The health inequities of Australian Aboriginal and Torres Strait Islander women and girls

A review of the literature

Women's Health West acknowledge the traditional custodians of the land on which we work, the people of the Kulin Nation, and we pay our respects to Elders and community members past and present. We express solidarity with the ongoing struggle for land rights, self-determination, sovereignty and the recognition of past injustices. We express our hope for reconciliation and justice.

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Authors: Dr Melissa Graham, Dr Hayley McKenzie, Ms Greer Lamaro Haintz and Ms Kehla Lippi, Centre for Health through Action on Social Exclusion (CHASE), School of Health and Social Development, Deakin University

Author of background: Elly Taylor

Editors: Elly Taylor and Kelly Ventress

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Contents

Background

Women's Health West provides specialist family violence services to women and their children, and delivers prevention programs that promote equity and justice for women and girls in Melbourne's west. Women's Health West is committed to providing culturally safe and accessible services for Aboriginal women and children. We employ dedicated Aboriginal family violence case managers who provide culturally sensitive services and support to Aboriginal and Torres Strait Islander women and children who experience family violence. We deliver health promotion programs that are guided by, and delivered to, Aboriginal and Torres Strait Islander women and young people in a culturally sensitive and respectful way. To strengthen this work and further our commitment to reconciliation, and a future in which Australia's First Nation Peoples' right to self-determination, land, cultures and histories is upheld and celebrated, we commissioned Deakin University to undertake this literature review. The report explores the literature on the health inequities of Australian Aboriginal and Torres Strait Islander women and girls and will support the provision of evidence-based health promotion programs and practice to support closing the gap in social, cultural and economic disadvantage experienced by Aboriginal and Torres Strait Islander women and girls in Melbourne's west.

Introduction

This literature review examines the health inequities of Aboriginal and Torres Strait Islander women and girls, with a specific focus on sexual and reproductive health, mental health and wellbeing, and the prevention of violence against women. Further, this review specifically explores promising practice in the design and delivery of culturally-appropriate health promotion programs. The findings are presented according to the layers of 'Fair foundations: The VicHealth framework for health equity' (VicHealth 2015) that include the socioeconomic, political and cultural context; daily living conditions; and health-related knowledge, attitudes and behaviours. The three priority areas of sexual and reproductive health, mental health and wellbeing, and the prevention of violence against women, are discussed as themes within each of these three layers.

In Australia, Aboriginal and Torres Strait Islander people experience greater health inequities compared to non-Aboriginal and Torres Strait Islander people. Social determinants influencing these health inequities include the legacy of historical colonisation, including contemporary experiences of cultural misconnection[1] and racism (Wright & Lewis 2017). Aboriginal and Torres Strait Islander people experience lower education, employment and income rates, which in turn are associated with poor health outcomes and increased health risk factors (ABS 2013). Additionally, these circumstances and outcomes are linked to the historical disadvantage and lack of equal opportunities for Aboriginal and Torres Strait Islander people, in comparison to their other Australian counterparts (Australian Human Rights Commission 2005).

The review is framed by the World Health Organisation's (WHO) conceptualisations of sexual and reproductive health, mental health, and violence against women. Sexual health and reproductive health are distinct yet related concepts. Common underpinnings are that they relate to the multiple dimensions of health, including physical, mental, emotional and social wellbeing; are contingent on respectful approaches to sexuality, sexual relationships and reproduction; and are underpinned by human rights declarations. Sexual and reproductive health also encompasses maternal health. This review highlights the limited evidence regarding sexual and reproductive health inequity for Aboriginal and Torres Strait Islander women and girls, yet highlights maternal health as a 'window of opportunity' to connect with, and engage, Aboriginal and Torres Strait Islander women (Brown et al. 2015, p. 36).

Sexual and reproductive health is impacted by social and behavioural determinants. A report by Women's Health West examining the social determinants of sexual and reproductive health identified the key determinants as; poverty and socioeconomic status, violence and discrimination, gender norms, public policy and the law, cultural norms, and access to affordable and culturally-appropriate health services (Taylor 2011). The behavioural determinants that impact on an individual's sexual and reproductive health outcomes are; sexual expression, sexual practices, religious beliefs and practices, reproductive practices, contraceptive practices, sexual and reproductive health literacy, and drugs and alcohol use (Taylor 2011). Action to improve sexual and reproductive health must take these determinants into account. Specifically, Arabena (2016) states that the social determinants concerning structural and systemic barriers to quality services for Aboriginal and Torres Strait Islander women need to be redressed to achieve health equity and societal equality. Further, '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' (Arabena 2016, p. 88, cited in Commonwealth of Australia 1997).

Mental health is central to the WHO's overarching definition of health, being a '...state of complete physical, mental and social wellbeing, and not just the absence of disease of infirmity' (WHO 1948). Specifically, mental health is '...a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (WHO 2001 (Updated 2016)).

[1] Cultural misconnection can be understood as the separation of individuals, families, and communities from those aspects of culture based around 'strength, resilience and empowerment', such as 'identity, traditional cultural practice, connection to land and nature, language, healing, spirituality, ancestry and belonging, and Indigenous knowledge' (Lowitja Institute 2014, pp. 2, 4).

Mental health and wellbeing is influenced by a range of biological and social determinants (Dudgeon et al. 2014). There are unique factors influencing mental health and wellbeing among Aboriginal and Torres Strait Islander populations related to the historical context, sociocultural factors, and sociopolitical factors. This includes histories and enduring legacies of colonisation, dispossession and disempowerment, related experiences of racism and discrimination, and intergenerational trauma (Dudgeon et al. 2014; Tighe et al. 2017). The impacts of the historical and contemporary contexts are compounded by culturally inappropriate health and social services that fail to recognise First Nations forms of knowledge (Dudgeon & Walker 2015; Dudgeon et al. 2014), and thus impose symbolic violence by reinforcing colonial structures in service delivery. Dudgeon and Walker's (2015) model of determinants of social and emotional wellbeing of Aboriginal and Torres Strait Islander peoples emphasises the interplay of social and historical determinants. The model highlights the central role of multiple connections as determinants of wellbeing, including connections to spirituality and ancestors, family and kin, community, culture, and country.

