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Setting a New Agenda: Developing an Aboriginal and Torres Strait Islander Women's Health Strategy

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Abstract

The Australian National Aboriginal and Torres Strait Islander Women's Health Strategy was developed to reflect the health priorities of Aboriginal and Torres Strait Islander women, as identified by Aboriginal and Torres Strait Islander women themselves. This article describes the process used by the Australian Women's Health Network to develop the strategy. The women involved in the research used the talking circle method and engaged with Aboriginal and Torres Strait Islander women through a process referred to as 'talkin' up', where women 'talk back' to one another about issues that matter to them. In this article, we describe the power of the talkin' up process, as a way for Aboriginal and Torres Strait Islander women to identify their own issues, discuss them in context and talk in a culturally safe environment. The strategy which emerged from this process is an accurate reflection of the issues that are important to Australian Indigenous women and highlights the improvements needed in Aboriginal and Torres Strait Islander women's health to strengthen and underpin women's health, Indigeneity and their sense of well-being as Aboriginal and Torres Strait Islander women.

Introduction

Many academics refuse to acknowledge that Aboriginal people's existence and conceptions of themselves are very different from their own. Objectification does not convey a 'true' picture of anyone; objectification, in fact, creates a false image of Aboriginal people, more like a caricature than a portrait. If Aboriginal people determine how the picture of them should be created, and with what materials and techniques, the final composition will more accurately depict Aboriginal people and the vitality of their lives (Wheaton 2000, 156).

Wheaton clearly highlights the obstacles we face as Indigenous Australian women as well as the strength and persistence required in order to not only develop but also create new thinking around Indigenous women's health and wellness. The Australian *National Aboriginal and Torres Strait Islander Women's Health Strategy* (Fredericks, Adams, Angus and the Australian Women's Health Network Talking Circle 2010) was developed to address this inequality. Aboriginal and Torres Strait Islander women who work in women's health areas and in health services were invited to come together and talk about what they saw as their health priorities. Aboriginal and Torres Strait Islander women's oral evidence was used together with evidence from other sources to develop a national health strategy for Aboriginal and Torres Strait Islander women.

Oral evidence for the strategy was gathered through the Australian Women's Health Network Aboriginal and Torres Strait Islander Talking Circle (AWHN-TC). It involved a series of gatherings throughout Australia in 2009, and culminated with a workshop in Brisbane on 30 April 2010. This entire process was led by Aboriginal and Torres Strait Islander women, *in collaboration with* other Aboriginal and Torres Strait Islander women, *for* Aboriginal and Torres Strait Islander women.

Consistent with Wheaton's argument, the processes of developing and publishing the strategy, as well as the strategy itself, reflects Aboriginal and Torres Strait Islander women's health priorities, in accordance with what Aboriginal and Torres Strait Islander women understand their priorities to be. What is written in the strategy about Aboriginal and Torres Strait Islander women comes from Aboriginal and Torres Strait Islander women themselves, through processes suggested by them. The information in the strategy could thus be said to be 'more accurate' than information gained through other approaches.

This article discusses the role of the AWHN-TC in developing the National Aboriginal and Torres Strait Islander Women's Health Strategy. It places the strategy within the context of the national agenda for Aboriginal and Torres Strait Islander women's health, explains the strong and empowering processes used to develop the strategy, summarises the key recommendations and highlights the links between women's health, Indigeneity and a sense of well-being, through the voices of Aboriginal and Torres Strait Islander women.

The national agenda for Aboriginal and Torres Strait Islander women's health

The National Women's Health Policy (NWHP) was published in 1989, under Labor Prime Minister Bob Hawke. It was designed to address women's health needs, after a '20-year process of lobbying by women's groups to make the health system more responsive to the needs of women' (Wass 1998, 33). The women's health movement was able to utilise the new directions in 'public health' and understandings of the concepts of liberation and injustice, to successfully become stakeholders in the direction of health in Australia (Broom 1999, 2). The NWHP was the result of a consultation process with women's groups throughout Australia 'built on the recognition of the social model of health and the impact that the social environment has on health and health choices' (Wass 1998, 33).

