

Chapter 1: ‘If You Don’t Have Health, What’s the Use of Living?’

Koori Voices from the Goulburn–Murray Rivers Region on Health and its Determinants

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Introduction

It is often assumed that social factors leading to better health in mainstream Australian society will have the same outcome in Koori communities. However, this would require Aboriginal social processes to be similar to mainstream processes. Not only are there distinct cultural values contributing to different social processes in Koori communities, but the ongoing social marginalisation of Koori people from mainstream society contributes to a substantially different social domain. Research in the Goulburn Valley found that levels of depression were higher among Kooris employed in Aboriginal organisations/positions than those unemployed (Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001:139). Similarly, another study in the Goulburn Valley found no correlation between the level of formal education and employment status among Kooris (Alford 2002:20). These counter-intuitive findings are also reflected in income- and education-related studies in other Aboriginal communities (Hunter 2000; Malin 2003).

There are various models that conceptualise the processes of social determinants of health, some of which are multi-level explanatory frameworks. 'These multilevel explanatory models organise sets of empirical observations, and structure the relationship between these observations' (Anderson 2001:257). For example, Brunner and Marmot's (1999, quoted in Anderson 2001) social model of health interposes social categories, such as work and social environment, between categories of social structure and the psychological domain. This identifies 'upstream' factors important in contemporary public health thinking (Anderson 2001:249). Turrell and Mathers (2000) have developed a complex model linking upstream factors (for example, government policies and social, physical, economic and environmental determinants) to midstream factors (for example, psychosocial factors, healthcare system and health behaviours) and to downstream factors (for example, physiological systems, socio-economic inequalities and biological reactions). Another model, focusing on the relationship of racism to health (Williams 1997, quoted in Anderson 2001), distinguishes between 'basic' or structural causes (such as economic, political, legal, culture and

racism) and their 'surface' causes (such as health practices, stress, psychosocial resources and medical care). While the surface causes can be changed, this does not address the underlying structural causes of health (Anderson 2001:255).

While these models may be useful in providing a systematic approach to policy development in Aboriginal health, it is not clear that such policy will be effective without reformulating it to embrace the values, practices and contexts of Aboriginal people. As Anderson argues, 'interventions in policy will only impact on population health outcomes if they impact on individuals or the relations between individuals' (Anderson 2001:257). Robinson (2002:1) expresses a similar point:

'notions of hierarchy and class may need to be replaced with culturally informed notions closer to lived experience... [and] psycho-biological research needs elaboration with respect to processes generating strain and risk within the life cycle'.

This paper embraces the call by Robinson (2002) and Anderson (2001) to understand Koori health from a cultural position. A launching point must be in understanding how Aboriginal people conceptualise their experiences of health and its determinants. Discovering how Aboriginal communities and individuals think about, respond to and understand health can be the basis for developing strategies for these communities and individuals to improve health, including addressing the determining social processes. Through talking with groups of Koori people about their experiences and understandings of health and its causes, this exploratory study documents the voices of some Koori people and relates these to the existing understandings of the social determinants of Koori health. This is based on the belief that Aboriginal communities are owners of their health and it is only through interventions built on understanding their perspectives of health determinants that changes in health are also owned, implemented and successful. So the research aims were to identify a range of Koori perspectives of health and its causes in the Goulburn–Murray Rivers region, and to compare these perspectives to current understandings of the social determinants of health.

While seeking Koori voices, the project acknowledged at the outset that 'research is probably one of the dirtiest words' for Indigenous people (Smith 2001:1). Research on Indigenous communities has involved exploitation, disrespect, theft of

knowledge and beliefs, and misinterpretation (Humphrey 2000). However, there is a need for community-level information to support community control (Hunter 1995) and enable communities to be better placed to address local issues in the interests of their members. For these reasons, this study worked in partnership with existing organisations and relationships.

Setting

The project was conducted in the Goulburn–Murray Rivers region of northern Victoria and southern New South Wales. This region includes several Koori communities situated along the Murray and Goulburn Rivers, including Shepparton–Mooroopna, Cummeragunja, Echuca, Kerang, Swan Hill and Wodonga. The project stemmed from a pre-existing partnership between these communities and the School of Rural Health, The University of Melbourne, in Shepparton. This partnership formed the Koori Health Partnership Committee (KHPC), which includes representatives from every Koori organisation providing health services in the region, as well as other community-controlled Koori organisations in the Goulburn and Murray Rivers area. The project was first approved by the KHPC as a whole and all members were invited to participate. The project was conducted under the research protocols previously established with the KHPC, which include community control of data, project protocols and approval for any findings, reports and papers arising out of the project (see Henderson *et al.* 2002).

It is estimated that the Koori population in this region is approximately six thousand people. The population is growing with more than half estimated to be under the age of thirty (Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; Victorian Advisory Council on Koori Health 2001). Unemployment rates are high and incomes are generally low. Most towns have one or more community-controlled organisations that offer health programs but only some (specifically Shepparton–Mooroopna, Cummeragunja, Swan Hill, Robinvale and Echuca) have a health service that includes medical care.

An Indigenous Goulburn–Murray history

The Maloga Mission was established in 1874 on the New South Wales side of the Murray River. In 1880 a Protector of Aborigines was appointed in New South Wales. The Protector had the power to create reserves and to force Aboriginal people to live on them, which brought about the establishment of Cummeragunja in 1888. Reserves were set up far enough away from towns so that contact with Europeans was limited. Segregation was a key part of Aboriginal Protection Policy. By 1910 there were 116 reserves, with 65 per cent of these created as validation of Aboriginal occupation or in response to requests for land. In Cummeragunja's case the original allocation of 1800 acres was increased to 2965 acres in the early 1900s amid constant resistance from local European settlers. However, it never reached a size that was viable to support the Cummeragunja population despite ongoing petitions from Cummeragunja residents (Barwick 1972:50–1). The government policy that able-bodied residents should support themselves and their families by working outside the station led to active expulsions from 1908 and the bulk of the land leased out to local non-Aboriginal farmers (Barwick 1972:56–7). In the 1920s a number of organisations lobbied for civil rights, self-determination and the abolition of the Aborigines Protection Board. *The Aborigines Act 1940* introduced a new policy of 'assimilation'. The Protection Board was abolished and replaced by the Aborigines Welfare Board. In the name of assimilation, the board concentrated on the revocation of reserves and the relocation of the residents into towns. This policy was opposed by white rural communities and led to struggles over segregation. White residents refused to sell land to the Aborigines Welfare Board, thus denying Aboriginal people even a house block in their own country.