Prevention of violence is integral to the attainment of mental health, sexual and reproductive health, and overall health. Violence against women is considered to be 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life' (United Nations General Assembly 1993). This definition has been adopted by the WHO.

Aboriginal and Torres Strait Islander women and girls are more likely to have experienced violence, and are 32 times more likely to experience family violence-related assault than non-Aboriginal and Torres Strait Islander women (Steering Committee for the Review of Government Service Provision 2016). The determinants of violence against Aboriginal and Torres Strait Islander communities are often linked to conditions of social and economic disadvantage. These conditions are also often deeply rooted in the historical context of colonisation, dispossession, and structural violence, the loss of traditional cultural norms regarding social structures and practices, and intergenerational trauma (Buxton-Namisnyk 2014; Government of Victoria 2012). Furthermore, Aboriginal and Torres Strait Islander people's experiences of family violence are characterised by multigenerational effects (Royal Commission into Family Violence (Victoria) 2017) that are part of, and due to, the legacy of historic and contemporary political and cultural trauma for individuals, families and communities. This contributes to poorer physical and mental health, as well as homelessness. Responses for the prevention of violence among Aboriginal and Torres Strait Islander communities require unique, tailored responses (Blagg et al. 2015). Current research and best practice advocates the need for any such response to involve planning with and by the communities themselves, and for responses to be holistic, consider intersectionalities, and be culturally safe and relevant (Buxton-Namisnyk 2014; Cripps & Davis 2012; Olsen et al. 2016). The Victorian Aboriginal Child Care Agency (VACCA) (2017), in line with the findings of the Victorian Royal Commission into Family Violence, recommends conforming to the state's commitment for self-determination for Aboriginal and Torres Strait Islander people, as well as investment in the Aboriginal and Torres Strait Islander community and its organisations. Further, Wendt and Baker (2013) suggest the historical experience of colonisation must be acknowledged within this space, including 'dispossession, disempowerment, poverty, and cultural, social, and geographic dislocation' (p. 512), and its impact upon contemporary experiences of family violence. In this way, the intersection of cultural dislocation, multigenerational trauma, and inadequate policy responses impact upon the 'level of poverty and violence in Indigenous communities' (Nickson et al. 2011).

This review recognises culturally-appropriate health promotion as a way of creating a culturally safe environment, where Aboriginal and Torres Strait Islander people 'feel safe and secure in [their] identity, culture and community' (Gooda 2011, p. 123). Further, VACCA (2017) suggests the concept of cultural safety can be used to promote culturally competent mainstream environments, and community environments that assist to strengthen Aboriginal culture. A culturally safe environment can be a place or process that facilitates the re-claiming of norms and the empowerment of Aboriginal and Torres Strait Islander peoples (Gooda 2011).

Method

A systematic search of the literature was conducted through multiple platforms via EBSCOhost, Embase, Cochrane, and Informit (Appendix A). The concepts of health inequities, determinants of health, health promotion, resources, programs, policy, sexual and reproductive health, mental health and wellbeing, and prevention of violence were searched. The inclusion criteria included research published in English between 2010 and 2017, which focused on evidence outlining health promotion programs or interventions for Aboriginal and Torres Strait Islanders. The search was focused on women or girl's sexual and reproductive health (including maternal health), mental health and wellbeing, and the prevention of violence, however, research that included women or girls, but did not specifically target this group was also included. Research was excluded if it did not address inequity in relation to one of the priority areas.

The search strategy was conducted in multiple phases.

1. Each concept was searched individually, resulting in 73,260,541 journal articles.
2. Each concept was searched in combination with a secondary search term, such as 'health inequities' and 'social determinants of health', resulting 39,204,526 journal articles.
3. The concept 'health inequities' was searched with 'Aboriginal and Torres Strait Islander peoples' and 'women and girls', resulting in 261,014 journal articles.
4. The concepts 'health inequities' and 'Aboriginal and Torres Strait Islander peoples' and 'women and girls' were searched with 'health promotion' or 'resources' or 'programs' or 'policy', resulting in 171,332 journal articles.
5. The concepts 'health inequities', 'Aboriginal and Torres Strait Islander peoples' and 'women and girls', 'health promotion' or 'resources' or 'programs' or 'policy' were searched with 'sexual health' or 'reproductive health', resulting in 92,874 journal articles.
6. The concepts 'health inequities', 'Aboriginal and Torres Strait Islander peoples' and 'women and girls', 'health promotion' or 'resources' or 'programs' or 'policy', 'sexual health' or 'reproductive health' were searched with 'mental health' or 'wellbeing' or 'prevention of violence', resulting in 3,820 journal articles.
7. Manual removal of 1,250 duplicates was performed, resulting in 2,570 journal articles.

Title and abstract analysis of these 2,570 articles was undertaken. Those that did not meet the inclusion criteria (n = 2,524) were excluded. The full text of the remaining 46 articles was retrieved.

In addition, specific relevant websites (Appendix B) and Google advanced searches were conducted. Grey literature was searched using Google advanced site: gov.au and site: org. The concepts of 'health inequities', 'Aboriginal and Torres Strait Islander peoples', 'women and girls', 'health promotion', 'resources', 'programs', 'policy', 'sexual and reproductive health', 'mental health', 'wellbeing', and 'prevention of violence' were combined. A total of 70 website results were found for .org.au, 60 for .edu.au, and 51 websites were found through gov.au. From these websites, 29 documents were retrieved.

