



YWCA NSW & WomenSpeak Community Consultation:

*Aboriginal & Torres Strait Islander
Women's Health & Wellbeing*

FINAL REPORT



Supporting people at critical times



Contents	Page
YWCA NSW	3
WomenSpeak	3
Objectives	4
Overview of the Day	4
Record of Discussion	6
Smoking Cessation	6
HIV & Hepatitis C	6
Family Planning	7
Chronic Disease	8
Diabetes	8
Health Planning for our Elders	9
Healthy Relationships	10
Obesity	10
Mother & Baby Support	11
Complementary and Alternative Medicine	11
Representation of Aboriginal people in health and community services	12
Transport and Access	13
Young People and Sexual Health	14
Closing the Gap – Summary of Findings of the Day	16
Aboriginal Workers	16
Service Providers	16
The Sector	17
Government and Policy	17
Philosophy and Cultural Awareness	18
How Non-Aboriginal Women Can Stand Together in Solidarity with Aboriginal Women	18
Summary of Evaluation Findings	20

This report is a record of the consultation. The content and opinion expressed in the report represent the views of those who attended the day only. They do not necessarily represent views of YWCA NSW.

Please note that where the term 'Aboriginal' is used this refers to all Aboriginal and Torres Strait Islander people.

YWCA NSW

The YWCA is one of the largest NGOs in the world working in 132 countries across thousands of communities to support 25 million people experiencing vulnerable times. YWCA NSW is a not for profit organisation led by women, working in disadvantaged communities throughout NSW. Our aim is to stop the transfer of intergenerational disadvantage, delivering innovative programs & services tailored to meet the needs of the families living there. We contribute to our own long-term financial sustainability through a social enterprise model which includes two Sydney based Hotels and other independent revenue streams. We support vulnerable people, at those critical transitions periods in life when they are more prone to fall through the gaps, equipping them with the skills, training and support they need, as well as the practical assistance, to feel confident and connected in their lives. Transition points include the 'home to school' transition, 'school to work or further study', and the transition to parenthood. Our aim is develop connected people engaged in their community. We strive to promote inclusive, sustainable communities. Our 'Y It Takes A Village' strategy underpins all of our work and this is centred upon collaborating with key community and service providers to ensure services are coordinated, effectively targeted and achieve the best results for people and the area in which they live.

YWCA NSW currently delivers a suite of more than 60 programs to meet the needs of over 15,000 people across approximately 90 communities. Many of these programs directly engage Aboriginal individuals and families. We are extremely proud of our Aboriginal Encore program, a unique gentle exercise program for women who have experienced mastectomy, lumpectomy or breast reconstruction surgery at any time in their lives. We recently saw the start of our Aboriginal Women's Healing program, a program developed and delivered by Aboriginal women specifically for Aboriginal women which is being delivered in Lismore, Nowra and Kempsey. The Y has a long history of involvement in reconciliation projects in NSW and we thank the WomenSpeak network for giving us the opportunity to consult and connect with Aboriginal women from across NSW on this occasion.

You can find out more about the work that YWCA NSW does at www.ywcansw.com.au.

THE WOMENSPEAK NETWORK

The WomenSpeak Network is one of four national women's secretariats that are supported by government as a way to get policy advice on issues important to women. WomenSpeak is a network of 37 non-government organisations that have a specific focus on the impacts of policy and service delivery on women in Australia. WomenSpeak Network is funded by the Australian Government Office for Women to undertake consultations through its members on issues affecting women in Australia. While they have done some great work over the last six years of operation, one issue they have continued to be concerned about is how to better support Indigenous organisations to be involved in the network, and how organisations can better meet their responsibilities in responding to issues that impact on Aboriginal women.

This concern led WomenSpeak to reflect over the last year on how better to do this, and resulted in a project proposal entitled 'Inclusiveness and Representation: WomenSpeak Network exploring new ways to stand in solidarity with Aboriginal and Torres Strait Islander women'. A core activity of the proposal was to support state and

territory women's consultations and gatherings between women's organisations and Aboriginal and Torres Strait Islander women and organisations.

The project objectives were:

1. Listening to Aboriginal and Torres Strait Islander women: WomenSpeak Network support empowerment of Aboriginal and Torres Strait Islander women and organisations to be involved in national policy development and implementation.
2. Doing things better: WomenSpeak Network assist member organisations improve processes, structures and service delivery in terms of better support and partnership with Aboriginal and Torres Strait Islander women.
3. Dialogue with government: WomenSpeak Network advocate for Australia's national policies to respect, protect and fulfil human rights for Aboriginal and Torres Strait Islander women.

The outcomes from the consultation events are to be collated and submitted in a national report for the Office for Women at the end of the year. This will be available on the YWCA NSW website at www.ywcansw.com.au under the 'latest news' section.

