Health of Women in Rural Queensland

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This paper addresses the major health concerns of rural women in Queensland. It is suggested that women’s health status is affected both by the biology of women and their socio/economic status. Women’s bodies and women’s roles have traditionally been accorded less status than those of men. Women’s health problems have been exacerbated by this fact which has also mitigated against funds being made available for specific health programs for women.

These impediments to women’s health and well-being are particularly pertinent to rural women who are isolated geographically as well as by race, ethnicity, age or disability. The generally lower socio/economic status of country women, in comparison to country men, and their traditional roles as primary carers combined with the changing rural economic environment and family structures may be one of the causes of increased stress and stress related illnesses of rural women. New initiatives in women’s health attempt to address the issues specific to the status of rural women’s health through community consultation, pilot studies and the continued evaluation of the appropriateness of existing health structures.

I was born and raised in western Queensland and have travelled widely throughout Queensland speaking with women about their perceptions of health and health services; discussing with them their needs and desires for improved health and health care. There is no doubt that rural women are doubly disadvantaged by geographical location. Queensland is a particularly decentralised State and this situation causes specific problems for the health care of Queensland’s country women. There is a desperate need for improved health programs for women in rural areas; for health information, education, and greater access to health services that women both want and need. It is my contention that we must work together to improve the health status of women by increasing this access and involving women in decisions and policies regarding their health and health care. During 1987 and 1988 women across rural Australia identified the following health needs as of particular importance for the potential improvement in the quality of life of women in rural and remote areas of Australia:

- access to information for a variety of reproductive health problems
- cancer screening
- centres for treating the repercussions of violence
- counselling to aid in stress management, quality of life issues, and help with relationships and mental health problems
- support for women as carers
- access to specific women’s health services for information on a wide variety of women’s health issues.
As in other States the major concerns of all rural women in Queensland are those which centre around access and information. The issues which impact most strongly on the health of rural women in Queensland include isolation and the present instabilities of economics and changing family structures.

Furthermore, a priority in any consideration of rural women's health in Queensland must be the comparatively large communities of Aboriginal and Torres Strait Islanders. The health issues for Aboriginal and Islander women include those already identified above but are necessarily different in emphasis and organisation, since a vital consideration in the health of Aboriginal and Islander women must be the repercussions of dispossession. It is imperative that cognisance be taken of the impact of substandard living conditions on the mental and physical health of aboriginal and Islander communities and the appallingly low life expectancies of their people by world standards. It is the important issues for all Queensland's rural women—isolation, economics and family structures—and the special and extremely urgent needs of aboriginal and Islander women, that I would like to consider here.

Isolation

The National Women’s Health Policy endorses the World Health Organisation’s definition of health as a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity, isolation has the potential to affect the social well-being of country women. It is a consideration in terms of availability of and access to health and other support services. It is also a major consideration in stress and stress related conditions.

A survey of sixteen remote communities around Australia found that of the seventy-two social and community services generally available, the average number of services available to these communities was generally less than half. Exceptional differences were found in the availability of women’s services (from Life has Never Been Easy 1988:31). Likewise, seventy to ninety-five per cent of women living in towns or cities have access to a good range of health services within one hour’s drive compared to the health services available to around four per cent of women in more remote rural areas. Women necessarily need different services from those provided for men, that is, from those services provided for under the rubric of the ‘general community’. This is not only for the very obvious reason that women and men have different bodies and therefore have different physical needs, but also because women’s socio-economic and sexual status has historically been lower than that of men. The areas of concern for women include, therefore, not only gynaecological and reproductive health care but the availability of those services which address them as carers of men, children and the elderly, and, sadly, as the potential victims of violence.

The rural women of Australia are noted for their independence and stamina. It is my experience that rural women often appear unwilling to seek help for duties which they perceive to be their own rather than the concern of society as a whole. This may be the case even when it is clear that the physical and mental well-being of a woman is at risk. However, when a woman is moved to seek help she may be faced with the problems of distance; viz inadequate transport and communication, a lack of appropriate women’s services, the lack of privacy common in small communities, or a lack of alternative accommodation should she wish to change her circumstances. For example, in Dingo, Queensland, residents share telephone party lines which in one instance services twenty-one homesteads. Clearly, a woman faced with the probability of being overheard by her neighbours is unlikely to confide in either friends or potential telephone counselling or support services, about either marital problems, or concerning violence in the form of incest/rape, marital rape, or ‘domestic’ violence. The frustration of limited and sporadic access to these lines is, furthermore, a barrier to the comfort of friendly chats to other women or relatives when the
going gets a bit tough.

