PURPOSIVE SURVEY 2006

women's Health

women's health goulburn north east

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'I'm starting to feel burnt out at the enormous need in our community'

Women's Health Goulburn North East (WHGNE) was established in July 2000. Previously known as NEWomen, Women's Health Goulburn North East is the government funded, specialist women's health service for the Goulburn Valley and north-east Victoria.

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We greatly appreciate the time and thoughts of those who informed this report with such a wealth of information.

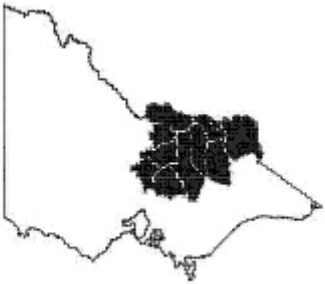
This resource is a snapshot of the health and wellbeing of women in the North East of Victoria and the Goulburn Valley (the Hume region).

It is a resource for the ongoing improvement of health services to women. We anticipate people will draw from this body of evidence when applying for funding or planning future work.

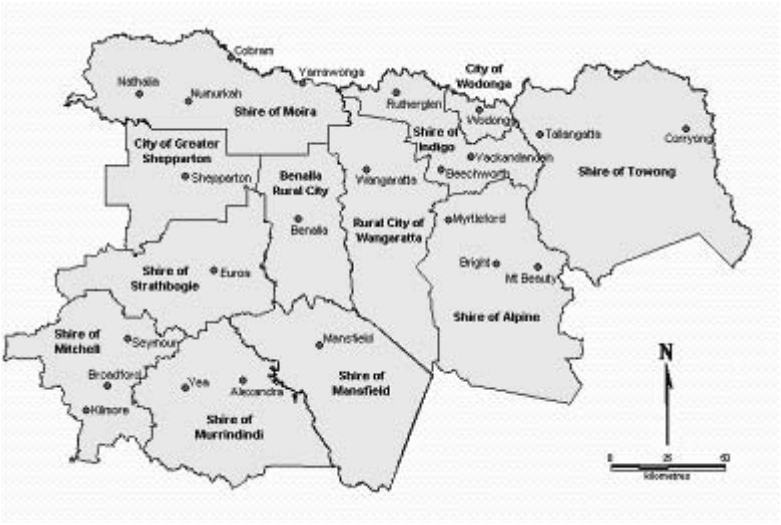
Please contact us if you would like assistance in using this information for the benefit of your agency and the women you work with.

Table of Contents

Geographical boundaries



Hume Region



Introduction and methodology

This is a 'snapshot' of the health needs of women within the Hume Region. It was captured by asking people with an interest and /or expertise in women's health and wellbeing to give their **opinion** relating to the health and wellbeing needs of women in their local area.

Purposive surveys have been conducted each three years from 2000 to gather the views of 100 women with knowledge and/or expertise in women's health in their local region. Between 200 and 400 questionnaires were emailed or posted out in each survey. Some received the questionnaire in both ways and were asked to return just one. No reminders were sent. Once 100 surveys were returned, we coded and analysed the data using *Minitab* - a quantitative data software package. In each of the three surveys, respondents represented all parts of the region - from provincial centres to small towns to remote areas. The sample is described in ***Appendix 1***.

As the title suggests, this survey is purposive, and therefore targeted to people with particular knowledge, so it is not representative of the population. In a purposive survey, 'researchers purposely choose subjects who, in their opinion, are thought to be relevant to the research topic[1]'. They seek 'individuals, groups, organizations, or behaviours, that provide the greatest insight into the research question[2]'. Like other forms of non-probability sampling, purposive sampling does not claim representativeness. It is used for exploration[3]. De Vaus[4] writes that it can provide useful information and that 'such a method can provide cheap and surprisingly efficient predictions'. Political polling, for example, often uses purposive sampling[5].

This 2006 survey replicates two previous surveys - the first conducted in 2000 and the second in 2003 - and contributes to our understanding of women's health in the Hume region, as women describe the human experience of life, health and illness.

1 Sarantakos, S (1993). *Social Research*. Sth Melbourne: MacMillan. p. 138

2 Miles & Huberman (1994), p. 34 cited in Devers, K. et al. Study Design in Qualitative Research in Education for Health Vol 13, No. 2, 2000, 263-271

http://www.educationforhealth.net/EfHArticleArchive/1357-6283_v13n2s15_713664908.pdf accessed 14.8.2007

3 Sarantakos, op cit, p. 137

4 De Vaus, D.A. (1991) Surveys in Social Research (3rd Ed). London: Allen & Unwin. p. 78.

5 De Vaus, ibid.

Key findings

- Our survey again identified lack of **bulk billing** as the biggest issue for respondents, with 90% of respondents indicating that lack of bulk billing is problematic. Three years ago this figure was 91% and in 2000 it was 84%.

- Of the 90%, 78% cited lack of bulk billing as a *significant problem*.

- 79% found **access to services** generally to be problematic, 37% of these saying it was a significant problem. This has remained fairly constant over the past two surveys.

