

# AUSTRALIA'S FIRST PEOPLES



## Female Lifecycle, Health and Wellbeing Plan

Northern Sydney Local Health District 2015-2020



Health  
Northern Sydney  
Local Health District



The  
Gaïmaragal  
Group



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NSLHD Australia' First Peoples Lifecycle, Health and Wellbeing Plan.  
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[www.intranet.nslhd.health.nsw.gov.au](http://www.intranet.nslhd.health.nsw.gov.au)

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#### Version control and distribution.

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# FOREWORD

I am delighted to present to you the Northern Sydney Local Health District (NSLHD) Australia's First Peoples Female Life Cycle, Health and Wellbeing Plan 2015-2020. This is the first Aboriginal Women's Health Plan written for Northern Sydney Local Health District. This Plan had its origins in the NSLHD Aboriginal Health Services Plan 2013-2016.

The Australia's First Peoples Females Life Cycle, Health and Wellbeing Plan will provide direction for improved holistic health care outcomes for Aboriginal and Torres Strait Islander women in NSLHD. It is consistent with National and State Frameworks and acknowledges the appropriate local Aboriginal nations in and surrounding NSLHD as traditional custodians of the land.

This Plan will provide continuing strategies across NSLHD directed at enhancing the health and the social emotional wellbeing (SEWB) of Aboriginal and Torres Strait Islander women living in NSLHD. The Australia's First Peoples Females Life Cycle, Health and Wellbeing Plan acknowledges the partnerships with all key stakeholders including those services within NSLHD.

The Australia's First Peoples Female Life Cycle, Health & Wellbeing Plan 2015-2020 has been endorsed by the NSLHD Clinical Council and the NSLHD Board.

I would particularly like to acknowledge Susan Moylan-Coombs and Eliza Pross from The Gaimariagal Group, the NSLHD Aboriginal Health Service and Nolda Baker from Sydney North Shore and Beaches Medicare Local for their commitment and hard work in developing this Plan and for providing the very best holistic health care to Aboriginal and Torres Strait Islander women in NSLHD.

I am confident that this Plan will deliver the best quality holistic health care to Aboriginal and Torres Strait Islander women, and NSLHD will be the leader in the delivery of accessible, equitable, high quality and culturally proper holistic health care to the Aboriginal and Torres Strait Islander women in the NSLHD.



**Dr. Andrew Montague**

Acting Chief Executive  
Northern Sydney Local Health District

# WELCOME



Wellness is holistic; its definition is personal and is driven by the person that is you. Wellness is within and is different for every one of us. For Australia's First people also we have the burden and trauma of who we are; cut off from ancestral homes, dreams and ambitions quashed by the dominance of the Anglo-European governance that we live under and within.

Our wellness is linked to mother earth; we need to recognise our ontology: the philosophical knowledge of the nature of being, becoming, our existence or reality as well as the basic categories of being and our Aboriginal relations. It is discovering who we are.

The lands and waterways of the Lane Cove Valley, the harbour and the Northern Beaches of the Gai-mariagal are matrilineal land, it is our mother and it welcomes all Australians. If you don't know where you come from or if you cannot get back to country 'you still belong this land'. This is what has been told to me by my gran, my mother's Mum. Irrefutably I am the grandson of Clarice Malinda Lougher, the last practising Matriarch of the clan known as Gai-mariagal. Originally there were eight sub-clans, two whose names are gone who occupied the eastern plain now under water, the six remaining are the Gariagal, the Gatlay, the Gaymai, the Turra-muragal, the Cammeraigal and the Burra Burragal. The Booragul, the Canna-gal and numerous other family groups whose names are often thrown around by 'experts' are indeed sub-clans of the six stated above. If we looked at a pyramid, at the apex, the group's name overall is the Gai-mariagal, the six remaining groups fall under it and the numerous other family groups are the lower bottom line of the intricate kinship structure that makes up the Gai-mariagal. Note the spellings are different to many non-indigenous written texts and are an interpretation in English of the oral history pronunciations. Let the experts and critics debate the names for all they like, however we are what we are! Spelling at the end of the day is a colonial interpretation.

Clarice Lougher (Nee Morris) was an amazing woman, born during a drought in 1895, a mother of three a grandmother to ten, and an aunty and sister to many hundreds. She always had some food for those in need, we lived on the edge, but her husband built her a home before he died so she had a base to give, help and live as the last matriarch of our clan. As a child, sunburnt, tired and sitting on the Curl Curl sand dunes after a dinner of pipis and blue swimmer crab, she would tell you of the goodness in the land. The cool breeze on your cheek and sunburnt body after a summer's day frolicking at the beach was Biami's breath. He was cooling you down before you went home to bed. It was time to say your prayers to the evening star, the daughter of Yiah the sun, and await the rise of Nagaree the moon to the east. A time also to thank the spirits for the day, its food, the laughter and the fun, and to ask for safe travels as we walked the 3-4 miles home. Wellness for Nan was a clean bed and clothes for us kids, a full stomach and teaching us respect towards the land and all things alive.

Should we do something wrong, show disrespect or be sick there was a big dark bottle on the pantry shelf. Castor oil, served in large amounts from the biggest spoon in the kitchen. I buried that spoon; put it in the rubbish bin and it always came back? When money was tight Nan would make up the black goo out of special leaves and things, it would stink the house out, a black bubbling brew but it cured anything from diarrhoea, constipation, a tendency to drink alcohol, too much sun, just about anything except broken bones but even then you would get a dose daily to keep your temperature down and help the pain. It didn't help the pain but you stayed silent so you limited the intake of that vile black goo that stuck to your teeth ensuring you tasted it for hours. Wellness in a bottle, yuk! Now wellness to me was the love of my Nan, her ample body frame where a young boy could be cuddled with much love and affection and her clothes carried the faint smell of camphor to keep the moths at bay, it kept your sinus clear.

Wellness is the stories, the respect of all stones, trees, birds, fish, animals and humans. It is the respect of life and the land that provides. When we understand that, then we as First Australians can look at the societal issues that torment us, and really they are insignificant when you watch the Moon, (Nagaree) rise, or Yiah (the sun) dance on the water at dawn or take that next breath of air and be thankful for who you are.

Storm over Middle Harbour: "Never anger the spirit of a woman, as a tormented Biami appears in the clouds as she dominates the fragile colonising influence on the land of the Gai-mariagal". Dennis Foley, 2015.

  
**Dennis Foley**  
Gai-mariagal Custodian

## ART WORK AND CULTURAL MATERIAL

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All requests to use or reproduce any cultural knowledge provided by MinMia must be made in writing to The Gaimaragal Group.

**Contact Susan Moylan-Coombs at [susan@gaimaragal.com.au](mailto:susan@gaimaragal.com.au).**

## EXPRESSION OF THANKS

The Director of the Northern Sydney Local Health District Aboriginal Health Service, Peter Shine would like to thank the following people for their assistance in the preparation of this Plan:

The Gaimaragal Group for their consultancy and preparation of this Plan

Minmia and Dennis Foley for their cultural knowledge and guidance

The NSLHD Aboriginal Health Service in particular Gladys Wilson and Alana Rousselot

# GLOSSARY OF TERMS

<b>Anangu</b>	First Australians from Central Australia
<b>Biala</b>	First Australian Girls' Hostel located in Allambie Heights
<b>Biami</b>	Creator, as per NSW Aboriginal language
<b>Booragul</b>	A sub-clan of one of the eight sub-clans of Gai-mariagal
<b>Bungee Bidgel</b>	Aboriginal Health Clinic, Hornsby Hospital
<b>Burra Burra-gal</b>	One of eight sub clans of the Gai-mariagal
<b>Burruberongal</b>	A sub-clan of the Darug Nation
<b>Cammeraiga</b>	One of eight sub clans of the Gai-mariagal
<b>Canna-gal</b>	A sub-clan of one of the eight sub-clans of Gai-mariagal
<b>Gai-mariagal / Gaimariagal</b>	First Australian language group or Nation in coastal NSW
<b>Garigal</b>	One of eight sub clans of the Gai-mariagal
<b>Gatlay</b>	One of eight sub clans of the Gai-mariagal
<b>Gaymai</b>	One of eight sub clans of the Gai-mariagal
<b>Country</b>	The land area in which a First Australian person was born or considers home
<b>Koori</b>	Collective term for First Australians from NSW
<b>Lore</b>	Traditional law
<b>Miwi</b>	Soul or spirit (Wirradjirri language)
<b>Murri</b>	Collective term for First Australians from QLD
<b>Nunga</b>	Collective term for First Australians from WA
<b>Nyoongah</b>	Collective term for First Australians from parts of WA and SA
<b>Nagaree</b>	The Moon (Gai-mariagal language)
<b>Nungeena-tya</b>	Mother Earth (Wirradjirri language)
<b>Palawa</b>	Collective term for First Australians from Tasmania
<b>Stolen Generations</b>	Refers to collective generations of First Australian victims of removal policy/s
<b>Turra-muragal</b>	One of eight sub clans of the Gai-mariagal
<b>Wanai</b>	Teenager/youth (Wirradjirri language)
<b>Warrigal</b>	Dingo (Wirradjirri language)
<b>Wirradjirri</b>	The largest First Australian language group or nation in central NSW
<b>Yiah</b>	The Sun (Gai-mariagal language)
<b>Yolungu</b>	First Australians from Arnhem Land

Throughout this document, the term 'First Australians' or 'Australia's First People' is used instead of Aboriginal and/or Torres Strait Islander, and/or Indigenous. This definition is preferred terminology as used by the National Congress of Australia's First Peoples. We recognise and respect that First Australians identify in various ways.

# FIRST AUSTRALIANS IN NORTHERN SYDNEY

The Northern Sydney First Australian community is diverse. Many of us come from different original home countries, some of us were born here, and some of us have come to live here for various different reasons.

Community members will identify in various ways. We have Murri, Koori, Nyoongah, Nunga, Yolngu, Anangu, Palawa<sup>1</sup> and Torres Strait Islander peoples living and/or spending considerable time in the region - for education, health care or to be with family who were born here. People may also identify from their tribal groups or Country. So while people may call this place 'home', many of us will also strongly associate with other Countries as well.

We have various members of the community who are members of The Stolen Generations, and were brought here as a result of government policies that saw the removal of children from their birth parents.

There are differing opinions about the boundaries and name of which Country we are in, in the Northern Sydney Region. This contention is complex, however you can't go wrong paying respects and acknowledgement to all: Gaimariagal, Guringai and Darug. It will usually depend who you're talking to as to what Country they acknowledge. Leave the debate to the historians and Councils!

This region is often overlooked when it comes to First Australian services. Compared to other areas we have less First Australian specific health and community services, owned and managed corporations, or cultural specific infrastructure. The community is often underidentified and this can be for various reasons: a perception by mainstream services that there is not a community here, assumptions made based on visual appearance (for example fairer skinned First Australians), lack of acknowledgment of First Australians who do identify, stigma and racism. We have heard many stories through the creation of this Plan about people being denied their identity through the schooling system, health services and/or other community services. We often hear that the numbers of First Australians in Northern Sydney are small. But there are over 2 500 of us and that doesn't include what we believe to be a significant under-identified population. As a group we continue to experience poorer health outcomes than our mainstream counterparts. There is a significant issue of equity for us when it comes to health care and social and emotional wellbeing (SEWB).

As one member of the wider community said: "We were the first to be invaded and are the last to be recognised". There is a community here, we are strong and we are proud. We also have a lot to offer as a community. As we are diverse, we possess a lot of knowledge and culture from all over this country. We want to share it, practising and living our culture is one of the major things that makes us well.

In any community (not just First Australian) where there is trauma and insecurity, people can feel the need to fight for their identity. Lateral violence can be a consequence of community members' insecurity, which often stems from their own experiences of racism, dispossession and/or lack of recognition. We need an environment in Northern Sydney that supports us to be who we are, and to focus on the beautiful parts of our culture. We need a community that supports us to be productive, resilient and secure in who we are.

We want to see and be part of a community of people who are strong, proud and WELL. We want to practise culture, care for our Elders and raise and support strong children and youth. We want to learn and share. We believe this Plan is a strong step in that direction. We recognise that this Plan is the first step toward specifically recognising and addressing the health and wellbeing of females in the Region and is not fully inclusive of all of the issues First Australian women face. We acknowledge that various social determinants of health need to be identified and addressed to build diverse strategies for health and wellbeing, and that various future plans and activities will need to be created in addition to this Plan.

We are First Australians living in Northern Sydney. Susan's ancestry is Woolwonga and Gurindji from the Northern Territory, and she came to Northern Sydney as a member of the Stolen Generations. Eliza's ancestry is Palawa with family also from Yuin Country and was born in Gaimariagal Country. We hope this Plan takes us all one step

<sup>1</sup> All words used to describe groups of First Australians from various states and territories.

We also acknowledge people may identify within other sub-groups such as Goori or Koori among others.



closer toward our collective wellbeing in Northern Sydney. This Plan has been developed in consultation with a number of strong, inspiring First Australian women across Northern Sydney. Many of these women walk with physical, emotional, mental and spiritual 'un-wellness' every day and we really appreciate them sharing their stories, experiences, ideas, struggles and aspirations for something different, to contribute to this plan. Many of these women have been working toward better outcomes for First Australian community members for some time. Specifically, members of the community including Susan Moylan-Coombs, Caroline Glass-Pattison and Sue Pinckham have been pivotal in shaping community initiatives such as the Northern Sydney Aboriginal Social Plan and the Guringai Festival which too has assisted to get us to where we are today as a community.

We have also mentioned throughout the Plan the importance of having strong and well First Australian men. The wellbeing of our men and boys directly impacts on our wellbeing as females and communities. We have been blessed with the support and strength of two men in particular: Peter Shine and Dennis Foley. Both of these men have supported and guided the development of this Plan, and have done so with the utmost respect and honour of women. We thank you both.

We also acknowledge the non-Indigenous men and women who have supported this planning process, and provided guidance, expertise and encouragement to make this happen- the inaugural First Australian Female Health Plan in the region. We often say we are less than 3% of the population and if we are truly going to improve outcomes for First Australians we have to work in partnership with respect for what all people with the right intentions and vision can bring to the table, regardless of colour. We want to see an end to cultural divides that result in stagnation in progressing great things for First Australians.

We can be strong, we can practise our culture, we can do things for ourselves with our communities to strengthen our identity. We also need to accept and welcome support from outside our community, particularly in Northern Sydney where we are such a minority community.

Lastly, but most importantly, we acknowledge MinMia, for her cultural guidance and knowledge. MinMia is an Elder and Lore Woman and has been one of our teachers over a long period of time. MinMia is a Wirradjirri<sup>2</sup> woman. She has had a long association with the community on the Northern Beaches in particular, she is also a teacher of Women's Lore across Australia and internationally. We thank you Memeee for all your knowledge and guidance for this project and always.

We are excited about the next steps for Australia's First people in this region.

  
**Susan Moylan-Coombs**  
Director, The Gaimaragal Group

  
**Eliza Cross**  
Consultant, The Gaimaragal Group



<sup>2</sup>This is MinMia's preferred spelling



## POLICY CONTEXT

### National and NSW Reports and Policies National Aboriginal and Torres Strait Islander Health Plan 2013-2023

This Plan provides a long-term, evidence-based policy framework as part of the overarching Council of Australian Governments' (COAG) approach to Closing the Gap in First Australian peoples disadvantage. The vision is that:

**“the Australian health system is free of racism and inequality and all Aboriginal and Torres Strait Islander people have access to health services that are effective, high quality, appropriate and affordable. Together with strategies to address social inequalities and determinants of health, this provides the necessary platform to realise health equality by 2031”.**<sup>3</sup>

The Plan is built around five major enablers and six groups of strategies related to life stages.

### National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009

This Framework contains nine guiding principles that emphasise the holistic and whole-of-life view of health held by First Australians<sup>4</sup>. The Framework was endorsed by the Commonwealth, State and Territory governments and represented agreements among a wide range of stakeholders on the broad strategies that needed to be pursued.

