PURPOSIVE SURVEY 2010

women's Health

'It's been a tough decade.'

women's health goulburn north east

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WOMEN'S HEALTH
GOULBURN NORTH EAST

'It's been a tough decade.'

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 fourth Purposive Survey 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.

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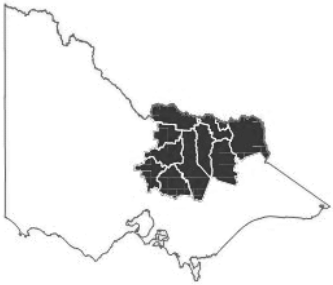
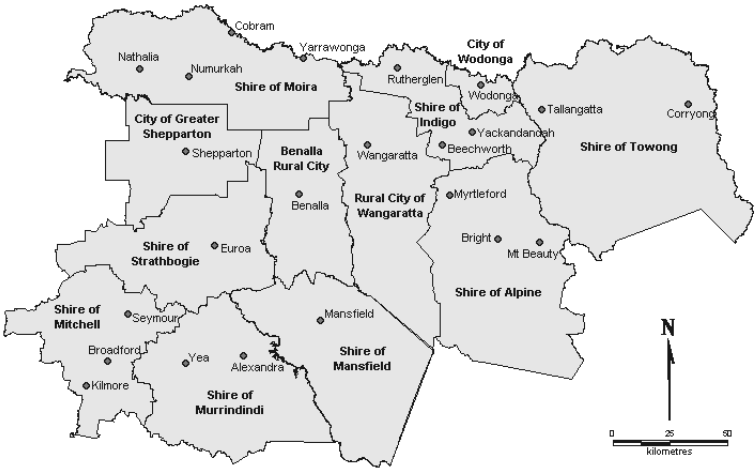
Geographical boundaries



Hume Region



Part 1

Introduction and methodology

This is now the fourth survey conducted by WHGNE since 2000. The purposive survey aims to capture a 'snapshot' of the health needs of women within the Hume Region. Every three years or so, WHGNE asks 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.

Between 200 and 400 questionnaires were emailed or posted out in each survey. This year, reflecting the almost universal access to email, less than 50 questionnaires were posted. Once 100 surveys were returned, we coded and analysed the data using *Minitab* – a quantitative data software package. In all four 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, organisations, 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 2010 survey replicates three previous surveys – conducted in 2000, 2003, 2006 and 2010. The knowledge gained 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

The first survey in 2000 reflected a more positive outlook on women's health and wellbeing in the Hume region than has been reported in subsequent surveys. This 2010 survey closely replicates those in 2006 and 2003, confirming the ongoing downturn in the rural economy due to drought, climate change and global economic changes. In 2009, this was exacerbated by the tragic bushfires. Some comments, this year, mention an upturn in farm prices, yet the sense is that this is a short-term reprieve for rural families hard-hit over the last decade.

Rural Issues

A continuing concern is the exodus of young people from rural areas as a result of decreasing education and employment opportunities. Struggling farmers report feelings of failure especially when theirs is a family farm, passed down through generations. They feel that, despite impossible odds, the bleak future is somehow their fault.

There is uncertainty about their lives - their ability to remain on the farm, their ability to provide for their children and the almost certain knowledge that they won't be passing the farm on to their kids, despite it having been in the family for generations sometimes. There is a sense of being the generation that failed about this, a real sense of inadequacy - failure and grief and loss as well. (Respondent)

Respondents commented specifically on a lack of knowledge of rural issues amongst city-based politicians and a lack of political will to address them.

There is a general view that success is somehow related to city living, having material possessions, engaging in urban pastimes that has allowed the focus to be on providing for Melbourne or Sydney ahead of the bush. Look at the way it has been possible to implement the pipeline to Melbourne, depleting the Goulburn Valley of their water in order to service Melbourne. There has been real anger in the country over this. (Respondent)

The outlook for future expansion in the agriculture field is almost impossible due to such high expenses and low returns within the industry ... Even though this season is much better than the previous 15 years of drought, most farming families have such high debts so the outlook is still quite bleak ... [There is] frustration at the lack of understanding of rural issues by governments. (Respondent)

Poverty

Again, this survey emphasises the experience of financial difficulty and poverty for many women in this region. The effect is profound and multi-generational.

In the 2010 survey, many comments related to unequal pay and superannuation for women, and the reduction of income caused by pregnancy and caring for children.

Well women's clinics and access to services

A strong theme in comments was the lack of well women's clinics across the north-east of Victoria and the Goulburn Valley. This concern, combined with concerns about the paucity of female GPs and the problems with bulk-billing access, could be addressed through the employment of nurse practitioners in smaller centres and the establishment of well resourced well women's clinics in the major provincial centres.

- In 2010, 82% of respondents stated lack of access to specialist women's services was problematic, with 53% of these stating it was a significant problem.
- Of the 89% of respondents who indicated that lack of bulk billing remains problematic, 77% indicated it was a significant problem. In previous surveys, this figure was 90% (2006), 91% (2003) and 84% (2000).
- 80% found access to services generally to be problematic, 37% of these saying it was a significant problem.
- 78% stated lack of participation in decision-making in relation to health services was problematic and 75% indicated that lack of involvement in decisions about their own health was problematic.

All have remained fairly constant over the ten years of the survey.

Health of Aboriginal women

The health of Aboriginal and Torres Strait Islander women is a key priority for both the Victorian and the Federal Governments.

"In August 2008 the [Victorian] Premier signed the 'Statement of Intent' to reduce the 17 year life expectancy gap between Indigenous and non-Indigenous Australians by 2030. The Victorian Government has taken action to support this commitment with funding for reforms to build sustainable social change, embed system reform and position Victoria to meet its commitments to Closing the Gap in Indigenous Health outcomes in partnership with the Commonwealth." (http://www.dhs.vic.gov.au/data/assets/pdf_file /0003/341562/6---Closing-the-Gap-in-Indigenous-health.pdf)

This survey includes responses from three Aboriginal and Torres Strait Islander women. These responses point to low levels of access to the internet amongst Aboriginal women, the high cost of healthy foods and the lack of health training opportunities for Aboriginal women. Mental health is an issue, compounded by a lack of service provider understanding of the importance of culture and kinship. Two respondents advised that the 2009 bushfires destroyed sacred sites, resulting in grief and spiritual mourning for Aboriginal people.

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

Mental health

Mental health continues to be under-resourced and failing to meet needs in this region with 75% of respondents indicating that emotional & mental health is inadequately addressed in their area.

The role of women

Expectations of women are high in the context of hard times and natural disasters, and is reinforcing of traditional gender roles. Women must take on multiple roles, such as working on the farm or in the business; working off-farm; and nurturing partners, children and parents as well as vulnerable neighbours, friends and acquaintances. Care for partners involves specifically caring for their mental health, and supporting 'depressed farmer husbands'. The sudden and wide-scale loss of business and employment as a result of bushfire in 2009 similarly increased the burden on women to keep the family financially viable, and together.

