



Chapter 15: Culture as a Determinant of Aboriginal Health

Michael Morrissey (University Department of Rural Health, Northern New South Wales*)

Rogelia Pe-Pua (University of New South Wales)

Alex Brown (Menzies School of Health Research)

Ahmed Latif (Northern Territory Department of Health and Community Services)

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Introduction

In this scoping chapter, we do not attempt to present a comprehensive literature review on culture and health, since to do so would take much more than could be contained in this chapter (if it could be done at all). Nor do we delve into the intricacies of cultural theory any further than is needed to provide a sufficiently robust conceptual basis for the purposes of this chapter. We also make no attempt to describe in any detail the cognitive and social structures and processes comprising the different cultures that might impact upon Aboriginal health, partly because, as we shall demonstrate later, the current literature provides no basis for such a task; but, also, mainly because of our argument that the static description, categorisation and comparison of cultures, which was the central concern of classical anthropology, should not be our main approach in any case.

This chapter begins by addressing, in an extremely minimal frame, some of the more prominent social science approaches to the concept of culture and also to the question of the link between health and illness, canvassing the sociology of culture, varieties of medical anthropology, cultural explanatory models and culture care theory. This is followed by an exploration of the Australian literature on culture and Aboriginal health, where we will show that there is a virtual absence of systematic theoretical and empirical work in this area. We will also demonstrate that in the rare instances where culture is examined as a health determinant there is a generalised indifference to the theoretical approaches discussed.

The second half of the chapter attempts to suggest how the 'absences' we expose might be remedied. First, we argue that appropriate methodology must be developed and deployed, and in this context we give some examples from the development of Indigenous psychological research in the Philippines and decolonising methodology in New Zealand. Then we suggest a (non-exhaustive) list of areas in which such a methodology might be deployed.

Culture

Culture as social process

At the level of cultural theory, the major points we wish to make are that culture is an elusive concept and that it is impossible to understand *cultural processes* unless they are located in the context of *structures of power*.

Kroeber and Kluckhohn (1952) compiled from an extensive literature analysis no less than 164 different implicit or explicit definitions of culture that had been used by anthropologists. Following this, Williams (1983:90) described the word culture as 'one of the two or three most complicated words in English' and as having three main uses:

- i. a general process of intellectual, spiritual and aesthetic development
- ii. a particular way of life, whether of a people, a group, a period, or humanity in general
- iii. the works and practices of intellectual and especially artistic activity (Williams 1983, p. 90).

A further distinction of immediate relevance is that:

*In archaeology and in cultural anthropology the reference to culture or a culture is primarily to material production, while in history and **cultural studies** the reference is primarily to **signifying** or **symbolic** systems. This often confuses, but even more often conceals, the central question of the relations between 'material' and 'symbolic' production, which, in some recent argument... have always to be related rather than contrasted (Williams 1983:90–91, author's emphases).*

These are crucial distinctions for the purposes of this chapter because the concept of culture has been extremely pervasive in health policy for over fifty years as a vehicle for interpreting the health and behaviour of both Aboriginal people and migrants. Also, as we shall later show, the implied definition of culture in this discourse, almost without exception, has been one that emphasises 'signifying and symbolic systems' as opposed to 'material production'. Moreover, in terms of the three broad usages specified

by Williams, the Australian discourse has leaned heavily to the first and third; and where it has included 'a particular way of life', this has almost always been restricted to the private, familial sphere (e.g. Castles *et al.* 1991).

What this boils down to is that the dominant discourse related to culture in Australia has been one that excises whole areas of the 'way of life'. Thus, dance is culture but the organisation of industrial production is not; cuisine is culture but the organisation of the welfare system is not; and 'traditional' health beliefs are cultural in nature but 'modern' medicine is not because it derives from a scientific paradigm that makes truth claims, which transcend individual cultures.

The complexity of these matters extends even further than this, however, since Aboriginal people generally do not enter these cultural negotiations on equal terms, but as the less powerful party by far. In such a situation it is the more powerful parties that set the limits of what Bourdieu calls a *field* in which what is, and is not, valued cultural capital can be defined according to the interests of the more powerful parties (Bourdieu 1977:70–78).

Worsley's book *Knowledges* (1997) attempts to synthesise Williams's work and that of other theorists in specific cultural contexts. He criticises Williams's use of the term 'cultural materialism' and substitutes a framework of what he calls 'dialectical sociology'. Thus:

one has to say that culture, since it deals in ideas and values, is not material. While material objects certainly exist... we cannot understand what an object from another culture is unless we understand what it means to those who produce and use it.

The opposite, idealist, assertion is equally mystifying: ideas and values do not float about in the air, nor do all of them have the same significance for social behaviour... Social relations, then, have to be looked at in dialectical terms as an interplay between ideas and other kinds of constraints on behaviour, from hunger to social pressures (Worsley 1997:348–9).

Culture, then, is not a static set of beliefs or mores but something that is continually reconstructed through social processes, which involve, among other things, unequal relations of power between the groups participating in these processes. Langton crystallises this point in the context of Australian visual media, highlighting the dynamic and historical nature of culture:

The most dense relationship is not between actual people, but between white Australians and the symbols created by their predecessors. Australians do not know and relate to Aboriginal people. They relate to stories told by former colonists (Langton 1993, quoted in Anderson 2000:429–30).

