GENDERED HEALTH IN COMMUNITY CONTEXT

AIM: To explain a gendered approach to health. To describe the major health problems of women and men. To discuss mental and other key health problems from a gendered perspective, which recognises that economic development has strongly modified the caring roles formerly required of women and the risk taking roles formerly required of men. To discuss the management of the sex industry as a key site for meeting health related social needs.

A GENDERED APPROACH TO HEALTH IMPROVEMENT

One's sex is biological, but one's gender is constructed according to what society considers is appropriate for masculine or feminine identity. The requirements of this vary greatly, depending upon the particular societies and families which construct each individual. A gendered approach to health involves the belief that men and women's interactions with each other, and the social circumstances under which they interact, contribute significantly to sex related differences in their health. Key sites of gendered interaction are families, workplaces and areas of sport, recreation and entertainment. Connell points out, however, that although a gendered health perspective treats health as the outcome of the relations between men and women, higher socio-economic status is a better indicator of overall good health than gender is. A gendered approach, which is also focuses primarily on reducing the health and related effects of socio-economic disadvantage, might therefore be the most logical perspective from which most sex or gender related health risks could be effectively identified and controlled. This approach is probably most easily delivered in coordinated community, employment and sport or recreational programs.

From a historical and gendered perspective, the risk taking behaviour traditionally required of men at work is related to the caring behaviour traditionally required of women at home. An approach to health promotion which addresses social relationships therefore contrasts with the epidemiological approach to health. The latter tends to treat men, women, and their diseases separately, in terms of sex-based aggregates of diagnoses. The epidemiological focus on disease management needs to be related effectively to a broader, regional and community based management approach to the promotion of health and sustainable development, which focuses primarily on men and women as they relate to each other in family, work and other community settings, in order to improve the lives of everybody. Because they are most vulnerable and also the future generation, the needs of children must generally come first. This is reflected in family policy, if not necessarily in reality.

The Women's National Health Policy became a government focus in 1985 after a major women's conference in Adelaide. Over the next few years there was a great deal of community consultation, and Australian Health Ministers endorsed the policy in 1989. It emphasised the importance of primary health care and a social perspective on health. It also notes the link between socio-economic status and the health of women. The areas singled out as most important for action in regard to women were:

- Reproductive health and sexuality
- The health of ageing women
- Emotional and mental health
- Violence against women
- Occupational health and safety
- The health needs of women as carers
- The health effects of sex role stereotyping on women

The National Women's Health Program was jointly established by Commonwealth, State and Territory governments to implement the policy. It recognised the need for improvements in health services for women, including the provision of more relevant health information and research. It also recognised the need to increase women's participation in health decision-making and to train health workers to deal more appropriately with women and their health concerns. However, a broader, regional and gendered approach to community problems is also necessary to understand the way in which women and men's historical, political and individual interactions with each other contribute to their health or lack of it. Ideally, this should assist further development of wellbeing for individuals, families and communities. In order to meet community problems from a gendered perspective, the role of sport and entertainment need to be considered, as well as communication, education or other social service.

The first National Men's Health Conference was only held more recently, in 1995, in spite of the fact that men have higher death rates at all ages than women do. This is principally associated with men's higher rates of heart disease and lung cancer, and with their greater rates of injury. In comparison with women, men attend general practitioners' and specialists' surgeries less frequently, and spend less time in hospitals, to which they are also admitted at lower rates. Men appear to give less thought to protecting their health than women do. The differences in their behaviour probably reflect the differing traditional role expectations of men and women. Men have been primarily expected to be 'strong and brave', as befits a primary breadwinner, whereas women have primarily been expected to be 'caring and sensitive' to the needs of children and all other family members. Both sexes should eat less sugar and high fat foods, exercise more, give up smoking, reduce alcohol consumption, and manage their other health risks better if they can.

The Men's Health Research Agenda and Background Report was provided to the Minister for Health and Aged Care in 1998. It was commissioned by the Commonwealth Health Department in response to growing community and professional interest in men's health. It contains recommendations gained from a wide-ranging research review and related consultation.
A gendered approach to health now requires a coordinated plan for implementation of both the National Women's Health Program and recommendations from the later report on men. The prioritisation of treatment and relevant research programs should be aimed at meeting men and women's needs, which have also been identified consultatively, in a regional planning context. The protection of children obviously also needs to be considered in an integrated, community based manner. A gendered approach to health should therefore be coordinated effectively with all existing health promotion and treatment initiatives to address major diseases and related community health problems. Health promotion was discussed in the first lecture. It should occur in national and regional contexts, and focus particularly on improving the health of high-risk groups in communities and at work.

