion, disease prevention, equity of access to appropriate and affordable services and strengthening the primary health care system are necessary, along with high quality illness treatment services;
- information, consultation, advocacy and community development are important elements of the health process.

In accordance with these principles, Liverpool Women's Health Centre aims to provide a service which:

- encompasses all of women's lifespans and reflects women's various roles in Australian society, not just their reproductive role;
- promotes the participation of women in debate and decision making about health issues, their own health care, health service policy, planning, delivery and evaluation;
- recognises women's rights as health care consumers, to be treated with dignity, in an environment which provides for privacy, informed consent, confidentiality and safety;
- acknowledges that informed decisions about health and health care require accessible information, which is appropriately targeted for different socio-economic, educational and cultural groups;
- uses existing data, research and policy concerning women's health, as well as incorporating women's views about their own health and the best strategies to address their health needs, in service planning and development;
- provides appropriate women's health care to women in local communities that takes account of a statewide, co-ordinated approach;
- ensures equity and accessibility of services without financial, cultural, geographic or other barriers;

- ensures effective community management and operation of the centre by women;

- provides a broad range of services and strategies within a preventive and holistic framework, which:

    - are provided by women for women;
    - value women's own knowledge and experience;
    - facilitate the sharing of women's skills, knowledge and experience;
    - link women's individual experience and health needs to the social and cultural context of women's lives;
    - empower women;
    - challenge sex-role stereotyping and gender discrimination which affect health;
    - increase the accessibility, sensitivity and acceptability of health services for women;
    - relate to identified health priorities at the local and state level
    - identifies and links the issues affecting women's lives and engages in political action that promotes social change for the benefit of women.

These principles are informed by the National Women's Health Policy through the Discussion Paper "National Policy on Women's Health - A Framework for Change" (1988) and taken from the Manual of Standards for Women's Health Centres (1995).

2. Centre Planning and Evaluation Processes

LWHC uses a range of planning and evaluation tools to inform its service development and operations.

- **Needs Assessment**

This is done every 3- 5 years and a report produced which assists with development of Centre Plans. The current report was completed in 2007. It includes:

-surveys of clients and women in the community (approx. 100)
-focus groups (6 – 10)
-demographics & epidemiological data
-review of LWHC service data

- **Annual & Half Year Reviews/ Planning**

This Centre is involved in Annual Planning and Half Year Review Days which look at Centre Action Plans for the year and review and evaluate progress and achievements against plans. Staff and Management Committee members are participants in this process.

The Annual Planning is also informed by:

-Occasional mini-survey of clients (30) to get a sense of groups and services wanted.

Following Annual Planning each Centre team will also develop a team work plan which guides their work for the year.

- **Evaluation**

LWHC monitors and evaluates its progress and the quality of its services in a range of ways these include:

