Yarning about the Social and Emotional Wellbeing of First Nations Women and Gender Diverse People Webinar Transcript | Wed 21 May 2025

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Prof Rhonda Wilson (00:00):

Hi everyone. My name is Professor Rhonda Wilson, and I would like to welcome you here tonight. Welcome to our social Emotional Wellbeing for First Nations Women and Gender Diverse People Yarning Circle tonight. Today is World Day for Cultural Diversity for Dialogue and Development, and it seems to me an excellent day to be having a dialogue that is about cultural safety and cultural diversity. So I'd like to tell you a little bit about what you'll experience this evening in this yarning circle. And if you haven't experienced a yarning circle before then I'm just going to explain a little bit about the yarning process. So right now we are kind of preparing for our yarn, and in a moment we'll do some cultural protocol. You might be familiar with that as an acknowledgement of country, for example. But we will attend to cultural protocol as the first and very important action of our yarning circle.

(01:11):

We'll then move through to a bit of a social yarn with the panel that will join me tonight. And that social yarn gives us an opportunity to get to know one another a little bit and to form a trust with each other and to develop some safety in the conversation that we have in a moment. Then we'll move through to more of a topical yarn. And the two topics we'll explore tonight are about perinatal social emotional wellbeing and perimenopause, menopause, social and emotional wellbeing. Towards the end of our yarning circle, we will develop some new knowledge and actually the panel doesn't know exactly what that new knowledge will be tonight, but it will emerge through our deep and reflective discussion and our mindful listening and our attention to each other. The panel is made up of healthcare professionals, all First Nations people, and we will bring all of our collective knowledge to the yarning Circle And out of our discussion we hope to be able to produce some new knowledge and that new knowledge will then move into the final phase of the yarning circle where we will find a way to respectfully conclude the yarning circle and we will leave the yarning circle with some action about ways of remembering what it is that we have discussed tonight.

(02:47):

So that's a little set up for you about what we're going to be doing. And so now I'm moving through to our cultural protocol and the cultural protocol is I'd really like to acknowledge elders past, present, and emerging on whatever country that you are listening to this yarning webinar on today throughout Australia. I'm sitting on Darkinung country on the central coast of New South Wales where it is very, very wet at the moment, flooding further to the north. But I would like to pay special respect to elders in the country where I'm coming to you from as a Wiradjuri woman. Respect is a very important aspect of culture and we have a special word for that in Wiradjuri language called Y India Mara. And it is a very deep respect and an attentive and deep listening respect and a love that we put into our work as well.

(04:03):

So I would like to pay respect to elders past and present and acknowledge traditional countries all over Australia of the Aboriginal and Torres Strait Islander people. People. I'd now like to move into our social yarn and on your screen you'll begin to see the panel members that are coming into our yarning circle

tonight. And I would like to acknowledge our fabulous a chat room facilitator attending to the online yarn tonight as well. Dr. Guy Cameron, who I gather has been working with you all for some time while we dealt with the technical difficulties earlier. So a big shout out to Guy. I think that he has already done a fabulous job in paying respect and bringing our yarning to life. But right now I would like to tell you a little bit about myself. As tonight's facilitator, I'm a mental health nurse, a credentialed mental health nurse, and I've been working in nursing for about 38 years.

(05:20):

I'm professor of mental health nursing at RMIT University and I'm also the president of the Australian College of Mental Health Nurses. My work is largely in mental health nursing. My research work in mental health, nursing in digital health, first Nations, social emotional wellbeing and menopause. And I look after a large team of PhD students, some of whom are First Nations people as well. And for me that work is indeed ceremony and it is my goal produce as much scientifically sound evidence to support health practise and mental health practise going forward with the goal of improving the health and mental health outcomes of First Nations people. I'd like to introduce you to Professor Donna Hartz, Dr. Kirsty Jennings and mental health nurse Katrina Ward. And Donna, I might start with you if that's okay. Could you tell us a little bit about yourself and who's your mob and where you're from?

