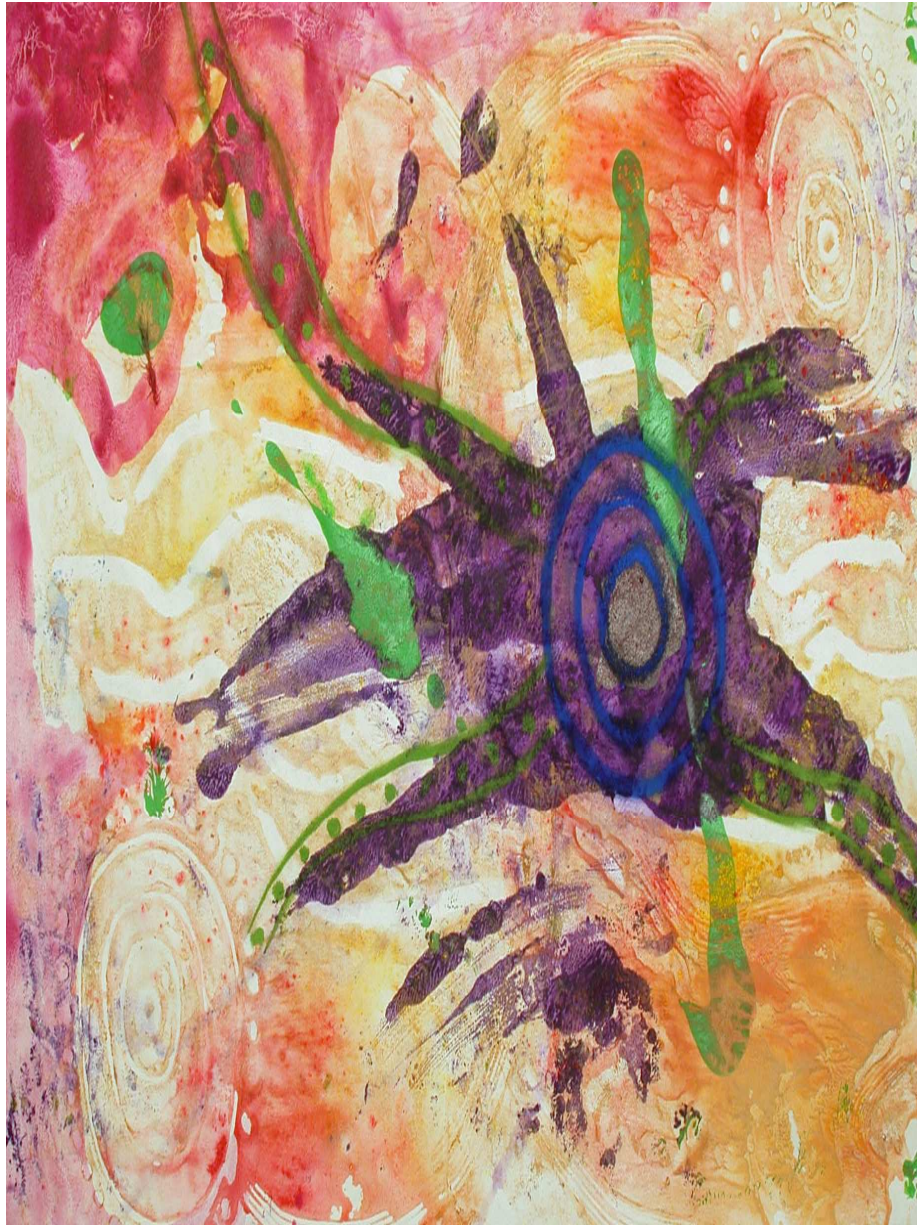# National Aboriginal and Torres Strait Islander Women's Health Strategy

"This image is of my woman's site on Country where I live. It is where I travel to for maintaining my mental, emotional, spiritual and physical well-being. Within this place I can speak with my inner self and to my ancestors. It is where I seek clarity, guidance and reassurance, and affirm my Aboriginal identity." Pamela Croft Warcon

Australian Women's Health Network

Artwork

Women's Site in Country, 2002. Pamela Croft Warcon, Kooma Clan of the Uralarai People of South Western Queensland

The work is from Pamela Croft Warcon's *Stories, Histories and Memories Mud Map* series undertaken in 2002-2003. This Mud Map mono-print represents an exploration of the interconnected and intertwined stories, histories and memories that lay within our heartland – mother earth. Within this series, Pamela Croft Warcon explores and experiments with mono-prints and mixed media (oil, acrylic and ochres) to map connections to place. In doing so, she creatively reveals the sets of relationships within place including the physical, physiological, social, spiritual and metaphysical.

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Dedication

We sincerely thank and dedicate this report to all the Aboriginal and Torres Strait Islander women who provided important input into this Strategy.

We would like to acknowledge all Aboriginal and Torres Strait Islander women working in women's health for their continued work and dedication to the Aboriginal and Torres Strait Islander community.

Foreword from AWHN

When compared with other women in Australia, Aboriginal and Torres Strait Islander women are considered the most socially and economically disadvantaged and have the poorest health status. As research on the social determinants of health shows, socio-economic disadvantage is strongly associated with poor health outcomes.

For this reason, the Australian Women's Health Network (AWHN) has always endorsed a social view of health, and therefore supports the social determinants perspective adopted by the Commonwealth consultation paper, *Development of a New National Women's Health Policy* (2009). AWHN recognises that the social determinants of health intersect – particularly race, gender, culture and socio-economic conditions. One of the major social determinants, minority group status (including that associated with colonisation), is a root cause of serious health inequalities. Gender is also a basic social determinant. AWHN stresses that the new National Women's Health Policy (NWHP) must focus on these determining factors so that the health needs of those with the greatest risk of poor health can be more adequately met, especially the health needs of Aboriginal and Torres Strait Islander women.

AWHN received funding from the Australian Government through the Women's Leadership and Development Program in 2009 to undertake consultation with Aboriginal and Torres Strait Islander women and provide input into the submission process for the new NWHP. The resulting documents – AWHN's *Submission to the Development of a New National Women's Health Policy* (AWHN 2009), the AWHN Talking Circle Submission (Angus et al. 2009) and this Strategy – together make a valuable contribution to the developing women's health agenda.

AWHN understands that immediate, medium and long-term action needs to be taken to address the gap between Aboriginal and Torres Strait Islander and non-Indigenous women's health. A whole-of-government approach is required, not just action within the health portfolio. A first step has been made in listening to what Aboriginal and Torres Strait Islander women see and understand to be main issues, and in facilitating an articulation of these views. We hope to see these views reflected in forthcoming policy documents.

It is important to note that this Strategy does not replace other national or State and Territory documents which identify priorities and needs. The aim is to supplement existing work.

Thanks go to all the Aboriginal and Torres Strait Islander women who participated in the consultations and workshops leading up to the writing of this document. Over 400 Aboriginal and Torres Strait Islander women identified health issues, gaps and barriers to services in 2009. More Aboriginal and Torres Strait Islander women have been involved in 2010, including those who attended a national workshop in Brisbane on 30 April. Others sought to be involved, but time ran out. Thanks go to the non-Indigenous women who worked alongside

Aboriginal and Torres Strait Islander women in support of the project. I thank the women of the Australian Women's Health Network Talking Circle personally for undertaking this work and maintaining momentum.

I would like to say a special thank you to Bronwyn Fredericks, Karen Adams and Sandy Angus for bringing all the previous work together in this document, which can now be used by health advocates in policy development processes.

What is now required is the political will to endorse and appropriately fund the recommendations. We call on the Commonwealth government and other governments to take appropriate action as part of the strategy to 'close the gap'.

Gwendolyn Gray

Gwendolyn Gray
National Convenor
Australian Women's Health Network (AWHN)

Executive Summary

The Strategy presented in this report was developed through the Australian Women's Health Network Talking Circle in 2009-2010. Over 400 Aboriginal and Torres Strait Islander women were involved in the consultations. The Action Areas and Recommendations presented in this Strategy were raised and discussed by the women who contributed to the Talking Circle.

This Strategy is not intended to replace any other national or state/territory identified priorities or needs. Instead, this Strategy supplements other work.

Aboriginal and Torres Strait Islander women experience extremely poor health outcomes. They have a right to determine for themselves what their health system will look like. This Strategy is part of that process. If Aboriginal and Torres Strait Islander women continue to have their sense of identity marginalised and eroded, they will continue to have the poorest health of any group of women in Australian society.

Recommendations

Action area A: Supportive environments

1. Include childcare in Aboriginal and Torres Strait Islander employment and education programs.

2. Deliver Aboriginal and Torres Strait Islander women's leadership programs aimed at development and advancement.

3. Ensure Aboriginal and Torres Strait Islander boards and committees have equal numbers of male and female Aboriginal and Torres Strait Islander members (including government and statutory authority boards and committees).