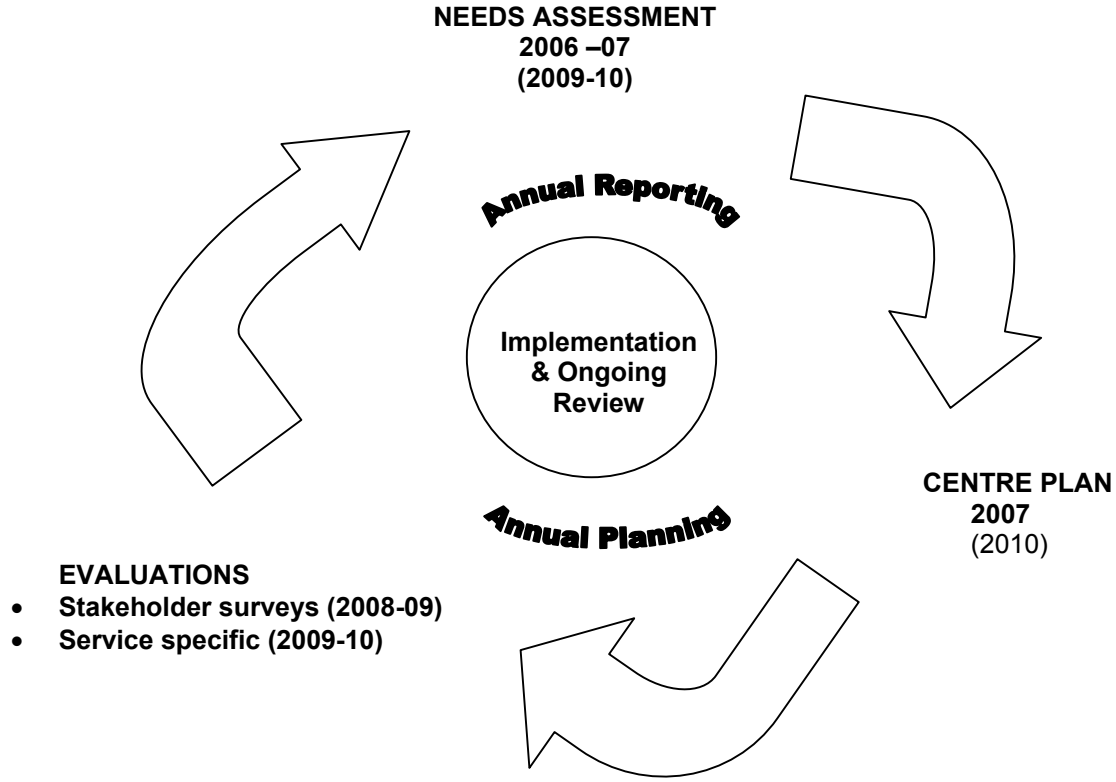
- 3 yearly Service Specific Client Feedback Surveys
  -Counselling (20)
  -Clinical (60)
  -Health Promotion (15)
- 3 yearly Stakeholder survey (30)
- Group/ Workshop Process Evaluation Surveys
-Client Feedback Book monitored in monthly staff meetings
-Annual staff appraisals

- **Reporting**

This consists of :

-Annual reporting to the funding body(s) and the broader community
-Quarterly reporting to the management committee

Centre Planning Cycle



3. Summary of Key Influencing Documents

The work of this centre and the planning towards this document has been influenced by a range of documents. There has been little work done on a planned approach to women's health within NSW Health or at a Federal Government level over approximately the past 5 years. For this reason there has been a reliance on government documents which although excellent are out of date. Key influencing documents included:

Needs Assessment Report, Liverpool Women's Health Centre, 2007

Some suggested actions for the Centre include:

- Continued focus on addressing violence against women
- Health of Aboriginal women
- Continued work with young women especially using peer education
- Building social connections between isolated women
- Build work with lesbian community
- Offer language specific groups which and other strategies which address the health of refugee women, women from new and emerging communities and building access of Arabic speaking women
- Build women's access to physical activities
- Continued opportunities for education of nutrition
- Provide opportunities for women to develop skills for managing depression and building emotional wellbeing.
- Look for opportunities to build clinical staff
- Explore strategies for supporting women in contact with the prison system
- Work in partnership with other organisations

Women's Health: The New National Agenda, AWHN, 2007

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

- *Using a social model of health*- "a broad range of environmental, socioeconomic, psychological, and biological factors impact on health, and that, to large extent, it is the settings, conditions and experiences of everyday life that determine good or poor health outcomes for women at all ages."

- *Incorporating a diversity analysis* to ensure that the needs of all groups in the community, including indigenous women, are taken into account. Specific groups facing greater disadvantage are identified:

    - indigenous women
    - women in rural and remote areas
    - women of culturally and linguistically diverse backgrounds, including refugees
    - women with disabilities
    - women as carers (both of children and elderly relatives)
    - lesbians, bi-sexual women, transgender and intersex people
    - women in prison or detention.

Suggested national *health priority areas* the are:

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

Within these priority areas, the network identifies critical issues to be incorporated such as:

- improving indigenous health and life expectancy
- health care for our rapidly ageing population
- obesity
- drug and alcohol abuse

The benefits of *adopting a gendered approach* to the already agreed national health priorities and using an *inclusive and accountable process* for further development and implementation of the new women's health policy were also highlighted.