Prof Donna Hartz (06:34):

Yama Malalia, that's Hello, friends in Gamilaraay language, excuse me. A bit nervous and I've got a bit of a frog in my throat. So my Nana's country is Kamilaroi also in some areas it's called Roi. And I'm Professor of Midwifery and Clinical Chair of Midwifery at Western Sydney Local Health District and Western Sydney University. I live up on Darkinung country. So I'm coming to you up on the central coast of New South Wales. And much of my work in research has been in birthing on country services and prior to that continuity of midwifery care for women, which is holistic, wraparound, ensuring that the women have good clinical and wellbeing outcomes. And more recently some of my work is around smoking cessation in pregnancy in particular for Aboriginal and Torres Strait Islander mothers and breastfeeding support services. So I think that's probably enough for me. Thanks for having me. I'm really excited to be yarning with you all tonight.

Prof Rhonda Wilson (07:46):

Well, that's fabulous. Thank you. And Dr. Kirsty Jennings, where are you from? Who's your mob?

Dr Kirsty Jennings (07:55):

So my name's Kirsty, my mob are Biripi people of the nation is in Taree, mid North Coast, unfortunately, very flooded at the moment here in New South Wales. I'm originally trained as a social worker and worked in aboriginal mental health in Kempsey, which is also on the mid north coast of New South Wales. And I retrained in Medicine and got my fellowship as a General Practitioner. So now I work in General Practise. I am a academic and teach into the medical programme at the University of Newcastle. I work privately and I also work as a staff specialist in justice health, which is a passion area for me. So I'm incredibly interested in talking about social emotional wellbeing and how really that helps us get better health outcomes for our mob.

Prof Rhonda Wilson (08:43):

And it's fabulous to have you with us tonight. Thank you so much. And Katrina Ward Treen Mama T, Mama Treen.

Katrina Ward (08:52):

Yeah. Save the best to last.

Prof Rhonda Wilson (08:53):

Who's your mob, where you from?

Katrina Ward (08:58):

Yama Ming. Yeah, I'm Treen. I originate from out in the Ngiyampaa Wangaaypuwan people from Wongaibon Nation on the other side of the Bogan River we line up against with the mighty Wiradjuri country tonight. I'm here on Wiradjuri country down in Bathurst where it's a bit wetter, so I pay my respects to all our mob around here as well. But I've had a longstanding history of working within mental health and social emotion wellbeing in our remote and rural areas. Currently I'm the chief operations manager for the Warrener and Wild Aboriginal Medical Services. So I see a lot of issues occurring there within our social emotional wellbeing from our First Nations people. And I'm really passionate about trying to pull together our holistic health models and to try and bring back together our culture as such and just our reconnection back to country for all our people, but particularly our young people. I'm also fortunate enough to be doing my PhD at the moment and having the wonderful Rhonda as my chief supervisor, so she's a mighty strength behind there and keeps the whip out at me. But that's all good and it's all about trying to get those better health outcomes for our mob and trying to improve overall and close this gap they've been trying to close for the last 30 years. Yeah,

Prof Rhonda Wilson (10:33):

Thank you so much. And it's just such a privilege to be here tonight with you deadly women and thank you so much for your time. I'd like to just give a little bit of information if I can, about why would we be interested in First Nations women and gender diverse social emotional wellbeing. And I guess it's aboriginal ways of knowing, being, doing, and belonging that we are very interested in inclusion and diversity. And so some of these things that impact social emotional wellbeing for women are certainly going to impact gender diverse people as well. And so we are mindful of that and we are paying attention to a diverse intersectorial group, I suppose embedded within an intersectorial approach when we think about wider health spectrums across Australia. So we're really interested in that inclusion and diversity.

(11:43):

I've been looking at a few stats lately and one of the interesting but not good stats that I have noticed from the mental health dashboard, the annual mental health dashboard that we get from the Commonwealth tells us that mental health concerns are rising for women in Australia. And in particular, almost half of young women in Australia under the age of 34 now have a mental health condition. Now that is a steep climb from the period of reporting previously that was sitting at about 26% I think. So it's almost dabbled in the space of a year and certainly as we've transitioned out of covid and mental health and social emotional wellbeing has been on the climb I suppose. So that's for all women, all young

women in Australia. But when we think about First Nations young women, what we are seeing and some of the research we've done locally in the region where I live is we have looked at the mental health presentations in ed of First Nations and indeed the whole population.

(13:10):

But the thing that we really noticed about First Nations people and First Nations young women was that there was that matching steep incline in presentations in ED for mental health presentations for First Nations young women. And there has been an increase in suicidal ideation and self-harm for First Nations young women as well. So I think that that is a very big concern for us. And we know in First Nations cultures that mothers and aunts and grandmothers do have a special role in the community as well. And the other thing that we know about social emotional wellbeing is that cultural safety is linked to the social emotional wellbeing outcome outcomes for first nations people. So where we see poorer cultural safety, then we often see poorer mental health or social emotional wellbeing outcomes and indeed broader health outcomes as well. So we know that cultural safety is very, very important.