The 46 journal articles and 29 documents were reviewed against the inclusion and exclusion criteria. From this, 53 articles and documents were excluded. Of the remaining 22 articles and documents included in the final review, eight focused on sexual and reproductive health, ten on mental health and wellbeing, and four on violence prevention.

Socioeconomic, political and cultural context

Sexual and reproductive health

Literature about the socioeconomic, political and cultural context of sexual and reproductive health inequities related to socioeconomic factors, and access to culturally-appropriate, accessible healthcare and services.

Socioeconomic factors

The literature highlighted the complexities of engaging Aboriginal and Torres Strait Islander women in sexual health programs and maternal care due to the culmination of experiencing multiple social and socioeconomic topics, including homelessness, financial hardship, substance use, mental health problems and teenage pregnancy. These compounding topics have been associated with a heightened risk of contact with child protection services and out-of-home care (DHS 2012). The 'Babies to Bumps and Beyond' program focused on the health and wellbeing of the family with the provision of a case-worker to assist with support service access. Evaluation of the program found these strategies positively impacted the women's experience, with all children remaining in their mothers' care at completion of the program (Burrows, Allen & Gorton 2014).

Access to culturally-appropriate, accessible healthcare and services

Community consultation was identified as important in the development of culturally-appropriate and competent care, including collaboration with the community, and other local organisations, in the design and ongoing monitoring and evaluation of programs. The development, planning and implementation of the 'Aboriginal Maternity Group Practice' program included community consultation through the inclusion of a steering group of six Aboriginal community members, Aboriginal grandmothers (referred to as 'respected women' in the local community), and Aboriginal Health Officers (Bertilone & McEvoy 2015; Bertilone et al. 2017). This enabled the program to be developed and evaluated regularly, and provide culturally competent services. The 'Aboriginal Family Birthing' program also engaged community consultation in the design of this program (Brown et al. 2015). Similarly, the development of the Far North Queensland sexual health strategy was based on a participatory approach through two community reference groups, known as the 'Youth and Relationships Networks' (YARNs). YARNs engaged community members along with representatives from relevant organisations such as health service employees and community organisation workers, in a series of focus group discussions and individual interviews to inform the design and implementation of a culturally and community congruent sexual health strategy (Whiteside et al. 2012). The participatory YARNs approach led to the successful development and delivery of culturally sensitive sexual health programs that include improved access to condoms, and sexual health information through sponsorship of 'Indigenous Hip Hop events' that increase community awareness and empower young people to take control of their health.

Organisational partnerships were also highlighted in two maternal health programs ('Bumps to Babies and Beyond' and the 'Baby Basket' program) (Burrows, Allen & Gorton 2014; McCalman et al. 2015). The SHIMMER program, aimed at increasing chlamydia and gonorrhea testing among young people (aged 15 to 29) attending Aboriginal primary healthcare services, also emphasised the need for partnerships (Graham et al. 2015). A central feature of the program was the partnership between the services and the SHIMMER sexual health physician and an Aboriginal project manager. These collaborations were found to be effective at enhancing cultural competence in practice, although further details of the relationships or engagement processes were not provided to help guide future practice.

The literature identified the need for localised culturally-appropriate care. For example, the 'Baby Basket' program was based on the local Murri[2] way of engaging with the women and their families around health topics through 'yarning' (McCalman et al. 2015). Similarly, the 'Aboriginal Maternity Group Practice' program was based on the concept of 'Birthing on Country' that recognises the cultural and spiritual significance of birthing on ancestral lands for the Noongar people of Western Australia.

Mental health and wellbeing

Literature about the socioeconomic, political and cultural contexts of the mental health and wellbeing of Aboriginal and Torres Strait Islander women, and promising practice in culturally-appropriate health promotion programs, is limited. Only one study specifically evaluated a culturally-appropriate health promotion program focusing on Aboriginal and Torres Strait Islander women's mental health and wellbeing. However, other research has considered Aboriginal and Torres Strait Islander women's mental health and wellbeing as a part of broader study aims. Across this body of research, two themes emerged: access to culturally-appropriate, accessible healthcare and services; and women-led and community-based programs.

Access to culturally-appropriate, accessible healthcare and services

A report by Beyondblue (2013) highlighted six factors that should be included in perinatal mental health services for Aboriginal and Torres Strait Islander women, with culturally-appropriate and safe services key. Further, the inclusion, and recognition, of socio-cultural factors such as land, country, ancestors and spirits, Elders in decision-making, family and community, as well as an extended family structure, fathers and male family members, and ideas of kinship, culture, spirituality and humour, are central to the promotion of resilience and support. However, the non-government organisation has not, as of yet, implemented any targeted programs for Aboriginal and Torres Strait Islander women in this way.

The provision of culturally-appropriate services to respond to mental health and wellbeing highlighted the need for service collaboration. Carey (2013) investigated a remote Aboriginal and Torres Strait Islander community social and emotional wellbeing service, with service providers, participants and referrers, including men and women, and those from non-Aboriginal or Torres Strait Islander backgrounds. The community-based approach emphasised the importance of developing trust and rapport within the community, with services such as family therapy and counselling provided. Barriers identified in the program included the remoteness of the community and the diversity of Aboriginal languages spoken (Carey 2013). Similarly, Nagel, Hinton and Griffin (2012) explored the training of service providers for the Aboriginal and Torres Strait Islander mental health initiative Yarning About Mental Health Program, also highlighting the importance of collaboration with the community, with stories from service users being central to understandings across cultures.