Connell states that Aboriginal and Torres Strait Islander men, those from non-English speaking backgrounds, men with disabilities, gay men, those of lower socio-economic status and rural men, are usually identified as bearing the burden of men's health disadvantage. Women in these groups share many related problems. Australian Institute of Health and Welfare statistics show that major health problems of both sexes are mental stress in the earlier years of life, and cancers or cardiovascular disease in the later years. Unintentional and intentional injury is an added major problem for men. In a gendered approach to health the risk taking behaviour of men needs to be seen as the historical counterpart of the caring behaviour typically required of women. Meeting the current health needs of both sexes requires a focus beyond what traditional scripts for masculinity and femininity have demanded of people. Changing work, family and individual expectations need to be understood in all relevant cultural and regional community contexts.

Economic, political, cultural and personal requirements relating to management of workplaces, homes and communities keep changing, and can be further shaped, in order to meet the diverse needs of individuals and the requirements of a democratic and caring society more effectively. Maximising the potential for flexible work and education choices to meet individual need and providing minimum welfare standards for all is necessary in all cultural and regional contexts.

OVERVIEW OF THE HEALTH OF AUSTRALIAN WOMEN

According to the Australian Institute of Health and Welfare, the disease and injury burden for younger women, as for younger men, is dominated by mental disorders, which make up almost 34% of all health problems for the age group 25-44. The principal mental disorders are depression and anxiety disorders, which make up 37% and 33% respectively of all mental disorders. They mainly cause disability rather than mortality. Cancer is the second leading cause of disease and injury in this age group, accounting for 13% of total disease. The biggest individual cause of cancer is breast cancer, which makes up 37% of the cancer problem. Cancers contribute mainly to mortality rather than disability.

In women aged 45-64 the leading cause of disease and injury is cancer, which contributes 33% of the total disease burden for this age group. The main cancers are breast cancer, lung cancer and colorectal cancer. The second and third largest causes of ill health are cardiovascular disease and mental disorders. Cardiovascular disease is dominated by ischaemic heart disease and stroke. Mental disorders are dominated by depression and anxiety disorders. Cancer and cardiovascular disease contribute mainly to mortality, and mental disorders contribute mainly to disability.

The three leading causes of disease and injury burden in women over 65 are cardiovascular disease, cancer, and nervous system and sense organ disorders. The largest single cause of disease and injury burden in older women is ischaemic heart disease. Other major problems are stroke, Alzheimer's disease and other dementias, chronic obstructive pulmonary disease, and breast cancer.

THE HEALTH OF AUSTRALIAN MEN

The Australian Institute of Health and Welfare states that the disease and injury burden for men aged 25-44 is dominated by mental disorders, which make up over 27% of the total burden for this age group. Mental disorders are commonly substance abuse disorders (alcohol and illicit drugs) and depression, which respectively make up almost 37% and 27% of mental disorders in this group. They mainly cause disability rather than death.

The leading causes of death or poor health in the 25-44 age group are depression, road traffic accidents, alcohol dependence and harmful use, and HIV/AIDS. Unintentional and intentional injuries are the second and third leading causes of disease and injury for this group. They account for 15.5% and 12% respectively of total disease. Almost half of unintentional injuries come from traffic accidents. Suicide and self-inflicted injury are also a major problem.

The two leading causes of disease and injury for men aged 45-64 are cardiovascular disease and cancer, which contribute 26% and 25% respectively of total disease for this age group. The cardiovascular disease group is dominated by ischaemic heart disease and stroke. The biggest contributors to the cancer group are lung cancer and colorectal cancer. Both cardiovascular disease and cancer contribute mainly through mortality rather than disability. The largest single cause of disease and injury in men aged 45-64 is ischaemic heart disease, which contributes almost 17% of the total disease for this age group. The other leading causes of the disease burden

are lung cancer, chronic obstructive pulmonary disease, hearing loss and diabetes. The pattern of disease for men older than 64 is similar, but prostate cancer, Alzheimer's disease and other dementias are also key problems.