(14:24):

Now I'm going to move us on to this topical yarning. And so we've got two topics for you tonight. The first one is perinatal social emotional wellbeing, and that perinatal period is from conception to the baby's first birthday. And so it's that whole period that we are interested in around social emotional wellbeing. And I want to tell you about a colleague of mine, her name is Chris, and she's a Torres Strait Islander woman and she's a very experienced mental health nurse. And in fact, when she became pregnant just after 35 years of age, she had fairly robust mental health and social emotional wellbeing and was quite well-informed about the topic as an experienced mental health nurse's health. But her experience of that perinatal period, she found that her social emotional wellbeing deteriorated significantly. And part of that was she said she felt odd and she was denoted with all of these risk factors that the risk factor was she was first nations, then she was over 35, she was obese, she had diabetes, and all of these were denoted in the negative as risk factors.

(15:58):

So while she had positive social emotional wellbeing to start with, it started to deteriorate with this negative discourse. And then even when her blood pressure and her blood glucose levels were stable and within normal range, she was still negatively framed because people were saying to her in maternity services for instance, why isn't your blood pressure high? Why don't you have high blood glucose levels? And then she was warned that her baby will be too small and that she should even think about preparing for a stillbirth. So she had all these professional forecasts that eroded her social emotional wellbeing and her hope dwindled. And over that perinatal period, she experienced depression. And one of the things she really yearned for was a closer connection with women's business, but public health services wouldn't allow her to have those aunts and mother and grandmother to support her. And one of the things that helped her recover in the end was to go back to country and to connect with that strong women's business and that supported her in her social emotional wellbeing. So I guess I just wanted to maybe throw to Donna, what are some models that might be able to privilege First Nations experience and do something about this negative discourse that people like Chris might experience?

Prof Donna Hartz (17:55):

Look, I think we all know about the nature of most health services. We're dealing with a colonial colonisation or post colonisation period. And although well-meaning we still have services that have got policies and procedures and that work counter to the safety of our first nations women. And then on top of that, we are plagued with unconscious biases and overt biases and outright racism. We've got a huge body of work that talks about racism kills. So when you look at your colleague going to seek care in a time where they're seeking knowledge, they're seeking relational care, we know that works the relational care because pregnancy and childbirth is a time of enormous hormonal change in particular with the role of oxytocin and prolactin. And we know that those hormones can be the love and connect hormones. So when we end up with stress that counters that we end up with a very unwell woman and then that also influences the intrauterine life.

(19:28):

So you think about our growing babies that when we have women that are living with complex stress and what you're talking about is over discrimination within the service, which causes a layer of stress and distress, the stress hormones that are released through the HPA then become activated across the interuterine and the placental barrier. These hormones go into the amniotic fluid, the baby becomes a wash with stress hormones. So we end up with a mother who is stressed. And if you think about this, your friends is in quite a solid and health and wellbeing state originally that's been impacted and will impact the baby and has impacted her life. When you think about the impact for the majority of people there and for our mob, they're often dealing with a lot of complex life situations and they then have also got those hormones that are a wash with the baby growing.

(20:38):

And what that does when you have those stress hormones in tro, it affects the epigenetics of that baby. It actually affects them on a cellular level. And we know that with the turning on and off of genes in utero, it affects long-term chronic health and what's the biggest killer of our mob? So we know that the services that protect women are relational care. Now some of the early work that we've done for women generally is around continuity of midwifery care and continuity of care models where the women have somebody they know caring for them and they have all the services that wrap around them. When we take this concept and place it within the Aboriginal and Torres Strait Islander space, it may be in mainstream services, but we would like to see more of it in the ER or the Aboriginal community health sector, is that we know that when we have cultural support and connection, and often it could be one of the nies, one of the aboriginal health workers or practitioners working alongside midwives who are specialists in birth working alongside doctors and social workers depending on the needs of the woman.