Aboriginal people did not live by the geographic restraints of State borders but by traditional landmarks. In the late 1930s a number of residents left Cummeragunja in protest of the slave-like living conditions and sought employment and education. Many families moved to Daish's paddock between Shepparton and Mooroopna (which was not prone to flooding, but is still by the river). When the Queen visited Australia and Shepparton, the local council gave the Aboriginal community a parcel of land (Rumbalara) to hide the 'eyesore' of people living in sub-standard conditions. At Rumbalara, small, cramped houses were built; some had large families and extended family members living in them.

The discriminatory effects of these policies are still felt today.¹ Unemployment in the local Koori community is three times the non-Indigenous level; school attendance of fifteen to nineteen year olds is only half, compared to 83 per cent of the wider population; with income levels at 80 per cent and home ownership less than half that of the wider population (ABS 2001, quoted in Victorian Local Government Association 2005). Local leaders have claimed that these discrepancies between mainstream and Aboriginal Australians are the very reasons that Aboriginal people made the brave decision to work at improving Aboriginal life and living standards. Since colonisation until now, many Aboriginal people have worked tirelessly, lobbying politicians, gaining mainstream support, and eventually establishing and administering Aboriginal community-controlled organisations in the 1970s. There are over 135 Koori organisations established throughout Victoria, such as the Victorian Aboriginal Legal Service, the Victorian Aboriginal Health Service and other Aboriginal community-controlled health services.² When Aboriginal organisations are numbered it is easy to see why some mainstream Australians think that Aboriginal people get special 'treatment'. However, the fact that Aboriginal Australians still live with health standards that can only be compared against the health standards of Third World countries shows otherwise.

Methods

Data collection

Before data was collected, approval for the project was gained in February 2004 from the KHPC. The study design was developed to encourage a diverse range of perspectives from the local Aboriginal communities about the social determinants of health. Focus groups were used because a group discussion could encourage responses about the topic to build (Krueger 1994). Further, focus groups were viewed as culturally appropriate because they did use direct questioning but enabled discussion of ideas while not seeking

personal information. Once the study design was developed, approval for the research was gained from The University of Melbourne Human Research Ethics Committee.

The focus groups were semi-structured. A set of seven questions was developed to ask participants about the major health issues in local Aboriginal communities, who is affected by these issues, the causes of these issues and what is known about these issues and their causes. To ensure that participants would discuss the social determinants of Aboriginal health (as presented in academic literature), three handouts were developed and each group was asked to comment on them. This discussion was held at the end of the group discussion, so as not to be leading and to maintain the open-ended questions at the outset of each focus group. The three handouts were based on the existing literature and described (1) rates of disease and other physical health indicators, (2) the socio-economic correlates of health, and (3) claims about the causes of Aboriginal health for which there is little evidence, including self-esteem, dispossession, racism and role models (see Appendix). All seven questions were asked at each focus group and discussion flowed from each question, which often led to further questions. Some focus groups lasted one hour, while others lasted up to three hours. Focus groups were facilitated by, and notes recorded by, the first three authors. In order to be culturally appropriate, where participants were primarily women, a female facilitated, and vice versa. All participants seemed engaged in discussion and members of all groups participated at some point.

Data were collected in June, July and August 2004. Each organisation in the KHPC was mailed a letter asking if its staff, clients/service users or members would be willing to participate in focus groups. Follow-up telephone calls were made to the Chief Executive Officer/Manager of each organisation to again ask for support. If an organisation was willing to participate, the Chief Executive Officer/Manager determined the protocol in which permission from participants was to be obtained and how the focus groups were organised. Some organisations agreed for staff to be asked, while others agreed for groups of service users and/or members to be asked. Some organisations requested Board

¹ 'Aborigines and Torres Strait Islanders comprise the least healthy identifiable sub-population in Australia' (Thompson 1998:37). Life expectancy at birth is seventeen years shorter, death rates are higher and infant mortality is greater than non-Indigenous Australians (Deeble *et al.* 1998; Thompson 1998). Indigenous Australians have higher rates of chronic illness morbidity, related to the high rates of Type 2 diabetes, heart disease and circulatory system disorders, stroke and renal disease (Thompson 1998).

² There are also youth hostels, adult hostels, drug and alcohol recovery centres, women's refuges, Community Development and Employment Projects, childcare centres, elderly hostels and Koori units established within most hospitals, police stations, TAFE colleges, the Victorian Aboriginal Child Care Agency, a number of Koori Open Door Education schools and a Koori educator within most primary and secondary schools.

approval first and this was obtained. Following the specific protocols for each organisation, participants were asked, a focus group time arranged and written consent gained from each member of the focus group. All focus groups were conducted at a site chosen by the hosting organisation—in all but one case at the organisation in question. Using an inclusive approach, the only criteria maintained was that all participants were Indigenous. In some situations participants were reimbursed for their time, while in others the organisation was reimbursed for staff or service user time, depending on the protocol set by the organisation.