It is unclear how many Aboriginal and Torres Strait Islander women were engaged in developing the NWHP (Commonwealth of Australia 1989). However, it did encompass numerous health prevention areas, including reproductive health and sexuality, the health of ageing women, emotional and mental health, violence against women, occupational health and safety, the health needs of women as carers, and the effects on women's health as a result of sex role stereotyping. This resulted in the development of programs from the NWHP and various other state and territory policies¹ which took the form of women's health centres, mobile women's health programs, sexual assault programs, women's cancer prevention programs and alternative birthing programs throughout Australia. According to Wass (1992, 51), women's health philosophy is based on the premise that women cannot control their lives until they control their bodies. Thus, some feminists who were active in the Australian women's movement in the early phase focused on women-only health centres where women could make decisions in regards to their own bodies and health care. This also included recognition of the importance of sexuality, particularly crucial for radical feminists. Tong (1989, 110), for example, suggests that as sexuality is part of a woman's identity, a violation of a woman's body is a violation of that woman's identity and of her autonomy over her body.

This ethos of women in control of women's bodies also included women's opposition to the biomedical model which focused on body parts, disease and illness, and was professionally dominated by men (Wass 1998; Weeks 1994). The women's health movement has generally adopted the social model of health and the primary health care model of health care delivery. These models extend well beyond the reductionist and individualistic approaches that are so entrenched within the traditional biomedical model of health care. Indigenous women had already opposed the biomedical model through their advocacy within the Aboriginal community-controlled health movement since the 1970s and the establishment of Aboriginal community-controlled model of comprehensive primary health care services (National Aboriginal Health Strategy Working Party 1989) which advocates for a holistic approach to health care for the individual, family and community.

In fact, Aboriginal and Torres Strait Islander women were engaged in delivering community-controlled comprehensive primary health care prior to mainstream Australian health services (Fredericks and Legge 2011; National Aboriginal Community Controlled Health Organisation 1993; National Aboriginal Health Strategy Working Party 1989).

Women's health centres tend to be community-based organisations that are driven by women members, women staff and women volunteers. The services available from these centres are thus established *by* women *for* women. Aboriginal and Torres Strait Islander women had already articulated that Indigenous women should be in control of issues that fell within the woman's domain (Daylight and Johnson 1986; National Aboriginal Health Strategy Working Party 1989). In this regard, Aboriginal and Torres Strait Islander women benefited from some NWHP-related programs since it focused on women and the community of women being in control of women's health. Some of the funded programs focused on concerns faced by Aboriginal and Torres Strait Islander women (Daylight and Johnson 1986).

The continued success of programs commenced under the NWHP were inhibited through limited funding opportunities and government support avenues. Aboriginal and Torres Strait Islander women's specific access to the funds was limited to birthing programs and centres, sexual assault programs and shelters (Dorman 1997; Harrison 1991). Access to the funds for Indigenous women tended to only focus on particular parts of women's health and not the full suite of programs available to other Australian women. As has been documented, the women's health centres and programs that were developed for all women struggled to cater for the needs of Aboriginal and Torres Strait Islander women and few Aboriginal and Torres Strait Islander women were engaged in their governance structures or staffing bases (see Fredericks 2010, 2009; Kraack 1999; Moore 1997; and Rockhampton Women's Health Centre 1999, 2000, 2001 for examples). Moore (1997) undertook an analysis of the establishment of the Gladstone Women's Health Centre (Central Queensland) and provides an understanding of how such centres operate in terms of service delivery, issues addressed, employee profile and client satisfaction. She failed to address Aboriginal and Torres Strait Islander women's issues or how Aboriginal and Torres Strait Islander women and women who are other than Anglo-Australian have their needs met. The evaluation undertaken of the Rockhampton Women's Health Centre (WHC) in 1999 by Kraack shows that there is not a great deal of ethnic diversity among women who use the centre. The evaluation reveals that '95% of women surveyed were of English or European origin. No Torres Strait Islander[s] use the centre ... a low number of a[A]boriginal clientele. There are also few women of NESB [non-English speaking backgrounds] using the centre' (Kraack 1999, 11). The ethnicity of the staff was not noted in the evaluation of the early annual reports. Comments provided by other services during the evaluation allude to why Aboriginal and Torres Strait Islander women might not use the service. As Kraack states:

