

2. With Only Their Bare Hands

We had no one on our side, no political parties, no governments, no armies, no police, no trade unions and no religions. All we had were ourselves—women.

— Zelda D'Aprano (in Robertson n.d.:Ch. 16)

The Australian women's health movement embarked on a journey of discovery in the early 1970s, knowing little more than that the existing system was causing deep pain and was not meeting women's needs. Members had scarcely any money and often knew little about health, the health system or how government worked. However, as they listened to each other's experiences and formulated their critiques, they developed two aims: first, they wanted to change the power relations of society that placed women in a vulnerable, subordinate position, and second, they wanted to support the women they were hearing from, many of whom were desperate to find compassionate medical services. In order to politicise the problems they saw, they needed to articulate a set of concerns. This task was not an easy one, not only because it was virgin territory but also because criticism of science, medical science and the medical profession was uncommon at the time and practically unheard of from women! Moreover, they had to speak out in public about unmentionable topics that opened them to portrayal as extremists—easy targets for ridicule. Rape and incest were completely taboo subjects and even domestic violence was hardly mentioned at the time, even within the counselling community.

Initially, women's attention focused on reproductive health issues where the gaps were glaring; however, a broader approach, a social view of health, soon developed from the stories and experiences that were shared. In the process of working for the structural reforms that follow from a social perspective, women faced formidable opposition: from the medical profession, from the religious right and its institutions, from bureaucracies bent on doing things the way they had always been done, and from governments that had no feeling for holistic health perspectives and often lacked the political will to confront powerful opposition.

This chapter presents a sketch of the political and service-providing activities of the early years. Because Broom (1991) has provided a detailed account of the establishment of Australia's first dozen 'founder' women's health centres, only a summary is presented here. The second part of the chapter examines the establishment of the first refuges and services for women who had experienced sexual assault. Setting up separate services was radical action, especially for women without resources, and is a distinctive feature of Australian activism.

In other countries with strong women's health movements, relatively few such services were established and even fewer have endured. The separate women's health sector is testimony to the strength of the Australian movement and to the dedication of its members.

Women's Health Centres and Services

The 1970s was a 'period of ferment and hope that the world could be a better place' (Auer 2003:3). As in the United States, women in Australia met in consciousness-raising (CR) groups in the late 1960s where one of the aims was to unlock the silence about women's personal experiences and to draw out the political implications. Women also found these processes therapeutic (Orr 1994:209). Issues were discussed and evaluated in small groups, with a particular focus on the effects of traditional female roles, such as responsibility for caring. Women acted as each other's sounding boards; 'old inhibitions and superstitions about women's physiology and psychological natural impediments were realised for the crap it was' (Melbourne University Consciousness-Raising Group 1974:46). The disruption of conventional views about the female role and the development of new norms about what constitutes femininity emerged from these processes. Many groups attempted to work systematically and to devise new practices to replace the old, especially in relation to households, sexual relationships, raising children and participation in public life (Connell 1987:30–1).

Jean Taylor (2003) describes her CR/WL experience in Melbourne as follows:

From the moment I joined the Brunswick CR group, I was completely involved. The Women's Liberation Centre was set up, with a telephone for information and support and also as a meeting place for unfunded activist groups. I started doing roster there. The centre was basically a large meeting space at 16 Little Latrobe Street. So women could either drop in, if they were in the city, and pick up the latest position paper... or subscribe to the *Women's Liberation Newsletter*...so much was being published and written about and women were ringing in about all sorts of things. Domestic violence was rife and by the mid-1970s referrals to refuges became crucially important.

CR and WL groups were being established at the same time. Mass gatherings were held in an atmosphere that was peaceful but often radically confrontational. For example, thousands of women, with their children and dogs, attended the 1972 International Women's Day (IWD) march in Sydney, playing havoc with traffic. They carried flags and banners, sang and chanted. There were Hyde Park picnics, concerts and street theatre depicting the stages of women's lives. A few women removed their T-shirts in protest against double standards and

were protected by others when police tried to move in. A man from the New Theatre, wearing a bearskin, was arrested for wheeling a model of a giant penis through the streets in a barrow—a send-up of prevailing masculinist views. IWD Sydney made a profit from the day, which was used to rent the first WL House in the city (Stevens 1985).

In CR and WL groups, health emerged as an urgent issue but activists initially had no idea how to respond. As Zelda D’Aprano (in Robertson n.d.) describes the situation:

Answers had to be found and found fast, for many of these women were desperate. Quickly we had to gather information and pass it on. Off we went to find sympathetic doctors; to talk to nurses we knew; and to read everything we could find. Off to seminars, conferences, into courses to find out how the healthcare system worked; into jobs within the system; calling public meetings to see if what seemed wrong, really was. We found it was much worse.

The wish to support women who needed services that were unavailable is easy to account for but the determination with which women set about establishing their own health centres and crisis-support services with so few resources is not so easily explained. Not only were women short of money, they were also inexperienced politically. They knew little about lobbying, conducting advocacy or dealing with bureaucracy. As Lyn McKenzie (1979), a founding member of the Melbourne Women’s Health Collective, recounts, few members of the collective had any experience in writing submissions or seeking funding and few had ‘access to the manner in which the bureaucratic maze could be successfully tackled’ (McKenzie 1979:40).

Reproductive health and, to a lesser extent, mental health issues were early priorities. Adelaide WL recognised the need for easily understood information about contraception and in 1970 planned a pamphlet called *What Every Girl Should Know about Contraception*. Run off in early 1971 and reprinted several times, it was distributed widely to schoolgirls, working women and university students, among others (Kinder 1980:49–51).¹ In its 1971 manifesto, Adelaide WL declared that women had the right to control their own bodies and called for publicly funded birth-control education, the abolition of the 27.5 per cent sales tax on contraceptives and the establishment of community-based birth-control centres.² It argued that local health centres should provide services for

1 The pamphlet inspired the highly controversial Sydney publication *What Every Woman Should Know*, first printed in July 1971 (Stevens 1995:15).

2 While WL took action on reproductive health issues, including contraception, from 1970 onwards, the newly formed WEL was directly responsible for having the luxury tax removed. WEL made a submission in the middle of 1972 to the tariff review being undertaken by the Tariff Board. As a result, the ALP promised

psychological disorders and that free abortion on demand should be available. Mental health issues and 'dealing with doctors and psychiatrists' were priorities when the Adelaide Women's Health Group formed in 1973. By the time planning for the Hindmarsh Women's Health Centre was under way in 1975, a social view of health was being articulated. The new centre was to 'provide a coordinated community-based service which would cover the physical, psychological and social aspects of women's health care'. Preventive primary health care and health education would be made available and women's health research and community action would be promoted (Radoslovich 1994:14–17). Such a broad agenda was at the cutting edge of ideas at the time. The following list provides a summary of the main services established in the 1970s.

Selected Women's Health Centres and Services Established in the 1970s

1972

- Children by Choice, Brisbane, family planning and abortion information service.

