Health gaps in the indigenous culture

Introduction

This assignment will be focusing on indigenous culture and their health. A national strategy ‘ Closing the Gap’ will be initially summarised to explore the current gaps and the plans that have been taken by the Australian state and federal governments. The health issues of indigenous Australians will be reviewed in comparison with the non-indigenous population, which will include a discussion about how the European settlers are considered to have contributed to the current health and psychosocial concerns of indigenous people. Additionally, the health of indigenous Australians will be compared with other indigenous groups in the world. Finally, health promotion strategies initiated by the governments to improve indigenous health outcomes will be identified and additional interventions will be proposed.

Closing the G ap Campaign

Although Australia is considered one of the richest countries in the world, indigenous Australians continue to suffer systematic inequalities and can expect to live 10-17 years less than non-indigenous Australians (Australian Human Rights Commission, 2014). In 2008, a formal apology was made to indigenous Australians and the Government acknowledged, recognised and apologised for their past wrongdoings and committed to taking further steps for indigenous health equality (Australian Government, 2009). This is known as the Closing the Gap Campaign. The goal of the Closing the Gap Campaign is to close the health and life expectancy gap between Indigenous and non-indigenous Australians within a generation. The Australian Governments committed to working towards reaching six targets to reduce the visible gaps

in life expectancy, infant and child mortality, childhood education, literacy and numeracy skills, school completion rates and employment rate (Commonwealth of Australia, 2010). The Governments have implemented strategies to the recognised areas, or the Building Blocks: early childhood, schooling, health, healthy homes, safe communities, economic participation, governance and leadership. Also, a report is being published annually on the progress that Australia has made towards this national objective.

Morbidity and Mortality

In 2006-2010, the mortality rate for indigenous Australians was 1. 9 times greater than for non-indigenous people across all age groups. Approximately 50% of indigenous people reported having a disability or long-term health condition and hospitalisation rate for indigenous people were 40% higher than other Australians (Commonwealth of Australia, 2011)

Babies born to indigenous families were twice as likely to be of low birth weight compared to non-indigenous babies, in 2005-2007. The death rate of indigenous infants and children is double the rate of non-indigenous infants. Maternal mortality rates for indigenous women were 2-5 times greater than for the non-indigenous women (Australian Institute of Health and Welfare, n. d).

In 2008, 32% of young adult indigenous people (aged 16-24 years) reported having high levels of psychological distress, which was 2. 5 times the rate for non-indigenous people (Commonwealth of Australia, 2011). Moreover, indigenous young adults died at a rate 2. 5 times as high as that of the non-indigenous population. For adults aged 35-45, the death rate was 6-8 times

higher than the national average (Australian Indigenous Health *Infornet* , 2013a). It was estimated that 12. 4% of indigenous people aged over 45 years have dementia, compared to 2. 6% of non-indigenous people in that age group (National Aboriginal Community Controlled Health Organisation, 2012). Around 44% of older indigenous adults reported their health as poor and the mortality rate in aged indigenous population is doubled the non-indigenous rate.

Health Issues

For many thousands of years before European settlement in1788, indigenous people enjoyed good health and harmonious existence, relying on a hunter and gatherer life. Connection to the land is fundamental to indigenous wellbeing and the core of all spirituality (Aboriginal Heritage Office, n. d.). Both men and women participated in hunting and they sourced food from the water, hinterlands of the area and the surrounding bush. Since European settlement, indigenous cultural heritage has been broken and indigenous people have experienced disadvantage in aspects of living standards, life expectancy, education, health and employment (Australian Government, 2009).

Outcomes for education, employment, income and housing are much poorer than that of non-indigenous people (Australian Indigenous HealthInfornet, 2013a). During the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (Australian Bureau of Statistics, 2006), around 12% of indigenous people reported having long term cardiovascular diseases and this rate was 1. 3 times higher than non-indigenous. Many indigenous people

experience significantly higher rates of cancer, diabetes, psychological distress, renal disease and respiratory disease than the national average.