OBJECTIVES

WomenSpeak consultation events have taken place around the country in 2008. The NSW event took place on Monday 15th September, bringing Aboriginal and Torres Strait Islander and non-Aboriginal women together to discuss women's health and wellbeing. The objectives of the day were as follows:

1. To obtain recommendations for action for the report to be submitted to the Federal Office for Women.
2. To give opportunities for all women to understand and share the health issues affecting Aboriginal communities.
3. To provide a forum for discussion regarding the potential for collaboration between Aboriginal and non-Aboriginal women in addressing these concerns.

OVERVIEW OF THE DAY

The day was opened by Gayle Osborne, Head of Programs and Services at YWCA NSW. This was followed by a Welcome to Country and dance by local Elder Aunty Ali Golding. Lillian Holt and Jo Wilmot from Relationships Australia (South Australia) spoke to the audience about Whiteness and Wellbeing followed by Lesley Russell from the Menzies Institute of Health who outlined what the gap between health outcomes for Aboriginal women and non-Aboriginal women looks like. Denele Crozier from Women's Health NSW introduced Faye Worner from Waminda (South Coast Women's Health & Welfare Aboriginal Co-op) and Tracey Quinn from Cumberland Women's Health who spoke about best practice initiatives in Aboriginal health.

Over 150 women attended the consultation, 40% of whom identified as Aboriginal. The majority of the day was spent in small discussion groups, in the morning these looked at specific issues associated with health and wellbeing; the outcomes from these sessions are outlined in this report. The afternoon discussions considered the concept of 'Closing the Gap' more broadly. These discussions provided vital opportunity for non-Aboriginal and Aboriginal women to talk together, learning about

the issues and sharing emerging practice from the field. Dot Henry an Aboriginal member of WomenSpeak who has been a driving force in these gatherings spoke about the need for a representative body for Aboriginal women in the afternoon. The day was brought to a close with a brief speech by Gayle Osborne followed by an Aboriginal dance performance from local Thulli dancers.

Opportunity for networking was a key component of the day. An hour was provided for lunch during which there were performances from local Aboriginal singers and songwriters; Rhubee Neale and Kenneth Smith, Krista Pav and Nadeena Dixon. Many attendees made comment about the value of the networking and relationship building opportunities that they experienced throughout the day. We were made aware of many of the connections made; women arranging meetings to discuss ways to integrate their programs and learn from one another, women offering their time to volunteer for organisations represented, Aboriginal PhD students gaining knowledge and contacts to progress their research projects, and one woman was even reunited with someone that they went to university with many, many years ago!

RECORD OF DISCUSSION

All outcomes below have been taken directly from written feedback by both Aboriginal and non-Aboriginal women from discussions where both Aboriginal and non-Aboriginal women were present. The general issues associated with the topic are presented first, followed by examples of good practice in the field and then the recommendations made by the discussion group.

▪ Smoking Cessation

50% of the Aboriginal community smoke and children start younger than their non-Aboriginal counterparts. Elders and staff from Aboriginal controlled organisations regularly smoke, so there is a lack of positive role models to support giving-up or not starting smoking. Generally it was felt that there is a perception within the health and community services sector that smoking cessation is not a priority issue; there are also cost barriers to smoking cessation. There is a lack of Aboriginal target measures to encourage smoking cessation.

Two programs were mentioned that people were aware of in this arena: Smoke Check run by the University of Sydney and a smoking cessation program run by the Greater Western Area Health Service for health workers and their families.

The **recommendations** made for those developing policy were as follows:

- Integrate smoking cessation programs into maternal health programs.
- Denormalise smoking – there is a need for a targeted, Aboriginal specific smoking cessation program:
 - o Has to be about talking, not just posters.
 - o Has to work with Elders to get them to stop smoking.
 - o Has to work with peers to reduce peer pressure to smoke.
 - o Could integrate healthy eating/make the links between being able to taste your food if you stop smoking.
- Ensure nicotine replacement therapy gets onto the pharmaceutical benefits scheme for Aboriginal people.
- Do not focus on smoking bans.
- Fund research to provide an evidence base for Aboriginal smoking cessation programs, identify culturally appropriate approaches and then fund their implementation.

▪ HIV and Hepatitis C

Hepatitis C is four times more prevalent in the Aboriginal community. There is the same rate of HIV infection in Aboriginal and non-Aboriginal populations but the break down in route of transmission is different. For example, injecting transmission is about 18% in the Aboriginal population, but makes up only 3% of transmission in the non-Aboriginal population. Individuals are often infected with HIV and hepatitis C together due to transmission through injecting. The major point raised in this discussion is that there is reluctance to talk about HIV & hepatitis C especially around major routes of transmission e.g. injecting drug use. Stigma & shame stifles conversations. There is a need to increase the number of conversations taking place in order to increase awareness. 'Sharing' as a cultural norm may have an impact on high rates of transmission of Blood Borne Viruses (BBV).