1974

- Adelaide Women's Shelter, also known as Naomi Women's Shelter.
- Bonnie Women's Shelter, Sydney.
- Collingwood Women's Health Centre, Melbourne.
- Elsie Women's Refuge, Sydney.
- Hobart Women's Shelter.
- Leichhardt Women's Community Health Centre, Sydney.
- Nardine Women's Shelter, Perth.
- Rape Crisis Centre, Melbourne.
- Sydney Rape Crisis Centre.
- Women's Health and Community Centre, Perth.
- Women's Liberation Halfway House, Melbourne.

1975

- Alice Springs Women's Centre, primarily a refuge, Northern Territory.
- Blacktown Community Cottage, Sydney.

to remove the luxury tax on contraceptives, make the contraceptive pill free through the Pharmaceutical Benefits Scheme and support the development of family planning networks. Action on all areas was taken as soon as the Whitlam Government gained office (Sawer 2008b:37–8).

- Bringa Women's Refuge, Dee Why, Sydney.
- Brisbane Rape Crisis Centre.
- Canberra Women's Refuge.
- Darwin Women's Health Centre.
- Hindmarsh Women's Health Centre, Adelaide.
- Hunter Region Working Women's Centre, now Hunter Women's Centre, New South Wales.
- Launceston Women's Shelter, Tasmania.
- Liverpool Women's Health Centre (which later participated in establishing Sunshine Cottage, a local childcare service, Amberley Single Women's Refuge, Rosebank Sexual Assault Service, Dympna House, an incest counselling service, Campbelltown Women's Health Centre and Jilimi Aboriginal Women's Health Centre, now Waminda), Sydney.
- Women's House Health Centre, Brisbane.
- Women's Health and Community Centre Rape Crisis Centre, Perth.

1976

- Adelaide Rape Crisis Centre.
- Central Coast Women's Health Centre, Gosford, New South Wales.
- Christies Beach Women's Shelter, South Australia.
- Marrickville Women's Refuge, Sydney.
- Marty House, Woolloomooloo, Sydney, for women with substance-abuse issues.
- Sexual Assault Resource Centre, Perth.

1977

- Bankstown Women's Health Centre, Sydney.
- Bessie Smyth Feminist Abortion Clinic, Sydney.
- Cawarra Women's Refuge Aboriginal Corporation.
- Women's Health Care House, Perth.
- Women in Industry, Contraception and Health (now Multicultural Centre for Women's Health), Melbourne.

1978

- Anne Women's Shelter, South Australia.
- Geelong Rape Crisis Centre, Victoria.
- Warrina Women's Refuge, Coffs Harbour, New South Wales.

1979

- Elizabeth Hoffman House, emergency accommodation and support for Aboriginal women and their children, Melbourne.
- Sexual Assault Service, Queen Victoria Medical Centre, Melbourne.
- Wagga Wagga Women's Health and Support Centre, New South Wales.
- Working Women's Centre, Adelaide.

New South Wales

Australia's first women's health centre was established in Leichhardt, Sydney, in January 1974. The preparatory work was done by members of Control, a grassroots abortion referral service. The need for the centre was amply demonstrated when the first client arrived before the furniture and, within six months, a 10-day wait for an appointment developed (Broom 1991:4). Women came from all over Sydney—17 per cent travelling from the outer western suburbs—which alerted staff to serious unmet need. It was decided to apply for funding to establish another centre in Parramatta. In the meantime, a group of women had begun to meet in Green Valley. They wanted a multipurpose women's centre and a refuge. They learned that Leichhardt had plans for a western Sydney centre and successfully petitioned to have it located in Liverpool (Liverpool Women's Health Centre web site).

Liverpool Community Women's Health Centre was opened in April 1975, the premises having been painted and prepared by the women themselves. Leichhardt Women's Community Health Centre (LWCHC) also established the Bessie Smyth feminist information, counselling and abortion facility (Broom 1991:1–14). Following a community-development approach, these centres helped to establish more agencies, including Sunshine Cottage, a local childcare service; Amberley Single Women's Refuge; WILMA, a women's health centre in Campbelltown; Rosebank Sexual Assault Service; Jilimi, now Waminda, Aboriginal Women's Health Centre on the South Coast of New South Wales; and Dympna House, an incest counselling service. The Leichhardt centre was also involved in the establishment of the Workers' Health Centre in Lidcombe, by way of its interest in occupational health and safety (OHS) issues. Both Liverpool and Leichhardt were inundated with inquiries from groups wishing to set up their own centres, demonstrating the urgency of the need being expressed. Staff supported initiatives in Bathurst, Wagga Wagga, Bowral and Nowra.

The Bessie Smyth Foundation provided supportive, holistic, non-judgmental services, delivered in a setting intended to be homely rather than clinical. Clients were able to bring their children if they had no-one else to care for

them. A charge was necessary to make operations viable but it was recognised that even a small charge was beyond the capacity of some women. Bessie Smyth staff therefore set up the Powell Street Clinic in Homebush in 1977 to provide information and counselling support on the basis that no woman should be turned away because of inability to pay a user fee.³ Information was provided in 13 languages plus English, both over the phone and face-to-face.

After 25 years, Powell Street became financially unviable and was sold to Marie Stopes International in 2002.⁴ As well as providing 42 000 safe, affordable abortions and countless counselling and support services, Bessie Smyth provided training for health professionals and student placements. Clients came from all walks of life and included marginalised and disadvantaged women, 'illegal' migrants, sex workers, women in prison, women leaving prison and women with drug and alcohol-related problems. With the funds from the sale of the Powell Street Clinic, the foundation continued to provide counselling, referral, information and support services for destitute women. Repeated efforts were made to secure funding for the establishment of a State-wide information service, similar to Queensland's Children by Choice (of which more below). In 2008, operations ceased, although the foundation was retained, in case a 'window of opportunity' should emerge for the establishment of a new women's reproductive health service.

Another early New South Wales centre is the Working Women's Centre, near Newcastle, set up in 1975, as a multipurpose centre, providing health, legal aid, counselling, information, employment and childcare services. An enormous amount of work was involved in setting up and maintenance because funding had to be secured from a variety of separate sources (Broom 1991:15–16)—a situation that continues in 2010! The centre, now the Hunter Women's Centre, has been unable to obtain the services of a doctor since 2003. It provides short, medium and long-term counselling, undertakes casework and outreach where resources allow and runs support groups and health-related activities, including dancing, Tai Chi, massage and meditation.

3 A user fee, charge, co-payment or out-of-pocket expense—terms used interchangeably in Australia—comes about when there is a gap between the Medicare rebate and the fee charged by the provider. User charges constitute a serious financial barrier to the use of medical services.

4 For the same reason, Sexual Health and Family Planning ACT transferred its abortion service, Reproductive Health Services, to Marie Stopes in 2004.