Evaluation of the community-based mental health e-tool's 'Stay Strong' app and 'ibobbly suicide prevention' app, for Aboriginal and Torres Strait Islander people aged 18 to 35, found these tools were positively viewed by community members (Povey et al. 2016). The community members included five women and three men identifying as Aboriginal and Torres Strait Islander in Darwin. However, Povey and colleagues (2016) recognised low community awareness of the tools and their potential use in diverse communities (such as rural communities with little internet coverage) to be barriers, as well as individual factors such as motivation to change and awareness of mental health issues. Further, no specific outcomes for women and girls were reported.

Lee and colleagues (2013) explored support groups for Aboriginal and Torres Strait Islander women accessing alcohol and other drug treatment services to determine how effective the support groups were at meeting the women's needs. The women's group was attended by a range of services staff, linked to the alcohol and other drug treatment services, providing support for financial or housing concerns, as well as assistance with organising meetings and paper work to engage with child protection or the courts (Lee, Dawson & Conigrave 2013). Education was also provided to women, including how to access and engage with the relevant agencies involved in health, housing and justice. This was reported to be very important as it related to improving problem-solving skills, and building self-efficacy and confidence (Lee, Dawson & Conigrave 2013).

[2] Aboriginal and Torres Strait Islander Queenslanders

Women-led and community-based programs

The involvement of Aboriginal and Torres Strait Islander women in the development of culturally-appropriate mental health and wellbeing programs is essential. The Winja Ulupna ('women's haven') program, in collaboration with the Galiamble ('dry place on a hill') alcohol and drug services for women and men respectively, aimed to enhance Aboriginal women and men's relationships. The program did not specifically redress Aboriginal and Torres Strait Islander women and girls mental health and wellbeing, but recognised the 'silencing' of Aboriginal women's voices 'in many families, communities and community organisations' (Anderson et al. 2013, p. 12). Multiple programs have implicitly redressed the silencing of women's voices through women-led initiatives (Fredericks et al. 2016; Togni 2016; Walker et al. 2014). For example, the Uti Kulintjaku Project, led by senior Aboriginal women, aimed to develop a culturally-appropriate understanding of mental health within the community, in collaboration with non-Aboriginal health workers (Togni 2016). The program focused on the interpretation of language within medicalised and Aboriginal understandings of mental health, and utilised 'emotion' work to facilitate the exploration of feelings in the promotion of healing. Similarly, Walker and colleagues (2014) 'Indigenous Women's Wellness Study' used discussion circles, based on Laenui's (2000) model of decolonisation, with 'yarning' led by local Aboriginal and Torres Strait Islander women Elders. Factors such as flexibility, reflection, exercising traditional practices and the relationships formed within the discussion circles were found to enhance the women's wellness. The 'Dead or Deadly' program that focused on the general wellbeing of Aboriginal women also reported successful outcomes for Aboriginal women-led programs, however, specific details of this process were not included (Fredericks et al. 2016).

Prevention of violence against women

Literature about the socioeconomic, political and cultural context of the prevention of violence against Aboriginal and Torres Strait Islander women and girls, and promising practice in culturally-appropriate health promotion programs, is also limited. Of the available evidence challenging social cultural normative power relationships emerged as a central component.

Challenging social cultural normative power relationships

Redressing power relationships and negative stereotypes are important for socioeconomic, cultural and political equity to prevent violence against women. An example of action at the local level was demonstrated by the 'Aboriginal Woman Against Violence Project' (Rawsthorne 2014). The project involved participants meeting with professional service providers as students or advocates rather than as clients. Rawsthorne (2014) suggests this strategy challenged the dominant socio-normative power relationships of provider-client. This was found to be important in increasing the women's knowledge and trust of the local services. Furthermore, upon completion of the program, students or advocate participants received a certificate recognising their achievement and their new role as Aboriginal mentors. This helped to disrupt normative stereotypes of dependency, hopelessness and despair, and empower women by recognising their strengths and resilience (Rawsthorne 2014). A similar approach was also found to be successful in the development of Yarnabout Cards by the Suncoast Cooloola Outreach Prevention Education (SCOPE) and the Nungeena Aboriginal Corporation for Women's Business Inc. (Nungeena). The Yarnabout Cards, or 'Indigenous Strength cards', were developed as a tool to facilitate strength-based, holistic counselling around domestic violence (Nickson et al. 2011). The project was community-led; with SCOPE asking Nungeena how to enhance the healing that was taking place within the centre, a central focus on Aboriginal and Torres Strait Islander understandings of violence, and non-Aboriginal and Torres Strait Islander workers adopting 'a conscious lens of being 'the learner' instead of 'the expert' (Nickson et al. 2011, p. 92). These processes were found to be central to cross-cultural community development.

Research by the Department of Social Services (DSS) (2015) focusing on the attitudes of young people aged 12 to 24 years old towards violence against women suggests, for Aboriginal and Torres Strait Islander young people, culturally-appropriate tailored programs are essential in changing 'culturally engrained norms' (p. 46). This was due to a range of factors including the higher acceptability of physical violence, verbal aggression being interpreted as jokes, and the 'shame attached to acknowledging, reporting and disclosing violence', with young Aboriginal and Torres Strait Islander girls in this study reporting a 'strong desire to conceal the experience of any disrespectful or aggressive act' (DSS 2015, pp. 46, 8). To this end, the DSS (2015) recommends culturally-appropriate programs that challenge norms around violence and facilitate help-seeking behaviour. Daily living conditions

Daily living conditions

Sexual and reproductive health

The review found provision of health services to be an integral component of daily living conditions impacting sexual and reproductive health equity, specifically in relation to maternal health. Themes identified included: continuity of care and family-centred care; trust and rapport; culturally competent health workers; family and community engagement; and inter-sectoral or inter-agency collaboration, and integrated services. These themes were centred on the provision of culturally competent care.