<sup>3</sup> National Aboriginal and Torres Strait Islander Health Plan 2013-2023, (2013). Commonwealth of Australia, Canberra.

<sup>4</sup> Dudgeon, P, Milroy, H and Walker, R (eds) (2014). Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice. Commonwealth of Australia, Canberra.

### The nine principles are<sup>5</sup>:

1. Aboriginal and Torres Strait Islander health is viewed in a holistic context that encompasses mental health, physical, cultural and spiritual health. Land is central to wellbeing. Crucially, it must be understood that while the harmony of these interrelations is disrupted Aboriginal and Torres Strait Islander ill health will persist.
2. Self-determination is central to the provision of Aboriginal and Torres Strait Islander health services.
3. Culturally valid understandings must shape the provision of services and must guide assessment, care and management of Aboriginal and Torres Strait Islander peoples' health problems generally and mental health problems in particular.
4. It must be recognised that the experiences of trauma and loss present since European invasion are a direct outcome of the disruption to cultural wellbeing. Trauma and loss of this magnitude continue to have intergenerational effects.
5. The human rights of Aboriginal and Torres Strait Islander peoples must be recognised and respected. Failure to respect these human rights constitutes continuous disruption to mental health (as against mental ill health). Human rights relevant to mental illness must be specifically addressed.
6. Racism, stigma, environmental adversity and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander peoples' mental health and wellbeing.
7. The centrality of Aboriginal and Torres Strait Islander family and kinship must be recognised as well as the broader concepts of family and the bonds of reciprocal affection, responsibility and sharing.
8. There is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships and tribes as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings in urbanised, traditional or other lifestyles and frequently move between these ways of living.
9. It must be recognised that Aboriginal and Torres Strait Islander peoples have great strengths, creativity and endurance and a deep understanding of the relationships between human beings and their environment.

### Overcoming Indigenous Disadvantage: Key Indicators 2014 Report

The Overcoming Indigenous Disadvantage (OID) report measures the wellbeing of Australia's First Peoples. It is the sixth report in a series commissioned by all Australian Governments designed to measure progress in overcoming the disadvantages faced by many First Australians<sup>6</sup>. The OID report is produced by the Steering Committee for the review of Government Service Provision which is made up of representatives of the Australian Government and all State and Territory governments and observers from the Australian Bureau of Statistics and the Australian Institute of Health and Welfare<sup>7</sup>.

The report reviewed and summarised progress against key COAG targets and headline indicators. High level social and economic outcomes that had been identified as directly influencing priority outcomes for First Australians. Results were mixed in relation to positive change for First Australians nationally against each of the key indicators. Some of these macro and micro reportable outcomes included, in relation to<sup>8</sup>.

<sup>5</sup> National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2004-2009

<sup>6</sup> SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, Overcoming Indigenous Disadvantage: Key Indicators 2014, Productivity Commission, Canberra.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid (overview report).

### **Life expectancy:**

- Life expectancy for First Australians increased from 67.5 years to 69.1 years for males and from 73.1 years to 73.7 years for females;
- The gap between First Australians and non-Indigenous Australians narrowed from 11.4 years to 10.6 years for males and from 9.6 years to 9.5 years for females.

### **Young child mortality:**

- From 1998 to 2012 there was a significant decline in mortality rates for First Australian children aged 0-4 years (from 217 to 146 deaths per 100 000 population), with the greatest decrease in the infant (0<1 year) mortality rate.

### **Disability and chronic disease:**

- In 2012 little had changed in the rate of disability for First Australians. In fact the rate of disability increased to 23% in 2012 from 21% in 2009. After adjustments for differences in population age structures the rate of disability for First Australians was 1.7 times the rate for non-Indigenous Australians.

### **Household and individual income:**

- After adjusting for inflation, median real Equivalised Gross Weekly Household income (EGWH) for First Australians increased from \$385 in 2002 to \$492 in 2008 however did not change significantly between 2008 and 2012-2013 (\$465). This compared to the non-Indigenous median EGWH of \$869 in 2011-2012.

### **Access to Primary Health Care:**

Access to services is a complex concept with multiple variables. Therefore the report explains the inability to identify a single measure of access to primary health care. However Proxy reports indicated that:

- The proportion of First Australians reporting their health as excellent or very good decreased from 44% in 2008 to 39% in 2012-2013
- The proportion of First Australian adults reporting that they had not seen a GP or specialist in the previous 12 months fell from 19% in 2001 to 14% in 2012-2013 (the most significant decrease was in remote areas).

### **Potentially preventable hospitalisations:**

In 2012-2013 after adjusting for differences in population age structures, hospitalisation rates for potentially preventable conditions were higher for First Australians than for non-Indigenous Australians specifically:

- For chronic conditions more than four times the rate
- For acute conditions more than twice the rate
- For influenza and pneumonia more than three times the rate
- For other vaccine preventable conditions almost six times the rate

### **Obesity and nutrition:**

- In 2012-2013 69% of First Australians were overweight or obese. After adjusting for differences in population age structures, this was 1.2 times the proportion for non-Indigenous adults in 2011-2012.

### **Mental Health**

- In 2012-2013 almost one third of First Australians (30%) reported high/very high levels of psychological distress, an increase from 27% in 2004-2005
- After adjusting for differences in population age structures, the proportion of First Australian adults experiencing high/very high psychological distress in 2012-2013 was almost three times the proportion for non-Indigenous adults in 2012-2013



### **Suicide and self-harm:**

After adjusting for differences in population age structures:

- The suicide death rate for First Australians in 2008-2012 was almost twice the rate for non-Indigenous Australians
- The hospitalisation rate for intentional self-harm for First Australians increased by almost 50% from 2004-2005 to 2012-2013, while the rate for other Australians remained relatively stable

### **Potentially avoidable deaths**

'Potentially avoidable deaths' are defined by deaths that are potentially avoidable through changes to lifestyle, health behaviours and access to effective primary prevention, early intervention and appropriate medical treatment. The report states that:

- For the period 2008-2012 three quarters of First Australian deaths were potentially avoidable (7079 out of 9438 deaths), compared with two thirds of non-Indigenous deaths (112 076 out of 169 111 deaths)
- After adjusting for differences in population age structures, mortality rates from potentially avoidable deaths declined at a greater rate for First Australian 0-74 year olds than it did for their non-Indigenous counterparts

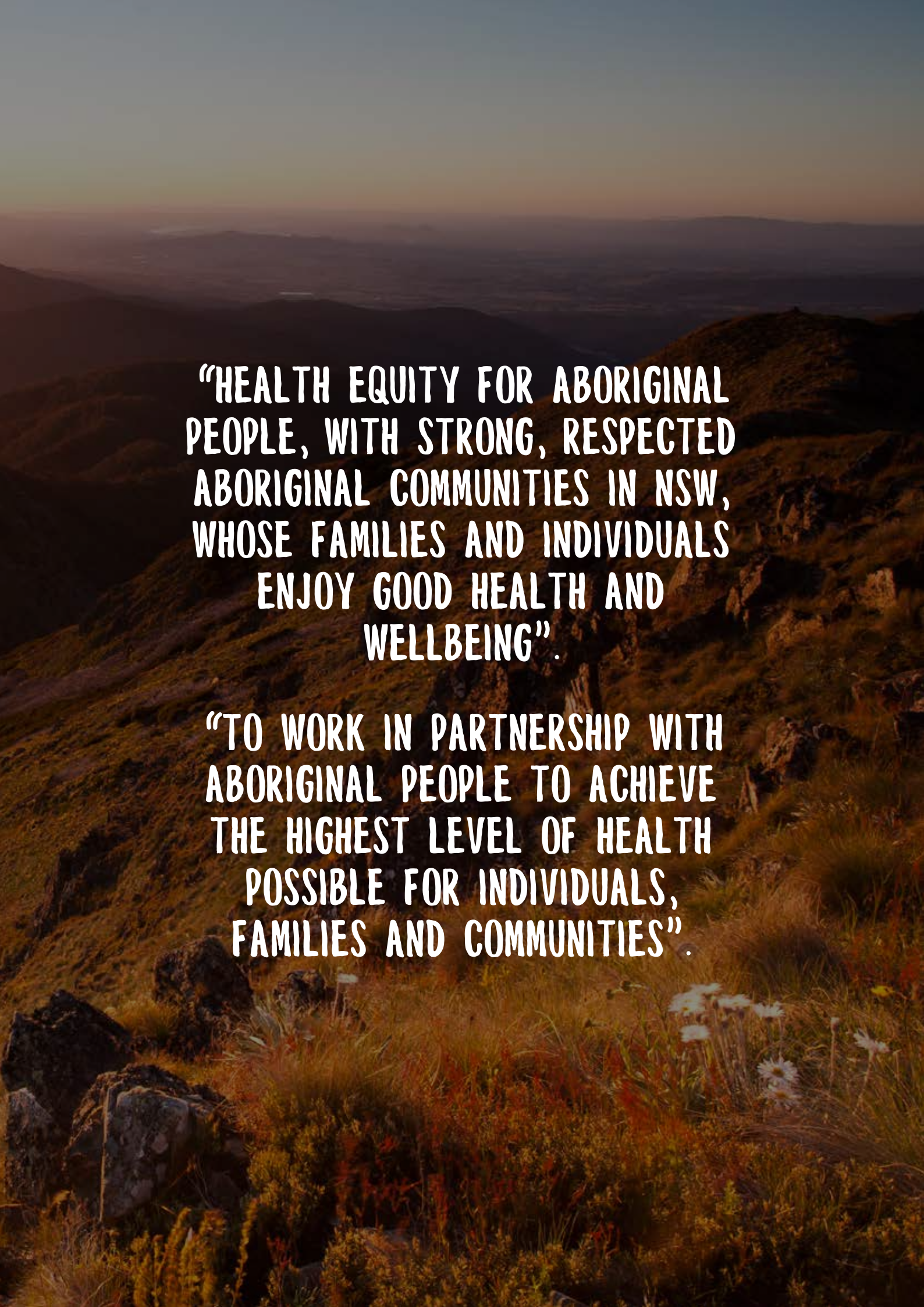
# NEW SOUTH WALES (NSW) ABORIGINAL HEALTH PLAN 2013-2023

The NSW Aboriginal Health Plan is a result of the NSW Government's commitment to closing the health gap between First Australian and non-Indigenous people in NSW. The State Health Plan's vision and goal are:

The Plan recognises the importance of the NSW Aboriginal Health Partnership between the NSW Government and the Aboriginal Health and Medical Research Council (AH&MRC) at the state level and the continued need for strong partnerships between NSW Local Health Districts and Aboriginal Community Controlled Health Services at the local level

## **The Strategic Directions for Aboriginal Health articulated in the State Plan include:**

1. Building trust through partnerships
2. Implementing what works, and building the evidence
3. Ensuring integrated planning and service delivery
4. Strengthening the First Australian workforce
5. Providing culturally safe work environments and health services
6. Strengthening performance monitoring, management and accountability



**“HEALTH EQUITY FOR ABORIGINAL  
PEOPLE, WITH STRONG, RESPECTED  
ABORIGINAL COMMUNITIES IN NSW,  
WHOSE FAMILIES AND INDIVIDUALS  
ENJOY GOOD HEALTH AND  
WELLBEING”.**

**“TO WORK IN PARTNERSHIP WITH  
ABORIGINAL PEOPLE TO ACHIEVE  
THE HIGHEST LEVEL OF HEALTH  
POSSIBLE FOR INDIVIDUALS,  
FAMILIES AND COMMUNITIES”.**

# POPULATION STATISTICS

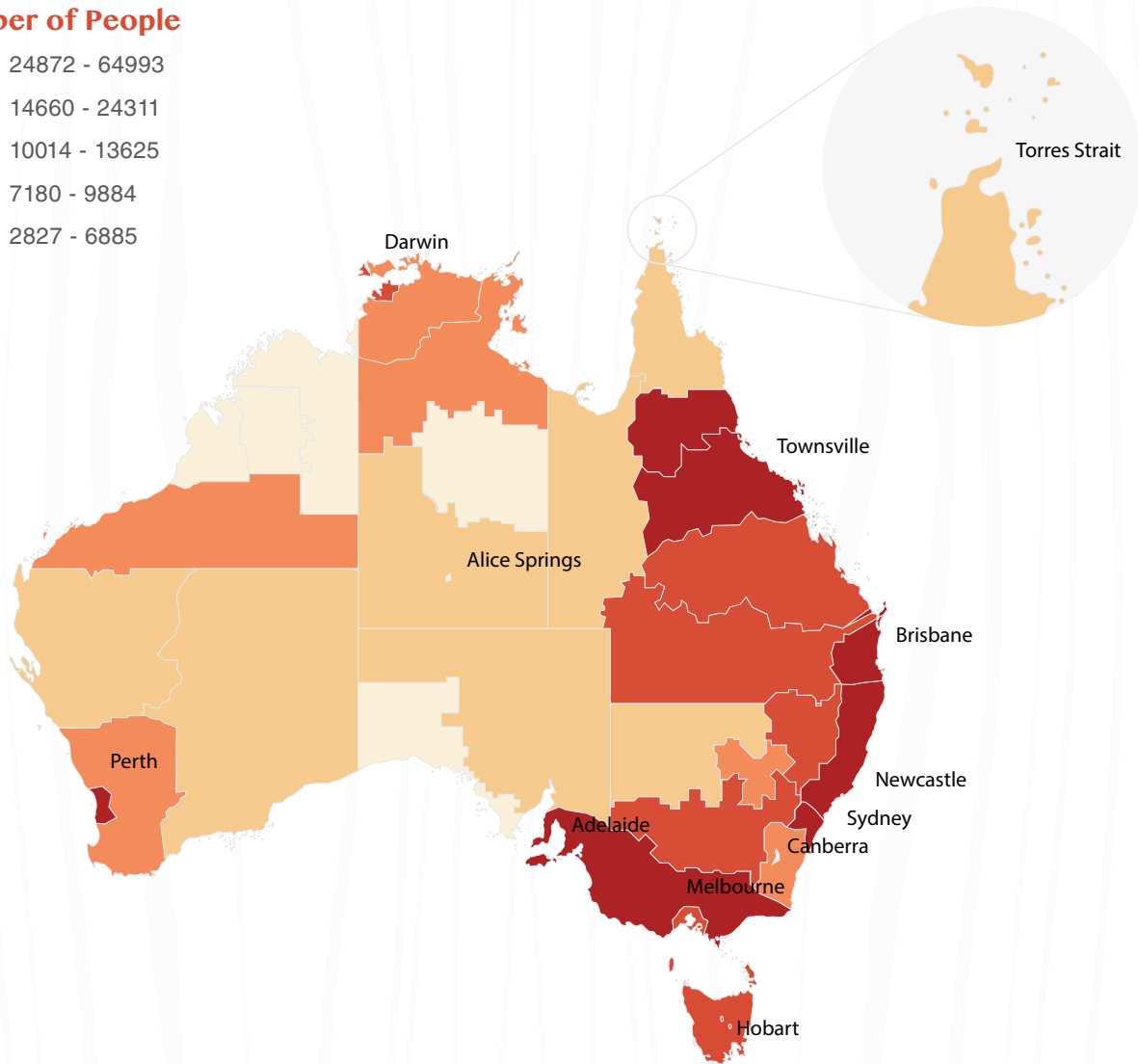
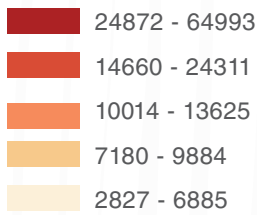
## Australian Demographics

Based on the 2011 national census as at 30 June 2011, an estimated 670,000 people identified as a First Australian. This was 3% of the total Australian population (22,340 000 people).

Australia's First people reside across the country; however populations are concentrated in certain areas nationally. This population distribution is represented in the image below<sup>9</sup>.

Source 1:

### Number of People



<sup>9</sup> SCRGSP (Steering Committee for the Review of Government Service Provision) 2014, Overcoming Indigenous Disadvantage: Key vIndicators 2014, Productivity Commission, Canberra.