It is important for the WHC to address [A]boriginal issues and issues of cultural sensitivity. The perception of some service providers is that WHC is culturally insensitive. This must have a significant impact on the numbers of [A]boriginal women using the service (1999, 27).

Moore (1997) and Kraack (1999) demonstrate the problematic nature of some women's health centres and the women's movement in their ability to cater for the needs of Aboriginal and Torres Strait Islander women. Overall, the Australian women's health agenda has varied in its ability to incorporate the health and well-being needs of Aboriginal and Torres Strait Islander women (Angus et.al 2009; Queensland Aboriginal and Torres Strait Islander Women's Task Force on Violence 2000). Women's health policy documents, women's health centres and women's services that generalise about all women's oppression have, to varying degrees, minimised the position of different groups of women, including Aboriginal and Torres Strait Islander women (Fredericks 2010). Aboriginal and Torres Strait Islander women's needs have sometimes been overlooked and are sometimes still overlooked. For example, we know that some Aboriginal and Torres Strait Islander women continue to experience extremely high levels of violence and sexual violence in their lives and communities (Angus et.al 2009; Queensland Aboriginal and Torres Strait Islander Women's Task Force on Violence 2000).

Aboriginal and Torres Strait Islander women should not have to feel that they have to make a choice between womanhood and identity when trying to access services (Fredericks 2009). The choice between a specific women's service or a specific Aboriginal and Torres Strait Islander service is one that makes little sense: Aboriginal and Torres Strait Islander women cannot have culture without womanhood. To attempt to split ethnicity from womanhood, or womanhood from ethnicity, is a European/North American dualistic form of reasoning (Fredericks 2003).

Pitting them against each other through the separation of services does not allow them to exist together. Moreover, it does not allow Aboriginal and Torres Strait Islander women to demonstrate their resilience, capacity and ability to exercise their rights to make health decisions as Aboriginal and Torres Strait Islander women. It forces Aboriginal and Torres Strait Islander women to place their needs as Aboriginal and Torres Strait Islander women to the side in order to access services that meet their needs as women like other women. This may result in the reproduction of relationships of domination as Indigenous women have to hand over their control to non-Indigenous women to get their needs met or their issue addressed. Health services and their managers in this context need to ask why Aboriginal and Torres Strait Islander women would participate in services, activities and events that might re-instate non-Indigenous power and guardianship over and over again. All of this may be happening within the place that is a women's health service or program. If this is going on, it does not allow Aboriginal and Torres Strait Islander women to exercise their rights as sovereign Aboriginal and Torres Strait Islander women (Fredericks 2010).

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

In developing the new National Women's Health Policy, the Australian Government has undertaken a range of consultations with women, community groups, health service providers and state and territory governments, with the Australian Women's Health Network (AWHN) contributing to the submission process (Australian Women's Health Network 2009). However, these consultations were predominately undertaken with non-Indigenous women and women's organisations. There were a limited number of Aboriginal and Torres Strait Islander women who contributed during the consultation process. In 2009, the AWHN received approximately \$100,000 in funding from the Australian Department of Health and Ageing (Gender and Reproductive Health Branch) to consult with Aboriginal and Torres Strait Islander women and to provide input into the submission process for the new National Women's Health Policy. It was a concern that the AWHN received the funds, rather than an Aboriginal and Torres Strait Islander women's organisation. While there was no national Indigenous women's organisation that could have undertaken the project, there were regional women's organisations that could have led the project on behalf of Aboriginal and Torres Strait Islander women. Indigenous women had to work within the governance of the AWHN made up of predominately non-Indigenous women. The AWHN established the Australian Women's Health Network Talking Circle (AWHN-TC), made up of Aboriginal and Torres Strait Islander women, to develop the National Aboriginal and Torres Strait Islander Women's Health Strategy. This strategy was launched at the AWHN national conference on 19 May 2010. It is important to note that the strategy does not replace other national, state or territory documents which identify health priorities and needs. Instead, it supplements existing work.