Participants

In total nine focus groups were conducted with sixty-two people (thirty-five women and twenty-seven men). Focus groups ranged in size from three to eleven participants. Some groups were entirely male, others entirely female, while most were mixed gender; this related to the organisation's members/users. The estimated age of participants was between eighteen and fifty-five years. While some participants were staff members with above average levels of income, the majority were members of organisations (general members of the community), while others were service users with particular health and related issues. As a result, participants included drug and alcohol clients, invited community members, members of sporting clubs, and staff in health and cultural organisations. Participants were mainly from Shepparton–Mooroopna but organisations from other parts of the region also participated.

Data analysis

The focus groups were audiotape recorded and notes were also taken. First, the data was analysed by identifying any health issues and social determinants of health reported at any time during the focus groups. Each health issue and cause is presented. Second, major themes were identified to report on the key issues related to health and social determinants as discussed by participants. This presents the findings of the discussions, which move beyond specific issues to describe the relationships, social processes and relevant issues, as discussed by these groups. This process entailed each focus group being analysed as a whole to identify the major understandings of poor health, health determinants and emergent themes. This allowed for each group discussion to be understood in context and as a group discussion. In all cases, we have tried to preserve the meaning of the participants and groups.

Finally, the relationships between the key themes were analysed, with similar themes being grouped together. The interrelationships of these themes were then used to critique mainstream models of social determinants of health applicability to Aboriginal health. These three levels of coding and analysis were undertaken by the first three authors, one of whom is Aboriginal, and each level was undertaken by at least two authors so they could be checked.³ Once the analysis was complete, a draft of the paper was provided to each participant and each participating organisation, and discussed at length with the KHPC. This ensured that Koori interpretations of the data and the key issues raised were included in this paper.

Findings

The nine groups were asked to identify the major health issues in their communities. While many of the Koori participants mentioned specific illnesses and medical conditions (diabetes, hepatitis and cancer), others talked about social issues (drugs and alcohol, family violence and child abuse) and some identified very broad issues, such as 'identity', or issues around 'awareness' and 'understanding' (see Table 1). When talking, participants rarely separated health issues and causes, and frequently mentioned social, cultural and political issues as both health issues and causes.

When asked to identify the causes of these health issues and what is related to these health issues, responses were again diverse and expansive. Many talked about 'awareness', as well as 'pressure' from others and the normalising of poor health behaviours (see Table 1). Some identified particular health and social behaviours, while some spoke about 'dispossession', 'loss' of rights and cultural issues/changes. Interestingly, all responses discussed were viewed as related to health and there was a high level of agreement within the groups when issues were raised.

When asked how respondents knew that these health issues and causes exist, most respondents said they see it, experience it or hear about it in their families and the wider Koori community. When asked who was affected by these issues, Kooris talked most frequently about young people, but others indicated that older people, single parents and/or 'everybody', all community members, were impacted by these issues. Several groups also stated that these issues are 'community' issues, not individual issues.

³ All three authors undertook the final level of analysis.

TABLE 1: Health issues and their causes as reported by participants

Health issues identified	
Harmful substance use	People are unaware
Diabetes	Foetal alcohol syndrome
Cancer	Identity issues
Hepatitis	Lack of bulk billing
Heart disease	Mainstream services lack knowledge of Aboriginal health
Loss of sight	Not addressing the 'real' issues of health
Unmotivated people	Gambling
Diet and nutrition	How treated by doctors
Mental health/illness	Preservatives in and processed food
Liver/pancreas/kidneys	Oral health
Family violence	Lack of role models
Child abuse	Lack of emphasis on prevention
Suicide	Lack of activities for youth
Smoking	ADHD
Ear, nose and throat	Learning disabilities in children
Unprotected sex	Hearing
Causes/correlates of health issues identified*	
Unaware of risks/lack of health education	Lack of understanding in wider community
Peer pressure	Mental illness
Family issues/breakdown	Unsafe practices in daily life
Lifestyles	Stolen generation
Lack of role models	Diet/non-traditional foods
Low self-esteem	Education based on lies (e.g. Australian history)
Broken spirits	Lack of recreational activities/boredom
Cultural practices not as strong	Racism
Lack of rights, e.g. land rights	Paranoia
Struggles with mainstream society	Treatment by doctors
Loss and grief	Sexually active at young age
Low education and literacy levels	Lifestyles have changed
Avoidance of other issues	Don't know who to ask for help
People think it's normal/general acceptance	Trouble with police
Unemployment	Body/metabolism not used to current lifestyle
Teachers don't understand our issues	History
Crime	Financial issues
Sharing custom (share food, drink...)	Effects of medication
Lack of transport	People don't care

* Responses are listed in order of those most frequently mentioned to those mentioned only once, with the first column responses followed by those in the second column.

At the conclusion of the group discussions, all participants were given three handouts (see Appendix). Nearly all the information they contained was mentioned prior to presentation. The handouts were developed to aid discussion but it was found that generally they were not necessary to stimulate ideas. Some respondents said the information was new, stating that they were 'shocked' to see how common their own issues were in other Aboriginal communities. Some expressed frustration and anger that nothing seemed to be being done, and asked what the point of this study is if these figures are just being 'swept under the table'. Many indicated that while they knew Indigenous health was bad, there was a real 'shock of seeing it in writing', especially the dramatic differences between Indigenous and non-Indigenous health. Some were not surprised at these statistics but commented that it made them feel sad and noted that 'if you're honest with yourself' you often see children whose future is very bleak. In some groups, Kooris expressed sadness about the lack of change over recent decades. The statistics were not questioned and many groups acknowledged the similarity between their own community and communities in more remote regions of Australia. There was discussion about 'what are they doing with these figures now they've got them!' A few Kooris stated that they appreciated having the information to keep for their own use.