Continuity of care and family-centred care

Maternal care delivered across the spectrum of pre-natal through to post-natal care was identified in several programs. However, the duration of the continuity of care into the post-natal period varied from the initial post-birth phase (The 'Malabar' project) (Homer et al. 2012), to eighteen months post-birth (The 'Bumps to Babies and Beyond' program) (Burrows, Allen & Gorton 2014), or three years post birth (The 'Baby One' program) (McCalman et al. 2015). These initiatives aimed for women to maintain contact with familiar health workers throughout the pre-natal to post-natal period. Notably though, upon completion of the shorter-duration 'Malabar' project, women were referred to other programs or services for follow-on care. Continuity of care in the pre-natal period helped women to feel supported, unique, and to build trust and rapport with health workers that inspired confidence in the women's own personal abilities. It also helped to support the transition of women into hospital at the time of birth (Homer et al. 2012). Central to the model of continuity of care in 'Bumps to Babies and Beyond' and the 'Baby One' programs was a family-centred and empowerment approach, which was able to be undertaken through engagement in the women's, and their families', usual home environments through the longitudinal nature of the continuity of care.

Trust and rapport

The relationship between the women and the healthcare workers was found to be important to the delivery of effective maternal care in the 'Baby Basket' program, the 'Malabar' program, and the 'Aboriginal Family Birthing' program. In the absence of this trusting relationship, research found that women were sometimes reluctant to seek healthcare advice or assistance and would be less likely to disclose vital health information (McCalman et al. 2015). In contrast, where trust and rapport was established, it encouraged women to access services they might not otherwise have, such as Pap smears (Homer et al. 2012). Health workers seeking to understand the women's lives beyond their healthcare experience was crucial for building trust and rapport. Through home visits, the 'Baby Basket' program provided an opportunity for dialogue and 'yarning' to build relationships between women and the healthcare workers (McCalman et al. 2015). This enabled health workers to gain insight into women's, and their families', health concerns and increased trust and rapport between healthcare workers, women and their families, and within community (McCalman et al. 2015). Similarly, evaluation of the 'Aboriginal Family Birthing' program found women reported midwives asking about and supporting them with other aspects of their daily lives rather than just their public services experiences, helped to build trust and rapport (Brown et al. 2015).

Culturally competent health workers

The provision and training of culturally competent health workers was a critical factor across multiple programs. The majority of programs employed Aboriginal and Torres Strait Islander health workers, education officers and/or included Aboriginal community members in this capacity, which was found to increase the effectiveness of the programs. The 'Malabar' program involved the employment of midwives, Aboriginal Health Education Officers, a community health worker and a child and family health nurse. Aboriginal Health Education Officers work alongside midwives and nurses to ensure community engagement and cultural safety (Homer et al. 2012). Similarly, the 'Aboriginal Family Birthing' program included the creation of an Aboriginal

Maternal Infant Care Worker, who took on a leadership role within maternity services (Brown et al. 2015). The Aboriginal healthcare worker engaged, collaborated, and exchanged skills with the midwives. Staff were provided with ongoing training and education as part of the 'Aboriginal Family Birthing' program. Staff training was also present in the 'Aboriginal Maternity Group Practice' program with Aboriginal staff receiving training from the Aboriginal Maternal Services Support Unit, within the Western Australian Department of Health. Aboriginal staff included an Aboriginal Health Officer, and Aboriginal Grandmothers (respected women in the local community with good community networks), to provide support (Bertilone & McEvoy 2015; Bertilone et al. 2017). The 'Baby Basket' program used local engagement and knowledge to provide culturally competent care, with Aboriginal and Torres Strait Islander health workers generally employed in their community of origin (McCalman et al. 2015). This strategy was suggested to create a 'culturally safe place', as the local health workers had local cultural knowledge and unique insights into the dynamics of the communities. These factors were reported to contribute to increased clinic visits by the women, in combination with the rapport built, and education provided, through the initial basket delivery.

Family and community engagement

A focus on women, their families, and their communities, was found to have a positive influence on maternal health, and the health and wellbeing of the community. Engagement spanned a focus on families (such as in the 'Bumps to Babies and Beyond' and 'Baby Basket' programs), through to the wider community (such as in the 'Aboriginal Maternity Group Practice' program), individual family-tailored programs focusing on families' practical needs such as case management or parenting education (for instance, in 'Bumps to Babies and Beyond'), through to focusing on social and emotional needs (for instance, the 'Malabar' program). Home visits were an important strategy for family and community engagement (Burrows, Allen & Gorton 2014; McCalman et al. 2015). The family-oriented home visiting approach was cited as enabling health workers to build rapport with the whole family and ensure the program was responsive to the community's needs (McCalman et al. 2015). It also helped to enhance families' personal and professional networks (Burrows, Allen & Gorton 2014). The range of community members engaged was also important to consider. The 'Aboriginal Maternity Group Practice' program went beyond engaging directly with families, to involve community advisory groups, steering groups and forums, and the inclusion of Aboriginal grandmothers.

