Putting our house in order

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Improving family planning for Aboriginal and Torres Strait Islander women – ideas, directions and a useful conceptual model.

When I was asked to present at the 2011 RANZCOG Indigenous Women's Health Conference on the topic of family planning, it was with some hesitation that I accepted. The brief was family planning for Aboriginal and Torres Strait Islander women, particularly those in rural and remote communities in Queensland. What are the issues, what are the gaps? What could we do better? Despite the availability of a range of effective methods of contraception, what do we know or sense about the unmet need? The discussion that follows is broad: it offers a framework of family planning that Aboriginal and Torres Strait Islander communities, their organisations and service providers can perhaps draw from.

Too often, the topic of family planning is assumed to be limited to a discussion about the provision of a range of contraceptive methods. It is easy for service planners to focus on these technologies, the drugs and the devices, the service interface that provides the means for preventing unwanted pregnancy. The problem with just this perspective, however, is that it overlooks the human factor, the reality of human lives. As the saying has it: most accidents are caused by humans and most humans are accidents. It is also said (although it is hard to know who to ascribe this reference to) that humans are the only species that have sex for non-procreational purposes, in other words, for pleasure!

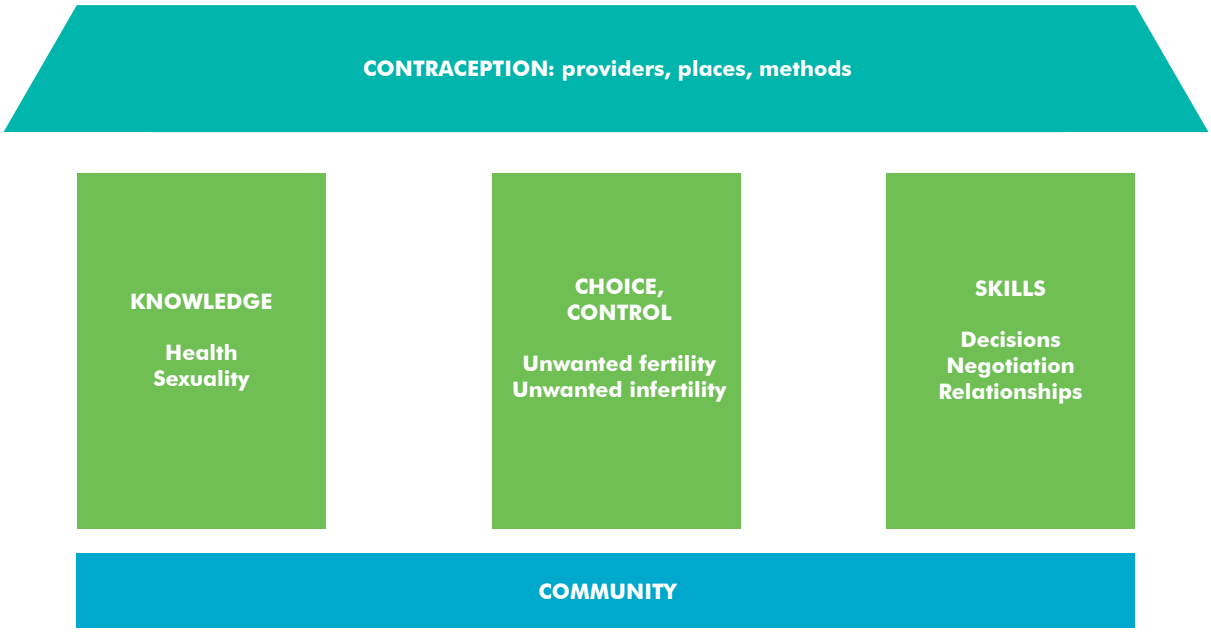
Globally, many countries have family-planning programs, the foundations of which may be any or all of the following objectives:

- Population control.
- Maternal and child health improvements.
- Reproductive rights of individuals.
- Economic/education advancement for women and communities.
- Empowerment of women as individuals.

Australia invests very little in family planning and, ironically, at a time where developing nations are now taking a broader view encompassing women's needs and rights (in addition to previous population-control and public-health perspectives), women's reproductive healthcare has seemingly vanished from our Australian policy landscape entirely. Closing the gap has many challenges, but could do well to specifically include family planning as one cornerstone for child and maternal health improvements and women's economic and educational advancement.

There is still important work to be done generally in ensuring quality contraception provision in Australia, particularly addressing access issues for Aboriginal and Torres Strait Islander women, young people, and those in rural and remote communities. Quality contraception service provision:

- occurs on the background of communities, families, peer groups, health settings and systems;
- supports informed 'choosers' and must ensure access to information on all available methods;
- works against barriers to access without being coercive;



A conceptual model of contraception services as an over-arching roof of a house, which has the community at its foundation, but requires strong pillars to connect the two.

- recognises and supports the healthy sexuality, specific needs and particular vulnerabilities of young people; and
- recognises that 'failures' occur (hence the importance of emergency contraception and access to safe legal abortion).

