

Addressing structural challenges for the sexual health and well-being of Indigenous women in Australia

Kerry Arabena

According to the most recent national data in Australia, chlamydia and gonorrhoea were 3 and 18 times more likely to be diagnosed in Aboriginal populations, respectively, compared with the non-Indigenous population, with 16–19 years old Indigenous Australians carrying the greatest burden of these infections.¹ Reports confirm that almost half this age group living in remote communities has one or more of gonorrhoea, chlamydia and trichomonas infections.² In addition, significant increases in the prevalence of chronic hepatitis B and higher rates of hepatitis C acquired through burgeoning injecting drug use, combined with high rates of chronic disease, means there is a significant burden of disease among Aboriginal and Torres Strait Islander people that costs individuals, communities and health systems dearly.³

Current Australian efforts in this area focus on prevention, early detection and treatment, monitoring and provision of care for people living with disease. These efforts, however, are not collectively addressing the complex array of needs of those many Indigenous women and children experiencing vulnerability. An increasing number of Indigenous women in Australia and globally are now demanding that politicians, policy makers, practitioners, researchers and educators coordinate their efforts to identify and address barriers to effective sexual and reproductive health services, and also to change the marginalised position of Indigenous peoples in their respective countries.

Indigenous women and their children need health equity and societal equality. This can be achieved by redressing structural and systemic barriers to quality services, and working together to realise human rights for all Australians.

This year my friend, whose 17-year-old sister went missing 22 years ago, attended a Canadian conference on the over-

representation of Indigenous women as homicide victims and missing persons. Meeting other Indigenous women with similar experiences, particularly those involved in the *No More Stolen Sisters* Amnesty International Campaign,⁴ provided her with healing and hope. Her elation turned into despair, however, as 2015 reports to the Australian Parliament confirmed that Indigenous women are among the most disadvantaged in our society on all social indicators, including over-representation in the criminal justice, child protection and welfare services.⁵ This vulnerability is experienced across and between generations of Indigenous women, particularly where access to family-strengthening activities, quality primary healthcare services and opportunities to participate in education and employment are low. In addition, Indigenous Australian women die around 10 years younger than those in the non-Indigenous community, have higher rates of chronic diseases and have experienced violence in the forms of intimate partner violence, sexual assault, institutional racism and stigmatisation.⁶

The Australian Government's response to the entrenched disadvantage of Australian Indigenous peoples has been the policy of 'Closing the Gap'. This national campaign—with support from the health sector, NGOs and business—aims for health equity between Aboriginal and Torres Strait Islander people and non-Indigenous Australians through eliminating the current wide discrepancy in life expectancy and health outcomes. It requires non-Indigenous Australians to work with Indigenous people in the design and delivery of quality health solutions that are locally driven and controlled, provide pathways for self-determination and sustainability of outcomes. Such an approach matches Indigenous peoples' holistic health concept contained in the National Implementation Plan 2015–2023: all health efforts should refer to the physical well-being of an individual and also to the social, emotional and cultural well-being of the whole community in which each individual lives.⁷

This gap in life expectancy and health equity is but one indicator of a loss of elementary human rights. The other is in the numbers of our people living a socially functional life and those living a life of pain, humiliation and dysfunction.⁸ Thus, human rights frameworks need to inform a broadening of service-led and community-led responses to the current epidemic rates of sexually transmitted infections, HIV and hepatitis C, particularly among those injecting drugs, and to address trauma related to sexual assault, sexual abuse and intimate domestic violence. The current inequitable situation is not congruent with the rights and responsibilities framework advocated for by Indigenous Australians to enjoy and control their sexual and reproductive behaviour in line with their cultural values, kinship practices and ethics; to be free of diseases that are treatable or preventable; and to have no fear, shame, guilt and myths about their sexuality and sexual relationships.⁹

Having such a framework is critical: in current Australian political discourses Indigenous women are 'sexualised and racialised' as 'the other'¹⁰; or regarded by health practitioners as 'vectors of disease' or 'vehicles for health gain', particularly through pregnancy, and are punished or rewarded according to these views. Indigenous Australians are impacted on by perverse incentives built into policy drivers, particularly those focusing on sexual and reproductive health choices that have simply increased the numbers of Indigenous women exchanging money for sex, or led to an over-representation of teenaged parents rather than high school completion statistics. Vulnerable women make short-term decisions that entrench their experience of disadvantage in the longer term. Indigenous mothers are also described as neglectful in the first years of their children's life, as evidenced both by the large number of child removals and in attempts to care for children with chronic diseases, such as childhood anaemia, who are already stigmatised with 'failure to thrive'. Early childhood experiences of sexual assault and trauma have led to Indigenous women being incarcerated at an unprecedented rate.¹¹

Increasingly these experiences of male-perpetrated domestic violence, child removals, mental health and the discourses that impact policy and funding decisions affect young women and compromise the future health and well-being of entire families and communities. Despite our best efforts we are failing to support Aboriginal and Torres Strait

Correspondence to Professor Kerry Arabena, Centre for Health Equity, The University of Melbourne, Melbourne VIC 3053, Australia; kerry.arabena@unimelb.edu.au

Islander women appropriately in achieving good health and well-being and taking their rightful place in Australian society.

Sir Michael Marmot says changing the marginal position of Aboriginal and Torres Strait Islander women will need an approach that takes in the whole of life—starting with women of childbearing age, focusing on the care of infants and young children and proceeding through the life course.¹² What Indigenous women are saying is that an approach that strengthens culture and takes in the whole of life—starting with women, their partners and extended family and communities—is needed. This requires all Australians to have a role in improving gender equality and supporting women's economic empowerment, safety and leadership.

Health equity can be achieved through health system responses that include new approaches to adolescent health—preventing adolescent pregnancies, promoting birth spacing, sexual health, reproductive health and personal planning and development programmes—and using social media and introducing new technologies for diagnosing, testing and treatment. Societal equality will be achieved by improving the role and value of women in Australia, with a focus on those most at risk, and by encouraging health and other systems to be couched in human rights and responsive to the needs of women and children.

Finally, we need to redefine young Indigenous people as the implementers of equity gain in families. This repositioning of the young as equity implementers for the next generation will change the current deficit language to empowered language, and position them as leaders and carers able to meet the future needs of their families. This will require us to develop the capacity of both family and societal systems to prevent Indigenous women from being exposed to unsafe living conditions. It will also require the

simultaneous implementation of proactive not reactive interventions—in parental mentoring, in facilitating cultural understandings for service staff and their broader community, and in establishing effective treatments. Only then can we truly say we are addressing structural challenges that facilitate health, well-being and societal equality for Aboriginal and Torres Strait Islander peoples.

Twitter Follow Kerry Arabena at @ArabenaKerry

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