Grace de Jesus-Sievert

Empowering Women Workers in Australian Industry

by Sevgi Kilic

Immigrant women have been shown consistently by research and practice not to be adequately catered for by existing Australian social structures and institutions, in particular health and welfare services. Immigrant women, therefore, form an 'at risk' group in relation to the provision of these services within the Australian context. Some researchers would argue that immigrant women workers in Australia constitute an oppressed social class (Centre for Urban Research and Action 1976, p.112). In fact, immigrant women workers are terribly disadvantaged. They are mainly concentrated in the semi-skilled and unskilled sectors of industry, and tend to remain within the same type of industry all their working lives. The dual responsibility of home and work leave little time or energy to seek important information on health and work-related matters. Nor do most have the time to learn English through the usual channels. Services are rarely open after their work hours, while language and cultural differences constitute further enormous barriers.

In 1977, many discussion groups within the immigrant women's groups took place around the theme of general women's health and contraception. Women found that they shared similar experiences, humiliations and frustrations with family planning services and their general search for contraceptive advice resulting primarily from a lack of communication with health professionals. Consciousness raising and education of the community in general and of related professions, was believed to be the first essential step.

With the assistance of two women academics from Monash University, a video *Without Knowledge Without Choice* was made by immigrant women for screening at a public forum which was held in August 1977. Two hundred people from a wide range of immigrant women's groups, health and community workers, some politicians and health bureaucrats attended this forum where they listened to immigrant women discuss, in their own language (with English voice-over), their experiences in this area.

Anna, a Greek woman had twelve backyard abortions performed by another Greek woman who was a midwife. She knew that qualified doctors performed abortions, but had more faith in her country women.

Franka, an Italian woman and her husband had decided that a combination of the con-

dom and/or the withdrawal method, backed up with the option of abortion would be the contraceptive method they would use. Religion was not important. If she was desperate enough she would have an abortion, but she would not have one just for the sake of it.

For **Anna** and **Franka** and other immigrant women, family planning became a new problem. In their homeland an extended family would have shared the responsibility of child-minding: in Australia it is necessary for working class families to have two incomes to make ends meet.

Maria, another Italian woman recently arrived in Australia, was used to medically prescribed contraceptives, but did not know where to access the service in Australia. In contrast to **Anna** and **Franka**, she felt that Australia lagged behind Italy in the provision of family planning services. In Italy, for example, women's health centers and clinics are numerous and freely accessible during working hours as well as after office hours.

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A young mother who spoke English shared how she had not had intercourse with her husband, for fear or getting pregnant again. It was not until the infant welfare sister asked a few probing questions that she found out she was already using the pill, but did not know what she was taking or why.

Another young woman was on the pill but was inserting it vaginally. She only found out she was taking it incorrectly when she became pregnant and went to the hospital for an abortion.

Margaret, a Yugoslav woman went to her doctor with abnormal menstrual pains and was told she needed a minor operation. It was not until much later when she went back to her doctor to tell him she had been trying unsuccessfully to get pregnant over the last few months that he told her he had given her a hysterectomy to cure her endometriosis.

A thirty-three year old Turkish woman went into the hospital for an appendectomy. When she awoke from her operation she was told she had a hysterectomy as well, although she had only signed a consent form for her appendix.

The above are only a few of the many stories women told of their experiences. They have been included here to portray a small, but traumatic picture of one aspect of women's lives which led them to take action on their own behalf. The forum resolved that multilingual family planning and health information needed to be taken out of the clinical context and into the community, into the workplaces of immigrant women. In line with the slogan, *Without Knowledge Without Choice,* the rationale was that with the proper information women would have a choice and some control over their bodies and their lives.

Moreover, it was felt important that immigrant women themselves, who not only spoke the same language, but shared cultural and other life and work experiences with women in the workplace, should be involved in the process of sharing such information with immigrant women workers.

Birth of Action for Family Planning

From this forum, a women's group calling itself Action for Family Planning (AFP) was formed. Most important, the forum resolved

that AFP would be an organization run by and for immigrant women who would be encouraged to participate at all levels of the organization thus empowering and radicalizing immigrant women. A pilot factory education program on health matters and family planning, plus a 'lay educators' training course were some of the activities of the group. Through formal and informal networks in the various immigrant communities, immigrant women were recruited as 'lay educators' to take part in the training course and voluntarily conduct the pilot factory visiting program. AFP purchased a projector and paid translations of literature books, relevant films and books from overseas in the women's own languages.