Victoria

The concept of worker control and the principle of collectivity was alien to the members of the HCC [Hospitals and Charities Commission]. (McKenzie 1979:41)

Two issues dominated the overflowing speak-out organised by WL, the Union of Australian Women and the YWCA in Melbourne in 1973: poor health care and lack of information. Women gave testimonies about poor-quality services and about services they could not find or could not afford. The Melbourne Women's Health Collective was formed after the meeting, supported by a donation of \$490 from an abortion trust fund that had recently closed. Premises were rented for the Collingwood Women's Health Centre and furnished from donations and small grants. Within a few months, the centre had five doctors, several nursing sisters, a naturopath and a dietician. Service provision was voluntary, although after Medibank, the Commonwealth's new national health insurance scheme, came into operation, medical services could be bulk billed. Demand was heavy, as in New South Wales, and evening sessions often lasted until midnight (Hull 1986). Dorothy Broom (1991:12–14) has described the funding difficulties experienced as a result of federal processes and State-level political intransigence but, briefly, Commonwealth funding was to have been channelled through the Victorian Hospitals and Charities Commission (HCC) in 1975. The commission, however, imposed conditions that were unacceptable to the collective, including that services be provided for both men and women, that men be allowed to join the collective and that doctors be paid by fee-for-service rather than salary or other means. Compliance was unthinkable. The Melbourne Women's Health Collective closed its doors for clinical services at the end of 1975 and requested that the grant money be returned to the Commonwealth (Hull 1986; McKenzie 1979).

South Australia

The health bureaucracy appears to have had an unfavourable view of the women's health centre from the start. (Quoted in Auer 2003:5)

As in Victoria, in South Australia, the health bureaucracy strongly opposed separate women's health centres. Opened in 1976 after operating from the house of one of its doctors, the Hindmarsh Women's Health Centre was the first in South Australia. The founding collective hired an old building and renovated it, assisted by volunteers, male and female. Expectations were high: a comprehensive, women-centred, child-friendly service would provide comprehensive services including relationship support and would help women to reach their potential

(Radoslovich 1994:15–16). Commonwealth funding was temporarily blocked in the Health Department but Hindmarsh became established and operated successfully for four years. In 1980, however, disagreement broke out between women who thought the centre had lost its independence and vision through its close alignment with government and those of a more moderate persuasion. An unsympathetic government lost no time in withdrawing funding and appointing an administrator. The Women's Adviser to the Department of Premier and Cabinet was a key player in trying to salvage something from the ashes, and the Health Minister, Jennifer Adamson, was supportive. In response to vigorous grassroots lobbying, the minister was able to preserve the funding for another centre. Shortly afterwards, Adelaide Women's Community Health Centre was established in North Adelaide and most of the Hindmarsh staff moved to work there. The original collective, however, decided to continue operations, providing some medical services, workshops, herbal treatments and massages (Broom 1991:19–21, 93–101; Radoslovich 1994:19–21).

Western Australia

In Perth, women formed the Women's Centre Action Group, which met weekly at the WEL premises from October 1972 onwards. Establishing a refuge was chosen as the top priority. Preparatory work proceeded through 1973 and the Nardine women's refuge was opened in July 1974. Shortly afterwards, the Women's Health and Community Centre at Glendower Street began operating on a voluntary basis and was officially opened in 1975 after it received Commonwealth funding. The focus was on providing services for all women on the grounds that women from all income groups suffered discrimination and stereotyping in the medical mainstream. A split between radicals and moderates—described to me as 'an implosion'—led to the withdrawal of funding in 1976. Again, the money was preserved for another centre, and Women's Health Care House opened in 1977 (Broom 1991:14–15). The small premises led workers to feel they were operating from 'a resurrected sardine tin' but the centre was able to move to its present location at 100 Aberdeen Street in 1989 (Stroud 1989:3). Medical, counselling, information and postnatal depression services are provided along with support and advocacy for women suffering mental health problems and women experiencing domestic violence. Community-development projects and workshops are held, child care is available for clients and development and training are provided for health and social welfare professionals.

Queensland

At a time when State politicians were telling women that everything they could possibly need was being provided in hospitals, grassroots women set up Women's House Health Centre in Brisbane in 1975, as part of a multipurpose centre. Participants remember it as 'a hotbed of dispute' between women with different feminist orientations. Differences were not just between radicals and reformists but also between women of different sexual persuasions. Early management committees did not keep accurate records so the auditor was unable to produce an audited set of accounts and the centre lost its funding after less than two years. A variety of fundraising activities was used to survive. Some services, mainly refuge services, continued on a voluntary basis but the centre had to move to save money. The second set of premises was in poor repair but was nevertheless full to overflowing with women needing shelter. At this time, Premier, Joh Bjelke-Petersen, said there were no homeless young people in Queensland and returned \$14 million to the Commonwealth Department of Housing.

The centre was eventually funded under the National Women's Health Policy (NWHP) in 1990 (Broom 1991:16–17). Among the 'memorable moments' of the early years was the arrest of Women's House workers for singing *Lest We Forget* for women raped in war.

Northern Territory

In Darwin, local WEL women, supported by general practitioner Lyn Reid, wrote a health centre funding proposal to the Health and Hospitals Services Commission (HHSC) in 1974. Darwin Women's Health Centre, a combined health centre and refuge, was opened in 1975, having been delayed for six months, this time not by the local bureaucracy but by Cyclone Tracy. Divisions among members and identification with radical elements gave the NT Government an opportunity to withdraw funding in 1980. In Alice Springs, too, WEL women were behind the establishment of a women's centre, which was primarily a refuge and was opened on a volunteer basis in an old house in 1975. It provided crisis counselling, referrals and emergency accommodation, but it too lost funding in 1980, and although volunteer workers tried to continue, the service was closed and the house bulldozed (Broom 1991:21–2). Local women, however, worked to re-establish a centre and 14 months later Women's Community House was opened as a refuge in an old building which was intended to be temporary. It took a further nine years to arrange for specific-purpose accommodation and a renamed Alice Springs Women's Shelter opened in 1991. The service has

expanded, gaining a children's support worker, an outreach worker, a domestic violence counsellor and a community-development and training worker. An outreach service for women and children who do not want to stay at the shelter and transitional housing arrangements operate at other locations. The service, which is jointly funded by the NT and Commonwealth governments through the Supported Accommodation Assistance Program (SAAP), is open to women from all cultural backgrounds.

Refuges, Shelters and Houses⁵

The needs of women and children escaping domestic violence are as complex and varied as the many kinds of violence that are being escaped from. (Pateras 1997:4)

The Australian refuge movement has been a major force in having violence recognised and accepted as a serious women's health issue. The political pressure generated at the local level slowly percolated upwards, in due course finding expression in national policies. Violence against women has deep historical roots. In eighteenth-century Britain, the law still allowed men to beat their wives, and nineteenth-century English and Australian laws regulated violence rather than outlawing it. It was a major issue for first-wave feminists: Louisa Lawson wrote with outrage about it in *The Dawn* in 1891 (Spinney n.d.:1; Weeks and Gilmore 1996:141). Despite more than a century of activism, however, the National Council to Reduce Violence against Women and their Children (hereinafter referred to as the National Council) (Commonwealth of Australia 2009a:20) found that one in three Australian women still experience violence at some time in their lives. The majority of perpetrators are men, and women are mostly assaulted in their own homes, often repeatedly, by men they know. Violence is a major cause of homelessness for women and children. In 2003–04, the Australian Institute of Health and Welfare (AIHW 2005a) found that 33 per cent of women in SAAP-funded services were escaping violence, along with 66 per cent of accompanying children.