Thus, in this process of cultural construction, the more powerful participant's definition of the culture of 'the other' is itself an important element, irrespective of its consonance (or lack of it) with any empirical reality. This is not only because it enables the relatively powerful to set the ground rules for what is legitimate or feasible, but also because of its effect in structuring the field in which the self-identity of 'the other' is formed (Karlsen & Nazroo 2002:4).

The preceding argument leads us to an important point, namely that the project of investigating the cultural dimensions of Aboriginal health is not in any way bounded by elucidating the content and practice of *Aboriginal* culture(s), enormous as that task might be. This is because Aboriginal health is deeply affected, not just by Aboriginal culture, but also by the exposure of Aboriginal people to non-Aboriginal cultures and subcultures of various sorts. In fact Aboriginal culture *itself* has been profoundly altered by these contacts (as the history of the last 200 years makes blindingly obvious), and probably continues to be altered in ways that are often not so obvious (see, e.g. Ross 1987; Goodall 1996; Rowse 1990; Bell 2002). This is unarguably true at Williams's 'material' level of culture. Later we argue that it is probably true in terms of 'signifying and symbolic systems' also.

Culture, social science and health

In this subsection we review very briefly some of the approaches through which the social sciences (especially anthropology and sociology) address the culture–health nexus and articulate the concept of culture to the study of health, illness and disease. It should be noted that it is our intention simply to map some dimensions of the field to form a backdrop to our examination of Australian literature. We make no judgments about preferred approaches and neither do we claim that our map is complete.

Medical anthropology

We take as our starting point a *The Lancet* article in which Helman describes the concerns of medical anthropology as follows:

Medical anthropology is the study of how people in different cultures and social groups explain the causes of ill-health, the types of treatment they believe in, and to whom they turn if they do get ill. The scope of medical anthropology also extends to how these beliefs and behaviours relate to biological and psychological changes during both health and disease (Helman 1991:1081).

Specifically, medical anthropology has focused on the widening gap between medical and lay perspectives on ill health, that is, between 'disease' (the biomedical model with emphasis on physiological data, which is seen as more real than social or psychological data) and 'illness' (the subjective experiences of the patient and the meanings that are given to such experiences). The field is also concerned with body image, which concerns the way lay theories of anatomy and physiology may influence how people interpret and respond to physical symptoms. The field is also concerned with the culture of biomedicine.

Political medical anthropology and critical medical anthropology

The field of medical anthropology is monolithic. There are distinct theoretical and methodological schools within the discipline, probably the most important being what is variously known as political economic medical anthropology or critical medical anthropology. The approach of this school has been:

distinguished from conventional medical anthropology, not simply by its scope of analysis but more fundamentally by its priority of embedding culture in historically-delineated political-economic contexts. Accordingly, the relevance of culture is not restricted to ethnomedical conceptions but extends to issues of power, control, resistance and defiance surrounding health, sickness and healing (Morsy 1996:23).

This critical perspective, which dialectically links culture and power relations, has had very little impact in Australia and virtually none in health research. What critical anthropologists and many third- and fourth-world scholars in other disciplines refer to as decolonising methodologies is a requisite for advancing understanding of the social determinants of Aboriginal health.

Explanatory models and the culture care theory

Some important examples of work in medical anthropology that emphasise the culture–health nexus are to be found in the work of Kleinman and Leininger.

Kleinman investigates the reasons for differences in perceptions of health and illness between healthcare professionals and patients, which he interprets by arguing that medical knowledges are socially constructed cultural systems. He uses the concept of explanatory models (EMs) to illustrate the potential conflict that may arise due to different cultural constructions of medical knowledge. EMs refer to 'the notions about an episode of sickness and its treatments that are employed by all those engaged in the clinical process. The interaction between the EMs of patients and practitioners is a central component of health care' (Kleinman 1980:105). 'EMs are responsible for the cultural shaping of clinical reality' (Kleinman & Mendelsohn 1978:320) through the categories and value orientations that patients and practitioners bring to the clinical process.

Kleinman (1980; Kleinman & Mendelsohn 1978) identifies three forms of medical knowledge—EMs that are cultural systems in themselves. Any health situation can involve (a) the EM of the professionals; (b) folk EMs (held by non-professional healing specialists); and (c) popular EMs (held by the patient's family and community). The popular EMs are likely to exert a great influence in the patient's social construction of the health problem, and yet this is the least studied.

The practical implication of the concept of EMs is obvious. Healthcare professionals/workers should show a willingness to understand the folk and popular EMs and work through what the best treatment will be.

But is knowing the EMs enough? Kleinman argues that the healthcare system should focus more on 'healing', rather than 'curing':

*Healing, in one sense, is the sum of the core clinical tasks of the health care system. This implies that it is the cultural system as a whole which heals. This type of healing we shall refer to as **cultural healing** (Kleinman 1980:35).*

Like Kleinman, Leininger's culture care theory aims to 'discover human care diversities (differences) and universalities (similarities) and to use this knowledge to provide culturally congruent nursing care as a pathway to health and well-being or to help people face disabilities and death' (Leininger 1995:102).