The health status of Aboriginal and Torres Strait Islander women

Aboriginal and Torres Strait Islander women collectively have the poorest health status of any group of women in Australian society. The Australian Bureau of Statistics (ABS) (2009) estimates that Indigenous females born between 2005 and 2007 could be expected to live 9.7 years less than non-Indigenous Australian females. A range of health issues cause this difference in life expectancy. Indigenous women are 1.4 times more likely to have cardiovascular disease than non-Indigenous women. Cardiovascular disease is the leading cause of death for Indigenous women living in Queensland, Western Australia, South Australia and the Northern Territory, with Indigenous women 2.7 times more likely to die as a result of cardiovascular disease than non-Indigenous females at any age, but particularly in younger age groups (Burns, Maling and Thomson 2010, 7–8).

The three leading causes of death among Aboriginal and Torres Strait Islander women are diseases of the circulatory system, cancer, and endocrine, nutritional and metabolic diseases (including diabetes) (Australian Bureau of Statistics 2007).

The most common cancers causing death are of the respiratory and intrathoracic organs (mainly lung). Digestive organ cancers were each responsible for 20 percent of the deaths from cancer among Aboriginal and Torres Strait Islander females, and female genital cancers (mainly cervix cancer) for 17 percent (Australian Bureau of Statistics 2007). The statistics about other health conditions such as other cancers, diabetes, kidney disease and respiratory disease are no better. For example, compared to non-Indigenous women, Aboriginal and Torres Strait Islander women are ten times more likely to have kidney disease, four times more likely to have diabetes, and almost twice as likely to have asthma (Australian Bureau of Statistics 2007). The most common types of health conditions reported by Aboriginal and Torres Strait Islander women are eye/sight problems (54 percent), back pain/symptoms (23 percent), heart/circulatory diseases (23 percent) and asthma (22 percent) (Australian Bureau of Statistics 2007). Aboriginal and Torres Strait Islander women report high levels of long-term health conditions: 85 per cent report one or more long-term health conditions, compared with 77 per cent of Aboriginal and Torres Strait Islander men. The prevalence of multiple conditions is also higher among women, with 68 per cent reporting two or more long-term conditions, compared with 58 per cent for men (Australian Bureau of Statistics 2007; Australian Indigenous Health InfoNet 2010). This is considerably higher than the health conditions and more long-term conditions experienced by non-Indigenous women (Australian Bureau of Statistics 2007).

Disabilities and premature ageing are a particular concern for Aboriginal and Torres Strait Islander people, who tend to experience a younger age of chronic disease onset than the non-Indigenous population. This younger age of onset is acknowledged as a barrier to accessing appropriate care—particularly as Aboriginal and Torres Strait Islander clients do not fit the normal patient profile for chronic disease and present as anomalies in a wider health system (Peiris et al. 2009). The 2006 Census of Population and Housing (Australian Bureau of Statistics and Australian Institute of Health and Welfare 2008, 55) reports that approximately 4 per cent of the Aboriginal and Torres Strait Islander respondents recorded that they needed assistance with core activities on a consistent basis. These core activities include eating, bathing, dressing and general self-care, mobility and communication. The level of assistance required by Aboriginal and Torres Strait Islander people was twice as high as the assistance required by the Australian population overall (Australian Bureau of Statistics and Australian Institute of Health and Welfare 2008, 55). Aboriginal and Torres Strait Islander women with long-term health conditions and disabilities are more likely to report high/very high levels of psychological distress than women with no long-term health condition (34 per cent compared with 21 per cent) (Australian Bureau of Statistics 2007).