Strategic Framework for Women's Health – SWSAHS 2000 – 2005

Health issues for women were classified as:

Social factors

- Socioeconomic status
- Indigenous health
- Cultural diversity
- Social support
- Violence against women

Life cycle factors

- Young women
- Older women

Specific health issues

- Reproductive health
- Breast and cervical screening
- Disability
- Mental and emotional health

Strategic directions identified were to:

- Incorporate a gender based analysis within an equity framework to further a shared sense of direction and responsibility
- Work in collaboration with others to address the social determinants of health
- Advance research on women's health experience and morbidity
- Develop and apply an appropriate health outcomes approach to women's health
- Focus on women most in need

Strategic Framework to Advance the Health of Women, NSW Health, 2000

- Identify the groups of disadvantaged women and those with the poorest health outcomes
- Target services and develop appropriate programs to address their particular health issues
- Identify and address gaps in service provision

Groups to be targeted include:
- Aboriginal and Torres Strait Islander women
- Women of non English speaking background
- Women with a disability
- Women of low socio economic status
- Women carers
- Lesbians
- Older women
- Young women
- Rural and/ or remote women
- Women who experience violence

Key Strategic Directions
- Incorporate a gendered approach to health
- Work in collaboration with others to address the social determinants of health
- Advance research on women's health experience and morbidity
- Apply a health outcomes approach

Women's Health Outcomes Framework, NSW Health, 2002

Links social determinants to health outcomes

Key determinants of health for women are:
- Gender
- Social networks and cohesion
- Socioeconomic status
- Changing roles and social status of women

National Women's Health Policy 1989

Identified Priority Areas were:
- Reproductive health and sexuality
- Health of ageing women
- Emotional and mental health
- Violence against women
- Occupational health and safety
- Health needs of women as carers
- Health effects of sex role stereotyping on women

Identified Key Action areas were:
- Improvements in health services for women
- Provision of health information for women
- Research and data collection on women's health

- Women's participation in decision making on health
- Training of health care providers

Future Directions for Health in NSW – Towards 2025, NSW Health 2007

This document identifies the vision and broad goals for NSW Health into the future.

It identifies the challenges facing the health system as:

> A growing population; an ageing population; availability of carers and volunteers; cultural diversity; changing way of life resulting in reshaped community and social relationships; advances in technology driving changes in clinical practice and service delivery; more active consumer role; continuing expectations regarding clinical quality and patient safety; complementary therapies; rising levels of chronic illness; new diseases and other risks to health; persistent health inequalities; shortfall and maldistribution of health staff; complexity between Commonwealth and State responsibilities; environmental risks; private sector; rising costs.

Equity in health is identified as the key principle underlying the 7 Future Directions.

These are:

- Make prevention everybody's business
- Create better experiences for people using health services
- Strengthen primary health and continuing care in the community
- Build regional and other partnerships for health
- Make smart choices about the costs and benefits of health services
- Redesign and reinvigorate the health workforce
- Be ready for new risks and opportunities

Ottawa Charter for Health Promotion, WHO, 1986 and Bangkok Charter, 2005

LWHC is focused on a preventive holistic approach to health and this approach is informed by the principles of the Ottawa Charter.

This identified that health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment.

The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity. Health is created and lived by people within the *settings* of their everyday life; where they learn, work, play and love.

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.

Health promotion strategies and programmes should be adapted to local needs and possibilities and take into account differing social, cultural and economic systems.

Health promotion action should encompass:

- Building healthy public policy
- Creating supportive environments
- Strengthening community action
- Developing personal skills
- Reorienting health services

The Bangkok Charter 2005 built on the Ottawa Charter and was developed in a world where globalisation is a reality. It highlighted the importance of **:**

- *advocacy* for health based on human rights and solidarity
- *investment in sustainable* policies, actions and infrastructure to address the determinants of health
- *capacity building* for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- *legislation and regulation* to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people
- partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

4. Community and Health Profile

(This section is directly sourced from Liverpool Women's Health Centre Needs Assessment Report 2007)