Leininger argues that all cultures have their 'secrets' or ways of caring for others at different stages of life, during crises and under different human conditions. This is culture care (Leininger 1995:105). Within and across cultures or collectivities, there are variabilities and/or differences (diversity), as well as commonality and/or similarities (universality) in culture care and the challenge for healthcare providers is to discover what these are and how to use this knowledge to take action. The goal of discovering culture care is to provide culturally congruent and competent care, defined as:

those cognitive based assistive, supportive, facilitative or enabling acts or decisions that are tailor-made to fit with individual, group or institutional cultural values, beliefs and lifeways in order to provide or support meaningful, beneficial and satisfying health care or well-being services (Leininger 1995:106).

The uses of culture in Aboriginal health research

The 'absence' of culture

In this section we review the ways in which the concept of culture has been deployed by health researchers and service providers in relation to Aboriginal people historically, and over the last fifteen years or so.

A good starting point is a comparison of two books published twelve years apart, both designed to provide overviews of the state of Aboriginal health, and research concerned with it. These are respectively *The Health of Aboriginal Australia*, edited by Janice Reid and Peggy Trompf (1991) and *The Health of Indigenous Australia*, edited by Neil Thomson (2003).

The most striking comparative feature of these two books is that the Thomson anthology is much more firmly set within the mode of traditional biomedicine and quantitative epidemiology than the earlier one. The Reid and Trompf volume contains several chapters that employ an anthropological perspective and directly address issues of culture in almost one-third of the total text.¹

Such considerations are virtually absent from the Thomson collection. For example, Altman's (2003) chapter on the economic and social context of Aboriginal health devotes just over half a page to culture, this being mainly a list of factors that keep people out of the labour market. Hunter's (2003) chapter manages a thirty-page review of the literature on Aboriginal mental health in which he utilises the noun 'culture' only twice (pp. 145 & 146) and the adjective 'cultural' three times (pp. 128, 133 & 137). (This would seem a remarkable feat but it probably reflects the material he chose to review fairly accurately.)

The Thomson volume as a whole lists only three index entries for what it terms 'cultural factors' and in this it cleaves to at least one modality in Aboriginal health research, which is either to ignore socio-cultural factors completely or acknowledge their 'importance' and then proceed as if they do not exist.

This is exemplified by the chapter on diabetes, which states that 'diabetes, in a broad sense, is a disease that arises from a web of social and economic determinants' (Irvine, Kirov & Thomson 2003:98). The determinants then go unmentioned for the rest of the chapter except for the startling assertion that:

non-modifiable risk factors include...

- race/ethnicity...
- degree of modernisation or 'Westernisation' (Irvine, Kirov & Thomson 2003:96).

It should be stressed that this comparison is illustrative rather than indicative. It illustrates that it is still possible to write a considerable text on Aboriginal health virtually without reference to cultural factors and still to be seen by many people as authoritative. It would take a much longer and more detailed analysis than we have space for here to establish

that there has been a *generalised* decline in consideration of cultural factors, although the material presented below from Morrissey (2003b) certainly indicates that such approaches still comprise a tiny proportion of the overall research output on Aboriginal health.

There is a very long history in Australia of health researchers simultaneously stressing the importance of cultural factors in interpreting the health of whatever minority group they happened to be studying while totally neglecting any attempt at systematic investigation of the social processes involved. This has been a constant in relation to both Aboriginal and migrant health.

As long ago as 1978, Martin (1978) attempted to assess the way in which the Australian medical system approached the health needs of immigrants by reviewing all the available and relevant literature published since 1945. Of the 118 items reviewed by Martin, the vast majority portrayed immigrants as in some sense importing their problems. Only ten of the articles nominated the inadequacy of Australian healthcare provisions as a problem, and the overwhelming tendency was to stress the pre-migration experience of the immigrant, the migration process or the immigrant's 'culture' generally as being in some sense pathogenic (Martin 1978).

This example has considerable relevance to the subject of this chapter in two ways. First, Martin's description of the migrant health literature in 1978 could well apply to a very large proportion of what has been written about the social determinants of Aboriginal health up to 2004. Second, Martin's review illustrates the argument made above, that in an unequal cultural negotiation it is the relatively powerful participant who interprets the engagement. In the case of material reviewed by Martin, what she called the medical 'definers' of various migrant cultures were able not only to interpret these encounters in ways congenial to themselves, but, by consigning their patients' problems to the realm of 'culture' (as they defined it), were able to place them securely outside the sphere of feasible social or medical action.

The continuities between the 1970s literature on migrant health and contemporary discourses on Aboriginal health are illustrated by Morrissey (2003b), who searched health databases over the years 1990 to 2002 for publications that dealt to any degree with the social aspects of Aboriginal

¹ Gray, A., Trompf, P. & Houston, S., *The Decline and Rise of Aboriginal Families* (pp. 80–123); Brady, M., *Drug and Alcohol Use among Aboriginal People* (pp. 173–218); Reser, J., *Aboriginal Mental Health: Conflicting cultural perspectives* (pp. 218–92); and Mobbs, R., *In Sickness and in Health: The sociocultural context of Aboriginal well-being, illness and healing* (pp. 326–8).

health. From the Health & Society Database he retrieved 433 citations and abstracts, which were searched for:

- use of appropriate social theory as an organising framework for research design;
- discussion of results in terms of social theory; or
- other theoretical discussion beyond the level of assertion (such as 'it is obvious that the health problems of Aboriginal people cannot be understood in isolation from their experience of 200 years of oppression').