Pilot factory visits in cooperation with Trade Union organizers took the team of twelve bilingual 'lay educators' to several factories (clothing, meatworks and metal trades) in the inner and western suburbs. The language groups covered at that time were Italian, Greek, Spanish, Serbian, Croatian and Macedonian. Although the visits were targeted at women, interested men in the workplaces were included in the discussions. Information exchange extended beyond the workplace to the homes of the women, their extended families and their community at large. Immigrant women not only showed an interest in contraceptive information, they communicated freely in their own language with other women they trusted.

Through lobbying and enlisting support from a wide range of networks, the issues of concern to immigrant women workers were being canvassed and the community at large were made more aware of these issues.

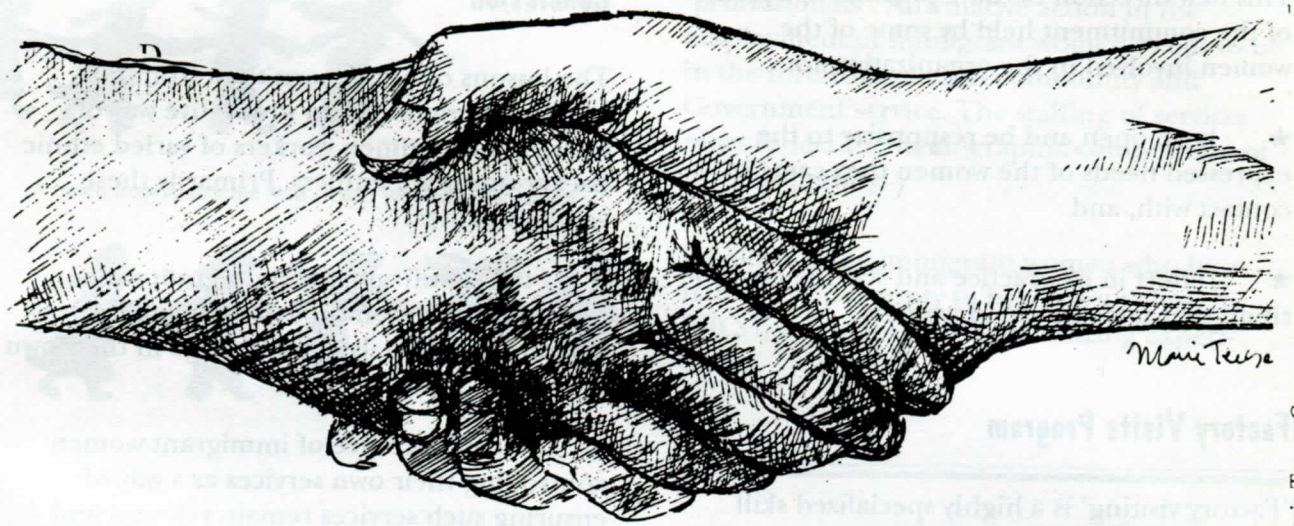
Change of Direction

After the initial years, immigrant women workers' concerns from family planning and contraceptive information broadened to include other health and industrially-related aspects of their lives. Increasingly, women were requesting information and referrals regarding workers' compensation; occupational health and safety matters; childcare; maternity leave; sick leave entitlement; long service leave; superannuation; award provision; English classes on the job; union training; sexual harassment and workers rights in general.

Healthsharing Fall/Winter 1992

In particular they were interested in discussing ways and means by which they could take up issues at their workplace in their own behalf, such as participating in existing local and/or central union structures or alternatively establishing new ones, such as women's shop floor committees.

Through this direct and very personal contact with the women workers, it was found that women generally suffered from ill health as a direct result of their working conditions. Women consistently complained of repetitive movement injuries; breathing problems (industrial asthma); back complaints; sore legs; varicose veins; headaches; deafness; tiredness and 'nerves', i.e. stress; high blood pressure; depression; dermatitis and other skin allergies; sore eyes; abdominal pains; premenstrual tension; irregular and/or heavy periods; vaginal infections, irritations and discharges; cystitis; kidney and urine infections; migraines; loss of libido and many other complaints.



Marie Terese Guerrero

These complaints were valid considering the working conditions under which the women worked. Most factories visited were dusty, dirty and extremely noisy. Heavy lifting, repetitive movements and handling of chemicals were invariably involved. Standing all day wet on slippery concrete floors and exposed to extreme temperatures were just some of the inhumane and stressful working conditions of these women.