The fact remains that Aboriginal and Torres Strait Islander women have poor health and this continues despite government attempts to make progress on Aboriginal and Torres Strait Islander health status. At times, it is difficult to believe that the situation will change and to envisage a time when it will not be the case. With some health issues, the statistics may even become worse. This is of major concern and should be a priority for the health sector on the basis of equity and social justice (Baum 2002). Moreover, it should be of critical importance to the women's health agenda, which needs to work towards incorporating the health and well-being needs of Aboriginal and Torres Strait Islander women into broader policies. Women's health policy documents, women's health centres and women's services that generalise about all women's oppression tend to minimise the position of different groups of women including Aboriginal and Torres Strait Islander women. When they speak in broad terms about women's health concerns they can also minimise the urgent need to address the health status of Australia's Indigenous women.

These critical concerns were what underpinned the Australian Women's Health Network's (AWHN) quest to engage Aboriginal and Torres Strait Islander women in the National Aboriginal and Torres Strait Islander Women's Health Strategy which would then be a document that could contribute to the Australian National Women's Health Policy.

Women talkin' up

The Australian Women's Health Network Aboriginal and Torres Strait Islander Talking Circle (AWHN-TC) included representative Aboriginal and Torres Strait Islander women from each state and territory, particularly those who work in women's health.

A snow-balling methodology meant that some 51 Aboriginal and/or Torres Strait Islander women attended the talking circle meetings at some point. These women helped in directing the development and implementation of the project.

Throughout the project, the AWHN-TC members actively sought to increase their membership. The AWHN employed a full-time project officer to work with the talking circle on the project from June–August 2009, and then part-time from August 2009, until the strategy was launched in May 2010. The project officer contacted each member of the AWHN-TC to invite them to arrange consultations with women in each of their local communities.

The AWHN-TC gatherings took place in every major city and some regional towns within non-government organisations, government department offices and Aboriginal and Torres Strait Islander community health/medical services. Others took place in coffee shops and restaurants, hospital board rooms, community-controlled Aboriginal and Torres Strait Islander meeting rooms and board rooms, health service meeting rooms, common rooms attached to residential complexes, hospital staff rooms and under trees away from other people. Meetings took place in urban areas, capital cities and rural areas. The location of these meetings is included within the Australian Women's Health Network National Talking Circle's *Submission on National Issues, Barriers and Recommendations Concerning the Health Status of Aboriginal Women for the Development of the 'National Aboriginal Women's Health Policy' as Identified by Aboriginal Women, Community Women, Partners and Service Providers* (Angus et al. 2009). A list of some 400 women who participated in the individual face-to-face consultations, groups meetings, workshops, focus groups and/or who provided written or verbal feedback via email or telephone in the project work that led to the submission is included in the strategy (Fredericks et al. 2010, 45).

During the active work phase, members of the talking circle made every effort to consult with a broad and diverse group of Aboriginal and Torres Strait Islander women. However, throughout most of the process, few Torres Strait Islander women were involved. Towards the end of the process, every effort was made to ensure that Torres Strait Islander women were engaged and active participants. This was achieved by inviting key Torres Strait Islander women who had the capacity to contact other Torres Strait Islander women and who could encourage them to come along to a gathering or who would be prepared to be contacted for an interview. A national face-to-face meeting was held in Brisbane on 30 April 2010 in which Torres Strait Islander women participated. The work undertaken by the Aboriginal Women's Task Force (Daylight and Johnson 1986) also notes the limited number of Torres Strait Islander women who participated in that national consultation process during the mid-1980s. They stated that 'we believe that their different cultural values mean that their views and needs are not necessarily the same as those of Aboriginal women' (Daylight and Johnson 1986, v). It was also very difficult considering the time and resources available to show the differences between Aboriginal and Torres Strait Islander women's needs and the needs between differing groups of Aboriginal women. In addition, very few smaller rural and remote communities could be visited during the project due to the resource and time constraints. In an attempt to get across some of these issues, the project officer consulted with some executive staff of community-controlled organisations by phone.

