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## **Gendered Indigenous Health and Wellbeing within the Australian Health System: A Review of the Literature**

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# Gendered Indigenous Health and Wellbeing within the Australian Health System: A Review of the Literature

Bronwyn Fredericks, Carolyn Daniels, Jenni Judd, Roxanne Bainbridge, Kathleen Clapham, Marlene Longbottom, Mick Adams, Dawn Bessarab, Len Collard, Clair Andersen, Deb Duthie and Rowena Ball



December 2017

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## Recognition Statement

CQUniversity's Office of Indigenous Engagement and the National Indigenous Research and Knowledges Network Health Node acknowledge the sovereignty of Aboriginal and Torres Strait Islander peoples as the original custodians of Australia. Aboriginal and Torres Strait Islander cultures are persistent and enduring, continuing unbroken from the past to the present, characterised by resilience and a strong sense of purpose and identity despite the undeniably negative impacts of colonisations and dispossession. Aboriginal and Torres Strait Islander people throughout Australia represent a diverse range of people, communities and groups, each with unique identity, cultural practices and spiritualities. It is not our intention to homogenise in summarising the data gathered in this project and, where possible, we endeavour to disaggregate analyses to recognise geographical, social and culture diversity.

We acknowledge and pay our deepest respects to Elders past, present and future throughout Australia.

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## Cover artwork

The painting reproduced on the cover represents womanhood, with mother and daughter being guided by grandmother/mother. The 'leafy' structures are the initiation steps or processes they have to undertake on their journey from childhood to adulthood and to become leaders and lore practitioners. Its title is *The seed to womanhood*; it was painted by Michael J. (Mick) Adams.

## Foreword

Welcome to this monograph, which I am proud to be part of and proud to be asked to lead. This work commenced as a conversation between Indigenous researchers who were members of the National Indigenous Research and Knowledges Network (NIRAKN) Health and Wellbeing Node who are intimately aware of the ongoing crisis in Indigenous health and wellbeing. As we progressed our collaborative conversation, we agreed to focus on several specific areas and commenced with this review of the literature about gendered Indigenous health and wellbeing in order to gain a deeper understanding of what is known and what research has taken place. This work does not set out to include all work produced, but to open up the discussion on ways to offer a greater focus on and improve gendered Indigenous health and wellbeing. We offer this monograph as a contribution to the larger conversation that needs to be had, to develop a broader understanding of Indigenous gendered health and wellbeing and what needs to happen in bringing about positive health outcomes for Indigenous peoples in Australia.

Professor Bronwyn Fredericks, CQUniversity, Australia

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## Executive Summary

This report discusses the outcomes of a review of gendered Indigenous health literature involving a systematic search of peer-reviewed and grey literature, and government and non-government reports.

Traditionally, Indigenous men and women maintained distinct gendered realities. Colonisation and the subsequent introduction of the patriarchal system altered these realities, negatively impacting on Indigenous men's and women's health and wellbeing in a cumulative and continuing way.

This report provides an overview of gendered Indigenous perspectives of health and wellbeing, and discusses some of the intervention strategies in Australia that have attempted to address these issues. In providing a context for understanding gendered Indigenous health perspectives, this report discusses the place of Indigenous peoples in contemporary Australian society and the complex historical factors that inform the relationship between Indigenous and non-Indigenous peoples.

Systemic racism is embedded within systems and institutions in Australia. Racism and the combined effects of social, political and historical determinants, influence the health outcomes experienced by Indigenous peoples. Mainstream primary healthcare services have failed to meet the health and wellbeing needs of Indigenous peoples. In contrast, the emerging network of Aboriginal Community Controlled Health Services provide culturally appropriate health care and outperform mainstream services in the health and wellbeing outcomes achieved for Indigenous peoples. Maintaining and expanding these health services through appropriate government funding strategies is vital for improved healthcare outcomes for Indigenous men and women.

Future research is needed to not only describe the situation of gendered Indigenous health and wellbeing, but to involve Aboriginal and Torres Strait Islander women and men in the ways that health services serve this community. More work is needed to build strong evidence of what works in improving gendered Indigenous health outcomes.

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## Abbreviations

ACCHS	Aboriginal Community Controlled Health Services
AIATSIS	Australian Institute of Aboriginal and Torres Strait Islander Studies
HWBN	Health and Wellbeing Node
NATSIHP	National Aboriginal and Torres Strait Islander Health Plan
NIRAKN	National Indigenous Research and Knowledges Network
ARC	Australian Research Council
NAHSWG	National Aboriginal Health Strategy Working Group
NATSIWA	National Aboriginal and Torres Strait Islander Women’s Alliance

## Key terms and organisations

Waminda	Waminda South Coast Women’s Health and Welfare Aboriginal Corporation
NintiOne	NintiOne Foundation
Healing Foundation	Healing Foundation
National Congress	The National Congress of Australia’s First peoples
UNU	United Nations University
AWHN	Australian Women’s Health Network

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# 1. Introduction: Gendered Indigenous Health and Wellbeing

This review examines the literature (both peer reviewed and grey) on gendered Indigenous health and wellbeing within the Australian healthcare system.<sup>1</sup> The review was first undertaken during 2014 as a collaborative research activity by the Health and Wellbeing Node (HWBN) of the National Indigenous Research and Knowledges Network (NIRAKN). The process of conducting the review was published in a paper *'Ngulluck Katitj Wah Koorl Koorliny / Us mob going along learning to research together': Drawing on action research to develop a literature review on Indigenous gendered health and wellbeing* (Fredericks, et al., 2014). A second paper explored gender and the Australian health system utilising Pictorial Conceptual Metaphors (Fredericks, et al., 2015). The review was further developed in 2015-2016, and is presented in full in this monograph.

## 1.1. National Indigenous Research and Knowledges Network (NIRAKN)

NIRAKN was established in 2013 with funding from the Australian Research Council (ARC-SR120100005). It aims to develop a critical mass of Indigenous researchers within Australia who can address the needs of Indigenous people by using culturally responsive approaches to research. NIRAKN is a collaboration of 44 Australian Indigenous researchers who are at different stages of their research careers and are based at one of 21 Australian universities and 5 partner organisations (the partner organisations are NintiOne, Waminda South Coast Women's Health and Welfare Aboriginal Corporation, the Aboriginal and Torres Strait Islander Healing Foundation, the National Congress of Australia's First Peoples, and the United Nations University). NIRAKN operates from the premise that Indigenous knowledge systems should inform and frame the network's research (NIRAKN, n.d.). It is supported and guided by a 10-member Advisory Board of people who are recognised as leaders and Elders within the Indigenous community.

Within its first four years, NIRAKN operated through a hub and spokes model. The central hub was overall responsibility for administration, coordination and capacity building. The four spokes (or nodes) developed and conducted NIRAKN's research program. The four research nodes were (1) Indigenous Sociology and Knowledges; (2) Indigenous Health and Wellbeing; (3) Indigenous Law; and (4) Yuraki – History, Politics and Cultures. Node membership was fluid, with several researchers

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<sup>1</sup> Throughout this review, we used the terms 'Indigenous', 'Aboriginal', 'Torres Strait Islander' and 'Aboriginal and Torres Strait Islander' to apply to all first peoples of Australia.

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belonging to multiple nodes or working across nodes on interdisciplinary research projects (NIRAKN, n.d.).

As a research network, NIRAKN has six key aims, to: (1) build a strong network of Indigenous researchers; (2) support postgraduate and early-to-mid-career Indigenous researchers; (3) connect Indigenous researchers both nationally and internationally, and develop a culturally supportive and inclusive environment for multidisciplinary research; (4) develop ongoing integrated research collaborations with government, research bodies, industry, community and philanthropic organisations; (5) seek national and international recognition for Indigenous research expertise, knowledge and innovation; and (6) inform community and government policy and program delivery relating to Indigenous research agendas by utilising Indigenous knowledge and expertise (NIRAKN, n.d.).

NIRAKN has an interdisciplinary focus, with members from a broad array of disciplines and research backgrounds. While many NIRAKN members knew each other personally before the network was formed, few of the researchers had previously worked together. Forming NIRAKN gave us the opportunity to work together under one banner and explore new ways of working that would both progress our research agenda and allow us to consider whether we could further Indigenise our research practices.

### **1.1.1. The NIRAKN Health and Wellbeing Node**

Members of NIRAKN's Health and Wellbeing Node focussed on an holistic, gendered approach to health, viewed through the lens of social and emotional wellbeing (NIRAKN, n.d.). As researchers, we are conscious of the ongoing crisis in Indigenous health and the urgent need to develop research approaches that could lead to positive health outcomes for Indigenous peoples in Australia. When we formed the node, we agreed to focus on the strong links between gender, social and emotional wellbeing, reproductive health, and chronic diseases such as heart disease and diabetes. Our work program started with this review of the literature about gendered Indigenous health and wellbeing. The literature review, developed over time alongside our research projects, became a platform for understanding the field of work and developing our collaborative work practices.

## **1.2. Defining Gendered Indigenous Health and Wellbeing**

Indigenous peoples in Australia view health from a worldview that is significantly different from the biomedical model. Understanding this different way of viewing health and life is fundamental for providing health care for Aboriginal and Torres Strait Islander peoples (Sherwood & Geia, 2014). The

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National Aboriginal Health Strategy Working Group (NAHSWG) describes the Indigenous health worldview in this way:

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 cycle of life-death-life. (NAHSWG, 1989, p. ix)

A gendered view of Indigenous health recognises that health and wellbeing may have different implications for men and women. In 2002, the World Health Organization (WHO) released the Madrid Statement which recognised the gendered nature of health, stating:

To achieve the highest standard of health, health policies have to recognize that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities. (WHO, 2002, p.2)

In this literature review, the term 'gender' is used to reflect the roles and status ascribed to people through socialisation and cultural determination; in contrast, 'sex' is a status that is biologically determined by markers such as chromosomes, hormonal profiles and internal and external sex organs. Gendered, socialised behaviour makes up gender identity and determines gender roles (WHO, 2002).

Historically, Indigenous women and men held different gendered roles (Fredericks et al., 2014; UNOSAGI, 2006). Although Clan groups traditionally had common ties of culture that held people together, gendered realities defined the specific interests and roles of women and men (Fredericks, Adams, & Best, 2014). Indigenous women's business was (and is) the customs, cultural practices and laws shared among women and taught to young women by their Elders; this business is shared among women and not always shared with men. In the same way, Indigenous men's business was (and is) the knowledge and activities that are shared among men and not always shared with women.

Gender remains a contested topic in Australia and is described as a socialised condition that relies on cultural norms (Fredericks, Adams, & Best 2014). In the health sector, gender issues tend to focus on equity of access, the different health needs and outcomes experienced by women and men, and the impacts of gendered, social and socioeconomic issues and educational opportunities.

Indigenous communities have multiple ways of defining gender roles and behaviours and there are wide variations across groups and communities. The impact of gender as a social determinant of

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health for both women and men is broader than biological differences between the sexes (Phillips, 2005). Both men and women are subject to the health effects of gender. Gender is a socially and culturally determined construct that can be defined as the roles and expectations attributed to men and women in a given society, which may change over time, place and life-stage (Phillips, 2005). Gender is an important social determinant of health and this monograph attempts to gather the literature, and define Indigenous gendered health.

## **2. Approach to the Literature Review**

This literature review addresses three broad questions:

- What does the literature tell us about Indigenous gendered perspectives of health and wellbeing?
- How do existing policy frameworks incorporate Indigenous perspectives on gendered health and wellbeing?
- What effective strategies, services and programs have been implemented to address Indigenous gendered health and wellbeing needs?

In addressing these aims, this literature review seeks to:

- Review the current peer-reviewed and grey literature about Indigenous gendered health and wellbeing and identify gaps in the literature
- Describe national, state and territory policies and strategies which have been put in place to address Indigenous gendered health and wellbeing
- Identify effective programs, projects and initiatives relating to Indigenous gendered health and wellbeing
- Identify learnings from the literature and consider what changes are needed.

### **2.1. Search Strategy**

The literature reviewed in this study was gathered through an initial search process that incorporated bibliographic sources from leading university, institutional, organisational, government and non-government databases and clearing houses. Relevant databases included the Australian Indigenous HealthInfoNet, The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS), government websites including the Australian Institute of Health and Welfare, government department websites, and the Central Queensland University Discover It database (a

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single search tool that enabled database access to CINAHL, PsychINFO, PubMed, Aboriginal Studies and others).

Search terms included 'gendered health', 'health', 'Aboriginal', 'Aboriginal and Torres Strait Islander', 'Indigenous', 'Australia', 'cultural training', 'colonisation', 'racism', 'systemic racism', 'women's health', 'men's health', 'male health', and 'ACCHS'. The terms in Figure 1 show the explosion of terms for 'Aboriginal' that were used.

**FIGURE 1 TERMS USED TO SEARCH ELECTRONIC DATABASES**

gender AND
Women Or Men
Health AND/ OR Wellbeing
Aborigines OR Aboriginal OR Aborigine OR Indigenous OR Indigenous Australians OR Indians, north American OR north American Indians OR First Nations OR Native Canadian OR First Nations OR Native American OR Maori OR Indians, central American OR central American Indians Or Inuit OR Cree OR Indians, south American, OR south American Indians

Further academic and grey<sup>2</sup> literature were identified through scanning reference lists from journal articles, grey literature and reports. The literature included a range of reports (technical reports, progress reports, advanced reports, statistical reports etc.) conference papers, theses, bibliographies, government reports and documents not published commercially.

Relevant documents were recorded in an EndNote library and Dropbox. Standard internet search engines also included Google and Google Scholar.

## **2.2. Methods of Analysis**

The literature were analysed in two parts: a descriptive summary to categorise the articles, and a thematic review to summarise the issues.