Several projects and programs were discussed that people were aware of in this area. All of the initiatives listed below fall under the NSW HIV/AIDS, STI & Hep C Strategies Implementation Plan for Aboriginal People 2006-2009:

- Chopped Liver play – raising hepatitis C awareness and addressing stigma in Aboriginal communities (developed and played by Aboriginal people).
- Play your cards right – sexual health/BBV card deck.
- Dr BBV game – board game aimed at young Aboriginal people (developed by the Aboriginal Health and Medical Research Council of NSW, AHMRC).
- Arts programs – Boomali collective runs programs during Mardi Gras encouraging dialogue around HIV.
- ‘Enjoy your freedom’ campaign– AH&MRC & NSW Health partnership, developed by Circus Group and led by Aboriginal people the whole way.
- HIV & Us Mob/ Hep C & Us Mob – booklets developed to increase awareness of testing, care and support issues.

Much of this is considered best practice - NSW is the only state which has been able to keep HIV transmissions steady recently, where increases are being reported elsewhere. The interventions that seem to work best are interactive group learning and discussion.

The **recommendations** made for those developing policy were as follows:

- The NSW HIV/AIDS, STI & Hep C Strategies Implementation Plan for Aboriginal People 2006-2009 should be used as a sound platform for all strategies aiming to address issues around BBV in Aboriginal communities.
- Community participation, interaction and ongoing dialogue are required.
- Work with and consult genuinely with Aboriginal communities from the start of any new initiative.
- Make no assumptions –ask AHMRC for data that is known (and what is not known).
- Base work on information that Aboriginal communities have already told the health sector – e.g. by working with NSW HIV/AIDS, STI & Hep C Strategies Implementation Plan.
- Work with Elders and communities on developing ways to make sure our youth know how to protect themselves.
- ALWAYS: develop by and for Aboriginal communities with consultation at every stage.

▪ **Family Planning**

The need for community consultation and empowerment is great in this area. Programs where Elders work with younger women are recognised as especially valuable. Liverpool Women’s Health has established a young women’s peer education program – Weeo Wiser. It has three key components making it successful – a healthy relationship focus, outreach to schools and train the trainer. Work in schools is identified as best practice, talking about attitudes and breaking down stereotypes is necessary.

The **recommendations** made for those developing policy were as follows:

- Recognise that specialist family planning services are essential.
- Empower communities and individuals.
- Work to increased employment for Aboriginal people in frontline services.

- Build on current successful services and programs rather than creating new ones.
- Encourage young women to talk about sex.
- Double funding to services the Aboriginal community are already using e.g. Aboriginal Medical Services.
- Encourage and support partnership between existing Women's Health Centres & Aboriginal Medical Services.
- Increase education around careers in health.
- Enable & facilitate safe youth forums to hear the voices of youth around sexual issues.
- Support and develop respect programs for boys.
- All programs should start with 'respect and self-esteem programs'.
- Programs and education should start in primary school.

▪ **Chronic Disease**

The major chronic diseases experienced by Aboriginal people are: heart disease, kidney, respiratory, failure to thrive (children) and diabetes. The causes of disease are considered to be: lack of connection to land, chronic stress, fear of health services, lack of positive role models and a Westernised diet. Many people think that hospitals are places that you go to die and so are reluctant to be admitted.

Discussion focused on the importance of realising that this issue is not simply about funding. Approaches to the issue must consider spiritual healing – we should model initiatives on the New Zealand approach to acknowledging and healing. There is recognition that achievement should be celebrated and praised in order to raise cultural pride and thus increase wellbeing.

The **recommendations** made for those developing policy were as follows:

- Practicalities must be considered e.g. hospitals should not be too cold.
- Increase funding to support more Aboriginal health workers.
- Remove the 'Westernised restraint' put on Aboriginal health workers.
- Support, develop and market positive Aboriginal role models.
- Stop consulting with the community and conducting special reviews – get on with the job.
- Extend core service provision rather than implementing short term programs.
- Have a friendly Aboriginal face at hospital reception.
- Design a system which supports the follow up of a problem e.g. computerised records. Need to modify systems to respond to cultural needs and want e.g. walkabout.
- Develop services using Waminda as a model of community NGO women's health service, a social model of health. This will increase the feeling of ownership.
- Increased pay for Aboriginal health promotion workers and workers in Aboriginal Medical Services.

▪ **Diabetes**

Two main issues were identified here: firstly, the pressures experienced by individuals, the overload of the workplace or looking after grandchildren – these limit the ability to prioritise one's health even if 'educated'. Second is the need for more staff to be

working in this area. In addition, staff working in this area need to have access to other health professionals and greater access to education and training.

Examples of best practice in service delivery include the Heuter 'live strong' program - a six week lifestyle program, an Indigenous healthy foot program – an awareness program run in schools and a healthy weight program run in Newcastle. Much of the time there are barriers to accessing support programs and these need to be addressed before best practice service delivery can be fully utilised.