4. Provide community development opportunities to de-normalise violence in Aboriginal and Torres Strait islander communities. For example, promoting the value of Aboriginal and Torres Strait Islander women in the community, men supporting Indigenous women in the community, and healthy cultural forms of communication.

5. Involve Aboriginal and Torres Strait Islander women in the planning, design, development and monitoring of buildings, houses and services, including the choice of sites and building type.

6. Organisations and agencies to employ and support career advancement of equal numbers of male and female Aboriginal and Torres Strait Islander employees within structural levels.

Action area B: Health service access and equity

1. Implementation of cultural safety accreditation and annual audit by women's health providers. This should include policy review, physical environment review (such as Aboriginal and Torres Strait Islander relevant posters, artwork, flags and pamphlets), staff cultural competency training, partnerships with Aboriginal and Torres Strait Islander health services and Aboriginal and Torres Strait Islander women members of organisation boards and committees.

2. Implementation of premature ageing policy and programs by women's health providers for Aboriginal and Torres Strait Islander women. For instance, home and community care or rehabilitation support for women experiencing early onset of chronic conditions.

3. Provision of social/cultural health and peer support opportunities and programs – such as basket making, textile and fibre work, shell and wood works, story work and social food gathering and cooking.

4. Report on Aboriginal and Torres Strait Islander women's participation and outcomes in women's health services, such as, cancer screening, STIs & BBVs notifications, birth outcomes, chronic disease outcomes etc.

Action area C: Women in the health workforce

1. Promote the role and importance of Aboriginal and Torres Strait Islander Health Workers working in women's health.

2. Increase the number of Aboriginal and Torres Strait Islander women working and studying in the health workforce particularly in women's health areas.

3. Biannual Aboriginal and Torres Strait Islander women's health conference.

Action area D:

1. Employ a National Aboriginal and Torres Strait Islander Women's Health Senior Policy Officer.

Introduction and Context

It is the right of Aboriginal and Torres Strait Islander women to determine for themselves what their health system will look like. Aboriginal and Torres Strait Islander women and their organisations must have a pivotal role in consulting, designing, developing, implementing and evaluating health services for Aboriginal and Torres Strait Islander women.

In this project, Aboriginal and Torres Strait Islander women who work in women's health areas and in health services were invited to talk about their health priorities. This oral evidence was used in collaboration with evidence from other sources to develop a national health strategy for Aboriginal and Torres Strait Islander women.

The oral evidence for this project was gathered through the Australian Women's Health Network Talking Circle (AWHN-TC). It involved a series of gatherings throughout Australia in 2009 and culminated with a workshop in Brisbane on 30 April 2010. In this report, the Aboriginal and Torres Strait Islander Women's Health Strategy is presented through three priority action areas, each with a set of recommendations and measures:

- Supportive environments
- Health service access and equity
- Women in the health workforce
- Employment of a National Senior Policy Officer.

Historical context

Prior to 1788, Aboriginal and Torres Strait Islander women generally had a relatively good lifestyle and generally good health (Saggers & Gray 1991: 59). Thomson claims that, when Australia was invaded in 1788, Aboriginal Australians were 'physically, socially and emotionally healthier than most Europeans of that time' (1984: 939). This is also noted in the *National Aboriginal and Torres Strait Islander Health Strategy, Consultation Draft* (NATSIHC 2001: 5).

Information relating to the pre-invasion health of Aboriginal and Torres Strait Islander peoples is based upon historical records, impressions and observations made by European explorers, and it presents a consistent picture of the health of Aboriginal peoples. Captain James Cook, said to have 'discovered Australia' in non-Indigenous historical accounts, outlined on several occasions the status of Aboriginal peoples he observed: 'of middle stature straight bodied slender-limb'd the Colour of Wood soot or of dark chocolate… Their features are far from disagreeable' (Clark 1966: 51). Phillip, Australia's first Governor of the land mass, had similar impressions (as outlined in Stone 1974: 20). Eyre, a European explorer writing on the Murray river area, described the Aboriginal people of that area as 'almost free from diseases and well-shaped in body and limb' (quoted in Cleland 1928). There are other similar accounts in historical records (Elphinstone 1971: 295; Dampier in Abbie 1976: 5).

This is not to say that, prior to colonisation, Australia's Aboriginal and Torres Strait Islander peoples were without illness or that they did not experience health issues. For example, the National Aboriginal and Torres Strait Islander Health Council (NATSIHC) (2001: 3) and Franklin and White (1991: 3) report there were probably high rates of infant and child mortality. This was also true of European cultures at the time. What is clear and without question is that, prior to invasion, Aboriginal and Torres Strait Islander peoples were solely responsible for carrying out health practices through traditional healing, using health and healing practitioners. The health practices carried out were embedded within the cultural and spiritual values of Aboriginal and Torres Strait Islander peoples (NATSIHC 2001: 5). It is also clear that Aboriginal and Torres Strait Islander peoples were of generally good health prior to invasion and the subsequent colonisation.

The colonisation of Australia had a profound impact on Aboriginal and Torres Strait Islander women. The invasion, with the establishment of the British penal colony at Botany Bay, began a destruction of Aboriginal and Torres Strait Islander lifestyles and cultures through colonisation, and involved killings and massacres, and the removal of children, peoples, lands and islands (Blainey 1994; Evans, Cronin & Saunders 1975; Lippmann 1994; Rintoul 1993; Rosser 1985).

Past government policies and practices – which included interventions, colonisation processes, missions, massacres, separations and abuses – were focused on denying rights. They particularly denied the right of 'Indigenous peoples being Indigenous peoples', that is, the right to live as Aboriginal and Torres Strait Islander peoples, practice culture as Aboriginal and Torres Strait Islander peoples, and exist and be Aboriginal and Torres Strait Islander peoples on Aboriginal and Torres Strait Islander land. Such policies were premised on assumptions of Indigenous peoples as 'heathen', 'uncivilised, 'primitive' and 'immoral' (Henderson 2000). Documents of the early 20th Century reveal the belief that Australian Aboriginal and Torres Strait Islander peoples would be exterminated or assimilated as time went by (Kidd 1997).

Current context

Aboriginal and Torres Strait Islander women know that they are collectively sicker, poorer, less educated, more unemployed, less skilled, face greater numbers of their families in jail, die younger, attend a greater number of funerals in any one year, are subject to higher levels of violence and racism and sexism, and are regarded as marginal and a minority more than non-Indigenous Australian women. A plethora of reports, policies, practices and interventions, national/state/territory and regional health strategies, issues-based health strategies and health reforms address the health status of Indigenous people. Together, they go further than ever before in linking the impacts of colonisation, social and emotional well-being issues, and general health and well-being for Aboriginal and Torres Strait Islands peoples (NATSIHC 2001). These issues are still current and still need addressing.

So what would good health for Aboriginal women and Torres Strait Islander women look like? Be like? Be experienced as? The National Aboriginal Health Strategy (NAHS 1989) provided the following definition of Aboriginal and Torres Strait Islander peoples' perception of health, which is most commonly referred to in reports and presentations: 'Health is not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life' (NAHS 1989: ix). For Aboriginal and Torres Strait Islander women this means:

> Health .... is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity. (NAHS 1989: ix)

In 1993, the National Aboriginal Community Controlled Health Organisation (NACCHO) issued a Manifesto on Well-Being from which all policy direction and work was directed. The Manifesto includes a position on Aboriginal women's health, which argues that health for Aboriginal and Torres Strait Islander women is linked to the restoration of Aboriginality, dignity, respect, roles, responsibilities, self-determination, participation, coming to terms with law, lore and culture and to regaining 'a state of well-being at least equal to that which existed prior to colonisation and as referred to in the NACCHO definition of health' (1993: 13). In the NACCHO Manifesto, the positioning of Aboriginal and Torres Strait Islander women's health is clear and concise. The underlying premise of these statements is that the cultural and human rights of Aboriginal and Torres Strait Islander women are tied to their health and well-being.

This is, in essence, what underpins this Strategy. It is based on a belief that, unless Aboriginal and Torres Strait Islander women are empowered and affirmed as Aboriginal and Torres Strait Islander women, few gains will be made in their health status. In this way, it reaffirms what Indigenous women have articulated in numerous other national, state and territory documents over the years (see, for example, Daylight & Johnstone 1986; Kirk et al. 1998; 2000a; 2000b; and The Aboriginal and Torres Strait Islander Women's Task Force on Violence 2000, to name a few). If Aboriginal and Torres Strait Islander women continue to have their sense of Aboriginality and Torres Strait Islander identity marginalised and eroded, and are further disempowered, they will continue to have the poorest health of any group of women in Australian society. As explained in the above documents and others, identity, land, history and improvements in Aboriginal and Torres Strait Islander health are integrally linked. Furthermore, that they are 'as central to improving Indigenous health status as are adequate infrastructure and health care service' (Baum 2002: 253).