- 79% stated lack of **participation in decision making** in relation to health services was problematic and 72% indicated that lack of involvement in decisions about *their* own health was problematic. These have remained fairly constant over the six years of the survey.

- In this year's survey, three new issues were included. The most striking finding was that 88% of respondents indicated (lack of) **access to specialist women's services** was problematic. Of these 57% indicated it was a significant problem.

- Three-quarters of respondents (75%) indicated that **inadequate recognition of diversity** was problematic, with 31% of these indicating it was a significant problem in their area.

- For 69% of respondents, **inadequate safety and security** was problematic in their area, with 21% of these indicating it was a significant problem. *[See Table 1. p. 6 for details of these points above.]*

- The striking finding from an examination of respondents' comments is that **financial difficulty and poverty** is a reality for women in our region.

- Equally salient is the emphasis given to the negative health effects of the traditional **role of women** as nurturer.

• It is not surprising, then, to note that self assessed **health status is poorer** in 2006 than in the 2003 or 2000 surveys. This applies to women in Victoria as a whole as well as Hume region women. *(See p. 7)*

• The glaring gap in the findings of this survey is the lack of feedback about Aboriginal women's health. This is despite including in the sample people who work with Aboriginal communities, and two specific questions on diverse and specific populations. This may be due to a lack of knowledge and the virtual absence of a region wide evidence-base. Or it could be unsuitability of the method of data collection. It is perhaps unsurprising in that the Aboriginal community can be invisible in may ways.

Yet we know from national statistics that Aboriginal women have a life expectancy of 63, which is 19 years lower than the general community[6].'Aboriginal people have the lowest health status of any identifiable population group in Australia ... Prevalence of disease is up to 12 times higher than the Australian average[7].' In December 2006, an open letter to National, State and Territory leaders and the Australian public, signed by 37 key health and human rights agencies, concluded that, 'It is inconceivable that a country as wealthy as Australia cannot solve a health crisis affecting less than 3% of its population ... We call on the support of the people of Australia to help stop this needless suffering[8]'. A comparative analysis of Indigenous poulation national health data in Australia, New Zealand, Canada and USA finds that Australia ranks lowest in the league table of first-world nations working to improve the health and life expectancy of Indigenous people[9].

As Hume region includes subtantial communities of Aboriginal people and two key agencies in Mungabareena Aboriginal Corporation and Rumbalara Aboriginal Co-operative, it is impingent upon all of us to work to eliminate health inequities. We recommend that you consult with your local Aboriginal corporation or co-operative in relation to their specific and issues. These conversations can be reported as anecdotal data to support submissions or give evidence for work practices.

6 Australian Bureau of Statistics (2002) *Deaths Australia, 2001*. Canberra: Australian Bureau of Statistics

7 Dept of Health and Human Services, Tasmania.
http://www.dhhs.tas.gov.au/agency/pro/aboriginalhealth/index.php Accessed 8.8. 2007.

8 Weniton, M et al. *Rising to the health challenge for Aboriginal and Torres Strait Islander peoples: what will it take?* MJA 2007; 186 (10): 491-492
http://www.mja.com.au/public/issues/186_10_210507/wen10402_fm.html accessed 8.8.2007.

9 Oxfam Australia & NACCHO. April 2007, *Close the Gap: Solutions to the Indigenous Health Cisris facing Australia*, Fitzroy

How women are affected by these issues

The key findings in the box above tell us the issues that women have identified as problematic in their local communities. They tell us '***what***' is a problem. However, the next question of the survey asked '***how*** women are affected by these issues'.

A total of 67 respondents wrote comments in answer to this question. Of the 164 separate comments:

- more than a third (38%) were about women being affected through lack of access to services, primarily through waiting lists and limited services; lack of GPs (especially female GPs) and a lack of choice in GPs. Other comments related to a shortage of specialists and the lack of specialist women's services.

- 21% of comments related to the lack of bulk billing, financial difficulties and poverty.

- 9% of comments noted that the lack of public transport or cost of transportation restrict access to services.

- 7% of comments were about lack of participation in decision making about own health; and the difficulty in accessing information which means women are less able to make informed choice. Comments suggested that women are not using services because they are not aware of their existence.

The other comments (24%) ranged over 30 topics, such as dissatisfaction with the current health system; the challenge of social isolation; women experiencing domestic violence having to move away for support; and the health of older women.

Changes in identified health issues over three surveys

A number of women's health issues have been identified through national and state policies. The questionnaire in 2000, 2003 and 2006 asked the *same questions* about seven of these issues, making the responses comparable across the years. The issues were: access to services, access to information, participation in health service decisions, involvement in own health, training of health professionals, bulk billing, and safety.

We asked respondents how problematic each issue was in their local area. Table 1 details the findings. For most, the answers remained much the same. The exception is 'Access to health information', which is steadily improving. Those who say it is 'Not really a problem' have increased from 23% in 2000, to 26% in 2003 and now to 37%. Although internet connection is still not possible in all parts of the region, the general ease of finding health information via the internet could account for better access to information.