This analysis resulted in a mere twenty-eight publications that met the criteria and many others that made theoretical *statements* linking poor Aboriginal health status to various socio-cultural and political factors (Morrissey 2003b).

Whose culture?

In 1991 the report of the National Inquiry into Racist Violence (NIIRV) stated:

Strategies to address the problem of racist violence against Aboriginal people must be linked with policies aimed at improving the status and the standard of living of Aborigines in Australian society... Structural changes are necessary to eliminate institutional racism and to provide appropriate services for the victims of racist violence (HREOC 1991:260, 269).

The report was notable for its insistence that racism was not just a product of individual racist 'rednecks', but that it was deeply structured into 'mainstream' institutions and 'mainstream' culture, a view that historians and social scientists have argued for many years (e.g., Kidd 1997; Hollingsworth 1998; Cowlshaw & Morris 1997; Macdonald 2001).

This emphasis on racism has scarcely penetrated the literature on Aboriginal health. For example, in 2004 an article was published in *Social Science and Medicine*, which advocated a 'life course' approach to the treatment of end stage renal disease (Cass *et al.* 2004). This article was both notable and typical in three main ways. First, the authors, after a fairly extensive bibliographical review of the literature demonstrating the links between what they call socio-economic 'disadvantage' and health, produce a list of recommendations, which is virtually barren of any suggestion as to how these structural inequalities could be addressed.² Second, the *cultural underpinning* of social and economic marginalisation—institutionalised racism—is not mentioned, the clear implication (by default) being that it forms no part of the 'life course' of Aboriginal people. Third, the extent of the authors' engagement with the question of culture is confined to a single paragraph that analyses the cultural aspects of Aboriginal people's interaction with non-Aboriginal Australia entirely in terms of cognitive and linguistic dissonance at a micro, individual level, ignoring the structural and institutional factors stressed by the NIIRV.

In all of this they are not alone. The vast bulk of the (scarce) Australian literature on social gradients in health effectively treats social inequality as in some sense the product of forces beyond the scope of feasible social action. The absences of any attempt to address the issue of racism and the extremely restricted application of the concept of culture, however, are much more immediately germane because they typify important absences in the debate on social determinants in Australia and also because they are heavily intermeshed with each other.

The typicality of this approach cannot be doubted. The Thomson (2003) volume to which we have previously referred contains only one index entry for racism (and even then, the word is not actually used on the page for which it is indexed). More generally a search of the ATSIHealth database under the keyword 'racism' turned up twenty citations only for the past ten years relating to Aboriginal health, in most of which the topic was addressed peripherally only.

Krieger (2003), in reviewing American literature, admits at the outset that 'research on racism as a harmful determinant of population health is in its infancy'. In order to advance the field Krieger (2003:194) sets out to:

² One recommendation, for improved educational participation, may be an exception to this but the authors do not ask how this might be achieved, nor why this need exists in the first place.

address three interrelated issues from the vantage of an epidemiologist guided by an ecosocial perspective (Krieger 1994, 2001[a], 2001[b]): (1) links between racism, biology, and health, including recognition of biological expressions of race relations and racialized expressions of biology; (2) methodological controversies over how to study the impact of racism on health; and (3) debates over whether racism or class underlies racial/ethnic disparities in health.

The really important point of this quotation is that restricting the cultural negotiation between Aboriginal and non-Aboriginal people to considerations of cognitive and linguistic dissonance is a frame that cannot possibly accommodate the sort of questions Krieger is posing. It is also necessary to stress that this is the way in which cultural interaction has almost exclusively been portrayed in Australian cross-cultural health research, both in the Aboriginal and migrant contexts (e.g., Sinnott & Wittman 2001; Vicary & Andrews 2001; Maher 1999, to cite some recent contributions).

An additional dimension is described by Brady (1995) and Muecke (1992) who, among others, have drawn attention to the ways in which 'simplistic and static' notions of culture may form a mental 'prison' for Aboriginal people by being transformed from the 'dynamic present and future of peoples (and not just their past)' to 'a "thing" that you either have or have lost' (Brady 1995:1490).

What do whitefellas 'know' about Aboriginal culture?

We said at the beginning of this chapter that we would make no attempt at *describing* Aboriginal culture(s), but it is necessary to make three broad points. First, the bulk of the existing canon of anthropological/ethnographic work relating to Aboriginal people was produced well over twenty years ago. Second, most of it related, in any case, to social groupings unrepresentative of the way of life of the majority of Aboriginal people even at the time the research was done. Third, Aboriginal societies have changed very rapidly in the past twenty-five years in directions about which the existing canon tells us very little, driven by social forces about which it tells us even less.

The only one of these assertions needing argument is the third, since the other two can be verified easily enough through database searches. If the third needs any argument, let us point to three indicators of rapid social (and hence *cultural*) change since the early 1970s.