In Blackwater, Queensland, as in other mining towns where homes are owned by the company, women have spoken of the problems of finding alternative accommodation when marriages have broken down. This may result in women and children staying within unsatisfactory relationships or facing the added trauma of leaving friends, perhaps jobs and schools, and with the concomitant problems of custody and access for children of the marriage.

Privacy is another important factor in the consideration of services for rural women. During the survey of women in rural Australia it was common for women to state that while people in small communities tend to offer each other assistance in times of crisis, there is also a tendency for ‘certain problems’ to be kept very much within the family or close friendship networks. The Report suggests that:

Marital problems and domestic violence are among those situations where a woman may feel ashamed or embarrassed if her position is widely known. While professional workers in a local community are just as likely to respect the confidentiality of clients as are those in large centres, the probability of seeing a counsellor in day-to-day life is certainly increased in small towns. If a woman has just poured out her most intimate problems and feelings, it is not surprising that she might feel uncomfortable.

Furthermore the Report goes on to point out that:

Some women spoke of their reluctance to seek the services of the local doctor in relation to certain conditions because of the likelihood of seeing him at the club on Friday night or at the next school board meeting. One woman said: “everybody here knows that when the doctor is on holidays and a locum from somewhere else is filling in, the women line up for their Pap smears”. Other problems mentioned in the Report that relate to privacy concern the relationship of women to doctors. One problem referred to is the lack of confidence (often young) women have in male doctors, another is the itinerant nature of doctors in some remote areas which works against the possibility of the development of patient/doctor trust.

Economics

While isolation is of prime concern in the consideration of rural women’s health needs, the relationship of health to the downturn in rural economics has also been remarked upon by rural women and those responsible for rural services. Many women have added outside paid employment or replacement of the hired labourer to their role as primary carer and performer of household duties. This added burden has in some instances resulted in physical debilitation and increased emotional and mental stress. Much of this stress goes unrecognised as such, or is treated with tranquillisers and other medication which may not be appropriate. Failure to address the root cause of the problem may in fact exacerbate both physical debilitation and emotional stress. A recognition of the double burden carried by women and a revaluing and sharing of household duties by other members of the family is necessary if women’s health is not to suffer from the current economic environment.

Family Structures

Many young people are moving to larger towns and cities in search of paid employment. The majority of rural children over the age of twelve attend high schools in areas many miles away from their homes, this often necessitates boarding away from home during term time.
The changing structure of the family affects women's lives in various ways. Ann Summers identifies the social expectations of women's role within the family thus:

women are caught in an enveloping double bind when they devote their entire lives to their families: their 'selves' are constructed on this premise, yet their 'selves' are threatened when they do it. The hostility, bewilderment or despair experienced by women who realise this is often turned inwards against themselves - depression - rather than outwards against the cause of their 'self dislocation - aggression'. (from: National Women's Health Policy, 1989: 14).

Men's responses to the changing roles of rural women may be influenced by a perceived threat to their traditional power base. Feelings of impotence may be an understandable response to a new and different situation which is difficult to come to terms with. However, women's changing role in society is not limited to rural women and many women are choosing alternative roles to those traditionally expected of women. The increase in male violence against women has been linked to the changing family structure and economic problems. While increased stress for both men and women may be related to family structures and economics these issues cannot be accepted as an excuse or legitimate reason for male violence.

The impact of isolation on women and its relationship to violence cannot be underestimated; recent research by Lyla Samyia on 'domestic' violence in country areas suggests that there is a disproportionate number of domestic homicides in rural areas compared to those in metropolitan areas. Samyia says that this situation is often attributed to the widespread possession of firearms and isolation.