Violence is a major cause of ill health: intimate partner violence was the leading contributor to death, disability and illness for Victorian women aged between fifteen and forty-four years in 2004, ahead of well-recognised risk factors such as high blood pressure, smoking and obesity. Intimate partner violence contributed 8 per cent of the total disease burden for Victorian women aged between fifteen and forty-four years and 3 per cent of the burden for all Victorian women in

5 'Refuge' is the term generally used in Victoria, New South Wales and Western Australia, while 'house' or 'shelter' is more common in Tasmania, South Australia, Queensland and the Northern Territory (Weeks 1994:44).

that year (VicHealth 2004). Violent relationship experiences are associated with allergies and breathing problems, pain and fatigue, bowel problems, vaginal discharges, eyesight and hearing problems, asthma, bronchitis, emphysema and cervical cancer (Loxton et al. 2006). This major health risk factor is not easily or effectively addressed in the conventional medical system.

The magnitude of the problem emerged early in CR groups and phone-ins (Smith 1985:26; Weeks and Gilmore 1996:143). Women sought refuge from violence and sometimes because their children were being sexually abused (Geddes 2007:2). With almost nowhere for women to go, collective members often provided accommodation in their own homes; however, the problem was too big to be solved in this way and feminists knew that prevention required that the issue be taken out of the private sector where it was invisible and debated publicly (Orr 1994:9–10). Elimination would require fundamental changes in societal values, in public policy, in the conduct of relationships and in the status and economic independence of women. Sustained political action would be necessary.

Feminist refuges were established to provide immediate support and to lobby on key issues, such as public housing, income support, employment, education and child care. Refuges also supported women after they moved on, where necessary (Orr 1994:210). One of the first attempts to establish a refuge ‘by women for women’ was in 1971 when Joyce Johnson and Elizabeth Hoffman set up a facility for Aboriginal women and their accompanying children in Melbourne. Both women worked at the Aborigines Advancement League, where women who needed crisis accommodation often presented. ‘Aunty Joyce’ and ‘Aunty Liz’ also took women into their own homes. The original attempt failed and the facility was taken over by a hostel (Smith 1979) but the two women continued to work towards a refuge. In 1979, under the auspices of the Aborigines Advancement League, they established a service that later became Elizabeth Hoffman House. A community-controlled organisation, with a management committee and elected office bearers, the house was incorporated in 1984, when it secured independence from the League. The underpinning philosophy is that Aboriginal people have a right to self-determination and self-management and that each community is best able to identify its own needs and develop and monitor its own programs. It provides emergency accommodation for Aboriginal women and children, counselling and support services (Elizabeth Hoffman House web site).

In 1974, non-Aboriginal women established refuges in Sydney, Melbourne, Adelaide, Perth and Hobart. The story of the way Elsie, the first permanent 1970s refuge, was set up and maintained in Sydney has been told in detail by one of the founders, Anne Summers (1999:315–26). Briefly, a refuge working group of the Sydney Women’s Commission, looking around for appropriate premises, noticed that the Church of England held unused buildings in Glebe.

The group wrote to the church, hoping to negotiate to rent a house for a modest sum but the church refused to meet with them. Outraged, the group decided to squat in one of the houses. Having let themselves in by forcing a window, they found that the house next door was also vacant and shared the large backyard. They then contacted television networks and announced that Australia's first feminist refuge had opened.

Premises are one thing. Operational money is another. The rundown houses were soon crowded, women and children often had only the clothes they stood in and there was no money for food and electricity. Summers relates the struggle to obtain government funding, the compassion of women who came to help, the generosity of local Glebe merchants, who often gave what was needed, and the lengths that were taken to survive. She recounts the determination to continue political action as well as provide a service for women. Elsie survives today, one of 83 refuges for women and children in New South Wales.

In Melbourne, more than 100 WL members became part of the Halfway House Collective formed in April 1974. The group met for months, writing letters, funding submissions and a manifesto and attempting to gain media coverage. Following Elsie, they considered squatting, since public authorities, churches and private developers all owned empty houses. The idea was rejected, however, on grounds that stability was needed for women and children already in precarious circumstances. Instead, efforts were made to persuade owners to allow empty houses to be used (Women's Liberation Halfway House Collective 1977:13).

Eventually, a community woman offered the use of a house for a year and WL Halfway House opened in September. The collective had a flat decision-making structure, with both service users and workers involved in planning strategies and running of the house. A roster was organised in four-hour shifts, with one woman remaining overnight, along with transport and babysitting rosters. Jean Taylor (2003) describes her experience:

I became involved in roster work...That was amazing...I had no idea, really, what I was doing. I went along because some of the Brunswick CR group volunteered at a public meeting to become members of the committee...it was very difficult to get funding because the government wasn't funding refuges...We just kept putting in submissions.

Within two months, the centre was running out of space and money. It survived on donations and proceeds from fundraising events, such as jumble sales. WEL assisted by setting up a trust fund to pay for electricity, rates and phone. Besides running costs, residents needed money to set up new accommodation in order to move on. In early 1975, modest Commonwealth funding was obtained and the

collective was able to pay its workers. The first employees were a diverse group, including 'a mother of six, a counter-culture freak, a Toorak lady, a heavily feminist dyke, a dedicated resident intent on bringing fun to the Women's Movement, a trained statistician that never was and one that defies all attempt at description' (Women's Liberation Halfway House Collective 1977:113).

Working conditions were onerous and a division threatened to open up between paid workers and the rest of the collective. One ex-worker has left a record of her feelings: it helped in the job to have 'no heart' to avoid emotional involvement, to enjoy being a hermit because there was no time for social life, to be able to function well on minimal sleep and to own a truck to carry around 'all the necessary papers, speeches, cards, articles and files' (Women's Liberation Halfway House Collective 1977:115).

When the original house was sold, another round of letter writing, lobbying, speaking to the media and searching for premises began. The HHSC grant included only \$50 a week for rent. A former private hospital was located on the outskirts of the city. After the move in April 1975, however, it transpired that the lease was not renewable because the building was earmarked for demolition. Another frustrating search began; no-one was prepared to consider letting to a feminist women's refuge. Suitable premises were eventually found and the house moved for the third time in 20 months.

Another problem was conflict with the Victorian Government about confidentiality of location. Collective members insisted on secrecy in order to protect women from angry partners. After a protracted struggle involving media debate and direct action, a compromise was reached: selected government women, who visited at least once a year and reported on operations, became address holders (Orr 1994:217; Women's Liberation Halfway House Collective 1977:32–3, 69).

Political action focused on housing shortages, income-support requirements and police handling of domestic violence. Direct action included a demonstration outside the Victorian office of the Commonwealth Department of Social Security in May 1975, which drew attention to the inadequacy and uncertainty of the pensions available to women who had no other means of support. Later that year, a campaign to increase the availability of low-cost housing included squatting in unoccupied Housing Commission flats. In the same year, the collective wrote a submission to a police inquiry on behalf of women who had used the house. It argued that women experiencing domestic violence found the police unsympathetic and unreliable and that distrust was common. A number of recommendations were made, including suggestions for police training, but the collective was told that the submission did not fall within the terms of reference of the inquiry.