Safety

The issue of inadequate safety and security has shown some improvement over four years, with 38% indicating it is not really a problem in 2010 compared to 28% in 2006. Unfortunately, it still leaves 59% of respondents indicating it is a problem.

See Table 1 for details of all points above.

The internet

Inclusion of questions about the internet in the 2010 survey found that respondents believed the internet has affected the lives of rural women by improving access to information and resources (27% of comments); increasing knowledge of world events (19%); and increasing personal socialising and support (20%). Respondents also noted their perceptions of negative aspects of the internet. These included risk of anti-social behaviours, addictions, and social and family breakdowns. Some felt children were becoming too reliant on it.

Emerging issues

Emerging issues appear to include drug and alcohol issues, and the lack of options for women to give birth outside the major provincial centres.

There is no detoxification centre for drugs and alcohol in the area.

A surprising number of local babies are born drug dependent and must stay in the hospital for long periods of time.

There has been closure of hospitals in the area. There is only one maternity hospital here now, servicing a huge area. (Respondents)

Part 2

Identifying health policy issues - changes over four surveys

A number of women's health issues have been identified through national and state policies. The questionnaire used in 2000, 2003, 2006 and 2010 asked the same questions about six of these issues, making the responses comparable across the years. The issues were:

- bulk billing
- participation in health service decisions
- access to services
- involvement in own health
- access to information
- training of health professionals

In 2006, three new questions were added:

- Access to specialist women's services
- (Inadequate) recognition of diversity, and
- (Inadequate) safety and security

We asked respondents how problematic each issue was in their local area. Table 1, following, details the findings. For most, the answers remained much the same. **It is of concern that the lack of bulk-billing remains a significant problem to 77% of respondents, and that this has barely shifted between 2003 and 2010.**

While greatly improving between 2000 and 2006, 'Access to health information', remained steady in 2010 at 37%, perhaps reflecting that there has not been a great improvement in internet service provision over the past three years.

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

	Significant problem % (coded 8-10)				Problematic % (coded 5-7)				Not really a problem % (coded 1-4)			
	2010	2006	2003	2000	2010	2006	2003	2000	2010	2006	2003	2000
Lack of bulk-bill	77%	78%	80%	68%	12%	12%	4%	16%	9%	10%	11%	13%
Specialist women's services	53%	57%	Not asked N/A	N/A	29%	31%	N/A	N/A	17%	11%	N/A	N/A
Participation re health services	35%	32%	39%	54%	43%	50%	37%	31%	20%	13%	19%	12%
Access to health services	37%	37%	41%	47%	43%	42%	39%	38%	19%	20%	17%	14%
Involvement re own health	22%	22%	32%	42%	53%	50%	44%	31%	23%	26%	18%	26%
Access to information	19%	16%	14%	35%	42%	47%	54%	40%	37%	37%	26%	23%
Training of health care providers	22%	22%	20%	22%	40%	41%	45%	41%	35%	34%	30%	34%
Recognition of diversity	36%	31%	N/A	N/A	31%	44%	N/A	N/A	30%	24%	N/A	N/A
Safety and security	19%	21%	N/A	N/A	40%	48%	N/A	N/A	38%	28%	N/A	N/A

Missing data from 2010 from top row = 2, 1, 3, 1, 2, 2, 3, 3, 3.

How women are affected by these issues

These findings tell us the policy issues that women have identified as problematic in their local communities. They tell us '***what***' is a problem. We sought, also, to understand '***how***' women are affected.

A total of 77 respondents wrote comments to explain ***how*** women are affected by each. The comments focussed on three major areas:

1. Difficulty in accessing health services because of waiting lists and limited services (18% of comments). A further 15% were comments about the shortage of GPs, unsuitable GPs (because of cultural background or insensitivity) and limited female GPs, and 7% related to the shortage of specialists. The lack of culturally specific services including for women who need interpreters, for lesbians and for Aboriginal women were mentioned in 6% of the comments. Further comments were specifically about the great difficulty in accessing specialist women's services such as women's health clinics.
2. The lack of bulk-billing and the way access to bulk-billing is often monitored and decided by doctors (14% of comments) and poverty, unemployment and rising costs of health care (4%).
3. Isolation, the distances involved in accessing services, the lack of public transport and the need to own a private vehicle to access services, especially for older women (5%).

Other comments related to:

- [For women affected by violence] The lack of support and options due to limited or non-existent domestic violence and sexual assault services in parts of the region; the scarcity of female police officers; and the lack of safety for women working after hours in emergency departments and refuges.
- The lack of women in health management, lack of involvement in decisions, stereotyping and rural conservativeness leading to women feeling disempowered.
- The widespread unmet support needs of Hume region women in relation to mental health issues, teenage pregnancy, and ageing – leading to isolation and despair.

Part 3

Adequacy of local response to health topics

Respondents were asked their opinion of whether the following issues were being addressed Adequately or Inadequately (with a *Don't Know* option):

- Rural and remote issues
- Emotional and mental health
- Ageing
- Health of women with disabilities
- Sexual and reproductive health
- Women as carers
- Health of specific groups
- Young mothers
- Health of lesbians

Table 2, following, shows responses for each of the four surveys.

Emotional and mental health remains significantly problematic as three-quarters of respondents stated this health issue is inadequately addressed in their area. This figure has remained consistent for a decade, indicating little progress in improving response to people with emotional and mental health problems.

The same is true for the health of rural and remote women, with around three-quarters of respondents stating it is not being adequately addressed in each of the last three surveys.

Half of respondents stated that violence against women is inadequately addressed, remaining fairly consistent over the decade.

The health of young mothers appears to be emerging as a problem. Respondents indicating it is inadequately addressed has increased from 31% in 2006 to 41% in 2010. Their comments illustrate diminishing services and birthing options for women living outside the major provincial centres of Wangaratta, Wodonga and Shepparton. One respondent compared this situation with previous decades:

I am now 50 years old, and have lived in this area most of my life. When I was a child, a baby could be born at Chiltern hospital. In the 1980s they could still be born at Tallangatta and many other smaller towns around the area. This allowed mothers to remain local, enjoying the support of family and friends, and making it easy for other children to visit their mum in hospital more often. Now all these areas (and many more) must be crammed into Wodonga hospital or sent right away if it can't cope with demand at the time. Many women are very upset about this. (Respondent)

Most respondents were unable to comment on the adequacy of health services to lesbians, perhaps indicating this is an important area for research.

More than half stated the health of specific groups of women - including Aboriginal women and culturally and linguistically diverse women - are inadequately addressed. This is emphasised by many comments pointing to discrimination and the lack of culturally appropriate services and sensitive health professionals.

Half of the respondents added further comments, reinforcing that the issues facing the health sector in providing services to a rural area are primarily: the limited access to services, specialists, female GPs; limited access to transport; geographical isolation; the lack of information and awareness of services; the lack of culturally specific services and specialist women's health services and clinics; and the apparently 'crisis-driven' approach to providing mental health services.