(21:51):

But what we know is once we have that woman in that relational, that therapeutic relationship with a midwife with her aboriginal navigator or spiritual cultural navigator where we know that everything that comes up for that woman, whether it's housing or DV situations or Centrelink or mental health problems, if we can enable that wraparound holistic service, we know that it produces outcomes. Now, the phrase that's been utilised these days is birthing on country project, the national project. And that phrase in itself was brought to life from the early work of the Inuits in Canada, but adapted by elder women at a gathering at in partway, which is modern day Alice Springs. And they endorsed birthing on

countries a concept which is not about necessarily giving birth next to this beautiful swollen river here for me on Roy country, but it could be anyway. It could be.

(23:12):

It's about giving birth and getting the best start to life. So it's a metaphor for the best start to life. So the models of care for birthing on country, whether it's with an aboriginal medical service or with mainstream service, if we can provide continuity of care with the midwife or with our cultural navigator, with all the services that the women need, that we know that this can produce better health outcomes and in particular wellbeing. So remember, our mob have a lot of their taken away from we are overrepresented in the child protection space causes another level of angst when approaching mainstream services and nearly most women will give birth in a hospital. So they're under that whole strict gaze of are you a good enough mother? Are you complying with medical practise? And when you have that wraparound service, that cultural navigator, that midwife holding the ground for them, it enables them to be able to have their own identity and have a level of de-stressing or deescalating to enable the newer hormonal mechanisms to work better and more efficiently.

(24:24):

But most appropriately, we find that with these services we're able to produce, like I said, better clinical outcomes like reductions in preterm birth, bigger babies, they grow healthier babies because they're born term and they don't have the stress, they're more likely to breastfeed, which in itself gives that long-term effect and that bonding with the baby, with the oxytocin and the prolactin, and it enables women to go forward in the world. As we all know, for many of us that are mothers, we know being an early mother, even when you're in a privileged position, is difficult. So for those of our mob that are not in a privileged position and do have all those complex health stressors, it can be even more difficult. And the continuity goes beyond the birth. It goes into the early childhood period. The importance is connection. Our culture is based on connections and relationships and feeling safe.

(25:20):

So being able to support those women and their families to get the supports that they need and that includes the fathers or the significant partners. And really important to remember that for mob, it's an extended family. It's not usually one mother or one father. Sometimes there can be a few. You heard Rhonda talk about mama train there before. She's a mother to many, many of our mob out on her country and sometimes there's lots of different aunties and they may not be familial sisters or brothers or aunties or nanas or mothers, but they're cultural and spiritual. So I think services that we know when they provide continuity of care and wraparound services.

Prof Rhonda Wilson (26:05):

Yeah, yeah. No, that's beautiful description. Thank you so much. Kirsty, what about the diagnostics? I suppose that clinical interface and framing of a First Nation's mother in that perinatal period by her biometrics and diagnostics. How do you see that fitting or not fitting?

Dr Kirsty Jennings (26:34):

I think you're absolutely right. I think it doesn't fit anymore in our changing environment. And what I'm loving now is that as health practitioners we're really moving towards understanding strengths-based perspective in working with community. And as I think you mentioned, a lot of deficit discourse sits

within particularly medicine and we also talk a lot about, or I've heard talk about indigeneity as a risk factor for disease. And I think we need to really unpack that and say indigeneity is not a risk factor for poor health. Aboriginal and First Nations people, experiences of those social determinants of health put them at higher risk of developing poor health outcomes. We need to really differentiate those two things so that we're not asking people, we should have high blood pressure based on just your background. What are we framing in terms of this woman's strengths? And we know from a lot of research that is out there, culture is a protective factor for people for social emotional wellbeing outcomes.

(27:34):

So her connection to home, her connection to her mob and referencing elder and women's knowledge in the community is important. So I think we need to move away from that biophysical parameters that we have had for so long and think about more strengths-based perspective. And when we are working with people, and I absolutely agree with Donna, it's relationships. If we can have great relationships with our patients, if we can really work on concepts around clinical yarning in developing great communication skills for health workers, we really start to break down those barriers for people and really get to the heart of what's happening for this poor lady in this situation. And you can understand why somebody in the system. I think we underestimate the impact of intergenerational trauma in communities and how that impacts people's experience in working with health professionals that have largely been responsible for removing children.