The first is the massive alteration in the pattern of age-specific death rates. This, in itself, is likely to have had massive effects on cultural production and reproduction, although the existing literature tells us very little about the nature and extent of these effects.

Second, the legal and social space within which Aboriginal culture can function has altered radically.

In practical, physical and legal terms major changes have occurred since the 1960s: the repressive legislation has all but gone, albeit leaving scars which will take a generation to fade: the system by which Aborigines were minors in law... has ended (Tatz 2001:5).

Third, a massive indicator of social and cultural change is the very subject of the book from which the last quotation was taken. There is widespread agreement that suicide was virtually unknown in pre-invasion Aboriginal cultures. There is also plenty of evidence from contemporary studies to show that Aboriginal suicide was a rarity as late as the mid-1970s (Tatz 2001:24–5).

The point of all this is that before even thinking about some of the paths indicated by Kleinman and Leininger there must be some clarity about what is being responded to at a cultural level. Aboriginal culture, like any other, is not static and Aboriginal people neither become bereft of culture when they 'lose' the traditional, nor are they suddenly transformed into non-Aborigines. Any real attempt to respond to Aboriginal culture must be based on creating a social space in which the lived reality of Aboriginal culture can assert itself over and against the social construction of that reality by non-Aborigines.

In part, as we argue in the next section, creation of this social space necessitates changes in the emphasis and methodology of research, since research has been an important process in the reproduction of relations of inequality. Much more is involved, however, and not the least of this is the self-reflexive admission by researchers that medical research, like any other sort, is a cultural product that often derives from relations of extreme inequality between the researcher and the researched. Unless these inequalities are confronted at the level of research *process*, it is inevitable that they will be embodied in the research *findings* and, to the extent that research findings are embodied in health service practice, in that practice also.

Culture and methodology

General considerations: Biomedicine and Indigenous research methods

Research methodology is often a contentious subject but controversy is not confined to the apparent belief of some medical researchers that the words 'quantitative' and 'objective' are synonyms. The question of methodology has been a major area of concern among Aboriginal scholars and throughout the fourth world for many years. As the Maori scholar Linda Tuhiwai Smith states:

Research is one of the ways in which the underlying code of imperialism and colonialism is both regulated and realized. It is regulated through the formal rules of individual scholarly disciplines and scientific paradigms, and the institutions that support them (including the state) (Smith 1999:8).

For this reason, she asserts, the word itself, 'research', is probably one of the 'dirtiest words in the Indigenous world's vocabulary' and that there is an urgent need for Indigenous people to 'research back' (Smith 1999: 8).

This is a call that is being made by a number of researchers, and to some effect in a number of areas (Brady 1999; Humphery 2001). Currently writers such as Rigney (1999) and Lui and Sherwood (2000) advocate the necessity for theoretical frameworks and epistemologies that reflect and privilege an Indigenous Australian worldview. They also strongly identify the need for respect for alternative ways of knowing or knowledge and, in doing so, continue an argument going back thirty years (see Humphery 2001; WPAHBH 1981; Langton 1981a, 1981b; Langford 1983).

In spite of this advocacy, it cannot be said that this long-running debate regarding Indigenous control of, and benefit from, the research process has had much effect on the conduct of research into the health of Indigenous people. The vast bulk of this research remains fixed in the mode of what McMichael (1999) labels 'black box' epidemiology and biomedical science (Morrissey 2003b).

In other words, elucidating the effects of something as pervasive, complex, ambiguous and changing as culture is a task of a radically different sort from, say, establishing quantitatively the incidence of tuberculosis—and one that makes its own methodological and epistemological demands. For Indigenous peoples, for example, segregating the biomedical from the broader context of the 'lived experience', constructed within the realm of the cultural world, has the effect of abstracting from the totality of causation, and subsequently limits the potential outcomes of interventions that fail to incorporate and accept different ways of knowing.

Adopting a research approach that is appropriate to Aboriginal culture and conditions is essential in elucidating the centrality of culture in health, healing and (particularly) chronic disease and injury. To this end, there are lessons from the field that can be drawn from the experience of Philippine and New Zealand scholars who have 'indigenised' their research methodology to suit Indigenous research.

The Philippine experience with indigenisation

The Philippines has a long history of adopting an Indigenous research approach in the social sciences, spearheaded by an indigenisation (or decolonisation) movement in Philippine psychology that started in the early 1970s (Pe-Pua & Protacio-Marcelino 2000). The Indigenous approach can be described in terms of its informal cultural, formal structure, and technological procedures.

In terms of values and ideologies, Indigenous research recognises knowledge as inseparable from praxis, consciousness, identity and involvement. In terms of beliefs and theories, a multi-method, appropriate and total approach is the way to obtain valid information. In terms of norms and assumptions, the researcher seeks to be one with the group being studied, by way of his/her actions (Enriquez 1992).

In terms of division of labor, the Indigenous researcher and participants work at the level of unity. The researcher uses his/her ability to systematise things, with the participants reconfirming such efforts. In terms of distribution of power, power rests not on the Indigenous researcher but on the culture-bearer participants who provide and determine the scope and limits of research (Enriquez 1992).