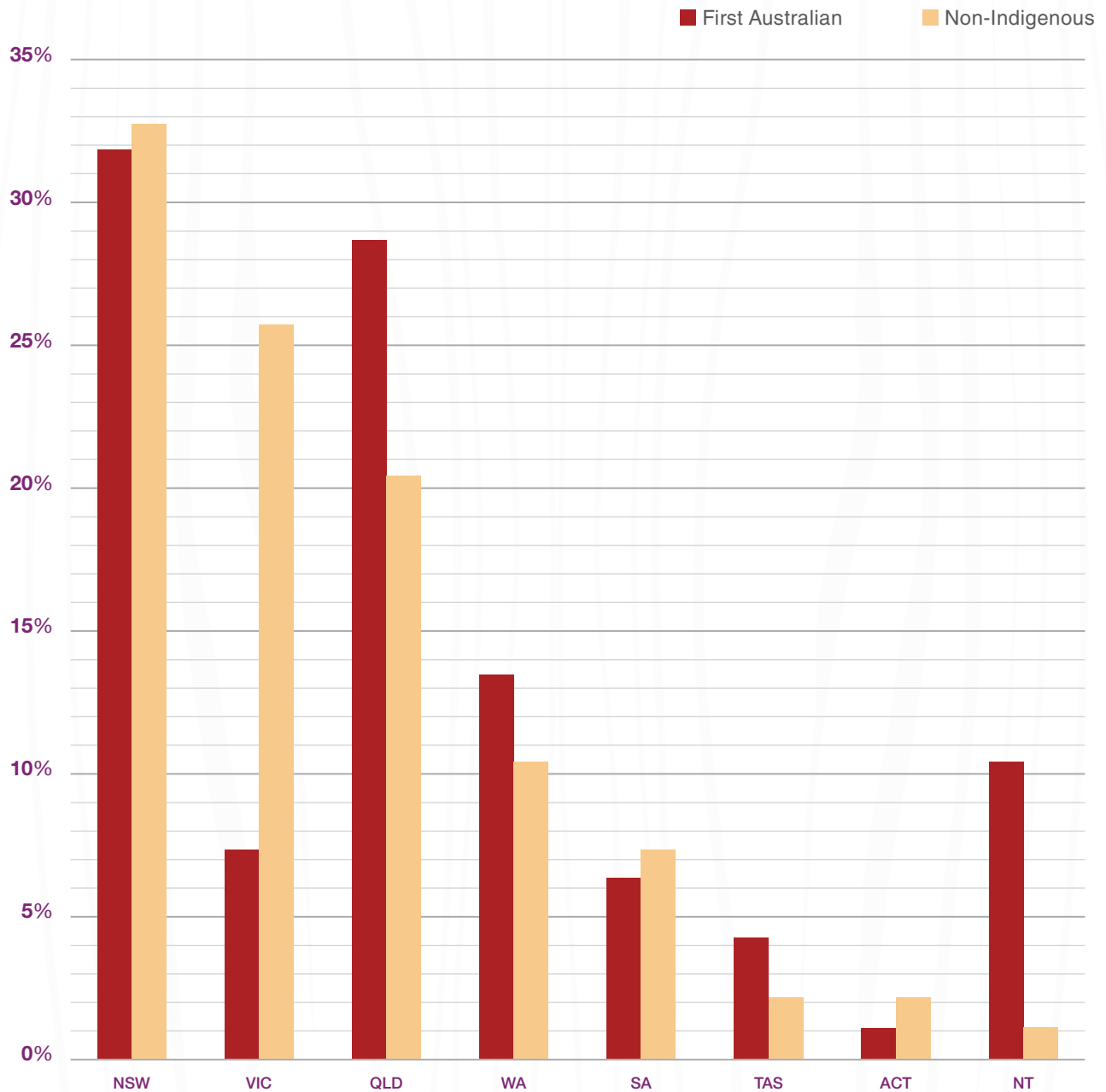


## NSW Demographics

In the 2011 census it was also demonstrated that 31% of First Australians resided in NSW, albeit the largest proportion of non-Indigenous people also resided in this state.

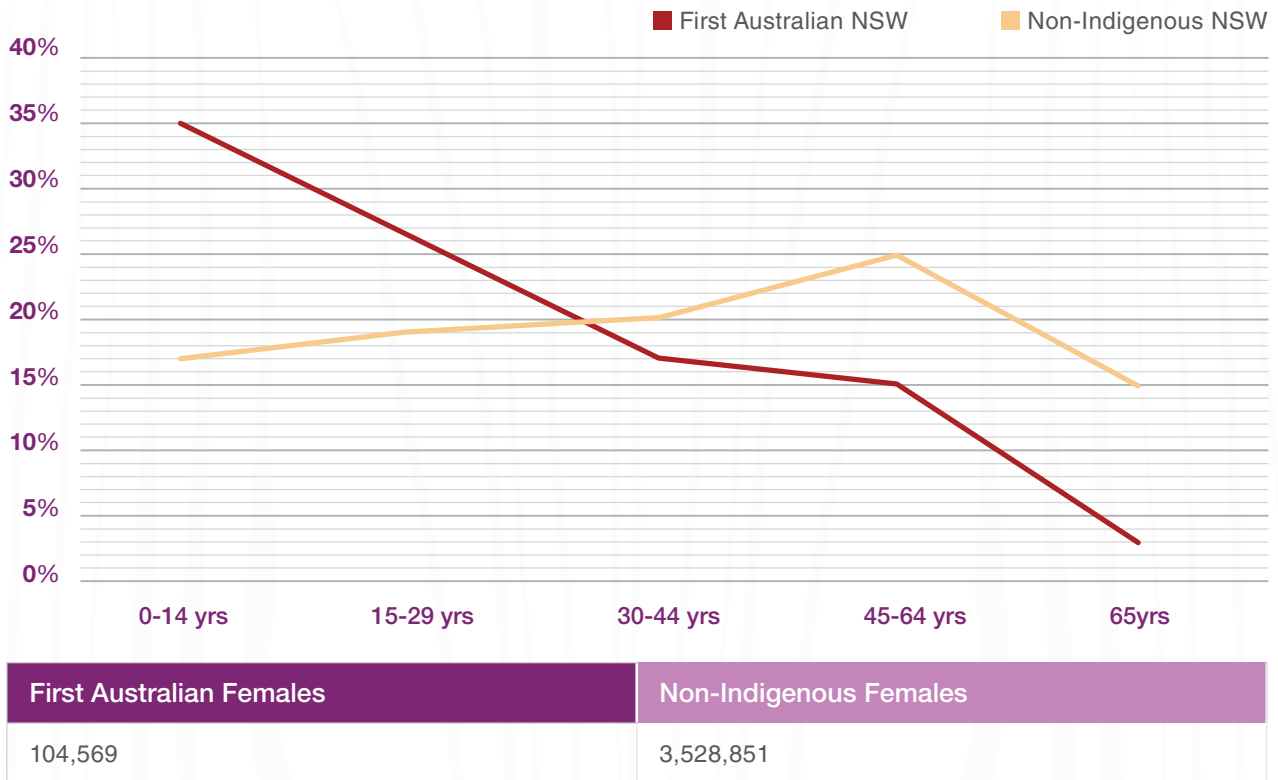
The following charts demonstrate the proportion of First Australian and non-Indigenous people residing in each Australian state and territory

**Source 2:** State/Territory Population Proportions by Indigenous Statute (ABS 2011)



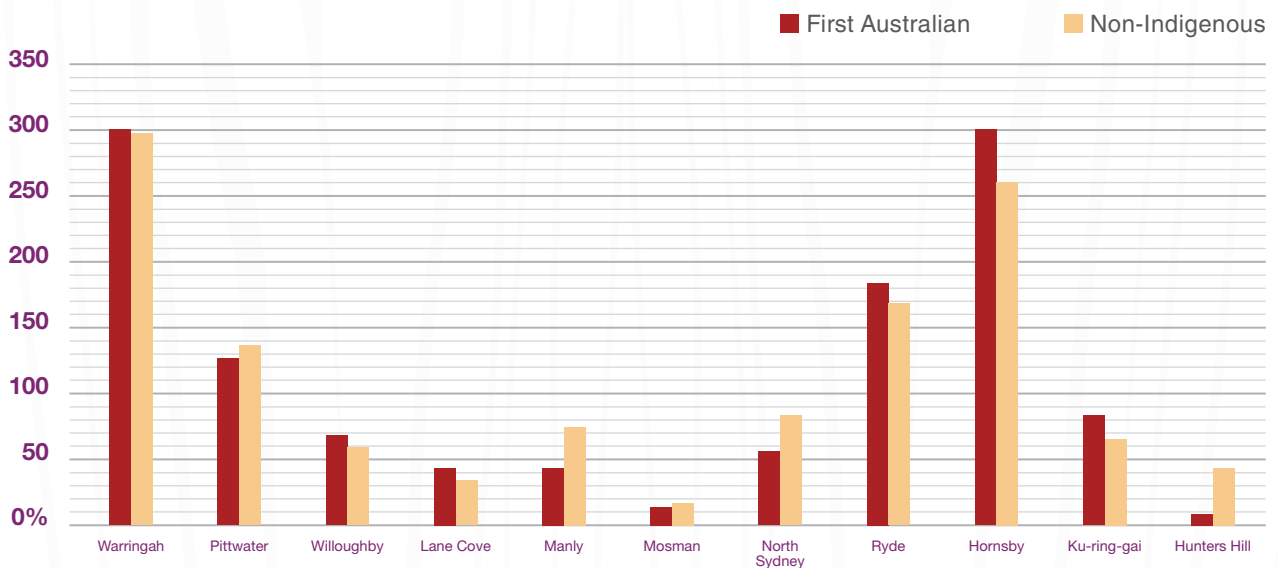
Total Population numbers	First Australian	Non-Indigenous Australian
Australia	669,881	21,670,143
New South Wales	208,476	7,010,053

**Source 3:** NSW Female Population by Indigenous Status



### First Australians in Northern Sydney

**Source 4:** First Australian Population in Northern Sydney by Sex (ABS 2011)

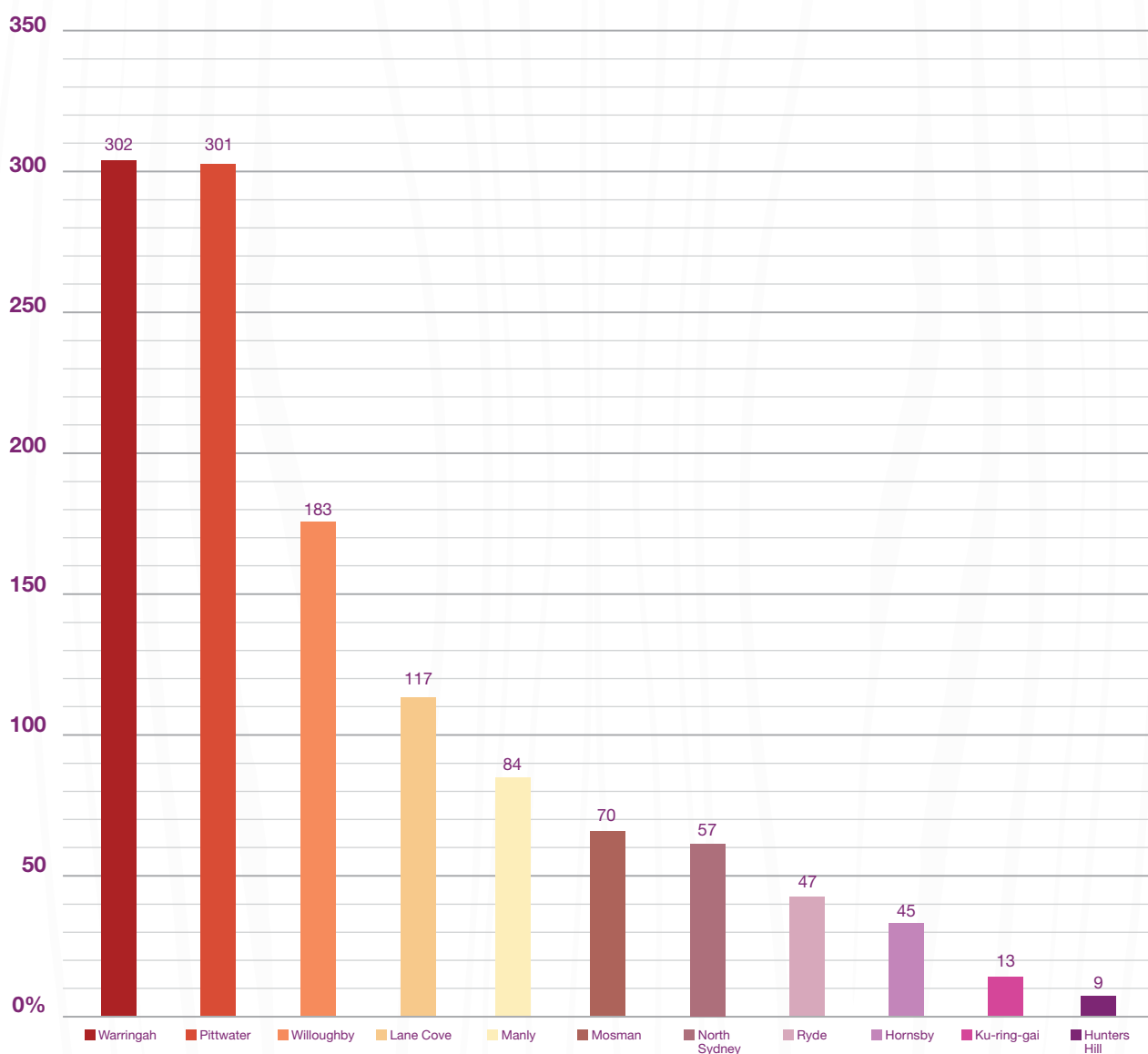


In the 2011 Census 2,460 people identified as a First Australian. The population was equally distributed in terms of gender with 1,228 females and 1,232 males. The largest First Australian population resides in the Warringah and Hornsby Local Government Areas (LGAs) of Northern Sydney.

# FIRST AUSTRALIAN FEMALE POPULATION IN NORTHERN SYDNEY

In the 2011 Census there were 1,128 females who identified as First Australians living in Northern Sydney. The following graph shows the First Australian female population by Northern Sydney Region Local Government Area (LGA), demonstrating the highest population of First Australian females residing in the Warringah and Hornsby LGAs.

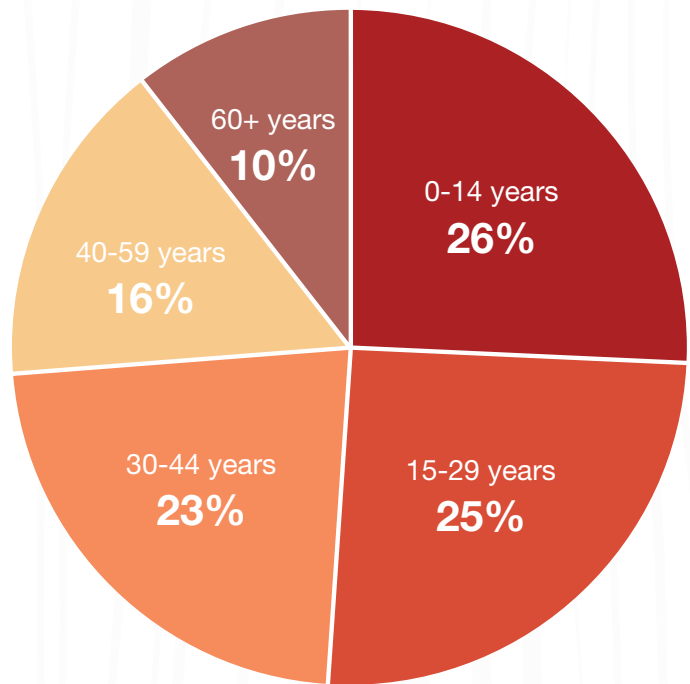
**Source 5:** First Australian Females in Northern Sydney by Local Government Area (ABS: 2011)



The majority (53%) of First Australian females resides in the Warringah and Hornsby Local Government Areas.