The first handout focused on physical health and discussion of these statistics moved from agreeing with statistics, based on participants' own observations and experiences, to political issues, social and psychological stress and change. There were many comments about the lack of change in health and questioning about whether the statistics would be 'different in 50 years'. There were a couple of discussions about sameness, and while wanting similar health statistics, Kooris did not want to be viewed as or treated the same as white Australians. The second handout focused on health behaviours and established social determinants such as education, income and employment. Again, stories moved from specific examples to reasons for unemployment, young people leaving school and the political, social and cultural reasons for lower income, education and employment levels. There was also discussion about change, with participants arguing that 'it doesn't have to be as bad as it is'. However, there was little optimism for improvement. The third handout identified more structural determinants of health and respondents reiterated issues mentioned previously, including the need for education, the need to address identity issues, the need for positive role models, and the need for leaders and acknowledgment of history, including the need for an apology for the stolen generations.

From the discussion of health issues and their causes, throughout all the focus group discussions, three overarching themes were identified—*holistic approach to health*, *identities* and *relationships with mainstream*. Within each of these, a number of closely related sub-themes were discussed, with all having strong interconnections to the overarching theme.

Holistic approach to health

The holistic perspective of health was evident in the ways in which participants talked about health. Discussions about physical health, specific health conditions and biomedical issues were usually brief and talk evolved quickly into more holistic, social, political and identity issues. For example, after briefly listing a range of health issues in response to the first question, one participant stated, 'I think you have to start with... the spiritual side of stuff because then everything else physically comes off that and that's just the past history'. This led into a discussion about the need to address issues around children's identities—how they feel about themselves and their culture. Another response to the first question related to the lack of knowledge by mainstream service providers of Koori health and the underlying causes. Discussion focused on the inability of mainstream services to effectively address the community's needs. Similarly, responses to the first handout listing health status statistics also connected specific health issues to broader cultural, social, economic and historical issues. Physical health issues were discussed but a holistic approach surrounded the discussions of all health issues. Within this holistic approach, however, a few specific issues constantly recurred, including the importance of health knowledge, youth and the devastating role of drugs and alcohol.

Health knowledge: There was a widely held view that Kooris generally did not have enough health information to be properly informed on the range of health issues facing them. One member expressed some incredulity at having been through the education system and not knowing how bad the health statistics of Koori people were. This person was aware of negative health outcomes resulting from practices such as drug abuse, but was not aware of the wider causes and impacts to the whole community. The majority of the focus groups also identified lack of education on specific health issues such as hepatitis C, AIDS and diabetes. Stories described dramatic changes in contextual factors, such as lifestyles, life being 'fast and money-driven' resulting in greater reliance on fast food, and considerably less exercise than when present-day adults were kids. Most participants

wanted more information about health, particularly about the relationships between lifestyles, health conditions and prevention.

There was criticism that schools were narrow in their health education, providing sex education but not focusing on other life skills. In one person's words, 'They [schools] have a lot to answer for... they're not delving into [the real reasons]... These kids are sexually active at thirteen years of age, twelve years of age!' However, some participants acknowledged that 'we've got teachers out there that do a wonderful job' but they do not have the skills to deal with kids with behaviour problems. Others groups suggested that the lack of health information was related to leaving school at an early age.

Youth: There was a major concern for young people; adults expressed concern for young people's health and future. For example, one person stated, 'youth are the ones that are affected'. When asked who was most affected by the issues mentioned, 'kids' was the most common response, with many then going on to say 'everybody'. 'Our youth' was not only the primary concern for these groups, but young people were the key motivation for wanting change. When discussing concerns for young people, stories reflected how young people were treated: education ('they get to Year Nine but after that it gets too hard'); following other kids (this could be both positive and negative); and drugs and alcohol. Some Kooris talked about young people having more responsibility than in the past and also facing more risk, such as exposure to harmful substances.

Drugs and alcohol: Alcohol and drugs were repeatedly identified as a key health problem. Numerous reasons were proffered as to the importance and prevalence of this practice. Participants spoke of people drinking 'to wipe themselves out', 'to be the hero' and 'to take their minds off other things'. When elaborating on these reasons, participants identified the pressure on individuals to take their minds off family deaths, stress in all facets of daily life or 'the real world' and associated problems such as depression. Some participants spoke of being regretful when they were told what they had done under the influence, and even scared; the easiest way to escape those emotions and fears was to drink more. Other participants

identified the fear of people thinking 'the grog's going to run out' and that many individuals get into the habit of drinking all their lives. Other participants identified additional issues such as peer pressure (or family pressure) and the strong desire to belong. As one participant said, 'Some people can't walk away from the grog or drugs [because then you'd be alone]'. Linked to this issue is the notion of loyalty—that family would think you are against them if you criticised their practices.

Identities

The importance of identity was discussed in all focus groups. It was viewed as being impacted by a number of closely related concepts such as self-esteem, shame and role models, with gender and place being the underlying contexts that contributed to the construction of individual and community identities. Embedded in their discussions of health and health behaviours was the participants' sense of who they and their children were.

Self-esteem: Identity was linked in talk to some of the bigger, macro social determinants through self-esteem. As one participant explained:

There has never been recognition of who the first people are... I don't even think we realise that when the leader of our country says we don't acknowledge that there was a stolen generation or... [local Aboriginal] people never existed [reference to unsuccessful Native Title application]—I don't think [we've]... realised the damage that does.

At a more individual level, the role of lack of confidence was repeatedly identified by participants as a critical health issue, particularly for young people. One participant spoke of being 'scared and ashamed' at school, where 'being black' for him was the equivalent of 'being stupid'. One group agreed that Kooris' spirits are often broken when they are young, resulting in an attitude of not being good enough to do well. Practical health benefits of self-confidence were spoken about; for example, one participant stated, 'If you've got good self-confidence that also helps you deal with the grieving process 'cause you're more confident to let your feelings known to your close relatives instead of just holding it in'. Some participants stated that issues of self-esteem and confidence caused their own identified health problems.