CHANGING WORK AND PERSONAL RELATIONSHIPS

For centuries society has conceived of wives as the most appropriate source of domestic love, caring work and even family moral order, while men were predominantly family breadwinners. This conception has now been strongly eroded by the rapid development of the services market, and by women's demand for equal treatment at work. Throughout the 20th century the mass production of a widening range of services increased rapidly, and women entered the services work force in ever increasing numbers. The process of rapid and confusing change in gender related expectations was also shaped by the advent of the contraceptive pill in the 1960s, no-fault divorce in the 1970s, and the increasing recognition of homosexuality. Thanks to the passage of anti-discrimination legislation, which commenced in the 1970s, equal opportunity between the sexes is now officially seen as the ideal. Homosexual partnerships are also officially approved, although the legitimacy of homosexual marriage and childrearing are still being questioned. The harassment of women or other people on the margins of a privileged group is now unacceptable.

Increases in divorce and single parenthood have occurred partly as a result of this comparatively new economic freedom and call for equality for individuals, regardless of their sex or ethnic background. In this context, education is vital which teaches young people about their social and sexual responsibilities to themselves, to each other, and to their children. Equal opportunity also depends upon all work and social services being flexibly managed to meet the cultural and individual needs of parents and children as effectively as possible. Australia has signed International Labour Organization Conventions in support of these goals and this is reflected in its legislated occupational health and safety, anti-discrimination, parental leave, childcare, and related education, consultation and service requirements.

Women gradually entered professional and managerial occupations in larger numbers in the period after World War 2. This movement has occurred concurrently with reductions in semi-skilled or skilled work and training in manufacturing occupations traditionally undertaken by men. Equal opportunity surveys now regularly report on the proportions of women in higher status occupations, which traditionally have always been the preserve of men. Women typically remain clustered at the lower levels of career ladders, either because this continues to suit others, or because it suits the women themselves. As job opportunities for women have expanded, they have also had fewer children. The average number of births per woman has been declining in Australia since the peak in 1961 of 3.6 babies per woman. By 1998 the total fertility rate had dropped to 1.7, below the replacement level. Childbearing is also being delayed until later in life. Births to teenage mothers decreased by 38% over the period 1978 to 1998, and births to women in their twenties also declined. Conversely, the fertility rates for women aged in their thirties and forties increased substantially.

International time use surveys now regularly report on the sexual division of labour in the home. In Australia, Wajcman and Bittman have shown that women typically do 77% of the housework, childcare and shopping. However, men do more paid work. When paid and unpaid work was combined, the researchers found that men and women do virtually the same amount – about 50 hours per week. The time use surveys of Wajcman and Bittman found that the greatest gulf is not between the sexes but between those adults with young children and those without. Men and women with no children get eight times the amount of adult leisure that couples get whose youngest child is under two. When their youngest child is under two, mothers devote more than

30 hours a week to primary, direct childcare. More than half of this time is spent on physical care – carrying, comforting, feeding, changing, dress and bathing. By contrast, the fathers average eight hours a week on childcare, of which almost a third is devoted to play.

SUPPORT FOR CONSIDERED AND CONSIDERATE PARENTING IS VITAL

Deciding upon and balancing paid work and family aspirations or commitments may put considerable pressures on relationships, particularly when peoples' socio-economic status means that their self and family management options are comparatively limited. In an ageing society, the policy emphasis on de-institutionalisation is unlikely to reverse this kind of pressure. Until comparatively recently, the social scripts which required each male to be the main family breadwinner, and which constructed the female as his dependant, family carer, were strictly demanded and ideally seen as immutable. Individual men and women now constantly negotiate work and family roles, which were once automatically adopted and seldom questioned openly. They often also mourn the loss of what they think might or should have been the case.

In this context it is vital for society to provide a full range of education, family planning and social services. These should promote an environment where all children are wanted, and can be loved and supported effectively by parents who consider their children's' concerns at least equally with their own, whatever the state of their relationship with the other parent. It is also vital for strong work and community support to be provided so that parents can fulfil their individual potential, as well as meeting their responsibilities to their children and to others.