**Source 6:** First Australian Females in Northern Sydney by Age (ABS: 2011)

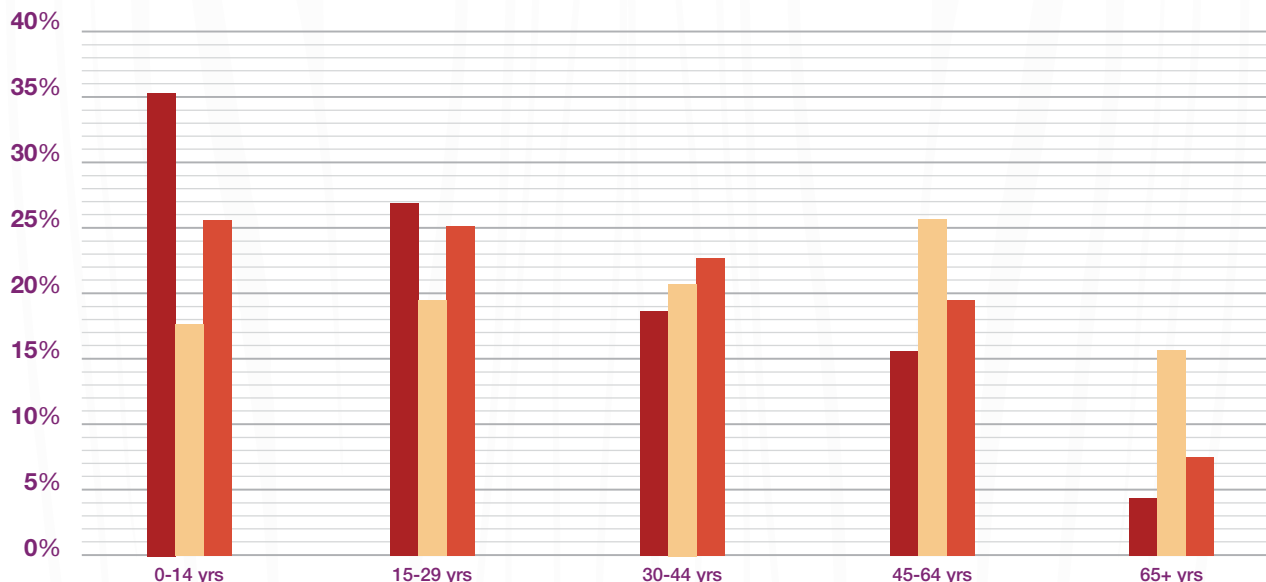
- 0-14 yrs
- 15-29 yrs
- 30-44 yrs
- 45-60 yrs
- 61+ yrs



While the majority of the First Australian female population (74%) is aged under 45 years of age, this age distribution is different to that of the mainstream population in Northern Sydney. This pattern of age distribution, with higher relative proportions of younger people is consistent with population demographics in NSW and nationally.

The following diagram shows the comparative age distribution for female First Australians (both in NSW and Northern Sydney) in comparison to non-Indigenous counterparts.

**Source 7:** Female Population Age Distribution by Indigenous Status (ABS: 2011)



While the pattern for age distribution of First Australian females in Northern Sydney is more similar to the NSW First Australian age distribution than the non-Indigenous distribution, we do have a higher proportion of women aged over 45 years than the comparative NSW First Australian population.

# NORTHERN SYDNEY FIRST AUSTRALIAN HOSPITAL PRESENTATIONS AND ADMISSIONS

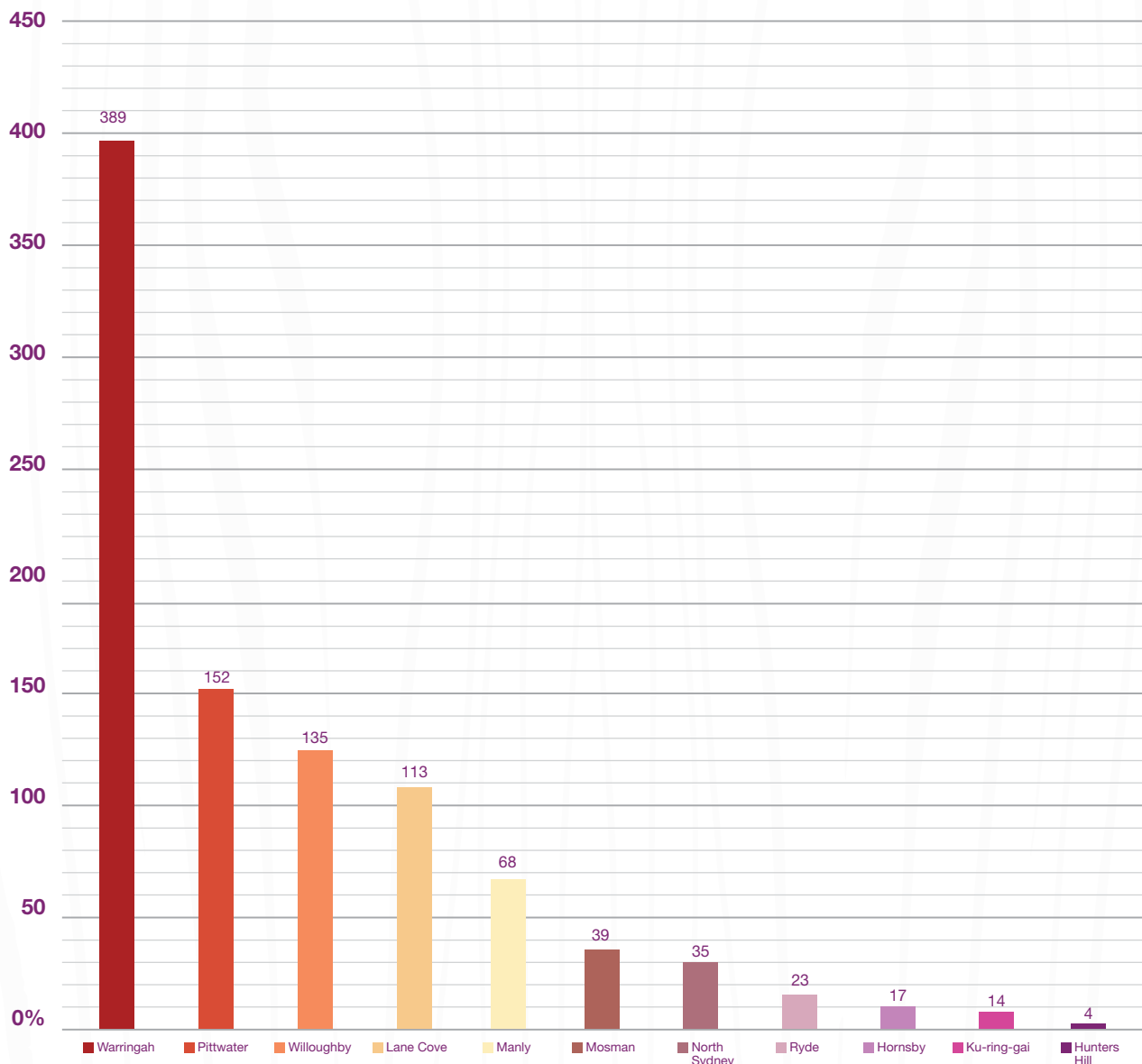
Statistics were compiled from NSW Hospital Admissions data to identify hospital admission frequency and characteristics for First Australian females residing in the Northern Sydney region. The statistics identified a total of 989 First Australian females admitted to Northern Sydney Local Health District public hospitals during the reporting period.

It is noted however, that this data only accounts for females identifying as First Australians and as discussed this identification rate may not fully reflect the actual population of First Australians in Northern Sydney.

## Admission Reasons

The following diagram shows the reasons for admissions for the period July 2013 to January 2015 for all public hospitals in the Northern Sydney Local Health District and inclusive of Emergency Department presentations (which accounted for approximately 40% of all admission records). There were 989 recorded admissions for First Australian females in total.

**Source 8:** First Australian Femal Admissions by Age (July 2013 to January 2015)



### The diagram shows that:

- The highest number of admissions (excluding admissions categorised as ‘other’) was for pain related conditions. Descriptions of pain were diverse
- There were a relatively large number of admissions described as pregnancy related. There was limited information about the nature of these admissions however, so should be interpreted with some caution
- ‘Other’ admission reasons accounted for a large proportion of admissions, and included a wide range of conditions including, for example: allergies, lacerations, skin conditions, gastro related symptoms, fever, and a range of other descriptions
- Chronic conditions, including respiratory or cardiac conditions, cancer and diabetes had proportionately lower admission rates

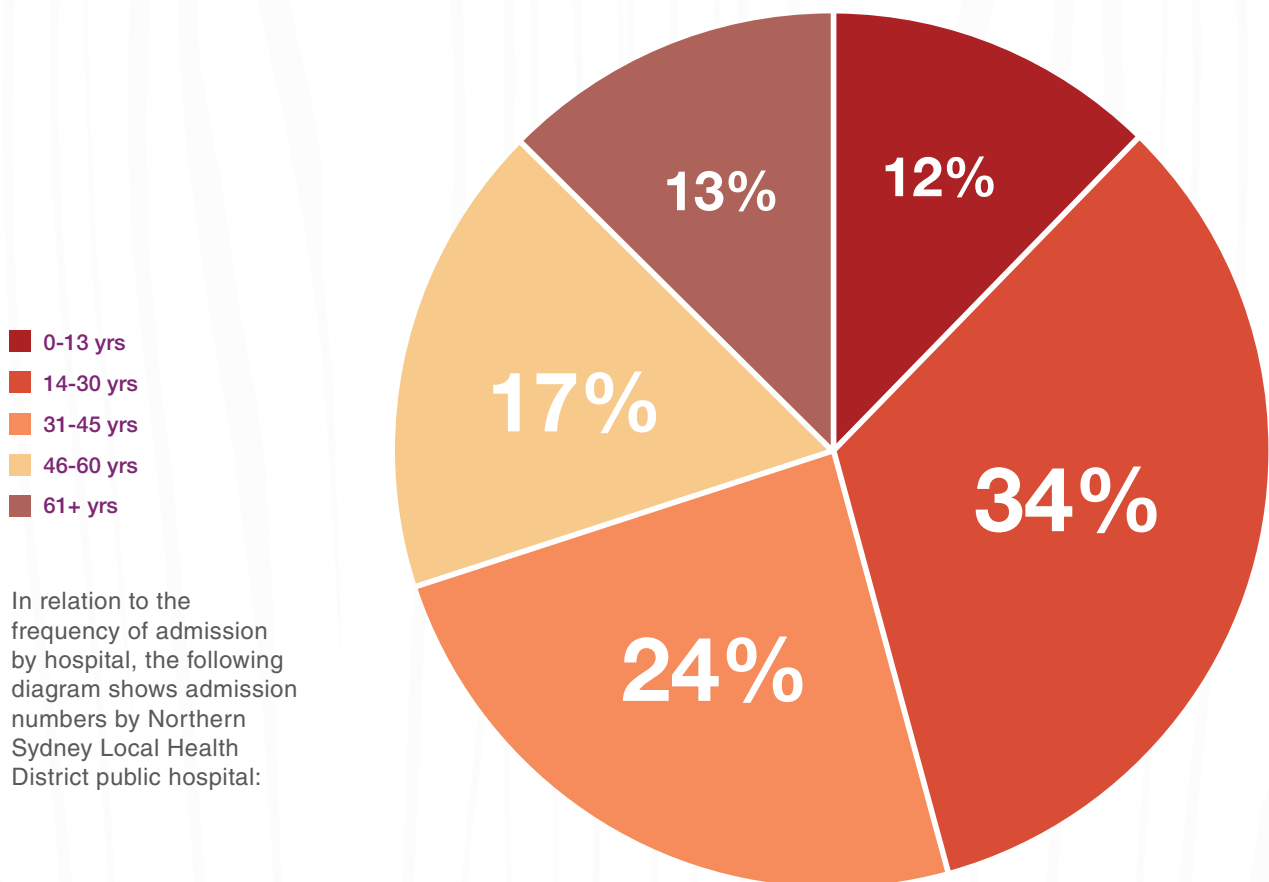
The highest proportion of admissions for First Australian females was as a result of pain related conditions. Presentations to the Emergency Department represented a high proportion of the total, at around 40%.

### Age distribution of female admissions

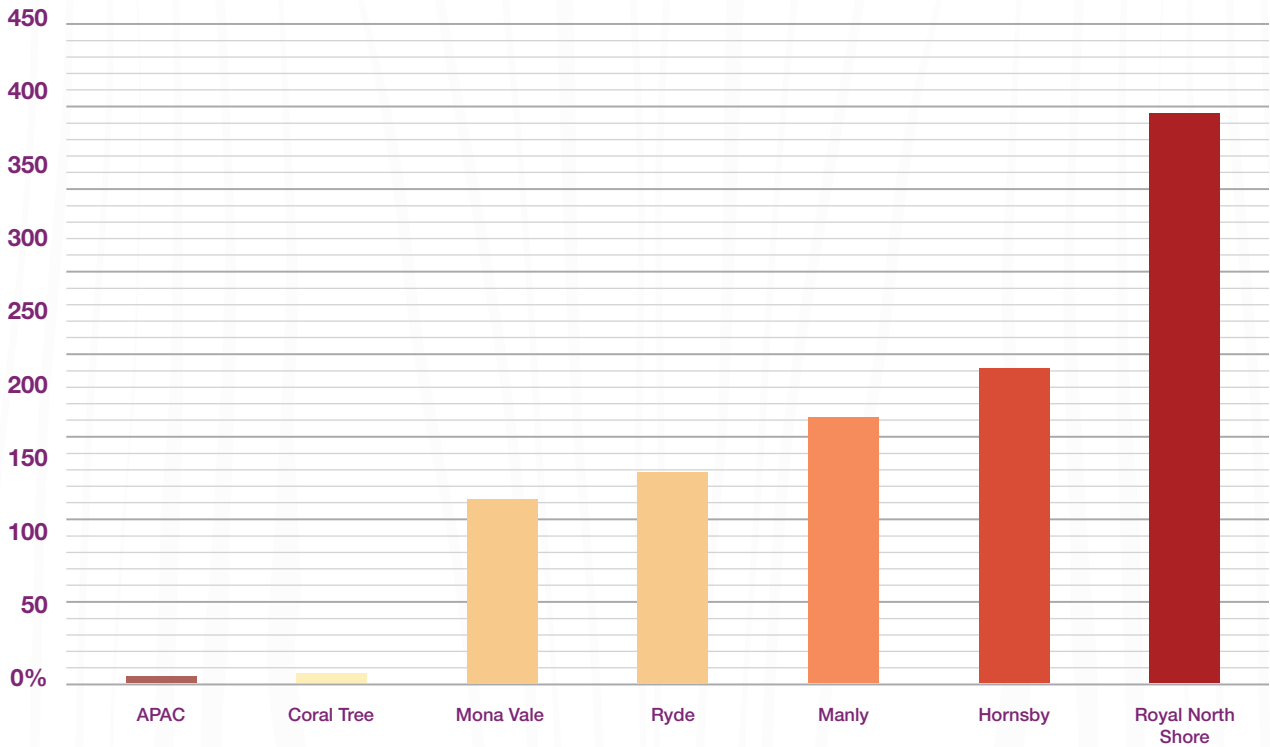
In relation to age the majority (70%) were aged 45 years of age or younger. This was higher than the mainstream comparison, whereby approximately 55% of female admissions were aged 45 years or younger. For First Australian females the group experiencing the highest rate of admission was females aged between 14 and 30 years of age (34%). This compared to a rate of 20% for non-Indigenous admissions for 14 to 30 year olds.