Shame: Negative aspects of shame⁴ were closely connected to self-esteem and continually arose in the context of Koori interaction with the mainstream. Ridicule was seen as a form of control used by the mainstream, reinforcing a Koori's lack of self-esteem, knowledge and/or power. Stories reflected that shame prevents participation in education and other social arenas. Adults were identified as having a key role in regards to shame: 'That's something we have to get out of the young [people]'. Shame was also directly linked to silence on important issues, such as child abuse. Participants spoke of a culture of denial in families about abuse issues: 'you're not going to discuss this outside of your family walls because it's a shame job', so perpetrators get away with it. Participants also identified how valued families are in Koori communities and how raising divisive issues, such as child abuse, could result in them being blamed for splitting the family. They also spoke of the failure of mainstream institutions, such as the law and support services, in dealing with abuse issues.

Role modelling: The importance of positive role models was repeatedly raised as a key health issue. In most of the group discussions there was a strong emphasis on same-gender role models within the family and community. This was generally viewed as more significant than high-profile 'outsider' or non-local role models. For example, one young person felt that young Kooris will not achieve in education 'if you don't got the support of your own people'. These discussions suggested that negative role models were seen as instrumental in the normalisation of substance misuse. Some participants spoke of 'growing up with it' from an early age, seeing aunts and uncles drinking all the time. In other cases it can become a defining characteristic of the group, where 'they're all bad'. Particular concern was expressed about boys lacking father figures in single-parent families. Most people identified that having two parents was better than having only one. And it was repeatedly raised that a good father was very important for the development of the young men:

[M]y dad's... not really been there for me... If you haven't got a role model to look up to, if you don't have that then it really affects you. I wish I had my dad... wish I knew my dad when I was a little baby but that's the way life is...

One participant claimed that 'Aborigines are too easy lead', and spoke of the importance of having white friends and being able to associate with these friends, as well as family

and friends in the Koori community. This was confirmed by another participant: 'I hang around my white mates because my black mates over there get me in trouble'. This sparked some controversy within the group, where another respondent countered that positive peer environments should be just as feasible within the Koori community. A member of another group spoke of how strong Kooris are and that they are not necessarily looking for the easy way out (for example, just get a prescription) but need to be informed of other options to problems.

Concern for young girls was also talked about, where some mothers identified problems around youngsters becoming sexually active at very young ages. Some mothers spoke about their feelings of failure; these women felt that despite their own positive role modelling and constant caring, their daughters, nevertheless, had become involved in drugs and got pregnant at an early age—the very outcomes they were seeking most to avoid, based on their own experiences.

Place: A strong context for identity occurring across most of the focus groups related to the importance of 'place'. Participants spoke of how they were 'identified as black' wherever they went. Home was a place where they talked about feeling 'safe' in their identities. For some, including young people in the groups, this was a barrier to leaving their home and community environments; a new 'place' meant being identified as 'black' at all times.

The Rumbalara Football Netball Club was highlighted as an extremely positive development in the community's social development. It is a place where people feel accepted, together and comfortable. One participant mentioned:

I wouldn't want to play at another footy club... We got offered money everywhere, no one's took it. We all want to play together, stick together... We can have fun without... getting high... There's not the same vibe [at other clubs]. Rumba offers a vibe.

Another participant spoke of the club as keeping 75–80 per cent of players away from drugs and alcohol, as well as helping with racism. Other participants spoke of the role of the club in developing leaders and role models. The club's Healthy Lifestyle Program has had a major impact in connecting Kooris with a local gym to pursue fitness—from a handful a few years ago to now about eighty participants.

⁴ In the context of the focus groups participants spoke about shame primarily from a negative perspective. However, shame can characterise a number of mixed emotions, usually felt all at once, demonstrating feelings of ill comfort for Aboriginal people to have a focus on them, good or bad. Humility partly describes this feeling.

As one participant said, 'That would be the first time that so many people are accessing the gym and that's marvellous!'

It was also recognised that many more 'places' such as the football netball club should be established to provide opportunities for fitness, social participation and being able to feel good about oneself, again with gender appropriateness of these places a significant consideration.

Relationships with the mainstream

The poor relationship between the Koori and mainstream communities was repeatedly raised as a deeply felt issue both at an individual and institutional level. At the individual level, experiences of racism provide an ongoing and profound impact on identity and self-esteem, with particular sites, such as school, frequently discussed. Poor service delivery and neglect of duty of care towards Aboriginal people by mainstream services was seen as compounding existing, deep-rooted social and health problems. These issues were talked about in terms of historical experiences of the Koori community, namely dispossession and colonisation, subsequent loss of traditional cultural practices, ongoing discrimination, the poor understanding of these issues by the mainstream community and the ongoing intergenerational effects that arise from all these factors. On the positive side, participants spoke of the benefits of associating with white people (for example, self-confidence, obtaining 'employment) and the strong desire to maintain relationships and friendships with non-Aboriginal people and to be part of the broader society'.

Racial discrimination: There were numerous stories of racial discrimination at school in many of the groups, and this was believed to be a significant contributor to low self-esteem in young Kooris. Many participants saw education as the first major attack on Koori identity; they talked about getting 'picked on' at school for being black and some teachers 'write you off' as a 'useless blackfella'. Some participants spoke of being expelled from school after physically confronting racist remarks from peers. Such racism was also seen as structurally entrenched, with some teachers employing racist language and the misrepresentation of history. Participants talked about Kooris engaging in physical confrontation because

of their lack of confidence to express themselves in words. Some participants acknowledged that 'we've got teachers out there that do a wonderful job', but they run into trouble with not having the skills to deal with kids with behaviour problems. Relationships with police were also identified as a critical issue, with a strong belief that groups of Koori youth (and Koori people generally) are targeted because of their colour. One group spoke of family socialisation processes that instilled fear in young Kooris towards police because of historical experiences of discrimination. Workplaces were also identified as other sites of significant discrimination.