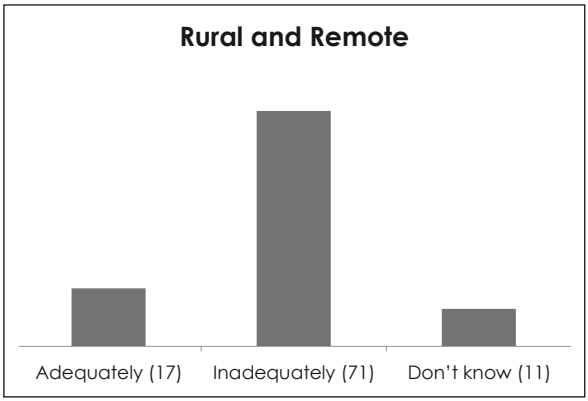
When asked to nominate other issues that we had not specifically asked about, respondents wrote about poverty and unemployment; the cost of health care; drought, climate change, natural disasters; drug and alcohol issues and the lack of parenting support. Respondents wrote about globalisation, and within Australia, the politically driven inequitable allocation of resources.

■ Table 2 Responses for each 3-yearly survey

Issue	Inadequately	Adequately	Don't Know	No response
Sexual and reproductive health	43% (2010)	35%	22%	3%
	36% (2006)	42%	21%	1%
	41% (2003)	33%	22%	4%
	52% (2000)	29%	15%	4%
Ageing	50%	36%	14%	6%
	37%	44%	19%	3%
	52%	36%	10%	2%
	44%	34%	18%	4%
Emotional and mental health	75%	16%	9%	4%
	71%	23%	6%	1%
	74%	18%	6%	2%
	77%	9%	11%	3%
Violence against women	54%	25%	22%	3%
	61%	23%	6%	1%
	55%	25%	17%	3%
	63%	17%	17%	3%
Women as carers	50%	23%	27%	4%
	62%	18%	20%	2%
	57%	23%	16%	4%
	58%	13%	24%	5%
Rural / remote women's issues	71%	17%	11%	3%
	78%	9%	13%	2%
	72%	11%	16%	1%
Young mothers	40%	42%	17%	3%
	31%	41%	28%	1%
	(Not sought prior)			
Health of Aboriginal and CALD women	55%	25%	30%	6%
	42%	11%	47%	4%
	55%	10%	28%	7%
	(Not sought in 2000)			
Health of women with disabilities	48%	23%	28%	5%
	44%	17%	39%	1%
	54%	10%	33%	3%
Health of lesbians	23%	5%	72%	3%
	23%	8%	69%	2%
	31%	9%	57%	3%

The 2010 responses

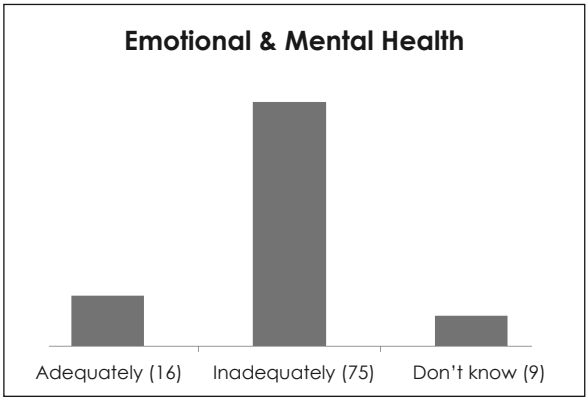
The charts below show results for the 2010 survey, along with quotes from respondents to exemplify each problem.



Missing data = 3

71% indicated that rural/remote women's issues are inadequately addressed in their area:

The country areas have become demoralised, their banks have closed, their hospitals closed or reduced to nursing homes with a view to closing them, and services reduced to a minimum.



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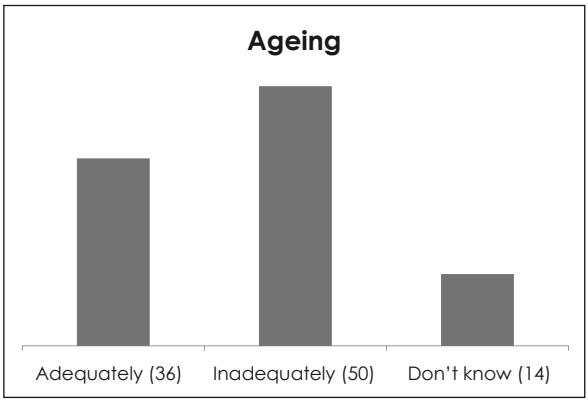
75% indicated that emotional & mental health is inadequately addressed in their area.

Mental health providers are very few and far between, they have very long waiting periods and are most expensive. None of them bulk bill.



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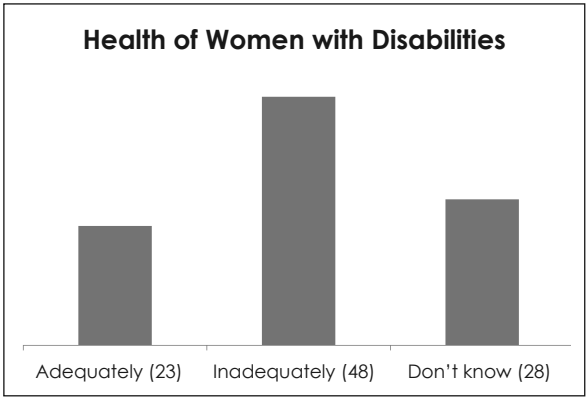
36% indicated that ageing is inadequately addressed in their area.

There are stress issues for older women caring for a partner or other family [which] can be very isolating – never enough support.



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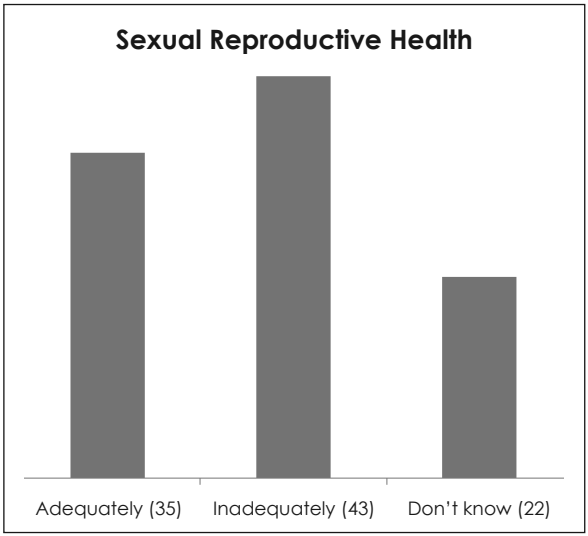
48% indicated that health of women with disabilities is inadequately addressed in their area. One comment related to a child:

I have a child diagnosed with ASD. I receive no respite. I work 3 days per week and have a partner and two other children. It has taken 13 months of being on a waiting list. Not enough service providers and therapists … hence being thrown back onto mothers to juggle work and learning to help my child.