FLEXIBLE WORK AND QUALITY MANAGEMENT ARE REQUIRED

Does the increasing and conflicting range of choices, expectations and demands placed on men and women in a competitive global economy also produce a growing army of the psychologically wounded? From the statistics outlined earlier it seems that substance abuse, depression and anxiety are now the leading causes of ill health for both men and women. A more optimistic way of looking at this picture may be to say that Australians are living longer, healthier and freer lives, and that this has allowed them to look more critically at aspects of their situation that were once regarded as an inevitable or unmentionable part of life. However, it is also likely that rapid technological and social changes are promoting greater stress, including in the relationships between the sexes, and particularly for lower socio-economic groups.

Ellard, a leading Australian psychiatrist, writes critically about an apparent explosion in stress and work related burnout. Freudenberger has described the latter as potentially involving exhaustion, detachment, boredom and cynicism, impatience and heightened irritability, a sense of omnipotence, a sense of being unappreciated, paranoia, disorientation, psychosomatic complaints (such as headache), depression and denial of feelings. This litany of diverse complaints suggests that people should normally expect to find their work satisfying, as well as productive activity. Historically this is a fairly new idea, which may not be as widely shared by employers who want to remain in business, as workers or taxpayer-funded researchers would like. However, a happy and healthy worker is also likely to be more productive, so a range of relevant work and community partnerships to promote mutual satisfaction are obviously important.

Ellard seems to regard burnout mainly as a diagnosis invented by health professionals with less training and research expertise than psychiatrists, in order to describe the diverse situations of people who are unhappy at work. Some of the research suggests that burnout occurs **whenever the expectation level is dramatically opposed to reality and the person persists in trying to reach that expectation.** Ellard says:

> Burnout seems to be the syndrome, which arises when a person who has a strong neurotic need to succeed in a particular task becomes confronted with the impossibility of success in that task. A corollary of that definition, derived from my own clinical experience, is that when such a person accomplishes one task his or her neurosis will impel him or her to attempt a more formidable one, so that eventual failure is guaranteed. The rational person, confronted with a task which is distasteful, debilitating, depressing or impossible, will pass it by and do something else. The neurotically driven will keep on at it.

Ellard talks about the difficulties imposed on individuals by the pathological need to succeed and says that it is a cruel burden, which torments the person into endless attempts at self-improvement and achievement.

> The torment is never satisfied for the internalised parental figures who have motivated the sufferer for so many years are never satisfied either. Neurotic guilt and anxiety drives the sufferer on to self-destruction.

Whether or not the problem lies in unrealistic expectations of the afflicted individual, their employer or the system, it seems that a large part of the answer to work related stress lies in the availability of a broader range of more flexible work options, and more consultative and informed management. This is necessary to increase the paths available to both sexes in a way which also allows them to manage their family and work responsibilities as effectively as possible.

REDUCE RISK THROUGH WORK AND COMMUNITY PARTNERSHIPS

The idea that unbalanced states of mind are diseases – physiological or psychological abnormalities that can be cured through professional intervention – is a comparatively recent, Western and professionally dominated way of conceptualising unhappiness. This perception suits drug companies and health industry workers, because the major cures for these problems are seen as drugs and counselling, which they dispense. Ellard puts an alternative view about addiction and depression when he says:

> Drug addiction is not a disease; it is a way of life. One might as well try to dispel poverty by examining the poor. Some people like climbing mountains, others fly ultra light aircraft, or go to work in Beirut. Those who want a peaceful and untroubled life do not do these things. More often than not, addiction is associated with social disadvantages, with a belief that one is powerless and can never escape from the bottom of the heap. Often as not this belief is well founded. It is perhaps better to look forward to the next fix or the next bender than to look forward to nothing at all. It may be that when the ideal society has been achieved there will be little addiction…

Such a perception sees drug abuse as risky behaviour, which is an escape from the rigours or monotony of life. A wide variety of risk taking is a traditional and expected element of men's work and masculine behaviour. Risk taking is intimately identified with courage, excitement, prowess, control and advancement. It is the gender counterpart of the risk averse and caring behaviour expected of women. High levels of unintentional and intentional injury are an outcome of this male script, particularly for those are not academically inclined, and who cannot effectively seek fulfilment in the world of professional, academic or business competition.