The **recommendations** made for those developing policy were as follows:

- Utilise the knowledge of the community when implementing programs & services.
- Look at patient outcomes rather than service delivery when evaluating services (e.g. look at rates/severity of disease rather than counting appointments).
- Lifestyle support should include the person, the family and the community.
- Increase Aboriginal health worker numbers; provide access to education & training for them along with the support to implement the strategies learnt.
- Increase screening services.

▪ **Health Planning for Our Elders**

There is an expectation in the Aboriginal community that workload is shared; and it is recognised that the workload of our Aboriginal workers is huge. The increase in labour required for caring means that women have little time to prioritise their own health. What is more, there is a great burden of responsibility on Elders which leaves them even less time to prioritise their health. Many women are raising grandchildren, and there is also an increase in Aboriginal people caring for those with a disability.

One of the key issues to overcome is that currently aged care services do not cater for the 'younger old' – for many Elders this starts at 45-50 years. Because of the mortality age gap there is a need to redefine age when accessing health services.

The **recommendations** made for those developing policy were as follows:

- Increase numbers of Aboriginal workers; organisations have to be committed to properly supporting workers.
- Re-define 'old age'.
- Require non-Aboriginal organisations to provide Aboriginal male and female health programs.
- Encourage and incentivise white workers to stand up and support Aboriginal women.
- Acknowledge the importance of doing things that the community wants when the systems block.
- Expand the YWCA NSW Big Brothers Big Sisters program to grandparents.
- Address discrepancies in foster care support for Aboriginal women.
- Pressure agencies to make services culturally appropriate & be professional – white fellas have to be more political and demand accountability.

▪ **Healthy Relationships**

In order to promote and build healthy relationships it is important to increase awareness of what constitutes healthy and unhealthy. A number of programs and services are seen as good practice in the field. These include SHINE delivered by Citycare – a woman’s program run in schools; Health and Family Circle (Redfern) – embedding knowledge in families, working to prevent childhood sexual assault, DV and providing mentoring and Aboriginal EC program and mentoring (Lismore) – providing opportunity for older members of the community to discuss their childhood. Other women’s groups where relationships and self-esteem are discussed and a non-judgmental environment is fostered are seen as positive initiatives.

Further, there is a need in this domain to work with the family, not just the individual. In some cases it is beneficial to work with extended family which often challenges existing policy. Those experienced in this area note that initial contact is important and that there are different ways of building rapport. Looking at different approaches to parenting is important as is adapting teaching and presentation skills according to the family or group of individuals.

The **recommendations** made for those developing policy were as follows:

- Recognise the need for connectedness – everyone involved in policy making should have an understanding of Aboriginal history and the importance of the land.
- Work from the inside out – build relationships with communities and service providers instead of simply tying relationships to the funding timeline.

▪ **Obesity**

Education and knowledge for young people is in high demand when looking at the obesity issue. Women want to increase their knowledge in order to look after their young ones – ‘good health for women, better health for my daughters’. Women are keen to learn from each other about ways to make positive changes to their diet and to get advice on where to find good food. Availability and affordability are key issues.

Early education is considered essential – healthy eating in primary schools must be encouraged. In addition it is important to teach the teacher, and this should include school caterers. Transport is an issue – lack of mobility is a problem in accessing good and varied food sources and exercise facilities. In some cases good food and exercise facilities are simply not available. It should be noted that obesity should be considered alongside psychological issues such as self-esteem, self-image and depression. A big question is about who is accountable and responsible for the obesity problem, is it individuals or the community?

There are some successful programs that are promoting healthy lifestyles in the community. The Koori Lifestyle Club provides line dancing sessions, breakfast clubs encourage healthy eating in young people and other adults are also involved and programs which engage people in looking after community gardens and other land care projects are good for physical activity.

The **recommendations** made for those developing policy were as follows:

- Ensure that there is appropriate food at conferences and meetings.

- Subsidise 'lite & easy' programs.
- Support and promote permaculture projects, for example – community gardens.
- Support early intervention programs that work in schools.
- Support long term sustainable funding for programs aiming to combat obesity.
- Fund and staff general community development offices.
- Support small support group models.

▪ **Mother and Baby Support**

A large problem is that in many cases mothers do not know where to go for support. In addition many staff working in this area are stretched and do not have the time to engage mothers who may be most in need of additional support services. There are a lack of services in rural areas and little to no community consultation to find out the needs of the community in this particular area of health and wellbeing. The approach of staff to clients is key in these types of services – staff need to come with a respectful attitude, not superior and not expert. It should be noted that often workload exceeds paid hours, especially for Aboriginal staff.