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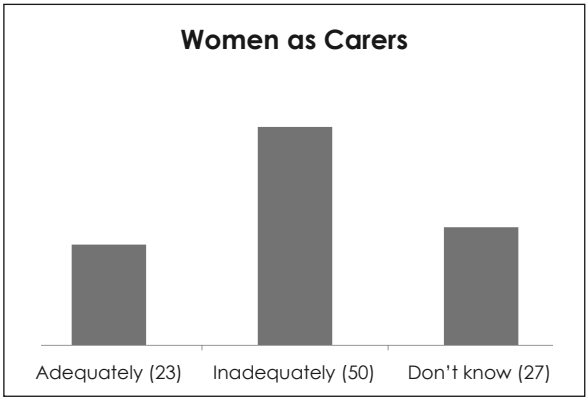
43% indicated sexual and reproductive health is inadequately addressed in their area:

There are few if any sexual health programs and young people have been "lectured" by the local pharmacy when trying to access the morning after pill.



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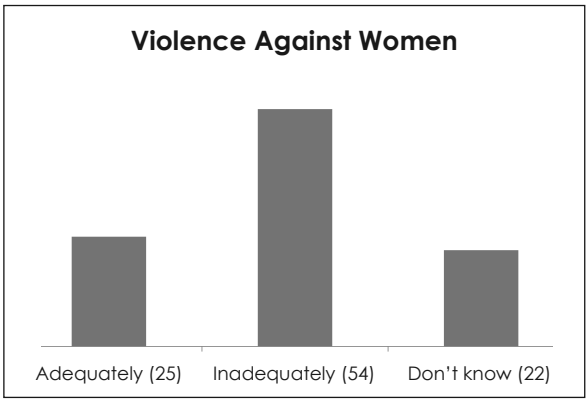
50% indicated that 'women as carers' is inadequately addressed in their area.

Over the past five years there has been no time when I have not known of at least five women confronting life threatening illnesses for themselves or the partners they care for. The impacts emotionally, physically and financially has a huge impact upon their wellbeing and lifestyles.



54% indicated that violence against women is inadequately addressed in their area.

Locals don't seem to think violence against women exists!

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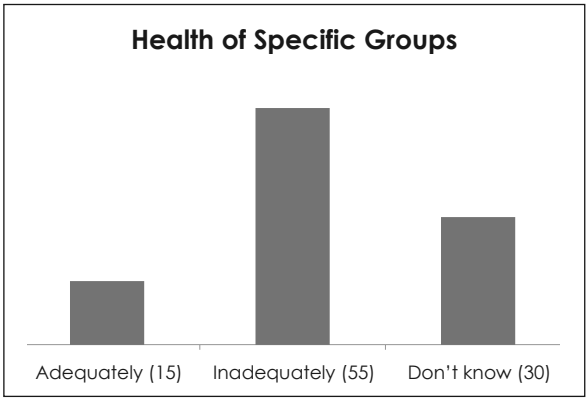

55% indicated that the health of specific groups of women, including Aboriginal women and women of culturally and linguistically diverse backgrounds is inadequately addressed in their area.

Aboriginal women and those of CALD backgrounds have reported feeling uncomfortable and misunderstood in using local health services and have experienced racism in the local community.

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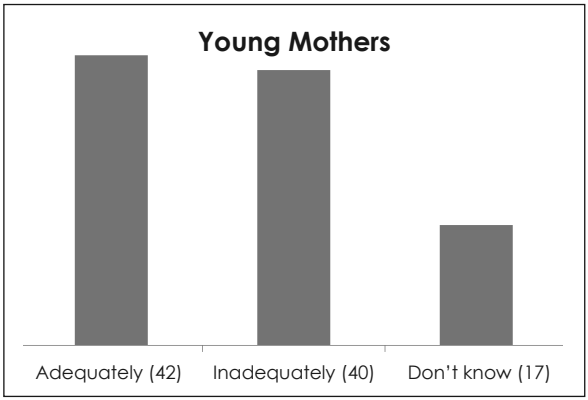

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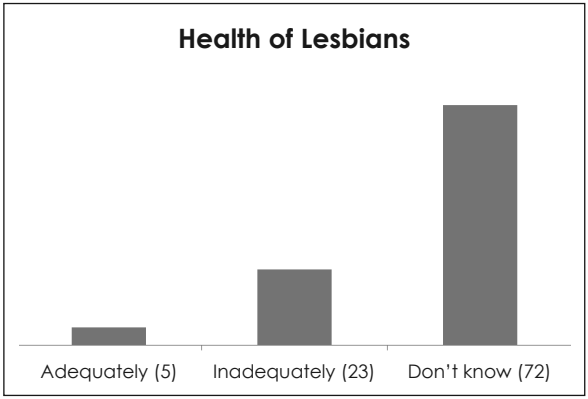
Respondents were split on how well the health of young mothers is addressed in their area. This probably reflects the issues raised that women in Wangaratta, Wodonga and Shepparton are well served, but outside these centres, there are few services or birthing options.

I think of the young and vulnerable women [here] who are having babies at very young ages … without the resources to cope with them. They are developing terrible mental health problems and I believe they may be finding themselves in this situation in response to their feeling so marginalised in the first place.



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72% of respondents stated they 'Don't Know' how adequately the health of lesbians is addressed. Only 5% stated it is adequately addressed.

There is a lack of recognition of diversity - in particular sexual orientation and non-traditional lifestyle choices - and at times discrimination because of this.

Part 4

Rural economic downturn

In 2010, this survey expanded the questions on the rural economic downturn, to include questions on drought and bushfires.

Table 3, following, shows that 84% of respondents stated women in their local area were affected by the rural economic downturn; 87% stated local women were affected by drought; and 68% by bushfire.

■ Table 3: Opinions as to whether women are affected by rural downturn, drought and bushfire

	Yes %	No %	Don't Know %
Rural downturn	84	4	12
Drought	87	4	9
Bushfire	68	21	11

In answer to a specific question about how this affects women, 85 respondents wrote a comment on the rural downturn; 83 on the drought; and 71 on bushfire. These focussed on the pivotal yet demanding role of women within family and community. Expectations of women are high in the context of hard times and natural disasters, and tend to reinforce traditional gender roles.

As farming and rural businesses continue to suffer this decade-long drought, exacerbated by the tragedy of bushfire, women must take on multiple roles of working on the farm or in the business, working off-farm, nurturing partners, children and parents as well as vulnerable neighbours, friends and acquaintances.

Care for partners involves specifically caring for their mental health and supporting 'depressed farmer husbands'. The sudden and wide-scale loss of business and employment as a result of bushfire in 2009 similarly increased the burden on women to keep the family financially viable, and together. Despite this, increased family breakdown appears to result from the immense financial and emotional stress.

Inevitably, women neglect their own health.

Some respondents wrote about the unequal pay rates and superannuation for women; the uncertainty of maternity leave for many women, and the limited childcare that restricts women's ability to find

or retain paid work. Increasing interest rates threaten women's ability to meet mortgage repayments. Some spoke of partners taking control of women's income, and of women's concern about the effect of poverty on their children.