As Sanson-Fisher, Campbell, Perkins, Blunden and Davis (2006) note, there is no agreed mechanism to evaluate the contribution of research into health outcomes, nor are there any measures of the

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<sup>2</sup> Grey literature refers to 'that which is produced on all levels by government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers'; (New York Academy of Medicine, 2002).

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extent to which research is translated into policy and practice. We adapted the method for our descriptive summary from the work of Sanson-Fisher et al. (2006) to define the types of publications we found as descriptive studies, measurement studies, intervention studies, meta-analysis or not original research. We then defined the publications as either peer reviewed or not peer reviewed. These categories are defined below:

- Descriptive studies: described the size and nature of health and illness issues, using original research
- Measurement studies: developed valid, reliable and culturally appropriate measures for use in Indigenous populations. These could include measurement qualities of a clinical screening or diagnostic tool, and/or questionnaires assessing variables such as health risk behaviours or attitudes
- Intervention studies: focused on effectiveness and acceptability of clinical or public health interventions among Indigenous peoples
- Meta-analysis studies: use statistical techniques to analyse the combined results of numerous previously published studies to get a more complete answer or picture to the issue of concern
- Not original research: documents that provide policy, frameworks and strategies that are based on original research.

The second part of our analysis examines the articles' content and summarises the key themes that emerged. We selected articles for analysis using an iterative process of examining first the article titles, then the abstracts, and finally the full texts. Articles were excluded for any of five reasons: (1) if the study population was not an Indigenous population within a larger dominant population, (2) if the study did not present an understanding of the Indigenous gendered health issues, (3) if the study did not directly relate to Indigenous gendered health and wellbeing, (4) if the study did not directly relate to Indigenous gendered health and wellbeing as an outcome, or (5) the study was not available in English.

The literature review included published and unpublished items produced before 2015. A total of 136 documents were included in the review.

### **2.3. Limitations**

While we adopted a systematic search strategy using widely recognised databases, we identified a large number of reports, policies and strategies through government websites and by scanning the

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references lists of other papers. This suggests that the online search strategy has limitations due to the large volumes of grey literature in the field, the capacity of the various databases we used and the methods of accessing older documents.

### **3. Background**

#### **3.1. The Health Status of Indigenous Australians**

In 2011, an estimated 548,370 Indigenous peoples lived in Australia, comprising approximately 2.5 per cent of Australia's population. Approximately 33 per cent of Indigenous people live in urban areas (ABS, 2011).

It is well established that Indigenous people in Australia experience much poorer health than non-Indigenous people (AIHW, 2011a; Dudgeon, Wright, Paradies, Garvey, & Walker, 2014; SCRGSP, 2014). Indigenous peoples are the most disadvantaged group in Australian society. They experience high rates of unemployment and incarceration, low income, sub-standard housing, and a high rate of ill-health and mortality (ABS, 2012b). The life expectancy for Indigenous Australians is less than that of non-Indigenous Australians – by almost 10.6 years for males and 9.6 years for females (SCRGSP, 2014). The continuing health disadvantages experienced by Indigenous peoples are historic in nature (Saggers & Gray, 1991).

In 2006-10, the most common causes of death amongst Indigenous Australians were circulatory diseases (26 per cent), neoplasms including cancer (19 per cent), and external causes (15 per cent). The external causes include suicide (30 per cent), transport accidents (28 per cent), accidental poisoning (10 per cent), assault (9 per cent) and accidental drowning (4 per cent). Almost two-thirds of the deaths by external causes occurred amongst the 15-39 year age group (AHMAC, 2012). Four groups of chronic conditions – circulatory disease, endocrine/metabolic/nutritional disorders (including diabetes), cancer, and respiratory disease – account for the almost 70 per cent of the gap in mortality between Indigenous and non-Indigenous Australians (AHMAC, 2012).<sup>3</sup>

There is increasing evidence that the high level of ill-health and mortality within the Indigenous population in Australia is associated with a broad range of social and economic determinants (Carson, Dunbar, Chenhall, & Bailie, 2007; Marmot, 2011), which arise from historical and

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<sup>3</sup> The mortality gap is defined as the difference between Indigenous and non-Indigenous Australians in potential years of life lost because of premature mortality (AIHW, 2010).



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contemporary racism, colonisation and oppression (Dudgeon et al., 2014; Fredericks 2008a; Paradies, Harris, & Anderson, 2008).

### **3.2. The Legacy of Colonisation**

Since Australia was colonised by the British in 1788, Indigenous men and women have been the targets of genocidal policies and practices (Tatz, 1999) and have experienced family decimation through forced removal of children (HREOC, 1997). Indigenous men and women were also physically displaced as their land was taken to progress British economic interests (Broome, 2010; Dudgeon et al., 2014; Reynolds, 1987).

Land is fundamental to Indigenous people; traditionally each individual belonged to certain places where they had and continue to have spiritual connections and obligations to country. Land was not owned by people; people belonged to the land (Dudgeon et al., 2014).

Indigenous people see themselves as part of a continual Dreaming process (Atkinson, 2002). Dreamings are not just of the distant past; they 'are the processes of human action in co-creation with the great Creators and the ancestral beings, who continue in the present, the continuing birth, life, death, rebirth, renewal that is human activity across millennia' (Atkinson, 2002, p. 32). Indigenous people's spiritual beliefs tie them to the land, to other members of the group and to all things in the natural world (Dudgeon et al., 2014).

At the time of colonisation, Indigenous people were hunter-gatherers who lived at one with their country; all of nature and other humans were understood and spiritually connected (Dudgeon et al., 2014). Colonisation brought destruction on Indigenous people and their culture. However, a period of rapid adaptation by Indigenous peoples was halted as oppressive legislation was enacted across all states and territories to strip Indigenous people of their human rights (Dudgeon et al., 2014). Between 1905 and 1967, people were moved into government reserves and missions, where cultural genocide was effected through family dispersion, loss of language and ceasing of cultural practices (Dudgeon et al., 2014). Peters-Little (2000) suggests this enforced segregation kept Indigenous people isolated on missions and reserves and, in some instances, actually assisted in keeping their links to history and each other alive.

From the time of colonisation, Indigenous peoples resisted invasion and oppression and maintained an ongoing struggle for equality (Dudgeon et al., 2014). Within this space, Indigenous people reclaimed and maintained cultural processes and practices (Dudgeon et al., 2014).

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In spite of the legacy of colonisation and the diametrically opposed views of Western and Indigenous concepts of land ownership, Indigenous people have maintained their claims to rights over their ancestral land (Miliwanga & Clapham, 2012). Tied in with belonging to the land, Indigenous people's self-identity is viewed collectively, enmeshed with all aspects of life, spirituality, country, culture and community (Parker & Milroy, 2014). Indigenous people's identity is about descent, culture, upbringing and life experiences; it does not relate to the colour of a person's skin or the percentage of 'blood' they have (Dudgeon et al., 2014). With colonisation, children of both European and Indigenous heritage were born (Robinson & Paten, 2008). Having both Indigenous and non-Indigenous ancestry does not make people any less Indigenous (Dudgeon et al., 2014).

### **3.3. Aboriginal Philosophy and Health**

Aboriginal philosophy and its impact on health care is an important factor influencing health outcomes for Aboriginal people (Morgan, Slade, & Morgan, 1997). Indigenous languages have no single term or expression for 'health' as it is understood in Western society (NAHSWG, 1989). 'Health' to Indigenous people takes in all aspects of their lives, including control over the physical environment, dignity, community, self-esteem and justice, with a social system based on inter-relationships between people and land, people and creator beings, and between people (NAHSWG, 1989). Western ideology, which is embedded in the concepts of linear time, individual commitment, emphasis on possessions, falling away from spirituality to worldly views, environmental pillage and devaluation of relationships (between people, families and community), contrasts sharply with the fundamental belief system of Indigenous peoples (NAHSWG, 1989).

Aboriginal spirituality, and thus Aboriginal health, was (and is) fundamentally land-centred (NAHSWG, 1989). Indigenous people did not segment an element of their life as 'health'; rather health embodied life and included land, environment, physical body, relationship, law and community (Fredericks, Adams, & Best, 2014).

### **3.4. Other Factors Impacting Indigenous Australians' Health Status**

Social, political and historical determinants, including racism, permeate the social, political and historical fibre of Australian society. These factors impact on Indigenous men's and women's health today (Durey, 2010). The effect of these determinants on Indigenous health is played out in the statistics.

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### 3.4.1. Social Determinants

The World Health Organisation Commission on Social Determinants of Health (CSDH, 2008) found that dramatic differences in health within a country are closely linked with degrees of social disadvantage. The key determinants of social inequalities in health come about because of the circumstances in which people grow, live, work and age, and because of the systems put in place to deal with ill health (CSDH, 2008; Marmot, 2011; Wilkinson & Marmot, 2003). The conditions in which people live and die are shaped by political, social and economic forces; in other words, the effects of the various systems in their community. The Commission's (CSDH, 2008) report recommended that change is needed, including: improvements to daily living conditions; revision of the unequal distribution of power, money and resources; and measurement of the impact of actions and issues facing disadvantaged peoples. In Australia, the social determinants that affect Indigenous people's lives include socio-economic status, poverty, housing, education, employment, racial discrimination, exposure to violence, trauma, stressful life events and access to community resources (Gee, Dudgeon, Schultz, Hart, & Kelly, 2014; Zubrick, Holland, Kelly, Calma, & Walker, 2014). These social determinants occur simultaneously, creating a negative impact on Indigenous Australians' health and wellbeing both concurrently and cumulatively (Gee et al., 2014; Zubrick et al., 2014).

### 3.4.2. Historical and Political Determinants

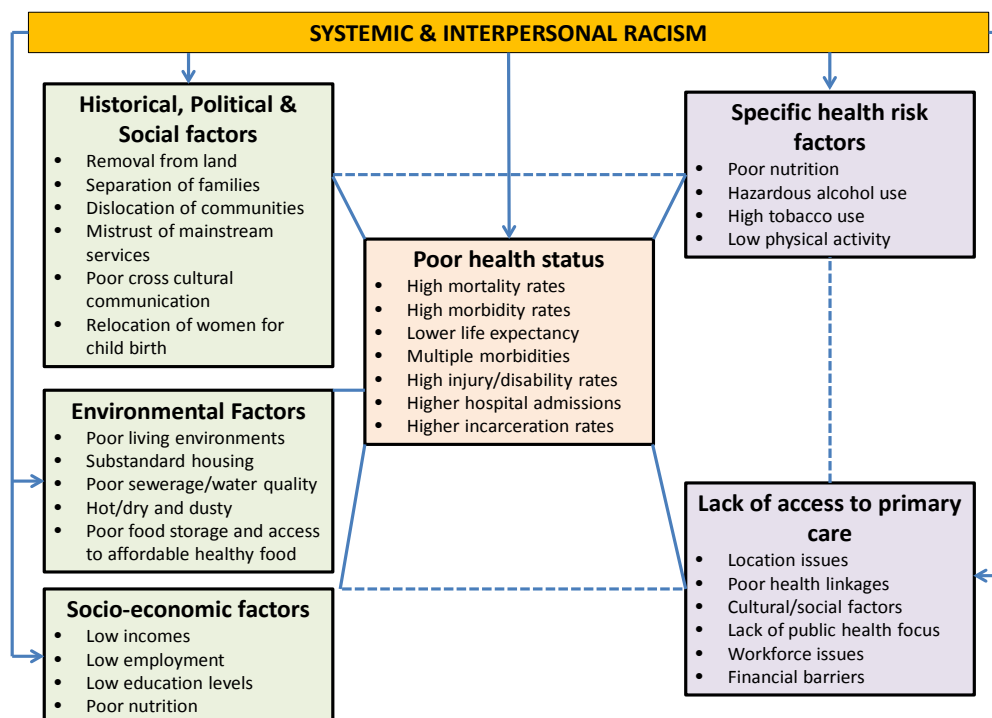
Historical and political determinants are also relevant to discussions about Indigenous Australians' life experiences, health and wellbeing (DoHA, 2004; Swan & Raphael, 1995).

Historical determinants need to be understood within the context of colonisation and its legacy, and include the effect of past government policies, the magnitude of historical oppression, and experiences of cultural displacement. Historical determinants are also relevant in considering the extent to which communities managed to absorb cultural displacement and develop self-governance for the maintenance and renewal of cultural continuity and control (Gee et al., 2014).

Political determinants include unresolved issues stemming from colonisation to the present day, such as access to land and Native Title, control of a range of resources, cultural safety and security, along with human rights issues and Indigenous rights of self-determination and sovereignty. These political determinants are recognised as contributing to health and wellbeing and reducing health inequities for Aboriginal and Torres Strait Islander peoples (DoHA, 2004, p. 7; Gee et al., 2014, p. 62; Ring & Firman, 1998).

Historical and political determinants together influence cultural determinants of health, as they help to shape the environment and circumstances into which Indigenous people are born (Gee et al., 2004). These complex interacting factors contribute to the relatively poor health outcomes for Indigenous Australian peoples and reflect the findings of the Commission on Social Determinants of Health (CSDH, 2008; Marmot, 2011). These factors are summarised in Figure 2 (Queensland Government, 2012).

**FIGURE 2 FACTORS IMPACTING ON INDIGENOUS AUSTRALIANS' HEALTH STATUS – INTERACTIONS OF HISTORICAL, POLITICAL, SOCIAL AND PHYSIOLOGICAL DETERMINANTS**



Source: Adapted from Queensland Government 2012, p. 7.