■ Table 1: Health issues and respondents' opinions of how problematic each one is within their local area

	Significant problem			Problematic			Not really a problem			No response		
	2006	2003	2000	2006	2003	2000	2006	2003	2000	2006	2003	2000
Lack of bulk-bill	78%	80%	68%	12%	4%	16%	10%	11%	13%		5%	13%
Specialist women's services (new question)	57%			31%			11%			1%		
Participation re health services	32%	39%	54%	50%	37%	31%	13%	19%	12%	5%	5%	3%
Access to health services	37%	41%	47%	42%	39%	38%	20%	17%	14%	1%	3%	1%
Involvement re own health	22%	32%	42%	50%	44%	31%	26%	18%	26%	2%	6%	1%
Access to information	16%	14%	35%	47%	54%	40%	37%	26%	23%		6%	2%
Training of health care providers	22%	20%	22%	41%	45%	41%	34%	30%	34%	3%	5%	3%
Recognition of diversity (new q)	31%			44%			24%			1%		
Safety and security (new q)	21%			48%			28%			3%		

Self assessed health status

Respondents were asked to rate their own health according to the World Health Organisation definition:

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity.

Table 2 compares responses for Hume region over the three surveys, and interestingly, shows that self assessed rates of poor and fair health have increased to almost double over the six years. This is not a random sample and is not representative of the general population of Hume region. However, the rates given for Victoria as a whole ***are*** representative. They show the same result of a substantial increase in the proportion of women saying their health is only *poor or fair*.

For Victoria there is at least a three-fold increase in women saying their health is only *poor or fair*, and a drop from 30% in 2000 saying their health is *excellent* to 11% in 2005. At the other end of the scale, rates for *very good* dropped by 11%.

Sixty Hume region respondents explained why they gave the score they did. In explaining a good rating, thirteen respondents commented about taking responsibility for self motivation; another 13 about holistic health; and 8 wrote of having strong relationships. Of those explaining poorer assessments, 12 wrote about the burden of expectations on women; 9 about neglecting their own health and needs; another 9 gave comments on their own poor physical health such as being tired; and 6 wrote of feeling increased stress in recent years.

■ Table 2: Women's self assessed health Victoria and Hume

Rating	Victoria 2000	Victoria 2002	Victoria 2005[10]	Hume 2000	Hume 2003	Hume 2006
	%	%	%	%	%	%
Excellent	30.2	13.5	11.5	19	19	22
Very Good	43.5	35.7	34.3	55	59	42
Good	21.3	34.7	37	20	14	24
Fair	4.4	13.5	13.7	5	6	8
Poor	0.6	2.7	3.3	0	2	4
	100	100.1	99.8	99	100	100

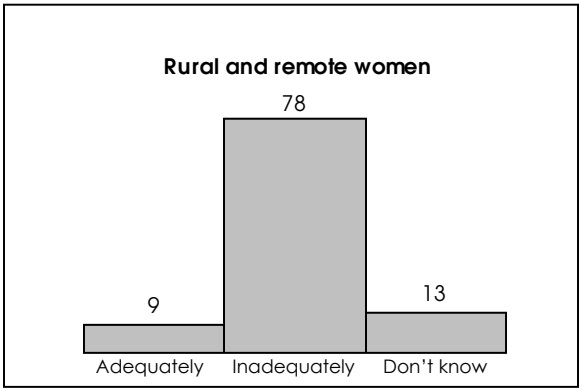
Missing data = 4

10 Victorian Government Department of Human Services (2005) Victorian Population Health Survey 2005: Selected Findings. Accessed http://www.health.vic.gov.au/healthstatus/downloads/vphs/vphs2005_s3.pdf (23.7.2007)

Adequacy of response to a range of health issues

Respondents were asked their opinion of whether a range of separate health issues were being addressed *Adequately or Inadequately* (with a *Don't Know* option). The results are shown in the graphs following and in Table 3 on page 14.

In addition, respondents were invited to comment. Thirteen women commented on lack of access to services, 8 on lack of access to information, 7 on lack of coordination and integration and 6 on their dissatisfaction with the current health system. Lower numbers of respondents commented on a further 26 topics.



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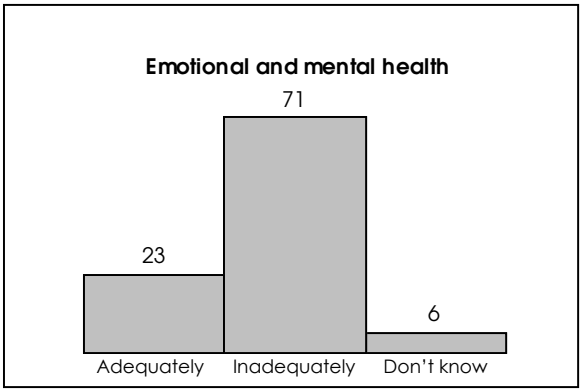
78% indicated that rural/remote women's issues are inadequately addressed in their area:

[There] can be a clash of personalities or mistrust in a professional's assistance to women and due to lack of choice some women can ignore or not attend a certain health service as there may be only one professional.