There are some well thought of programs that work with Aboriginal communities. Malabar Midwives offer support services for 18 months during pregnancy. They provide case management, multi-disciplinary services with continuity of care – clients have the same team/midwife throughout care. AMIHS (Aboriginal Maternal and Infant Health Strategy) programs work with women after birth and handle complex caseloads. In Wodonga, women are supported to access antenatal care; they are encouraged to stay in touch with services and are given appropriate referrals.

The **recommendations** made for those developing policy were as follows:

- Provide childcare facilities in conjunction with mother and baby support services so that mums can benefit from one on one time with their new baby.
- Provide long term and recurrent funding for services that are having a positive impact.
- Understand that many performance indicators currently in use are not realistic.
- Ensure within any funding model that there is money set aside for continual professional development for those already 'on the job'.
- Realise that cultural awareness needs to have a system of review and measure of appropriateness.
- Use initiatives such as pamper days to advertise service providers in the area so that members of the community know where to go for support.
- Support art therapy programs which incorporate priority issues e.g. domestic violence.
- Support a community coordinator role who will distribute information to workers and the community about programs in place across the region.
- Base Aboriginal specific programs in Aboriginal controlled organisations.

▪ **Complementary and Alternative Medicine**

Approaches to health and wellbeing other than Western medicine may include but not be limited to: bush medicine and bush tucker, acupuncture, traditional Chinese medicine, healing through arts, dance, culture and exercise. Diet is also important: "Let food be thy medicine and medicine thy food" – Hippocrates. There is a need for

us to go back to the old ways and teach and learn about bush medicines; unfortunately there is also a fear that knowledge of bush medicine will be stolen and become commercialised. There is also a need for a greater awareness of alternative medicine amongst medical staff as well as the community. We should try to adopt a holistic approach to health and wellbeing as much as possible. Access to services remains as issue.

The Victorian Government has a good approach to alternative medicine; and the Alaskan health model is also strong in this area. The Gnibi College at Southern Cross University is very highly regarded.

The **recommendations** made for those developing policy were as follows:

- Appoint an Aboriginal Minister for Health.
- Support, promote and encourage healing through arts and culture.
- Acknowledge that song, dance, visual arts and creativity are important means in developing transparent relationships and partnerships with health services.
- Utilise Aboriginal programs that are existing successful working models – e.g. Waminda pamper days.
- Respond to what women and children want rather than Government driven policy.
- Encourage and enable the Western medical model to work in conjunction with alternate therapies.
- Incorporate education about complementary alternative medicine into secondary education; and make tertiary courses available.
- Federal & State government must make funding long term and have a consistent approach.

▪ **Representation of Aboriginal People in Health & Community Services**

Recruitment of Aboriginal health staff is widely recognised as a challenge, and there are a number of reasons for this. Firstly, there is a need to ensure that appropriate models of teaching are in place and that there are Aboriginal training facilities – access to training is an issue. It should also be noted that in many cases Aboriginal people learn differently e.g. through auditory and oral methods. ‘One size fits all’ training isn’t enough; more flexible training is needed and Aboriginal training organisations that teach differently should be encouraged. Of course, access to quality education at an early age is also imperative.

Once working in this sector, there must be quality support in place for Aboriginal workers. Mentors for Aboriginal workers is one suggested method of support. It should be noted that health workers often work in isolation, and often Aboriginal workers are treated like Aboriginal ‘experts’ and are thus placed in silos. Aboriginal staff are often sent to Aboriginal Medical Services from mainstream services which results in mainstream services having very low percentages of Aboriginal employees. It is important to have an ongoing relationship with Aboriginal health workers all the time – not just during events like NAIDOC week!

It is essential that it is recognised that Aboriginal workers have strong connections to extended family and community and don’t ‘knock off’ at 5pm; they are available after hours. These people are trapped between two worlds i.e. employed as health worker but also working for the community. Aboriginal health workers never ‘take their hat off’. Workplace burn out is common due to low resources, low numbers of

crucial key persons and often having only one Aboriginal worker for a large regional area.

There is also concern that often there is only one Aboriginal representative on committees – we should aim to avoid tokenism.

Australia has a history of discriminatory health practices (e.g. through hospital segregation) and discrimination is still pervasive; some parts of the Australian community still don't realise this. Everyone needs access to cultural learning, at least an introduction, in order to respect Aboriginal culture. However, people must be aware that you cannot learn about Aboriginal cultures in a one day session!

The **recommendations** made for those developing policy were as follows:

- Invest further in Aboriginal health workforce development.
- Increase support networks for Aboriginal health workers.
- Re-establish Aboriginal women's centres – they are especially important for older Aboriginal women.
- Support mentoring programs – this is especially important in training up younger Aboriginal workers.
- Increase funding for Aboriginal cultural education courses for staff in the health and community services sector, plus investigate the potential use of online delivery.
- Listen to the wishes and experiences of Aboriginal people.
- Increase funding in order to increase the sustainability of Aboriginal specific services.
- Provide long-term funding to Aboriginal Medical Services.
- Increase the number of Aboriginal training facilities.
- Make cultural awareness training mandatory in health services.
- Encourage employers to provide flexibility for funerals.
- Fund existing successful programs rather than creating new programs.
- Ensure funding is for periods greater than one year.
- Ensure there is clinical supervision for all staff with client contact.
- Ensure mentoring, succession planning and traineeships are in place for Aboriginal staff.
- Develop an Australian Women's Health Framework with associated long cycles of funding.