### 3.4.3. Historical Determinants and Health Professional Training

Sherwood's (2013) discussion about colonisation (an historical determinant) and its impact on Indigenous health recommends that all health professionals who work with Indigenous people should be trained in Australia's colonial, political, social and economic histories to understand their contribution to the social health determinants that undermine the health and wellbeing of Indigenous Australians. Burns et al. (2013, p. 1) also suggest that strategies for improved Indigenous health outcomes 'need to include knowledge and awareness of the history, experience, culture and rights of Indigenous [peoples]'. For Burns et al. (2013), this includes the training received by nurses. Sherwood (2013, p. 28) asserts that 'most Australians including Indigenous Australians have not

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benefited from a balanced and well informed historical account of the past 200 and something years'. This 'lack of knowing' has affected 'the way health providers have delivered health to Indigenous children, mothers, fathers, and their communities' (Sherwood, 2013, p. 28).

Nursing education, which in the Western tradition was founded in the 1880s following Florence Nightingale's (1820-1910) reforms (Harding, 2013), is built around a lack of cultural understanding about Indigenous ways of being, thinking and doing. Australian nursing education and practice has always been grounded in the values, beliefs and expectations of the dominant Western culture, and is based on the theoretical and practice frameworks of other first-world, English-speaking countries (Dickson, Lock, & Carey, 2007). This distances the practice of nursing from the more holistic models of many Indigenous Australians (Best & Fredericks, 2014).

Best practice health care for Indigenous Australians requires that health workers, other health professionals and those studying in health disciplines appreciate the underlying philosophy of Aboriginal health, with its focus on the wellbeing of the whole community. This is in direct contrast to the standard medical management of individual patients who present with a health problem (DoH, 1996, p. x). Often, though, when Indigenous men and women enter the healthcare system, nurses practising under the Western model exhibit little cultural awareness, particularly regarding the importance of gender distinctions and community consultation (Downing, Kowal, & Paradies, 2011; Fredericks, Adams, & Best, 2014; Thomson, 2005).

#### 3.4.4. The Concept of Racism and Indigenous Health

Racism is embedded in Australia's colonial history, institutions, policies and culture. It is also embedded within the psyches of non-Indigenous Australian people (Fredericks, 2008). Racism can be conceptualised as one of the multiple types of oppression, including gender (sexism), sexuality (heterosexism), age (ageism), class (classism), physical and mental able-ness (able-ism), nationality, religion and others (Paradies, 2006a). Bonilla-Silva (1996) used the term 'racism' to describe the racial ideology of a racialised social system where racism is only part of a larger racial system. Similarly, Paradies (2006a; 2006b) considers that manifestations of racism generally ensue from societal systems where unequal distributions of power (and consequently resources) are based on the notion of 'race'. 'Race', in this instance, can be defined as a social construct that includes the idea of difference based on phenotype, ancestry and/or culture, entwined in complex ways with other forms of privilege/oppression (Paradies, 2006a). The privilege/oppression social system concerns differences between groups, which are expressed through attitudes, beliefs, behaviours,

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laws, norms and practices (Paradies, 2006a). The concept of racism as a form of privilege/oppression is embedded in a societal system where peoples are divided into 'races' (Paradies, 2006a).

Colonialism was underpinned by white racism which, in turn, introduced a cycle of poverty for Aboriginal people (Broome, 2010). While racism is frequently measured by differences in socio-economic status, there is often a link between socio-economic variables and health indicators. This means that reducing the socio-economic gap for Indigenous peoples will lessen, but not eliminate, health inequalities (Larson, Gillies, Howard, & Coffin, 2007). In contemporary Australia, it is institutional (or systemic) racism, which is embedded within institutions and systems, that excludes and discriminates against Indigenous peoples through a lack of cultural consideration (Dudgeon et al., 2014). Moreover, interpersonal racism expressed through demeaning comments and behaviours towards Indigenous peoples is often experienced within various government and non-government systems (and Australian society more broadly) (Larson et al., 2007). The effect of this exclusion and discrimination is low self-esteem, mistrust of the dominant culture, internalised racism, denial and poor health outcomes (Dudgeon et al., 2014), coupled with a lack of confidence in accessing mainstream health services (AHMAC, 2004). Disapproving of racism and changing the language within the system is not enough to change the situation (Fredericks, 2008). Larson et al. (2007, p. 328) maintain that '[w]ithout fundamental changes in how members of the dominant Australian culture behave towards Aboriginal people, initiatives to improve health services, educational and employment opportunities may have limited impact on health inequalities'.

### 3.4.5. The Concept of Indigenous Communities

Indigenous peoples' notions of community differ from Western notions of community. For an Indigenous person to be a member of a community, they need to identify as Aboriginal and be known to the group (Dudgeon et al., 2014). Contemporary notions of Indigenous community relate to political agendas, where Indigenous peoples were removed to missions, reserves and fringe camps as part of the process of colonisation, dispossession and dispersal (and later for bureaucratic convenience) (Dudgeon et al., 2014). For Indigenous peoples in Australia today, there remains a strong sense of what it means to belong to a community where society is made up of structured and strong kinship ties, family ties and networks (Dudgeon et al., 2014). The kinship system teaches young Indigenous men and women about the relationships which connect Indigenous families to each other, their community and the land; it is through these relationships that they learn where they fit into the family and community systems, and where they develop self-identity (Bessarab, 2006).

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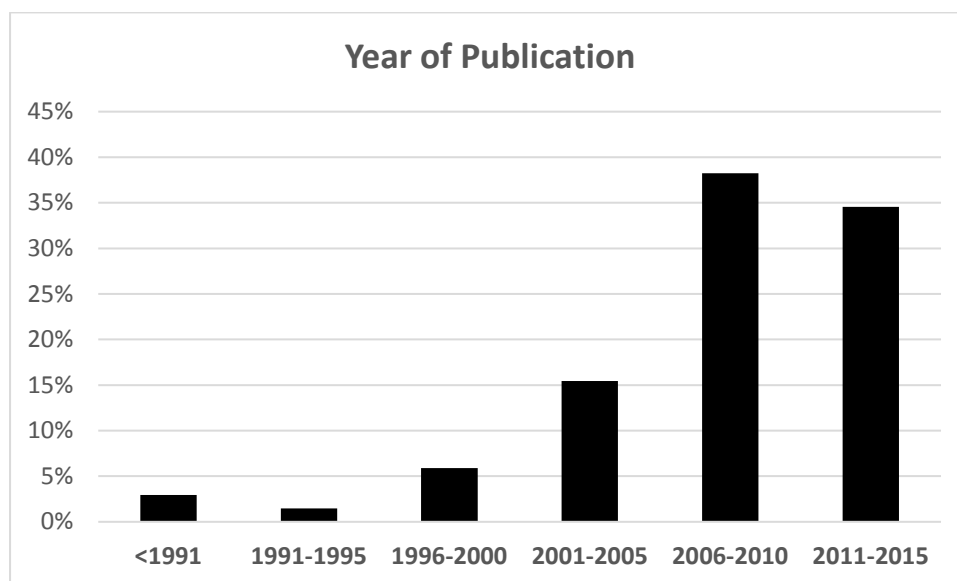
## 4. Overview of the Literature Surveyed

This section summarises the literature reviewed and gives a broad overview of what the literature tells us about Indigenous gendered perspectives of health and wellbeing.

### 4.1. Study selection

Publications were included in the literature review if they addressed the gendered health of Indigenous women and men and were published in 2015 or earlier. The literature search provided 136 publications meeting these criteria. Approximately 70 per cent of the literature was published between 2006 and 2015 (see Figure 3). The literature review revealed that the number of publications relevant to gendered Indigenous health grew steeply between the 2001-2006 period and the 2007-2010 period, with a slight drop-off in publications from 2011-2015. Very little literature was published prior to 1996.

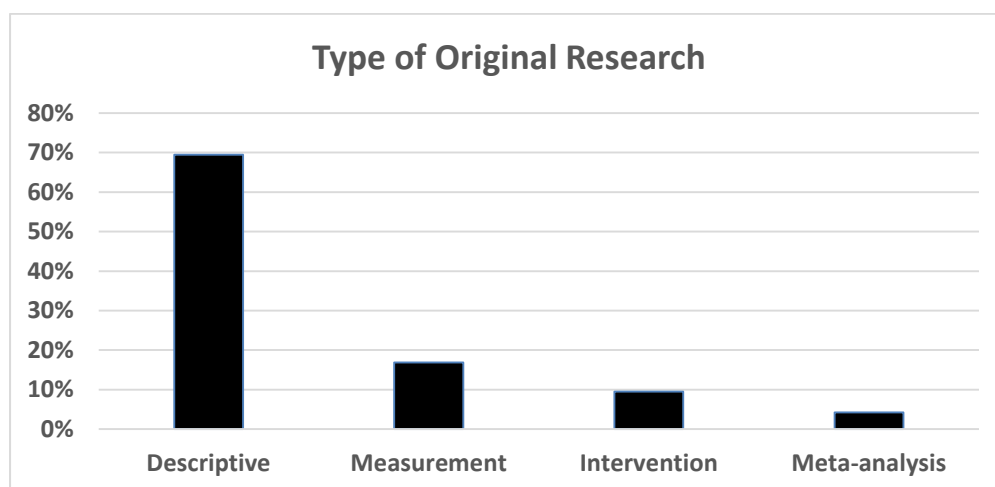
**FIGURE 3 YEAR OF PUBLICATION**



The published literature was classified in two ways (see Figure 4):

- Peer reviewed (43.1 per cent) or not peer reviewed (56.9 per cent)
- Descriptive (69.5 per cent), measurement (16.7 per cent), intervention (9.4 per cent), meta-analysis (4.2 per cent) and not original research (28.6 per cent).

**FIGURE 4 TYPE OF ORIGINAL RESEARCH**



The majority of papers (67) reviewed were descriptive (69.5 per cent). Descriptive research in Indigenous gendered health provides valuable information on health patterns and determinants. However, it does not provide evidence about how to create change and does not monitor change as it occurs.

Measurement studies accounted for 16.7 per cent of the literature reviewed. These mostly included reports of questionnaire-based studies assessing variables such as health-risk behaviours or attitudes. Intervention studies accounted for 9.4 per cent of the literature reviewed. These described (and in some cases evaluated) interventions related to smoking, nutrition and physical activity, and women's health.

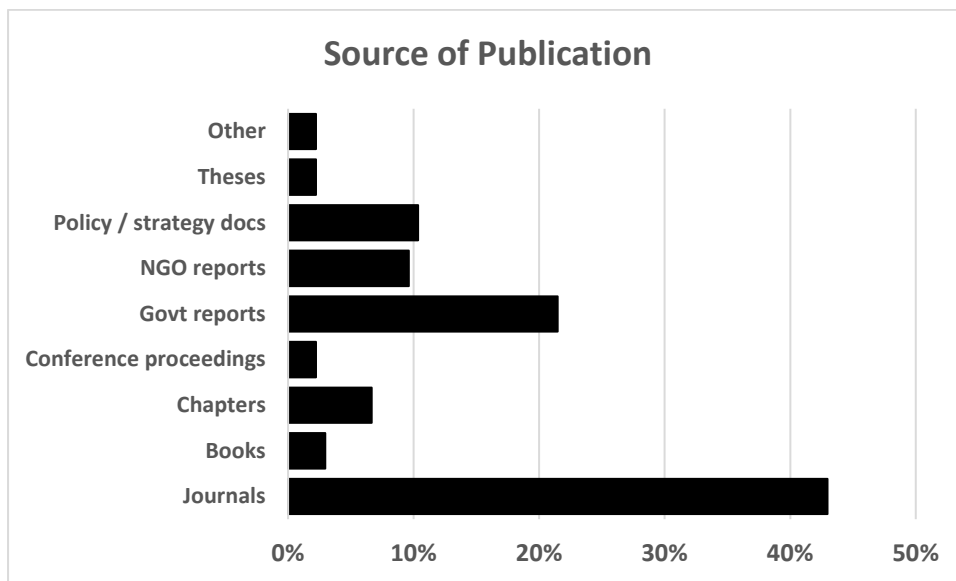
Meta-analysis papers accounted for just 4.2 per cent of the literature reviewed. These papers present the combined results of numerous previously published studies to provide a more complete answer or picture to the issue of concern.

The literature categorised as 'not original research' (28.9 per cent) included policy discussions, frameworks and strategies that were not based on original research.

The literature was also categorised according to its publication source. The review included material from journals (43 per cent), books/monographs (3 per cent), book chapters (6 per cent), conference proceedings (2.3 per cent), government reports (21.5 per cent), non-government reports (9.8 per cent), policy and strategy documents (10.4 per cent), theses (2.2 per cent), and other (1.5 per cent) (see Figure 5).



**FIGURE 5 SOURCE OF PUBLICATIONS**



## 5. Gendered Health Issues

This section summarises the gendered health issues relevant to Indigenous peoples that were revealed in the literature. Themes from peer-reviewed literature and grey literature are synthesised into one discussion.

### 5.1. Gender and Life Course Position

Gender is a factor that influences Indigenous men’s and women’s experiences of health throughout the course of their lives (Osborne, Baum, & Brown, 2013). Life-course position (such as adolescence, early adulthood and later adulthood) produces recognisable patterns. For example, in later adulthood, chronic diseases (such as cancer, diabetes and heart disease) are evident and become dominant considerations (Osborne et al., 2013). However, many health and wellbeing challenges that seem particular to later life stages are influenced by conditions and lifestyle choices made in younger life stages (for example, the cumulative effect of smoking) (AIHW, 2011a). Accumulated life experiences of social, economic and cultural inequality shape Indigenous men’s and women’s health disadvantage (Osborne et al., 2013). Social and economic determinants of health interact with gender and life course experiences and the resulting health outcomes reflect the interactions between these factors (Osborne et al., 2013).