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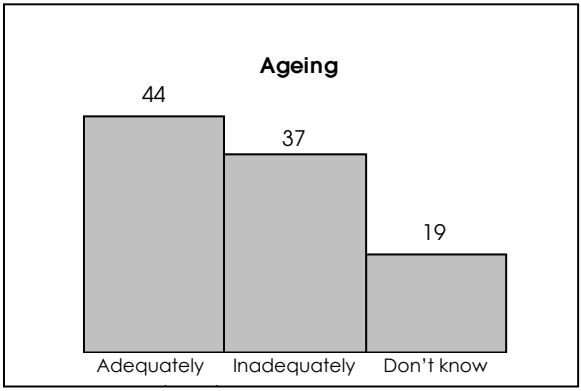
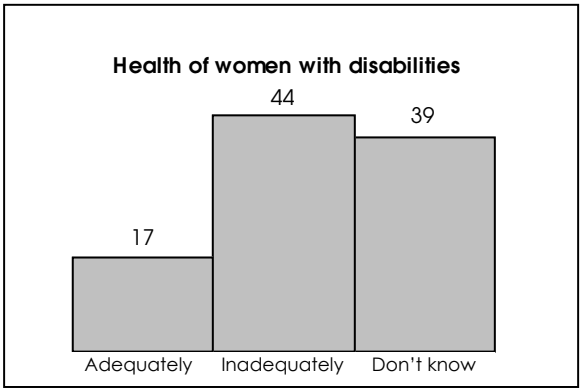
71% indicated that emotional & mental health is inadequately addressed in their area.

Women are under significant stress and this adversely affects all women in our area. Those with underlying mental illness do not receive the level of support available to city women.



37% indicated that ageing is inadequately addressed in their area.

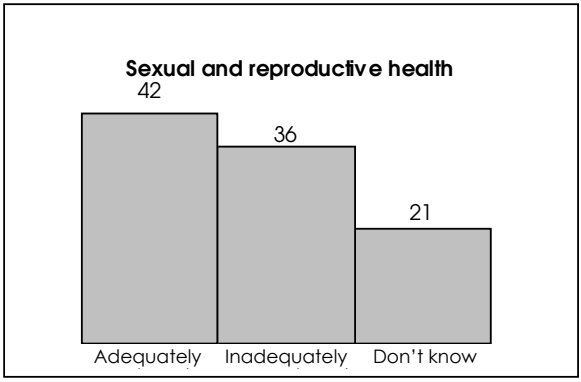
I am seeing a number of women 50+, not partnered who have chronic physical ill health …They are struggling with image problems, financial problems (often losing their home) inability to get alternative work, and then mental health issues set in.



Missing data = 1

44% indicated that health of women with disabilities is inadequately addressed in their area.

The complex needs of women with intellectual disability or ABI ... requires a coordinated approach to manage support.



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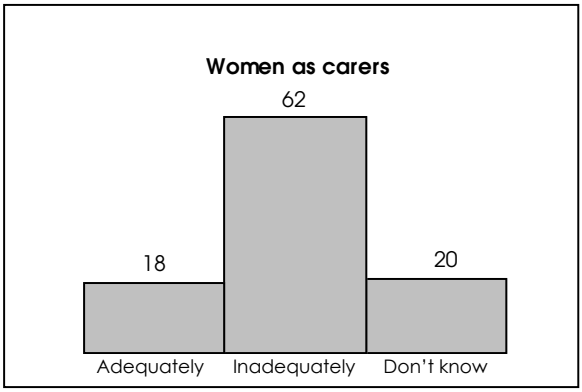
36% indicated sexual and reproductive health is inadequately addressed in their area:

Young women are ignoring advice about sexual activity; risk taking is back on the agenda.



62% indicated that 'women as carers' is inadequately addressed in their area.

Women as carers are invisible.

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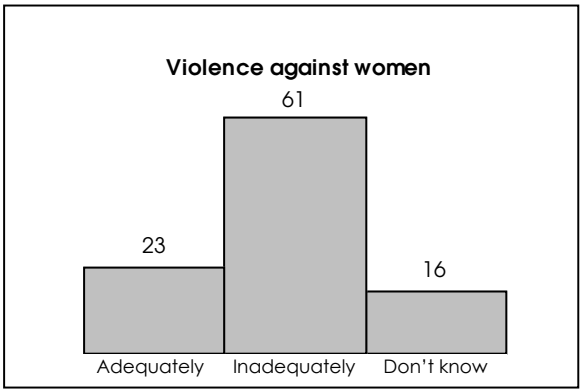

61% indicated that violence against women is inadequately addressed in their area.

Violence continues to be a huge problem for young women aged 16-25.