Men in lower socio-economic groups typically do more dangerous work than women or other men. National OHS Commission statistics suggest that each year over 400 men and less than 30

women are killed at work. Men also appear to be injured at work at two and a half times the rate that women are. The industries with the highest fatality and injury frequency rates are transport and storage, mining, construction, manufacturing, agriculture, forestry, fishing and hunting. Women typically enter retail, health and community services, education, clerical or other service related work.

State OHS acts provide all employers with a duty of care to provide a safe place of work, and provide all workers with a duty to work safely. Employers are required to identify and control risks in consultation with workers which have been provided with information and training about the hazards of their work. More management and research attention to the effective control of high-risk work is clearly required at the workplace and industry level. For best effects this should occur in combination with appropriate regional projects to promote a healthy lifestyle in regard to food, exercise, and drug use. Men have traditionally been expected to regularly die in war, and to risk losing their lives or money in search of making a better living.

Except in times of war, successful masculinity is traditionally defined by the level of economic support a man provides for his family. It is to be hoped that the social necessity for major combat, brutal competition, and its related risks has largely passed, as a result of economic development, the advent of the welfare state and international health and environment protection goals. However, being able to support individuals or communities adequately, rests increasingly on high levels of value added production, in an environment where an increasing number of people apparently feel that the competitive and narrow schooling and work race is beyond them. This can be perceived either as a social threat, or as a collective management opportunity to design a broader, more equitable and multicultural society. Opportunities for thrilling, educating and serving communities, which are inherent in popular entertainment and in sport, may equally provide flexible work for some, and vital outlets for emotions which must be denied or repressed in mainstream Australian life. Such outlets also provide a range of alternative meanings and performance hierarchies to which people may aspire and to which the admiration of others may be directed. This promotes social richness and cohesiveness. In mainstream areas of work, on the other hand, status is usually based on formal qualifications, rather than on alternative experiences in entertainment, sport or service related capacities.

A broader view of health promotion and the risk management requirements of state occupational health and safety acts should provide a general corrective to economic or physical risk taking behaviour which seems thoughtlessly automatic or alienated. Employment, education, and health programs which promote better personal and work relationships, including the management of depression and substance abuse should be developed to meet regionally identified needs. The development of exciting, affordable but less dangerous sports and other recreational and artistic pastimes, particularly for young people of both sexes, is particularly important. This is the future.

1 THE BENEFITS OF AN INTERNATIONALLY GUIDED SEXUAL FOCUS

Western feminists have often said that men see women as ‘sex objects’. It is true that stereotypic good looks have often become a source of higher status for women lucky enough to possess them. As a result, such women have also had opportunities for a variety of alliances with men with career promise, or who already occupy more elevated positions. For centuries it has been the case that the only socially approved sexual activity for women has occurred within long term, monogamous marriage, usually with partners of a similar or slightly higher social status. As women have gained equality with men, the sexual opportunities of both sexes have expanded

along with the market, but the ideal of life long monogamy has remained the central demand of most people's relationships. Men have often secretly paid for sexual pleasure elsewhere as well.

Most people seek to be loved and treated fairly. Historically, however, the major effect of sex role stereotyping has been to divide women into 'Damned Whores' or 'God's Police' (to borrow from Summers' wonderfully exact and evocative book title about Australia's history). This lingers on, but thankfully not in the World Health Organization (WHO) definition of sexual health, which describes it as 'the integration of physical, emotional, intellectual and social aspects of sexuality in a way that positively enriches and promotes personality, communication and love'.

Winn calls for the establishment of a recognised field of sexual health promotion with all sexual health activities, whether clinical or educational, to be planned, implemented and evaluated within the Ottawa Charter health promotion framework of the WHO. Nutbeam and Blakey define sexual health promotion as 'the holistic process of enabling individuals and communities to increase control over the determinants of sexual health, and thereby managing and improving it throughout their lifetime'. Presumably everyone should benefit from that, particularly people who are sexual victims, or who violently act out their sexual difficulties, or whose yearnings have been ignored or silenced. But what might these sentiments mean in policy and service terms?