While the daily smoking rate of Indigenous men and women has decreased over the last decade, the smoking rate amongst Indigenous people remains significantly higher than amongst non-Indigenous

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people (ABS, 2014). Tobacco smoking increases the risk of coronary heart disease, stroke, cancers and other conditions (ABS & AIHW, 2005). It is the most preventable cause of poor health outcomes and early deaths among Indigenous peoples (AIHW, 2011b).

On average, Indigenous women experience motherhood at an earlier life stage than non-Indigenous women (AIHW, 2011a). Child birth and caring duties have gendered implications and are experienced differently by young Indigenous women and young Indigenous men (Osborne et al., 2013).

Indigenous men and women experience greater rates of violence than non-Indigenous men and women. This, too, has gendered implications, with Indigenous women more likely to be hospitalised than Indigenous men as a result of family-related violence (AIHW, 2011a; Osborne et al., 2013).

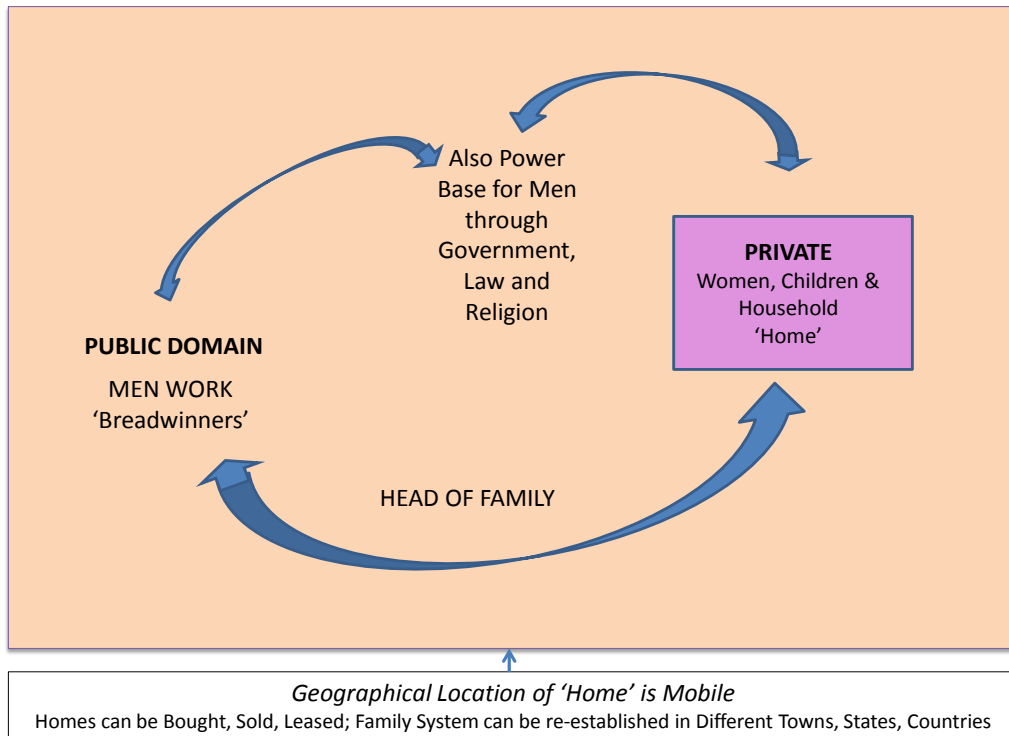
## **5.2. Indigenous Gender Perspectives and the Influence of Western Patriarchy**

Indigenous society accepts that there is men's business and women's business and that this understanding is not based around inequality (Bessarab 2006; Fredericks, 2010; Fredericks, Adams, & Best, 2014). Brock (2001) explains, that 'unlike western societies, where gender has been a marker of empowerment (male) and subordination (female), gender in Aboriginal societies defines different fields of influence and empowerment . This gender-specific authority is protected by maintaining a separation between "male and female spheres"' (p. 9). These 'male and female spheres' are known as men's business and women's business. The activities and knowledges relating to each gender's business are not shared between the genders (Brock, 2001, p. 9; Fredericks, Adams, & Best, 2014). Even today, Indigenous people uphold the separation of men's and women's business, particularly in relation to health interventions (Fredericks, Adams, & Best, 2014).

The Western patriarchal concept of gender probably resulted from Western European historical and sociological approaches to the development of social and family structures. Patriarchy is based on systemic societal structures that institutionalise male physical, social and economic power over women. This process is fundamentally different from Indigenous understandings of masculinity and femininity (Bessarab, 2006; UNOSAGI, 2006). Men's and women's domains in the patriarchal system are clearly defined; men's domain is the public sphere where they were seen as breadwinners supporting their families, while women remain in the private sphere of the house to rear children and keep the house. Childcare, viewed as women's work, is not recognised as having economic value in the way that 'men's work' is acknowledged. A man is viewed as head of his nuclear unit,

independent of family life, in charge of his emotions, and in control of his wife and children (Bessarab, 2006) (refer to Figure 6).

**FIGURE 6 WESTERN PATRIARCHAL CONCEPT OF GENDER**

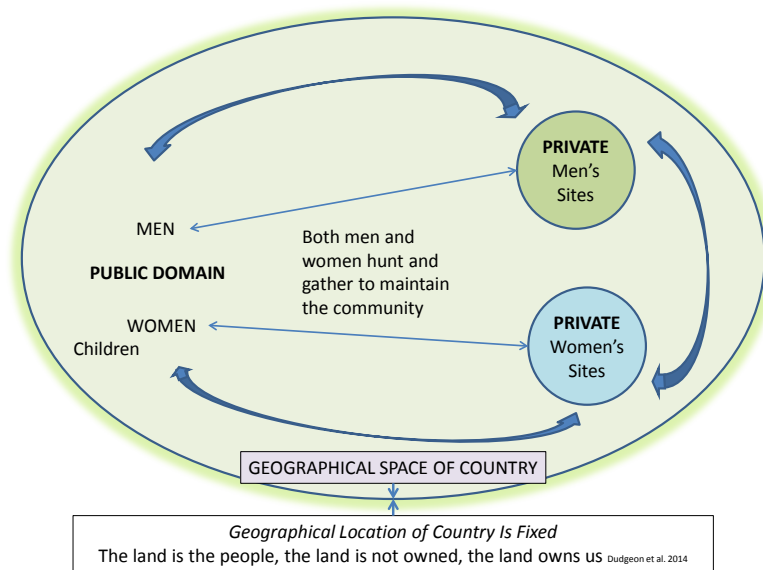


Source: Adapted from Bessarab 2006, p.239.

### 5.3. Indigenous Concept of Gender

Within Indigenous cultures, the concept of gender and the interaction of gender with public and private domains is different from the dominant Western concept. In Aboriginal society, the public domain extends to the geographical spaces of country and community life, where both men and women engage in activities relating to physical, emotional and spiritual survival (Bessarab, 2006). The private domain relates to specific men's and women's geographical sites in country, where ceremonial and spiritual business was carried out for cultural maintenance (Bessarab, 2006). For Indigenous people, gender is linked to the ways they relate to the landscape and is integral to development of cultural identity (Bessarab, 2006) (refer to Figure 7).

**FIGURE 7 ABORIGINAL CONCEPT OF GENDER**



Source: Adapted from Bessarab 2006, p.240.

#### **5.4. The Impact of Western Patriarchal Concepts of Gender on Indigenous Concepts of Gender**

Under the traditional Western patriarchal system, men were seen to have power over women (Bessarab, 2006). It was this power imbalance that the feminist movement challenged as they fought to gain equal rights. Feminists tended to focus on the role of patriarchy and the ensuing unequal power structures between men and women. White feminists assumed that all women shared the same gendered experiences and it was not until the issues of Indigenous women and subjugation were raised to challenge this assumption that Indigenous women were given a voice (Bessarab, 2006; Moreton-Robinson, 2000). For Aboriginal women, feminist issues were not about unequal relationships with their men as defined by white feminists; instead, it was more relevant to consider a partnership where both genders were fighting for racial equality in a dominant Western racial system (Bessarab, 2006; Moreton-Robinson, 2000). Within the functioning of their spiritual responsibilities and community life, neither sex was more powerful than the other. In Indigenous society, men and women coexisted within the functioning of their spiritual responsibilities and community life (Atkinson, 2002; Bessarab, 2006).

Colonisation disconnected Indigenous men and women from their country, and the country was cleared for homes, farms and roads (Bessarab, 2006). Torn from their foundations that lay in the earth, Indigenous men and women emerged from the violence of colonisation suffering ill health,

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sickness and trauma. Colonisation forced Indigenous people to conform to change and adapt to the Western model of gendered roles (Bessarab, 2006).

White male violence and the domination of Aboriginal people from the time of colonisation helped to influence Aboriginal perceptions that male violence was the norm (Bessarab, 2006). What is more, Indigenous men were placed in the same subordinate and dominated position as Indigenous women, with both genders being seen to be in need of care and protection (Bessarab, 2006). The circumstances of being cared for caused Indigenous men's subjectivity to be feminised within a colonial system that essentially made them powerless and invisible (Bessarab, 2006). Indigenous men, no longer able to care for their families, had to learn new ways of being a man. One outcome was to internalise the violence and brutality carried out against them during colonisation (Bessarab, 2006). In the context of transformation of Indigenous maleness, some men were able to transition to new ways of maleness through work and their role of breadwinner and others were not (Bessarab, 2006). Some of those unable to obtain work or transform (or conform) chose powerful and controlling male identities to represent their maleness resulting in social issues of domestic violence, abuse and criminal activities (Bessarab, 2006).

### **5.5. Diversity of Gender Concepts in Contemporary Society**

The introduction of Christianity and Western concepts of gender identity influenced traditional Indigenous concepts of gender, resulting in a wide variation of gender concepts across Indigenous communities (Fredericks, Adams, & Best, 2014). While Indigenous societies have traditionally had clearly defined gender roles, there is wide variation in contemporary society. For example, some communities readily accept 'sister girls' where a male dresses and behaves as a female (Fredericks, Adams, & Best, 2014). Indigenous children today are socialised about masculinity and femininity within contemporary Australia's multi-racial, multi-cultural society that combines both Indigenous and Western ways of knowing and doing (Bessarab, 2006). Fragments of traditional gender roles sit alongside Western understandings in some communities, while other communities are dominated by Western concepts of gender (Fredericks et al., 2014).

### **5.6. Indigenous Australian Males' Health and Wellbeing**

Indigenous men are not homogenous; the health needs and profiles of urban, rural and remote men can vary (Wenitong et al., 2004). However, broad patterns are clear. In 2006, chronic disease was the main cause of the 75 per cent mortality gap between Indigenous and non-Indigenous males aged 35-54 and included ischaemic heart diseases (27 per cent), liver disease (mainly alcoholic liver disease)

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(12 per cent), Type 2 diabetes mellitus (8 per cent), and other forms of heart disease such as heart failure (7 per cent) (AIHW, 2012). The mortality gap rose to 95 per cent for Indigenous men aged 55-74 (AIHW, 2012).

Amongst Indigenous men, high rates of tobacco smoking, risky alcohol consumption, illicit substance use, chronic disease (such as lung cancer, diabetes and kidney disease), health conditions (such as scabies, trachoma and acute rheumatic fever that are uncommon in the general population), and hospitalisation (with 45 per cent of hospitalisations for dialysis) contributed to poor health (AIHW, 2012).

### **5.7. Indigenous Australian Women's Health and Wellbeing**

For Indigenous Australian women, colonisation had a profound and lasting impact (Fredericks, Adams, Angus, & the AWHN Talking Circle, 2010). Indigenous Australian women have a lower life expectancy and poorer physical and mental health across most dimensions when compared with non-Indigenous Australian women (DoHA, 2010c).

Indigenous women are much younger than the non-Indigenous women (ABS, 2013). At the end of June 2011, just under half (45 per cent) of Indigenous Australian women were less than 20 years of age, compared with 24 per cent of non-Indigenous women (ABS, 2013). At the same time, only 3.8 per cent of Indigenous women were aged 65 years or older, compared with 15.2 per cent of non-Indigenous women (ABS, 2013).

In 2011, Indigenous women had more babies at a younger age than non-Indigenous women; 19 per cent of the babies born to Indigenous women were delivered by teenagers, compared with 3.8 per cent of babies born to non-Indigenous teenagers (ABS, 2012a). Indigenous Australian women are likely to access antenatal care later in their pregnancy and less frequently than non-Indigenous Australian women. This may be due, in part, to a lack of access to appropriate care (AHMAC, 2012). Commencing antenatal care late in pregnancy is associated with low birth weight babies, pre-term births and perinatal mortality (AHMAC, 2012; Burns et al., 2013).

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## 6. Policy Frameworks Relevant to Indigenous Gendered Health

### 6.1. International

International policies and declarations assist Australia to strengthen and prioritise its policy approaches to gendered health issues. As the World Health Organisation acknowledges, to achieve the highest standard of health, health policies have to recognise that women and men, owing to their biological differences and their gender roles, have different needs, obstacles and opportunities (WHO, 2002). Translating international policies and declarations into practice at the domestic level remains a challenge.

#### 6.1.1. UN Declaration

Australia formally endorsed the UN Declaration of the Rights of Indigenous Peoples in 2009, two years after it was adopted by the UN General Assembly. Importantly, the rights recognised in the Declaration constitute ‘the minimum standards for survival, dignity and wellbeing of the indigenous peoples of the world’ (UN, 2007, Article 43).

The Declaration has 47 Articles that recognise the rights of indigenous peoples. These include: self-determination; land and natural resources; developing and protecting cultural, political, religious and educational institutions, and intellectual property; freedom from discrimination, assimilation and destruction of culture; economic and social development; environmental conservation; free, prior and informed consent, consultation, and participation in decision-making; fair and mutually acceptable procedures for conflict resolution; and fair and adequate compensation for rights violations. Although not legally binding, the Declaration calls attention to the needs of particular groups, including Indigenous elders, women, youth, children and people with disabilities.