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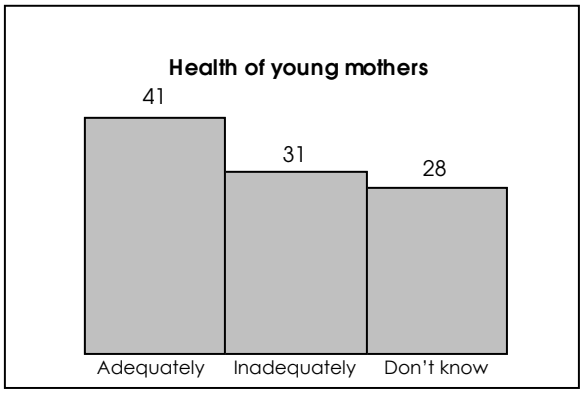


31% indicated that the health of young mothers is inadequately addressed in their area.

Young mothers need ongoing close contact and support.

Missing data = 1

Responses over the three surveys

Table 3 shows responses for each three year survey. Over the three surveys the two issues that respondents feel are worse now than in previous years are Rural and Remote Women's Issues and Women as Carers. However, many issues still remain significant areas of concern.

Particularly noteworthy is that around three-quarters of respondents indicate emotional and mental health is not being addressed adequately in their area. While it has improved steadily over the three surveys (77% in 2000; 74% in 2003 and 71% in 2006) fewer respondents say they 'Don't Know' which may indicate more people are seeking help with emotional and mental health issues and there is more awareness of available responses - or their non-existence.

■ Table 3 Responses for each 3-yearly survey

Issue	Inadequately	Adequately	Don't Know	No response
Sexual and reproductive health	36% (2006)	42%	21%	1%
	41% (2003)	33%	22%	4%
	52% (2000)	29%	15%	4%
Ageing	37%	44%	19%	3%
	52%	36%	10%	2%
	44%	34%	18%	4%
Emotional and mental health	71%	23%	6%	1%
	74%	18%	6%	2%
	77%	9%	11%	3%
Violence against women	61%	23%	6%	1%
	55%	25%	17%	3%
	63%	17%	17%	3%
Women as carers	62%	18%	20%	2%
	57%	23%	16%	4%
	58%	13%	24%	5%
Health of Aboriginal and CALD women	42%	11%	47%	4%
	55%	10%	28%	7%
	(Not sought in 2000)			
Health of women with disabilities	44%	17%	39%	1%
	54%	10%	33%	3%
Health of lesbians	23%	8%	69%	2%
	31%	9%	57%	3%
Rural / remote women's issues	78%	9%	13%	2%
	72%	11%	16%	1%
Young mothers	31%	41%	28%	1%
	(Not sought prior)			

Rural economic downturn

Table 4 shows that 84% of respondents indicated that women are affected by the rural economic downturn, with only 5% saying they are not.

A total of 76 respondents wrote comments, and, of these almost half (48) wrote about poverty and financial strain; and 17 wrote about the extra burden women carry through expectations based on gender. It is not unusual for women to be expected to work on and off farm; to care for their children and their own parents; to watch out for signs of depression in husbands and partners; and to keep an eye on neighbours.

Seven wrote about depression and anxiety, and six about the drought. A further 23 categories of comments were given.

Table 4: Opinion as to whether women are affected by the rural and economic downturn

Yes	84%
No	5%
Don't know	11%
	100%

Missing data = 6

In answer to a specific question about *how* financial considerations affect women, 67 respondents gave a comment.

While 47 comments were strictly about poverty, 16 were about lack of transport, 14 about particular issues associated with low income groups, 9 about lack of childcare, 8 about unemployment and another 8 about the burden of the expectations placed on women. A further 21 categories of comments were given.

Due to the economic downturn some mental and emotional health issues have manifested as drug and alcohol issues as clients are self medicating.

Women endure depression, anxiety and other mental disorders from stress and isolation associated with a rural lifestyle.

Mental and emotional health

When asked about how mental and emotional health issues affect women, 74 responded, 23 commenting about depression and anxiety disorders; 18 about the prevalence of mental health disorders; 11 about inadequacy of the mental health system; 10 commented about the burden of the expectations placed on women; 10 about social isolation; 8 about increased stress in recent times; 8 about family breakdown and relationship problems; 7 about poverty and financial strain; 6 about emotional stress and 6 about limited access to services and waiting lists.

What women said ...

In this final part of the document, we hear directly from the women who completed this survey, their words unfiltered by analysis. Reading through their quotes gives a sense of what women in our region are dealing with in their lives.

We believe this qualitative data can be effectively used to include a sense of 'the lived experience'. Victor Sidel famously said that, 'Statistics are people with the tears washed off[11]'. The words that follow allow us to clearly see the people - tears and all - and will add depth to submissions, or in arguments for changed services.

The quotes are organised under headings, although some quotes could easily fit into more than one category. Feel free to use these quotes, recognising only the generosity of the women who completed the survey and who shared their experience and knowledge.