The following graph shows the age distribution for all public hospital admissions for First Australian females in Northern Sydney:

Source 9: First Female Admissions by Age (July 2013 to January 2015)



**Source 10:** First Australian Female Admissions by Hospital (July 2013 to January 2015)

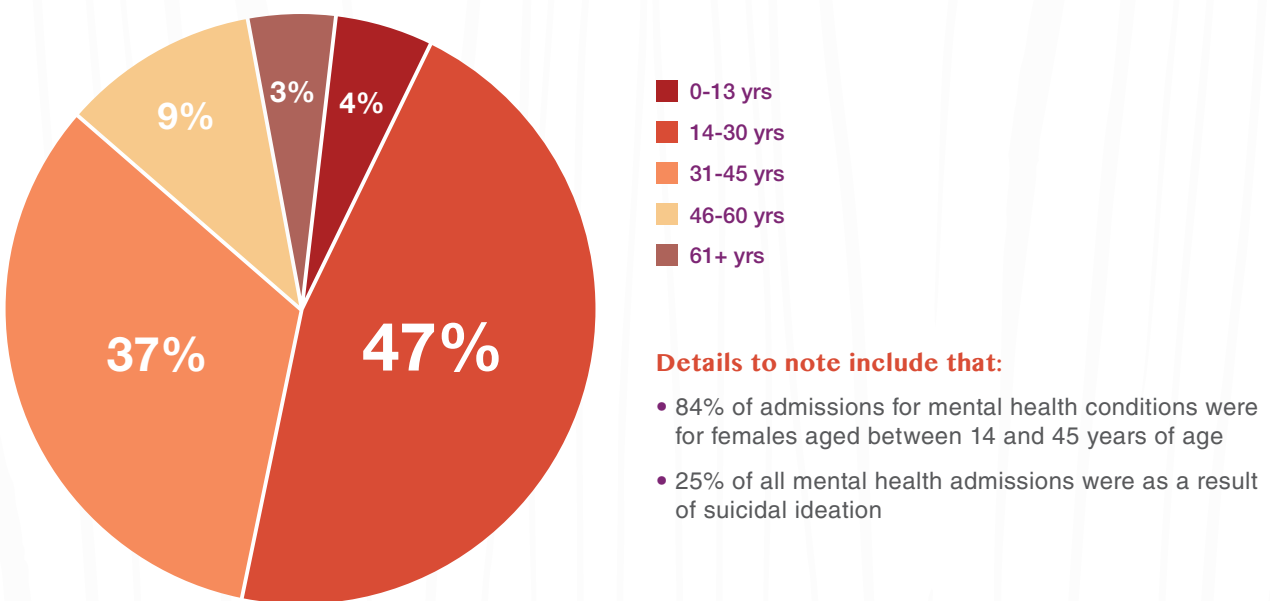


### Mental Health admissions

During the reporting period there were 68 mental health admissions, accounting for 7% of total admissions (this figure excludes drug and alcohol admissions, as well as mental health related admission reasons otherwise captured in the 'other' category).

The following diagram shows all mental health admissions by age for First Australian females in Northern Sydney:

**Source 11:** First Australian Female Mental Health Admissions by Age (July 2013 – January 2015)



# FIRST AUSTRALIAN FEMALE HEALTH CHECKS

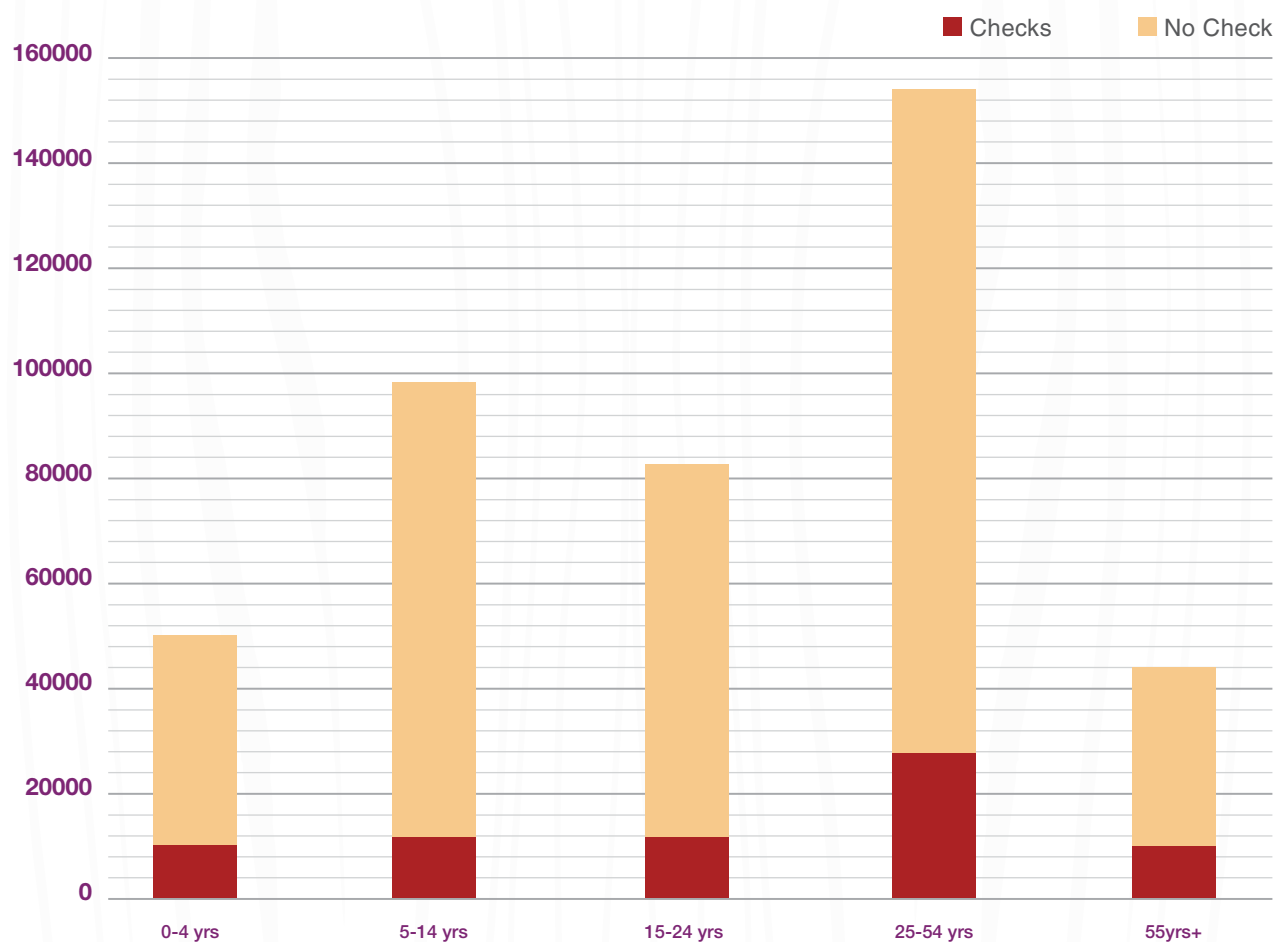
## NSW Health Assessments

Primary Health Practitioners are encouraged to undertake health assessments for First Australians, claimable under the Medical Benefits Scheme (MBS) Item 715. The aim of the MBS health assessment item is to help ensure that First Australian people receive primary health care matched to their needs by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality.

For the purpose of this item a person is a First Australian if they or their parent or carer identify them as being of Aboriginal or Torres Strait Islander descent .

The following diagram shows the total number of health checks undertaken for First Australian females in NSW:

**Source 12:** First Australian Female Health Checks (MBS Item 715) in NSW by Age (2010-14)



The proportion of First Australian females who received health checks under the MBS Item 715, between 2010-14, was 16%. The lowest proportion by age was females aged 5-14 years (11%) and those aged 15-24 years (14%). Females aged over 55 years were most likely to undertake health checks at 24% of all First Australian women in that age cohort.

<sup>10</sup> www.health.gov.au

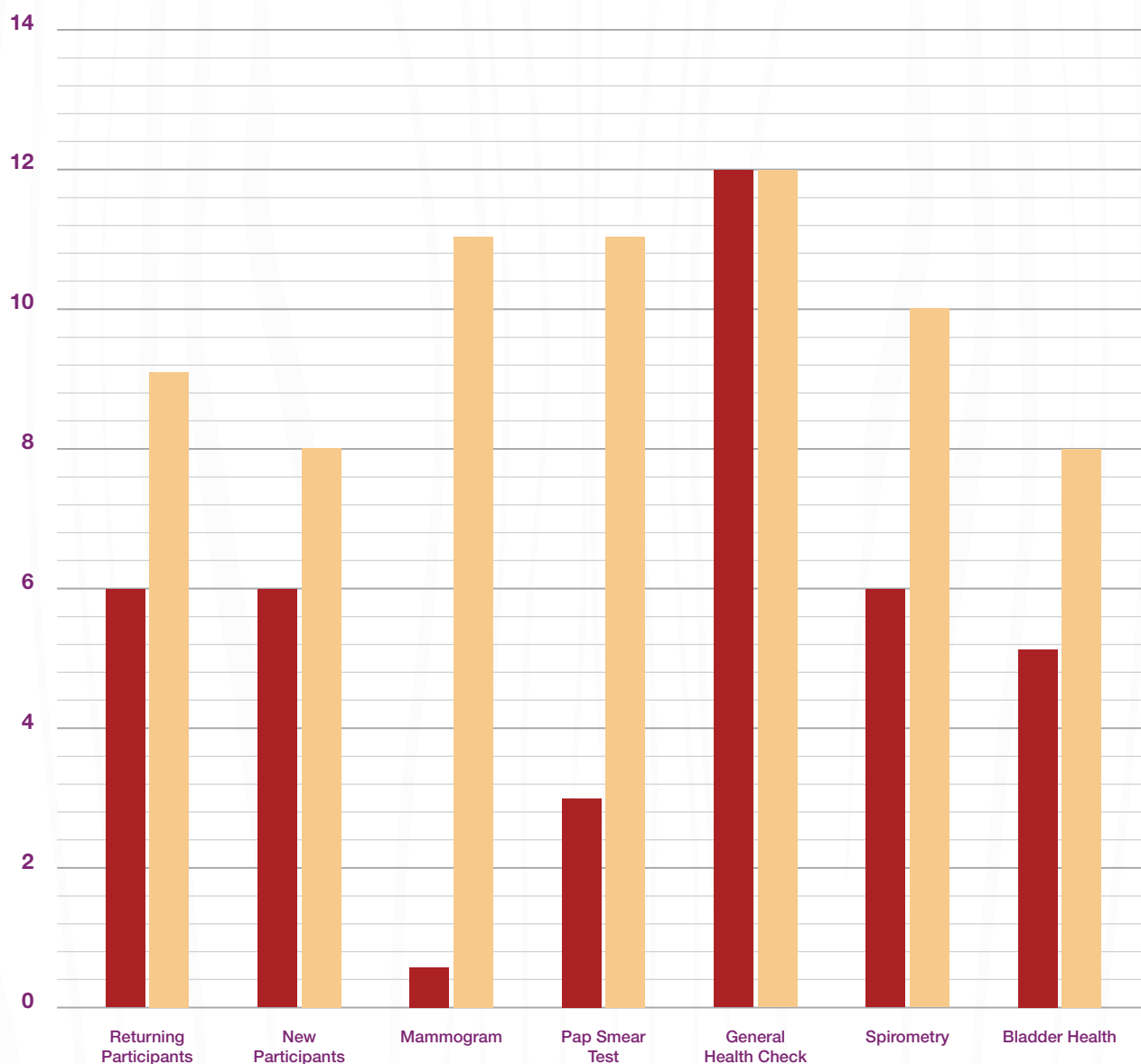


# NORTHERN SYDNEY HEALTH CHECK PROJECT

First Australian women residing in Northern Sydney are invited to participate in annual female health checks 'Aboriginal Women's Health Check Day' facilitated by the NSLHD Aboriginal Health Service. The target group for the health check day is generally adult females with a focus on older women aged over 45 to encourage participation in mammograms. While not comparable to NSW health check rates due to the different target, it could be surmised that generally a lower proportion of First Australian females residing in Northern Sydney participate in the local health checks, than the broader NSW population in the health assessment process.

The following diagram shows the participation patterns for the NSLHD Aboriginal Women's Health Check Days for 2013-2014:

**Source 13:** Northern Sydney First Australian Female Health Check Day participation 2013-14



# NORTHERN SYDNEY SERVICE SYSTEM

The following diagram provides a broad overview of the service provision for First Australians and specifically First Australian females in the Northern Sydney region:

While a service utilisation analysis for First Australian females was not within the scope of this Plan, through discussions with providers and First Australian community members, anecdotally:

- Community members express some difficulty in accessing and maintaining consistent relationships with general practitioners (GPs) in the Region. There were reports of inability to see local GPs due to book closures as well as inability financially to access services that do not bulk bill
- The community care service network is extensive, albeit there is only a very small proportion of providers who auspice Aboriginal specific services and none of these organisations are Aboriginal Non-government Organisations (NGOs). The Aboriginal Home Care Service, Wangary are considered underutilised in Northern Sydney
- People experienced financial barriers in accessing fee-for-service programs, specifically specialist services and GPs that do not bulk bill. Medication costs were also identified as a financial stress for many. Financial pressures were more significant for people with low wage jobs who earned just over the threshold for subsidised services. Single mothers were also identified as a group of women experiencing significant financial stress
- There were access barriers that related specifically to perceptions of lack of cultural safety, respect and validation within mainstream health services. Community members were supportive of the NSLHD Bungee Bidjel initiative, however advocated for the need for longer operating hours to enable better access. Some community members identified a preference for accessing the Aboriginal Medical Service (AMS) in Redfern, however others identified preferences for accessing local services over the AMS- this was mixed.

Currently other than the NSLHD Aboriginal Health Service located at Royal North Shore Hospital and the Bungee Bidjel Aboriginal Health Clinic located at Hornsby Ku-ring-gai Hospital, there are no other First Australian specific NSW Health funded services located in the Northern Sydney.





# THEMES, ISSUES AND OPPORTUNITIES

## Underpinning Philosophy

Community members were invited to attend regional community consultations to explore issues that impact and influence First Australian females' health and wellbeing. The following information and recommendations are based on and structured with respect to the following principles, First Australian females in Northern Sydney:

- Come from various 'home' Countries across Australia. While many First Australian females were born in Northern Sydney their cultures, stories, histories and experiences are influenced by where they or their families and ancestors call 'home'
- Construct their health and wellbeing as inseparable from the broader health and wellbeing of First Australian males and the collective wellbeing of their First Australian communities. Thus, while initiatives discussed primarily focus on First Australian females, health and wellbeing outcomes are inextricably linked with the collective outcomes of First Australians in the broader sense
- Define and practise their culture and spirituality in diverse ways. While concepts, values and belief systems are often aligned, it is important to respect the differences and individual choices and constructions of culture and spirituality that First Australian females express
- Discussed some of the issues associated with identification, including stigmatisation, lack of recognition and fear that has led to under-identification. There was a sense that the identification was under-representative of the population and while improving was an ongoing source of marginalisation for First Australians
- Appreciated that western medicine was an important contributor when it came to addressing and preventing ill-health. However, people generally constructed their definitions of wellbeing within a much broader framework incorporating mind, body and spirit. Western medicine and formal services were considered as one of many contributing factors for improving health and wellbeing
- Identified intergenerational trauma as a major whole-of-community factor that continues to influence the health and wellbeing of people. While descriptions and manifestations varied, approaches that were multigenerational and holistically inclusive of mind, body and spirit were identified as fundamentally important
- Liked the idea of expressing health and wellbeing themes, issues, and opportunities in line with the female life cycle and stages. This is seen as one way of communicating concepts from both a cultural and western health paradigm into a shared dialogue for wellbeing and system change and as a related concept.
- Expressed the implicit tension between western 'systems' (the health system being one of these) and their culture, and expressed that 'wellbeing' in its most holistic sense would be improved through closer alignment of the two. Thus purely improving health services within a western health paradigm without respecting and incorporating broader notions of cultural resilience, utility and autonomy of expression would not lead to better outcomes for First Australian females.