The UN Declaration provides guidance to Australia in advancing the rights of Indigenous peoples and includes the basic building blocks of good health and wellbeing (Mick Gooda, in AHRC, 2010, p. 2).

Gender mainstreaming is a strategy that emerges from the UN documents, and is designed to reduce disparities between women and men. It involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities (UNOSAGI, 2006, p. 2). The UN recognises that ‘gender equality’ may be less relevant to Indigenous cultures than ‘gender complementarity’, with a symbiosis that values both women’s business and men’s business and a complementarity that ensures both mutual respect and balance (UNOSAGI, 2006, p. 2). This concept of ‘gender

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complementarity' is highly relevant to discussions about gender within Australia's Indigenous community.

## **6.2. National Policies and Frameworks**

Within the Australian context, there have been several policy approaches to improve gendered women's and men's health since the development of the *National Aboriginal Health Strategy* (NAHSWG, 1989). In some cases, these approaches have been directly relevant to gendered Indigenous health, such as the *National Indigenous Women's Health Strategy* (Fredericks et al., 2010), and the *National Male's Health Policy Supporting Document – National Aboriginal and Torres Strait Islander Male Health Framework Revised Guiding Principles* (DoHA, 2010a). Over time, these policies have been absorbed into generic health policies and strategies which may or may not deal directly with gendered approaches.

### **6.2.1. Closing the Gap in Indigenous Disadvantage**

In 2005, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Tom Calma, released the *Social Justice Report 2005*. It called on Australian governments to initiate strategies to achieve equality in health care for Indigenous Australians within a 25 year timeframe (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2005). This report led to the 'Close the Gap' public awareness campaign that was backed by peak Indigenous and non-Indigenous bodies, non-government organisations and human rights organisations who worked together with the aim of achieving equality of life and health expectations for Indigenous peoples (Closing the Gap, 2013).

In 2007-2008, the National Indigenous Reform Agreement (NIRA) was established to frame the task of 'Closing the Gap' in Indigenous disadvantage and was endorsed by the Australian government (COAG, n.d.). The national approach to closing the gap between Indigenous and non-Indigenous Australians began with a framework for dealing with Indigenous disadvantage (DFHCSIA, 2013). It included six ambitious targets: closing the life-expectancy gap within a generation (by 2031), halving the Indigenous child mortality rate for children under 5 within a decade (by 2013), ensuring all remote community Indigenous children aged 4 have access to early childhood education within 5 years (by 2013), halving the gap in reading, numeracy and literacy for Indigenous students within a decade (by 2018), halving the gap in year 12 equivalent attainment for Indigenous students (by 2020), and halving the gap in employment levels for Indigenous people within a decade (by 2018) (DFHCSIA, 2013).



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The strategy builds on the United Nations Declaration of the Rights of Indigenous Peoples. It adopts a strengths-based approach to ensure policies and programs improve health, social and emotional wellbeing and resilience, and promote positive health behaviours. It places culture at the centre of health and wellbeing for Aboriginal and Torres Strait Islander people and identifies the rights of individuals to a safe, healthy and empowered life. The 2013 Prime Minister's Report on Closing the Gap outlined the progress made towards meeting these targets; the importance of gendered Indigenous health perspectives was not identified (DFHCSIA, 2013).

### **6.3. Gendered Healthcare Policies in Australia**

Policies that recognise a gendered approach to health grew from a social determinants of health perspective, which broadly maintains that the greater the disadvantage, the more negative the effect on health (CSDH, 2008; DoHA, 2010c; Marmot, 2011; Thomson, Midford, Debuyst, & MacRae, 2010; Wenitong, 2002).

#### **6.3.1. The National Women's Health Policy**

The first gendered health policy in Australia was the *National Women's Health Policy: Advancing Women's Health*, released in 1989 (DoH, 1989). Its priorities were to maintain and develop health services and prevention programs, treat and avoid disease through targeting health issues that would have the greatest impact, and address inequities through broader reforms relevant to the social determinants of health. The policy was developed as the women's health movement was gaining momentum, under the broader banner of the women's movement (Fredericks et al., 2010). The long-standing policy was reviewed in 2009-10 through consultation involving discussion papers, forums and submissions, resulting in the *National Women's Health Policy 2010* (DoHA, 2010c).

As part of the review of the *National Women's Health Policy*, a submission was made by the National Aboriginal and Torres Strait Islander Working Group for the development of an Indigenous Women's Health Strategy (Fredericks et al., 2010; Fredericks et al., 2012). This submission was developed through the Australian Women's Health Network Talking Circle in 2009-10, with more than 400 Indigenous women involved in consultations that identified health issues, gaps and barriers to health services (Fredericks et al., 2010). The premise underpinning the strategy was a belief that, unless Indigenous women are empowered and affirmed as Indigenous women, few gains will be made in their health status (Fredericks et al., 2010). Whilst the *Women's Health Policy* and the *Indigenous Women's Health Strategy* have advanced women's health issues, much work remains to close the gap on Indigenous women's health outcomes.

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### 6.3.2. The National Male Health Policy

The first *National Male's Health Policy* (DoHA, 2010b) was introduced in Australia in 2010, 21 years after the first *National Women's Health Policy*. In 2009, the Australian government completed an extensive literature review, held public forums and consultations, and received submissions relevant to developing the *National Male's Health Policy 2010* (DoHA 2010b). The term 'male health' was used (rather than 'men's health') because the age when a boy is considered to be an adult (man) depends on cultural norms around gender, roles and ageing (AIHW, 2012); 'male health' was considered to be a more inclusive term.

The *National Male's Health Policy* provides a framework for improving men's health in Australia through six priority areas for action: (1) optimal health outcomes for men by promoting recognition of the valuable roles men have in family and community life, (2) health equity between population groups of men by giving policy priority to males who experience the greatest health disadvantage, (3) improved health for males at different life stages, (4) a focus on preventive health for males, (5) building a strong evidence base on male health, and (6) improved access to health care for men by encouraging health services to be responsive to men's health needs (DoHA, 2010b). Participants in consultations around the policy development identified the importance of recognising and addressing key social determinants of male health such as income, education, employment, injustice experienced by Indigenous peoples, relationships, violence and geographic location (DoHA, 2010b).

### 6.3.3. National Male Health Policy Supporting Document

A priority of the *National Male's Health Policy 2010* included achieving equal health outcomes between population groups of males, particularly Indigenous males (Thomson et al., 2010). A supporting document to the *National Male's Health Policy* was developed to represent the views of the National Aboriginal and Torres Strait Islander Male Health Leadership Group (a non-government body). This document – the *National Male's Health Policy Supporting Document, National Aboriginal and Torres Strait Islander Male Health Framework Revised Guiding Principles* (DoHA, 2010a) outlines 11 guiding principles for improving the health of Indigenous males (DoHA, 2010a): (1) reconstructing male empowerment and self-determination; (2) an holistic approach; (3) continuity of care; (4) shared, integrated, collaborative and responsible processes; (5) partnership approach; (6) strategy and policy development; (7) access and support; (8) the health workforce; (9) the evidence base; (10) allocation of funding; and (11) governance (DoHA, 2010a). The principles are intended to address the needs of Indigenous males in an empowering and holistic way, taking into consideration the social determinants of their health (Thomson et al., 2010). The principles highlight

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accountability, collaboration, support and community control of health services as an aspect of building the knowledge and capability of Indigenous men in order that they better understand and control the determinants that affect their health. The principles also emphasise the value of collaborative research with communities and the need to increase the number of Indigenous males in the health workforce (Thomson et al., 2010). While the intent of the guiding principles is to encourage ownership and change, it is clear that the gap in the health status of Indigenous and non-Indigenous males is still very wide.

The *National Male's Health Policy* recognises the injustice experienced by Indigenous men, and recognises that while '... today many Aboriginal and Torres Strait Islander males are fulfilling important roles and responsibilities as Elders, custodians of the land, husbands, fathers, sons, grandfathers, grandsons, brothers, uncles, nephews, providers, teachers and mentors', the fact remains that Indigenous men have a significantly shorter life expectancy than any other group in Australia (DoHA, 2010b, p. 16).

The health disadvantage faced by Indigenous males can be traced back to the emasculation and dehumanisation of Indigenous men through the process of colonisation that disenfranchised them from their role and status afforded them through lore and ceremony, which was traditionally maintained through fulfilling their obligations (NACCHO, 1995). Western society violently and institutionally imposed alien values on Indigenous men that included gender and racial discrimination, materialism, working for self not the community, disease, drugs, nutritionally bankrupt food, disrespect for human rights, and disrespect for the land and environs (NACCHO, 1995). The inherited effect of this violence and dispossession caused the health and wellbeing of Indigenous men to deteriorate dramatically to a point where their individual, family and community existence is often characterised by low self-esteem, violence, poverty, high rates of morbidity and mortality including low life expectancy (NACCHO, 1995). These losses engender high levels of alcohol abuse, self-harm, violence and consequential inter-generational family dysfunction, poor male role models and profound health implications (Thomson et al., 2010). As a result, there is little incentive for Indigenous boys to attend school and training to prepare them for adulthood and little incentive to participate in work. This means that the cycle of male disenfranchisement, demoralisation and poor health continues (Thomson et al., 2010).

#### 6.3.4. National Aboriginal and Torres Strait Islander Health Plan

The *National Aboriginal and Torres Strait Islander Health Plan 2013-2023* (NATSHP) provides the foundation for all State and Territory Aboriginal Health Plans (DoH, 2013). It provides a long-term,

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evidence-based policy framework as part of the overarching Council of Australian Governments (COAG) approach to Closing the Gap in Indigenous Disadvantage. The key premise is that Aboriginal and Torres Strait Islander people have the right to live a healthy, safe and empowered life, with a strong and healthy connection to culture and country. This plan commits the Australian government to continue working across governments and sectors to invest in making health systems accessible, culturally safe, appropriate, effective and responsive for all Aboriginal and Torres Strait Islander people. Its goal is to support good health and wellbeing across the life course, and to continue to target risk factors at key life stages. The plan recognises that key life stages provide strategic points of intersection between 'health, mental health and social and emotional wellbeing, and provide a patient-centred platform for different agencies, organisations, government, stakeholders and representative bodies to work together to plan and deliver better co-ordinated and focused programs' (DoH, 2013, p. 5). The plan acknowledges that sustained improvement in this area requires system-level action across the health system and the social determinants of health.

NATSIHP provides a national framework in partnership with a range of other plans and strategies to Close the Gap in Indigenous disadvantage (DoH, 2013). Some of the plans and strategies that link to it include:

- *National Anti-Racism Strategy 2010-2020*
- *Roadmap for National Mental Health Reform 2012-2022*
- *National Aboriginal and Torres Strait Islander Suicide Prevention Strategy 2013*
- The renewed *Aboriginal and Torres Strait Islander Social and Emotional Wellbeing Framework*
- *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework*, including supporting the take-up of health careers and support for people working in the health and healing professions
- *Review of Higher Education Access and Outcomes for Aboriginal and Torres Strait Islander People*
- *New Directions: Mothers and Babies Services* (an Australian Nurse-Family Partnership Program) (DoH, 2016) and *Strong Fathers Strong Families* (DoH, 2014).

These plans and strategies all recognise that the various interventions must work together from a social determinants and strengths approach to improve Aboriginal and Torres Strait Islander health and wellbeing. Gendered Indigenous health issues are incorporated within the strategies and plans.

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## 6.4. State/Territory Policies

Each state and territory government translates the National Aboriginal and Torres Strait Islander Health plan into their own jurisdictional approaches. Since the roll-out of the National Men's and National Women's policies in 2010 and the subsequent Indigenous Men's and Indigenous Women's strategies, most states and territories have located women's and men's business as part of their generic Aboriginal Health Plans (NSW Health, 2012; DoH Vic, 2014; SAHD, 2010; Queensland Government, 2010; NT Government, 2015; DH/AH WA, 2012; DHHS Tas, 2006; DoH ACT, 2016).

A number of states and territories have specific women's health policies and strategies that are based on the *Women's Health Policy 2010* and the *Indigenous Women's Health Strategy 2010*. All of these policy and strategy documents for women's health recognise that the social determinants play a strong role in improving the health of women, particularly the health of Aboriginal and Torres Strait Islander women.

### 6.4.1. Victoria

The Victorian Women's Health and Wellbeing Strategy 2010-2014 (DoH Vic, 2010) builds on the previous Victorian women's health and wellbeing strategies (2002-2006, 2006-2010) and aims to improve and promote the health and wellbeing of Victorian women with a focus on identified populations where targeted approaches are required. The four broad priorities are to: (1) improve health and reduce illness, (2) enhance mental health and reduce poor mental health, (3) prevent violence against women and improve the health response, and (4) optimise the sexual and reproductive health of women (DoH Vic, 2010). This strategy also supports the Victoria's plan for preventing violence against women.

### 6.4.2. Western Australia

The *Western Australia Women's Health Strategy 2013-2017* (WADH, 2013) is based on five policy goals to address the social determinants of health for women, as set down by the Federal government in the *National Women's Health Policy 2010* (DoHA, 2010c):

- Gender is recognised as a key determinant of women's health and there are beneficial outcomes for women in health services
- Health responses reflect the different needs of women according to their life stage, race, social, cultural, psychological and economic circumstances
- Women with the highest risk of poor health are identified and prioritised

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- The health system is responsive to all women, with a clear focus on illness and health promotion
  - The evidence base on women's health is advanced through effective and collaborative research, data collection, monitoring, evaluation and transfer of knowledge (WADH, 2013).