▪ **Transport and Access**

Access to health services continues to be an issue for many women and families. Meeting the cost of transport (where it is available) is often a problem, and this is accentuated when transport costs for the patient's carer and family (which are often large) also need to be factored in. Where funded community transport services are provided there is often a lack of awareness about these and thus they are under used – services need to be promoted more widely. Availability of transport, both public and private can be problematic; thus making access to promoted health service difficult or even impossible. Programs are often established without consideration as to how community members will access them – this then impacts on the program's success. As well as cost, flexibility is a consideration; timing of services is often irregular or services do not run at the required times. There is a lack of continuity across the state – some areas have community transport schemes and others do not. There are also questions around the appropriateness of community transport funding criteria.

Lack of transport means that individuals have reduced independence, are unable to access employment and cannot connect to other families. This means that there are isolated Aboriginal families in small communities which often lack the 'critical mass' that is required for services to be viable in those areas.

Other issues associated with this topic include the problems that people with disabilities have in accessing public buses, the facilitation required for young people obtaining driving license (in some cases fines block this pathway) and that health services appointments are often difficult to meet due to family commitments – school pick ups, for example. It is generally felt that Government views addressing transport issues as 'too hard a basket'.

The **recommendations** made for those developing policy were as follows:

- Train staff in small communities to maintain vehicles.
- Encourage and enable the set up of deregulated services i.e. private individuals can set up transport services.
- Promote funded transport services better e.g. the taxi transport subsidy scheme.
- Enable health services to be taken out into the community (outreach).
- Encourage health and community service providers to work together to cluster services and reduce the need to travel to different locations.
- Bring Government departments together to work in partnership to overcome the transport issue.
- Incentivise big businesses to work with community organisations to increase corporate sponsorship opportunities.
- Carry out a census survey looking at transport use and availability.
- Investigate the information currently collected by Aboriginal Medical Services on utilisation of transport, access to services, no shows to appointments and so on.
- Implement feeder transport services to clinics.
- Produce a directory of transport service providers & what they provide. Ensure maps are available to the community outlining all service and where there are restrictions.
- Consider best ways of communicating with individual communities - word of mouth, pictures, newsletters etc.
- Fund and develop programs that encourage and support individuals in the community to own and drive their own transport so that community has independence and ability to be self determining, plus this will increase employment and education outcomes.
- Investigate and implement successful models of car pooling, loan or leasing in rural & remote locations.

- **Young People & Sexual Health**

Although there are many resources, young people sometimes have very poor factual knowledge, or worse, misinformation when it comes to sexual health education. Sexual health education should include respect for self and consider self esteem as an issue; importantly, it should be entertaining as well as informative in order to engage young people. Often young people do not want to be seen picking up information so alternative delivery methods should be considered, and services must be user friendly. Sexual health education does not only have to be delivered in schools. Education can happen in the community where there is trust between the

educator and the community, for example, at festivals where there is extensive access to young people or between peers. Where education occurs in schools it must be noted that this should occur early so that those who leave school in years 9 and 10 are not excluded. Aboriginal health workers play a key role in imparting sexual health information to young Aboriginal people.

The Croc Fest Youth Fest has been regarded as a successful venue to promote good sexual health practices. A good peer education program was 'Safe Summer Survival' where trained and paid peer educators target young people in popular 'hang outs' in Sydney. Maries Stopes runs several well known campaigns – 'Telling It Like It is', 'Snake Condom Program' and 'Sex Text' (where questions get answered). 'Condom Freedom' is a youth campaign that is about to be released and is expected to have a positive impact as it was developed with communities. Albury- Wodonga's 'Women & Self-Esteem' course (attended by non-Aboriginal women) is good but there is uncertainty whether it is appropriate/acceptable to Aboriginal women – this is clearly an area for future investigation.

The research project that is currently underway by the UNSW National Centre for HIV Social Research which will assess levels of knowledge, risk practice and access to health services in relation to sexually transmissible infections (STIs) and blood-borne viruses among Aboriginal people aged 16 to 30 in New South Wales will be very useful in informing future strategies for service delivery in this area.

The **recommendations** made for those developing policy were as follows:

- Use community trauma and/or specific events to open conversations with young people.
- Ensure there is capacity for there to be Aboriginal leaders in every program.
- Provide more funding for sexual health education programs.
- Ensure self-esteem is addressed in sexual health education programs.
- Ensure programs take a holistic approach to the person when addressing this subject; health, sexuality and relationships, trust and environment should all be considered.
- Encourage service providers to employ a range of strategies and resources.