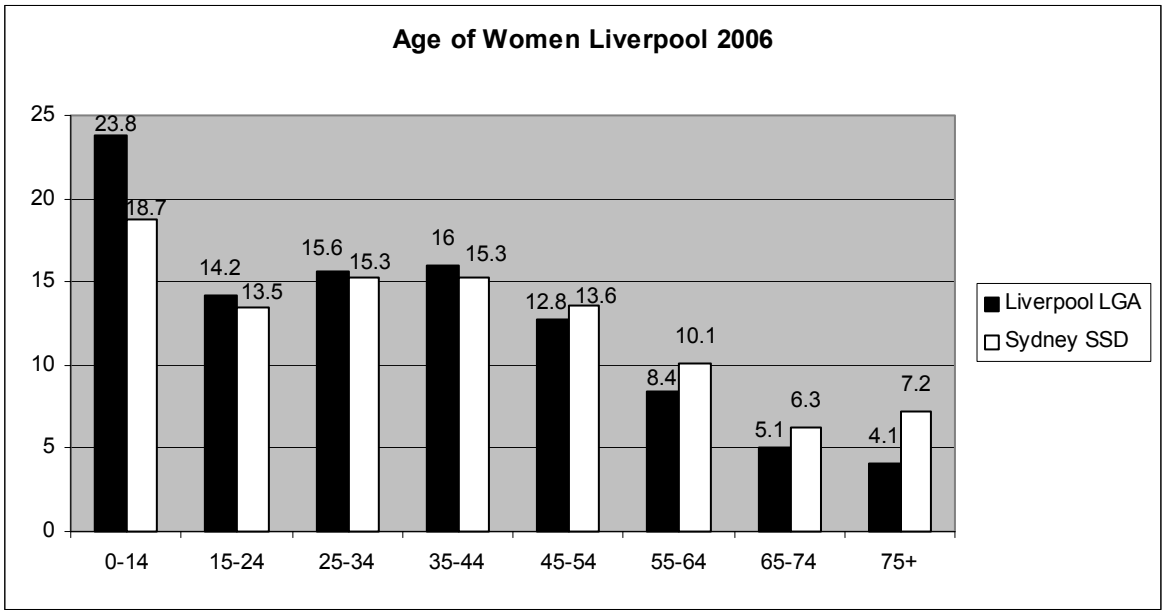
▪ Summary of Demographics for Liverpool LGA

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

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

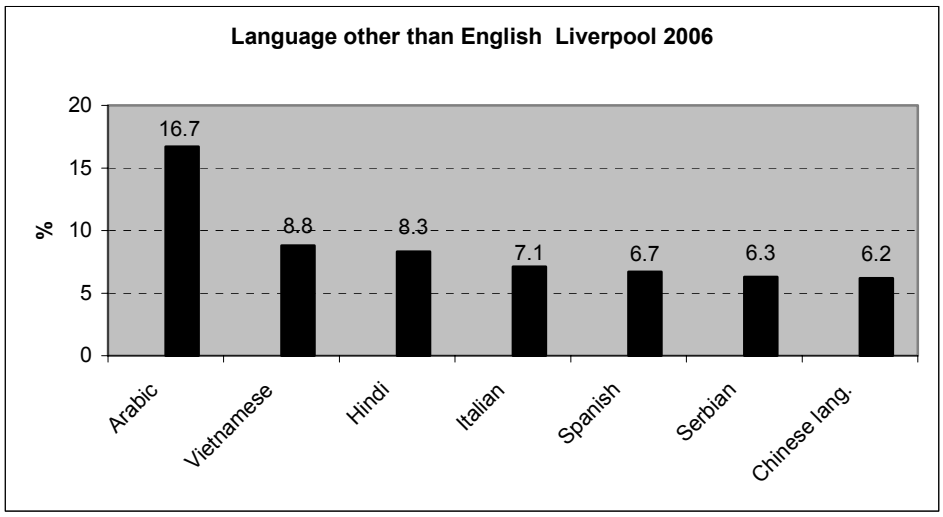
1.3% of the population identified as indigenous and this has remained steady since the last census. In absolute numbers it has grown slightly This is slightly higher than the proportion for all of Sydney which is 1.1%. 1165 Liverpool residents who identified as indigenous were female. In absolute terms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

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



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 ie. in all migration streams during this period was Arabic (45.9%), Vietnamese (6.1%), Hindi (3.3%), Serbian (3.2%), Mandarin (2.5%) and Spanish (2.3%).