### 6.4.3. South Australia

The *South Australia Women's Health Policy* (DoH SA, 2005) sets out three priority action areas: (1) improving women's economic status, (2) increasing women's leadership and participation, and (3) improving women's safety and wellbeing. The policy recognises that Aboriginal people are over-represented among Australians facing disadvantage. It seeks to develop a system that is sensitive and responsive to women's health needs, improve health outcomes and access for Indigenous women, ensure that women from all backgrounds get the services they need in ways that respect their culture and rights, reduce the factors that contribute to poor health for women, and ensure a continuum of care for women across all life stages.

### 6.4.4. Northern Territory

The *Policy Framework for Northern Territory Women 2015-2020* (DLGCS NT, 2015) has four key focus areas: (1) women's safety, (2) health and wellbeing, (3) economic security, and (4) leadership and participation. This policy framework recognises the differences in health outcomes and statistics for Indigenous and non-Indigenous women.

The Policy has five policy goals that aim to address key social determinants:

- Highlight the significance of gender as a key determinant of women's health and wellbeing
- Acknowledge that women's health needs differ according to their life stage
- Prioritise the needs of women with the highest risk of poor health
- Ensure the health system is responsive to all women, with a clear focus on illness prevention and health promotion
- Support effective and collaborative research, data collection, monitoring, evaluation and knowledge transfer to advance the evidence base on women's health (DLGCS, 2015-2020).

## 6.5. State Indigenous Men's Health Policies

State and Territory governments have adopted a range of strategies to address Indigenous men's health, usually located within broader men's health policies. Specific policies relevant to Indigenous

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males are difficult to locate. In most cases, jurisdictions address specific gender issues within their broader Aboriginal and Torres Strait Islander Health Plans.

### 6.5.1. Victoria

The *Victorian Men's Health and Wellbeing Strategy* (DoH Vic, 2010) is a foundation document designed to guide change and deliver better health outcomes for all Victorian men and particularly for groups of men with the poorest health. It addresses three areas:

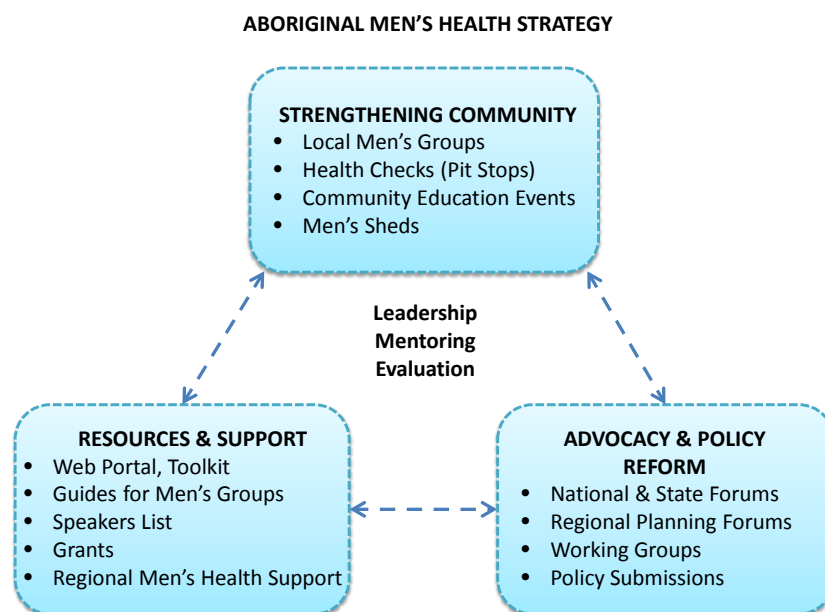
- Reduce health inequalities and improve the quality and length of men's lives by focusing work on the six identified priority conditions that have large gender-specific impacts on men
- Promote and facilitate men's healthy living by supporting healthy lifestyles and strengthening men's health knowledge and behaviours
- Strengthen health and community service delivery to men by encouraging inclusive service models and service delivery practices.

Victoria's strategies for men's and women's health link directly with the document *Well Proud: A Guide to Gay, Lesbian, Bisexual, Transgender and Intersex Inclusive Practice for Health and Human Services* (DoH Vic, 2009). This guide recognises the additional discrimination that Aboriginal and Torres Strait Islander people face and offers an evidence-based approach to inclusive health services.

### 6.5.2. Western Australia

Western Australia has a specific strategy for Aboriginal men's health: The *WA Aboriginal Men's Health Strategy 2012-2015* (WADH, 2012). This strategy outlines approaches to strengthen communities through local men's groups, health checks and community events, and resources and support. The strategy recommends providing guides for men's groups, speakers' lists, grants and advocacy. It recognises the value of policy reform via forums, working groups and policy submissions (refer to Figure 8).

**FIGURE 8 WA ABORIGINAL MEN'S STRATEGY**



Source: Adapted from WADH 2012, p. 2.

### 6.5.3. Northern Territory

In the Northern Territory, a men's health strategy unit was established within the Department of Health in 2011 to provide expert advice, leadership and strategic direction in men's health, with a particular focus on Aboriginal males (DOH NT, 2013). It has a number of functions:

- Develop a strategy for improving the health and wellbeing of males in the NT
- Integrate a male gender perspective into Departmental policy, plans and programs
- Develop and support research capacity on gender and health including the establishment of a data collection process which provides accessible data on key health and wellbeing indicators which can inform program development
- Establish and support a network which encourages information sharing and collaborative program development
- Increase men's use of health services through workforce training, development and increasing the male health workforce
- Improve public awareness about male health and improve men's knowledge about, and use of, preventive health and well-being services
- Invest in the planning and development of targeted health promotion and disease prevention strategies



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- Provide advice and support for implementation of targeted health programs for Aboriginal males.

## **7. Effective Strategies Addressing Indigenous Gendered Health and Wellbeing**

Most government departments have a range of resources and health service plans for Aboriginal and Torres Strait Islander women and men. Many services are also getting much better at collecting data from Aboriginal and Torres Strait Islander peoples (though some data collection issues rely on whether people identify as Aboriginal and/or Torres Strait Islander). Data collection is important: having correct data allows governments to direct appropriate services and resources to these population groups. This section discusses a number of effective strategies, services and programs designed to address Indigenous gendered health and wellbeing. One strategy that has been particularly effective is Aboriginal Community Controlled Health Services.

### **7.1. Aboriginal Community Controlled Health Services (ACCHS)**

An Aboriginal Community Controlled Health Service (ACCHS) is a primary healthcare service established and operated by a local Aboriginal community through a locally elected Board of Management. ACCHSs deliver holistic, comprehensive and culturally appropriate health care to their community (Alford, 2014). ACCHSs are supported by the National Aboriginal Community Controlled Health Organisation (NACCHO), a peak body that supports more than 150 ACCHSs across the country. NACCHO's history extends back to a meeting in Albury in 1974 (Alford, 2014; NACCHO, n.d.; 2013).

The first ACCHS was established in Redfern, Sydney, in 1971, because mainstream services were not dealing adequately with the health needs of Indigenous people (Alford, 2014; Hayman, White, & Spurling, 2009). Today, ACCHSs operate in a range of urban, regional and remote settings. They range from large multi-function services to small services that rely on Aboriginal Health Workers and/or nurses to provide most of the primary health care. ACCHSs often have a preventative, health-education focus (Alford, 2014).

ACCHSs are a cost-effective approach to health care, providing a better return on investment than mainstream services, and adding substantial economic value to Indigenous communities. They also have positive impacts on education and other sectors (Alford, 2014). The concept Aboriginal community control informs the structure of ACCHSs and links to Aboriginal people's right to self-

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determination (Alford, 2014). In terms of access and outcomes, ACCHS services outperform mainstream services primarily because mainstream services deliver clinical care rather than the culturally appropriate comprehensive primary health care (Alford, 2014). While some mainstream health services offer specific programs for Aboriginal and Torres Strait Islander people (such as Public Health Networks (PHNs), community health centres and GPs), cultural sensitivity and access to appropriate services can be a problem.

Mainstream primary healthcare services continue to fail in not meeting the health and wellbeing needs of Indigenous people. Alford (2014) argues that more than 50 per cent of all avoidable deaths amongst Aboriginal peoples relate to primary prevention and are due mainly to the 'Four A' barriers to accessing health services: availability, appropriateness (cultural), acceptability, and appropriateness (to health need) (Alford, 2014). These barriers persist, particularly in major cities. This may, in part, be attributed to the pervasive assumption that mainstream health services are a satisfactory substitute for Indigenous peoples in urban Australia (Alford, 2014).

Many ACCHSs offer specific services for men, women and children. Some examples include: maternal and child health programs, men's business and women's business areas, and a variety of other gender-specific programs. There are also specific-issue programs, such as social and emotional wellbeing, alcohol and other drugs programs, and sexual health programs.

## **7.2. Indigenous Women's Health Services**

Specific strategies and services for Indigenous women's health issues exist in both ACCHSs and mainstream services. In addition, some national policy platforms advocate for Indigenous women's health issues. Some of these are highlighted below.

### **7.2.1. Case Study: Waminda's Wellbeing Program**

Waminda's Women's Wellbeing Program is one example of a culturally appropriate, gender-specific health and wellbeing program coordinated by an ACCHS. Waminda is an ACCHS servicing the Shoalhaven region in NSW. The Waminda Women's Wellbeing Program opened as a 10-week pilot program in the community of Nowra in 2010. It offers physical health check-ups, chronic disease management and education, and exercise and cooking programs focused on prevention and early intervention (Firth et al., 2012). The 10-week pilot was so successful that participants asked for it to continue (Firth et al., 2012).

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Waminda secured funding to continue operating the Women's Wellbeing Program, and initiated a range of flexible approaches built around Indigenous women's needs. Waminda consulted with local women and empowered women to participate in the program (Firth et al., 2012). To date, participants include 51 Indigenous and 3 non-Indigenous women (including service support staff) who have benefited physically, mentally, socially and emotionally. Many have expressed a desire for additional exercise sessions (Firth et al., 2012). In 2012, a tobacco cessation program was introduced, and soon after 17 participants were actively addressing their smoking habit (Firth et al., 2012). This program was added to with other successful programs, including the Dead or Deadly Program (see Fredericks et al., 2016).

Community engagement and individual support are concepts that are vital to the successful outcomes of the Women's Wellbeing Program. Participants receive extensive individual support when they begin the program, including transport if required (Firth et al., 2012). The program scaffolds with the intentions of the *National Women's Health Policy* and the objectives of ACCHSs by providing culturally appropriate health care, through local initiatives, for local issues, which are deliberated over by local communities (Alford, 2014; DoHA, 2010c).

### 7.2.2. National and International Indigenous Women's Conferences Since 1989

Organising National and International Women's health conferences and forums for professionals, community members and other stakeholders is a successful strategy for advancing policy and planning around Indigenous women's health issues. The first Indigenous Women's conference, 'Finding Common Ground', was held in Adelaide on 7-12th July 1989. This conference had over 1200 delegates from across Australia and from 16 other countries (including New Zealand, the United States, Sami Land/Norway, Canada, Palestine and France). Workshops covered a broad range of topics and led to resolutions about Indigenous women's health issues.<sup>4</sup> Since then, two organisations have facilitated conferences relevant to women's health: the Australian Women's Health Network<sup>5</sup> and the National Aboriginal and Torres Strait Islander Women's Alliance.<sup>6</sup>

### 7.3. The Australian Women's Health Network (AWHN)

The Australian Women's Health Network [AWHN] is the peak women's health organisation in Australia. It is run by volunteers and provides a national voice on women's health through advocacy and information sharing. AWHN hosts a national conference every five years. The AWHN Talking

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<sup>4</sup> The conference report, convened by Jo Willmot, is held at the National Library of Australia.

<sup>5</sup> Further information available on the website: <http://awhn.org.au/>

<sup>6</sup> Further information available on the website: <http://natsiwa.org.au/>

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Circle successfully lobbied the Australian Government to develop the National Aboriginal and Torres Strait Island Women's Health Strategy in 2010 (AWHN, 2009).

### 7.3.1. National Aboriginal and Torres Strait Islander Women's Alliance (NATSIWA)

The National Aboriginal and Torres Strait Islander Women's Alliance [NATSIWA] was established in 2009 to empower Aboriginal and Torres Strait Islander women to have a strong and effective voice in domestic and international policy advocacy processes. Its vision is 'to protect the health, human rights and fundamental freedoms that are significant to Aboriginal and Torres Strait Islander Women through cultural preservation, health education and coalition building' (NATSIWA, n.d.).

## 7.4. Indigenous Men's Health

Specific strategies and services for Indigenous men's health issues exist in both ACCHS and mainstream services. Some of these are highlighted below.

### 7.4.1. Aboriginal and Torres Strait Islander Male Health Training Package

The *National Male's Health Policy Supporting Document* identified that increasing the number of Indigenous men in the health workforce is vital to improving health outcomes for Indigenous males (DoHA, 2010a). The first comprehensive accredited training package specifically designed for Aboriginal and Torres Strait Islander male health was recently developed and piloted (Tsey et al., 2012). The package's goal is to increase the capacity of health workers and improve access to health services for Indigenous men. It seeks to fill a gap in workforce training and promote health worker empowerment and wellbeing (Tsey et al., 2012).

Evaluation of the pilot phase adds to the evidence that when specific Indigenous male-friendly health programs are available, Indigenous men's health-seeking behaviour improves (Tsey et al., 2012). The evaluation also suggested that if not enough male health workers are available, male and female health workers can work in partnership with mutual respect and trust to improve access to health services for Indigenous men (Tsey et al., 2012).

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### 7.4.2. National Indigenous Male Health Conferences

The first National Indigenous Male Health Conference<sup>7</sup> was held on 5-6th October, 1999, at Ross River Homestead in the Northern Territory. It provided an opportunity for Indigenous males from all over Australia to express their perspectives and experiences of health and explore initiatives for the future. The convention created a forum for Indigenous males and other males working in the Indigenous male health field to share their experiences and aspirations in the safety of an ‘all male’ (and mostly Indigenous) environment.