The aim of the talking circle and the talkin' up processes was to consult with and engage Aboriginal and Torres Strait Islander women to identify and develop a set of priorities and key actions to improve the holistic health status of Aboriginal and Torres Strait Islander women and their extended families and community members. This work included face-to-face meetings, telephone discussions, word-of-mouth reports, focus groups, broadcasts, email responses and one-on-one interviews. All were recorded and used in supportive and culturally safe ways to share the stories, wisdom and knowledge of Aboriginal and Torres Strait Islander women's issues.

As Indigenous Australian women, our sense of whom we are and where we come from is not only an internal inherent extension of ourselves but underpins the everyday understandings of who we are and where we belong, in and within community and the others within that community. We name ourselves as Indigenous women. Within this project we named ourselves and each other as Indigenous women, and established our relationality and accountability to each other within the research relationship (Martin 2008; Wilson 2008). The research in the first instance included the talking circle, the project worker and the members of the AWHN committee.

It then moved to include all the women in the face-to-face meetings, telephone discussions, word-of-mouth reports, focus groups, broadcasts, email responses and one-on-one interviews. What happened through the consultations was a process that Aboriginal and Torres Strait Islander women refer to as 'talkin' up'.

Talkin' up in this context means to speak up, outwardly and back to one another and to others. Aileen Moreton-Robinson, in her book *Talkin' Up to the White Women* (2000, 187), explains the term as 'speaking back'. The talkin' up process has previously been used during project work and research with Aboriginal women (for example, Fredericks 2008; 2007; 2003; Vickery, Clarke and Adams 2005). Daylight and Johnstone (1986) also used similar research strategies in highlighting the issues of Aboriginal women in their seminal work *Women's Business*.

In order for the AWHN-TC to understand what Aboriginal and Torres Strait Islander women saw as their health priorities, the process needed Aboriginal and Torres Strait Islander women to 'talk up' about women's health. Many Aboriginal and Torres Strait Islander women saw this as an opportunity to demonstrate their knowledge and ways of knowing about their health. Moreover, the women were able to be themselves within the process—to be Indigenous women and make Indigenous women's knowledge, concerns and issues the centre of the work. They did not have to leave their knowledge at the periphery of a community of all women.

During the consultation phase of the project, the project officer spoke with a wide variety of Aboriginal and Torres Strait Islander women, including those who are full-time carers of young children and older people, public servants, students, workers in community-based organisations and shop assistants. From our personal experiences as Aboriginal women, we know that everyday life is filled with the sharing of what Aboriginal and Torres Strait Islander women are doing, their children, family, men, work, social activities and 'catching up' with what each other is doing or news from the 'grapevine' (Aboriginal community news). The AWHN-TC aimed to become part of this sharing. The discussions sometimes focused or touched on issues of alcoholism, battery and violence, exploitation, memories of the past, those who have gone before, worries for the future (including worries for their children, grandchildren and the grandchildren of their grandchildren). Women shared their stories of family and communities. They included within their discussions blood relatives, people married into their families and bonded family members. The Aboriginal and Torres Strait Islander women involved bonded with each other in the storying of their issues and concerns. They too became bound in relationality and accountability to each other (Martin 2008; Wilson 2008). Even if they didn't agree with each other on the priority of issues, they worked through their concerns and fostered connections with each other and the issues at hand. Talkin up in this context enables the process to be both supportive and facilitative of Indigenous ways of working and of sharing knowledge (Martin 2008).

Many of the stories told during the AWHN-TC process helped to contextually ground the issues found in the literature. It was about ensuring an accurate understanding of the situations, as articulated by Wheaton (2000, 156) in the quote at the beginning of this article. It enabled a teasing out of the health issue from the perspective of Aboriginal and Torres Strait Islander women. For example, the issues associated with co-morbidities such as diabetes and heart disease, coupled with arthritis, levels of disability, early aging and access to superannuation. In this way, the women themselves worked towards accurately depicting Aboriginal and Torres Strait Islander women's health priorities, according to what they as Aboriginal and Torres Strait Islander women understood their priorities to be.