Inter-sectoral or inter-agency collaboration and integrated services

Inter-sectoral action, integrated services and the provision of practical support were factors related to improved healthcare access across all the programs. Positive experiences of healthcare services were reported in the 'Bumps to Babies and Beyond' with the provision of transport increasing attendance at appointments, immunisations and breast-feeding rates (Burrows, Allen & Gorton 2014). Furthermore, the collaboration across health services was cited as an important factor in improving maternal and child health outcomes in several programs (Burrows, Allen & Gorton 2014; Homer et al. 2012). Women involved in the 'Malabar' program reported accessibility, that included practical factors such as parking and provision of transport, as well as the service's connection to the hospital and health professionals (including obstetricians, paediatricians and Aboriginal Health Education Officers) as positive aspects of the program that decreased the need to travel (Homer et al. 2012). In the 'Aboriginal Maternity Group Practice' program, Aboriginal grandmothers assisted with access to services, including transport (Bertilone & McEvoy 2015). The program also included a home-visiting service and outreach clinics in women's refuges, Aboriginal community centres, and mobile general practitioner services. Additionally, access to local community health service providers that include general practitioners, obstetricians, child health services, imaging services, and pathology services, were coordinated by program staff, with these program characteristics viewed positively.

Inter-sectoral action was identified as essential to redress the social determinants of health for many women. The 'Bumps to Babies and Beyond' program provided case management to women, and their families, with an emphasis on individually tailored care, including linkage to support services such as housing and Centrelink (Burrows, Allen & Gorton 2014). While the 'Aboriginal Maternity Group Practice' program did not provide individual case management, the program workers assisted women with accommodation, financial, or administrative assistance through care coordination processes. This included referrals to relevant partner organisations such as social services, relevant government agencies, and organisations that provide financial or housing assistance. The 'Aboriginal Maternity Group Practice' program was influential in the promotion of culturally competent care in partner organisations in three of the five districts it was implemented (Bertilone et al. 2017).

Mental health and wellbeing

The daily living conditions in relation to the mental health and wellbeing of Aboriginal and Torres Strait Islander women, and promising practice in culturally-appropriate health promotion programs, is scarce. However, the limited evidence suggests that healthcare services and supports are critical components.

A study by Lee and colleagues (2013) that explored support groups for Aboriginal and Torres Strait Islander women who access alcohol and other drug treatment services found support groups provided a positive and supportive environment, as an alternative to current 'medicalised' treatment settings. Further, the support group was found to promote earlier treatment, as well as increasing access to services and support networks, due to the group's private and relaxed setting (Lee, Dawson & Conigrave 2013). The women's support group was referred to as having a 'family' atmosphere, and was beneficial as it provided supportive relationships and helped women 'feel like they were not alone'.

The Dead or Deadly program provided a range of healthy lifestyle activities, which were associated with women's empowerment (Fredericks et al. 2016). The program promoted wellbeing in a holistic sense, with women reporting the social networks facilitated by the program beneficial to their mental health. Additionally, the program's practical supports (in gaining a driver's license or employment) were cited as important empowerment tools that positively impacted upon their wellbeing. These factors improved the women's feelings of agency and control of their lives (Fredericks et al. 2016).

Prevention of violence against women

Literature about the daily living conditions specifically related to the prevention of violence against Aboriginal and Torres Strait Islander women and girls was also scarce. However, the creation of culturally safe spaces, family engagement, and trust and rapport were central approaches among prevention of violence against women programs. Aboriginal and Torres Strait Islander women's experience of violence, and help-seeking behaviour, is recognised to be negatively affected by compounding experiences of overcrowding, mental health, drug and alcohol problems, and lower literacy and educational attainment (Wendt & Baker 2013). Further, historical experiences (such as the forced removal of children), feelings of shame, and limited access to culturally competent services, are recognised as barriers to leaving family violence situations.

Culturally safe spaces

Of the evidence currently available, it appears the creation of culturally safe spaces for women in everyday community life is important. One strategy employed by the 'Aboriginal Women Against Violence Project' was peer-mentor groups (Rawsthorne 2014). These groups facilitated social support through the sharing of experiences, opinions, and a meal. These factors increased trust and rapport between the women, and fostered friendships and support networks within the community (Rawsthorne 2014). These groups empowered women to take on leadership roles in their communities, against violence, through providing a culturally safe space for women to discuss their experiences of violence and to facilitate knowledge and trust between women and local service providers.

A transitional housing program in South Australia for Aboriginal and Torres Strait Islander women and children experiencing homelessness related to family violence found the provision of a safe environment to be paramount in their program (Wendt & Baker 2013). Women reported feeling safe and relieved upon engagement with the program, which saw them move into secure, safe housing. Additionally, the program's offices being convenient and close to the women's housing was rated highly, as it facilitated informal contact with staff (as opposed to scheduled appointments). The housing and program office created a safe environment where women developed friendships and support networks with other women in the program (Wendt & Baker 2013). The housing program operated with the long-term aim of transitioning women and their children into public housing tenancies. However, women were able to make this transition on their own terms, and were not 'pushed or rushed' to leave the service. Moreover, the housing program offered women who had transitioned outreach for up to 12 months. These factors enhanced the women's feelings of safety (Wendt & Baker 2013). Women accessing the housing program were provided with practical support in order to alleviate stressors related to fulfilling basic needs, such as food and shelter. Women were provided with appliances and furniture, items for their children (nappies, school uniforms), public transport tickets, and assistance with food (Wendt & Baker 2013). This support enabled women to attend to their own needs, mental wellbeing, and to the wellbeing of their children.

Family engagement

The transitional housing program aimed to improve women and their family's wellbeing (Wendt & Baker 2013). This was rated highly among the women, with the housing program workers acting as advocates for the children. Support was provided around children's activities and included access to learning materials, attending school excursions, childcare, liaising with schools, and general child health and wellbeing. The program also facilitated the women's connection to their extended families, with members able to stay with women in the program. This was recognised as central to the cultural-appropriateness of the program (Wendt & Baker 2013).