The National Male Health Reference Group was formed from the 1999 conference. Since then, Male Health Conferences have been held regularly, with the 8th Indigenous Male Health Conference<sup>8</sup> held in 2015. The conferences provide a focussed approach for considering Indigenous male health around a specific theme (the 2015 theme was *Sharing the Knowledge: Male Health is Everyone’s Business*).

### 7.4.3. Indigenous Men’s Groups

Indigenous Men’s Groups provide an important approach for addressing family violence, suicide, and other social and emotional wellbeing matters (McCalman, Baird, & Tsey, 2007). Support groups can be powerful agents for change when people participate together to increase their capacity and knowledge, develop shared meanings and change their social environment (McCalman et al., 2010; Wenitong et al., 2004). In a meta-synthesis of five studies examining Indigenous men’s support groups, McCalman et al. (2010) found that, in spite of constraints, local men’s groups inspired social cohesion and worked to shift social norms towards respect, responsibility and improved wellbeing for men and their families.

### 7.4.4. Case Study: Red Dust Healing through Acknowledging the Past and Changing the Future

The Red Dust<sup>9</sup> Healing Program adopts an interdisciplinary approach working through ACCHSs, mainstream health services, and Aboriginal Elders (Powell, Ross, Kickett, & Donnelly, 2014). It was developed by two Indigenous men to counter the effects of the history of dispossession, rejection

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<sup>7</sup> Further information available on the website:

<http://www.ethicalnutrition.com.au/menshealth/malehealth.htm>

<sup>8</sup> The 8<sup>th</sup> Aboriginal Men’s Health Conference was held in conjunction with the 11<sup>th</sup> Australian Men’s Health Conference under the banner of ‘2015 Men’s Health Gathering’. Further information available on the website: <http://www.indigenous.gov.au/news-and-media/event/2015-men%E2%80%99s-health-gathering>

<sup>9</sup> Further information available on the website: <https://www.thereddust.com/>

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and powerlessness of Indigenous peoples (Powell et al., 2014). It aims to promote healing of the persistent effects of rejection, grief and loss common across Indigenous communities.

The Red Dust Health Program has been operating for more than six years, and has supported more than 5,000 participants in 300 communities across Australia (in urban, regional, rural and remote areas) (Powell et al., 2014).<sup>10</sup> The success of the program is attributed in part to the personalised approach and ‘the opportunity to come away with something that immediately applies to their daily troubles and deep personal unmet needs’ (Powell et al., 2014, p. 466). Moreover, the values and philosophy of Red Dust Healing tie in with the holistic approach to Indigenous male health outlined in the *National Male’s Health Policy Supporting Document* (DoHA, 2010a).

### **7.5. Research Approaches – Male Reproductive Health Disorders and Indigenous Men**

The *National Male’s Health Policy Supporting Document* states that Indigenous male health research should be designed, approved, conducted and disseminated in collaboration with Indigenous males and their communities (DoHA, 2010a; Thomson et al., 2010). A recent research project was designed to better understand reproductive health disorders among Indigenous men, particularly because early detection may assist in identifying chronic disease (Jackson et al., 2010). The project was supported by ACCHSs, governing councils and Elders of the communities involved (Adams, Collins, Dunne, de Kretser, & Holden, 2013).

Reproductive male health disorders are an important topic for research in Indigenous communities. There is evidence that the recognition and treatment of reproductive health disorders (including erectile dysfunction) is lacking in Indigenous communities, due to barriers to help-seeking that include shame, culturally inappropriate services and lack of awareness (Adams et al., 2010). The research showed that providing a culturally safe environment encouraged Indigenous men to talk about sensitive health issues (Adams et al., 2013). It also revealed that Indigenous men often remain silent about reproductive health issues due to fear of confidentiality breaches within the community and stigma associated with sexual problems (Adams et al., 2010). A lack of culturally appropriate health services for men, the predominance of female health professionals, and health services not encompassing the cultural aspects of family and gender all added to the barriers experienced by Indigenous males (Adams et al., 2013).

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<sup>10</sup> According to the Red Dust website, by mid-2017 more than 11,000 people had been through the program, with more than 3,000 information sessions and 1-day workshops now delivered. See <https://www.threddust.com/the-red-dust-story>

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The research demonstrated that culturally appropriate care, within the framework of Indigenous culture, requires that Indigenous clients with gender-specific health problems be treated by a health professional of the same sex (Morgan et al., 1997).

## **8. Culturally Appropriate Gendered Health Programs**

More than three decades ago, a submission from the South Australian Health Commission to the National Aboriginal Health Strategy Working Group (NAHSWG) stated that problems had arisen in the health system because of the ‘failure to recognise and adequately address the very fundamental differences in the belief system on which concepts of health and illness are based in Aboriginal and Western cultures’ (NAHSWG, 1989, p. 60). The Working Party identified the need for culturally appropriate, relevant coursework and clinical experience for health workers, in order to increase workers’ understanding of Aboriginal health issues (NAHSWG, 1989). This submission led to the introduction of cultural awareness training programs (Downing & Kowal, 2011).

The terms ‘cultural awareness’, ‘cultural safety’, ‘cultural security’, ‘cultural competency’ and ‘cultural respect’ are widely used in the health sector. In this section, we provide an overview of the different terms and the processes used in cross-cultural training.

### **8.1. Cultural Awareness**

Indigenous cultural training in Australia is built around a ‘cultural awareness’ framework that aims to educate health workers about Indigenous culture (Downing & Kowal, 2011). While the content of cultural-awareness programs can vary, most share a common focus: (1) to increase participants’ awareness and knowledge of various cultural, social and historical factors relating to Indigenous people generally and to Indigenous groups and/or communities more broadly; and (2) to promote participants’ self-reflection about their own culture, biases and tendency to stereotype (Thomson, 2005). Cultural-awareness training is intended to help participants gain a greater understanding of the diversity of values, beliefs and behaviours underlying Indigenous Australian culture and their own cultures (Thomson, 2005).

Research suggests that cultural-awareness training in Australia is relatively ineffective (Downing et al., 2011; Thomson, 2005). This is, in part, attributed to the way that cultural-awareness training focuses on the individuals working in the health system, rather than on the system itself (Thomson, 2005).

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## 8.2. Cultural Safety

The concept of cultural safety was initiated in Aotearoa New Zealand through the seminal work of Irihapiti Ramsden (2002), who presented the concept from the point of view of the Indigenous voice (Kemble, 2004). The aim of cultural safety is to address the effects of colonisation within the dominant health system by focussing on the level of cultural safety that an Indigenous person feels when seeking health care (Downing & Kowal, 2011; Downing et al., 2011; Polaschek, 1998; Williams, 1999).

Cultural safety involves identifying the position of certain groups (such as Maori) in society. It is how this group is perceived and treated that is relevant to cultural safety, rather than how the group members act or think (Polaschek, 1998). A cultural-safety paradigm seeks to effect systemic change by encouraging health workers to reflect on how they and the health seeker sit within cultural frameworks by exposing and confronting the discourses and assumptions that are used by the dominant structures and systems (Downing & Kowal, 2011).

Cultural safety has been adopted as a policy in Australia. However, it has been developed here by the dominant Western culture (Kemble, 2004), unlike in New Zealand where it was developed by Maori nurses to analyse nursing practice from their perspective (Polaschek, 1998). It is important to note that the major difference between Maori and Indigenous Australians is the great diversity of the Indigenous population in Australia (Maori are a united and collective race in New Zealand) (Kemble, 2004). From an Indigenous Australian perspective, a first step in creating effective cultural safety training material would involve examining the purpose of cultural safety and whose needs it is serving. It would also involve consulting and trusting Indigenous reality as the basis of policy and actions (Kemble, 2004). Kemble (2004) argues that essential elements in developing cultural safety include effective consultation to guarantee that Indigenous voices are heard and making cultural safety a national issue with nation-wide implementation. In addition, the teaching and content of cultural safety training needs to be adapted to suit the geographical location (Kemble, 2004).

The struggle for cultural safety requires social change through education (Kemble, 2004; Ramsden, 2002; Turia, 2004). Ramsden (cited in Turia, 2004) attests that social change is difficult:

In the neo-colonial environment this requires a profound understanding of the history and social function of racism and the colonial process. It also requires a critical analysis of existing social, political, and cultural structures and the physical, mental, spiritual and social outcomes for people who are different. It is a given that this type of knowledge is not taught



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in a general educational pedagogy which is normally about maintaining the status quo which underpins a conservative economic system based on individual success .... It is consequently very difficult to move the issues of cultural safety in relation to Maori health forward since that basis of this work lies in establishing an understanding of national and local issues and their impact on health. (Ramsden, in Turia, 2004)

Cultural safety was explicitly developed as a way of decolonising the health system (Downing & Kowal, 2011). Kemble (2004) has called for those in positions of influence to change the nursing curriculum and policy to ensure cultural safety for Indigenous Australians. This process is fraught with difficulty, as change is needed for improved health outcomes for Indigenous peoples in Australia. Systemic racism is an ongoing issue that smothers equity and understanding.

### **8.3. Cultural Security**

The concept of cultural security was introduced in Western Australia in the late 1990s (Thomson, 2005). Coffin (2007) maintains that both cultural awareness and cultural safety must be addressed in order to progress toward cultural security. Cultural awareness depends on the individual health worker and their knowledge of Aboriginal culture (Coffin, 2007). Cultural safety involves the ways that health providers work with individuals, organisations and occasionally communities (though their actions are usually not standardised as policy and procedure) (Coffin, 2007). Cultural security, on the other hand, links understandings and actions through policies and procedures to create processes that are initiated from the time an Indigenous person first seeks health care (Coffin, 2007).

Cultural security involves a change in focus; away from the attributes of health professionals, toward the attributes of the health system and the interactions between professionals and clients (Thomson, 2005). No matter who in the health service attends an Indigenous client seeking health care, they should know the culturally relevant policies and procedures to follow (Coffin, 2007).

### **8.4. Cultural Competency**

The concept of cultural competency was developed in the United States to reduce disparity between the general population and so-called 'minority' groups. Cultural competency has been evolving since the late 1980s (Cross, Brazon, Dennis, & Isaacs, 1989; Thomson, 2005). Cultural competency focuses on the competence of the organisational culture (where the health workforce reflects the diversity of the population), the systemic culture (with elimination of systemic barriers), and the clinical culture (with cultural knowledge, skills and behaviours vital for delivery of quality care to all patients) (Betancourt, Green, & Carrillo, 2002; Thomson, 2005). Thomson (2005) argues that

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‘cultural respect and cultural safety will only be achieved when the various aspects of the healthcare system are culturally competent’ (p. 9). In Australia, cultural competency is embodied in the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health, 2004-2009 (AHMAC, 2004; Thomson, 2005).

## **8.5. Cultural Respect**

In the early 2000s, the evolution of cultural training in Australia saw the concept of cultural security incorporated into the broader concept of cultural respect (Thomson, 2005). The Cultural Respect Framework, prepared by the Australian Health Ministers’ Advisory Council’s Standing Committee on Aboriginal and Torres Strait Islander Health Working Party, defines cultural respect as ‘... the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples’ (AHMAC, 2004, p. 7).

The Cultural Respect Framework aims to influence corporate health governance, management and delivery of the Australian healthcare system, to rework policies and practices in a way that is culturally respectful. It recognises the significance of recommendations in other major reports focussed on the health and wellbeing of Indigenous peoples and does not replicate, replace or supersede existing key national strategies for Indigenous health (AHMAC, 2004).

Cultural respect is achieved when the health system is a safe environment for Indigenous peoples – a place where cultural differences are respected (AHMAC, 2004). For many years, policy has focused on building the knowledge and awareness of health workers, resulting in varied levels of cultural skill and changing the behaviours of some individuals in the system. However, focussing on health workers’ skills and knowledge is a narrow approach; system-wide change requires focusing on the system level (AHMAC, 2004; Thomson, 2005). Fredericks (2008) pinpoints this issue: ‘I call upon knowledge to be more than awareness and that knowledge should encourage and instil the will for change and action’ (p. 81).

The Cultural Respect Framework presented in Figure 9 is not a cross-cultural competency training tool. Instead, it is an overarching framework encompassing a number of dimensions with the intention of systematically lifting the cultural competency of mainstream health services (AHMAC, 2004). The Framework acknowledges that attitudes and knowledge-based strategies are an important foundation for change, but also recognises that attitudes and knowledge must be linked to changed behaviour and action (AHMAC, 2004).

FIGURE 9 THE DIMENSIONS OF A CULTURAL RESPECT FRAMEWORK



Source: Adapted from AHMAC, 2004, p. 10.

The dimension of knowledge and awareness focusses on cultural awareness and understanding the history, experience, culture and rights of Indigenous peoples (AHMAC, 2004). The dimension of skilled practice and behaviour addresses changed behaviour and practice through formal education and training and through performance management processes to encourage good practice and culturally appropriate behaviour (AHMAC, 2004). This dimension supports cultural safety and recognises that traditional Indigenous peoples' healing practices are legitimised (AHMAC, 2004). Indigenous traditional healers can play an important role in the health and wellbeing of Indigenous peoples.

The dimension of strong relationships ensures that health providers' business practices secure and uphold the cultural rights of Indigenous peoples and addresses the balance of Indigenous and non-Indigenous health professionals working in an organisation (AHMAC, 2004). The final dimension, equity of outcomes, focuses on the outcomes experienced by individuals and communities that are maintained, monitored and evaluated through feedback at the organisational and system level (AHMAC, 2004).