History of the Women's Health Strategy

In the 1970s, the women's health movement gathered momentum, encompassed under the broader women's movement. Around the same time, a number of health developments were taking place, including the community health movement, the Aboriginal community health movement, and the focus on 'consumers' within the health field. The women's health movement was able to use the new directions in 'public health', and the terms of liberation and injustice, to successfully become stakeholders in the direction of health in Australia (Broom 1999: 2). As a result, a number of women's health services, programs and centres were established throughout Australia.

According to Wass (1992: 51), the women's health philosophy is based on the premise that women cannot control their lives until they control their bodies. Thus, some feminists who were active in the women's movement in the early phase focused on women-only health centres, where women could make decisions about their own bodies and health care. This also included concepts of sexuality, which Tong argues was crucial for radical feminists (1989: 110). Tong suggests that, as sexuality is part of a woman's identity, a violation of a woman's body is a violation of that woman's identity and of her autonomy over her own body (1989: 110). She notes that radical feminists perceive heterosexual relationships as legitimising domination and subordination linked to male and female behaviour of dominant and aggressive, and submissive and passive (1989: 110).

Fredericks (2003) argues that the heterosexual relationships described by Tong symbolise and reflect western patriarchal viewpoints of relationships and western perceptions of male and female behaviours. She argues that there can be cultural differences (and sometimes similarities) in the behaviours and practices which may be understood to be female (Fredericks 2003). Huggins (1994; 1993; 1991) and Moreton-Robinson (2000) clearly articulate relevant issues for Aboriginal and Torres Strait Islander women, including the experiences of multiple interrelated oppressions, which can be linked back to health service access.

The women's health movement, in the initial stages, focused on gynaecological and reproductive concerns and especially highlighted access to contraceptive measures. The movement later went on to address a wide range of health issues and health care. In recent times, there have been further developments within the women's health movement which have led to variations between services, programs and centres. Some of the differences include the levels of participation by women, and the balance between clinical, health promotion and education programs (including well-being programs, sexual assault counselling, programs specifically for younger women or older women, 'complementary therapies' (also called 'alternative therapies'), lesbian and/or bisexual support programs and a range of others).

The women's health movement has generally adopted the social model of health and the primary health care model of health care delivery. These models, while linked, extend well

beyond the reductionist and individualistic approaches that are so entrenched within the traditional biomedical model of health care. Aboriginal and Torres Strait Islander women benefit most through initiatives and programs that are delivered through a social model of health and comprehensive primary health care (as demonstrated by the Aboriginal and Torres Strait Islander health movement).

In the late 1980s, The Federal Government acknowledged the inequalities that Australian women experienced within the health system and, in 1989, the National Women's Health Policy (NWHP) was published (under Labor Prime Minister Bob Hawke). This was developed after a '20-year process of lobbying by women's groups to make the health system more responsive to the needs of women' (Wass 1998: 33).

The NWHP was the result of a consultation process with women's groups and Wass (1998) states that it was 'built on the recognition of the social model of health and the impact that the social environment has on health and health choices' (p. 33). It is unclear how many Aboriginal and Torres Strait Islander women were engaged in the process of developing the NWHP. The Policy was directed at 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, and the effects on women's health as a result of sex role stereotyping (Commonwealth of Australia 1989).

Alongside the NWHP, several government jurisdictions developed women's health policies. For example, Queensland Health developed the document *Towards a Queensland Women's Health Policy – Social Justice for Women*, for the purpose of preliminary planning (1992). Program responses to the NWHP and various State and Territory policies took the form of women's health centres, mobile women's health programs, sexual assault programs, women's cancer prevention programs and alternative birthing programs. When the NWHP was launched, the only States without women's health centres were Queensland and Tasmania (Broom 1991: 81).

According to Weeks (1994), women's services developed from two different sources: one being a direct result of the women's movement responding to women in crisis (for example, women's refuges), and the other from women in the community coming together for self-help, to network and for social action on issues (1994: 36). As funding became available via both the Commonwealth and State/Territory governments, women's collectives aimed their activities towards accessing the funds. Aboriginal and Torres Strait Islander women benefited through some of the advocacy action undertaken by the women's health movement – particularly strategies around control over their bodies and highlighting the inappropriateness of the bio-medical model of health for women. However, Aboriginal and Torres Strait Islander women had limited access to funding and, when they did, it was mostly for birthing programs and centres (Dorman 1997; Harrison 1991), sexual assault programs and shelters.

Overall, the women's health agenda has varied in its ability to incorporate the health and well-being needs of Aboriginal and Torres Strait Islander women. Women's health policy

documents, women's health centres and women's services that generalise about all women's oppression have, to varying degrees, minimised the position of different groups of women, including Aboriginal and Torres Strait Islander women. By marginalising Aboriginal and Torres Strait Islander women in this way, Aboriginal and Torres Strait Islander women's needs are sometimes overlooked. Aboriginal and Torres Strait Islander women should not have to feel like they need to make a choice between womanhood and identity when trying to access services. Aboriginal and Torres Strait Islander women cannot have culture without womanhood. To attempt to split ethnicity from womanhood, or womanhood from ethnicity is a European - North American dualistic form of reasoning (Fredericks 2003). Pitting these against one another does not allow them to exist together. Moreover, it does not allow Aboriginal and Torres Strait Islander women to demonstrate their resilience, capacity or the ability to exercise their rights to make health decisions as Aboriginal and Torres Strait Islander women. Furthermore, it does not allow Aboriginal and Torres Strait Islander women to exercise their rights as sovereign Aboriginal and Torres Strait Islander women.

Both the Government and the women's health agenda and women's movement need to understand that Aboriginal and Torres Strait Islander women's health should be the benchmark for all women in Australia and for Australian society. That is, by focusing on the health needs and improvements in health status of Aboriginal and Torres Strait Islander women, the overall health status of all Australian women, as reflected in the statistics, will show an improvement.

In 2007, the then Opposition Leader Kevin Rudd made an election commitment to develop a new National Women's Health Policy. In response to this commitment, the Australian Government released the *Development of a New National Women's Health Policy Consultation Discussion Paper 2009* (Commonwealth of Australia 2009). The Consultation Discussion Paper argues that the new policy will 'recognise gender as a basic determinant of health, which gives rise to different health outcomes and different needs for women and men' (2009: 1). It states that the new policy will 'emphasise prevention, health inequalities and the social determinants of those inequalities' (p. 1) including the needs of Aboriginal and Torres Strait Islander women.

In developing the new National Women's Health Policy, the Australian Government has undertaken a range of consultations with women, community groups, health service providers and State and Territory governments. The Australian Women's Health Network contributed to the submission process through a *Submission to the Commonwealth Government on the New National Women's Health Policy* (AHWN 2009). The Strategy outlined in this report, on behalf of the AHWN Talking Circle, complements the AWHN Submission. The authors hope that the new National Women's Health Policy will establish work to 'close the gap' between the health status and health outcomes of Aboriginal and Torres Strait Islander women and non-Indigenous women in Australia (see NACCHO & Oxfam 2007; SCRGSP 2009).

The AWHN Talking Circle

The Australian Women's Health Network Talking Circle (AWHN-TC) was established to develop the National Aboriginal and Torres Strait Islander Women's Health Strategy outlined in this report.

The AWHN-TC included representative Indigenous women from each State and Territory. Throughout the project, the AWHN-TC members actively sought to increase their membership, and to encourage greater Torres Strait Islander representation.

The AWHN-TC was organised by joint-convenors – an Aboriginal convenor and a non-Indigenous convenor – who worked in partnership to recruit members and increase support. They sought to strengthen the capacity for long-term sustainability of the group to ensure that Aboriginal and Torres Strait Islander women's voices would be included in present and future Australian women's health policy and initiatives.

The AWHN employed Ms Sandy Angus as its Project Officer from June – August 2009 to implement the Talking Circle and facilitate gatherings and consultations with Aboriginal and Torres Strait Islander women. The Talking Circle's work included face-to-face meetings, telephone discussions, word-of-mouth reports, focus groups, broadcasts and email, all used in a supportive and culturally safe way to share stories, wisdom and knowledge of Aboriginal and Torres Strait Islander women's issues.

The Talking Circle gatherings took place in non-government organisations, government department offices and Aboriginal and Torres Strait Islander Community Health/Medical Services. Others took place in coffee shops and restaurants, hospital board rooms, community-controlled meeting and board rooms, health service meeting rooms, common rooms attached to residential complexes, hospital staff rooms and under trees away from other people. Meetings took place in urban areas, capital cities and rural areas. Examples include Shepparton in Victoria, Alukura Women's Health and Birthing Centre in Alice Springs and in the Deed of Grant in Trust Community of Cherbourg, Queensland. Over 400 Aboriginal and Torres Strait Islander women were involved in the consultations leading up to the development of the Submission. The women who participated are noted in Appendix One.