(28:34):

So I think we also need to acknowledge our role in that process as medical practitioners and health practitioners and the system that we work within. And as you said, 48% of children in out-of-home care now are Aboriginal or Torre Strait Islander kids when we are three to 4% of the population. And that rate's actually going up. And so that's really challenging for us as well to think about how a woman can feel comfortable coming into a system that has been so treated preferentially so poorly and not want to disclose some certain aspects about how she's feeling about her health. So how we approach that, identifying what strengths are and moving away from that deficit discourse is incredibly important. Of course, we don't ignore any of those physical parameters, but it's only a small part of the piece of that person's experience and it's only part of the process. And working, stepping back as a medical practitioner and prefacing voices of community and other women who have a bigger role, midwives and nurses, social workers and a multidisciplinary team, sometimes we have trouble with that as medical practitioners stepping back and being quiet in a situation. And I think sometimes that has real value

Prof Rhonda Wilson (29:46):

And that deep listening that is so important to us. Yeah, that's beautiful. Thank you so much. And train you are a new grandma again and you're an important person and grandma and mother to many really in rural and regional New South Wales. What's that experience like as a new grandmother and as a mother, as an aunt, as a leader in your community in supporting rural First Nations social emotional wellbeing?

Katrina Ward (30:26):

Yeah, look, both Donna and Kirsty, you've touched on great points and all that. And I just need to highlight that for anybody who's working with any First Nations person, and I think my key word to bring home to people is inclusiveness. We need to include the extended families, the outer people who are there, whether it's the aunts or the sisters, the mothers, the neighbours, as aboriginal people traditionally we all brought up that one child. We were all there to nurture that child, to shape that child into its own cultural beings and to become the person it's going to be. And unfortunately with the way our health system has gone in that a lot of our people, both First Nations and non-First Nations people, we have to leave our homes to go and deliver our babies. And hence why programmes such as Birthing on country is so important to get that initial cultural connection to the country of where the person originates from.

(31:37):

But particularly in where I originate from, we have to travel at least three to four hours to a major regional centre and the mainstream services once you're there three weeks before. So generally that means uplifting your whole family, either taking, you might have several other children or you can't leave them back in your hometown or you can't afford to take 'em back there. So we unfortunately, as young mothers and new mothers, we put ourself at risk because we leave things till the last moment. And I've lived that with my own children where we've done the midnight dash and all this, but fortunately I've got a bit of medical knowledge there and a big whip to fling 'em along the way as well. But it's something that we shouldn't have to expose our young mobs to do. They should feel safe and comfortable to be able to present, whether it's to a local hospital or to a midwife who's willing to do a home birth, whatever their choice is, where they've got their extended family around them and not told, oh, well you can just have one or two people there because it might mean that there's five different aunties who are really integral and important to the birthing of this child.

(33:01):

And they've all got their own special qualities that bring to support that mum through to the procedure and just the whole experience of childbirth and motherhood. So we need to take that on board as well and keep those other people in the loop of what's going on and particularly the mom as well.

Prof Rhonda Wilson (33:24):

So I think what I'm hearing is a lot of talk from all of you about an awareness of trauma and intergenerational trauma, but also a listening ear and hearing and exploring where the strengths lie and utilising those strengths, drawing them in to bolster social emotional wellbeing of not just that woman but her whole network and community and mob around her. So beautiful discussion. Thank you so much. I wonder if I can move the discussion to now a slightly older group of women in that perimenopause and menopause phase of life. So I'll just give you a little bit of context about menopause for First Nations and gender diverse people. And to date in Australia, there has only been one research study done, and it was in country western Australia about 10 years or so ago. I think it had around about 12 participants, a qualitative study, and it was undertaken by non-indigenous researchers.

(34:43):

So this is a very, very small study, and that's all we have to inform our best practise in caring for Aboriginal and Torres Strait Islander perimenopause and menopause women and gender diverse people. So I think it's quite astonishing that there is a complete absence of research to inform best practise for

First Nations menopause, yet we have by contrast, 65,000 plus years of women's knowledge and women's ceremony where we do have understandings about women's business and women's health and wellbeing and social emotional wellbeing. So again, we've got this discord, I suppose it just doesn't quite fit with our Western health biomedical health systems. So I think it's a real challenge for us. And just further context, in Australia right now there's around about 76001st nations women in that 40 to 54 year age bracket. So that's a lot of women who are likely to be experiencing perimenopausal menopause or menopause.