The disaster of the 2009 bushfires added a new dimension of loss, suffering and grief to entire communities. In addition to unemployment and financial stress, women in the Hume region became homeless - sometimes with family, and sometimes alone - with immediate concerns of finding accommodation, relocating (sometimes out of their own community), uncertainty about the future, 'terror' of facing future fire seasons, and ongoing concerns for the mental and physical health of friends, partners, children, and community members. The trauma brought by the bushfires, for many, is long-lived and intensified by ongoing problems with rebuilding and unemployment.

Bushfires always inspired fear in the country, but the drought and changed weather conditions have changed that fear to terror. (Respondent)

Respondents spoke about the loss of sacred sites and cultural heritage as a result of the fires, and the spiritual mourning for Aboriginal people.

The loss of cultural heritage in culturally significant sites. Spirit mourning and loss and grief for these sites.

Culturally, the bushfires have destroyed a lot of sacred sites, heritage scatters[6] and exposed traditional practices.

6 'Surface artifact scatters are the material remains of past Aboriginal people's activities. Scatter sites usually contain stone artifacts, but other material such as charcoal, animal bone, shell and ochre may also be present. No two surface scatters are exactly the same.' http://www.ccmaindig.info/heritage/SitesArtifacts_SurfaceScatters.html (27.6.2010)

Mental and emotional health

When asked about how mental and emotional health issues affect women, 75 responded. Depression and anxiety disorders and increased stress were mentioned most frequently, accounting for almost a quarter of comments. The stigma of having a mental health issue was of concern to many respondents, as was the co-morbidity of mental health occurring alongside issues of homelessness, drug and alcohol dependency or in a context of family violence. Isolation was identified as both a contributor to mental health issues and a result.

The lack of after-hours care, suitable facilities and respite care across the region means women may struggle alone with mental health issues, or with the help of their own parents or children.

The internet

This purposive survey asked respondents about internet use. The world wide web has been hailed as providing new access to health information for rural people. We asked respondents about:

- their own internet use
- their opinions about how it affects rural life for women and
- the best and worst aspects of it

Table 4 shows that most respondents use the internet for social reasons (emailing, social networking and blogging) and two-thirds use it for work related purposes. Over a third use it for research and study. Very few use it for news and entertainment, personal interest and banking. Six percent of respondents use the internet for 'everything'. Only two used it for purchases, and just one respondent did not use the internet at all.

Table 4: Respondents' own internet use

	%
Social	83
Work	68
Research	39
Study	8
News & entertainment	7
Personal interest	7
Banking	4
Purchasing	2
Everything	14

Respondents believed the internet has affected the lives of rural women generally by improving access to information and resources (27% of comments); increasing knowledge of world events (19%); and increasing personal socialising and support (20%).

Other positive aspects were the new opportunities offered by the internet such as studying, increasing IT skills, employment options and quicker and more efficient services (such as bill paying and banking).

Respondents noted their perceptions of the negative aspects of the internet. These included the risk of anti-social behaviours, addictions, and social and family breakdowns. Some felt children were becoming too reliant on it.

Others pointed to technical problems of 'frustratingly slow' speeds and lack of coverage, as well as inequitable access due to cost.

When asked what the best thing about the internet is, 91 respondents wrote a comment, with a third of comments relating to improved access to information and almost a quarter referring to its convenience, with almost 24 hour easy access for most.

A total of 94 responded to what is worst about the internet, most commonly to wasting time; the cost and technological problems; the potential loss of privacy; and surfeit of advertising. Social costs were nominated, including reduction in human contact, greater inactivity leading to weight gain; and its seemingly addictive nature in terms of social networking, gaming, gambling and pornography.

Respondents wrote about the particular vulnerability of young people to exploitation, and exposure to bullying around the clock.

On the one hand it gives us access to things city people take for granted - but with the added stress of slow speeds, dial up connections, expensive and non existent service. On the other hand it has the potential to be the instigator of all sorts of disorders – unsocial behaviour, addictions, inability to converse, fat bottoms, and anger issues when technology fails. (Respondent)

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 wellbeing, and not merely the absence of disease and infirmity.

Table 5 compares responses for Hume region over the four surveys. Comparison with the last survey four years ago shows little change. (Please note this survey is not representative, but is indicative of the responses of 100 women in Hume region.)

Forty-three Hume region respondents explained why they gave the score they did. Those who rated their health highly wrote about self-care, including positive lifestyle changes to diet, alcohol consumption, exercise and achieving balance in their lives (24%). Strong relationships, spirituality, self-motivation and a well-thought out approach to life stages were helpful to respondents (6%).

Poor health ratings related to specific chronic illnesses (10%), cardio-vascular disorders (5%) arthritis, lupus, genetic problems, seizures, back problems, side-effects of medications, eating disorders, tiredness (9%) and overweight (5%), smoking and dental health (2%).

Stress (8%), depression and anxiety (6%), grief and loss, and bushfire issues (3%) explained some poor health ratings; as did financial issues (4%) as well as the pivotal role of women in the family and community; the tendency for women to neglect their own health; and family issues (6%).

Table 5: Women's self assessed health Victoria and Hume region

Rating	Victoria 2000	Victoria 2002	Victoria 2005[7]	Victoria 2007[8]	Hume 2000	Hume 2003	Hume 2006	Hume 2010
	%	%	%	%	%	%	%	%
Excellent	30.2	13.5	11.5	13.6	19	19	22	21
Very Good	43.5	35.7	34.3	34	55	59	42	43
Good	21.3	34.7	37	35.8	20	14	24	25
Fair	4.4	13.5	13.7	13.4	5	6	8	9
Poor	0.6	2.7	3.3	3.1	0	2	4	1
	100	100.1	99.8	99.9	99	100	100	99

7 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)

8 http://www.health.vic.gov.au/healthstatus/downloads/vic_health_survey_07_findings_part_c.pdf (28.7.2010) 2007 is the most recent data available.

Part 5

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 words 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[9]'. 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.

The rural downturn

[One business in a local town is] almost totally dependant on work from the farming community. They have struggled over the last 10 years, having to access government support to continue. The worst aspect, from their point of view, was the retrenchment of loyal employees. [The owners] have really struggled, both emotionally and financially. So the problem is a community issue.

I certainly feel concerned that unless we protect our food producers, we will eventually be importing most of our fruit/vegetables, giving us no control over chemical use - and then there's the reduced nutritional value of these imported products. We are risking the opportunity to retain a relatively clean/green environment to produce quality food.

Political apathy. No good will to country people. No power to get political help.

There is a general view that success is somehow related to city living, having material possessions, engaging in urban pastimes that has allowed the focus to be on providing for Melbourne or Sydney ahead of the bush. Look at the way it has been possible to implement the pipeline to Melbourne, depleting the Goulburn Valley of their water in order to service Melbourne. There has been real anger in the country over this

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

Male dominated politicians do not understand the real world of living in rural areas.

City business high flyers make too many decisions concerning rural issues.

I believe more needs to done to support rural communities to remain viable.

The drought is literally depriving families of their livelihood, crops are not growing, dams are dry, money is going out on feed for animals. People are in despair over this as it goes on year after year. I think hope of this drought ending is seeping away, and this is demoralising people and causing a great deal of fear and depression.