In the contextual grounding, there were echoes of racism and disadvantage experienced by Aboriginal and Torres Strait Islander women since the time of colonisation. This continues today. There was both resistance to the colonisers' ways and, at times, acceptance of the colonisers' ways through knowing the essence of survival in a contemporary context. At times, the women vented emotions that they had little opportunity to express in their daily lives. This showed us that the environments we provided were culturally safe and secure. At times, the women also laughed with such vigour that they held themselves tightly. Mostly, women talked and listened to one another, or the project worker listened to women with whom she talked on her own. Sometimes, one woman would put her arm on or around another, as sisters bound in relationality and accountability (Martin 2008; Wilson 2008).

The AWHN-TC was a powerful process for developing understanding. The power of witnessing and sharing experiences was forever present and entwined with respect for one another.

While women talked about their pain and frustration at living within a society dominated by non-Indigenous people, including non-Indigenous women, there was also the remembering of the complex and diverse Aboriginal and Torres Strait Islander cultures with their compendium of knowledge. There was the remembering of times when women were so very, very strong, and times when women were empowered within their/our own nations.

Developing the National Health Strategy

We are Aboriginal women and as Aboriginal women we know personally of some of the experiences expressed by other Aboriginal and Torres Strait Islander women in the talkin' up process. We brought our experiences to the writing up process. We also brought our Aboriginality. We wanted our Aboriginality and the Indigeneity of women to shape the policy. This project could not allow our Aboriginality to be 'left at the gate' of a community or 'on the keyboard but not on the screen', as we converse in casual conversation. If we had attempted to work with Aboriginal and Torres Strait Islander women in giving voice, and then not had our own voice within the process, it would have been a contradiction. It would conflict with the words of Moreton-Robinson (2000) and Wheaton (2000). We believe that Aboriginal and Torres Strait Islander women have been silenced for too long. We need to regain our voices and maintain our voices. We encouraged Aboriginal and Torres Strait Islander women not to be voiceless and silent. Examples of how this has been described in some of our previous work (See Fredericks 2007; 2003; Fredericks and Legge 2011; Vickery, Clarke and Adams 2005; Watson, Adams, Fredericks and Mahoney 2010). The placing of one's self in the Aboriginal and Torres Strait Islander women's domain is an imperative that connects us as Indigenous women to other Indigenous women. As expressed earlier, we too became bound in relationality and accountability (Martin 2008; Wilson 2008) within the process of the development of the strategy. We acknowledge that our own Aboriginality was integral to our work on the National Aboriginal and Torres Strait Islander Women's Health Strategy (Fredericks, Adams, Angus and the AWHN-TC 2010).

Sandy Angus worked as the Project Officer and prepared the *Aboriginal and Torres Strait Islander Women's Submission to the Commonwealth Government on the New National Women's Health Policy* (Angus and the AWHN-TC 2009), which outlined the health priorities and plans of action articulated by Aboriginal and Torres Strait Islander women involved in the AWHN-TC. The submission was also used to inform the development of the National Aboriginal and Torres Strait Islander Women's Health Strategy. Many of the stories that women shared with us during the consultation phase are included in the submission. They will never be forgotten nor disregarded. The timing of this work is crucial; many of us are losing our old people. We feel their loss day in and day out. The submission stands as testament to the women who have gone before, who are here now and who will be in the future. It reflects the personalised needs, identified barriers and gaps in services which need to be filled to improve the health status of Aboriginal and Torres Strait Islander women and their families. It also stands as an act of resistance in that the stories provide insight into the factors that impact on Aboriginal and Torres Strait Islander women's daily lives and identifies the factors that either constrain their choices or enable them to believe they can make changes.