During the active work phase of the Talking Circle, members made every effort to consult with a broad and diverse group of Aboriginal and Torres Strait Islander women. However, throughout most of the process, very few Torres Strait Islander women were involved. Towards the end of the process, every effort was made to ensure that Torres Strait Islander women were engaged and active participants, particularly at the national face-to-face meeting in Brisbane on 30 April 2010. In addition, very few smaller rural and remote communities were able to be visited during the Project. To address this, some community-controlled organisations,

including the executive staff employed in Aboriginal and Torres Strait Islander Community Health Services and other community-controlled organisations were consulted. Some organisations have yet to participate, including representatives of the NACCHO State and Territory affiliated bodies such as the Aboriginal Health Council Western Australia, the Victorian Aboriginal Community Controlled Health Organisation (VACCHO) and the Queensland Aboriginal and Islander Health Council (QAIHC). They were contacted a number of times during this project, but were unable to participate due to other priorities or the tight timeframe.

The aim of the Talking Circle process was to engage Aboriginal and Torres Strait Islander women in the identification and development of a set of priorities and key actions to improve the holistic health status of Aboriginal and Torres Strait Islander women and their extended families and community members. Sandy Angus was responsible for undertaking the consultations and, as an Aboriginal woman, was able to utilise Aboriginal ways of working and networking to her best advantage. Moreover, she was able to 'talk up' the project and encourage Aboriginal and Torres Strait Islander women to 'talk up' (Fredericks 2008a; Moreton-Robinson 2000). Talkin' up in this context means to speak up – outwardly and back to one another and to others. Aileen Moreton-Robinson (2000: 187) in her book, *Talkin' Up to the White Women*, explained the term as 'speaking back'. Within this process demonstrations of resilience and forms of empowerment and re-empowerment can take place with and for Aboriginal and Torres Strait Islander women. Redbird (1995) explains that Indigenous women need to speak of re-empowerment from the perspective that the process of colonisation, which subordinated Indigenous women, has been a process of disempowerment. Drawing on Redbird's work, re-empowerment additionally implies the rebuilding and reviving Aboriginal and Torres Strait Islander women's spiritual and cultural practices accompanied by healing and the claiming of and taking back power (Fredericks 2008b; 2010). As was evidenced during the Talking Circle gatherings and discussions, Aboriginal and Torres Strait Islander women are undertaking their healing work through cultural and creative processes and reclaiming their power through standing up and naming their issues and exercising their sovereignty.

Sandy Angus prepared the Submission (Angus et al. 2009) which outlined the health priorities and plans of action articulated by Aboriginal and Torres Strait Islander women involved in this project. The Submission was used to inform and guide the development of this Strategy.

The Action Areas and Recommendations that follow are based on the issues that Aboriginal and Torres Strait Islander women articulated as being of importance to them and their health and well-being. These issues were raised and discussed during the talkin'up. Each section also includes statistics and evidence to support and frame the argument being made. It is important to note that these Action Areas do not replace any other national or State and Territory identified priorities or needs. This Strategy supplements those identified priorities and needs as articulated by Aboriginal and Torres Strait Islander women.

Action Area A: Supportive Environments

Aboriginal and Torres Strait Islander women often live in unsupported and stressful environments. Aboriginal and Torres Strait Islander women are twice as likely as non-Indigenous women to report high to very-high levels of psychological distress. They also report more of this level of psychological distress than Aboriginal and Torres Strait Islander men (32% compared with 21%).

> **Indigenous women who are employed or have an adequate income are more likely to be happy.**

Family patterns

Supportive environments appear to be responsive to family approaches rather than individual approaches. For example, Aboriginal and Torres Strait Islander women who have children are more likely to complete higher education: 40% of Aboriginal and Torres Strait Islander women without children reported Year 12 as their highest level of school completed, compared to 20% on Indigenous women with children (Australian Insititute of Health and Welfare 2006). This suggests that an important element of a supportive education environment is consideration of the family rather than the individual. Therefore, education institutions need to consider that Aboriginal and Torres Strait Islander women are part of families and ensure that they are family friendly and supportive of families. In addition, there is a need for child care to be available within these institutions and within work places. It needs to be recognised that, while Aboriginal and Torres Strait Islander children are present for much community business, there are times when they need care so that adults can attend to community business, education and employment.

There are particular Aboriginal and Torres Strait Islander family patterns which indicate that Aboriginal and Torres Strait Islander women are more likely to be caring for others than non-Indigenous women. The Aboriginal and Torres Strait Islander population has more one parent families with dependent children (30% compared with 10% for non-Indigenous), fewer one parent families without dependants (about 33% compared with 53%) and a similar percentage of families that are couples with dependent children (about 37%) (Australian Bureau of Statistics 2006). Indigenous households are also larger than other households (an average of 3.3 persons per household, compared with 2.5).

On average, Aboriginal and Torres Strait Islander women have more children than non-Indigenous women (2.8 compared with 2.0). Aboriginal and Torres Strait Islander women are younger when they have their children, with almost half (49%) of Aboriginal and Torres Strait Islander women aged 20-24 years having at least one child, compared with 13% of non-Indigenous women (Australian Bureau of Statistics 2008).

Housing and violence

Housing was identified as a priority. Aboriginal and Torres Strait Islander women experience homelessness and a need for housing support at a higher rate than non-Indigenous women. On average, 1 in every 14 Aboriginal and Torres Strait Islander woman is client of a Supported Accommodation Assistance Program (SAAP), and 1 in every 13 Aboriginal and Torres Strait Islander children accompany their parent or carer to a SAAP agency. These rates are considerably higher than the 1 in 169 for non-Indigenous women and the 1 in 98 for non-Indigenous children (Australian Insititute of Health and Welfare 2009). If basic shelter and other physical needs such as food, water, sleep and safety are problematic for Aboriginal and Torres Strait Islander women and their children then it is problematic and difficult for them to consider other needs or issues such as employment or education (Maslow 1943).

Linked to homelessness is the experience of family violence. Aboriginal and Torres Strait Islander females and males are 35 and 22 times more likely to be hospitalised due to family violence-related assaults than their non-Indigenous counterparts. Aboriginal and Torres Strait Islander hospitalisation rates for family violence-related assault are highest among females and people aged 25–34 years. For Aboriginal and Torres Strait Islander females, one in two hospitalisations for assault are related to family violence, compared to one in five for males. Most hospitalisations (82%) for female family violence-related assault are a result of spouse or partner violence, compared to 38% in males (Al-Yaman, Van Doeland & Wallis 2006).

Throughout the consultations for this project, Aboriginal and Torres Strait Islander women stressed the importance of a holistic approach to addressing violence within their lives and within communities. For example, they wanted family support and counselling, and support for the perpetrators of the violence and the people that support them (sisters, brothers, mothers and aunties), not just support for themselves as a victim of violence.

What did women at the Talking Circle say ...

I announced that I was going to retire at 45 years of age and my work colleagues were stunned. I was 43 years old and my colleagues remarked that I had years left in me. What they did not know is that I had lost three babies before any of them reached 5 years of age, seen the passing of a sister and brother, been adopted as a child, lived in violent relationships and had a range of liver and kidney health problems. I was taking stock of my life and planning for some enjoyment.

The reality is that some of us are going to die before we can access the benefits of superannuation contributions and may therefore make the choice not to make any voluntary payments to superannuation schemes but to utilise the money while we are alive ...

Employment and income

An important aspect of having a supportive environment is access to employment and income. Aboriginal and Torres Strait Islander women who report feeling happy all/most of the time are more likely than those who reported feeling happy a little/none of the time to be employed (47% compared with 35%) and to have access to higher household incomes (27% compared with 16%) (Australian Bureau of Statistics 2007).

Aboriginal and Torres Strait Islander women earn less than their male counterparts, even though they are more likely to complete tertiary education. For example, the median income of full-time employed Aboriginal and Torres Strait Islander women was 95% of the median income of Aboriginal and Torres Strait Islander men working full-time ($680 compared to $718) (Australian Bureau of Statistics 2006). But

Median income

Indigenous woman	$680
Indigenous man	$718
Non-Indigenous woman	$791
Non-Indigenous man	$941

more Aboriginal and Torres Strait Islander females than males complete a postgraduate degree (0.6% compared with 0.2%) or undergraduate degree (2.7% compared with 1.5%).

Although the disparity between gendered incomes was less between Aboriginal and Torres Strait Islander women and men, Aboriginal and Torres Strait Islander women's incomes are far less than that of non-Indigenous women and men. For non-Indigenous women, the median income for those working full-time was 84% of the male non-Indigenous median income ($791 compared with $941) (Australian Bureau of Statistics 2006). More Aboriginal and Torres Strait Islander men than women report employment (58% compared with 44%), and more Aboriginal and Torres Strait Islander men than women report unemployment (11% compared with 8%) (Australian Insititute of Health and Welfare 2006).