▪ CLOSING THE GAP – SUMMARY OF THE FINDINGS OF THE DAY

This section aims to highlight the issues that were raised across various discussion groups throughout the day.

The Workforce

An overwhelming message throughout the day was that there are simply not enough Aboriginal people in the health workforce. There are a number of reasons for this, for example discrimination remains within health services, training and education is not accessible or does not meet the learning needs of Aboriginal students and family constraints mean long and inflexible work hours are impractical. Suggested ways to combat some of these barriers centre on ensuring there is training available which is sensitive to the needs and learning styles of Aboriginal students. It may be valuable to consider the provision of Aboriginal specific training services. The issue of poor educational outcomes for Aboriginal students was also raised often although was not discussed in detail at this forum.

For those that are in the workforce, burn out is common. Aboriginal workers never 'take their hat off'; they continue their role after hours in the wider community. It was recommended that organisations that employ Aboriginal health workers should realise that when these individuals leave work, they do not stop working and shoulder additional burden. It was recommended that additional support and debrief time should be made available to these workers. It would also be beneficial to provide flexible work practices to enable staff members to balance their work, community and family responsibilities. Some specific strategies for encouraging Aboriginal people into the workforce and retaining them there were discussed throughout the day. One of these was mentoring which fell into two categories: the mentoring of younger Aboriginal people in order to support and encourage them into the health profession and mentoring of those already in the profession to increase workforce retention. There was a question around whether there is appropriate representation of Aboriginal women on boards of directors within the sector. It is imperative that the inclusion of Aboriginal people on staff or boards is not tokenistic.

Service Providers

Discussions consistently outlined the benefits of non- Aboriginal service providers building relationships and developing partnerships with Aboriginal organisations at a grass roots level. Working collaboratively will enable non-Aboriginal organisations to be aware of the needs of the Aboriginal community which can then be taken into consideration when planning and delivering local services. Cross over between mainstream and Aboriginal services was viewed positively, with the ultimate outcome being the best service provision possible in an area. Generally it was felt that there are not enough support services for Aboriginal people across NSW and by working together existing services may become more accessible to the Aboriginal community. Grass root community engagement is also essential to increase participation and improve access to mainstream services for Aboriginal people. It was felt that new programs should not be developed when we already have successful models of service delivery in place in different areas across NSW.

Characteristics of successful service delivery to Aboriginal people were identified; services should focus on patient or client need and service provider strategy and

funding body reporting requirements must reflect this. Services must be non-judgmental and flexible; providing immediate service delivery with minimal delay in obtaining appointments. Participation rates for Aboriginal people are increased if Aboriginal workers are employed within the service. It was noted that more Aboriginal workers specializing in young disabled women's needs are especially needed. Men's and women's groups should be supported more widely; this is a popular environment for Aboriginal people to receive treatment and support.

Concern was raised around screening programs; the success of screening programs is often measured by the number of people seen rather than outcomes. Screening is often the easiest part of the problem to address, once problems are found, however, they must be treated and this is often where the challenge lies. Strategies must be in place to ensure that treatment is accessible for and utilised by patients who attend screening programs.

The Sector

Views around community consultation and data collection conflicted throughout the day; some thought that a lack of consultation remains, while others felt there has been too much and consultation now needs to be converted into action. Community consultation is seen an essential part of policy development and is valued amongst the community, but that it must translate into action in order to be valued.

Appropriate usage of mainstream and Aboriginal Medical Services was also discussed at length. Community workers often take clients to mainstream services in the first instance, rather than seeking out Aboriginal services in the area. Service directories may help in increasing knowledge of and access to more appropriate and targeted service providers in the area. In addition, non-Aboriginal people sometimes access their local Aboriginal Medical Services as GPs don't always bulk bill. This means that waiting times and numbers of appointments are reduced for Aboriginal people which, although these services are not exclusive, does not aid in closing the gap.

Monitoring and evaluation of programs and services was a common topic of conversation. It is widely recognised that the methods used for measuring 'success rates' are often inappropriate and result in service providers concentrating on achieving the outcomes required rather than the best outcome for the individual. An example of this is mentioned in the section above where the outcomes measured are the number of people seen by a service rather than the recovery rates of those patients. Key performance indicators and other measures of outcome must be developed in conjunction with the service provider. Greater resource and support is needed for service providers to ensure that evaluation processes are robust, meaningful and inform future practice successfully.