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

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

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

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

24.2% of dwellings were fully owned. 41.4% were being purchased. 30.6% were being rented. 26.9% of rental properties were Dept of Housing. For Sydney SD 31.9% of dwellings were fully owned, 33.1% were being purchased and 31.3% were being rented. For Liverpool the main difference here is that more dwellings are in the process of being

purchased and this may reflect a more youthful population as well as lower incomes. 15.4% of Sydney's rental dwellings were Dept of Housing which is significantly less than Liverpool. 0.02% of Liverpool's residents were homeless or in improvised dwellings on Census night. This is much lower than for Sydney which had 0.25% of residents homeless.

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

- **Health Profile**

Major Health Issues For Women

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

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

Cardiovascular Disease

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

Cancer

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

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

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

- **Major Health Risk and Preventative Actions for Cardiovascular Disease and Cancer**

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

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

•

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

Physical activity

Men are more likely to be physically active than women. Women's physical and sporting activity peaks in the 25-34 year age group at 67.7%. A 2003 NSW Health survey revealed that 40.7% of women aged 16 years and over reported taking adequate levels of physical activity. Levels of physical activity tend to decrease with age, with 54.3% of 16-24 year olds engaging in adequate levels, compared to 23.3% of women 65 years and over. (6)

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

Body weight

According to a NSW study of weight over time, women of all ages were heavier in 2000 than in 1990. The study also noticed that different generations experience different patterns of weight gain, because of the unique set of experiences presenting throughout their lifetimes:
- Women of the pre-war generation are much less likely to be obese than later generations.
- Women born after 1980 are in the highest 'obesogenic' generation. (8)
- Generation X women (born between 1963 and 1978) have the highest rising Body Mass Indexes (BMIs) of all generations. The greatest rise in obesity rates has been in 25–34 year olds. For this age group rates have more than doubled in men in the last 20 years and quadrupled in women. (9) This trend is higher in NSW than the nation as a whole. (8)

The 2006 NSW Health Survey showed that:
39.7% of women in SSWAHS are overweight with NSW averaging 43.3%
16.6% of women rate at levels of obesity whilst NSW averages 17.4%

Nutrition

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

89.3% of surveyed women in SSWAHS had knowledge of the recommended fruit serves per day (NSW 90.3%) only 28.8% of women surveyed in SSWAHS knew the recommended servings of vegetables per day, (NSW 37.7%)
Only 8.1% of women actually consumed the recommended servings of vegetables (NSW-12.4%). 43.5% of women in SSWAHS had 3 serves or more of vegetables a day (NSW 50.8%). 6.5% of women experienced 'food insecurity', i.e. if they ran out of food and couldn't buy anymore. This contrasts with an area such as North Sydney/Central Coast where there is 2% and with the State at 6%.

Tobacco use

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

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

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

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

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

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

The 2006 NSW Health Survey found that:
-in SSWAHS 18.5% of women smoke, 12.4% on a daily basis, and contrasts with North Sydney which has 8.3% daily smokers. Recent research has indicated a socio-economic factor in the tobacco industry's marketing to those who are more disadvantaged and vulnerable to nicotine use. This risk factor in disadvantaged populations will be outlined in the next section.
-GPs-(46%) in SSWAHS are less likely to discuss with patients and advise against smoking in contrast with 51.6% of GPs across NSW.

Alcohol Use

In a 2003 NSW Health Survey, 30% of all females reported 'risky drinking behaviour'. This is to be compared to 41% in males. Women in the 16–34 year age group were most likely
to report risky drinking (40.5%). *(15)*
32.2% of rural women reported risky drinking behaviour compared to 28% of urban women. *(16)*
'Short-term high risk drinking' (defined as 7 or more drinks in one day) declined progressively with age, peaking at 16-24 in females (27%). *(17)*
29.6% of women had 5 or more alcoholic drinks at least one day in the previous 12 months. *(18)*
In the 1999 Australian Schools Students' Alcohol and Drugs Survey, 20% of 15 year old girls
and 30% of 16 year old girls reported having had five or more drinks on one occasion *(19)*.
The overall rate of increase in hospitalisations due to alcohol was 36% for women, compared to 6% for men in the 11 year period from 1989/90 to 1999/00. *(20)*

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

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

Oral Health

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

Medical attention

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

Mental health

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

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

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

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

Screening for Cancers:

