A life changing experience – Insights on Indigenous women's health

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My interest in Indigenous health consolidated in medical school when I did an elective term in central Australia, comprising two weeks at Congress AMS in Alice Springs, and one month at Kalka in Pitjantjatjara lands. The latter was particularly life-changing – I made friends in a very short period of time and was included into a family within weeks. I was taken out looking for bush tucker, included in meals, and told lots of stories. There was a brief period at the beginning of watching and waiting but the community seemed to decide to be friendly remarkably quickly. This gave me pause for a lot of reflection, as I realised that this was far from the experience of many Aboriginal people, especially in country towns.

In many places, there remains a divide between Indigenous and non-Indigenous Australia. I decided when I was there that I wanted to work in an Aboriginal health service and hopefully make a contribution to improving the large health disparity.

My journey into Indigenous women's health

I became a Registrar in Obstetrics and Gynaecology at Westmead Hospital, Sydney, and continued looking for opportunities to look after Indigenous women. While on secondment at Nepean hospital I elected to go to Daruk AMS at Mount Druitt to see women who planned to deliver at Nepean, for one or more of their antenatal visits. When I started practice as a specialist in Obstetrics & Gynaecology at Royal Prince Alfred Hospital (RPAH), Sydney, in 1995, I had the opportunity to do the women's clinic at the AMS Redfern.

Initially, it was fortnightly and included both Obstetrics and Gynaecology patients. Over time it became a weekly Gynaecology clinic. There was obviously a need for an accessible specialist Gynaecology service. Over many years a lot of trust has built up, allowing women to feel more comfortable talking about their gynaecological, urological, or sexual concerns. Word of mouth is strong. I see women from all over Sydney and sometimes from country areas. The AMS bought appropriate equipment including a gynaecology bed and colposcope. Having an operating list at RPAH is essential to the running of the service, as well as good long-standing relationships with my gynaecological subspecialist colleagues, notably urogynaecology and oncology. There has been generous subspecialist level ultrasound support from Ultrasound Care.

Indigenous women's health needs

Providing accessible, affordable, comprehensive and culturally appropriate care is my aim and I think it is mostly achieved. The women feel particularly reassured to have continuity of care into the operating theatre at RPAH Women and Babies. I rarely have women not turning up for operating theatre. The Aboriginal health worker completing the women's clinic with me is essential to the service: arranging appointments, helping women feel comfortable during appointments, liaising with GPs about appointments and notifying women about normal results, if needed. I call women with abnormal results or they come back for discussion. GPs are very helpful with follow up as well.

It appears that the service is very successful in meeting the gynaecological needs of the Aboriginal and Torres Strait Islander women who attend the AMS Redfern. I am concerned by excess waiting times, both for appointments and within the clinic. The Aboriginal health worker speaks with the women waiting so that they know what to expect. I save two fortnightly appointments in my rooms for overflow from the AMS women's clinic, if needed. Specific women's clinic data collection is not taking place so it is hard to quantify the work done. In future, Medicare data may be available to review, or data could be extracted from Medical Director for this purpose.

One area that I think could be improved is conservative management of urogynaecologal problems. Affordable access to a specialised pelvic floor physiotherapist would be a great addition to the women's health service, for women of all ages.

The differences

Indigenous women's health differs from non-Indigenous women's health in ways that are many and varied on the one hand and non-existent on the other. Differences relate in part to socio-political and historical factors which led to Indigenous women avoiding mainstream gynaecological services. Historically, this usually involved a male practitioner in a large teaching hospital or in private rooms (with an associated fee). Aboriginal women often have complex family situations placing their own healthcare as a low priority compared with family matters.

Culturally safe gynaecological services in public hospitals have been scarce, although I think they are increasing with time due to greater awareness of Indigenous health disparity, promotion of flexible practices, and more female gynaecologists. Indigenous women need to feel that a specialist is genuinely interested in them and can have a holistic approach to their care, taking family considerations into account if needed. In many ways, Indigenous women are no different to non-Indigenous women, in that they simply hope for respect, clear explanations, time to consider advice, friendliness and holistic care. While non-Indigenous women are likely to continue with care if they don't receive this sort of care, Indigenous women are more likely to feel embarrassed or "shame", not take advice or even stay for appointments.

The five-year survival rate for breast cancer in Indigenous women is 81%, which is significantly lower than the five-year survival rate of 90% for non-Indigenous women. The mortality rate for cervical cancer is three to four times higher in Indigenous women than in non-Indigenous women. Possible causes may include elevated co-morbidity, and less complete care due to geographic remoteness, including transport and

accommodation difficulties. A significant factor is a cultural disconnect with mainstream services.

The women's clinic I do at the AMS in Redfern aims to optimise Indigenous women's health care. This is achieved through liaising our service with the primary healthcare provided by GPs, and subspecialist care at RPAH Women and Babies and the Chris O'Brien Lifehouse, Sydney.

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