**This Plan, attempts to share and integrate multiple perspectives into activities and recommendations to improve health and wellbeing outcomes, but also to create a new story for partnerships and shared approaches in Northern Sydney.**

The issue of identification was often raised by First Australian women of all ages through the consultations. Many women have their own stories about identification both in relation to cultural pride, as well as experiences of racism or challenges to their identity.

““

**Ok. My dad's name is Neville Janson and he kept his Aboriginal heritage hidden. He was a great bushman who carved me a yam digging stick with a snake around it. He could climb a tree with a hatchet in his belt using just a piece of rope.**

**He told me about his family coming from Wilberforce and how they knew how to live off the land. Hawkesbury river people who ate oysters and fished. He would take us kids fishing on Lane Cove River and we would catch blue swimmer crabs.**

Our family are descended from Mary Thomas of the Burruberongal clan of Darug nation. She was born at Freeman's Reach blacks' town. The land had an ancient Aboriginal camp. My convict ancestors, the Reynolds family married into the Aboriginal family of Mary who lived on the land alongside Bushell's Lagoon. I visited there recently and held some ancient stone artefacts from a knapping site near Hawkesbury High.

Neville died when I was 18 years old but his dark features and kind nature live on in me and my children. I am proud to acknowledge our Aboriginal heritage and I am sad that he did not live to be able to identify himself. He would have been proud.

**Julie Janson, Darug Woman**

““

**When I was in hospital recently, they didn't ask if I identified as being Aboriginal, and had ticked the 'neither' box. I was too sick to realise until I was going home and saw the admission form. All health professionals should ask, rather than ignorantly assume.**

**Natalie, First Australian community member**



**"THERE'S NOTHING  
WORSE THAN THE**

**'HOW MUCH ABORIGINAL  
ARE YOU?' QUESTION.**

**ALL OF ME IS  
FIRST AUSTRALIAN".**



# BROAD THEMES AND ISSUES

There were a number of broad overarching themes that arose through consultations, conversations and workshops with First Australian females living in Northern Sydney. These included:

- An expressed need for a 'space'. A physical space where women felt safe and culturally validated from which community and health related services could be accessed. There was general consensus that one barrier for accessing health care was a sense of insecurity and lack of cultural safety within (for example) hospitals and other mainstream health facilities
- That 'access' to health services continues to be a barrier. This included lack of effective transport, financial barriers (cost for services), restricted access to local general practitioners and/or inability to secure child care (and/or inability for mothers to bring children with them to appointments), as examples, all had an impact on the rate of access to health services
- A perceived lack of integration, information and linkage within the health system and between service providers led to people not receiving services and resources that they were entitled to/or eligible for. Examples included service providers not informing people of available subsidies (e.g. taxi/travel vouchers), lack of awareness of Closing the Gap entitlements and providers, and/or lack of referral to Aboriginal Liaison Officers (e.g. the Aboriginal Health Service, community Aboriginal Advisory Services, and/or Liaison staff within the Chronic Health Care Program)
- That mainstream health and social service systems were often not supportive of women identifying their Aboriginality. Many women said that people (hospitals, GPs, service providers) either didn't ask the identification question, or even, challenged people when they identified. Women gave examples about being angry and/or humiliated when this happened
- A perception that while there were a lot of resources available to people who were on pensions, or who had severe chronic health issues, there was a significant dearth of resources available for people who were on minimum wages (but just above eligibility for subsidies), or for people who had premorbid and/or preventable health issues. People felt that the message this gave (and the resulting effect) was that people's situations and health needed to deteriorate to a chronic state before support could be provided
- That the experience of racism, discrimination and stigmatisation was rife within the community and systemically within health and community services. Women felt that there was a significant need for the development of cultural competencies within the system but also that we could not rely on this. Women also saw the need for the development of community-based and owned initiatives that built the strength of First Australians and provided skills and resources to confidently practise and communicate culture
- The need to look more at causal factors that contribute to health behaviours that lead to poor health and wellbeing outcomes. Many of these causal factors relate to complex issues including but not limited to: intergenerational trauma, racism, parenting challenges, environmental factors, cultural suppression, socioeconomic issues and/or violence. Focusing only on the manifestation of illness, rather than the causal factors were not considered an effective strategy for improving health and wellbeing outcomes
- A perceived lack of commitment to ongoing support and initiatives to address complex and multifaceted health and wellbeing concerns. The community felt that health systems and community services provided 'flavour of the month' services and interventions without ongoing support. Many felt that this approach actually resulted in worse health and wellbeing outcomes than would have been the case without any service at all. Examples given included smoking cessation support and other supports to address addictive behaviours and/or substance misuse.

**Community members want to see approaches that reflect long-term commitment to addressing complex causal factors that lead to poor health and wellbeing outcomes, not just flavour of the month interventions and one-off services.**

**Every living thing has a story and an 'essence'. When you know what they are, all of a sudden everything is related. Everything is connected. Everything has a meaning and a purpose.**



## Teaching Story of Compassion: How the kangaroo got her pouch<sup>11</sup>

A long time ago in the dreaming, Biامي looked down on all of us and shook his head because he saw such greed and selfishness. He was sad. Now Biامي is never spiteful or cruel, never, but he can be sad.

“Look at them”, he thought. “I have to go and see just how selfish and greedy they are. So he came down and turned himself into an old, blind wombat and sat on the side of the road. Along came a warrigal.

“Please help me”, he said to the warrigal. “I’m blind and I’m thirsty and I’m hungry, and I need water and food”.

Then along came emu and old wombat said: “please, please help me. I’m blind and I’m thirsty and I’m hungry. Please help me.” Now the emu was in a hurry, you know, a big fast hurry. “GO! Go on! Get out of my way!” said the emu. One by one the animals came. And one by one they all abused or ignored the wombat. Every one of them was either in a hurry to get to some important place, or had some greed to fulfil, or was just too plain selfish.

Then along came a kangaroo, a mother kangaroo. Kangaroos didn’t have pouches then. They carried their babies- that’s why kangaroos have hands. They are very adept with their hands. So this mother kangaroo was carrying her baby and she looked down on old wombat with compassion.

“I’m carrying my baby” she explained. “So it’s hard to guide you unless you hang on to my tail. It will be a very bumpy ride but I know a place of green, green pastures and sweet, sweet water where you’ll be safe”.

Biامي hung on. I don’t think he quite bargained for what he got- but beggars can’t be choosers when you’re searching, even Biامي. So he hung onto her tail and off they went. She bounced him all over the place. It’s a wonder he didn’t have concussion by the time they got there. Well, he might have, I don’t know, I haven’t met Biامي to ask, but I will when I see him!

The kangaroo took Biامي to the green pasture and sweet water. Then just as she was about to leave, she looked up. Because kangaroos can be very tall, right across the other side of the water, she could see the hunters coming.

“Get down! Get down!” she warned the old wombat. “The hunters are coming and you’re in danger. Stay low and I will lead them away from you”.

She clutched her baby firmly, got the attention of the hunters and then took off. The hunters, holding their

spears, yahooped and ran behind her. They wanted meat! It was a long time later and dark when the kangaroo came back, sobbing and heartbroken. She said to old wombat, “I’ve lost my baby. I put her down and now she’s lost in the dark. I think the hunters got her”. Biامي was filled with compassion for the sacrifice this stranger had made for him.

He said, “lay down now and sleep and in the morning you can look for her”. So the mother kangaroo lay down and cried herself to sleep.

“She needs to be rewarded”, Biامي thought. So he went over to a paperbark tree and tore off a big piece of bark. Just as the sun was rising, the mother kangaroo awoke to see Biامي laying the piece of bark across her stomach, sealing it to her body and placing her baby in her arms. She looked into Biامي’s eyes.

“Biامي?” she asked.

“Yes”, he replied. “I am Biامي, and I have tested you. I became the blind wombat because I was testing all creation for greed and selfishness. You were selfless in your sacrifice for a stranger. You and your kind are now rewarded and will, throughout eternity, have this pouch to carry your babies in. From this day on you and your kind will only ever be able to go forward. So all those who need to move forward from pain or suffering, can call on your spirit to take them”.

Now every time you see a female kangaroo with her pouch, you’ll be reminded of the story of Biامي.

# OPPORTUNITIES

Despite the range of issues, barriers and concerns that were raised by community members there was also a sense of optimism and excitement about what could be possible if we were able to realign existing approaches to health care and simultaneously undertake activities that built cultural resilience and supported cultural expression.

Community consultations demonstrated that First Australian females were able to articulate the types of supports and activities that would improve their health and wellbeing in a tangible way.

Some of the broad opportunities that have been identified include:

- Engaging First Australian Elders to teach culture and/or facilitate the sharing of cultural practices within the community. Women expressed the value of strong culture: including networks and relationships as a 'protective factor' contributing to 'strong bodies, minds and spirits'
- Establishing community based workshops that supported people to communicate effectively, deal with conflict and respond in 'high stake' situations. Community members felt that while it was not their fault that broader society lacked capacity to create safe cultural environments and/or respond to people in culturally appropriate ways they could engage in opportunities to build individual and community resilience and coping mechanisms for responding to these situations. These skills were considered to be fundamental for people in dealing with racism, bullying (for younger girls) and/or in communicating cultural needs and preferences within formal service systems
- Developing community-based wellbeing programs that operate long term and focus on initiatives that equally value the health and wellbeing of the mind, body and spirit. Health providers and services could reach communities through these groups and provide information and access to their services as a component of the broader 'program'
- Developing First Australian community resources that cross community service and health systems to provide a one-stop information point regarding First Australian specific entitlements, services and programs as well as access to people that can provide advice and support
- Exploring intergenerational activities and approaches to health and wellbeing, including activities or forums that focus on female health (e.g. the NSLHD Aboriginal Women's Health Check Days) provide resources for parents in having conversations about health related issues with their kids (for example drugs and alcohol, sexuality, puberty), and/ or opportunities for older women and Elders to share their stories, experiences and teachings with the younger generations
- Developing community based programs that encourage physical exercise, positive body image, fun and that enable people of all fitness and activity levels to participate. Community members were interested in opportunities to participate in movement activities together and also identified the need for and interest in the inclusion of professionals to assist in addressing physical issues impacting on ability to exercise. For example, people were interested in movement programs that included physiotherapists and/or occupational therapists as a component of the program.

**Women identified the practice of culture and cultural activities as the foundation for health and wellbeing. They see opportunities for the integration of formal services and providers into community-based wellbeing programs that focussed equally on activities that lead to healthy minds, bodies and spirits.**

““

I would like to see people eating and making better choices about their food. When people at any age eat well, they are taking the opportunity to make a difference in their lives.

I believe that chronic illness is directly related to lifestyle. Good nutrition can prevent illness.

Depression, anxiety and brain health can be improved through getting the right nutrients. Getting enough water, not drinking too much alcohol and not taking drugs.

We know about obesity in our kids... Proper nutrition helps our babies get a good start. It makes me sad seeing unhealthy children.

As we get older, good nutrition can help prevent age-related illness and for older women assist with hormone changes post menopause. It really is the foundation.

I'd love to see weekly wellbeing groups for our community and cooking classes to help people make good choices and nutritious meals.

**Jessie, Wanai**  
Community Member and Nutritionist



Dianella berries, traditional food high in Vitamin C

Narrabeen Lakes an important place for local First Australian community.

# IMPROVING HEALTH AND WELLBEING THROUGH THE FEMALE LIFE CYCLE

## Birth and Childhood

The period of time between conception (the time at which a mother becomes aware of the child inside her) and until the female child menstruates for the first time, or a male child 'spills seed' for the first time is included in this life stage. For the purpose of this plan based on cultural definitions of children as 'genderless' until they 'spill seed' and are consequently gendered this plan concerns all children regardless of sex.

## Key Issues and Themes

### Antenatal

- It was identified that there was a lack of 'cultural presence' and 'cultural safety' in birthing units. This included general cultural visibility in the physical environment as well as a lack of culturally specific information materials
- Birth plan options and/or the integration of cultural preferences into antenatal care and classes etc. has been identified as lacking. This includes things like planning for cultural practices around the cutting of the umbilical cord, placenta retention for ceremony, attendees at the birth and/or any other important practice for a First Australian mother and her family
- Pregnant women would benefit from accessing First Australian staff should this be their preference. This could include access to First Australian people at the initial stages of the pregnancy as a component of birth planning and/or as a component of the birthing process (optimally with options for First Australian midwife staff).

### The birthing process

- Respecting and enabling expressed cultural practices through the birthing process was identified as important for the ongoing wellbeing of newborns. Cultural or other preferences for childbirth could include but would not be limited to, the timing for cutting the cord, retaining the placenta for cultural purposes and the inclusion of birthing partners during delivery
- Pregnant women identified a lack of cultural resources/information materials to support their pregnancies and birthing practices. This could include kits that outline females'/ families' options and support the development of cultural birthing preference plans.

### Post Natal

- Linking women into culturally relevant post-natal support was identified as an area that could be improved. This could include formal referrals (i.e. by identifying culturally relevant formal service supports) or informal (e.g. through other community based networks). One idea was that a regular community gathering could be supported by NSW Health, and that new mums could be given the details of these gatherings should they be interested in attending. The idea of such a group would be to support the ongoing development of 'natural' relationships that could then be independently progressed
- Developing culturally specific information about post-natal depression and/or other health behaviours that may impact maternal, child or family wellbeing should be explored. Definitions of wellbeing and illness from a cultural perspective (and associated response strategies) could also be explored.

<sup>12</sup> Nungeena-tya is Wirradjirri for 'Mother Earth'

<sup>13</sup> Miwi is Wirradjirri for 'spirit or soul' (not to be confused with birik)

<sup>14</sup> Wanai means puberty (from 12-15 to 30 years of age for females)

<sup>15</sup> M Smith "Under the Quandong Tree"



“

When you are born your placenta needs to be buried in the earth, in Nungeena-tya<sup>12</sup>, on its own. Then your journey is anchored and your Miwi<sup>13</sup> print waits there until you become a wanai<sup>14</sup>.

The placenta nourishes the earth and we are honouring Nungeena-tya by placing the responsibility of our child's journey with her.

**MinMia, Wirradjirri Elder and Lore Woman<sup>15</sup>**

### Rites of Passage

- Looking for opportunities to practise cultural ceremonies relating to newborns was considered important for some women to ground the baby and firmly establish the baby's spiritual journey. While identified as a community cultural practice this rite of passage was identified by some women as fundamental to the child's future health and wellbeing.

### Vaccination

- There were mixed feelings about vaccination within the community. The need for specifically targeted education about vaccination and the related conditions subject to vaccination need to be provided to First Australian women and their families
- Information about the timing of vaccination, including any options for the separation of vaccinations should also be provided to assist mothers and fathers in making vaccination decisions.

Mothers through the consultations discussed their role as nurturers of boys. As mothers and women our role in raising girls and boys through childhood is equal. Mothers expressed some concern about how modern society genders children at such a young age and that as women the inclusion of their male children in cultural activity was equally as important as it was for their female children.

**Mothers talked about how important it was for them that their children were allowed to be children. There are cultural differences in the expectations we place on our kids. Children should be allowed to explore and learn and be left to be kids. Modern society tends to place more expectation on children and this was a concern for mothers.**





**Traditionally, we used a range of bush remedies to build immunity and treat illness. Our remedies are for use internally and topically. Many of us still use these remedies when we are unwell, even though western medicine often does not acknowledge this.**

We would give these remedies to our children too. To make them strong and healthy. We don't consider our medicine as 'alternative' medicine. It is our TRADITIONAL medicine.

# YOUTH

The definition of 'youth' for the purpose of this Plan is in line with cultural definitions. The period of time for girls beginning at the time of first menstruation through to the time they become a 'woman' (Wanai years) traditionally around the approximate age of 30 years.

Through community consultations, individual interviews and contributions from women across the age spectrum a number of specific issues and opportunities have been identified.