It has been a tough decade. With two lots of serious fires, and the drought, the cumulative effects are wearing.

The relentlessness of it all, some reprieve this autumn, but the ongoing dry dry dry…

Many people who live in rural areas rely on the land for a living, with the severity of the drought, fires and so on; many have a very limited income this is particularly stressful for both women and men.

Political apathy/no good will to country people/ no power to get political help.

Drought has created stress and uncertainty. Ageing farming population is significant. Lack of industries.

There is a complex range of issues that have been slowly undermining rural life for a long time. Focus on education has led to many young people moving away for decades to go to uni or to access other types of employment only really available in cities.

Everything is so tinder dry, the hot winds are so much more relentless, and the summers so much longer that there is no longer a sense of being able to defend your property. Every summer holds the possibility that everything you own, all your treasures, family keepsakes, photos could be lost in a fire at any time.

Climate change is having a huge effect. This is quite new, but there have always been problems with drought, and the worry about drought and bushfire.

I think hope of this drought ending is seeping away, and this is demoralising people and causing a great deal of fear and depression. The mental health issues involved in this are really serious.

The country areas have become demoralised, their banks have closed, their hospitals closed or reduced to nursing homes with a view to closing them, and services reduced to a minimum.

Farming has been seen as an undesirable vocation for a long time now. The Government took away many of the protections, making it vulnerable to the market place. Foreign markets were able to produce at a cheaper rate. Gigantic supermarket chains developed the power to chop prices for produce to the bone, while costs kept soaring for the producer. It became seen by farmers themselves that it was not a good option for their kids, and they began to encourage their kids to go to the city back in the 1970s. This has been coming for a long time.

As with the drought, women usually experience a sense of grief and loss following the bushfires. Often the strain of attempting to put their lives back together is overwhelming.

Bushfires

Women who have been through bushfires often have post traumatic stress, financial problems. Often when a bushfire is on the men are away fighting the fires and the women are left at home often unprepared for a fire.

Three lines is not enough to describe the devastation in our area. Loss of house, possessions, community, sense of safety, jobs. Bereavements. Mental health issues including anxiety and depression, PTSD. Friction within the community and between communities. Worry about how children are coping. Sub-threshold levels of physical and verbal abuse. Marriage breakdown. For some women, increase sense of own strength, stronger links in the community, opportunities through government grants, improved personal money situation.

Loss of cultural heritage in culturally significant sites. Spirit mourning and loss and grief for these sites.

In summertime threat of bushfire is at the back of your mind constantly.

We had bushfires in 2003, 2006 and 2009. Lots of women get stressed as summer approaches. I know of women who are on anti depressants as a result.

I know of a number of families who lost their [homes] due to bush fires. Not only have they lost their home but personal and precious possessions, family pets and even loved ones. In some cases I know of some women who stayed at their homes while their partners fought the fires and had to get out without the support when the fires came through their area. Leaving behind many personal items has had a profound effect on these women.

The role of women

Women are expected - and tend to have to - work longer hours and do more within the home, their families, in employment and in their communities. The old saying - woman are the glue that keeps the family and the community together at the expense of their health

They prioritise for other members of their families rather than themselves.

Women are often supporting their men, working long hours on the farm, going to full time jobs to support the farm, and often this involves a lot of travel given the isolation and distance of the farm from the workplace. As well, there are the mental health issues of this, and that may be supporting a man who has developed mental health issues as a result of it all.

On the whole the women are expected to work (second income) both on and off the farm and at home-making and parenting [leading to] extreme tiredness.

Many women are supporting depressed husbands who are on the verge of bankruptcy because of lowered farming prices this in turn has a flow on effect for the whole family. The wife is trying to keep everything together - supporting the husband while at the same time trying to keep the family going often while working as well.

Women often neglect their own health concerns during this time [after the bushfires] because everything is very overwhelming and consuming that they do not have the time of the energy to take care of themselves. Often they are very concerned about everyone else in the family and their own needs very rarely reach the top of the "to do list".

New mothers

There is very little service for pregnant women in this area - GV Health appears to be the only place to go to have a baby.

The women of Albury Wodonga are disadvantaged compared with city women in regard to choice of service, not only for birthing services.

There has been closure of hospitals in the area. There is only one maternity hospital here now, servicing a huge area. It is in Wodonga.

Obstetric care requires significant travel and the closest providers do not offer a full range of services.

Some are returning to work while partners have reduced work. Some are weaning their young babies to return to work at six weeks, three months, six months - earlier than they otherwise intended.

[Young mothers without cars are] using taxis post-caesarean to visit babies in the special care nursery, and breast pump hire and accommodation needs can cause financial stress.

[There are] young and vulnerable women in Albury Wodonga (and other towns & places surrounding) who are having babies at very young ages, going on to have huge families without the resources to cope with them. They are developing terrible mental health problems – [difficulties] from their own childhoods, lack of education, often an intellectual disability as well, and feelings of being unable to access employment have led to poor decisions for their life and they are really at risk.

Mothers with young babies are in hospital for a very short time and in my experience many struggle in the first three months and the younger ones are sometimes reluctant to seek help.

Access to services and transportation

I believe there is still a huge problem in providing support to women in areas outside rural cities as community care funding formulae does not allow for distance factors and we are travelling long distances for adequate specialist health care.

Few services are provided on an outreach basis, and transport to local regional centres - Shepparton, Albury and Wangaratta - is not good.

Without a car women are disadvantaged, especially if widowed, elderly, handicapped – in accessing services.

Women who are already marginalised are often housed at a distance from town services, and may not know they exist, or how to access them.

Access to local oncology or specialist services [is limited and women] have to travel to Melbourne or Bendigo or Albury to receive necessary services. This can create an increase in stress and another financial burden on women and their families.

Distance is the biggest issue. Having to travel for specialist health care is difficult, particularly as many metropolitan providers have a lack of regard for and appreciation of the difficulties.

Transport to other areas is inappropriate e.g. bus leaves at 6am and doesn't return until 8pm.

[Women in remote and rural areas] are significantly disadvantaged as in many cases they are alone with little interaction with other women or women's groups. I believe many suffer in silence. They have limited access to specialist providers or maybe even a choice of GP depending on how remote she is. If she does require specialist treatment then she has to travel long distances, mostly on her own.

[Locally, there are] waiting periods of up to three weeks to see a doctor, limited bulk billing, no women specialists in our area and limited access to those outside our immediate region.

I believe I am the only female GP in [this town] who takes new patients – I don't provide out of hours care.

[Access to services] such as GPs who mostly have long waiting lists is a big issue for women and children. There are very long waiting lists to see specialist providers and those without health insurance can wait years for treatment. There are very few specialist providers in this area for mental health related illnesses, such as post-natal depression, depression, psychosis, drug and alcohol detox facilities are not available [here] to my knowledge.

Inability to access a GP due to the limited number in local area. Travel for specialist treatment can be prohibitive, especially if weakened by illness.

If you don't already know where to go for help and if you don't have kids, you're just sick, broke and alone, you don't get any help. If you do find help you have to jump through too many hoops to get a fair go.