When Aboriginal and Torres Strait Islander women participate in employment, they are seen to be participating in the broader market economy. In contrast, as Walter (2007) explains, those who are not employed and are 'marginalised from the market economy become "social problems" external to the system, and the solution to those problems is deemed to lie in the reform of the individual who constitutes the problem' (2007: 162). That is, Aboriginal and Torres Strait Islander people being unemployed is presented as the problem and therefore interventions are required to address the problem. The Howard Government introduced a range of new welfare reform measures that have come to be known by the terms 'Mutual Obligation', 'Income Management' and 'The Intervention' (Moreton-Robinson 2009; Cronin 2007). These 'new' welfare reform measures have been maintained by the current Rudd Government. Cronin (2007) demonstrates how Aboriginal and Torres Strait Islander people are maintained as recipients of welfare reform rather than as sovereign people with rights. He argues (as does Moreton Robinson and Walter) that this results in little change, even with successive governments who argue from different political angles or points of view (Cronin 2007: 179-200; Moreton-Robinson 2009; Walter 2007; 2009).

Health services

Health services, and the sites they operate from and with, are neither politically innocent nor neutral. Furthermore, they can work to marginalise and oppress, or to include and engage (Fredericks 2009a). Health services and health environments are 'instruments of the political: they are embedded with power and unwritten laws informing women, including Aboriginal and Torres Strait Islander women whether they belong or they don't belong' (ibid, p.41).

If Aboriginal and Torres Strait Islander women feel that they do not belong at health services, this will have a direct impact on whether they believe that the services are supportive environments and whether they might access those services. However, if thought, time and energy is built into the design and development of health service environments; then aspects around belonging and ownership can be addressed. Carefully designed health spaces and places can be a successful part of the equation in servicing the health needs of Indigenous women. But carefully designed health services require a commitment from governments and staff to see their services more comprehensively than they presently do. Careful design goes beyond just having the service and how it is delivered, to include issues about from what point or site the service is delivered. Weisman (1992: 10) explains that 'design is a reflection of prevailing social, political and economic values and is often symbolic of the place that each individual holds in society'.

Health services need to look for ways to improve and empower Indigenous women, rather than constrain them. They need to be Indigenous-women friendly, rather than being sites where the dominant culture controls all within the environment and reinscribes colonial stereotypes (Fredericks 2009a). To address this, planners, designers and managers of health spaces and health places need consider how Aboriginal and Torres Strait Islander women access spaces and places. For example, Dyck (1995) and Dyck, Lewis and McLafferty (2003) explore how women manage the physical, social and economic consequences of their illnesses, along with the complex layering of social, economic and political relations that frame their health. Their work suggests that culture and racism impact on the way in which Aboriginal and Torres Strait Islander women experience and engage with places that offer health services. This is supported by Fredericks (2009a: 41), who argues that if Aboriginal and Torres Strait Islander women 'are not part of the design process they are reflected within the social, political and economic values by their absence'.

It is very clear that environments – along with memory, representations, symbols and images – have a major role in showcasing who is of value and who is not. Aboriginal and Torres Strait Islander women can be left feeling marginalised, excluded, under-valued and not supported. They view these environments as unsupportive. Ultimately, unsupportive health service environments impact on and maintain the poor health status of Aboriginal and Torres Strait Islander women, and limit improvements to their health and well-being (Fredericks 2009a; 2009b).

Aboriginal and Torres Strait Islander women need to feel welcome, comfortable, secure and culturally safe if they are going to access and use health services openly, freely and happily, and in an informed and empowered manner. This is supported in research by Kirk et al. (1998), through their research focusing on Aboriginal and Torres Strait Islander women and cervical cancer in Queensland. It was also identified in research focusing on breast cancer screening, diagnosis, treatment and care for Aboriginal and Torres Strait Islander women in Queensland (Kirk et al. 2000a; 2000b). These type of strategies and considerations assist in Aboriginal and Torres Strait Islander women feeling cared about, valued and included and works towards meeting needs (Maslow 1943). It tells Aboriginal and Torres Strait Islander women that they are important too.

What did women at the Talking Circle say ...

I haven't been to any woman's health sites here where they deliver health services for us as Aboriginal women ... there is nothing really here for Aboriginal women, just for us. ... I've done all the baby business so I'm not going there (baby clinic). ... There is nothing here, not even an ethnic or migrant space. I've been to ethnic or migrant spaces and I have felt comfortable..... where there are migrant and ethnic women of colour ...

Action Area A: Recommendations and Measures/Monitoring

1. Include childcare in Aboriginal and Torres Strait Islander employment and education programs.

   Measure/Monitoring: Number of Aboriginal and Torres Strait Islander employment and education programs that have family friendly policy and offer childcare support or have childcare partnerships.

2. Deliver Aboriginal and Torres Strait Islander women's leadership programs aimed at development and advancement.

   Measure/Monitoring: Number of Aboriginal and Torres Strait Islander leadership programs and Aboriginal and Torres Strait Islander women attending leadership programs.

3. Ensure Aboriginal and Torres Strait Islander boards and committees have equal numbers of male and female Aboriginal and Torres Strait Islander members (including government and statutory authority boards and committees).

   Measure/Monitoring: Numbers of Aboriginal and Torres Strait Islander boards and committees with equal numbers of Aboriginal and Torres Strait Islander men and women.

4. Provide community development opportunities to de-normalise violence in Aboriginal and Torres Strait islander communities. For example, promoting the value of Aboriginal and Torres Strait Islander women in the community, men supporting Indigenous women in the community, and healthy cultural forms of communication.

   Measure/Monitoring: Number and reach of programs aiming to de-normalise violence in Aboriginal and Torres Strait Islander communities.

5. Involve Aboriginal and Torres Strait Islander women in the planning, design, development and monitoring of buildings, houses and services, including the choice of sites and building type.

   Measure/Monitoring: Number of Commonwealth and State and Territory housing and community infrastructure programs engaging Aboriginal and Torres Strait Islander women in decision-making.

6. Organisations and agencies to employ and support career advancement of equal numbers of male and female Aboriginal and Torres Strait Islander employees within structural levels.

   Measure: Numbers of Aboriginal and Torres Strait Islander men and women in structural levels of organisations and agencies, particularly government and NGO sectors focusing on Aboriginal and Torres Strait Islander issues.

Action Area B: Health Service Access and Equity

Aboriginal and Torres Strait Islander women's health outcomes suggest that there are inadequate access and equity within health services. In addition, audits of women's health services suggest a lack of organisational cultural competency (Reibel and Walker 2010).

Long-term health conditions

Aboriginal and Torres Strait Islander women report high levels of long-term health conditions (85% report one or more long-term health conditions, compared with 77% of Aboriginal and Torres Strait Islander men). Their prevalence of multiple conditions is also higher, with 68% reporting two or more long-term conditions compared with 58% of Aboriginal and Torres Strait Islander men.

> Indigenous women say their most common health issues are:
> * Eye problems
> * Back pain
> * Heart and circulation
> * Asthma

The most common types of health conditions reported by women are eye/sight problems (54%), back pain/symptoms (23%), heart/circulatory diseases (23%) and asthma (22%).

Compared to non-Indigenous women, Aboriginal and Torres Strait Islander women are 10 times more likely to have kidney disease, 4 times more likely to have diabetes, and almost twice as likely to have asthma (Australian Bureau of Statistics 2007).

The 2006 Census of Population and Housing (Australian Institute of Health and Welfare and Australian Bureau of Statistics 2008) outlines that approximately 4% of the Aboriginal and Torres Strait Islander respondents recorded that they needed assistance with core activities on a consistent basis (p.55). These core activities include: eating, bathing, dressing and general self-care, mobility and communication. The level of assistance required by Aboriginal and Torres Strait Islander people was twice as high as the assistance required by the Australian population (ibid. p.55). Aboriginal and Torres Strait Islander women with long-term health conditions and disabilities are more likely to report high/very high levels of psychological distress than women with no long-term health condition (34% compared with 21%) (Australian Bureau of Statistics 2007).

What did women at the talking circle say ...

People think it will take lots of money to fix our health problems and sometimes it might but often what we need is a small but genuine and significant shift in the way services are offered and delivered.

Mortality and premature ageing

Between 1996 and 2001, the life expectancy at birth for Aboriginal and Torres Strait Islander women was estimated to be 65 years – around 17 years lower than for all Australian females for the period 1998-2000 (Australian Bureau of Statistics & Australian Institute of Health & Welfare 2005). The three leading causes of death among Aboriginal and Torres Strait Islander women are diseases of the circulatory system; neoplasms (cancer); and endocrine, nutritional and metabolic diseases (including diabetes) (Australian Bureau of Statistics 2007). The most common neoplasms (cancers) causing death were of the respiratory and intrathoracic organs (mainly lung). Digestive organ neoplasms were each responsible for 20% of the deaths from cancer among Aboriginal and Torres Strait Islander females, and 'malignant neoplasms of the female genital organs' (mainly cervix cancer) for 17% (Australian Bureau of Statistics 2007).

In 2004-05, around one-third (32%) of Aboriginal and Torres Strait Islander women aged 40 years and over reported having regular mammograms, and just over half of those aged 18 years and over reported having had regular pap smear tests (52%) (Australian Bureau of Statistics 2006).