In the 15 months until the end of 1975, Halfway House received accommodation requests from 907 women and 1949 children but only 202 women and 304 children could be accommodated. Places were found for 38 women and 52 children in private homes, leaving 667 women and 1593 children who had to be turned away. The collective estimated that the voluntary time devoted to Halfway House during the period was equivalent to that of 25 full-time workers (Women's Liberation Halfway House Collective 1977:5, 85).

The first Adelaide women's shelter was set up in June 1974 in response to phone calls from women who had nowhere to go. A small group squatted in a vacant house belonging to the Highways Department, then informed welfare agencies of their existence and called for donations of furniture and volunteer support. The group had already established contact with the local Bowden/Brompton Community Development Group and was hoping for ongoing support. The condition of the house, however, was poor: 'there was no laundry, the roof leaked, a wall was falling down, there was only an outside toilet and the yard was not closed off' (Otto and Haley 1975:11). Feminist activist Sylvia Kinder (1980:150) has described the project as a 'desperate attempt to alleviate a pressing need'.

Unforeseen problems quickly emerged. First, establishing trusting relationships with women staying temporarily was sometimes difficult. Second, housing-market obstacles often prevented residents from moving on so conditions became overcrowded, dirty and fraught with disagreement, instability and lack of privacy. Third, some clients were simply homeless rather than escaping violence and some had drug, alcohol and mental health problems. Providing support required skills and resources beyond the means of the group, members of which were on a steep learning curve trying to obtain information about welfare benefits, legal rights, hospital services, housing availability and the like. Fourth, residents had varying attitudes and needs, creating friction and difficulties. Some wanted their partners to be able to attend the shelter to facilitate negotiations; others felt the need for sanctuary from men. Since the address was not secret, men sometimes turned up looking for women to date!

As in other feminist establishments, at the Adelaide Women's Shelter, the founders did not have a uniform view on principles. Most favoured cooperative, non-hierarchical management structures but one, it appears, did not, and saw herself as matron/landlady. Within the first month, heated arguments broke out and after less than six months a serious rift developed (Otto and Haley 1975:12–16). Members of the Highways Department were drawn into the dispute but the compromises put forward were unacceptable to collective members, who eventually withdrew (Smith 1985:28).

Another Adelaide shelter, Christies Beach Women's Shelter, was established in 1976 by a group of women who had met in the women's studies department at Flinders University. Initially, one of the women opened a drop-in centre at her shop, to which a steady stream of women trying to escape violence presented themselves. Soon the chairs were replaced with mattresses. Clearly a shelter was needed and lobbying began. The Housing Trust was eventually persuaded to provide a house but women had to raise money to pay the rent. The St Vincent de Paul Society helped with furniture and provided food vouchers in emergencies. In 1977, ongoing funding was obtained from the State Government.

As mentioned, the Perth Women's Centre Action Group (WCAG), comprising WL, WEL and others, decided to give priority to a refuge because the three existing centres for homeless women in the city were overflowing. In July 1974, Nardine Women's Refuge was opened in a three-bedroom house, without public funding. A mixed group of more than 40 WCAG-trained community women provided a 24-hour service. Operations were financed from donations. The principles were feminist and included the provision of respectful support and empowerment through self-help and collectivity. As in other pioneering refuges, at Nardine, the floors were soon covered with extra mattresses and overflow families were accommodated in private homes. Even then, in the first year up to four families each day were turned away (Murray 2002:21–31).

In 1975, the refuge moved to much larger premises, by which time it had secured State Health Department funding; however, the new house soon overflowed as well. The adjoining property was taken over and in the late 1970s a third house was acquired nearby. Collective members lobbied ministers and bureaucrats, staged rallies, attended forums, presented papers and wrote submissions. Direct action included accompanying a group of women and children to a departmental office and refusing to leave until something was done. The political climate in the second half of the 1970s was unsympathetic and feminist refuges were seen as politically embarrassing. The Premier, Charles Court, said on radio that the recipe for a successful marriage was a tolerant and patient wife. The police responded to a call for help from Nardine in the case of a violent incident by raiding the place instead, in the belief that the women were drug-taking hippies (Murray 2002:31–45).

Initially, Nardine workers were largely from Anglo-Australian backgrounds, with little understanding of the lives of Aboriginal and immigrant women. As experience grew, however, the refuge began to facilitate cultural sensitivity training and it gradually gained a reputation among Aboriginal women as a safe and accepting establishment. Nardine also implemented a policy of affirmative action in the employment of Aboriginal workers. Over the years, half or more of Nardine's residents have been Aboriginal women and their children who,

because of the difficulties of securing appropriate, affordable housing, sometimes remained at the refuge for long periods. The refuge worked politically to raise awareness of housing shortages (Murray 2002:46).

Nardine continues to operate as a feminist refuge, funded by State and Commonwealth grants and short-term project money. As well as operating a residential service, it provides outreach, counselling and advocacy services. It is managed by a small committee, supported by a broader collective. Political activism to achieve social change is still central to its work, along with education projects that promote zero tolerance of violence against women and children.

In Hobart, the Women's Action Group, which had a sister group in Launceston, was formed in 1972. In 1974, the Hobart Women's Shelter was opened, followed by the Launceston Women's Shelter in November 1975 (Magnolia Place Team 2007; Murphy 2006). Both centres were overcrowded, under-funded and subject to opposition and criticism from the beginning. As in other places, in Launceston, committee members disagreed about management principles. Stress was further increased because fundraising was a constant necessity. For example, in 1977, when the Launceston shelter needed larger premises, the Tasmanian Government agreed to provide 50 per cent of the money, leaving the committee to somehow raise the other 50 per cent. It succeeded.

The Canberra Women's Refuge Committee was formed in 1974 and the Canberra Women's Refuge was opened in a suburban house on IWD, 1975. Committee members visited both Elsie and the Adelaide shelter and talked with Melbourne feminists, seeking advice and information. As in other places, in Canberra, the guiding principles were feminist. The house, owned by the Department of the Capital Territory (the Australian Capital Territory had not yet gained independence from the Commonwealth), had sleeping accommodation for 16 women plus three cots—and one wardrobe! The lounge room was used as an office, relaxation room, play room and bedroom (Canberra Women's Refuge Collective 1976).

The Canberra committee undertook groundbreaking political work. In 1976, two major discussion papers were written, the first on women, violence and the law and the second, on women, violence and housing. These documents were distributed widely to local and national politicians and relevant others. The law paper argued that women and children had a right to live in the marital home and that consideration should be given to evicting violent partners. Police should inform women of their rights and refer them to legal aid, it was suggested, and interpreters should be employed, as necessary. The group met with the Registrar and other officers of the Family Law Court, talked with police

and met with the Assistant Police Commissioner. Public attention was drawn to the fact that non-molestation orders were often flouted and the police were asked to provide better protection for women.

The discussion paper on urgent housing needs argued that if refuges were to be able to take new clients, there must be a reasonable turnover of women and accompanying children. Because interim housing was so scarce, bottlenecks were forming. It pointed to the absurdity that women who were joint owners of a marital home were ineligible for emergency public housing. Interim housing was necessary to cover the period between separation and the settlement of financial and custody matters. Nor were women eligible for alternative accommodation if the home they had lived in was publicly provided. The paper also pointed out that two women, who might meet at a refuge and might want to split costs and help protect each other, were not eligible to share a government house. Moreover, single women with children were considered high-risk tenants in the private sector and rental bonds were out of reach of those surviving on public benefits. This paper was circulated to politicians, housing officials, the Real Estate Agent's Institute and other key groups. The committee met with the Commonwealth minister responsible for housing and gained certain concessions.