Influence of Non-indigenous population

European settlement has had a devastating impact on indigenous health and psychosocial wellbeing, which can be traced back to the beginning of colonisation. In the time following settlement in 1788, 10 million people have arrived in Australia and made it their home (National Museum Australia, n. d.). In this time, many of the natural resources were affected: fish supplies were depleted, native animal population were reduced and feral animals introduced, land was cleared and waterways were polluted. It is believed that many infectious diseases, such as measles, smallpox, influenza and tuberculosis, were introduced by the new settlers (The Fred Hollows Foundation, n. d.). These diseases caused major loss of life among indigenous populations and resulted in depopulation and social disruption. Direct conflicts and occupation of indigenous homelands meant that indigenous people lost control over many aspects of their lives. This loss of autonomy affected the capability of indigenous people to adapt to changes, which would eventually have consequence in poorer health status (Australian Indigenous Health *Infornet* , 2013b).

From the time European settlers first arrived in Australia, they had attempted to ‘ civilise’ the ‘ black races’. The Native Institution was designed to educate indigenous children in the European way; the policy of ‘ protection’ led to indigenous people being placed on government reserves or in church missions; the policy of assimilation forced indigenous people to live

in the same way and hold the same belief and values as the white Australians; many children were forcefully taken away from their families and placed in institutions or white families (Australian Museum, 2009). The children were brought up in Christian way, taught in English and raised to think and act as ‘ white’.

‘ Civilisation’ led to a loss of identity and resulted in cultural and traditional practices being destroyed, families bonds being disconnected, and the whole communities being dispossessed.

Dispossession of traditional lands caused loss, emotional distress, trauma and separation and meant that indigenous people were not able to hunt anymore. (Rowena Ivers, 2011). Indigenous people faced discrimination in education and employment (Northern Territory Department of Health, 2007). People became more dependent on welfare and allowances and rations were paid for laboured work. This led to a change of eating habits.

Traditional food were less encouraged and rations and communal feeding were broadly available and convenient (Northern Territory Department of Health, 2007). Under the influence of rations and communal feeding, a transition of meal patterns from traditional diet to ‘ westernised’ food has happened. Contemporary indigenous people may not want to resume the traditional hunter lifestyle or they may have lost the skills to hunt. The community store became their only food source. The community store usually stocked a very limited selection of food and popular foods are tinned meat and fruits, biscuits, tea, flour, sugar and tobacco. Fresh fruits and vegetables are less available in stores.

Indigenous people began smoking when they were paid in tobacco rather than cash. The use of tobacco, alcohol and illicit drugs increases the risk of chronic disease, cancer, as well as other health concerns, such as mental disorders, accidents and injury (Australian Indigenous Health *Infornet* , 2013a). Decreased levels of physical activity, less consumption of traditional diet and overeating of high energy foods are risk factors for non-communicable disorders, such as cardiovascular disease, cancer, diabetes and respiratory diseases.

Australian Indigenous vs. Worldwide Indigenous

Indigenous people are the traditional custodians of the land they have inhabited for thousands of years. There are approximately 370 million indigenous people worldwide, living in more than 70 countries (World Health Organisation, 2007). Despite the great diversity of indigenous peoples, many similarities exist between Australian indigenous and other indigenous groups.

Traditional indigenous people rely on their land for survival and traditional life is linked to the land. Common to many indigenous groups, colonisation negatively affected their physical, emotional, social and mental health wellbeing. Colonisation led to racial prejudice and dispossession of traditional lands which often cause poverty, under education, unemployment and increased dependency on social welfare. The changes of lifestyle caused severe inequalities in indigenous heath status, including emotional and social wellbeing (World Health Organisation, 2007).

Overall, they experience poorer health compared with non-indigenous groups. Their health is associated with a range of environmental and socio-economic factors: poverty, malnutrition, overcrowding, poor hygiene, environmental contamination, and infections (United Nations, 2009). Indigenous people had little natural immunity to microorganisms that were introduced to the land. The devastating infections depopulated indigenous groups.

Child health is influenced by inadequate nutrition, exposure to infectious diseases and poor living conditions. Childhood health complications are common in Australian indigenous groups as other indigenous groups elsewhere: low birth weight, skin infections, ear disease, dental caries, trachoma, parasite infection and respiratory infections. Although some diseases are prevalent in specific areas, the causes are similar: poor hygiene, malnutrition or water contamination.