Disabilities and premature ageing is a particular concern for Aboriginal and Torres Strait Islander people, and younger age of chronic disease onset has been acknowledged as a barrier to accessing appropriate care – particularly as Aboriginal and Torres Strait Islander clients do not fit the normal patient profile for chronic disease and present as anomalies in a wider health system (Peiris, Patel et al. 2009).

What did women at the Talking Circle say ...

For me, closing the gap will be when I next go to my support group meeting and I am not 30 years younger than everyone else, not the only 45 year old woman sitting there, with a group of other Australian [white] women where the youngest in the group is 72 years old and the oldest in the group is 90 something years old and we are all there because we need a heart lung transplant! It shouldn't be that we are there at a much younger age and that I am the only Aboriginal women there [probably] because the rest of my sisters have already died and not made the support group or the operation. I know they have died because this is such a health problem in our communities! … And you know what? … Never in my life did I ever smoke or drink [alcohol]. So if people say it is all my fault that I have these health issues because [all] Aboriginal people are drunks then I am the evidence they need to prove them wrong….. Kathy Malera Bandjalan

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Pregnancy and childbirth

Pregnancy, birth and child rearing are common life experiences for Aboriginal and Torres Strait Islander women and their families. In 2003, 14.1% of babies born to Aboriginal and Torres Strait Islander mothers were preterm (before 37 weeks gestation), compared with 7.6%

of babies of other mothers. Low birth weight babies (less than 2,500 grams at birth) were also more common (13%), compared to babies born to other mothers (6%). The perinatal mortality rate for babies of Aboriginal and Torres Strait Islander women was twice that for babies born to non-Indigenous women (Australian Institute of Health and Welfare 2008). Poor antenatal care access and birth outcomes for infants is linked to the development of chronic disease later in life (Eades 2004).

Sexual health and blood borne viruses

Sexual health is a key concern for Aboriginal and Torres Strait Islander women.

In 2008, the rate of chlamydia in the Aboriginal and Torres Strait Islander population in major cities was three times that among the non-Indigenous population; in remote and very remote areas, it was seven times that among the non-Indigenous population. The female to male ratio of chlamydia for Aboriginal and Torres Strait Islander and non-Indigenous people were 1.7:1 and 1.4:1.

Aboriginal and Torres Strait Islander women contract HIV at a higher rate than non-Indigenous women, suggesting a differing pattern of HIV transmission in the Aboriginal and Torres Strait Islander population. In 2008, the male to female ratio of HIV diagnoses in the Aboriginal and Torres Strait Islander population was 3.75, compared to 16.0 in the non-Indigenous population. HIV transmission in Aboriginal and Torres Strait Islander people compared to non-Indigenous people was higher for heterosexual contact (23% compared with 13%) and injecting drug use (22% compared with 3%) and lower for male homosexual contact (54% compared with 79%). Hepatitis C is also higher for Aboriginal and Torres Strait Islander women. In 2008, it was 13 times the rate for non-Indigenous females in the 15-19 age group, and 3.7 times the rate in the 20-29 age group.

Promoting well-being

Aboriginal and Torres Strait Islander views of health include a strong social element, and Aboriginal and Torres Strait Islander women have many social practices associated with well-being promotion. Arts and crafts are an important part of expression of identity for Aboriginal and Torres Strait Islander women. They are practiced in differing forms across Australia and often involve social gatherings of women. For example, they can include basket making, shell crafts, jewellery making, possum skin cloak making and painting, to name a few. Studies of mind-body responses have found that repetitive craftwork initiates a relaxation response, lowering blood pressure and reducing chronic disease risk (Benson 2000).

Aboriginal and Torres Strait Islander women express culture and identity by regularly walking their country to gather food and observe and interact with nature, science and the land. Walking is well known to improve well-being (Pucher and Dijkstra 2003) and is also associated with relaxation response (Benson 2000). Aboriginal and Torres Strait Islander women also

express culture and women's well-being by cooking together as a group. Social connection and peer support are well documented as improving people's health in a number of ways (Callaghan and Morrissey 1993). This can all work to improve and promote Aboriginal and Torres Strait Islander women's wellbeing even while experiencing high levels of illness and disability.

What did women at the Talking Circle say ...

These are not my recreational and relaxation activities, this is my healing work …
Lyn Stewart

…..Our organisation is so poor we can't afford to provide coffee and tea let alone tucker yet this works ... we appreciate that people will invite us in and sit and share some tucker and we like to do the same but we don't have that kind of funding built into any of our programs ...

There was one on one, the workers were friendly and I felt really relaxed. The worker could devote that time with you…

Action Area B: Recommendations and Measures/ Monitoring

1. Implementation of cultural safety[1] accreditation and annual audit by women's health providers. This should include policy review, physical environment review (such as Aboriginal and Torres Strait Islander relevant posters, artwork, flags and pamphlets), staff cultural competency training, partnerships with Aboriginal and Torres Strait Islander health services and Aboriginal and Torres Strait Islander women members of organisation boards and committees.

   Measure/Monitoring: Number of women's health services undertaking cultural safety accreditation and audits

2. Implementation of premature ageing policy and programs by women's health providers for Aboriginal and Torres Strait Islander women. For instance, home and community care or rehabilitation support for women experiencing early onset of chronic conditions.

   Measure/Monitoring: Number of women's health services with policy and programs aimed at supporting Aboriginal and Torres Strait Islander women experiencing premature ageing.

3. Provision of social/cultural health and peer support opportunities and programs – such as basket making, textile and fibre work, shell and wood works, story work and social food gathering and cooking.

   Measure/Monitoring: Number of social/cultural health and peer support opportunities and programs for Aboriginal and Torres Strait Islander women

4. Report on Aboriginal and Torres Strait Islander women's participation and outcomes in women's health services, such as, cancer screening, STIs & BBVs notifications, birth outcomes, chronic disease outcomes etc.

   Measure/Monitoring: Reporting conducted on Aboriginal and Torres Strait Islander women's participation and outcomes by women's health services.

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[1] Cultural safety is a term conceived by Maori Nurse Irihapeti Ramsden which means that there is no assault on a person's identity when accessing or interacting with a service (Stout and Downey 2006).

Action Area C: Women in the Health Workforce

Approximately 70% of the Aboriginal and Torres Strait Islander health workforce is made up of women (a total of 961). How many of these specialise in women's health areas is unknown (Australian Insititute of Health and Welfare 2009).

What we do know about Aboriginal and Torres Strait Islander Health Workers is that there is a high level of burn out and concerns about perceptions and recognition of their position within the wider health workforce and community (Tim 2002; Mitchell and Hussey 2006).

Aboriginal and Torres Strait Islander Health Workers specialising in women's health are funded by differing State and Commonwealth government programs. Professional and peer support networks for these women are limited, with this group rarely coming together for professional development or peer support opportunities. Networks tend to centre on the specific program being delivered, allowing only limited exchange and sharing of information.

> Aboriginal and Torres Strait Islander Health Workers expressed interest in furthering their careers in their own profession as well as other professions such as nursing and medicine and allied health.

What did women at the Talking Circle say ...

That's why you don't see us blackfellas there. It isn't that we are not interested in the topic if we have the money to go it is like one big long reunion except that we notice all the ones who have passed away and it's been years since we had the opportunity to catch up ... sad you know ... cuts to the heart ... and it impacts on our health.

Aboriginal and Torres Strait Islander Health Workers express interest in furthering their careers in their own profession as well as in other professions such as nursing and medicine. Barriers to further education include support, infrastructure and promotion (Felton-Busch, Solomon et al. 2009).

Apart from Aboriginal and Torres Strait Islander Health Workers, we know little about Aboriginal and Torres Strait Islander women working in the health workforce. Although numbers of Indigenous nurses and medical practitioners are reported, gender and specialist areas are not available (Australian Insititute of Health and Welfare 2009). We do know that Aboriginal and Torres Strait Islander people are underrepresented in undergraduate and postgraduate health courses and, although there has been a general trend of increasing numbers of students, a drop in numbers did occur in 2006 (Australian Insititute of Health and Welfare 2009). An estimated 2% of Aboriginal and Torres Strait Islander males and 4% of

Aboriginal and Torres Strait Islander females study at university or other higher education institution, compared with 5% of non- Indigenous males and 6% females (Australian Insititute of Health and Welfare 2006).

Outcomes that have been associated with increased employment include access to increased income and improved health status, self-esteem and well-being (SCRGSP 2007; Walter 2009; 2007). These outcomes are also the expected outcomes for Aboriginal and Torres Strait Islander women who participate in employment. The widely-expressed sentiment that all would be well if Aboriginal and Torres Strait Islander people 'would' or 'could' just 'get a job' fails to consider the historical processes and impacts of colonisation and the racialised social structures that impact on the daily lives of Aboriginal and Torres Strait Islander people and communities (this sentiment is clearly expressed in a number of government policies, Australian newspapers, and letters to the editor). 'Welfare dependency is depicted as the source of social and economic marginalisation rather than marginalisation seen as enforcing welfare dependency' (Walter 2007: 162). In essence, Aboriginal and Torres Strait Islander people are depicted as deficient and requiring change, rather than the systems that maintain the dominance and structural inequalities requiring change. It is not about just getting a job and developing employment programs for Aboriginal and Torres Strait Islander women. The historical processes and impacts of colonisation and the racialised societal structures that impact on the daily lives of Indigenous women and communities also need to be addressed (Walter 2009).