While much of the discussion spoke about personal experiences of racism, there was also a strong focus on racism at the *institutional* level. A common element of these stories was the need for the mainstream to develop a better understanding of issues affecting Koori people, as well as the need for mainstream services to better meet the needs of Koori communities. Issues within these stories indicated that many mainstream organisations were ignorant of the complexities of Kooris' concerns and fundamentally failed to address important issues, for example, the failure of the law and support services in dealing with sexual abuse issues. Participants also spoke of the failure of mainstream services to approach the community about how it could best meet their needs. In fact, the opposite was identified, whereby mainstream organisations were asking clients if they were Aboriginal or Torres Strait Islander and, if so, redirecting them to Aboriginal services.

History and its intergenerational effects: At the core of these discussions about the ineffectiveness of mainstream institutions is a lack of understanding of Koori history and the trans-generational impact that issues such as dispossession, the stolen generation and ongoing racism and social exclusion have on Koori individuals, families and communities. As one participant stated, 'Nothing has changed in the last 200 years... They're not looking at the issues, addressing the root of the problem [white people's attitudes].' Problems with substance misuse and the normalisation of these practices in some families were identified as evidence of intergenerational trauma. The ineffectiveness of services and interventions contributes to the maintenance of these patterns. As one person stated:

Lack of... self understanding, self awareness or self respect, or self love... As Aboriginal people we've been so devalued for generations and generations that it's ingrained in us, it's like something that's born in us when we're born... it's a way of life.

While all participants acknowledged their communities' responsibility for addressing these issues, they also saw the wider community as being equally responsible for improving their health and wellbeing. As one participant surmised:

You paint a house with rotting boards... six months down the track you've got to paint it again because the boards are still rotten and its showing and no amount of paint is going to fix it. And I think what the government is doing is painting rotten boards.

Trust: The cultural gap arising out of lack of knowledge and understanding by mainstream institutions and individuals, and the practical ramifications that this has for Kooris today—for example, poverty making affordability a key issue in accessing health care—contributes to an often extreme lack of trust by Kooris towards mainstream professionals and services.

They [doctors] don't understand, they don't want to understand or if they want to understand they still can't get their head around where the problem's coming [from]... [Their approach is] just deal with it, snap out of it, it's all your fault... [but] it's about your history... it's about your experiences from the past as to whether or not you feel comfortable approaching a health professional in the mainstream and more often than not you don't feel comfortable... and then you got to pay half your family's food bill on top of that for the honour!

One woman spoke of the enormous time and effort it took her to build a level of trust with a particular doctor and that 'there's so many doctors and none of them particularly want to deal with Aboriginal people... [Trust] is a huge, huge issue.' Like racism, distrust was also reflected at an organisational level—in one example it was felt that mainstream services consistently ignored the community report that had identified the health needs of the community: 'We use that document for submissions and partnerships, some which work, some not. Mainstream just stick it on the shelf.'

Discussion

This exploratory research has highlighted that health and its determinants in Koori communities is complex. Understandings of health are not simple but multi-layered and multi-faceted. Individuals and families are affected by the historical, spiritual, political and social issues, as well as the physical and psychological. Therefore, participants in this study suggested that poor Aboriginal health was

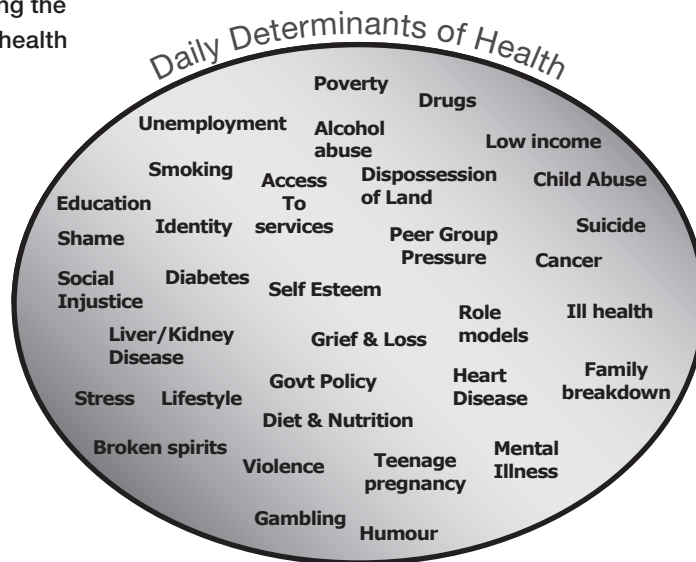
due to behaviours, racism, history and a range of factors, none separable from the other. Viewing health in this way means that actions to improve health are complex, if not overwhelming. While a range of health conditions and illnesses was mentioned, discussion moved quickly from these specifics to broader issues of community life, history, lack of resources and opportunities, racism and marginalisation. Health was closely associated with relational concepts such as self-esteem, shame, role models and identity. All the themes and sub-themes identified were also interrelated; stress, self-esteem and trust were seen to be symptoms of dispossession and racism. Similarly, despite the criticisms of the education system, no focus group sought to place blame solely on white teachers or the system, noting that 'we don't lift the bar high enough for ourselves so why should we do it for our kids' and that there was often a lack of family support to do well at school.

Daily realities

Health was not separated from racism, land rights, dispossession, lack of an apology or treaty, and loss and grief. Many stories were told about community members facing a range of issues simultaneously and the interrelationships between psychological, cultural, political, social and spiritual factors that all contributed to the cause and continuation of the issue: 'Aboriginal people... we are trying to fight an uphill battle dealing with our own family's issues and our own personal issues and our kids' issues.' For example, respondents talked about drug and alcohol use as an escape from socio-economic disadvantage, racism, deaths in the community and family issues and that the use of substances lead to unplanned pregnancies, poor diet, loss of traditional cultures and inability to address these issues. Smoking was acknowledged as a major issue; however, in the context of the Koori community there was a strong view that quitting smoking is simply not a priority for most Kooris—there are far too many more immediate concerns. Micro- and macro-level problems were combined and all manifested themselves simultaneously in the experiences of daily life. It is this interrelatedness and immediacy of issues that has led the authors to identify the complex *daily realities* as central to an understanding of Koori health.