The Canberra group also undertook direct action. For example, members 'sat in' a government house with a woman and her children who were threatened with eviction, after a bungle between departments in relation to rent. The eviction was averted. The group also formed a coordination team for ACT and New South Wales refuges in 1977, as part of a campaign to secure stable refuge funding from the Commonwealth (Canberra Women's Refuge Collective 1977).

In New South Wales, Bonnie Women's Shelter was opened in 1974 and the Blacktown Community Cottage was opened in 1975, along with Bringa Women's Refuge, Dee Why, which was set up by a feminist collective with help from unions, the Salvation Army and community groups. It works according to the principle of 'women helping women' and still operates. Marrickville Women's Refuge was established in 1976 after a funding struggle and a battle with the local council over premises. Marty House, Woolloomooloo, was founded in 1976 for women trying to recover from substance abuse in a house supplied free by the Sydney City Council.

The quest for Commonwealth funding for refuges is a complicated and protracted story, involving disagreement and confusion about which bureaucratic portfolio should be responsible. There were debates about whether funding should come from homelessness agencies or whether it should be provided by the social security or health departments. After interaction between feminists inside and outside government, the Women's Affairs Section of the Department of Prime Minister and Cabinet put a proposal to the Prime Minister that refuges be

funded under the Community Health Program, which was accepted in June 1975. At that time, 11 refugees were ready to be funded (Dowse 1984:139–49; Sawyer 1990:12–13). As discussed, however, the Fraser Government slashed Commonwealth funding, resulting in protracted funding insecurity. The next phase of refuge development is discussed in Chapter 3.

Sexual Assault Services

Feminists in the 1970s were intent on extricating sexual assault from the recesses of the private domain and placing it on public agendas—an unenviable task. They politicised the varieties of sexual violence prevalent in Western countries and argued that it was a systemic problem rather than a problem arising from the behaviour of aberrant individuals. For centuries, the attitudes and practices of the dominant culture had kept it ‘marginalised, secretive, pervasive and ignored’ (Doyle 1996:44). Whereas the anti-violence movement gained political support and early policy prominence, the same level of attention was not paid to sexual assault (Carmody 1990:303). In contrast, rape had become a major issue in the United States by the early 1970s.⁶

One of the reasons that feminist analyses of rape were slow to gain acceptance appears to be the strength of longstanding myths and stereotypes. Rationalisations that condone or trivialise rape and place blame on women and sometimes children have been identified in most countries and can be traced back to ancient times (Yarrow Place web site). In Australia, justifications are said to be deeply embedded as a result of the country’s ‘strange beginning’, when women were imported to provide sexual and other services. There is also a strand of thinking that sees Aboriginal women as ‘sexually available’ (Broom 2001:96). Sexual assault has been ‘woven through our landscape’ from the time of white settlement (Simmons 2009). As Shoebridge and Shoebridge (2002:1) argue:

Australia, perhaps more than most, is a masculine country...whose European settlement was by British and Irish, mainly male, convicts whose presence was supplemented later by boatloads of women, brought to civilise disruptive unruliness and begin building families... The masculine norm continued, through the mythology built up by participation in several wars, dominant industries such as mining and stock farming, and cultural obeisance to the romance of ‘the bush’—non-metropolitan Australia where men are men and women are incidental.

⁶ Despite early attention, however, the fictions around rape remain. ‘Few crimes in the United States today elicit as much scepticism and victim blaming as do allegations of rape and sexual assault’ (Weiss 2009:810).

That Australia is the country with 'the highest incidence of recorded gang rape in the world' (McFerran 1990:193) lends support to such analysis. In 2005, more than 950 000 Australian women reported being sexually abused before the age of fifteen—a horrifying statistic (Commonwealth of Australia 2009a:19). The 2005 Australian Bureau of Statistics Personal Safety Survey showed that 19 per cent of women over the age of fifteen had experienced sexual violence and that about one in three who were physically assaulted by partners were also raped (Commonwealth of Australia 2009a:19). A 17-country study in 2000 found that Australia was one of four countries with the highest risk of sexual assault (van Kesteren et al. 2000:4, 35–6).

Historically, women have been held responsible for preventing rape. Apart from not talking to strangers, they have been told not to dress 'provocatively', to travel in groups, to always carry money for a taxi and to stay home after dark. Elder (2007:133) records a recent case where a girl raped on a school trip was questioned in court about the length of the skirts she wore. The idea that rape is a woman's fault is so deeply ingrained in Australian culture that women's services have had to stress, regularly and repeatedly, that this is not so.

The National Council to Prevent Violence against Women and Their Children argues that 'sexual violence by male intimate partners remains one of the least recognised, underreported and consequently, least prosecuted crimes' (Commonwealth of Australia 2009a:19). The feminist argument that there is more danger from family members, friends, work colleagues and other known persons than from strangers is borne out by evidence: less than 10 per cent of attacks on young women are made by strangers. Sexual assault is more prevalent in rural and remote areas and among younger women, Aboriginal women and women with disabilities. Estimates are that less than 20 per cent of sexual assault crimes are ever reported. Of the small number that come to trial, less than 20 per cent result in the accused pleading or being found guilty (Commonwealth of Australia 2009a:17–20).

Feminists argue that sexual violence is a structural problem: men who commit sexual assault are tacitly supported by an unequal, male-dominated society in which women have inferior status. As in the case of domestic violence, feminists challenge power structures and argue that attitudes must change. The myths to be subverted include that women 'ask for' and enjoy rape, that children can be 'seductive', that only 'loose' women are raped, that women and children often lie about rape, that only bad, deranged or stressed men commit sexual assault and that men have uncontrollable sexual urges (Cook et al. 2001:1).

As in the health centre and anti-violence movements, the movement against sexual assault set about the twin tasks of providing support services and developing strategies to promote social change. The Sydney Rape Crisis Centre

formally opened in 1974. A group of volunteer women had been travelling 'all over Sydney' picking up women who had been assaulted and bringing them to the centre for counselling and medical services. The centre was funded by the Commonwealth in 1974, allowing workers to be paid. Currently known as the NSW Rape Crisis Centre, it is funded by the NSW Department of Health and adheres to feminist goals. It is not-for-profit and community controlled and its overarching purpose is 'upholding the rights of women to live in a socially just and equitable society and the rights of all people to live free of violence' (NSW Rape Crisis Centre web site). It provides 24-hour, seven-day-a-week telephone counselling and support, regardless of when the assault occurred. Support and information are provided about safety, emotional impact, possible actions and the availability of long-term services.

In Brisbane, Women's House established the Brisbane Rape Crisis Centre in April 1975, followed by a refuge the following month. As discussed, Women's House lost its funding after operating for less than two years but women continued to provide services on a voluntary basis. On condition that it raise \$2500 of its own, the management group received \$10 000 from the Commonwealth for a refuge in 1978. Not until 1983 did it receive funding for the Rape Crisis Centre.