In terms of problem definition, Indigenous researchers let the community of culture-bearers define the problems and issues (Enriquez 1992). Data collection follows what is described as a mutual-orientation model, where 'both data collector

and contributor give something to, and gain something from, the data collection' (Viney 1988, cited in Enriquez 1992:61). We can see from the above discussion that Indigenous research challenges the traditional role of researcher and participant. Enriquez (1992) argued that experimental and survey researchers wield a monopoly of power, making them 'research emperors', perpetuating their own interests and preserving the status quo, sometimes at the expense of the powerless Indigenous people. This power relation is modified in participatory research, where researcher and participants begin to share power and status and become co-equal. Indigenous research went a step further—reversing the power role relation (Enriquez 1992).

In unpacking the relationship between researchers and participants in Indigenous research, one guiding principle that emerged is that the level of interaction or relationship between the two parties (whether the researcher is treated as an insider or an outsider, for example) significantly determines the quality of the data obtained. Another principle is that researchers should treat research participants as equal, if not superior—as a fellow human being and not as a 'guinea pig' whose sole function is to provide data. Consistent with this, more importance should be attached to the welfare of the participants than to obtaining data from them. The goal of research is understanding, but not at the expense of the very people from whom this understanding will spring.

It will follow that research methods should be chosen on the basis of appropriateness to the population (and not sophistication of the method) and it should be made to adapt to existing cultural norms. Also, the language of the people should be the language of research at all times.

Decolonising methodologies in New Zealand and elsewhere

Linda Tuhiwai Smith, a Maori researcher, wrote her book *Decolonizing Methodologies: Research and Indigenous peoples* (1999) from a historical background that bears similarity to the Philippine experience of being colonised by foreign powers. The similarity with Australian Aboriginal experience, however, is more pronounced:

... research of Maori is marked by a history that has shaped the attitudes and feelings Maori people have held towards research. Research is implicated in the production of Western knowledge, in the nature of academic work, in the production of theories which have dehumanized Maori and in practices which have

continued to privilege Western ways of knowing, while denying the validity for Maori of Maori knowledge, language and culture (Smith 1999:183).

Smith poses the question, 'What happens when the researched becomes the researcher?': she answers this by describing the ways in which the Kaupapa Maori (Maori-centred) research approach 'has become a way of structuring assumptions, values, concepts, orientations and priorities in research' (1999:183). Kaupapa Maori research –

is related to 'being Maori'; is connected to Maori philosophy and principles; takes for granted the validity and legitimacy of Maori, the importance of Maori language and culture; and is concerned with 'the struggle for autonomy over our own cultural well being' (summarised by Graham Smith 1990, cited in Smith 1999:185).

The Maori experience shares a strong resemblance with Philippine Indigenous psychology experiences in terms of identity politics. The question of 'who has/have the right to determine the Indigenous research agenda and conduct research—the Indigenous or the non-Indigenous?' is always a sensitive one. In both the Maori and the Philippine contexts, the answer leans towards participation of both, for as long as the Indigenous orientation is upheld.

Both approaches also promote rigour and ethics in research, accountability to the people, 'giving voice' to the Indigenous, and bringing that voice back to them through reporting back and acting on the voiced concerns and issues.

In concluding the discussion about methodology, we need to clarify that we are not arguing that these are the only approaches that have value. Biomedical science has many indisputable achievements; and, in any case, we maintain our position that the field of culture in Indigenous health has more than one occupant. Understanding the role of culture in Indigenous health is as much a matter of critical understanding of 'white' cultures as it is of understanding Aboriginal culture. In this task we argue for *an end to the privileging* of quantitative and experimental approaches, but not for their *discontinuation*.

Paths forward

In this last section we indicate some areas where we feel research and action is needed. We have restricted ourselves to a few areas where we feel that cultural factors are centrally important, areas in which we are particularly engaged. In other words our objective is illustration rather than exhaustive listing. There are plenty of other fields needing systematic research, which could be added to what follows.

It will be observed that throughout this chapter we have stressed the absence from Aboriginal health research of disciplined, theoretically informed study of the culture–health nexus and the attendant questions of racism, power, subordination and exclusion that this would entail. Research alone will not resolve these issues, nor will research alone even show how they *might* be resolved. This will only be achieved through political and social processes, which research may assist with or impede, as a great deal of it already does at present. The main thrust of this chapter has been how it might do the former rather than the latter.

At the level of service provision, the challenge is to design structures that would permit the expression of cultural diversity and an aware incorporation of this into the services offered. The philosophical basis of this would be that mechanisms are provided to empower the Aboriginal people and the communities they come from in the sense that they should have the means to make healthcare professionals aware of the *actual content* of their lived reality. Thus, instead of the service provider relating to Aboriginal people on the basis of some real or imagined prior knowledge of their culture, the service itself should be structured so as to build-in sensitivity to culture in process, and also sensitivity to the complex interrelation between ethnicity, gender, social class and factors unique to or associated with particular localities. This *cannot* be achieved without confronting the realities of power and control; without which a mountain of good (whitefella) intentions and an ocean of cultural-awareness training will remain ineffectual.