Women's Health policy recognises the health implications of male violence. It has been shown that the Health system bears much of the economic cost of male violence. This is particularly so in terms of long term psychiatric and psychological counselling. Research on violence against women and its relationship to the Queensland Health system is currently being undertaken by the Women's Health Policy Unit.

Service Initiatives

It may be pertinent to note that when asked for their preferred sources of information on services and programs most women in the Remote Communities Survey said that they felt most secure with information and services diffused by persons rather than generalised through institutions, electronic media or mass media. Likewise, women's perceptions of the important aspects of services emphasised staff (type and number) information, and personal inputs to the services provided.

Attempts by the Queensland Women's Health Policy to address some of the needs and requests of rural women with respect to their isolation include: A commitment from the Government for $1 million to fund the Government's Breast and Cervical Cancer Screening Program, including funds for the expansion of the program. At the present time various pilot programs are being set up around Queensland which take into consideration the special needs of Queensland women. Future plans include further development of these programs including development of educational resources for non-English speaking background women.

The National Women's Health Program in Queensland has already funded a Mobile Women's Health Service. $377,000 has been made available for a twelve month pilot program. The aim of the pilot program is to test the usefulness and cost of using existing
community health facilities and a mobile team of nurses to provide counselling and a clinical and educative health service for socially and geographically isolated women.

The team of nurses undertook training to address such issues as violence and to obtain skills in inappropriate support and counselling as well as an intensive program on training in specific women’s health issues. The mobile service will operate out of Roma, Mt. Isa, Atherton, Mackay and Townsville, with overall co-ordination from the Department. 008 telephone lines which have been funded by the Department of Health Program, Queensland, include: the Queensland Council of Carers, a 24 hour support line. Under the National Women’s Health Program we have funded Protect All Children Today (PACT) a telephone incest support network; and the Brisbane Women’s Health Centre, for health resources, information and support, also through a 008 line. Two Regional Women’s Health Centres at Hervey Bay and Rockhampton have also recently been funded.

Aboriginal and Islander Women

The Report of the Survey of Women in Rural Australia claims:

The health status of Aboriginal and Islander women is poor. In Women’s Business, the Aboriginal Women’s Task Force describes the difficulties women confront in gaining access to services and highlights the implications of poor public sanitation for the health of their communities.

Besides the urgent issues of adequate housing, decent sanitation and access to services (and clearly related to the need for these basic human rights) the major health issues for Aboriginal and Islander women are:

- High perinatal and infant mortality
- Under nutrition
- Low life expectancy (15 to 20 years behind non-aboriginal and Islander communities)
- Extremely high rates of degenerative diseases and life-style/stress related diseases.

Attention to Aboriginal and Islander women’s health is imperative. It is not an overstatement to suggest that current conditions amount to what is in fact genocide.

The National Women’s Health Policy states that:

For Aboriginal women birthing is traditionally women’s business. As hospitals do not take account of traditional laws...it has been suggested that, in consultation with Aboriginal women, the establishment of culturally appropriate birthing centres should be considered.

The significance of this statement for Queensland may be understood if the conditions of birthing for women of the Cape York Peninsular are recalled. It has been recent practice for women from this area and the local islands to be moved to hospital bases far from home and loved ones to give birth. It is not so long ago that Aboriginal and Islander women were routinely sterilised on these occasions, usually without consultation with the women giving birth. The Commonwealth Birthing Initiatives program is, therefore, of considerable relevance to Aboriginal and Islander women from Cape York.

Policies and programs on cancer screening and birthing practices which are culturally appropriate for Queensland Aboriginal and Islander women are being put in place with the consultation and liaising of local Aboriginal and Islander Groups, the Aboriginal and
Islander Women’s Group in South Brisbane. Aboriginal and Islander Health and the Women’s Health Policy Unit.

Conclusion

During the seventies and eighties participants of Women’s Health conferences and meetings analysed women’s health problems, existing health systems, and women’s position in Australian society. These concerns have lead those involved in women’s health to the conclusion that “the problems women experience in relation to the health care system bear some relationship to their socio/economic status and the limitations placed upon them by society”. They consider, therefore, that “the current mismatch between the health needs and values of women and those of the health system demands action”. It is my vision that the nineties will provide the arena for concerted and collective action in the very important area of women’s health.