The roof

As clinicians and/or health service providers and planners, our contribution to improve family planning for Aboriginal and Torres Strait Islander women may seem obvious. We should provide contraception advice, supplies and, where chosen, the associated procedures. We aim to be opportunistic in early postnatal contraception initiation; and we try to be flexible in making our services appropriate, accessible and affordable. The needs of remote communities should surely then be met if we can take the appropriate clinical services to the women and support the work of local health staff, including Indigenous health workers. Mobile women's health nurses, the Royal Flying Doctors Service, GPs and O and G services all do excellent work in this area in Queensland, so why is there still the sense of considerable unmet contraceptive need for Aboriginal and Torres Strait Islander women? Focusing on contraceptive methods, improving access to contraception and other reproductive health services is not how we can make the most difference. These services are simply the most visible solution – the roof, if you will, of the houses seen from the planning flyover. While it is important that we advocate for houses to have decent roofs, those roofs will fall down if there are not walls or pillars or if there are not substantial foundations.

The pillars

From solid foundations, which lie within communities, come individuals who interface with health services. To seek and choose contraception effectively, women need knowledge and skills but they also need a sense of self determination, of control and choice. A wealth of literature in health promotion practice, from the Ottawa Charter through to evaluation of health literacy demonstrates this centrality of self-efficacy.[1]

Sexuality and relationships education (SRE) is a good thing: it helps prepare children to move from puberty through to adolescence confidently and the evidence shows that good-quality SRE delays sex and equips young people to negotiate and use contraception when they choose to have sex. We also know that if started early, it can be a child-protection strategy. Talking clearly and accurately is essential. Showing young children that parents, carers or early childhood workers are not ashamed or embarrassed about sexuality, helps children learn that they can talk with trusted adults. It is important for young children to learn about body parts, healthy relationships and consensual adult expressions of intimacy. Age-appropriate education involves teaching children the correct names for and functions of their body parts and teaching them to care for, respect and protect their bodies.[2]

Given the diversity of young people in schools, it is important that SRE programs cater to their varied needs. This also includes the provision of information in the broader context of relationships, values clarification and negotiation skills.[3] This is supported by research conducted with young people who have indicated that programs need to go beyond the provision of just biological information.

> 'Sexual education is not just about sex, but also social issues, such as personal safety, safe sexual activity, sexuality and puberty, safe partying, sexual assault and sexual wellbeing. Students also need to be educated on development issues, such as stereotypes, healthy relationships, defining stages of relationships, family planning…gender and sexuality.'
> YMCA Youth Parliament Member, 2009

Understanding the underpinning principles for sexuality and relationships education is essential if we are to talk about the relevance of this education to Aboriginal and Torres Strait Islander children, especially those in remote communities. Too often, at the highest levels, this term is misunderstood, demonised or avoided with a plethora of excuses and perceived barriers including cultural background. Yet, if the following principles are incorporated, it seems hard to understand the resistance.

> 'We need to add our voice to the call for high-quality SRE to be delivered to all Australian children, especially the most disadvantaged.'

According to WHO[4], sexuality and relationships education needs to:

- be more than the nuts and bolts and adverse outcomes;
- equip young people with skills;
- be delivered with inclusion of family, schools and wider community; and
- acknowledge the social norms and cultural, peer and family context of the adolescents.

There is no reason that culturally appropriate SRE, based on the above principles, should not be prioritised for Aboriginal and Torres Strait Islander children. In a study of young people's knowledge of sexually transmitted infections and safe sex in remote Far North Queensland, Fagan found that remote Indigenous youth had lower levels of STI knowledge than young people in a national survey and concluded that, 'there is an urgent need to strengthen school-based sex education and to develop innovative approaches to sexual health promotion'.[5]

At the 2011 Indigenous Women's Health Conference in Cairns, it was exciting to see some examples of innovative SRE programs now being run by Aboriginal and Torres Strait Islander community-controlled organisations in their schools and communities.

Sexual health is the freedom of worry from the unplanned consequences of sexual activity. Reproductive health implies that people are able to have a satisfying and safe sex life; they have the capability to reproduce; and that they have the freedom to decide if, when and how to do so. In a practical sense, globally, this translates to limiting the number of pregnancies, the spacing of births and delaying the age that young people become parents. We must, however, also acknowledge the social determinants of health and address poverty and disadvantage in all its manifestations and complexities and how these impact on the capacity and self-efficacy of individuals to exercise reproductive choice. This requires:

- A broader health-promotion framework; beyond clinics and beyond the health sector.
- Indigenous health worker training in sexual health that is broader than diseases and biological reproduction and that includes sexuality, relationships and sexual abuse and assault.
- Teaching non-Indigenous healthcare providers about cultural

issues in talking about SRE issues to Aboriginal and Torres Strait Islander people.
- Appropriate SRE and information: who is best placed to do this work and what training is needed?
- Peer education for adolescents, including young men.

As doctors, we must continue to strive to provide high-quality, flexibly delivered and affordable clinical contraception services to Aboriginal and Torres Strait Islander women, but we must also recognise our limitations and broaden our perspectives on this work. We need to advocate for the things that we know work and, while the specific evidence is not there yet for Aboriginal and Torres Strait Islander people, we know that sex and relationships education for young people works generally. We need to add our voice to the call for high-quality SRE to be delivered to all Australian children, especially the most disadvantaged.

Finally, I reflect on one of my favourite quotes: as a non-Indigenous person I believe it speaks to us as individuals or as organisations who seek to work with or for Aboriginal and Torres Strait Islander people in making a difference: 'If you have come here to help me, then you are wasting your time. But if you have come because your own liberation is bound up in mine, then let us work together' (Aboriginal activists' group, Queensland, 1970s).[5]

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