## Key Issues and Themes

### Building resilience and self esteem

- Addressing and responding to bullying in schools and particularly developing strengths and strategies for responding to bullying behaviour, including reporting behaviours and supporting friends
- Supporting young girls with issues associated with identifying as a First Australian. Many youth particularly those with fairer skin identified difficulties associated with being questioned (usually by non-Indigenous people) about their identity and identification as First Australians
- Supporting young girls to deal with racism and discrimination in a productive way. Ideas expressed included opportunities to meet with older women and Elders and to learn about culture. Reinforcing culture as a protective mechanism and builder of resilience.

### Health promotion and education

- Providing education and information about sexuality, sex and the physicality of being female. While general 'mainstream' education processes are one component of this integrating traditional teachings and knowledge into the discussions was also seen as beneficial
- Having open discussions about drugs, alcohol, smoking and other substances of addiction. Having these conversations early rather than as a result of addiction was seen as beneficial. Hearing real life stories and talking about consequences of behaviour was also discussed as a topic for potential sessions
- Finding opportunities to introduce female-specific health promotion and health management initiatives to youth which may include attending health sessions with their older female family members and friends. Opening female health check days up to youth and/or creating events outside of school hours was also discussed.

### Ceremony and Rites of Passage

- Young females were interested in talking about and participating in cultural ceremonies that related to their transition from child to young woman. Practising culture with older women was seen as something youth were interested in.

### Social and emotional wellbeing

- Young females from teenagers to young adults (around 30 years of age) experienced the highest rate of hospitalisation for mental illness-related issues of all females in Northern Sydney;
- Young people talked about racial bullying that seemed to be rife in schools. They noted this as one of the main sources of mental distress. It was also apparent that the nature of bullying had changed with the introduction of new social media technologies, such as those that facilitated anonymity and/or flash imagery that deletes itself once viewed. Young people access this social media at all hours of the day which made bullying and harassment a 24/7 concern for some
- Providing education for youth and parents on the safe use of social media technology. Identifying ways for parents to protect young people from inappropriate social media and/or internet usage in ways that do not overly restrict young people's productive engagement with these mediums could assist overall mental wellbeing
- For many youth in school being First Australian can be isolating. Particularly in schools with only a few First Australian students (or in some cases, one identified student), feeling disconnected from culture can cause mental distress for youth. Working with the Local Aboriginal Education Consultative Group to increase community presence in schools, for example looking at opportunities for guest talks or involvement in course content from a First Australian perspective could increase First Australian 'visibility'





“

**My mental health issues cropped up in my mid-teens. I struggled to fit in with my peers and I had a lot of trouble maintaining relationships. I was diagnosed with depression and anxiety in my teens. As I got older, these issues transcended into the workplace. The stress associated with this really got to me and I started declining quite rapidly. I was in and out of hospital and given the diagnosis of Borderline Personality Disorder in my twenties. It was really frightening at first, but then a bit relieving that there was a name for what I had experienced for so long.**

It was really important for me to have consistency in the care I was getting and mostly that didn't happen. There were so many different doctors, specialists, counsellors etc. They all had different approaches and I found that really hard.

I never want to go back there. I told myself I wouldn't feel like this for the rest of my life and that things would get better. It's been a long 2-3 years to get where I am now- I have a stable job, a good relationship with my partner and I pay rent. I am really proud of myself. Being able to do the things I love: hobbies, my work, socialising with friends makes me happy”

**Wanai, 27 years old**

- Northern Sydney is an area that sees youth come into Sydney for schooling and/or other medical reasons. In particular 'Biala Aboriginal Girls Hostel', 'Royal Far West' and 'Stewart House' (all on the Northern Beaches) are places where youth come and may be away from their families, friends and Country. Particularly for the girls at Biala they can be living in the Region throughout their high school years. Looking at ways to connect female youth with the broader community has been identified as a mechanism for increasing resilience and wellbeing for all women in the region
- There are over 800 First Australian students in private schools in the region. Members of the community had been approached to provide support to some of these students in response to home sickness and/or other situations that led to physical and mental distress. Community members want to look for opportunities to support young First Australians undertaking schooling in the area regardless of their home Countries being elsewhere
- Given the high rate of hospital presentation for young females with mental illness exploring opportunities for the availability of First Australian people to make visits could be explored as a way to connect young people with other First Australian people as an optional part of their admission. This could be coordinated through the NSLHD Aboriginal Health Service but could also involve community volunteers
- Preventative group work exploring what good mental health is for individuals and ways that mental wellbeing can be maximised was also seen as a mechanism for preventing mental unrest
- Young girls identified a desire for more planned and structured opportunities to spend time with older women. Youth were interested in the idea of mentor programs, something like Big Sister/Aunty programs where women of all ages could support and learn from each other. This was of particular interest for girls off-Country who were undertaking their schooling in the region.

### Expectations

- Similarly to the discussions with mothers about children there was a lot of conversation about the pressures and expectations placed on our youth. Women of all ages discussed how different it is for modern youth, with pressures of school, relationships, social media, study, careers and motherhood. Women talked about how there were such high social expectations for women generally to balance all these roles
- Traditionally youth were categorised as such until the age of 30 years when they would become adults. This period of adolescence is much longer than for western youth. Elders tell us that the role of youth or Wanais was to explore the world, experiment, make mistakes. And that the community expectation was that this was the role and expected behaviour of Wanais. In modern society the expectations are quite different and women thought this impacted on the social and emotional wellbeing of youth
- Women identified opportunities to celebrate and support female youth. This could be through ceremony, looking at ways to culturally support young mums, and/or community events to share teachings and cultural practices.

### Fertility, pregnancy and childbirth

(See detail in 'Childhood' Section).



“““

**I was having a bad time at school people were sending me stuff on my phone and it was bad. I changed schools and things got better.**

That same year mum took me to do my first ceremony. That made a big difference too. I feel much stronger inside, and even when people say bad stuff I cope better. I've learnt it's about them not me.

**15 year old Wanai**



Some examples of anonymous Facebook/text/ messages provided to us as examples some of many (from different people).

# WOMEN

The life cycle stage for women would have traditionally begun around the age of 30 (there would be variance from area to area) following a ceremony to transition a female from youth to womanhood. This stage would end at the time of menopause.

## Key Themes and Issues

### Mental Health and Wellbeing

- Women identified addiction as an area of significance. This included substance addiction: smoking, alcohol, food and drugs as well as gambling and other addictions such as technology addiction and shopping addiction. Many women talked about the underlying causes that led to or triggered addictive behaviours and believed approaches to treat these root causes were fundamental to the broader issue of addiction. Women talked about how they had previously participated in activities for say, smoking cessation only to shift their addictive behaviours to something else for example food. Women talked about the underlying psychology of the addictions for them and favoured activities that holistically addressed underlying causal factors as well as the treatment for the addiction. Women also talked about the lack of services that were ongoing in nature and gave various examples of how they had overcome an addiction for a period of time only to return to the addictive behaviour in the absence of ongoing support
- Women talked about their experiences of racism and or questioning of their identity as a major cause of mental illness. Women were interested in participating in formal and informal activities that supported them to assert themselves and/or manage conflict effectively
- Women discussed various constructions of mental illness and wellness that were often different to the definitions of mental illness within the mainstream mental health sector. Women believed that mental health services did not always respect individual accounts of what was happening for them which either resulted in diagnosis and 'treatments' that women did not associate with or the oversight of the experience if it was seen as outside the realm of the mental health service
- Intergenerational trauma was cited as a major source of mental illness. There were various examples of ways that this trauma manifested in women's behaviours, relationships with others, parenting skills, actions and health problems. Women are seeking opportunities to come together and practise culture to work towards healing of trauma and associated improvement of mental health.

### Preventative health and pre-morbidity

- Women told stories about how they had tried to access and been refused health services due to the lack of existence of a qualifying 'chronic condition'. They felt like their health needed to get to a chronic stage before becoming eligible for support and this was cited as a major frustration for women trying to prevent chronic illness
- Women were interested in becoming more educated about conditions that they may be pre-disposed to due to family history. They were keen to explore group educational sessions on chronic illness as well as accessing individual services to specifically break cycles of chronic illness within families
- There was an identified lack of preventative health services to support women in maximising their wellbeing as well as preventing illness. Activities such as physical exercise programs (with allied health qualified facilitators and associated access to allied health as needed), nutrition support and education, pre-diabetes education and weight management programs were all identified as activities women would be keen to participate in.

### About working with GPs...

““

**I was in need of a doctor for something urgent. I wanted someone who was good with First Australians and was culturally sensitive.**

I was recommended someone but when I tried to book an appointment I was told her books were closed.

**I don't understand how GPs can just close their books?  
No referral, nothing.**

**Anonymous, First Australian mother**

““

**I went to a ceremony with one of our Lore women/teachers. She sees colours and can tell you when there's something wrong in your body. She told me that she could see something in my uterus/ovary area- some kind of growth. Sometimes she can treat what's wrong with medicinal plants/other treatments, but this time she said I should go and get it checked out by the doctor.**

I hadn't had any symptoms really, so I wondered how I would broach the issue with my GP. Luckily my GP is very familiar with Aboriginal health issues she does some work with communities in the Northern Territory. I felt safe to go straight in and tell her a lore woman had seen something and suggested I get an ultrasound and blood tests. She didn't even flinch. I got the tests and they found a cyst. Luckily it was benign and everything else was fine.

While I was at the GP (I go very rarely), she asked if she could just do some other standard checks. I trust her and said that was fine. All was well and I am glad I did it. But I probably would never have gone if I didn't think she'd respect culturally, what I was telling her.

**Woman in her 30's**

### **Cultural expression and learning**

- Women expressed desire to practice culture and learn more about culture. They identified a direct link between cultural expression, pride, and wellbeing. Women are keen to explore opportunities for ongoing community based wellbeing programs with a cultural element
- Women were keen to identify opportunities to practise ceremony. This was considered as another activity that would build resilience for First Australian women

Women identified the difficulties practising culture within a mainstream health system that did not often respect or validate their cultural values or preferences. Women see the need for widespread cultural training within health and community services. Examples were provided where service providers explicitly denied women the right and opportunity to practise culture through the use of traditional medicines and other cultural practices and this was identified as a source of anxiety, shame and mental distress.

### **Access to services**

- Lack of flexible subsidised transport was identified a number of times through consultations. Specifically, medical transport for regular appointments such as dialysis or chemotherapy were identified as very difficult to engage on a reliable basis
- Access to general practitioners was identified as difficult for many women. Whether the health services were for themselves or their children, women often found that either 'books were closed' for GP practices or GPs didn't bulk bill. Many women identified that they didn't have a consistent GP: that they would use medical centres when it was urgent and that this did impact on continuity of care when often they didn't see the same GP each time
- Women that attended the NSLHD Aboriginal Women's Health Check Days provided positive feedback. Women enjoyed opportunities to come together and talk about health and many enjoyed being together to undertake various checks etc. Women enjoyed the days because they mixed culture, pleasant activities (like beauty therapies etc), food and health checks. Some women identified that they would enjoy the day even more if it was in a location that wasn't a hospital/health service/sexual health service.

### **Raising children**

- Women discussed at length their roles as mothers and aunties. Particularly as mothers, women spoke about some of the challenges kids faced in relation to bullying, racism and identity. Women were interested in exploring opportunities to support their kids and increase their resilience in dealing with some of these things
- Mothers of female children were interested in opportunities to conduct ceremonies with their girls and support them in learning and practising their culture
- Mothers of boys want to make sure that their children grow up to be happy, healthy and whole. Mothers of boys talked about looking for ways to 'grow their sons' culturally and find men they trusted to practise cultural activities with their sons. Mothers were concerned about social reactions to boys staying with them for example in women's toilets/change rooms or medical appointments. Culturally, women talked about how boys (and girls) were often considered 'children' and genderless until they were teenagers and that this definition of 'child' was different to mainstream definitions.

### **Informal Carers**

- Many women identified as carers of another person whether this be someone experiencing age related frailty or illness, mental illness, or disability. Women talked about how as First Australians often the construction of a 'caring role' or label as an 'informal carer' is different to mainstream definitions. Opportunities to provide culturally relevant information and/or access to carer-support services was desired by women.

### **Fertility, pregnancy and childbirth**

(See detail in 'Childhood' Section).



“““

**Every day I walk a path of recovery from the policy that removed children from their parents. I was stolen... I still feel the silent pain that is mine and my mother's.**

We need to move forward together with joint aspirations and a truly national story that acknowledges our shared past and embraces a shared future.

**Susan, community member  
Stolen Generations Survivor**

“““

**It begins, with the act of recognition. Recognition that it was we who did the dispossessing. We took the traditional lands and smashed the traditional way of life. We brought the disasters. The alcohol. We committed the murders. We took the children from their mothers. We practised discrimination and exclusion.**

It was our ignorance and our prejudice and our failure to imagine these things being done to us. With some noble exceptions, we failed to make the most basic human response and enter into their hearts and minds. We failed to ask – “how would I feel if this were done to me?”

**Former Prime Minister Hon. Paul Keating, Launch of the Decade of the World Indigenous People, December 10, 1992.**

# OLDER WOMEN

The life cycle stage for older women would have traditionally begun following menopause. At this point a woman would enter the 'Memeee' or grandmother stage.

## Key Themes and Issues

### Ageing illnesses

- Older women were interested in participating in activities that could assist in the prevention of chronic illness. Specifically, women were interested in group-based exercise and wellbeing opportunities- courses, community based programs and/or targeted talks or education opportunities
- Older women had different ways of talking about and conceptualising 'good health' in older age. There were a number of women who experienced chronic and acute health problems
- Many women experienced health-related problems that could be improved by different lifestyle choices and health behaviours. Specifically, diabetes, heart disease and obesity were identified as health conditions affecting older women
- A number of women identified the need for smoking cessation support. Even when women had given up smoking for a period of time many identified resuming the habit. Women expressed that should a longer term culturally appropriate smoking cessation support service be available they may have had a better chance of permanently 'kicking the habit'. Women could identify that their addictive behaviours (that also extended to food) would be best addressed by programs that were not short-term and that could provide holistic support: addressing physical, mental, emotional and cultural elements of addiction. Women were keen to see such supports being made available in the region
- Women had different ideas and constructions of 'dementia' and memory related conditions. They were keen to keep their minds active and identified practising culture and maintaining relationships with younger generations as a protective factor relating to 'healthy minds'.

### Social isolation

- While many older women lived with family, some women reported feeling socially isolated and lonely. Particularly for women who were struggling with an illness or had some mobility issues being unable to get out and participate in their community was a source of stress. Older women who lived alone were interested in organised community activities with transport
- Older women particularly, identified the NSLHD Aboriginal Women's Health Check Day as a positive source of social interaction and a good way to undertake health checks and learn about health promotion. Women were interested in new opportunities under a similar structure to explore other health related issues: for example, smoking cessation, healthy eating/nutrition, movement and gentle exercise and other health promotion talks
- Women were enthusiastic about other group-based health promotion activities. Examples provided included aquarobics, hydrotherapy, yoga or gentle exercise.

### Breaking cycles of intergenerational trauma

- Many older women had been directly affected by removal policies resulting in the Stolen Generations. Women talked about the ongoing trauma resulting from their or their family member's removal. Also discussed was the effect this trauma and associated guilt had on the next generations. Some described the 'victims' becoming the 'victimisers'
- Older women were anxious about the effects of intergenerational trauma
- It was acknowledged that there were not culturally-specific counselling services available to First Australians. There were various examples of times where women (all ages) were seeking counselling support, however 'gave up' seeking support when they were unable to access First Australian counsellors





““

**To the Stolen Generations, I say the following:**

**As Prime Minister of Australia, I am sorry.**

**On behalf of the government of Australia, I am sorry.**

**On behalf of the parliament of Australia, I am sorry.**

**I offer you this apology without qualification.**

We apologise for the hurt, the pain and suffering that we, the parliament, have caused you by the laws that previous parliaments have enacted.

We apologise for the indignity, the degradation and the humiliation these laws embodied.

We offer this apology to the mothers, the fathers, the brothers, the sisters, the families and the communities whose lives were ripped apart by the actions of successive governments under successive parliaments.