[11] http://www.healthpromotion.act.gov.au/news/conferences/files/2005EberhardWenzelOration.pdf

The role of women

At present many women are feeling the pressure. Often it is only women in the family holding things together and willing to ask for help. Modern living places more stress on women to be good at all the choices we make. I think our identities are just as prescribed as they were 50 years ago - but now we have more roles then ever before.

" Welfare to Work" will impact on women as they have to manage increasing family participation obligations [and the] higher pressure to work flexible hours impact on family.

Due to drought many women have to carry the burden of a depressed family member and then don't have the capacity to look after themselves.

Women have had to take on outside employment to compensate the family income. This in turn could mean having to place kids in day care, etc. Unable to spend enough time with kids. Having to find the money for day care.

Children/partners will be looked after and mother/wife will go without.

Having to maintain family unit, provide emotional support to men who feel a failure, not adequately supported to do these things, carry financial burden.

Country women tend to put themselves last on the priority list so attending to health issues would [be] seen as wasting money.

[Women are] neglecting their own wellbeing for family, travelling to gain employment putting further pressure on resources and family duties.

Isolation and expectations that women are raised tougher in rural areas.

Drought affected families - women supporting their men are carrying a huge load at the moment.

... Women still need to carry the burden of raising families, cooking, cleaning, working and still manage to look after themselves. We always put ourselves last and this stress takes its toll eventually.

By the time I have driven to work, taken the children to sports or activities, there are no resources ($ or strength) to take another trip for myself.

Women as carers

I do try to be balanced but there are times when I feel exhausted from working and being sole care giver to children and elderly parents.

We are the nurturers and when our grandchildren are in our care, [we] feel let down by[the children's] parents - quite often through broken promises. We pick it up but we feel the disappointments.

I feel like I am there for everyone else and really does anyone care about me other than what I can do for them? I am physically and emotionally drained...

Young mothers

My main concern as a working mother is lack of childcare and options...

Single mothers can attract a lot of judgement [...] from some community members.

A recognised concern is the inability to be able to give birth at the local (Seymour) hospital.

Access to services and transportation

For unsupported/unconnected/high risk women it's almost impossible to get to specialist appointments out of town due to almost non-existent public transport both to the next big town /city and within that town / city. Women who are supported can get a lift or someone will take them over.

Cost of transport with increasing fuel prices means hardship to travel to health care - or lack of public transport or overburdened community transport can make health care inaccessible.

I suspect young women without a car (living in rural areas) have lots of problems with access, and also older women living on farms with limited transport options.

The Community Health Services being moved out of the town centre in Benalla, I think means not as many young people in the age group I work with access them.

The tyranny of distance impacts significantly - both financial and physical burden of constant driving to access services can impact on emotional wellbeing.

Women who live on farms are at a distinct disadvantage to those that actually live in the country centres, i.e. increased problems in accessing services.

Women do not access services as early as they should, are not comfortable with accessing some services, are not aware of many others, cannot afford services, are not supported by their family to access services. [They] lack educational level to understand their needs fully [and] follow the actions of also poorly informed older family members.

Access to GPs and specialists

While there is a facility in this area, I was refused help due to their books being full and not currently taking on new patients. Too much need, not enough doctors [or] facilities.

In relation to access to specialist women's services, just getting into a female GP is often an issue and up to a week's wait.

The most common difficulty at present is access to GPs as all Wodonga GPs' books are closed.

GP service once a week only. Lack of transport.

Being able to access specialists is extremely hard and/or time consuming. Appointments in Melbourne are hard to attend and it can take a whole day to spend 20 minutes talking to one doctor. There are specialist services available here but the standard and quality are not the same as what is available in Melbourne.

Inadequate numbers of doctors in the area, therefore doctors are sometimes not taking enough time with a patient. 'Here's a pill' mentality trivialized the woman's health condition.

Difficulty getting appointments- too few general practitioners - few obstetrics & gynecological choices in the town.

People in general are waiting too long for appointments to see a doctor especially specialists. There are very few specialist women's services although there are several female health care providers. Access to services in rural regions is a health issue for all that reside there.

Living in rural Victoria, Specialist Women's services are really non-existent. General care from female GPs is scarce. Few and far between.

No specialized women's health service in area. Few female doctors. Little focus on women's health.

Limited ability to choose gynecologist and long delays getting into see them.

A recognized concern is the inability to be able to give birth at local (Seymour) Hospital.

Oncology services very limited. Specialist not trained in holistic approach. Even women GPs and specialists lack some sensitivity in dealing with women's health issues, e.g. Being told by female doctor, "Your cervix is a mess", or by a specialist (female) who doesn't acknowledge your alternative approach, "When it comes back and it will, there is nothing we will be able to do for you!" So if you want other options you have to travel to Melbourne

Bulk billing

Lack of bulk billing facilities is critical and whilst some GPs will allow this to happen it is not generally known.

Outrageous that [there is] no bulk billing - women are put off going to the doctor.

Bulk billing is a huge issue in our area. Women at times cannot afford to have money up front ...