Well women's clinics

Access to specialised women's services is a concern as travel is usually the most limiting for them to access services and more often than not it means travelling three and a half hours to Melbourne. This is a significant cost and has a huge impact on the family unit when their mother has to travel such distance or be away from the family to access specialised services.

Specialist women's health service, mental health service and Aboriginal health services are over one hour away. This distance and a lack of transport options makes access to health services difficult and increases isolation and the feeling of being overwhelmed.

I do not go to the local doctor in [town] if i can help it. I take a whole day off work, travel three hours to Clayton to the Jean Hailes Clinic for treatment of anything major.

Specialised women's services are very limited in this region. Women wait weeks or months to see a doctor through the public hospital clinics and then when they do get an appointment they may wait hours to see a resident doctor. Women who wish to see a women's health nurse for a pap test or a doctor who specialises in women's health issues may wait for months to get an appointment. Therefore, women may neglect to have routine tests (pap tests) or following up concerns that may lead to early detection/prevention.

Survivors of child sexual abuse need better care to encourage them to get the support they need to overcome the impacts.

Women's health clinics provide good holistic care in Melbourne but they are not available to rural women.

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.

Bulk billing

Bulk billing has improved but still often at the discretion of different practices and disadvantages those with less income.

Bulk Billing is an issue with few clinics offering the option, meaning patients have little to no choice in the healthcare professional they access. Also significant numbers of patients seen each day by Bulk Billing clinics removes the personal aspect of patient care and means little to no personal knowledge is retained by medical practitioners from visit to visit.

My own GP bulk bills - if I can wait six weeks to see him.

No 'known' bulk billing in Numurkah.

No bulk billing in the area is a real problem for women and children. It causes stress and for some families and reduction in attendance to services.

I have had a woman with pleurisy not able to see a doctor because she couldn't afford the bill if the doctor decided to charge her full fee. She did not have a car and had walked from X Street, all the way to X street and when told she had to see the doctor and he would decide if she was to be bulk billed, she left and walked home and then arrived here in tears.

Women feel judged by asking to be bulk-billed even with advocacy from an agency!

The lack of bulk billing may make people, especially those on medium incomes (who don't have health care cards) think twice about going to the doctor or having medical procedures because they have to find the money upfront. I don't understand why the doctors can't just charge the $30 (or whatever it is) upfront and then bill Medicare for the rest. That way the client doesn't have to find $60 upfront, which can be quite a lot of money to find if you don't have it and a barrier to accessing what may be very important medical advice or interventions. Seeing the doctor (or accessing specialist tests such as CT scans) becomes something of a 'luxury'! For example, I had a CT scan recently. I was told it was $500 upfront but that I could claim back $408 of this on Medicare. When I challenged them about why I couldn't just pay the $92 gap, they agreed I could! I found it odd that they could change the rules just because I challenged them, but that they don't offer this service freely.

Financial difficulties and poverty

Can't pay for health needs. Majority of primary carers are women and can't afford to pay for their children's / family's needs.

There is an absence of emergency housing, tight and expensive rental market in areas close to services while cheaper rentals are located further away from services in areas where there is a lack of public transport.

Women are still not paid the equivalent of men.

Wages not always same as males. Misogyny still exists re: women in some work areas so they remain male dominated.

Women treated unequally in the pay arena with work parity.

[Women have] less pay than males, off work due to pregnancy.

APPALLING SUPERANNUATION for women

Extreme lack of childcare limits women's ability to return to work after childbirth. The waiting list for spaces at the childcare centre is two years!! This in turn reduces women's incomes, self esteem and sense of connection to the community and makes it more difficult for women to re-enter the workforce in the longer term.

No sufficient parental leave… it needs to be PARENTAL LEAVE rather then maternal leave, better acceptance of men taking time off to be at home with the baby/children. More acceptance and flexible workhours for the woman to go back to paid work and have the father at home.

No money, further socially isolated through inability to do, go, be with other people. Embarrassment to admit doing it tough.

The cost of sending your child to school and they now need a computer as well; school excursions have become very dear; utilities have become dearer; groceries have become dearer; expenses of petrol and running a car; insurances needed for everything; debts that may have been incurred on the farm; cost of buying feed for animals; cost of putting in crops that then fail due to lack of rain; any health issues that have to be paid for; illness that means you cannot continue in a paid job; unemployment and difficulty in getting another job.

Women will often go without things that they need to reduce the financial pressures being experienced during tough times. Additionally, women will worry about the impact that financial hardships that they may be experiencing is having on their children. Children will often not tell their parents about camps, desires of going to uni, need of new clothes, school items because they do not want to place anymore strain on their parents. Often parents are aware of this situation but are helpless to do anything about it due to the enormity of the situation.

Violence against women

Domestic violence is a major problem which needs addressing in a far reaching manner.

Very patriarchal areas. Some women are silenced and children are silenced also. I feel that issues of family violence are far greater than the disclosures that are presented.

[A problem is] ongoing violence against women - especially towards young women - and the acceptability of it,

The overt violent nature of the streets in regional cities and the notion that women should not be on the streets if they want to be safe.

[Some women are] kept dependent on abusive men. You can't get housing if you've got no kids. You can't get a job if you're sick.

Many of the women who attend [the refuge] have not had quality health care for many years - or see it as important. When you are living as a survivor, economically, items such as health become a luxury.

Mental health

Increase in depression and anxiety issues. Hard to get good case management of women with psychiatric issues.

The lack of services for mental health is often spoken about but no action is ever further developed.

Mental health care needs to be addressed more adequately, friends are helping rather than professionals.

Mental support for women from teenagers to aged care is in need.

Anxiety, depression, using drugs and alcohol to mask inadequacies in not coping with day to day activities affects family and health.

Depression in rural areas has led to relationship breakdowns, violence, alcohol and drug reliance, and suicide in many cases.

I believe mental health providers are very few and far between, they have very long waiting periods and are most expensive. None of them bulk bill.

High level of depression. Mental health services are based in Seymour or Shepparton, so we rely on visiting mental health workers. Poor appreciation of mental and emotional issues by several local GPs, meaning that women will often be prescribed with anti-depressants with no referral for support.

For Aboriginal and Torres Strait Islander women and African women living with mental health issues ... there is a lack of health professional knowledge about cultural awareness.

Generally a healthy population except for significant mental health problems which directly links to Defence lifestyle (high mobility = isolation, extended periods of separation from partners because of Defence requirements, and impact of trauma on members exposed to risk and suffering and how this impacts on family health.

In my profession I feel I am seeing more and more cases of mothers with mental health issues ... and there seems to be a decrease in family support networks. More and more grandparents are raising their grandchildren.

It is difficult to get home help services for mothers with PND. No choice of obstetrician/gynaecologist. Huge waiting list with family care for emotional and relationship support. Insufficient staff to offer a therapeutic program for women with PND – even with interagency collaboration – we need two co-facilitators but can only locate one.

Social isolation of CALD community

There is no problem with recognising diversity here. Locals can spot it a mile off. It is the acceptance of diversity that is the problem.