Pap Smears

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

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

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

2003-2004 Screening Rates:

Biennial Cervical screening rates (%) by Age- AHS and LGA in NSW
SOUTH WESTERN SYDNEY AREA HEALTH SERVICE

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

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

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

Breast Screening

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

- ***Social Isolation/ Social Capital/ Safety***

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

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

Violence Against Women

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

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

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

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

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

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

The 1996 ABS Women's Safety Survey also found that younger women were more at risk of violence than older women: in the previous 12 month period, 38 per cent of women aged 18–24 had experienced an incident of violence, compared to 15 per cent for women aged

45 and over. In the 2005 Personal Safety Survey this gap seemed to have narrowed–though the percentage of younger women experiencing violence had gone down, the percentage of older women had gone up (26 per cent of women aged 18–24 had experienced an incident of violence, compared to 25 per cent for women aged 45 and over).

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

Sexual Violence

The 2006 Personal Safety Survey showed:

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

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

Liverpool Local Government Area
Sexual offences

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

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

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

Problem Gambling

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

- Males and females have different preferences for the type of gambling in which they participate.

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

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

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

HIV/AIDS and Hepatitis C

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

Pregnancy trends in NSW (37)

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

• Since 2000, the rates of low birth weight (less than 2,500 grams) and prematurity (less than 37 weeks gestation) in Aboriginal and Torres Strait Islander babies have been one and a half times to 2 times higher than the rates for NSW overall.
• In 2004 the peri natal mortality rate among babies born to Aboriginal and Torres Strait Islander mothers was 11.6 per 1,000, higher than the rate of 9.0 per 1,000 of babies born to non-Aboriginal or Torres Strait Islander.
- Births in mothers with the drug-related diagnoses (opioid, stimulant, cannabis) were more likely in women who were younger (particularly in the cannabis group), who were not married, who were Australian-born, and who were indigenous.

Population Groups With Higher Health Risks

Aboriginal and Torres Strait Islander Women

- ***Violence Against ATSI Women***

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

Health and Life Expectancy
Life expectancy for Aboriginal women in NSW is 63.6 years. *(38)*
An Aboriginal person born today can expect to live approximately 20 years less than their non-Aboriginal counterparts.

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

In 2001-2002 in NSW:
- the rate of hospitalisation attributable to alcohol was over three times higher in indigenous people compared to non-indigenous people;
- the current rate of involvement of indigenous people in drug and alcohol treatment is over three times more likely than for the non-indigenous population. *(39)*
- Based on BMI, 28% of indigenous females aged 18 or more could be classified as obese. This compares unfavourably with 19% of all females aged 18 or more. *(40)*

- ***Incarceration of ATSI Women***

-The level of, and growth in, the number of Aboriginal 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. *(41)*

- **Women from Culturally and Linguistically Diverse Groups**

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

Some key issues for CALD women:

Violent Relationships
There may be social, cultural and community pressures on women to remain in violent relationships. Many factors actually prevent these women from taking action.
For instance, a history of oppression, racism, entrenched poverty, lack of awareness of the laws relating to violence against women and concerns of further disadvantage. Evidently, such multi-causal factors also consistently impact upon their ability to access both the law and support services and may underlie the higher rates of violence, especially within specific communities. *(33,42)*

Health Issues *(43)*
Mortality rates among migrants from the United Kingdom and Ireland are closest to the rates for Australian-born people. In comparison, migrants from Asia have much lower standardised mortality ratios, with mortality rates 35% lower among males and 20% lower among females than their Australian-born counterparts. This is dependent on length of time in Australia.

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

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

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

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

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

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

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

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

Hospitalisation for *gastritis and duodenitis* among persons born in Other Europe, Asia and Other countries, as well as for calculus of the kidney and ureter among persons born in

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

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

Refugee Women

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

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

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

Lesbians *(45,46, 47)*

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

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

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

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

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

Younger lesbians are significantly more likely to report *problematic alcohol use* than heterosexual women and young gay men respectively. *(46)*
However, while less is known about alcohol misuse among lesbians aged 30 years and over, it is probable that problematic use of alcohol extends beyond young age due to a range of associated factors being experienced by many lesbians across age groups including sexuality confusion, social isolation, stress and low self esteem.
GLBT populations experience a higher rate of *mental health symptoms* and diagnoses as well as a generally poorer state of mental health than the general population. Depression and anxiety rated very highly whilst 'other psychological problems' rated relatively lowly in comparison.55 Research showed a widespread prevalence of depression and suicidal ideation (thoughts) amongst participants.