Comparative health service research

In most developing countries with diverse, multi-ethnic population structures, health systems have developed that reflect the social and cultural characteristics of the different population sub-groups. In the developed world, health systems in countries with a multi-ethnic population mix have not reflected sub-group cultural sensitivities. This is apparent in Australia, the United States of America, many European countries and, until recently, in the United Kingdom, as well, and was also true in many African countries prior to independence. While the technically advanced countries have provided very high quality of care in the private and public sectors and have implemented all the latest advances in medical technology and knowledge, the developing countries and the newly independent countries, all struggling with weak economies and low levels of industrialisation, have strived to provide health services that have addressed cultural sensitivities for the main ethnic groups in their countries. In so doing, developing countries have led the way in health delivery systems and have also guided global policy. In Australia, however, the most disadvantaged sector of the population, Aboriginal people, has been affected by the indifference displayed in health service provision (Lush, Walt & Ogden 2003; Ogden, Walt & Lush 2003).

There are many examples of successful implementation of healthcare delivery programs that have incorporated cultural norms and sensitivities. Such examples come from countries in Sub-Saharan Africa, India, Latin America and the Middle East, where there are instances of high-quality and culturally appropriate healthcare, in spite of prevailing and acute resource shortage. From many possible examples we refer to studies of HIV/AIDS prevention in East Africa (Willms, Chingono & Wellington 1996; Sewankambo, Spittal & Willms 2001), public health practice in Kerala (Kutty 2000) and primary healthcare in Cuba (Waitzkin, Wald, Kee & Danielson 1997).

Mental health research

In mental health research, culture has been accepted as an essential element of an individual's lived experience, is a critical consideration when assessing mental state and emotional wellbeing, and has been integrated within health service development and delivery in some countries (Durie 2001).

Understanding the expression, determinants and consequences of mental ill health is of the utmost importance to understanding the experience of disadvantage for Indigenous peoples. Aboriginal people throughout Australia suffer a disproportionate burden of mental illnesses and social and emotional wellbeing problems (SHRG 2003). Racism, stigma, environmental adversity and social disadvantage constitute chronic, perpetual causes of stress among Aboriginal communities, and, as such, have ongoing effects on the mental health and wellbeing of individuals. Factors contributing to the higher risk of mental illness and higher rates of grief, loss and trauma are complex and wide ranging. Erosion of family and community social structures through past policies leading to forced separations and undermining of traditional roles within families are likely contributors. The costs of ongoing social disadvantage, frequent premature deaths, high rates of suicide, injury and violence, and high rates of imprisonment, family violence and social dysfunction are important issues that must be considered as potential causes and consequences of a range of mental illnesses and social and emotional wellbeing problems faced by Indigenous peoples.

In comparison to the lack of representative mental health data in Australia, there is a wealth of data available from New Zealand and other parts of the world that shows that the mental health disparities experienced among minority groups defined by ethnicity are growing (Durie 2001).

Since at least 1974, the rates of first admissions for mental illness have been higher among Maori than non-Maori, and have continued to increase. Maori patients also exhibit different needs, receive different diagnoses, enter hospital through different referral mechanisms, and are more likely to re-admit (Durie 2001). Maori patients have also demonstrated poor treatment responses, are more likely to receive a misdiagnosis, and lack access to appropriate community care (Kokiri 1996).

One potential explanation offered by Durie is that the higher rates of mental illness among Maori are a result of 'cultural bias, if not frank discrimination' (Durie 2001:22).

The misapplication of diagnostic criteria because of cultural barriers is one element of cultural bias. Professionals tend to interpret patient presentations according to their own values and beliefs and, as such, are open to misinterpretation, misdiagnoses and, as a consequence, mismanagement. Culture can similarly impact on the way in which an individual experiences, processes and manifests symptoms, and, as a result, the manner and stage at which the individual presents for assessment and care.

In essence, to ascribe diagnostic relevance to predominantly Western 'voices' of the manifestations of various illnesses does so at the risk of excluding the important role of culture in illness expression and, subsequently, places groups of cultural minorities at risk of substandard and even harmful treatment or non-treatment on the basis of culturally dominant perceptions. Theories, explanations, assessment and treatment that deny the importance of culture, cultural norms and expressions of illness and wellness deny the centrality of culture to Indigenous people's everyday lived experience. They undermine and reject Indigenous worldviews of health as the outward manifestation of spiritual, social, emotional, physical and cultural realms. And they place an already disadvantaged population at risk of further adversity and poor outcomes in interactions with modern institutions of health and social services.

Racism and identity

We have already alluded to the importance of instating racism as an urgent field of research in relation to Aboriginal health, but a holistic approach to this topic would involve the relationship between racism and identity (see Karlsen & Nazroo 2002).

Durie argues, 'Identity is a pre-requisite for mental health, and cultural identity depends not only on access to culture and heritage but also on opportunity for cultural expression and cultural endorsement within society's institutions' (Durie 2001:54).