Trust and rapport

The development of trust and rapport was found to be central in building supportive relationships with program staff. The transitional housing program in South Australia for Aboriginal women and children who experience homelessness related to family violence found workers openness to be more important than their Aboriginality (Wendt & Baker 2013). Aboriginal women who accessed the service regarded the worker's 'helpfulness, approachability, friendliness, openness, and non-judgmental nature' to be directly related to their trustworthiness (Wendt & Baker 2013, p. 518). This was reported to facilitate women's openness and was related to redressing problems with finances, gambling, and drug and alcohol use and abuse. Furthermore, the relationships were central to women accessing education, training, and employment opportunities. Two of the fourteen women identified the importance of having Aboriginal workers employed in the housing program, with other women suggesting that problems with confidentiality can arise with local Aboriginal workers due to their small community size (Wendt & Baker 2013).

Health-related knowledge, attitudes and behaviours

Sexual and reproductive health

Health-related knowledge, attitudes and behaviours that impact on Aboriginal and Torres Strait Islander women's sexual and reproductive health, including maternal health include barriers to care and increased service participation.

Barriers to care

Barriers to accessing and engaging with maternal healthcare include the lived experiences of Aboriginal and Torres Strait Islander women. In 2013, women attending an 'Aboriginal Family Birthing' program or Aboriginal Health Service in South Australia were more likely to report physical violence, leaving home due to an argument, or that they had a partner with a drug or alcohol problem, putting them at higher risk for poorer outcomes than those women attending public care (Brown et al. 2015). These social concerns were reported by all Aboriginal women in the study, however higher levels of reporting were found among those attending an 'Aboriginal Family Birthing' program in a metropolitan area. These concerns were not reported among the other program evaluations.

Increasing service participation

Increased access to, and engagement with, services can improve a range of health outcomes for Aboriginal and Torres Strait Islander women and their children. For example, evaluation of the 'Malabar' program found it was influential in increasing the number of women presenting for their first antenatal assessment, and early access to care. Further, there was a four per cent annual reduction in smoking for the women attending the service (Homer et al. 2012). In comparison to the control groups, women who participated in the 'Aboriginal Maternity Group Practice' program were significantly less likely to have a pre-term birth, to need neonatal resuscitation and experienced a reduction in their baby's length of stay in hospital. Women in the 'Aboriginal Maternity Group Practice' program had a similar number of pre-term births to that of Western Australia in 2011, and lower than that of Aboriginal women in the Perth area.

Similarly, increased service participation in the SHIMMER and YARNs programs was associated with an increase in general sexual health for the young people involved (Graham et al. 2015; Whiteside et al. 2012). The SHIMMER program found collaboration between the Aboriginal primary healthcare services and SHIMMER sexual health physician and project manager resulted in an increase in sexually transmitted infection (STI) testing for Aboriginal women aged 15 to 29 years from 13 to 25 per cent. STI testing rates were highest among women aged 15 to 19 tears (Graham et al. 2015). Whiteside and colleagues (2012) evaluation of the YARNs program found positive sexual health behavioural changes among young Aboriginal people where due to their empowerment to take control of their health and relationships. The project was reported to be instrumental in the 300 per cent increase in condom use and screening of STIs reaching over 60 per cent of 15 to 24 year olds in far North Queensland (Whiteside et al. 2012). However, no specific outcomes for women and girls were reported.

Increasing service participation is critical to improving health outcomes. However, it is acknowledged that this can be difficult due to other individual level health-related knowledge and behaviours, daily living conditions, and socioeconomic, cultural and political factors that greatly impact on service participation.

Mental health and wellbeing

The limited available evidence on mental health and wellbeing among Aboriginal and Torres Strait Islander women and promising practice in culturally-appropriate health promotion programs suggests behaviour change and sense of self are important components.

A support group for Aboriginal and Torres Strait Islander women attending alcohol and other drug treatment services found the intervention of a support group to be a positive influence on changing substance misuse behaviours, as it was seen as an alternative activity to substance use. Moreover, the relaxed and safe setting was reported to help identify women's health topics and facilitate their access to services, in contrast to the usual 'medicalised' treatment setting (Lee, Dawson & Conigrave 2013). The support and education provided by staff was linked to building women's self-efficacy, and was reported to be central to the women's identity as 'women; mothers, aunties or grandmothers; community members; help-seekers at an [alcohol and other drug] treatment facility; and being of Aboriginal heritage' (Lee, Dawson & Conigrave 2013). Women having a safe space in which to interact and share experiences with other women in the group allowed some to take on role-model identities. These factors were reported as being central to women's empowerment. The Dead or Deadly program reported similar outcomes, with group exercise, health education, and camps providing safe Aboriginal women-led environments. This was associated with increasing positive health behaviours such as a reduction in smoking and an increase in physical activity, and was associated with improvements in mental health and wellbeing (Fredericks et al. 2016).

The mental health e-tool's 'Stay Strong' and 'ibobbly suicide prevention' apps, can be regarded as promising practice for improving wellbeing (Povey et al. 2016). Tighe and colleagues (2017) found the 'ibobbly suicide prevention' app decreased depression symptoms and general psychological distress. However, the 'ibobbly suicide prevention' app was recognised as having no impact upon suicidality or impulsivity. Further, mental health and wellbeing issues were acknowledged as being associated with the historical experience of colonisation, which was not acknowledged within the tools (Povey et al. 2016).

Evaluation of the 'Bumps to Babies and Beyond' program found it enhanced the women's understanding and connection with their unborn child, and once the child was born, connections to support groups facilitated the sharing of parenting knowledge and strategies, fostered parental self-esteem, confidence and self-efficacy (Burrows, Allen & Gorton 2014).