Aboriginal women and those of CALD backgrounds have reported feeling uncomfortable and misunderstood in using local health services and have experienced racism in the local community.

Indigenous women I know have very little information, and any cultural needs are ignored or dismissed.

There are not enough culturally specific services and information for women's business.

[This is] a very culturally diverse area with a large population of refugees from various countries with different cultural/religious backgrounds. Despite there being an increase in the number of medical practitioners from different cultural backgrounds also it is increasingly becoming difficult for [Australian-born women] to find a medical practitioner that suits their background … Some doctor's accents are very strong and people complain (away from surgery) that they cannot understand what doctor is saying.

Acknowledgement of diversity is one area that stands out for me especially living in a rural conservative location.

The most isolated and at risk women in my client base are those from non-English speaking backgrounds.

[Health professionals need] an understanding of cultural identity and how it impacts on health and access services.

Many practitioners access sound clinical training, but are not always culturally competent, or familiar with using interpreters.

Sexual and reproductive health

There are few if any sexual health programs and young people have been "lectured" by the local pharmacy when trying to access the morning after pill. Youth are not accessing condoms as they are uncomfortable.

Chlamydia in young women [is an increasing problem].

There is a lack of recognition of diversity, in particular sexual orientation and non-traditional lifestyle choices, and at times discrimination because of this.

[There is] discrimination regarding their being out or not as lesbian women.

Young same-sex attracted youth are difficult to support in rural areas.

Abortion access is very much more difficult for women in rural areas. Privacy a real issue when accessing services that may be available locally.

Women in decision-making roles

There are lots of women in decision making at the local level ... but not in funding bodies or government where the bickies are decided.

Male health professionals still dominant in the powerful positions that shape policy.

There are few women in senior decision-making roles in our health services. We have women in senior service delivery roles, e.g. Directors of Nursing, but very few women in Chief Executive roles, or Chairs of Boards.

The internet

I think it has opened up the world to them (or has the potential to for those who do not yet have access). They can access information readily, stay in touch with others, shop, work and even study online.

For those who can access it, it has been a useful tool to break down isolation, however there are still a number of women who do not /choose not to have access, especially older women, and women with low incomes.

I believe the internet has potential to improve the lives of more isolated women, however we are again disadvantaged financially with expensive and unreliable access (including landline and mobile reception).

Information is at their fingertips, which is great when you live a great distance away from facilities, but there is still lots of black spots where people cannot access the internet or have mobile phone coverage.

Very positive, able to network much more effectively with the local community and communication is opened up between family and friends, particularly those separated by distance.

When services are good, the communication options are amazing.

Pornography/degrading images of women/violence against women and the easy access of this for, in particular, young men/boys. The photo-shopped images and violence can become the norm for them and the belief that women are like/should be like these photo-shopped images or have violence as part of their lives – leading to more violence/body image/self esteem issues for women and less acceptance in diversity.

Appendix 1 The sample 2010

What parts of Hume region are represented?

All four parts of the Hume region are well represented, as shown in Table 6. When asked to indicate what they consider as their geographic area, responses reflect mostly Central Hume (29 respondents) and Goulburn Valley (24), with 20 respondents for Upper Hume and 19 for Lower Hume. Three respondents thought of the whole Hume region as their area of interest, and five said their area covered more than one part of the region.

Table 6: Where responses refer to

Central Hume	29	29%
Upper Hume	20	20%
Goulburn Valley	24	24%
Lower Hume	19	19%
Whole Hume region or more than one PCP region	5	5%

Size of locations where respondents live

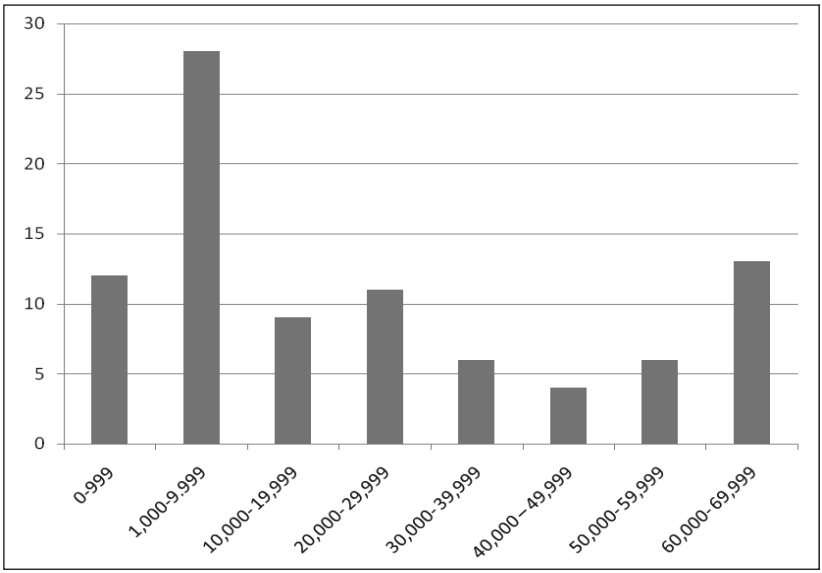
While a third of respondents come from provincial centres with populations over 30,000, 44% of respondents live in small communities of under 10,000 people, with 13% from communities with a population of 999 or fewer. This bias towards women from smaller communities, as in our previous surveys, helps identify issues for those living in smaller and more isolated localities. See Table 7.

■ Table 7: Population of locality

Under 1000	1-9,999	10-29,999	30,000+	Total
13%	31%	22%	33%	99%

Missing data = 7

Histogram of Population



Respondents gave 38 different postcodes across the Hume region. The nearest towns cited were Wangaratta(18%), Shepparton (16%), Albury-Wodonga (12%), Benalla(6%), Euroa (5%) Numurkah, Cobram and Yarrawonga (2%) Nathalia, Strathmerton, Seymour, Alexandra, Mansfield, Beechworth, Wandong and Kilmore (2%). The remaining participants were scattered over 15 other postcodes .

Health professional

Half of the respondents described themselves as a health professional (Three did not respond.) Correspondingly, half 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 8 shows that 7% are in unpaid work at home and/or in the community, 5% are studying, and the remaining 9% are self employed, working on the farm, retired or on disability pension.

■ Table 8: Employment

Full-time work	47%
Part time/ casual work	32%
Home /community work (unpaid)	7%
Studying	2%
Paid work and study	3%
Other (self employed, on farm)	9%
	100%

Age

Table 9 shows that 70% of respondents are aged between 35 and 59. 14% are over 60, and 14% are under 35.

■ Table 9: Age

Under 25	4%
25-34	10%
35-49	36%
50-59	36%
60+	14%
	100%

Missing data = 5

Birthplace and Ethnic background

93% of respondents were born in Australia, with 7% 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 countries, New Zealand and Canada. 20 respondents did not answer this question.

■ Table 10: Ethnic background

UK , Irish, Anglo	48%
Australian	40%
Indigenous	1%
European, German, Canadian, Tongan, Spanish	10%
	99%

Missing data = 15

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