In many factories the toilets were dirty and lacked sanitary disposal units. Toilets visits in 'progressive' workplaces were allowed to be taken 3-5 minutes twice daily, plus queuing at lunchtime. In other factories they were restricted to lunch breaks only. Not surprisingly women suffered vaginal infections as they were forced to wear layers of napkins or multiple tampons in order not to 'leak' all over the place due to the inability to change napkins and tampons as often as required when menstruating. Kidney and urine infections were also common from the after-effects of having to 'hold-on' for too long.

In some factories workers did not leave the work station because they were doing piecework and had to reach a certain target by the end of the day. In other workplaces, canteens were noisy, dirty, small, inaccessible or non-existent. Consequently, women either ate at their work stations, surrounded by dust and dirt or on the grass or footpaths outside.

The prospect of having their bonuses cut if they stayed too long in the toilets also kept them tied to their work stations. Most women made no claims for workers' compensation for fear of losing their jobs, as this had been the experience of their workmates. Husbands and wives working at the same workplace were even under greater pressure not to complain about the poor working conditions for fear of both losing their jobs.

The women workers generally found difficulty in raising these kinds of grievances with their union representative or management, primarily because of the language barrier. And because they were invariably all men, the women felt embarrassed, or found them to be insensitive to their demands on the rare occasions when grievances were indeed raised. In larger workplaces women did not even know their union or union representative.

The change of direction in 1982 from information exchange on family planning and contraceptive methods to general women's health and industrially related information led to a change of name from AFP to Women in Industry and Community Health (WICH).

This new direction became possible as a result of the commitment held by some of the women involved in the organization to:

★ keep open and be responsive to the expressed needs of the women they came in contact with, and

★ reflect in its practice and staffing composition that same group of women.

Factory Visits Program

'Factory visiting' is a highly specialized skill and the 'bilingual workers' are met by many challenges. Knowing a language and coming from the same ethno-cultural group is essential, but more than this is required. The uniqueness of the program, i.e. the direct and personal approach used, requires the use of a highly developed set of communication skills. The bilingual workers are required to: quickly create an interest in the subject matter; utilize limited time as effectively as possible; handle delicate subjects carefully and with tact and diplomacy; quickly assess the moods of the women workers and respond accordingly; present correct and up to date information; translate often difficult material in a manner which is accessible to the women at work. Often, illiteracy and semi-illiteracy of the women workers would require the 'bilingual workers' to not just hand out translated written information followed by an oral explanation, but rather to convey information verbally, yet taking care not to humiliate or patronize the women concerned, an important factor overlooked by other service providers. However, even when dealing with women who could read and write, the challenge would be to exchange the information in a manner that is harmonious with the traditional conceptual framework of the women workers.

Conclusion

The lessons one can learn then from the WICH experience as an innovative way of working with women workers of varied ethnic backgrounds are endless. Primarily these would include:

★ the significance of immigrant women taking up action on their own behalf, i.e. becoming the catalysts for change in their own lives;

★ the importance of immigrant women controlling their own services as a way of ensuring such services remain relevant and responsive to their own needs and change accordingly when different needs are manifested;

★ the significance of women working with other women whom they can directly identify with at all levels (not just language) and communicate with on an equal basis, while still providing a 'professional' service;

★ the need to take information and other services (whenever and wherever possible) to where women are, as opposed to trying to bring women to the service;

Women from Across the Seas - Asian Women's Association

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★ the importance for Government and other authorities to recognize that women's services need to be adequately resourced and funded;

★ the need for services to remain accountable to the whole community (via its funding body/ies, but principally accountable to their target group);

★ the significance of developing working relationships and networking as widely as possible, and at the same time working closely with the representatives of immigrant women workers, unions, as these provide the structures with legitimacy and strength to take up issues seriously.

The health system, government and other services, including unions, have become more responsive to the needs of immigrant women workers. This is manifested by the increase in available multilingual information and bilingual personnel. However, it must be repeated that the decision making structures of services aimed at immigrant women themselves must be the decision-makers and not just be used by 'professionals'. Affirmative action in the employment of immigrant women needs to be in the forefront of each community and Government service. The staffing of services must reflect the demographic composition of the community.

Finally, for the immigrant women who have had the opportunity to become involved in WICH, it has become a radicalizing experience.

About the author: *Sevgi Kilic* is the coordinator for information of WICH in Victoria, Australia.