What did women at the Talking Circle say ...

We can't go back .. it's just too damn late … we have lost so much – culture, family members, loved ones, language, land, roles and a job and decent ways to make a living – and we don't want to lose any more. We need to know how to work in the right way, to live in a changing world and yet we want to keep our cultural heritage. Do you understand what I am saying? Does what I have said make any sense to you? Because I have already said it so many times before.

Employment strategies

Strategies to employ Aboriginal and Torres Strait Islander people have been used by health and human service work places, housing and education departments, and social security, to address the needs of the Aboriginal and Torres Strait Islander populations they service. A number of government departments and agencies introduced Aboriginal and Torres Strait Islander employment strategies in the 1980s and 1990s to increase the recruitment and retention of Aboriginal and Torres Strait Islander people within their workplaces.

Australia has also witnessed the growth of specialised Aboriginal and Torres Strait Islander positions – also termed 'identified' or 'Aboriginal and Torres Strait Islander specific' or 'Indigenous designated' positions. Today, Aboriginal and Torres Strait Islander designated positions are in place in most government departments and agencies, and in some large non-profit community-based organisations. These include Aboriginal and Torres Strait Islander hospital liaison officers, program co-ordinators, field workers, health workers, research officers, health promotion officers, chronic disease coordinators, and many more such positions. There may also be positions which have 'Indigenous' or 'Aboriginal and Torres Strait Islander' written after the position title, for example, Public Health Nutritionist (Aboriginal and Torres Strait Islander Health).

Designated Aboriginal and Torres Strait Islander positions are not unique to the health arena, nor to any one government department or state or territory. For example, there are Aboriginal and Torres Strait Islander liaison officers, Indigenous project officers and policy officers in corrective services, juvenile justice sections, policing, housing, education and legal services.

The strategy of introducing designated positions has been replicated many times and this, coupled with the areas in which Aboriginal and Torres Strait Islander people work, has resulted in a strongly segregated Aboriginal and Torres Strait Islander workforce in terms of occupational type and employment sector (Walter 2007). A large proportion of Aboriginal and Torres Strait Islander people work in government employment and, despite the growth of the private sector employment market, Indigenous employment has declined within this market since 1991 (ABS 2001; Walter 2007).

While there has been growth in the number of Aboriginal and Torres Strait Islander designated positions or units within government departments and agencies, this does not mean that these positions are always occupied by Aboriginal or Torres Strait Islander people. Designated positions can also be occupied by non-Indigenous people. This issue was discussed a number of times at the Talking Circle workshop in Brisbane on 30 April 2010. For participants, this was not necessarily an issue when there are no suitably qualified Aboriginal and Torres Strait Islander people available to undertake the position and a strategy is developed so that there will be qualified Aboriginal and Torres Strait Islander people for such positions in the future. But it becomes an issue in communities or workplaces when Aboriginal and Torres Strait Islander people believe that there are a number of Aboriginal and Torres Strait Islander people who are suitable for the position and are not selected. In addition, it may increasingly become an issue when a non-Indigenous person occupies a position and there are Aboriginal and Torres Strait Islander people waiting for that person to move on to another role, retire or realise that 'maybe the reason they gained the position is no longer the reason they should be staying in the position' or that 'there may be other ways they can assist Aboriginal and Torres Strait Islander peoples and the struggle for social justice than occupying the position they are in' (Fredericks 2009c: 26). In this scenario, non-Indigenous people are

maintaining and protecting their own interests in Aboriginal and Torres Strait Islander issues by the denial and exclusion of Aboriginal and Torres Strait people (Moreton-Robinson 2004).

In order to make real differences for Aboriginal and Torres Strait Islander women, more Indigenous women need to be employed not just in service delivery but also 'in areas where they can participate in making organisational structural changes, to challenge the status quo and to address areas where ideological and theoretical differences can be developed and implemented' (Fredericks 2009c: 32). The strategy of designated positions may work against this goal. If Aboriginal and Torres Strait Islander women are employed to fill designated positions and to maintain the status quo or make slight adaptations, the marginalisation of Aboriginal and Torres Strait Islander women will continue (Moreton-Robinson 2000). Fredericks (2009c) states that 'if health services, systems and governments only ever appoint or employ Aboriginal people who fit into the Eurocentric frameworks of whiteness and never challenge or question, then some cosmetic changes will occur and some minor improvements will take place, but the entrenched stratified situation will remain' (p.32). In this case, Aboriginal and Torres Strait Islander women will continue to be marginalised, their health status will remain poor, and they still be considered the most disadvantaged group of people in Australia (Australian Bureau of Statistics 2008; Walter 2009).

In considering employment of Aboriginal and Torres Strait Islander people within designated positions, employers need to 'work out whether they want someone who will "fit in" within their work environment, who will organise a NAIDOC display once a year and canvass Aboriginal clients, or whether they want to challenge the way they operate and function, their philosophies and even the core values of their organisation, institution or agency or whether they want to do both' (Fredericks 2009c: 32).

Employers should also consider the employment of Aboriginal and Torres Strait Islander people for non-identified positions. Aboriginal and Torres Strait Islander people are part of the Australian population and hence should also be part of the Australian workforce. Workforce initiatives that are already in place to increase the number of Aboriginal and Torres Strait Islander people across all areas of the health workforce need supporting and strengthening.

A number of Aboriginal and Torres Strait Islander women who had worked over long periods of time or who were working expressed concerns regarding superannuation, early retirement provisions and Centrelink entitlements along with how dependent status was recognised. It was articulated that superannuation laws and entitlement rulings needed to be changed to reflect chronic disease patterns and levels of disability as experienced by Aboriginal and Torres Strait Islander women. It was additionally noted that the current laws governing superannuation schemes are restrictive in whom they classify as dependents. Therefore they also needed to be changed to reflect cultural differences in who may be classified as dependent.

Action area C: Recommendations and Measures/Monitoring

1. Promote the role and importance of Aboriginal and Torres Strait Islander Health Workers working in women's health.

   Measure/monitoring: Number of scholarships and promotional activities for Aboriginal and Torres Strait Islander women to work in Indigenous women's health. Regular opportunities for Aboriginal and Torres Strait Islander Health Workers working in women's health to come together, for instance, through continued meeting of the Aboriginal and Torres Strait Islander Women's Health Talking Circle or Indigenous Women's Alliance

2. Increase the number of Aboriginal and Torres Strait Islander women working and studying in the health workforce particularly in women's health areas.

   Measure/monitoring: Number/proportion of Aboriginal and Torres Strait Islander women studying and working in health areas and in women's health. Regular opportunities for Aboriginal and Torres Strait Islander women working in women's health to come together, for instance, through continued meeting of the Aboriginal and Torres Strait Islander Women's Health Talking Circle or Indigenous Women's Alliance

3. Biannual Aboriginal and Torres Strait Islander women's health conference.

   Measure/monitoring: Biannual Aboriginal and Torres Strait Islander women's health conference and evaluation.

Action Area D: A National Policy Officer

A commonly identified element in success of policy implementation across localised and broader cross regional areas is where advocacy and support for the policy implementation exists. This includes the presence of a human interface between the written policy and the wider world of stakeholders (Plumer, Kennedy & Trojan 2010). In Indigenous health, leadership with clear and consistent messages for health service quality improvement have been identified as important (Gardner, Dowden, Togni & Bailie 2010). To ensure this strategy is implemented there needs to be a human interface that provides this leadership and consistency. The employment of an Indigenous Women's Health Senior Policy Officer will be essential to ensure that recommendations from this strategy are implemented in a consistent way and measures and monitoring are conducted. Currently there is no national position and communication and networking of differing programs at State and Territory and National levels is limited and ad-hoc. Women's health programs (such as, Healthy for Life, cancer screening, maternal and child health, domestic violence and social and emotional well-being) have resources and processes aimed at improving women's health and improved networking and communication between these areas would enhance delivery.

What did women at the Talking Circle say...

I am constantly being contacted by people looking for information about women's health programs and resources. There needs to be better co-ordination so that women aren't re-inventing the wheel all the time with developing resources and programs. I can't keep up with my full time job anymore as well as do this work, it's too stressful, there needs to be a position that co-ordinates this type of activity. When people ask me who do I contact about Indigenous women's health at the national level I think there isn't really anyone employed to do this….

A National Policy Officer

Action Area D: Recommendations and Measures/Monitoring

1. Employ a National Aboriginal and Torres Strait Islander Women's Health Senior Policy Officer.

   Measure/Monitoring: Employment of National Aboriginal and Torres Strait Islander Women's Senior Policy Officer that co-ordinates implementation of this strategy.