These communities were not found to be ignorant about health and wanted more health information, identifying a readiness for change. However, having a myriad of inseparable issues confronting individuals and families constantly means the focus becomes coping here and

FIGURE 1: Conceptualising the Aboriginal experience of health



now—long-term health prevention cannot be acted upon. For example, faced with a lack of financial resources, the need for employment, physical health issues, emotional health issues, poor housing, social isolation and marginalisation from the mainstream community, how realistic is it to expect someone to diet or undertake a fitness program because they are ‘at risk’ of diabetes? After the third handout, one respondent stated, ‘Really, looking at this, it’s a wonder we are still sane!’ Similarly, another person commented that ‘the thing that has stopped us going off is our sense of humour’ and everyone agreed.

Therefore, this paper has found that Koori families face upstream and downstream factors daily, an issue not addressed in the models of social determinants discussed earlier in this paper. The pressure to deal with so many issues simultaneously results in lack of attention to biomedical health. It seems that Aboriginal people experience health in a way that could be depicted by placing all these factors chaotically in one circle, with the individual and their family at the centre (see Figure 1). No one factor can be separated from the other, hence prioritising issues and simply dealing with all the issues presenting simultaneously is easily overwhelming. Understanding the social determinants of health, then, is about understanding

the stories, experiences and daily life of individuals, families and communities that negotiate these many co-existing determinants daily. This highlights the importance of mental health, self-esteem and coping if one is to achieve positive health, but the intergenerational and community focus of health for Kooris means that these cannot be ignored, processed or easily addressed. Understanding this daily negotiation is a first step to addressing health from a holistic, empathic and Koori-led approach. Further, changing the marginalisation of Koori people, as exemplified in the lack of understanding and ignorance of history by the mainstream, is at the core.

While this model is based on a small sample in one area of the country, it questions the appropriateness of previous models of the social determinants of health that imply causes and effects that exist in a relatively linear relationship. It also raises questions as to the ‘content’ of the key social determinants of Koori health and their relationship to established social determinants such as those identified in the mainstream models. The cultural knowledges and social practices of Aboriginal people, including the focus on family/community, the social care of others and the human priorities that differ from Western society, clearly suggest that social determinants models for mainstream Australians are inadequate in the Koori context. It is not surprising, then, that programs in Aboriginal health also need to differ from mainstream programs in order to encapsulate the understandings of those using such programs.

Policy implications and conclusions

The emphasis on health education and wanting more health information at one level clearly indicates that Aboriginal people have embraced the importance of physical health. The identification of illnesses as important health factors, along with the need for bulk billing and adequate medical services, suggests that physical health and medical treatment is very important to these communities. This was made starkly clear in communities without an Aboriginal community-controlled health service, identifying detailed negative impacts on members of not having such a service. While this paper highlights the complexity in establishing a coherent vision for addressing the social determinants of Koori health, it also highlights the ongoing tragedy of the current response to Aboriginal health in the lip service paid to adequately addressing the 'surface manifestation' of poor health in the form of equitably funding Aboriginal primary health care services (see Deeble *et al.* 1998; Mooney 2003). The ongoing need for Aboriginal community-controlled health services to be at the centre of such primary healthcare provision is emphasised by the focus groups' litany of examples of the inability and/or unwillingness of mainstream services to effectively engage with the complexity of Aboriginal health. It is probably only with an adequately resourced community-controlled sector that an effective institutional base can be created to advocate for appropriate accountability of mainstream services to deliver on their responsibilities to Aboriginal people.

However, another at least equally important theme of the focus groups is that the relationship with the mainstream is far more than achieving equitable access to services—it is fundamentally about the relationship between Koori and mainstream societies, and the impact that this relationship has on Koori identity and self-esteem. As one participant said, referring to the negative role modelling in the Koori community:

We just got to break the cycle. We got to go out and mingle [with whitefellas]. Don't be ashamed. And if they do turn out to be rednecks, don't have nothing to do with them, just go and find somebody else...

This plea to be able to participate in mainstream society while maintaining Koori identity in a sense synthesises the multiple responses that refer to the need to address racism in schools, workplaces and other sites of interaction with the

mainstream community. It calls for non-Aboriginal people to be educated and to embrace the true history of this country, suggesting another important area for further research—that of mainstream attitudes to Koori people. As Reid and Tromph (1991:32) identify:

The constant pattern is that whether whites are hostile or well-intentioned, whether they know themselves to be ignorant or believe themselves to be well informed, the 'Aboriginal problem' is the problem of how white people should decide to deal with Aborigines.

Also, central to any further investigations on issues of identity is the centrality of 'place' and how policy can support the establishment of places that promote Aboriginal identity. In doing so, these places meet the social and emotional needs of community members, promote health and provide a basis for equal participation in mainstream society.

This means that the models of social determinants of health discussed earlier, which identify a range of health factors, need to acknowledge that the Koori experience does not separate the different types of and levels of factors. The challenge for social determinants research, then, is to articulate how 'upstream' or 'basic' causes simultaneously articulate on a daily basis with 'downstream' or 'surface' factors, and a range of what appear to be (at least some of) the primary motivational domains of contemporary Koori sociality. The ways in which all these factors blend in the complex negotiation of individual, family and communal identity becomes crucial. The corresponding challenge for government policy and programs is how they will be developed and implemented in a way that will see the simultaneous addressing of these factors in a way that accounts for contemporary Indigenous social reality, recognising that improvement of individual indicators in themselves do not necessarily correlate with better health. Health policies that take as their starting point how self-esteem, shame, role models and gender impact on identity, the vexed issue of Koori/mainstream relations and their interaction with health practices such as drug use are clearly needed. Otherwise, future policies, programs and efforts will be simply more examples of 'painting rotting boards'.

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Appendix

Handout 1: What do statistics say about the health of Aboriginal people?

Life Expectancy

- Life expectancy at birth is 17 years shorter than non-Indigenous Australians.