(36:15):

And we have no evidence to support the care of those women. And as I mentioned earlier, women in communities, they have a lot of responsibilities and in addition, when they're working in employment, they're often working in caring, social assistance, retail, customer service type roles. So there's a lot of investment of social and emotional attention both in their work, in their community obligation and then some of the challenges that come with social emotional wellbeing during that perimenopause menopause period of life. And of course there's a lot of uncared unpaid carer roles that these women are attending to as well. So I want to come back to you, Donna, and ask you a little bit about where does menopause education and particularly first nations perimenopause menopause education coming a curriculum for any of the health professions, and where did you learn about perimenopause menopause?

Prof Donna Hartz (37:40):

Well, as a nurse and midwife, I was thinking back to my nursing training, which is quite a long time ago now that we did learn about the reproductive cycle. We knew that menopause happened, but that was it. And then as midwives, we sort of stop at the six week postnatal visit really, unless we go and do child and family health. So in terms of managing menopause or providing support to women going through menopause, I think as a post-menopausal woman myself now you really didn't think about it. We weren't taught about it in school and we weren't taught about it at university. And it was one of those subjects that our parents and mothers didn't really talk about much. You just mark not remember my mother ever talking about it with us young women. And we were in the early twenties when she went through menopause.

(38:34):

But then for myself, it was something you didn't think about. It's not when you're having your first baby, you think, well, I'm having my first baby, you don't really think about it. You don't think about when you're 20, I'm going to have a baby when I'm 30. I'm thinking about it now, the whole experience. It's not until you're in it, you go, oh, right, what do I need to know now? So menopause, it's not until you get into it, you go like, well, there's not a lot of information around. I haven't been taught that much and nobody's told me too much. So it's been one of those invisible and unspoken, which a lot of women's health is unspoken position phases in your life or physiological change in your life, that is really profound. And I think as we were talking earlier, preparing you're almost living in two worlds because as women, we're behind the eight ball anyway.

(39:19):

So when you're a working woman going through physiological changes, and for many of us, we still have to be active members of work that you can't let your physical ailments compromise you in the

workplace. So you become two people, you become inside all the psychological and emotional issues that go on, and then you're suffering with the physical ailment, but you're out there with a mask on pretending that it's okay. I think now it's really wonderful to see, I think the generation behind us, it's now becoming met, perimenopausal. They're very proactive and very vocal about what goes on. You see them as mothers and now as young women whose bodies are going through perimenopause, they're more likely to talk about what's going on. And maybe we've started the dialogue with them too. So now we don't learn a lot about it. Curriculum's not been very kind to us. And in terms of Aboriginal and Torres Strait Islander women, as you said, we are just only trying to get them to have pap smears. We haven't been able to get out to many of the regional and remote areas to have good compliance with reproductive health screening mammograms and whatever, let alone talk about that business like women's business that no one really wants to hear about anyone or you didn't realise that anyone would want to hear about and suffer in silence. So then we've got a long way to go, long way to go to

Prof Rhonda Wilson (40:45):

Educate, so

Prof Donna Hartz (40:45):

Long way to go to lift the community's thoughts and realisations around what's happening for us.

Prof Rhonda Wilson (40:56):

And of course we've got the experiences across the spectrum for women and gender diverse people, the experiences that queer women, transgender people might have. It's going to be very challenging to manage all of that and to manage the load that we have in community in caring and also as you said, maintaining employment. And so it is a lot to take on Kirsty. I imagine that as a GP you must see a lot of First Nations women in that perimenopause, menopause period of life. And I guess that social emotional wellbeing is one of the challenges that people are balancing all the time. And you spoke earlier about strengths-based. What other gems can you share with us from your perspective about social emotional wellbeing and perimenopause menopause?

Dr Kirsty Jennings (42:10):

So I think it's a really interesting topic, and I think we were talking previously that people are much more empowered to talk about menopause now, which is great to see, but often when I was at medical school and most women that present are only really talking about those vasomotor symptoms, the flushing and things that they're getting. So understanding about what actually menopause happens in menopause, what's happening to your body, what's happening to your social emotional wellbeing, so liability of mood, all of those things. Joint pains kind of is not seen necessarily as being menopausal so often, even sitting down with somebody and going through what are you actually experiencing apart from those often known your hot flushes. So things like insomnia, sexual dysfunction, which we don't talk about in menopause, libido, wanting to have a normal sexual function. A lot of women have a lot of shame around that.