Some don't go to doctors unless it's an emergency because their clinic doesn't bulk bill and these women are on limited incomes.

Bulk billing is non existent and therefore discriminates against those on low income making them seek medical services only when desperate.

There are very few bulk billing services in the area for women of all ages and income. Few services bulk bill and if they do it is difficult to get in or you need a good relationship with the doctor to be bulk billed and it is at their discretion.

Financial difficulties and poverty

It's so hard to get into my own doctor and pay the extra [money] so I don't go.

Women unable to attend specialist appointments, or obtain x-rays /scans because they do not have the money to pay upfront (which is required).

I am working with women who are not taking their prescribed medication for chronic illnesses because they cannot afford to pay for them.

Costly to seek assistance and then pay for the script. Sometimes a week's food can be bought for the same price as a doctor's visit.

People on low income (who are not health care card holders) have difficulty finding money to fill scripts - just above the limit.

Decisions about health are impacted by financial situation, especially combined with high fuel prices.

Women will put family above own needs. If less money, won't use on own medical or dental needs but on her children's.

If a young person has moved out of home for over 12 months [they are] still means tested on parents' income by Centrelink, so cannot receive independent Youth Allowance.

Women are having to work harder to make ends meet - in this context, they will inevitably put their own health needs last.

Poverty is a disability. Money represents more commodities, more access to better life style, more opportunities for better schooling, more access to medical services and generally speaking even more social acceptance. Also money represents more autonomy and a wide spectrum of options

Being laid off from work, husbands not able to hold employment, farms not able to support family, businesses suffering under current circumstances, children not able to access work in area.

Very few women in farming enterprises have access to independent finances.

Supporting partners on the land and watching drought destroy everything.

Family payments especially when children visit on access - petrol /train costs etc. are a financial burden on women - custodial and non custodial.

Dairy farmer wives are doing it REALLY tough. Milk prices are crap, and now the cows are also expensive to feed and water, and not producing as much.

Women are generally the ones in control of budgets and household expenses. Because money is less available they have to be more resourceful with the household budget and bill paying.

Farming bankruptcy is different from losing a job. Aspects such as familial responsibility (after 3-4 generations of owning a farm and losing it is a major mental upheaval) and hence passed on to the women.

Violence against women

Difficulty accessing services for women experiencing violence. [They] most often have to move from their home town and all their support.

[There is] a lack of DV staff with those employed currently overworked.

[Health issues of concern is] young girls in violent homes - parental or partnered - very serious.

Mental health

Depression is a big problem affecting a lot of our clients through unhappy life experiences as a result of family/ relationship issues [and] abuse of drugs and alcohol. Suicide also presents.

Depression is a huge issue here. We need better mental and health services... We desperately need a mental health presence here. We have one counsellor one day a fortnight and that's not enough. There is a high number of mums on anti-depressants here but no support groups.

Depression and anxiety has limited [women's] capacity to direct their own lives, choose work, parent children, and care for others including extended family.

Community mental health services need to be more accessible and therapeutic counselling based not just medically based.

The easy fix of an anti-depressant doesn't fix the problem. Cheap or free relaxation/meditation classes would be more beneficial.

Mother with postnatal depression needing immediate assistance - no-one wanted to know or assist.

The inability to refer patients for psychological consultation if the GP has not completed the Better Outcomes of Mental Health training - thus again resulting in a financial barrier to good/appropriate care.

Counselling for women ...[when] recovering from the mental and emotional impact [of family violence] is inadequate. Respite ... from parenting and stresses is virtually non-existent.

I have (in the past two years) gone from a healthy, happy person to a person with huge stress related health problems. I now have a skin condition, chest pains, nausea, anxiety and migraines.

I work full time in the mental health sector. Life stress has led to own diagnosis of depression.

[There are] no specialist feminist workers in clinical mental health. Workers are stretched to the limit so [women's health issues] tend to be poorly dealt with.

Our area mental health service is poorly resourced so I feel people with more severe mental health issues sometimes receive inadequate care.

[We are] inadequately supported [with mental and emotional health issues] in the community - the situation needs to reach crisis before assistance is available.

Social isolation of CALD community

Very conservative area re: CALD Community - not much understanding of cultures - slow to change.

Women of non-English speaking background - there are too few of any one cultural /linguistic group to be able to provide support/ advice / interpreters.

The health system

I believe that older women face many problems - doctors' lack of interest and inadequate training (ageist attitudes).

Integration Health System brought centralisation and placed the decision making process in the hands of bunch of "experts". The very strong tendency to trust researchers and research kidnapped women participation from decision making process.

I work in the mental health sector. This field is still dominated by male psychiatrists who impose their views on female clients. The problem is further compounded by the culture/ethnicity from which psychiatrists come. Female clients have no decision making power in own health issues or services.

Sexual and reproductive health

[Inadequate response re] sexual and reproductive health - issues around prevention of pregnancy; access to terminations locally; costs involved... Access to termination is limited.