Bronwyn Fredericks and Karen Adams were invited to develop the strategy from the submission. By the time the National Aboriginal and Torres Strait Islander Women's Health Strategy was to be written there was only \$8000 remaining in the AWHN-TC project budget. Nevertheless, Fredericks and Adams made the decision to do the work, despite the fact that it was largely in a volunteer capacity. They felt bound in relationality and accountability (Martin 2008; Wilson 2008). They also believed that not to do the work would mean that the National Women's Health Policy would only be informed by the submission. In discussing the matter with the AWHN-TC and members of the AWHN it was decided that the project needed a strategy which had been developed as a 'stand alone' document, for advocacy reasons. That is, it needed a document that could be utilised for input into the National Women's Health Policy and as a lobbying and advocacy tool for Aboriginal and Torres Strait Islander women. It was decided that this is how the strategy would be written. Sandy Angus worked with Bronwyn Fredericks and Karen Adams in this process.

The *National Aboriginal and Torres Strait Islander Women's Health Strategy* (Fredericks, Adams, Angus and the AWHN-TC 2010) was published in hard copy and is free to download from the Australian Women's Health Network website.

A short, newsy article on the strategy and its launch was prepared for the *Aboriginal and Torres Strait Islander Health Worker Journal* (Fredericks, Adams and Angus) to assist in providing feedback to Aboriginal and Torres Strait Islander women and communities. In some Aboriginal and Torres Strait Islander communities, this is sometimes referred to as community feedback or community reporting on projects, while in others it may be referred to as parallel publishing whereby one article is written for a peer reviewed journal and another is written for a non-peer reviewed journal in a highly descriptive style using community terms and language.

We also wanted to be able to talk with women about the published report and begin talking with women about using it as an advocacy tool. This is also what we had committed ourselves to doing. Melissa Walker has assisted in this process by taking the document out within the community and using it as a platform for discussing women's issues and in the development of a well women's program. This is ongoing work for her and continues to give the strategy dynamism in the everyday lives of Aboriginal and Torres Strait Islander women.

Conclusion

It is the right of Aboriginal and Torres Strait Islander women to determine what their health system will look like. Aboriginal and Torres Strait Islander women and their organisations must have a pivotal role in consulting, designing, developing, implementing and evaluating health services for Aboriginal and Torres Strait Islander women (NACCHO 1993). The National Aboriginal and Torres Strait Islander Women's Health Strategy builds on what Aboriginal and Torres Strait Islander women said during the talkin' up process and on the previous work undertaken by Aboriginal and Torres Strait Islander women over the years (Angus et.al 2009; Daylight and Johnstone 1986; Fredericks, Adams, Angus and the AWHNTC 2010; Fredericks 2003; Harrison 1991; Huggins 1994; Moreton-Robinson 2000; Vickery, Adams and Clarke 2005). It articulates what is required to make a difference to the health and well being of Australia's Aboriginal and Torres Strait Islander women (Fredericks, Adams, Angus and the AWHN-TC 2010).

We hope that the National Aboriginal and Torres Strait Islander Women's Health Strategy and other works are used to develop Australia's new National Women's Health Policy. It is essential that this is done if Australia is to going to 'close the gap' between the health status and health outcomes of Aboriginal and Torres Strait Islander women and non-Indigenous women (see National Aboriginal Community Controlled Health Organisation and Oxfam 2007).

In the past, knowledge about Aboriginal and Torres Strait Islander women and our health and health care has tended to be constructed *about* us to serve the needs of people *other than us*. This strategy represents a view of how we see ourselves and the direction we would like our health services and health policies to take. This strategy is, therefore, a more accurate reflection of us. As we argue in the strategy, the health status of Aboriginal and Torres Strait Islander women and any improvements to that health status are intrinsically linked to our Indigeneity and the sense of well being of Aboriginal and Torres Strait Islander women. It is only through understanding this, embracing this and enacting this that we can become the healthy, empowered and strong sovereign Aboriginal and Torres Strait Islander women that we are supposed to be and can be!

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ⁱ Australia's governance structure is a federation of seven states and two territories, in addition to the Commonwealth government.