Domestic violence against women and children has only become a subject of investigation in recent decades. The sexual, emotional and related needs of men and those who service them have also been ignored or treated punitively by a polite and often hypocritical society, including sections of the health industry. However, sexual transactions and the needs they seek to satisfy are an obvious point at which some urgent social problems may be addressed from a gendered perspective, particularly in relation to crime prevention, HIV/AIDS control and disability support.

2

3 LEARNING WITH SEX WORKERS AND THEIR CLIENTS

The entertainment and personal services industries, including those directly or indirectly related to sexual expression, have expanded in recent decades. Prostitution has been called the oldest profession. Historical studies on the size of the sexual services market in the Western world suggest that men have purchased sexual services for recreational purposes since history began. This has usually occurred in secret. Although contemporary Australian prostitutes and related sex workers certainly provide a service and probably learn a lot on the job, their work does not lead to the educational and career opportunities which are open to people in most other occupational areas. In polite society, talking openly about the recreational sexual pursuits of men is like using four letter words in front of women – it is taboo. Such gender related taboos are indicative of a cultural mindset which appears determined to prevent the honest investigation of the needs of both sexes, particularly those in disadvantaged situations, in order to meet them more effectively.

Like money, sex may be a form of recompense, compensation or comfort. For example in 1998 the Australian National Inquiry into the commercial sexual exploitation of children and young people in Australia showed that the dominant form of commercial sexual exploitation of young people is 'sex for survival' and 'sex for favours', a survival strategy to exchange sex for accommodation, food, alcohol, cigarettes, drugs, clothes or money to obtain these daily needs. Other factors contributing to this choice of survival strategy include the need for emotional contact and sexual exploration. Such young people need accommodation, work and education opportunities, which can effectively meet them where they are. More mainstream education, work and family opportunities were never available in the first place or have already been rejected for some reason.

The conceptualisation and study of the sex industry ranges from a focus on hospitality, community or personal service work and standards, to issues covered by State Crimes Acts or Commonwealth legislation related to illegal immigration. Perkins and Bennett write that:

> 'prostitute women usually see their occupation as an essential community service, as therapy to some men, counselling to others, and a safety valve for the frustrations and bottled-up energies of most'.

A less optimistic presentation of self and others, written for a safety handbook for prostitutes advises:

> 'Always be aware of what's happening around you, especially when talking to mugs (clients). Try not to work when you are really out of it as it can affect your judgment. Always go on your first instinct'.

This appeal was sparked by concern about rapes, muggings and bashing of street prostitutes in Victoria. One area for research is whether better mechanisms for complaints and dispute resolution within the sex industry can prevent violence and assist the provision of services.

In 1998 the Macfarlane Burnet Centre for Medical Research contracted a market research agency to conduct telephone interviews with people in Victoria who had used the services of sex workers. This appears to provide one of the few pieces of Australian research into the characteristics and needs of clients. The researchers note that in 1990 a WHO review of the findings on HIV infection and risk factors among female sex workers, found the majority of studies were focussed on the sex worker, with less than 10% focussing on the client. When asked why they paid for sex, the top five responses of men contacted in the Victorian research were that they were paying for:

- Good sex (32%)(101 subjects)
- Convenient sex without commitments (20%)(62 subjects)
- Companionship and intimate contact (15%)(49 subjects)
- Alleviation of sexual frustration (13%)(42 subjects)
- Variety in partner and sexual activity (13%)(42 subjects)

The researchers argue for further study to examine the needs of clients of sex workers in order to effectively promote sexual health and related education throughout the community.

4 AUSTRALIAN EXPERIENCE WITH HIV/AIDS

Globally, HIV/AIDS is a major health problem. The disease occurs when contaminated bodily fluids, such as semen or blood, are transmitted to another body through a break in the skin. In developing countries, HIV/AIDS is predominantly a heterosexual disease, which is also passed on by pregnant women to their babies. The spread of HIV/AIDS is currently only preventable by the absence of high-risk behaviours, including promiscuous sexual behaviour, lack of use of condoms, anal sex, and sharing needles between the drug addicted.

In developed nations, homosexual or bisexual males, injecting drug users and prostitutes are seen as the major groups at risk of contracting HIV/AIDS or passing it on. However, Dowsett points out that the Australian HIV epidemic has apparently remained largely confined to male to male

sexual transmission of the virus, and that Australia's efforts have been among the most successful in the world at containing and slowing the rate of spread of HIV in communities. He puts this down to a combination of facilitating national public health policy, and sophisticated HIV/AIDS community activism which has led to prevention work among gay communities being undertaken almost exclusively by gay men themselves.