Adelaide feminists established a rape crisis centre in an old house in 1976. As well as services, the centre established a forum for discussing the multiple issues surrounding rape, including legal issues. The centre also operated as a safe drop-in place, where women could share their experiences, chat and read. Self-defence classes were offered and training modules for nurses, teachers and other professionals were developed.

A rape-crisis group was formed within Melbourne WL in 1973. It set about gaining information on key medical, legal and statistical issues. Some members found the issues too confronting, however, and the size of the group shrank. The following August, another group was called together by WEL, which included women from the original group. A 24-hour rape-crisis service was established and the name Women against Rape was chosen. Prevention was a priority. After meetings with police, and medical and legal professionals to disseminate information and suggest referral, the Rape Crisis Centre was opened in November 1974, operating from the premises of the Melbourne Women's Health Collective in Collingwood and funded by donations. Its establishment drew considerable media attention and women who had been raped were soon seeking services.

There followed a long and unsuccessful struggle to gain public funding. Because the centre was a long-term project, it was ineligible for International Women's Year funds. The Commonwealth Department of Health authorised funding in 1975 but in another instance of bureaucratic obstruction, the money

was blocked by the Victorian HCC on grounds that the organisation's aims were unacceptable: it was a women-only collective that did not depend entirely on professionals. It was decided to give up the quest for funding in 1976 because it sapped too much time and energy, and to operate independently. Collective members turned their hands to fundraising and pledged their own money on a weekly basis (Hewitt and Worth n.d.; Women against Rape Collective n.d.). Political action was continued until the late 1970s from WL Centre in Little Lonsdale Street, including campaigns for legislative reform and reform of court, police and hospital practices.

The Women against Rape Collective established the Geelong Rape Centre in 1978, following the poor treatment of a woman who had been raped. It ran on voluntarism and donations from workers, but, in 1984, it succeeded in gaining funding from the Victorian Health Department. In 1995–96, it was offering therapy groups for children, young women who were incest survivors, mothers of sexually abused children and adult women who had experienced incest. It also ran a men's group. A community-development worker coordinated community education in schools and for professionals. Campaigns included a week of action against domestic and sexual violence and a child-protection week (Geelong Rape Crisis Centre 1995–96). In 1999, it was one of seven organisations funded under the national Partnerships against Domestic Violence (PADV) to develop a model of best practice for working with children affected by family violence (Hunder 1999:iii).

In its early days, WEL formed the Rape Study Group in Melbourne to work for law reform and better services. Its advocacy resulted in the Victorian Rape Study Committee being established in the Department of Premier in 1977, which recommended the establishment of a government-funded 24-hour counselling service. The Queen Victoria Medical Centre set up a sexual assault service in 1979—the first public sexual assault service in the State. Another Melbourne group, the Campaign against Causes of Rape, was formed in response to a double rape-murder.

In Western Australia, the Women's Health and Community Centre had set up a rape-crisis service at Glendower Street in 1975 but it did not survive. A new centre was opened at Sir Charles Gairdner Hospital in 1976 in response to feminist concern about the treatment of women who wished to report a crime (Deller et al. 1979:771). The women who set up the second service prepared for it by holding consultations with the police, the Office of the Under Secretary for Law, the Women's Health and Community Centre, a panel of women doctors, officials from the Sir Charles Gairdner Hospital and forensic experts. The main aims were to provide comprehensive support services for victims of sexual violence, to promote greater community understanding and awareness, to establish appropriate education for medical, legal, police and health personnel

and to support and encourage research (Deller et al. 1979). When the original women's health centre reopened in 1977, it housed the local branch of the Australian Women against Rape group until 1985.

The operation of the Sexual Assault Resource Centre (SARC) became controversial in the early days as women's health activists expressed concern that a hospital setting might not be conducive to women-centred care. A compromise position was reached whereby the service remained part of the public hospital but was managed by an independent board. During its first 2 years, the centre saw more than 200 clients. SARC is now located at the King Edward Memorial Hospital.

Nationally, Australian Women against Rape, which had State-based branches, was established at the National Conference of Rape Crisis Centres in Sydney in 1976. The main objectives were raising public awareness of misogynist ideas, and law reform. The organisation argued for legal recognition of rape within marriage, for corroboration requirements to be dropped in rape cases, for the previous sexual history of victims to be inadmissible and for the legal definition of rape to be extended to cover oral and anal penetration and attempted penetration. In 1976, it organised a national demonstration in support of a Brisbane woman accused of making a false rape complaint and drafted model rape legislation (Grahame and Prichard 1996:16).

Other Early Women's Health Agencies

Women in Industry Contraception and Health (WICH), as it was known for many years, is a Melbourne service with a long and successful history, set up by a grassroots group of women. In response to a dire lack of information about contraception and related matters among immigrant women working in factories, a well-attended public forum was held, which resolved that family planning education should be taken out of the medical context and located within the workplace and the community. Two doctoral students, with a small group of immigrant workers and advocates, established Action for Family Planning in 1977. The founders developed a multilingual factory-visiting program, which took reproductive health education to women where they worked. Financial support came from the technical and further education (TAFE) sector and the Commonwealth, allowing multilingual workers to be trained. Another round of advocacy and lobbying in 1980, when funding was running out, brought support from the Victorian Health Department and the Department of Immigration. In 1982, the name was changed to WICH, reflecting decisions to move beyond reproductive issues towards women's health in its social context. Information dissemination and advocacy continued and regular newsletters were produced. The Factory Visits Program was expanded to include OHS, mental health and,

in the recession of the early 1990s, work, retrenchment and stress issues. At that time, a funding boost was received from the NWH Program and work was able to expand again, targeting a wider range of cultural and language groups.

In the second half of the 1990s, however, State funding was reduced, requiring the organisation to contract but it continued to respond to the needs of newly arriving groups. In 2000, the name was changed again, to Working Women's Health—again reflecting changing priorities. Bilingual health educators were trained in increasing numbers of languages, as resources permitted, and health education was extended to community settings, some of them rural, and to prisons. A library and resource collection was put together, including 10 000 health information items in 96 languages.

In 2006, the name was changed yet again, to the Multicultural Centre for Women's Health (MCWH), its present name, which reflects the 'organisation's multifaceted and comprehensive approach to immigrant women's health'. Currently, health information is provided in 19 languages in diverse locations (MCWH web site).

Another major 1970s initiative with a long and successful history is the Children by Choice Association (C by C), formed in Brisbane in 1972 from what had been the Queensland Abortion Law Reform Association. C by C was established as a family planning and abortion information service. Like so many women's services, it was set up in an old house, sparking a blaze of publicity, during which bricks were thrown through the windows. In Queensland at the time, termination was deemed illegal, even in a case where a woman had contracted rubella. Vasectomy was also illegal.