## 9. Discussion

### 9.1. What Have We Learned?

In Section 4 of this review, we described the broad patterns of published research and grey literature identified through our literature survey. More than 43 per cent of the publications were peer-

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reviewed journal articles; peer review provides confidence in the quality and standard of the content. More than 30 per cent of the publications were non-peer-reviewed government and non-government reports. The volume of publications has increased over time, with most of our reviewed papers being published between 2006 and 2015.

The increase in publications about gendered Indigenous health parallels the development of gendered Indigenous health policies. Most of the publications we found were descriptive and, while they may contribute to understanding the issues, they do not necessarily support service improvement or evidence-based interventions.

The lack of measurement data in the reviewed literature is concerning. Without culturally acceptable or methodologically robust measurement tools, the accuracy of research findings is questionable, and the impact of the work will remain limited. The literature also revealed very few intervention studies. This may be because there are political and pragmatic challenges regarding engagement with Aboriginal and Torres Strait Islander communities, and collaborating on interventions takes time and effort. Funding agencies rarely consider engagement processes, and assume that these aspects have been completed before the funding and the research begin. Experimental design can pose significant challenges in Indigenous communities, both in relation to costs and ethical issues. While the need to improve health outcomes for Indigenous gendered health is widely acknowledged, the lack of intervention research and evidence-based practice undermines our ability to develop and understand the best ways to create change.

This review examines a number of important issues that impact on gendered Indigenous health, including broad social determinants such as employment, education and culturally appropriate service delivery that takes into account the specific needs of Indigenous women and men. Evidence suggests that adopting a social-determinants approach is vital for developing culturally appropriate, gendered responses to Indigenous health issues. Specific policies are useful if they are carefully implemented and monitored, and if they provide helpful infrastructure for service delivery.

## **9.2. Gendered Health Policies**

Over time, specific gendered health policies have been absorbed into more generic health plans and policies. As a result of the Closing the Gap for Indigenous Disadvantage in the *National Aboriginal and Torres Strait Islander Health Plan* and the *Aboriginal and Torres Strait Islander Health Performance Framework*, regular reports are presented on progress against the required health outcome strategies. Only a few jurisdictions continue to have specific gendered health strategies.

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This could pose a problem in the future as the specific needs of males and females require different strategies. It is possible that the reduction in published literature evident since 2011 is a reflection of this trend to bundle gendered Indigenous health under more general Indigenous health policies.

### 9.2.1. Indigenous Women's Health

The conception of 'health' adopted by many health professionals may differ significantly from the more holistic models understood by many Indigenous women (Burns et al., 2013; DoHA, 2010c). The social and primary healthcare<sup>11</sup> models of health delivery largely adopted by the women's health movement are linked, extending beyond the reductionist and individualistic approaches embedded within the traditional biomedical model of health care (Fredericks, 2007, 2008a, 2008b; Fredericks et al., 2010). Indigenous women benefit most through a social model of health and comprehensive primary care. However, policies and services that generalise about all women's oppression and health needs can minimise the position of different groups of women, including Indigenous women (Fredericks et al., 2010). This can lead to Indigenous women's needs being overlooked because of marginalisation, causing pressure to choose between womanhood and Indigenous identity when trying to access services (Fredericks et al., 2010). Indigenous women cannot have culture without womanhood; it disallows the exercise of their sovereign rights as Indigenous women (Fredericks et al., 2010).

The *National Women's Health Policy 2010* maintains that 'generating equity in health for women means eliminating unfair differences in opportunities for health among different groups of women based on social, economic, cultural or geographical context' (DoHA, 2010c, p. 92). For this to apply to Indigenous women, specific strategies and approaches need to be considered to make services more culturally appropriate. If Indigenous women's sense of identity continues to be eroded and marginalised, they will continue to have the poorest health outcomes of any group of women in Australian society (Fredericks et al., 2010).

The large gaps in services lie in antenatal screening and young Indigenous pregnant women's health. Aboriginal and Torres Strait Islander women have approximately 6 per cent of Australian births, with a clear disparity in birth outcomes (Clarke & Boyle, 2014). Engaging with these young Indigenous women remains challenging and having them access services early is important in addressing both child mortality and low birthweight. With the majority of Aboriginal and Torres Strait Islander women living in urban or inner regional areas, most receive their health care from mainstream

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<sup>11</sup> Primary healthcare services include general practitioners, dentists, and pharmacists and are usually the first health service patient's visit with a health concern (AIHW, 2012).

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services. An important issue is that all practitioners need to understand how to work with Aboriginal and Torres Strait Islander peoples.

Factors that will make a difference in Indigenous women's pregnancy care include improving women's experiences of antenatal care, involving Indigenous women in the decision making about their own health care, and involving Indigenous community workers in translating medical care into culturally appropriate practices. Pregnancy continues to be a critical health issue for Aboriginal and Torres Strait Islander women: Indigenous teenagers have higher rates of pregnancy and higher rates of complication (such as preterm births and low birthweight) (ABS, 2011a). They also experience higher rates of anxiety and depression.

Significant improvements in the health of Indigenous women will be made from tackling the underlying social determinants.

### 9.2.2. Indigenous Men's Health

Indigenous men and boys remain less healthy than their non-Indigenous counterparts (Thomson et al., 2010). Progress has been made in recent years in understanding the health disadvantages experienced by Indigenous men. The development of national and state policy and strategy responses to guide services and practice should assist in addressing these gaps.

Indigenous male health is strongly affected by the social determinants of health, including economic opportunity, physical infrastructure and social conditions (Wenitong, 2002). Determinants such as housing, education, employment, access to services, social networks, connection with the land, racism, and rates of imprisonment continue to have an enormous impact on male health.

Addressing Indigenous male health needs to take a social determinants approach and involve Indigenous males as important participants in defining their social roles, within their own communities and within the broader Australian context. The *National Male's Health Policy* recognises the responsibilities that Indigenous males have for traditional practices, parenting and spirituality, and the relationships that these elements have on health and wellbeing (Thomson et al., 2010).

Indigenous employment in health services and broader services from government are important factors for helping services to become much more culturally appropriate. The National Indigenous Employment Strategy and the National Indigenous Education Strategy work towards greater

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participation of Indigenous people in the workforce, and will lead to a positive outcome for all Indigenous people.

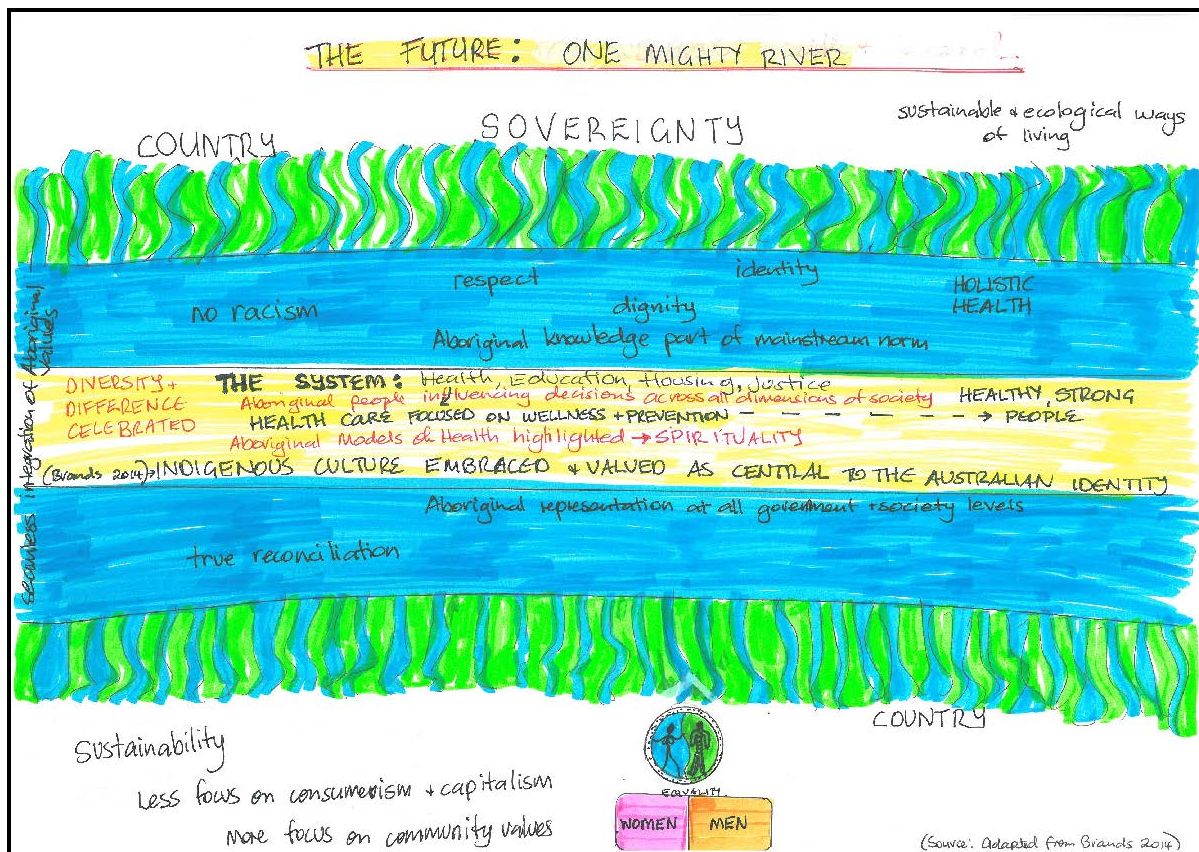
### **9.3. Future Directions for Indigenous Health and Wellbeing and Research**

Recent research led by Brands (2014) using futures thinking methods (Inayatullah, 2007) has considered how research can most effectively contribute to Indigenous health and wellbeing by 2030. During the project, data was gathered from 10 workshops conducted around Australia, identifying issues, trends and scenarios for Indigenous peoples and Australian society more generally, using the knowledge, experiences, opinions and visions of workshop participants (Brands, 2014). Several possible scenarios emerged, clustering around two divergent futures. The first possible future showed an inclusive, vibrant Australia where Indigenous cultures are valued and encompassed as central to the Australian identity. This future involved a reduced focus on consumerism, greater focus on sustainability and community values, and holistic health care which focused on concepts of wellness and prevention to keep people strong and healthy (Brands, 2014; Walker, Fredericks & Anderson, 2013; Walker et al, 2013a, 2013b).

The second scenario saw an Australia where economic and/or spiritual poverty lead to the rejection of diversity and an increase in the gulf between rich and poor. This future sees the dismantling of public services and legislation such as land rights, a place where business rights and interests override communities and individuals, and health care is focused on acute rather than preventive care (Brands, 2014).

First appearing in the theoretical development paper *Developing Pictorial Conceptual Metaphors as a Means of Understanding and Changing the Australian Health System for Indigenous People* (Fredericks et al., 2015), Figure 10 illustrates an emergent Pictorial Conceptual Metaphor: 'The Future: One Mighty River' (p. 99). This Pictorial Conceptual Metaphor depicts Brands' (2014) first scenario: one of equality, holistic health care, sustainable, ecological ways of living, where two peoples ways merge into 'One Mighty River' and where respect, dignity, diversity and difference are celebrated (Fredericks et al., 2015, p. 99). Pictorial Conceptual Metaphors provide an overall view of a system, identifying undercurrents. This communication method adds to understandings of systems, potentially delivering insights that contribute to systemic change which, in this case, relates to accessible, holistic health care for all Indigenous Australians (Fredericks et al., 2015).

FIGURE 10 THE FUTURE: ONE MIGHTY RIVER



Source: adapted from Brands, 2014; in Fredericks et al., 2015.

## 10. Conclusion

The ongoing effects of colonisation, embedded racism and lack of cultural understanding, plus the cumulative effect of social determinants continue to impact negatively on Indigenous men’s and women’s health. In Australia, social disadvantage and the relationship between Indigenous Australians and mainstream society are two major factors contributing to Indigenous men’s and women’s poor health outcomes. Cultural continuity, kinship networks, connection to land, spirituality, ancestry and connection to language are frequently identified by Indigenous Australians as health protective factors that enable them to maintain the spirituality that is central to their notion of health.

Systemic racism combines with social, political and historical determinants of health to contribute to the health outcomes experienced by Indigenous men and women. The high mortality and morbidity experienced by Indigenous men and women is an indictment against past and present government policies and the ‘system’ that maintains culturally ignorant practices. Systemic racism within the



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health system in Australia maintains the continued marginalisation and disempowerment of Indigenous men and women. Systemic racism and the behaviour of the dominant Australian culture towards Indigenous peoples effectively maintains the cycle of poverty, low self-esteem and poor health experienced by many Indigenous men and women. The effects of racism in the health system need to be confronted as a matter of urgency and a multi-tiered commitment to strategies linking policy to practice should be initiated. Part of this strategy requires preparing undergraduates and health professionals for culturally respectful health care with education programs that are evaluated for long-term improvements to practice.

Cultural respect, cultural security and cultural safety focus on the perspectives of the Indigenous people receiving health care. Cultural competence is a broader concept that focuses on the healthcare system through the individual, the organisation and the system. Cultural competence entails a whole-of-system approach that works in a concerted way across the sector to lift the performance of the system overall. This is a foundational element of a more culturally appropriate approach for working with Indigenous men and women.

The health and wellbeing programs and the research projects linked to the ACCHSs attribute their success to community consultation and involvement of the Aboriginal and Torres Strait Islander people in the process of getting more appropriate services. It is precisely this community consultation that many mainstream health services do not understand nor initiate (leading them to ignore or misunderstand Indigenous cultural practices). It is people from within the same culture as the recipients of a service who are most able or equipped to provide a culturally safe environment; this is a further reminder of the importance of employing more Aboriginal people in these services.

What we really need is research that builds on best evidence practice, informed by intervention and measurement studies, so that we can build a better system for working with Aboriginal and Torres Strait Islander people.

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