Lack of access to safe, cheap, confidential abortion.

For teenagers, ...a very high pregnancy rate in 2005.

Young women and pregnancy [is a health issue in the local area].

School nurses need to be giving out more info on sexual health and allow students to access condoms.

Information on birth control [is needed].

I am unclear my GP views on abortion, contraception, etc. so am unsure of whether to raise these issues with them.

I find clients are not diligent re. pap smears...also, contraception.

[Another health issue is] young women and self awareness around sexual health, expectations and illness.

Financial considerations in having contraceptive and HRT medications.

[Another health issue is] young women and STIs, pregnancy (planned/ unplanned) ...

Issues re. pharmacists (male and Catholic) not stocking the morning after pill.

Appendix 1 - The sample

What parts of Hume region are represented?

Answers from respondents referred to all four parts of the Hume region as shown in Table 5. When asked to indicate what they consider as their geographic area, responses reflect mostly Central Hume (34 respondents) and Goulburn Valley (20) concerns and 10 respondents each for Upper Hume and Lower Hume. Four respondents thought of the whole Hume region as their area of interest, and 15 said their area covered more than one part of the region.

Table 5: Where responses refer to

Central Hume	34	37%
Upper Hume	10	11%
Goulburn Valley	20	22%
Lower Hume	10	11%
Whole Hume region or more than one PCP region	19	20%

Missing data = 7

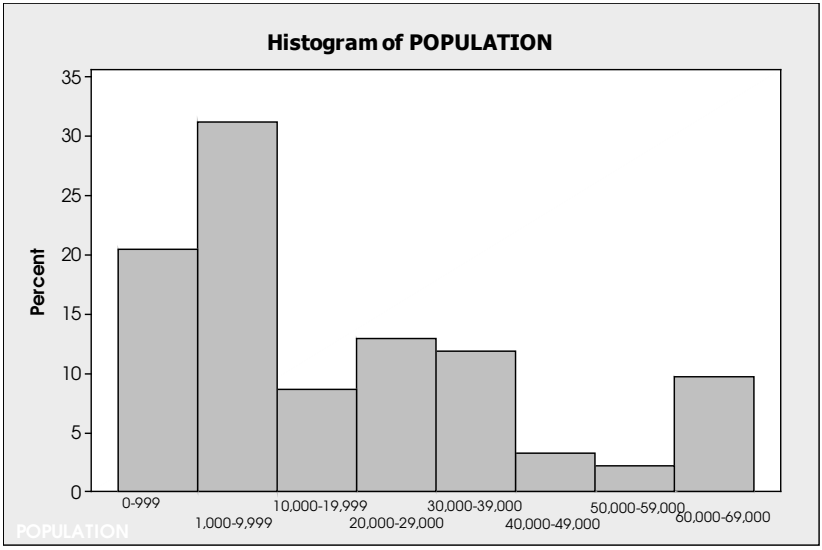
Size of locations where respondents live

It is interesting to note that 54% of respondents live in communities of under 10,000 people - 16% of these are from communities with a population of 999 or fewer. Whilst there is a bias towards women from smaller communities, this helps identify issues for those living in smaller and more isolated localities. See Table 6.

■ Table 6: Population of locality

Under 1000	1-9,999	10-29,999	30,000+	Total
20	31	22	27	100%

Missing data = 7



Respondents gave 45 different postcodes across the Hume region. The nearest towns cited were Wangaratta (27), Albury-Wodonga (9), Shepparton (9), Seymour (2), Benalla (4), Mansfield (3), Cobram (3) and Beechworth (3), and remaining participants were scattered over 37 other postcodes .

Health professional

While 47% of respondents would describe themselves as a health professional and 36% would not, a further 17% had mixed feelings. (Four did not respond.) 44% of respondents indicated they are employed as health professionals.

Employment

Just under half the sample is employed full time and a third is employed part time or on a casual basis. Table 7 shows that 9% are in unpaid work at home and/or in the community and smaller numbers are studying, self employed or working on the farm.

■ Table 7: Employment

Full-time work	49%
Part time/ casual work	35%
Home /community work (unpaid)	9%
Studying	3%
Other (self employed, on farm)	4%
	100%

Missing data = 4

Age

Table 8 shows that most respondents are aged between 35 and 59. 10% are over 60, and 14% are under 35.

■ Table 8: Age

Under 25	1%
25-34	13%
35-49	43%
50-59	31%
60+	10%
	98%

Missing data = 5

Birthplace and Ethnic background

82% of respondents were born in Australia, and 18% were born overseas.

When asked to describe their ethnic background, respondents indicated that about half are of UK or Irish descent; 40% state Australian; 1% are Indigenous Australians; and 10% are from a range of European, Eastern European and South American counties, New Zealand and Canada. 20 respondents did not answer this question.

■ Table 9: Ethnic background

UK , Irish, Anglo	48%
Australian	40%
Indigenous	1%
South American, Canadian, European, Eastern European, NZ	10%
	99%

Missing data = 20

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