Death Rates

- Death rates are 2.1 times greater than all Australian men and 2.4 times greater than all Australian women.
- Infant mortality rates (infant deaths per 1,000 live births) are 5.7 for all Australians but 17.9 for Indigenous Australians.
- Death rates from diabetes are 12–17 times higher for Aboriginal people.

Rates of Illness

- Indigenous Australians are between 2.5 and 3 times more likely to be hospitalised.
- Indigenous Australians also have a higher rate of chronic illness, especially Type 2 diabetes, heart disease and circulatory system disorders, stroke and renal disease.

- Up to 30% of Aborigines aged over 35 years have Type 2 diabetes, approximately 4 times higher than non-Indigenous Australians.
- Health problems relating to ear disease, eye disorders, mental illness, substance misuse, and social and emotional problems are also more common.
- Indigenous children have been found to have high rates of asthma, ear and hearing problems, skin problems and chest problems.
- Rates of injury and poisoning are approximately four times higher among Indigenous Australians than non-Indigenous Australians.

Fertility

- Aboriginal women have higher fertility rates, much higher rates of teenage motherhood, higher rates of low birth weight babies, on average 150–300 grams lighter.
- The rate of still-born children is higher as is the rate of low birth weight babies, on average 150–300 grams lighter.

Mental Health in the Goulburn Valley

- 46% of community members have been identified with a mental health problem, 41% of those aged 15–29.
- 14% of community members were identified as suffering acute depression.
- 54% of patients using the Victorian Aboriginal Health Service had evidence of mental health or depression.
- 57% supporting mothers with children were identified as suffering from depression.

Source: Thompson 1998; Deeble *et al.* 1998; Anderson *et al.* 2001; Gray & Boughton 2001; Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; Victorian Aboriginal Health Service 1999; Lancaster, Huang & Plunkett 1996.

Handout 2: According to published research, what characteristics determine the health of Aboriginal people?

Income

- While 25 per cent of non-Indigenous Australians earn less than \$20,000 per annum, 43 per cent of Indigenous Australians earn under this level.
- Similarly 20 per cent of Indigenous Australians earn more than \$40,000 per year whereas 43 per cent of non-Indigenous Australians earn more than \$40,000.
- 14% of the local Koori population earn more than \$350/week compared to 27% of the Victorian Koori population and 40% of the non-Aboriginal population.

Employment

- 30% of the local Koori population are unemployed compared to 28% of the Victorian Koori population and 10% of the mainstream population.
- Aboriginal workers are more likely to be employed as labourers than non-Aboriginal workers (24% and 9% respectively).

Education

- In the 2001 census, 57% of Aboriginal children were students.
- 11% of the local Koori population have completed post-secondary training compared to 20% of the Victorian Koori population and 34% of the non-Aboriginal population.
- 55% of Kooris leave school before 17 compared to 46% of non-Kooris in Victoria.
- Of those 18–24, 10% of Aboriginals are pursuing post-secondary education compared to 28% of non-Aboriginals.

Parenthood

- Aboriginal children are more likely to come from a single parent family.
- Rates of teenage motherhood is well above the same rates for non-Indigenous teenage mothers, 15 per cent in Victoria.

Diet

- Over 60% of Koori people in the Binjirru ATSIC region (including the Goulburn Valley) were overweight or obese, with a further 10% underweight.
- 60% of Aboriginal people aged 35+ have been found to be obese, 75% of women and 51% of men.

Substance Use

- Approximately 25% of those using the Victorian Aboriginal Health Service were identified as using illegal substances compared to 15% of all Australians.
- 58% of men and 30% of Aboriginal women in the Goulburn Valley engage in binge drinking, while 54% and 33% respectively have used marijuana.
- A local study found that 64% Koori adults smoked, almost 3 times as high as the non-Aboriginal population.
- Drinking began in the 12–14 age bracket and about 50% of those 15 to 17 were frequent drinkers.

Source: Alford 2002; Nicholls 1999; D'Abbs & Jones 1996; Ryan & Williams 1997; Victorian Aboriginal Health Service 1999; Winch 1999; Deeble *et al.* 1998; Rumbalara Aboriginal Cooperative & Department of Psychiatry, The University of Melbourne 2001; ABS 1996; Ryan & Williams 1997.

Handout 3: While some work (for example, government reports) claim that the following are important issues related to Aboriginal health there has been virtually no research to back up those claims

Social, emotional and cultural well-being of the whole community

Of those using the Victorian Aboriginal Health Services:

- 20% had been brought up in children's homes.
- 49% had been separated from both parents for significant periods of time during their childhood.

Racism

Of nearly 100 studies done worldwide into the health effects of racism only one has looked at Indigenous Australians.

Self-esteem

Both Aboriginal adults and young people have been identified as having low levels of self-esteem.

Disadvantage/poverty

The Aboriginal population is the most disadvantaged and impoverished group in Australia.

Culture

Some have suggested that there are cultural barriers to seeking health services, seeking health care and living healthy lifestyles.

Stress

Psychosocial stress is currently being explored for its impact on the natural defences of the body to fight off sickness. That is individuals subjected to excessive amounts of stress are more likely to develop physical illness.

Trust

It has been argued that government policy, actions by mainstream people and institutions has consistently undermined Aboriginal people's trust in the mainstream. Further, it is proposed that lack of trust in police, neighbours, government, employers, the education system and the broader community contributes to stress, which in turn can contribute to poor health.

Dispossession

Dispossession from land is thought to be a major cause of poor health.

Role Models

It is the quality of the relationships young people have in their lives, particularly from those they learn from, which can make a difference. Parents, schools, role models and others can provide this.

Source: Sibthorpe 1989; Tynan 2003; Kelly, Hertzman & Daniels 1997; Reid & Tromph 1991; Paradies 2004, personal communication; Victorian Aboriginal Health Service 1999; Mitchell 1996; Hunter 2000.