In this context, C by C made arrangements for women wanting an abortion to be referred to Sydney hospitals and organised help with travel costs. It lobbied, made submissions to public inquiries, picketed parliament, wrote letters and presented petitions, calling for the repeal of the relevant sections of the Criminal Code. The voluntary workers were trained and saw more than 300 clients per month, referred to them by doctors. So controversial was the work in 1977–78 that more than 120 media news items were generated. C by C staff persisted through a succession of crises in the 1970s and 1980s, which included attacks on clinics. Partly as a result, Queensland legislation was modified in 1986 but abortion was not removed from the Criminal Code.

Unable to gain government funding, the association nearly had to close because of serious financial problems in 1987; however, a request for support to the Planned Parenthood Federation of America, which normally funds only agencies in Third-World countries, was successful. The association was then able to expand its services, move into rural provision and offer some paid employment.

After three years, the US donor had its own funding reduced and was forced to discontinue support. Fortuitously, about the same time, the ALP was elected to government in Queensland after more than 30 years in opposition. Public funding was obtained in 1991, after which outreach, counselling, information, education and library services were expanded.

These activities brought renewed opposition from anti-choice forces, in the face of which the Goss Government shelved its election promise to remove abortion from the Criminal Code. Indeed, when a 'comprehensive' review of the Criminal Code was instigated in 1990, abortion laws were specifically excluded, even though one of the aims of the exercise was to ensure that the criminal law reflected contemporary attitudes. In response to a letter of objection from a women's group, the then Attorney-General replied that he would be acting improperly if he were to allow abortion laws to be reviewed because the Parliamentary Labor Party had unanimously decided that the subject 'was not on the agenda' (McCormack 1992:40). On Labor's defeat in 1996, the association lost its funding. Services were continued by volunteers but the hours of opening had to be reduced. Fundraising campaigns enabled the State-wide telephone counselling line to stay open. Labor's return to power in 1998, however, resulted in funding from Queensland Health, which continues.

C by C has been built on untold hours of unpaid and low-paid women's work and has provided extensive support services. It has worked steadily to raise public awareness about reproductive health issues and has lobbied and campaigned in support of legislative change. After almost 40 years, however, abortion remains in Queensland's Criminal Code, so powerful are the forces of the religious right and so reluctant are politicians to confront them.

Although it was not until the 1980s that women's health groups proliferated, a sprinkling of new groups formed in the 1970s to draw attention to needs in particular areas. The Women Behind Bars group was set up in Sydney in 1975, concerned with legal rights and women's health inside prisons. In Brisbane, the Women's Community Aid Association was established, taking up health and sexual violence issues and providing women with practical support. The Women's Health and Education Group was formed in Sydney in 1975 with the aim of contacting women outside the movement, especially rural women, young women and immigrant women (Grahame and Prichard 1996:154, 167). The Women's Information Centre Collective was formed in Townsville, which focused on rape crisis, abortion and women's services. Meanwhile, in far north Queensland, an Aboriginal welfare officer at the Cairns hospital, Rose Richards, became concerned that there was no halfway house for Aboriginal children brought to Cairns for treatment or for pregnant women awaiting the births of

their babies. In 1976, she began to care for people in her own home, assisted by two other Aboriginal women, using their own money when necessary. This grassroots initiative became a successful halfway house in the 1980s.

Another 1970s grassroots undertaking about which little seems to be known was a second national women's health conference, held in Newcastle in 1977, organised by the Hunter Region Working Women's Centre (HRWWC). More than 100 women attended, along with half a dozen men. The main session streams reflected a social view of health: 'Becoming Healthy', 'Women at Work', 'Fertility and Sexuality' and 'Especially Disadvantaged Women'. A workshop considered the possibility of an Australian version of *Our Bodies, Ourselves*. Bridget Gilling, well-known feminist and campaigner, put forward a critique of the overemphasis on curative medicine. Alice Day, a sociologist, presented the now familiar argument that the nature of women's work makes them sick, particularly their inferior position in occupational hierarchies (Day 1977). Recent epidemiological evidence supports Day's analysis (Wilkinson and Pickett 2009).

Conclusion

It is evidence of both profound need and passionate commitment that women set up so many separate services in the 1970s. Looking back, their achievements are remarkable, given the minimal resources at their command and the strength of the forces ranged against them. Working often in the face of criticism and sometimes ridicule, women's health problems were identified and articulated. With little more than their bare hands, Anglo, Aboriginal and immigrant women set up health centres, reproductive health agencies, factory visitation programs, refuges and sexual assault centres to provide urgently needed services that were scarcely available elsewhere. Many episodes of extraordinary effort and personal generosity have undoubtedly been lost to history because women were too busy campaigning and providing services to produce written records.

Women of the early years succeeded in their twin aims of working at both the service provision and the political levels, supporting women and promoting women's health as a major political issue. A social health perspective, which has provided the movement with a solid set of foundational principles for 40 years, was worked out and voiced.

The new centres and services created an institutional foundation from which political action could more easily be orchestrated, although, as Broom has documented, the high demand for services always threatens to divert women from advocacy and social change work (Broom 1991:120–2). Despite the disagreements and implosions in Anglo-Australian women's health centres, activists were able to influence public policy when political circumstances were

right. The campaigns around domestic violence and sexual assault brought hidden crimes onto the public agenda and paved the way for the extensive efforts of the 1980s and beyond. As Lynne Hunt (1994:390) has argued, the women's health movement worked outside the conventional health system, 'moved around' the medical profession and set up alternative services, creating a space from which to lobby for health system and societal change.



Movement members from all States and Territories gathered in Canberra in February 1994 to develop and write the AWHN Constitution. From left: Dorothy Broom (ACT), Manoa Renwick (ACT) and Sheryl Rainbird (Tas).

Photo: Julie McCarron Benson



Carol Low (Qld), Annette Burke, partly obscured, (NSW), Keren Howe (Vic), Cate Mettam (SA), Nancy Peck (Vic) and Dorothy Broom listen to constitutional deliberations, Canberra, February 1984.

Photo: Julie McCarron Benson



Annette Coppola and Deborah Gough from the Northern Territory put on their best smiles at the AWHN Constitution meeting, February 1994.

Photo: Julie McCarron Benson



Annette Burke, Andrea Shoebridge (WA) and Keren Howe at the AWHN constitution development meeting, February 1994. Jan Darlington (Qld), Gwen Gray (ACT), Fiona Hillary (SA) and Marian Palandri from Port Headland, WA (whose fare was paid by BHP) were also present.

Photo: Julie McCarron Benson



Meeting to discuss the evaluation of the National Women's Health Program, Juliana House, Canberra, 1996. From left: Manoa Renwick, Christine Purdon, Janette Gay, Barbara Gatler, Barbara Podger.

Photo: Manoa Renwick



Some of the members of the organising committee for the Third AWHN National Women's Health Conference, Canberra, 1995. From left: Pam Neame, Roslyn Sackley, Romaine Rutnam, Debbi Cameron and Jilpia Nappaljarl Jones (then Marjorie Baldwin-Jones).

Photo: Tony Adams



Tasmanian delegates at the Fifth AWHN National Women's Health Conference, Melbourne, 2005. Middle and back row from left to right: Karen Price, Yvonne Hardefeldt, Sally Riley, Tracey Wing, Joan Barry, Wendy Hartshorn. Front row: Morvan Andrews, Sue Moss.

Photo: Tracey Wing