Government and Policy

Government policies, decisions and existing programs were often considered. There was great support for FaHCSIA's Indigenous Women's Leadership Program and a call for it to be continued and extended. Disappointment was expressed at the discontinuation of the Community Development Employment Projects (CDEP) program. Funding was a major topic of discussion; the main recommendation is that funding cycles need to be longer. Health and wellbeing programs and services need

to run on a long term basis to enable them to have the greatest impact possible. It takes time for members of the community to build the trust and rapport with service providers that they require to access the service on a regular basis. It also takes time to see the impact of services on the health of whole communities. There is great support for consolidating and increasing the reach of existing successful programs and dovetailing programs within and across communities. This approach is favoured over developing new programs where there are already successful models in other areas.

It was highlighted that the term 'Aboriginal' is preferred rather than 'Indigenous'; this was an outcome of the Australia 2020 summit. It was requested that anyone working in this field, especially public servants, adapt their language accordingly. The importance of using clear, standard terminology and not political jargon when developing and communicating policy was highlighted. It was felt that Aboriginal individuals should always be in charge of Aboriginal services and centres.

Philosophy and Cultural Awareness

This was the most discussed topic throughout the day and is an essential component in all of the recommendations made in the text above. Consistency in philosophy across the sector is key. Socially there are already negative attitudes towards Aboriginal people and we must work to combat this. We must value everyone's different experience and knowledge and respect and trust each other, regardless of background. Non-Aboriginal women must increase their understanding, acceptance and acknowledgement of history since invasion and realise that the intentional destruction of identity, culture and language has led to the problems faced by Aboriginal communities today. Equally as important as understanding history is understanding that for Aboriginal people connection to land, spirit, healing and family is vital to wellbeing. For this reason holistic approaches to health and wellbeing are usually most effective in Aboriginal communities. It was suggested that joint activities between non-Aboriginal and Aboriginal women can generate trust at the beginning of a new relationship for example, story sharing.

It was advised that workplace education, school curriculum, and government all need to propagate a positive philosophy of change in order to close the gap. There was an overwhelming consensus that more should be done to make people more culturally aware. Short term this is seen as the responsibility of organisations – to make sure all their staff are culturally aware and not just those working directly with the Aboriginal community. It should also be noted that cultural awareness cannot be attained in a one day course! Long term, suggestions that Aboriginal history and culture should be mandatory in the school curriculum could mean that as the next generation comes up into the workforce they will already be culturally aware and thus workplace training will become less required. It was suggested that cultural awareness training should be mandatory for all staff working on Government policy.

How non- Aboriginal Women Can Stand Together in Solidarity with Aboriginal and Torres Strait Islander Women

The following points were gathered from conversations throughout the day:

- Women are keen to learn from each other, regardless of background, about how to make positive changes to their diet and to gain advice about where to access good food.

- Aboriginal health and community workers often continue their role within their community and carry additional burdens that others don't. Support in understanding this and giving these women opportunity to debrief and share their burden is welcomed.
- Aboriginal workers often feel isolated in their role, it is welcomed when other staff work with Aboriginal workers and spend time developing their relationship with them.
- Find out whether your program/service is culturally acceptable/appropriate for to Aboriginal women; if not can it be changed to be more inclusive? If so, can it be rolled out/promoted into Aboriginal communities? Aboriginal women are happy to discuss these questions with non-Aboriginal women.
- Build partnerships with Aboriginal organisations at a grass root level.
- Aboriginal women would like to have ongoing relationships with their non-Aboriginal sisters, not just during NAIDOC week!

Summary of Evaluation Findings

50% of attendees returned the evaluation forms. Of these 39% were Aboriginal, 50% were non-Aboriginal and 11% did not identify their background. The results of the questionnaire were as follows:

	Strongly Agree	Agree	Neither	Disagree	Strongly Disagree	No Response
I now better understand the issues affecting Aboriginal women's health & wellbeing	23.9%	51.9%	11.9%	6.6%	0%	5.3%
The speakers were relevant and informative	46.6%	47.9%	3.9%	0%	0%	1.3%
The day was relevant to my work/life	29.3%	57.3%	6.6%	1.3%	0%	5.3%
The day met my expectations	25.3%	55.9%	11.9%	3.9%	0%	2.6%
There were opportunities to meet people and network	50.6%	43.9%	2.6%	0%	0%	2.6%
There was a good range of discussion topics	33.3%	58.6%	2.6%	2.6%	0%	2.6%

When asked what about the day the responder most liked, popular answers included the guest speakers, the Welcome to Country and the networking opportunity. When asked what could have been different, there were mixed answers regarding the length of the consultation, a few thought it should have been a half-day event whereas many suggested it should have been anything between two days to one week! In general responders would have liked more of the day to be dedicated to discussion time.

When asked 'What the three major Aboriginal women's health issues today?' a huge variation in response was received. Those that came up a few times included: obesity, domestic violence, mental health, access to services, poor self-esteem and lack of education.

If you would like a full analysis of the evaluation data please contact Gail Hilton at gailh@ywcansw.com.au.

A very big thank you to all who lent their support in preparation of the event and to those who attended on the day, it wouldn't have been possible without you.