The expertise gained by people working in this area is likely to be very instructive in regard to a range of related health and sexual concerns. Baby boomers like me remember very well that the extravagantly popular and now highly commercial production of Sydney's yearly gay Mardi-Gras grew from the efforts during the 1970s of a comparative handful of people who sought primarily to be able to walk in the streets without being beaten up or arrested as a result of appearing to be homosexual. 'Reclaim the night' was the call of women and homosexuals alike. This is a call for the right to safety and freedom, especially from violence or harassment. People should always have the right to secrecy (confidentiality). However, people brave enough to speak their truth, in order to make the world a better place, should be encouraged and admired in my opinion.

5 PROMOTING HEALTH IN BROTHELS AND ASSOCIATED AREAS

Over the past two decades the major health interest in the operation of brothels and related sexual services in NSW has centred on prevention of the transmission of HIV/AIDS and other sexually transmitted diseases (STDs). Heymann's global and regional epidemiological study clearly indicates that Australian control of HIV/AIDS, chlamydia, hepatitis B, genital warts, herpes, gonorrhoea and syphilis can be favourably compared with that achieved anywhere in the world.

The promotion of the use of condoms, other good health practices and regular sexual health check-ups appears to have produced dramatic benefits since Donovan published 'Gonorrhoea in a Sydney house of prostitution' in the Medical Journal of Australia in 1984. Researchers at the Sydney Sexual Health Centre indicate that during the period from 1979 to 1995 there were remarkable health improvements in the urban female sex industry. In the early 1980s the women had high rates of STDs compared to the general population. By 1996 they were rarely diagnosed with bacterial STDs or HIV infection. The researchers attribute this change to a climate of law reform, the formation and funding of community organizations, peer education and support and improvements in the quality and accessibility of health services.

More recently however, the Sydney Morning Herald (11.9.99) reported the NSW Premier had expressed his concern about the effective operation of brothels in NSW, and his interest in establishing a review of the subject. His comments followed a series of articles during the previous week, which estimated that 400 to 500 brothels exist in the Sydney area alone, and that many operate illegally. In 1993 the NSW Dept. of Health found only two hundred female brothels or parlours in Sydney and sixty in rural areas; eleven male brothels and three transgender ones. Since the passage of the Disorderly Houses Amendment Act (1995), brothels which conform to government requirements may operate legally in NSW. NSW, Victoria and the ACT allow brothels to operate providing they have planning consent from their local government authority. South Sydney City Council has introduced a brothels policy in consultation with the sex industry and the wider community. The attitudes and practices of other Local Councils require further investigation.

The South Sydney Council Brothels policy recognises two types of brothels:

1. a home occupation private sex worker operation (parlour)
2. a commercial brothel

The policy outlines the planning requirements relating to the appropriate location of both operations. The planning policy supports the views of the Select Committee upon Prostitution in NSW, which held an inquiry in 1986. This found that the siting of any red-light area would present major problems, and that a single or a few zones would be inadequate and inappropriate to the existing level and nature of demand in NSW. The regulatory trend has been towards a model which permits consensual sexual activity between adults while preserving the amenity of the community at large. The Land and Environment Court deals with the resolution of disputes about the siting and effects of brothels on the surrounding community.

Sex workers in brothels are generally regarded as self-employed people rather than employees. However, the health and safety guidelines for brothels in NSW, produced in 1997 by the Health Department and the WorkCover Authority, regards them as 'deemed workers' who therefore should have the entitlements of employees. Other self-employed prostitutes work at home 'parlours' or from the streets. These various employment practices have related health, rehabilitation, cost and price implications.

Many difficulties occur in regulating the sale of sexual services in a manner similar to that applied to other work. This also raises the wider issue of the appropriate age for consent, which currently varies according to state, sex, and sexual preference. One possibility might be to introduce a duty of care concept into legislation related to sexual activity, along with the age requirements, which already exist for consenting sexual behaviour. This could be similar, for example, to the concept of 'duty of care' owed in state OHS Acts. Sexual activity is a complex matter. Sexual activity with under age people should always be considered wrong. However, as Justice Spigelman, Chief Justice of NSW recently pointed out (Sydney Morning Herald, 31.1.02, p.10)

> The existence of sentencing discretion is an essential component of the fairness of our criminal justice system. Unless judges are able to mould the sentence to the circumstance of the individual case, then irrespective of how much legislative thought has gone into the determination of a particular rule or regime, there will be the prospect of injustice in the individual case.