Women with Disabilities *(48)*

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

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

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

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

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

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

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

In1998, 92 per cent of people with a disability in NSW lived in private dwellings. 41 87 per cent of people with a disability living in households received care from informal sources.

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

Women in/ from Prison *(41)*

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

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

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

In a paper *Increase in Prisoner Population: Interim Report: Issues Relating to Women*, the NSW Legislative Council Select Committee on the Increase in the Prisoner Population found that *"The demographic information on female inmates overwhelmingly reveals backgrounds of serious economic and social disadvantage, mental health problems, violence and abuse and chronic drug and/or alcohol abuse."*
In addition it found
-that many women are the primary carers of children before incarceration;
-indigenous women are significantly over represented in the prison population;
-many are victims of sexual abuse;
-there are a high proportion of ex-state wards
-The increase in women prisoners combined with the complex needs and vulnerability of many mean that specific consideration should be given to the housing and support needs of women exiting prisons, including women with children.

Women as Carers *(49)*

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

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

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

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

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

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

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

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

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

Young women

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

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

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

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

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

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

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Acknowledgement is made of the research conducted by the NSW Office for Women and especially their brochure 2007, as contributing substantially to the following items in this profile: Mental Health, Alcohol and Tobacco use, Body Weight, HIV/AIDS, ATSIC Women, Women as Carers, Young Women and Pregnancy Trends in NSW)

5. Core Focus Areas

These focus areas form the basis for our detailed 3 year plan:

- Reproductive and sexual health of women through the lifespan
- Emotional mental and social wellbeing of women
- Health and wellbeing of Aboriginal women
- Health and wellbeing of women from culturally and linguistically diverse communities including refugee women and women in new and emerging communities
- Safety and wellbeing of women experiencing the effects of domestic violence and sexual assault
- Health and wellbeing of women who are differently abled.
- Integrated wholistic approach to women's health incorporating non medical with medical and counselling strategies, individual with group and socially focused strategies.
- Social justice and equality for women
- Health and wellbeing of young women
- Quality and infrastructure of the Centre

6. Areas of Strategic Focus

A detailed service plan follows outlining our work plans in relation to the above core focus areas. Some of these are of strategic importance in the sense that the Centre is attempting to develop into other areas or is attempting to address a gap or a newly identified need or there is an ongoing difficulty in addressing this issue.

They are (not in order of importance):

Target Groups:

- Working on partnership projects with *Aboriginal women* including continued work on the Aboriginal Women's Healing Space
- Improving access of *Arabic speaking, Vietnamese, newly emerging communities and refugee women* to the Centre
- Implement strategies that target *lesbian women*
- Health and wellbeing of *young women* including peer education project with young women on building healthy relationships
- Health and wellbeing of *differently abled* women
- Investigate outreach opportunities for LWHC in *outer areas of Liverpool and newly developing areas.*

Ways of Working:

- Continue to build *effective partnerships* with other feminist organizations, for example, to respond to violence against women
- Building a *research and evidence based* focus
- A public voice on social justice issues affecting women
- Incorporate *creative arts* into groupwork
- Public *promotion of our work and feminist principles* via conferences, papers and training programs
- Link in nationally and internationally with feminist movements

Health Issues

- Build women's access to *physical activities*
- Maintain a focus on responding to *violence against women*

Organisational Issues

- Ongoing Review of Policy and Procedures Manual including in areas of Information Management (such as program record management), Environment and Working with Women with Complex needs.
- Building staff hours and wages
- Employment of more doctors and nurses to improve clinical services and more strategic use of Medicare opportunities
- Operate a shared counselling model within the Centre
- Meaningful participation of local women/ consumers in the life and decision making processes of the Centre
- Improving the physical environment and space to better meet current and future staff and client needs
- Improved promotion of the Centre by more translations of Centre brochure, advertising in outer areas of Liverpool
- Participation in quality assurance procedures