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Glossary of Terms

The use of the word "Indigenous" women when used in this document refers only to Australian Aboriginal women and not to other Indigenous women of other countries.

ACCHS	Aboriginal Community Controlled Health Service
ACCHO	Aboriginal Community Controlled Health Organisation
ADoHA	Australian Department of Health and Aged Care
AHW	Aboriginal Health Workers
AIDA	Australian Indigenous Doctor's Association
AMS	Aboriginal Medical Services
AMS	Aboriginal Medical Service
APsP	Aboriginal Pap smear Provider
AWHN	Australian Women's Health Network
AWHN-TC	Australian Women's Health Network Talking Circle
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CRANA	Community Remote Area Nurses Association
CRCAH	Cooperative Research Centre for Aboriginal Health
DGP	Divisions of General Practitioners
DOGGIT	Deed of Grant in Trust (Community)
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
FAYS	Family Aboriginal Youth Service
FPNSW	Family Planning New South Wales
HPV	Human Papillomavirus
HWI	Healthy Women's Initiative
MOU	Memorandum of Understanding
MWHN	Mobile Women's Health Nurse

NACCHO   National Aboriginal Community Controlled Health Organisation

NWHP   New Women's Health Policy

OATSIH   Office of Aboriginal and Torres Strait Islander Health

PO   Project Officer

QAIHC   Queensland Aboriginal and Islander Health Council

RFDS   Royal Flying Doctor Services

STDs   Sexually Transmitted Diseases

VACCHO   Victorian Aboriginal Community Controlled Health Organisation

WACCHO   Western Australian Community Controlled Health Organisation

AHCWA   Aboriginal Health Council of Western Australia

Appendix One: Talking Circle Participants

Listed are the names of over four hundred (400) people, mainly women who participated in individual face-to-face consultations, group meetings, workshops, focus groups and/or who provided written or verbal feedback via email or telephone conversations in the project work that lead to the submission (Angus et al. 2009) and to this document. Sincere apologies to anyone whose name is spelt wrongly or not included in this list (attempts were made to ensure correction). Not all women wanted their names recorded and that request was respected.

Agnus Abott	Djaumbi Marika	Karen Glover
Ali Weston	Donna Sadler	Karen McNulty
Alisi Nasila	Dorinda Cox	Kate Challinger
Alison Bairnsfather-Scott	Dorothy Burton	Kate Giambazi
Andra Challinger	Elaine Peckham	Kate Lamb
Anna McGowan	Elvie Sandow	Kate Lamb
Anne Edwards	Frances Mathyssen	Kathy Malera Bandjalan
Annette Rabbitt	Frances Ryan	Katrina Stafford
Averil Scott	Freda Ogilvie	Kay Hookey
Avril Lowenhoff	Gail Keating	Kay Walley
Barbara Cox	Gail Smith	Kelly-Lee Hickey
Belinda Wilson	Gillian Ingram	Kerry Walker
Belita Gadd	Gwendolyn Gray	Kerry Walsh
Bonita Sansbury	Heather Castledine	Kim McCausland
Bronwyn Fredericks	Honey Highfold	Kim Morey
Carmel Murtagh	Ingrid O'Loughlin	Kylie Mogg
Carol Barlow	Iris McCleod	Kylie Shadford
Carol Hudson	Isabelle McCleod	Laverne Bellar
Carole Taylor	Jean Mack	Leanne Miller
Catherine Bolton	Jeanette James	Leanne Pilkington
Catherine Jacka	Jeanette Springham	Leeanne Hunter
Catherine McLaren	Jenny Harris	Leonie Dickson
Celia Moore	Jessica B-Scott	Lily Arthur
Cheryl Cowen	Jill Steele	Linda Hookey
Chris Kingsnorth	Jillian Skinner	Linda Lewis
Chris O'Brien	Jo-Anne Nicol	Linda Mc Bride -Yuke
Christine Cutts	Joanne Simpson	Linda Sexton
Christine Hookey	Jocelyn Hanson	Lisa Cook
Cindy Macklin	Jordana Angus	Lisa Peberdy
Cindy Turner	Joy Williams	Lisa Pigliafiori
Claudia Callus	Judith Parnham	Liz Hurrell
Colleen Williams	Judy Lirririnyin	Liz McEntyre
Coral Mack	Julie Gapalthana	Lorna Bosen
Coral Walker	Karen Bangarrapa-Bukulatjpi	Lorraine Webb
Courtney Hala	Judy Watego	Marilyn Wommatakimi
Daphne Bounghi	Julie Jackson	Teresia Portammi
Dawn Ross	Julie Maloney	Lucy Quartey
Dee Wallis	Julie Spratt	Luita Casey
Del Leslie	Julie Wright	Lyn Martin
Delvene Clarke	June Magrath	Lynette Miller
Delvene Cockatoo-Collins	June Sculthorpe	Linda McDinny
Denele Crozier	Kali Sailor	Lynette Moore
Denese Griffin	Karen Adams	Lynette Wanganeen

Talking Circle Participants continued

Lesley Barratt	Pat Stewart	Sheryl Cimera
Lesley Reilly	Pat Waria-Read	Shirley Fender
Lillian Simpson	Peta Sutton	Sister Phyllis Robertson
Mally Smart	Petah Hegarty	Staff - AWHN
Margaret Hampton	Phillipa Cook	Staff - Family Planning
Margaret Russell	Regina Coleman	Stephanie Hawkes
Margaret Stanley	Renae Longbottom	Stephanie Radke
Maria Grivorova	Rhonda	Susan Brophy
Marie Johnson	Rhonda Banks	Susan Wason
Marilyn Richardson	Ritjilli Manybarr Ganambarr	Susanne Ne
Marilyn Wise	Rose Nean	Teena Moffatt
Marion Bateup	Roseanne Longford	Terry Cubillo
Marion Edmondson	Roxanne Brown	Terry Stewart
Marlene Liddle	Elaine Gumun Dhamarrandji	Thelma Weston
Mary Bloxome	Tanya Dhamarrandji	Tinesha Miller
Mary Eatts	Rosie Smith	Tracey Eades
Mary King	Ruth Primrose	Tracey Hampton
Mary Myers	Sal Rogers	Tracey Quinn
Mavis Ingle	Samantha Hookey	Tracey Smith
Megan Howitt	Sandra Angus	Trish Heal
Melissa Wellington	Sandra McElligott	Tristan Martin
Merlee Simpson	Sandra Soki	Val Dearman
Merrissa Jose	Sandra Wallace	Val Dearman
Michelle Dixon	Sarah Bright	Valentina Snider
Michelle Fisher	Selena Lyons	Valma Mason
Muriel Brandy	Shai Grigg	Valmay Fisher
Natalie Kopp	Sharon Clarke	Veronica Riordan
Natalie Lloyd	Sharon Gallagher	Wendy Pomery
Norah Ansey	Sharon Nicholson	Yvonne Bell
Norma Shelley	Shelley Wellington	Yvonne Hill
Pamela Simon	Shelly Wellington	Yvonne Lenihen
Pamela White	Sherma Ugle	Zoe Luz

Appendix Two: AWHN Participants

The State and Territory participants of the Australian Women's Health Network - Talking Circle meeting held in Adelaide on 17th April 2009.

South Australia
Karen Glover
Christine Wilson
Debra Axlelby
Glenyise Coulthard
Ingrid O'Loughlin
Kerri Wilson
Kerry Rogers
Liz Hurrell
Mandy Ahmat
Joanne Wilmot
Sandra Miller

Western Australia
Dot Henry
Deanna Eades
Vicki Lambert

Tasmania
Jeanette James
June Sculthorpe

Australian Capital Territory
Jilpia Jones

Northern Territory
Marlene Liddle
Julie Wright

Queensland
Sandy Angus
Colleen Williams

New South Wales
Melissa Wellington
Shelly (Michelle) Wellington
Tracey Quinn

Victoria
Jody Saxton

Commonwealth Government
Maria Travers
Georgia Philips

Apologies
Maleta Nona, Torres Strait Islands

Australian Women's Health Network
Marian Edmondson
Vicki Lambert
Gwen Gray

Appendix Three: Workshop Participants

The participants at the Australian Women's Health Network – Talking Circle workshop held in Brisbane on 30 April 2010.

Gwen Gray (National Convenor, AWHN)

Irene Peachy (NACCHO)

Jenny Springham

Hazel Fisher

Leanne Gray

Louise Coutts

Celia Moore

Sharon Clarke

Leonie Dickson

Jeanette James

Dorinda Cox

Lorna Yarran

Catherine Jacka

Velmay Fisher

Cherissma Blackman

Vicki Lambert

Megan Howitt

Julie Wright

Charlene Lui

Wendy Lewis

Marion Edmondson

Jacqueline McCann

Louise De Busch

Karen Adams

Sandy Angus

Bronwyn Fredericks