Understanding what constitutes an 'Indigenous identity', how this is constructed through cultural practice and meanings, its self-construction and structural or societal construction, and the effects this can have on health and interactions with social institutions remains under-explored in the Australian setting. The development, transformation and maintenance

of 'Indigenous identity' is complicated by rapid changes in perceived and acted roles within community life and the broader society, and by the contribution of identity from both within the individual and from external forces. As outlined by Wenitong (2001), in relation to Indigenous male health:

The effects of colonisation have brought about stress, a sense of worthlessness and burden on the lives of Aboriginal people through introduced policies, destruction of societies and the restriction of identified traditional roles. It is essential to include these issues when attempting to address the health of Indigenous men (Wenitong 2001).

Despite an awareness of these issues in relation to the health of Indigenous males, little data exists on Indigenous constructs of masculinity, contemporary and traditional views of male identity, and their impact on health (Wenitong 2001).

The issue of identity as a determinant of health also covers the potential implications of conflict that can be created when individuals are placed in a process of transition between traditional and contemporary life.

People increase their sense of control over what is happening in their lives, when they define their own experience and situations in their own terms... Empowerment grows out of self-definition... It is harmful for outsiders to define the issues Anangu face today; whether it be called policy or planning. Sadly, many who undertake such responsibilities, do so because they want to help. They do not understand what they also take away (HALT 1991:1).

Incarceration

Overall, Indigenous people (predominantly males) are about sixteen times more likely to be incarcerated than their non-Indigenous counterparts (ABS 2002). A cluster of issues surrounds the issue of incarceration, all of them poorly researched and most of them having strong linkages to questions of culture. To name only a few:

- the health status of incarcerated people, including mental health;
- the effects of imprisonment on family formation and maintenance;
- the effects of imprisonment on cultural maintenance and transmission, including gender role models (particularly male); and
- the effects of imprisonment in perpetuating the cycle of poverty and exclusion from the labour market.

Poverty, unemployment, psychological ill health, poor education and lack of opportunity are important contributors to the high levels of dysfunction within Indigenous communities. The manifestations of dysfunction (such as anti-social behaviour, crime, violence, self-harm, substance misuse) are important causes of separation between generations of males. It follows that separation itself can serve to further break these important links, and perpetuate the high levels of ill health experienced by successive generations of Indigenous males. Thus separation can be seen as not only a result of dysfunction and ill health within communities, but as a direct cause of dysfunction itself.

Employment

Unemployment is certainly not something that is essentially Aboriginal at a cultural level. In the broadest and most profound sense, however, it is deeply cultural in nature, one of the most salient features of the cultural negotiation between Aboriginal and 'white' Australia.

Unemployment has consistently been shown to be associated with an increased risk of death (Kaplan & Keil 1993) and has been noted to be associated with higher rates of behaviours that increase risk for a number of physical illnesses, such as smoking, harmful alcohol use, poor diet and physical inactivity (Gerdtham & Johannesson 2003).

Unemployment is often quoted as a key determinant of the health disadvantage faced by Indigenous people, but it has rarely been explored in detail. Unemployment can impact on self-esteem, self-worth, and identity and, thus, on health and wellbeing. The valuable contribution of employment, as a process by which a person's identity and self-worth are often determined, has been undermined by the lack of any real opportunity for meaningful employment in remote communities. These impacts are compounded by the effects of loss of income and by poverty.

Employment itself is additionally problematic for Indigenous people, however, even (or particularly) when earning a good income. There is no convincing evidence of an income-related health gradient *within* the Indigenous population, although there is admittedly a paucity of convincing research in this area. In the absence of such research, however, there are reasons to suspect that there may be factors at work that inhibit the emergence of an income-related health gradient, such as a functional relationship between the size of the income unit and the income level of the main earner, and this may be a product of obligations (in particular income unit size) increasing with income (Hunter 1999; Morrissey 2003a). Also, the pressures on Aboriginal employees in 'white' organisations to speak for all Aboriginal people and to be instant experts on all Aboriginal issues is (anecdotally) the source of a great deal of unhealthy stress, although there is no systematic research on this topic.

The nature of work is also an issue requiring structured and careful thought. The number of Indigenous people employed within sectors of the labour market responsible for the delivery of services to countrymen and women—health, social services, welfare, non-government organisations, charitable institutions, prison settings, drug and alcohol services, and community controlled services—is not an insignificant number. This, then, exposes Indigenous employees to repetitive psychological stress and strain, dissatisfaction with institutional policy, practice and outcomes, frustration with inflexible rules and, above all, continual lack of headway in terms of alleviating the disadvantage of other Indigenous peoples. These are often frustrations felt, lived and repeated at a very personal and profound level for Indigenous peoples within the construct of their family and community, social and cultural worlds.

Concluding remarks

This chapter probably only ripples a section of the surface of a very large and very deep pond. Nevertheless, we hope it provides the basis for discussion about the way forward on a very important set of issues. There is no clear map in relation to this way forward, even in theory. This is because the social processes to which we draw attention are dynamic, shifting and interrelated—also, because the methodological innovations we propose involve a great deal of 'learning by doing'. This chapter, in short, is a series of questions rather than a set of answers.

Nevertheless, we *do* make one firm proposition: that until Aboriginal health research engages with social and cultural process in appropriate ways at both the theoretical and methodological levels, we have no prospect of understanding (and less still of *altering*) the social determinants of chronic disease and injury among Aboriginal people. The big question is how we learn collectively to integrate the social with the biomedical.

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