Prevention of violence against women

There was limited evidence available that demonstrated promising culturally-appropriate practice in relation to the prevention of violence against women and health-related knowledge, attitudes and behaviours for Aboriginal and Torres Strait Islander women and girls. This highlights a significant gap that requires attention. However, the transitional housing program, for Aboriginal women experiencing family violence, suggests the provision of individualised support enhanced Aboriginal women's mental health and wellbeing, and stopped 'women from needing to go back to violent relationships' (Wendt & Baker 2013, p. 524).

The transitional housing program's provision of practical support (housing, material goods) was found to enable women to focus on their and their children's health and wellbeing (Wendt & Baker 2013). The program was found to assist in the setting up of strong foundations for the women stable housing, practical supports, and entrance into education or training programs. These factors were associated with women's feelings of control and confidence and improvements in stability for their children (Wendt & Baker 2013).

Conclusions and recommendations

The review of the literature demonstrates that maternal health is an area of promising practice in the delivery of culturally-appropriate health promotion programs. The literature suggests culturally competent programs and services for Aboriginal and Torres Strait Islander women, such as maternal health, can improve health outcomes for women, their children, extended families and the broader community. Programs emphasised the need for integrated services that recognise the women's experience of disadvantage across multiple domains, and the importance of community-led strategies that challenge cultural and societal norms. Community-based programs, designed in collaboration with women they seek to engage, was a common factor across the majority of the programs. Specifically, this collaboration was linked to the provision of culturally competent healthcare, which was associated with positive health outcomes for women, and also their children, by curbing disadvantage, and 'breaking the cycle of trans-generational trauma' (Burrows, Allen & Gorton 2014, p. 9). As stated by Arabena (2016), maternal healthcare, and the health of Aboriginal and Torres Strait Islander women, needs to focus on culture and the whole life-span, and be inclusive of women, their partners and their extended families and communities.

Importantly, across the three priority areas, it is apparent that time needs to be invested in building rapport and trust with Aboriginal and Torres Strait Islander women, with an emphasis on acknowledging the expertise held by these women for effective programs and services. Furthermore, 'yarning' as a way of connecting was found to be an effective engagement tool, with a promising theoretical basis for future practice (Walker et al. 2013; Walker et al. 2014).

It is essential to note, the levels of the Fair Foundations Framework (VicHealth 2015) do not operate in isolation, but rather they are interconnected and interactive, and this is particularly apparent in relation to the lives and experiences of Aboriginal and Torres Strait Islander women.

Several gaps emerged from the review. Research has not included targeted sexual and reproductive health programs for women or girls. Additionally, there were limited studies regarding specific health promotion programs for mental health and wellbeing, and the prevention of violence against Aboriginal and Torres Strait Islander women and girls. No programs were found on sexual and reproductive health, mental health and wellbeing, and violence prevention programs for girls.

Aboriginal and Torres Strait Islander health and wellbeing is influenced by complex interplay of determinants including the socioeconomic context, social context, cultural context, racism and exclusion among other factors. For sexual and reproductive health, a notable determinant absent from the current literature on health inequities was gender norms. Further, with specific regards to health inequities of sexual and reproductive health, literature overwhelming focused on maternal and child health topics: inequities related to the broader suite of reproductive health issues such as sexually transmitted infections and sexuality is severely lacking. For mental health, determinants not explicitly noted in the current literature on health inequities included racism and race-based discrimination. For prevention of violence, structural determinants of health inequities are limited, including socioeconomic and sociohistorical contexts. Given the complexity of the multiple interactive social and structural determinants underpinning the three areas under review and the gaps in current literature, further work in research, policy and practice is needed.

Specifically, it is recommended:

- Health promotion programs should acknowledge the complexities of engaging with Aboriginal and Torres Strait Islander women due to their historical experiences of colonisation, racism, experiences of homelessness, financial hardship, alcohol and other drug use, violence, mental health and wellbeing issues, and teenage pregnancy, experiences of child services and educational disadvantage (Brown et al. 2015; Burrows, Allen & Gorton 2014).
- Community consultation, service collaboration and the involvement of Aboriginal and Torres Strait Islander women in forming the design, implementation and ongoing adaption of health promotion programs is crucial, taking into account the local cultural and spiritual beliefs to build a culturally-appropriate framework for health promotion programs (Bertilone et al. 2017; Brown et al. 2015; McCalman et al. 2015; Nickson et al. 2011).
- Empowerment for women and girls through involvement in building culturally-appropriate programs, through the provision of education on how they can navigate and access services, and through recognising their strengths and resilience. Involving and respecting local leadership will improve program and service engagement with these women. Practitioners need to engage with Aboriginal and Torres Strait Islander women in a way that places women's experiences first and acknowledges that they are experts in their own health and wellbeing (Lee, Dawson & Conigrave 2013; Nickson et al. 2011; Rawsthorne 2014).
- Government and health sectors need to focus on continuity of care, engaging with the families and communities of women, and address the social determinants through inter-sectoral action. Further, the provision of practical support in the form of transportation and childcare services will improve program and service accessibility. Moreover, the provision of open-ended holistic, safe, and secure housing is critical to the prevention of violence against women (Bertilone & McEvoy 2015; Brown et al. 2015; Burrows, Allen & Gorton 2014; Homer et al. 2012; Lee, Dawson & Conigrave 2013; McCalman et al. 2015; Wendt & Baker 2013).
- Practitioners need to build trusting relationships with women by taking into account the local cultural and spiritual ways of connecting, such as 'yarning' to build rapport and open up a dialogue. Through collaborating with community members and Aboriginal healthcare workers, culturally competent healthcare can be designed, delivered and evaluated (Beyondblue 2013; Homer et al. 2012; Lee, Dawson & Conigrave 2013; McCalman et al. 2015; Nickson et al. 2011; Walker et al. 2014).

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