Working Women's Centre

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IS THERE A NEED FOR HEALTH SERVICES FOR WOMEN AT THE WORKPLACE ?

The Charter for Working Women endorsed by the ACTU 1977 Congress calls for -

"Health and safety information which is both multilingual and comprehensive to be provided on the job" and

"Regular medical services including preventative medical care."

In previous Discussion Papers* we have emphasized the need for -

Regular monitoring of workers' health;
Information about work hazards
Family planning information.

We have suggested that unions could sponsor their own medical services. This paper looks in more detail at health services which could be provided - particularly family planning services - and discusses the special problems of migrant women.

MEDICAL SERVICES

A recent survey of women workers(1) found that 75 per cent of whitecollar workers and 50 per cent of bluecollar workers stated that tiredness was their greatest health problem. Women's dual roles - at home and work - cause excessive fatigue. They tend to neglect their health because they are too tired to seek medical attention and to have routine check-ups.

Another study(2) of 7000 female workers found needs for -

(a) genito-urinary advice once or more often in a year (this field includes such things as menstrual problems, pregnancy, vaginal and bladder infections, family planning and sexual questions);

(b) annual checks on blood pressure, cardio-vascular and other systems and for cancer detection;

(c) counselling on psychological matters;

(d) advice and treatment for occupational health problems.

The study indicated that one third of the women surveyed needed checks for detection of cancers of the cervix, breast and skin, referrals for further investigation and/or counselling on health, sexual, mental and marital problems.

Other surveys(3) have reported that women complained of bladder infections because they were unable to leave the assembly line and go to the toilet when they needed to for fear of losing their jobs.

Overseas reports(5,6,7) on the effectiveness of breast and cervical cancer screening at the workplace have emphasized the need for regular examinations at work. *"Many of these women in whom early breast cancer was detected while at work would not have had the opportunity or the inclination to attend a cancer detection center or to consult their own doctor with regularity."(8)*

NEED FOR UNION INVOLVEMENT

Because medical centres in industry are generally controlled by management (which leads to suspicion amongst workers) or are non-existent, there is an obvious need for unions to become involved in this field. Two unions which have shown initiative in this area are the Australian Workers' Union (NSW) and the Australasian Meat Industry Employees' Union (Vic.). Any other union wishing to investigate health problems affecting its members is invited to contact the Working Women's Centre.

** See Discussion Papers Nos. 1, 10, 14, 16, 21.*

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Most unions would agree that worker awareness is the first step towards better occupational health. Multilingual information about harmful chemicals and work processes should be an integral part of job induction training. Unions could play an active role in this type of preventive health care through their publications and by audio-visual aids.

DANGERS TO REPRODUCTIVE SYSTEMS

In Discussion Paper No. 14 we pointed out that there were a number of chemicals and work processes which could harm both men's and women's reproductive systems. One US chemical company using a chemical which causes sterility in men actually suggested that, instead of replacing the chemical, they should employ men who wanted vasectomies! At what further cost to their health? one might ask.

Unions in the US and Canada have fought the discriminatory practices of employers who have prohibited the employment of fertile women in various potentially hazardous areas. They have adopted policies and taken action for maternity/paternity leave provisions, regular medical examinations, the right to transfer to a safer job without loss of seniority or other benefits and the labelling of harmful materials.

FERTILITY CONTROL

Some workers, upon discovering that they are or have been working in an area which could affect their reproductive systems or a pregnancy, might require information about fertility control. Family planning services should be widely available, particularly at the workplace, for a variety of reasons. Some of these reasons are:

1. Women's childbearing function is often used to discriminate against them in terms of equal opportunity for employment, training, promotion etc.

2. The report of the Royal Commission on Human Relationships states: *"There are many couples in Australia who are able to have the number of children they want and to prevent further pregnancies occurring when their family size is completed. Others are unable to limit their families or to avoid unwanted pregnancies. If some of the reasons for this could be established, programs could be devised and implemented to enable people at risk to take more effective contraceptive action and to plan their family size."* (Vol. 3 p.35).

3. The increasing participation of women in the workforce has caused many of them to seek to limit the size of their families. However a number are unaware of effective means of doing so. This is especially so of migrant women who lack knowledge and information about family planning methods which *"are acceptable to migrants in a form harmonious with their traditional conceptual framework".(9)*

4. The Poverty Commission recognized that *"all individuals and families should, by choice, have the opportunity to plan pregnancies and family size. It is evident that many have not had this opportunity. It is even more obvious that many are not aware of or else have insufficient knowledge of birth control. This is particularly so with young people."(10)* The Commission considered that the groups for whom contraceptive services were inadequate included parents of large families, young unmarried women, Aboriginals and some migrant groups.

Table I indicates the extent of knowledge of specific methods of family planning amongst married women in Melbourne.

All workers have a right to family planning information and unions can play a vital role in education and dissemination of such information. In Japan, for example, family planning programs are run at workplaces by unions and companies for employees and spouses. These projects *"have proved a remarkable success in that birth rates have declined, recourse to abortion decreased rapidly and greater stability of family life contributed to the reduction of industrial accidents".(11)*

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Table I: Knowledge of specific methods of family planning (respondents under 60 years of age)

Method	Knowledge (percentage)		
	Have heard of or used	Have never heard of	Refused to answer
Pill	95	4	1
Withdrawal	91	8	1
Rhythm	89	10	1
Abstinence from sexual relations	84	15	1
Condom	79	20	1
Douching	72	27	1
Spermicides (named separately)	70	29	1
Grafenberg or similar rings	69	30	1
IUD	68	31	1
Diaphragm	67	32	1
Quinine pessary	37	62	1
Sponge	35	64	1
Spray foams, pressure pack and so on	31	68	1

Source: Caldwell, Young, Ware, Lavis & Davis, 'Australia: knowledge, attitudes and practice of family planning in Melbourne, 1971', *Studies in Family Planning* 4, 3 (1973), p. 52.