Community debate and dispute resolution systems should be designed to gather information and educate everybody, but the traditional, adversarial court process is largely inadequate for this task, if only because it keeps no effective statistics which could aid community management. Chapter nine of the Model Criminal Code developed in 1998 by a Committee of the Standing Committee of Attorneys-General, deals with the conditions under which prostitution might be regarded as 'sex slavery' or 'sex servitude'. The appropriate relationship of the code to the treatment of illegal immigrants and those who bring them to Australia requires investigation.

It is clear that Australia cannot count on maintaining its current cost-effective public health success in regard to the control of STDs, without continuous action research and health promotion programs carried out in regional contexts. This could build more widely upon the efforts already undertaken in this area. The lessons learned so far have strong implications for Australia's aid, trade and immigration related relationships with Asia and the rest of the world. The aim should be to focus on sex work in order to meet a range of societal needs more effectively, and in order to promote general knowledge about control of risks to health in Australia and the global community.

6 CONCLUSION

A gendered approach requires a recognition that the health problems of men and women are also related to their relationships with each other and with the wider environment. It contrasts with a medical approach to health, which focuses on prevention or cure of major diseases – such as cancers and cardiovascular disease. While mental health problems are experienced by both sexes, unintentional and intentional injury are an added major problem for men. In a gendered approach to health, the risk taking behaviour typically exhibited by men needs to be seen as the historical counterpart of the caring behaviour typically required of women. The combination of economic development and greater equality between the sexes has created contradictory pressures for many people, but particularly for men and women from socio-economically disadvantaged backgrounds. Adequately meeting the current health needs of both sexes demands a focus on what traditional scripts for masculinity and femininity have required of people, and how workplaces and communities ought to be self-managed in the light of apparent contemporary and future needs. In this context, sex work is an important area for health promotion and educational activity in order to meet the needs of particular groups of individuals and society in general.

FURTHER READING:

Commonwealth Dept. of Community Services and Health, National Women's Health Policy, Canberra, AGPS, 1989.

Connell, RW., Schofield, T., Walker, L., Wood, J., Butland, D., Fisher, J., and Bowyer, J. Men's Health: A Research Agenda and Background Report, presented to the Minister for Health and Aged Care by a research team from the University of Sydney and the University of Western Sydney, Ausinfo, 1999.

Ellard, J. The Anatomy of Mirages: A Psychiatrist Reflects on Life and the Mind, UNSW Press, Sydney, 1994.

Nutbeam D. and Blakey V., 'The concept of health promotion and AIDS prevention: A comprehensive and integrated basis for action in the 1990s', *Health Promotion International,* 5, 1990, 233-241.

Donovan B, Harcourt C., 'The female sex industry in Australia: A health promotion model', *Venereology*, 9, 1996, 63-67.

Dowsett, G., 'Sexual contexts, HIV prevention and gay men', *Venereology*, 8, 4, 1995, 243-248.

ECPAT Australia, Youth for sale: National inquiry into the commercial sexual exploitation of children and young people in Australia, Brisbane, 1998.

Heymann, D. 'Sexually transmitted diseases and AIDS: Global and regional epidemiology, *Venereology*, 8, 4, 1995, 206-209

Macfarlane Burnet Centre for Medical Research, Project client call: Men who pay for sex in Victoria, NHMRC, and Public Health and Research Dev. C'tee., 1998.

Model Criminal Code Officers Committee, Model Criminal Code: Offences against humanity: Slavery, Report to the Standing Committee of Attorneys-General, Canberra, 1998.

NSW Health Dept. and WorkCover NSW, Health and Safety Guidelines for Brothels in NSW, Sydney, 1997.

Perkins, R. and Bennett, G., Being a Prostitute, George Allen and Unwin, Sydney, 1985.

Winn, M., 'Sexual health promotion', *Venereology*, 9, 1, 1996, 68-73.