(43:06):

V care, vaginal dryness, all of those things that women will not necessarily want to talk about because there might be a lot of shame. I often find that women will have that deficit around menopause as well, thinking about, well, everyone says to me that I'm being crazy or that I have this menopausal rage or I've turned into this horrible bog witch. And that's usually from other people outside telling them all of this information when we're not really acknowledging that that is part of that menopausal process. And that emotional component is actually quite a large part of how we even would go about starting to talk about treatments, what is available. A lot of women have very little knowledge about what that might be. And often we'll think, oh, it's only hormones and we can talk about, no, there's lots of non-hormonal treatments that we can do.

(43:53):

There's lots of approaches at working towards addressing social and emotional wellbeing within that process as well. And that there is light at the end of the tunnel for this process and how long that might last. So I think there's a very big topic around menopause that we've just avoided, and particularly in First Nations women, I think because as Tanya said, that we prioritise family, we prioritise being home, going to school, being the parent, doing all of those things well above our own health at some times and to our own detriment at times. But having the time to be able to talk about ourself is often seen as being a little bit selfish at times by women. So acknowledging that no, it's okay to have time for yourself. It's okay to talk about this and there isn't any shame with that. I think 65,000 years wasn't of no knowledge that we have in women's health wasn't just looking about your follicle stimulating hormone or your oestrogen levels. It was about the experience that women were having. So acknowledging experience as part of menopause and not just treating on numbers I think is really important.

Prof Rhonda Wilson (45:01):

Yeah, and I love what you say about no shame, that's shame is something that really does impact first nations people and the willingness to talk about some of these ideas. And so yeah, that's really important for people to know about that shame can hold back from revealing some of the challenges that people have. And you've reminded me about sleep as well. And there's a lot of First Nations people who have crowded housing for example, and don't have housing security and food security. And when you don't have the surety of that, and certainly in Australia there is a rising number of homeless older women and first nations women are among those people, then just being able to sleep and have that cognitive function, the cognitive fog that comes with perimenopause, menopause, it's a big ask to manage that in some of the social situations that we do encounter. So yeah, thank you so much for that. Now, train rural and regional complexity, you talked a lot about that before, but for perimenopause, menopause out in the bush, that's not easy for First Nations women either you've got,

Katrina Ward (46:41):

Yeah, well nine times out of 10 the services they provide from a drive in or fly out services as such, you might come once a month and they're there to do the women's business or women's health screening as such. And while its can be a great service, it all depends on those people who nine times out of 10 are not First Nations people, but it's doing that background work and building those relationships you've, it all comes back to having that relationship first, getting that trust involved, building the rapport for people feel comfortable to come and talk about the shame that is associated with perimenopausal and

women. For an aboriginal woman to be able to share what's going on within their life at that time, it can be quite a burden for them. So they'll either just reluctantly not see anybody and suffer along the way.

(47:46):

And then the whole social emotional wellbeing becomes affected because they're ultimately going through a period of loss and grief. And I think that's where a lot of our gps and that they don't see our menopausal women and our perimenopausal people as having this loss in grief. They're losing the function of body parts that is integratable for us to us as First Nations people. We are the mothers, we are the nurturers. We are there to keep our bloodlines and our storylines following through from a cultural perspective. So once we start going through those changes, it can become a deep transgenerational loss for us as well. So I really believe that that impact needs to be taken into consideration as well when the full assessment is occurring, whether it be by women's health nurses or whether with the GP and that too, and what they wish to try and prescribe or whatever care they want for these individuals.

(48:52):

Of course we need to take that onto focus. And I just also with the experience of all your hormones and that changing, we've also got a big line of children in there as well. So we've got it where there's other family members who are having hormone or changes and balances so the whole family can become disrupted. And as you touched on Rhonda with the overcrowding, that's a major burden with our women to be able to feel safe or culturally safe, particularly if the house is full of males and other young people around them, they might not feel comfortable to be able to explore their own self and their own social and wellbeing.

Prof Rhonda Wilson (49:40):

And just that access to toilets as well. I mean it's a really critical time, isn't it, to be able to have good access and safe access to something as simple as an accessible toilet, for instance. So there's so much information that you've all shared. And I guess now we want to come to what have we learned tonight as we've discussed these really complex topics and they are really complex. Is there some knowledge that as we bring our ideas together that emerges that can take us forward with some clues about how to respond to social emotional wellbeing for First Nations women and gender diverse people? And I guess I come back to everybody on the panel again, what are the real takeaway pieces of knowledge that are going to be really important moving forward? And we're coming into that forming new knowledge part of our yarn.