In the United States a number of unions have sponsored their own family planning clinics and education programs with similar results.*(12)*

Fertility control education should form part of general health and preventive medicinal care as suggested in the ACTU Charter. The need for family planning programs is demonstrated by the fact that *"although effective methods of contraception exist, many unwanted pregnancies still occur . . . The Royal Commission on Human Relationships estimates that there may be as many as 100,000 each year in Australia, of which more than 60,000 end in abortion."(13)*

The Fertility Control Clinic in Melbourne surveyed 1100 patients in terms of occupation and ethnicity. Under the first heading the survey found that housewives constituted the biggest group (18.3%) and that of employed people the biggest group was unskilled factory workers (12.2%). Native-born Australians made up well over half the clients on an ethnic basis. Another survey of women seeking abortions at the Queen Victoria Hospital in Melbourne included a larger proportion of migrants (Greeks 17%, Turkish 13%, Italian and Yugoslav 12%).*(14)*

FAMILY PLANNING IN THE WORKPLACE

The Poverty Commission recommends that family planning information - and in many cases contaceptive provision - should be available in work-places where health workers are presently or could be employed.*(15)*

The Family Planning Association of New South Wales has conducted a number of pilot projects based on industry, specific ethnic communities and occupational groupings, eg hairdressers. Recommendations from these projects include:

(i) special courses for occupational health nurses in sexuality and menopause counselling;

(ii) family planning services to be provided on a sessional regular basis;

(iii) interpreters for family planning programs;

(iv) ethnic resource people to act as links between the program and ethnic communities;

(v) an understanding of cultural variations in contraceptive use amongst migrants and appropriate programs which would take account of these variations.*(16)*

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SPECIAL NEEDS OF MIGRANTS

In Melbourne The Action for Family Planning Group is currently undertaking a research study to provide family planning information and education services for migrants - in co-operation with the Clothing Trades Union and ethnic groups.

A preliminary study(17) found that migrant women were less likely to be referred for family planning advice and that, if they were referred, they were more likely than Australian-born women to be referred to the public sector. Migrants were also found to be less likely to use any method of contraception (particularly script methods).

Table II: Australian vs Mediterranean Immigrant Married Women "at risk"

	Migrants %		Australians %	
Referred:		34		84
Public sector	11		4	
Private sector	23		80	
Never referred:		66		16
Never used contraception	26		11	
Used only non-script	40		5	

Source: Kasnitz (1977) after Ware.

Amongst ethnic groups individual, social, cultural and religious factors act as obstacles to family planning. It is important to understand the attitudes and behaviour of men and women belonging to different ethnic groups. It is also important to inform them of existing services and that these services should be modified to accommodate migrants. The Poverty Commission was disturbed to find that migrant women were more likely than Australian-born women to use less reliable methods of contraception, particularly in view of the high incidence of migrants in very poor circumstances.

An example of the need to understand cultural differences at work was quoted by Roy Richter, Co-ordinator of the Central Migrant Resource Unit of the NSW Health Commission. He told how *"a traditional Turkish woman was forced to work in a pit under a car alone with a male worker. The woman collapsed several days later. She left the company without giving reasons. No-one realized that for a Turkish woman to be with a strange man unaccompanied by her husband violates a basic Turkish customary law."(18)*

In another study of migrant women at work(19) Helen Hurwitz relates how a Turkish woman sought her help because she had already had four abortions in two years. She had no idea where to go for assistance, how she could get an interpreter for counselling or treatment, what she could do about reliable contraception etc.

"Many of the migrant women for whom an unwanted pregnancy is a constant worry are so conservative or so unable to be frank and open with either their husbands or with strangers . . in asking for help and information . . It is a matter of serious concern to a family totally dependent for survival on having two incomes if, through lack of access to information, an unexpected and unwanted pregnancy threatens to curtail the income-earning capacity of the wife. This is especially so if the couple are already supporting and trying to find satisfactory facilities for several existing children."(20)

FAMILY PLANNING AN INDUSTRIAL ISSUE

It is obvious from Hurwitz' study that access to, knowledge about and use of family planning are work-related issues. Future action for the provision of health services for women must consider family planning in the general preventive medicine framework to cater for the needs of almost two million working women, of whom 63 per cent are married and 30 per cent have children under 12 years of age.

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There is increasing evidence of occupational health hazards which affect the reproductive systems of both men and women. It would seem essential to support broad induction training about health hazards at work and to ensure that workplaces are made safe for all workers. Every effort should be made to reduce or eliminate exposure to known teratogens, carcinogens and mutagens. Intensive epidemological and toxicological research should be carried out to define harmful substances and the occupational levels which present a risk - particularly to the pregnant worker.

Information about family planning measures is grossly inadequate, particularly among migrants. Current programs need to be modified to take into account traditional beliefs, attitudes and practices.

WHAT UNIONS CAN DO

Unions could consider joining together to sponsor a mobile doctor/clinic which could visit work places regularly as suggested in our Discussion Paper No. 1. Such a unit should provide health care which would aim to prevent illness rather than merely treat it. It could provide a referral service for workers who show symptoms of needing more extensive treatment. It could provide essential educational material on harmful chemicals and work processes and on family planning. It could monitor health and safety hazards on the job. Last - but not least - it could bring union members into closer contact with their union.

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