**Former Prime Minister Hon. Kevin Rudd, Feb 13, 2008.  
Parliament House, Canberra ACT.**

### Practising Culture and Teaching

- Older women identified the practising of culture as fundamental to their wellbeing as they age. Culturally during the 'Meme'e' years post menopause women's capacity to teach is realised. Older women identified a need and interest to share their stories and knowledge during their Meme'e years. Women were very keen to have more interaction with younger females. Specifically, they were interested in more interaction with children and youth and identified the wellbeing of younger generations as intricately linked to their own
- Older women wanted to continue to actively participate in the community. They are interested in meaningful employment and spoke about opportunities to continue to work potentially in a cultural capacity in schools, organisations or other community initiatives. Looking for ways to enable women to do this was seen as a way to maximise wellbeing and purpose in later life
- Discussions about the role and status of older people in society was also raised. For us as First Australians, older people and Elders are fundamental to the community structure. In modern societies often 'age' is seen as a 'disability' and youth is valued. Women of all ages were interested in challenging these stereotypes and looking for ways to empower and appropriately position older women as knowledge holders within the broader social fabric. This was considered one strategy for giving older women a sense of value and purpose in later life
- A number of women identified being a good role model to younger females as an important part of their lives as older women. Specifically, women who were not in optimal health identified a desire to improve their health, to enable them to be more available to their families but also to be a good role model for younger people.

### Dying with dignity

- Older women discussed what was important to them in later life. Western societies fear death, whereas traditionally death and dying is just another phase of our existence. Women wanted to live their later lives and die with dignity. They described the fundamental element of ageing and dying with dignity was choice. Whether this related to choice around health care and interventions (or decisions not to have interventions), and/or choice about cultural practices at end of life
- Women were diverse in their belief systems and cultural practices around later life and death. Fundamentally, the development of resources that support older women to make choices and decisions and have these known by family and health professionals in later life are of upmost importance. Opportunities to develop culturally relevant versions of Advanced Care Directives and/or palliative care resources was seen as one way of facilitating choice.



““

**I want to be a good role model. I need to look after my own health if I want my family and community to look after theirs.**

It's my job as an older woman to lead by example.

**Lois, Community Member**

““

**I have very clearly told my family that I would not want to be resuscitated. I believe that we come into this world when we are supposed to and we leave when we are supposed to.**

If we prolong our natural death, I believe this damages the spirit or soul which has implications for our next journey. This choice is very important to me.

**Older First Australian community member**

““

**You should never be thirsty when you pass away. Often, fluids are reduced or stopped at end of life. But this is very bad. If you move onto your next soul journey and you are thirsty we have been taught that you will come back with insatiable thirst. You will live your next life always searching.**

You will be greedy. It is very important you don't die thirsty. We also believe in painting the deceased's feet with white ochre. This assists us to walk into the spirit world with ease and without fear.

**Older First Australian community member**

# THE STRATEGIC PLAN

The Plan is presented in line with the female life cycle and associated physical, mental, cultural and spiritual elements associated with each stage. Various strategies relate to needs and identified initiatives across the life stages.

The recommendations are presented following community consultation and primarily focus on social and emotional wellbeing which has been identified by females in the region as the foundation for 'good health'. While various clinical health issues were also discussed it is supporting this sense of wellbeing that is seen by females as the priority during this planning period. Females believe that should this definition of wellbeing be more effectively supported better physical health will also be an outcome.

## Priority Ratings

■ Immediate    ■ Medium term    ■ Longer term

Strategy	Proposed Activities	Anticipated Outcomes	Priority
<b>Information</b>			
Develop an online First Australian Health Community Portal	<p>Establish a web-based Portal administered by the NSLHD Aboriginal Health Service.</p> <p>Map and upload community information through further community consultation and resource research.</p> <p>Develop a closed feedback section (visible only to the Aboriginal Health Service) where community members can provide online feedback on their experience/s through NSW Health.</p>	Community members and service providers have access to up-to-date information about First Australian health, community services, local stories and cultural information and referral pathways.	Immediate
Develop and document a comprehensive First Australian service directory	<p>Map existing providers of support services to First Australians across acute, primary health, community care and residential care sectors. Specifically identify First Australian specific, as well as mainstream services accessible to First Australians.</p> <p>Review existing Regional Directories. Develop a Northern Sydney Region First Australian Service Directory. Locate the directory on the First Australian Health Community Portal (including a printable version).</p>	First Australians have access to comprehensive information about culturally specific and mainstream health and community services.	Immediate
Develop culturally specific Advanced Care Directive/ death and dying resource	Identify existing Advanced Care Directive materials and assess cultural appropriateness. Work with palliative care and community care experts to develop culturally specific resources enabling First Australians to expressly identify end of life care preferences. Publicise the resource and locate electronically on the First Australian Health Community Portal.	First Australians are supported in their cultural preferences at end of life.	Immediate

Strategy	Proposed Activities	Anticipated Outcomes	Priority
<b>Primary Health</b>			
Increase access to General Practitioners	Identify/map GPs across the Region who: a) Bulk bill b) Are registered for Closing the Gap c) Have interest/expertise in First Australian Health  Upload GP information onto the First Australian Health Community Portal.	Regional map developed and accessible to the community and referring service providers to improve continuity of primary care for First Australians.	
Review operating times for Bungee Bidgel	Identify utilisation rates for current operating days. Review opportunities for extending operating times and/or increasing flexibility in current operating times.	Improve flexibility and consequent access capacity for First Australian community members.	
<b>Linkage and Coordination</b>			
Maximise early cultural liaison for all First Australian inpatients	Ensure all First Australian inpatients have contact with a member of the NSLHD Aboriginal Health Service  Explore opportunities for an after-hours oncall service- a 'warm line' for First Australians attending acute facilities after hours (particularly for mental health related admissions). This may include outsourcing to other appropriate cultural liaisons on a rotational basis.	All First Australians have optional access to a member of the NSLHD Aboriginal Health Service or the Aboriginal and Torres Strait Islander Health Education Officer.	
Improve post acute support and coordination	Map key community based health and service providers who are responsible or capable of the provision of post-acute care.  Conduct a coordination forum with key primary health (eg Primary Health Network) and community care providers.  Coordinate a Regional Memorandum of Understanding/Partnership Plan defining regional approaches to post-acute care.	First Australians receive more appropriate and integrated support post-acute to maximise wellbeing and reduce hospital recidivism.	
Improve post-natal community support	Identify existing post-natal referral pathways and support programs.  Consult with First Australian families to identify post-natal needs.  Identify opportunities to improve cultural competencies in post-natal services, which may include identification of new post-natal cultural support opportunities.	New First Australian mothers and families receive more culturally-appropriate support following the birth of their child.	

Strategy	Proposed Activities	Anticipated Outcomes	Priority
Establish early relationship with Aboriginal Home Care	Following the re-tendering of Home Care (estimated to occur end 2015), organise meeting to discuss Northern Sydney community needs.	Improved access to Aboriginal community care under new auspicing arrangements.	
Improve access to health related and community transport	Review existing service providers and eligibility requirements for health related transport. Liaise with existing providers to identify strategies to increase access to health related transport. This may also include liaising with Aboriginal Home Care in the provision of community transport.	First Australian community members' access to health services is not restricted by lack of access to transport.	
<b>Health Service Capacity</b>			
Improve the health system's practices relating to First Australian identification	Review existing cultural competency materials. Ensure physical prompts are visible in all hospital waiting rooms. Review existing triage processes and forms to identify adequacy of questions and/or location in materials.	Increased identification rate. Decrease anecdotal feedback about lack of opportunity for identification (and/or denial of identity) reported by First Australian community members.	
Establish a quarterly community speaker series	Identify core community specific cultural education topics in collaboration with the local community. Identify quarterly target recipients for the community education sessions. Employ local community members to participate through storytelling and cultural education.	Increase access to local community stories and knowledge by health staff. Engage local community members in the provision of localised cultural information, to 'ground' cultural knowledge for health providers.	
Improve culturally appropriate maternity practices	Review existing maternity policies and procedures, specifically in relation to birthing practices. Identify physical improvements to maternity facilities to increase cultural visibility and safety. Develop First Australian-specific resource materials, including information about cultural practices/options, rights and responsibilities and cultural birthing plans. Develop site-based resources and checklists to assist mainstream staff in the provision of culturally appropriate maternity care. Provide onsite education for maternity and allied staff (e.g. social work, ward clerks) in the support of cultural practices in maternity.	Maternity practices are more accommodating and supportive of cultural practices and preferences for First Australian families.	

Strategy	Proposed Activities	Anticipated Outcomes	Priority
Conduct an Annual Health Services First Australian Conference	<p>Develop an annual conference program in consultation with health professionals and the First Australian community. The program should encompass health and cultural priorities. Identify health experts and cultural experts to participate in the provision of content/ presentations.</p> <p>Invite health, community and primary health providers as well as the broader First Australian community. Also include other out of region Aboriginal service providers if they can add value to the Regional conference content.</p>	An annual opportunity to bring together the First Australian community and health and community service providers to advance collective knowledge and approaches to the improvement of First Australian health and wellbeing.	
<b>Infrastructure/ Physical Locations</b>			
Identify an appropriate community space for First Australian community gatherings (which could include Health checks and health talks etc.)	<p>Identify potential/available spaces that could be used by First Australian community for meetings and cultural gatherings.</p> <p>Consult with the community about the needs and preferences for such a space. Establish access/ booking procedures.</p>	First Australian community members are able to access an appropriate space to undertake cultural activities and gatherings.	
<b>Health Promotion</b>			
Conduct quarterly health forums for First Australian community members.	<p>Identify appropriate people to deliver health promotion talks (where possible, including NSW Health staff and a First Australian expert/contact) in the following areas (year one):</p> <ul style="list-style-type: none"> <li>• Nutrition and healthy bodies</li> <li>• Exercise and movement</li> <li>• Substances and addiction</li> <li>• Hormone change across the lifecycle</li> </ul> <p>Identify health talk priorities following year one in consultation with the community.</p> <p>Include optional health check opportunities in line with each health promotion area.</p> <p>Upload health promotion information onto online portal. Consider the development of webinar materials- i.e. recording of health promotion talks to maximise accessibility.</p> <p>Identify strategies for follow up care following each session.</p>	<p>First Australian community members receive health promotion information, in a culturally safe and targeted environment.</p> <p>Group-based health promotion is provided (as community preference) with opportunities for follow up care.</p>	

Strategy	Proposed Activities	Anticipated Outcomes	Priority
Provide targeted information sessions and/or resources relating to vaccination	<p>Review existing vaccination rates and explore community needs, concerns and existing knowledge relating to vaccination.</p> <p>Work with health professionals and cultural experts to identify vaccination options and development of resources.</p>	Increase community members understanding of vaccination and vaccination options.	
<b>Infrastructure/ Physical Locations</b>			
Increase youth-specific wellbeing initiatives	<p>Develop youth-specific information and resources addressing:</p> <ul style="list-style-type: none"> <li><b>a)</b> Bullying and resilience and good mental health</li> <li><b>b)</b> Safe use of Social Media</li> <li><b>c)</b> Substance use and addiction</li> <li><b>d)</b> Sexual Education</li> <li><b>e)</b> Dealing with puberty and hormone changes</li> </ul> <p>Consult specifically with First Australian youth to identify most effective content delivery methods. This may include local community forums with women of all ages and/or targeted resources and online programs.</p> <p>Develop content with both health expertise and cultural expertise, including resources for followup support if necessary.</p>	<p>Improve the resilience and strength of First Australian youth.</p> <p>Increase youth's knowledge to maximise wellbeing and prevent ill-health.</p>	
Provide constructive conversations workshop series	Identify cultural/coaching experts capable of providing community workshops. Workshops would be targeted at women and older youth to assist them in responding to and dealing with racism and other difficult situations impacting on their cultural identity.	Improve women's confidence and resilience in dealing with critical conversations. Ultimately prevent mental distress and illness resulting from racism and identity challenges.	
Conduct community Mental Health First Aid Training	Provide local Mental Health First Aid training for community members/leaders.	Improve communitybased responses to, and support of mental distress experienced by First Australians.	



Strategy	Proposed Activities	Anticipated Outcomes	Priority
Facilitate ongoing smoking cessation and addiction support groups	<p>Establish a long-term smoking cessation and addiction course.</p> <p>Develop First Australian specific information and resources to assist with smoking cessation.</p> <p>Seek community partnerships in the provision of support services.</p> <p>Identify and establish strategies for ongoing support and referral.</p>	Reduction of substance use, particularly smoking, and associated resumption of habits following cessation.	
<b>Infrastructure/ Physical Locations</b>			
Develop genetic counselling resources	<p>Identify core illnesses or health risks associated with being First Australian.</p> <p>Develop culturally specific resources providing tips for chronic illness prevention.</p> <p>Hold a community forum to explore concepts relating to genetic predisposition to chronic illness, including opportunities for follow-up consultations with genetic counselling services.</p>	Provision of information and opportunities for genetic counselling to reduce unnecessary health decline and maximise wellbeing.	
Develop healthy mind and memory resources	<p>Work with community partners, including Alzheimer's Australia and other community based (and primary health) dementia specialists, identifying any existing First Australian specific resources.</p> <p>Pending the existence of existing resources, explore opportunities for the development of community-specific resources to maximise mind and memory health and where necessary seek support for memory related concerns.</p>	Improved access to dementia and/ or memory loss resources and service supports.	
<b>Infrastructure/ Physical Locations</b>			
Establish annual awards series	<p>Identify Regional Cultural Award categories, including Cultural Pride/ contribution awards for community members as well as contributions to First Australian Health and Wellbeing for mainstream health and community service providers.</p> <p>Ensure award categories capture contributions across the life cycles.</p> <p>Establish a process for community and healthbased award nominations and application assessment.</p> <p>Develop recipient profiles emphasising their contributions to First Australian wellbeing.</p> <p>Provide annual awards at the Annual First Australian Health Conference and locate recipient and nomination information on the First Australian Health Community Profile.</p>	Formally recognise and encourage mainstream and community contributions to First Australian Health and Wellbeing.	

# SUMMARY

The Northern Sydney Local Health District Australia's First Peoples Female Health and Wellbeing Plan is a document that has successfully captured the voice of First Australian youth, women and older women living in the region.

The document is a culmination of research, data gathering and consultations with service providers, health professionals and First Australian females living on Gaimariagal land.

A number of consultations were held across the region to inform future business of the Plan and provide an insight into the needs and aspirations of females with regards to their health and wellbeing not only for themselves but also their children, families and the wider community.

The success of the Plan to date can be measured by the willingness of women to engage in the process through their provision of vital information regarding the Northern Sydney Local Health District's business and its ability to interface with the local community. The relationship of the NSLHD with the community has been a work in progress and as the relationship has improved so too has community health and wellbeing. With a concerted effort and focus on breaking down barriers, the NSLHD Aboriginal Health Service has been able to provide better health services to the community and continually nurture and build their profile with First Australian people. There is a sense that things are changing and heading in the right direction from the community's perspective.

The real success of this Plan will be when the health and wellbeing of First Australians improves and we are living healthy lifestyles with the same health expectations and outcomes as other Australians. When this occurs there will be no gap to close.

As an independent First Australian company the ability to hear community voices and link local aspirations with broader policy and health system frameworks has been a facilitating factor. Due to both consultants being members of the community, the process has been one that has benefited from local knowledge and networks. We again thank the community for trusting us with their stories and vision for improved health outcomes in the region.

There is always a fine line between communicating authentic community voices and aspirations and identifying specific measurable strategies based on western health outcomes and indicators. Ultimately, success will be measured by individuals themselves and the Plan has been created with more qualitative descriptions of social and emotional wellbeing.

That being said the Plan does provide key strategies and activities, the achievements of which are measurable and observable. We anticipate the need for a range of other activities and strategies that will be identified as an outcome of the early implementation of this Plan.

As the inaugural First Australian Female Health and Wellbeing Plan we present this as a framework and cornerstone for future work in this region.

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