Katrina Ward (50:55):

It goes straight up and it's part of the yarning process. It's that deep listening physicians and that and clinicians, we need to listen to what our people are trying to tell you what's happening in their life and not be dismissive of what they might be feeling. You need to take all that on board and build those relationships,

Prof Rhonda Wilson (51:22):

Relationship and deep listening, I think that's incredibly important.

Prof Donna Hartz (51:28):

I think that ties, sorry you go, Chris,

Dr Kirsty Jennings (51:31):

I'm sorry. I absolutely agree, and I think the cornerstone of relationships is communication. Yes, I think that really is important. We can be the best clinicians in the world, but if we are not communicating clearly with First Nations people, we're not going to get anywhere. I think it's incredibly important skill to learn and to learn to focus for a patient-centered model of care. We're looking at trauma-informed care and being very open to changing the narrative that we've had in health for so long around that deficit discourse and really concentrate on strengths-based, collaborative, patient-centered care and work on our communication. For me, that's the most important cornerstone of all interaction with our mob.

Prof Rhonda Wilson (52:11):

That's beautiful.

Prof Donna Hartz (52:13):

And women, they need to feel culturally safe. And that's exactly all of what Kirsty and Train had just listed pretty much that they will not come for care if they're not feeling that they're being respected, if they don't feel a connection, if we do not have First Nations workforce there that can understand or encourage the non-indigenous workforce to have insights. And I guess this is a part of this yarning. So the takeaway here is how can you listen and enable mob to front up and hear they have their stories told so they feel safe. And when you look at once their stories are told, there was another layer as you're talking about, and we're going to the menopausal women is the other story. Like we're talking about them being homeless, that economic crisis that they can end up in because of their physical ailments, not being able to purchase menor in menopause, but also the loss of work because they can't get to work so unwell and there is there perhaps a loss of relationship because their libido goes down. There is so much flow on. So I guess that providing that safe, culturally safe environment for them to express and then going back to that wraparound services, what's available to support them, whether it it's medicine or alternative medicines or yarning counselling, whatever it is they need listening and trying to help them to find their way forward.

Prof Rhonda Wilson (53:56):

Oh, that's beautiful. So I guess as we come to the end of the yarning circle, we've almost come full circle back again and we've talked about how important that social yarning is, that trust and relationship and communication being prepared to really deeply listen rather than to assume as health professionals we know best, but actually to give that opportunity to hear and not to jump in too soon with solutions. I think I heard Donna as well talking about the traditional therapies and I think train you were talking about that as well, that we need to have a wider set of solutions to support First Nations women and gender diverse people. What I really want to do now is just, and this is a very important part of our

yarning as well, is to express gratitude and respect for all the knowledge that you've shared with us, Donna and Kirsty and Trane.

(55:06):

And I know Guy has been doing that in the chat room as well. I just want to really express my very deep gratitude for your time and your knowledge and your willingness to share that with us all tonight. And just to convey my very deep respect for your knowledge, and I guess what we've together talked about today is really a transformation of it's the possibility of what can be in the future if we listen to First Nations voices and incorporate them in our clinical practise. And I guess there's a new song and a new story to emerge in that strengthens social emotional wellbeing outcomes for First Nations people. So I would really like to invite our listeners to really reflect on, and it's our job as yarning participants as well, to really go out of this yarning circle reflecting on what it is we've discussed, the actual ceremony that we've participated in tonight in having this deep discussion and hearing each other's perspectives.

(56:24):

And it's our responsibility to remain in harmony to that, to the yarn that we've had and to take that forward in our practise and hope that our colleagues listening in will do the same. So I really want to thank you so much for your participation tonight. And really now that brings us to the close of this yarning circle. I do want to let our listeners know that there is a feedback survey and we'd be really interested to listen to your experience of participating in this RN as well. We hope that it was useful for you and we want to thank you as well for sticking with us and listening and deeply listening and considering the ideas that we've discussed today as well. So thank you for your deep listening as well. If you are planning on claiming some CPD points, you can access the learning outcomes for this Yarning Circle webinar. It's on the supporting resources tab. I think it's in the top right hand corner. I don't promise that, but I think it's there somewhere and I'm sure you'll find it and you will be sent a certificate of attendance in the next couple of days as well to help you support your CPD claim. But I really want to thank you all for participating and wish you a very good night indeed. Thank you.