Many indigenous groups both in Australia and elsewhere do not have access to their traditional food and are highly dependent on commercially prepared food. Indigenous adolescents in Australia and other countries experience similar health related problems, such as tobacco and drug use, violence, mental and emotional disorders (Northern Territory Department of Health, 2007). Urbanisation causes rapid changes to indigenous lifestyle, foods high in calories, fat and salt and low in fibre. People live in an overcrowded and unhygienic environments and having less physical activity. The worsening of lifestyles has resulted in chronic diseases, such as obesity, hypertension, cardiovascular disease, type 2 diabetes and chronic renal disease.

Australian indigenous people in 2001-2004 had the lowest life expectancy for both male and female, compared to indigenous groups from New Zealand, Canada and USA. They also had the highest infant mortality rate and lowest birth weight. When comparing the age standardised mortality rate in 2003, Australian indigenous groups have the highest mortality rate for cancer, cerebrovascular disease, intentional harm, diabetes and HIV.

Health promotion strategies

The Australian Governments have implemented a range of initiatives across the states during 2009 and up to 2014 By recognising the areas that needs to be improved that include improvements to early childhood, schooling, health, healthy homes, safe communities, economic participation, governance and leadership. Delivery of health promotion programs is guided by principles that ensure all programs meet the targets of the Closing the Gap while being appropriate to the communities’ needs. All programs have to engage the local indigenous people and should be time sufficient and accessible to all indigenous residents (Council of Australian Governments, 2009). All initiatives are related to the Building Blocks and best practice has been sought.

For example, according to the latest Closing the Gap Prime Minister’s Report 2013,

health attention has been focused on implementing health promotions in the following areas that considered could facilitate achieving the goal of closing the gap in life expectancy and child mortality between indigenous and non-indigenous Australians. Areas such as chronic disease, primary health care,

health service, food security, oral health, ear and eye health, acute rheumatic fever and rheumatic heart disease, substance misuse, Foetal Alcohol Spectrum Disorders, indigenous sexual health, mental health, aged care, sport and recreation, culture, remote airstrips and road safety (Department of Families, Housing, Community Services and Indigenous Affairs, 2013). Comprehensive strategies have been undertaken to encourage people in communities undergo health checks, provide training of healthcare workers, deliver education on lifestyle change and self-management, provide affordable medicines and fund advertisements to increase awareness.

According to the Closing the Gap Clearinghouse annual report 2011-12 and 2012-13, some of the strategies work but may only have a short term effect (Closing the Gap Clearinghouse, 2013). However, some interventions trialled in indigenous community were unsuccessful because they were originally designed for non-indigenous populations and were considered culturally inappropriate. Education programs could have a limited impact on indigenous groups and may need to be employed in conjunction with other interventions. Barriers to the effective provision of program may arise due to short term and one-off funding, and the provision of the program may be discontinued due to indigenous groups' capacity to provide the service. Often the data is incomplete and cannot be assessed for effectiveness.

Proposal of additional interventions

The traditional indigenous people conceptualise their health as holistic. It encompasses everything: land, environment, family, relationship,

community, law and the physical body. Health for indigenous people is the social, emotional and cultural wellbeing of the whole community and the identity of being indigenous (Australian Indigenous Health *Infornet* , 2013b). The author's proposal of interventions to improve indigenous health outcomes is to return to indigenous people the keys elements that have been taken from them: equality with other Australians, their identity, freedom, culture, self-determination and their traditional lands.

They had good knowledge of their land, sources of water and food, the effects of seasonal cycles on plant foods and animals. Both men and women hunted food, which kept them physically active and emotionally well. The traditional diet had variety and was rich in nutrition: vegetable food provided vitamins and minerals and essential supplements for the body needs; meats were high in quantity and quality (Northern Territory Department of Health, 2007). Health and sickness were shaped by culture beliefs and traditions. Indigenous people believe that the protection of spirituality is fundamental to their health (1). Family relationship is at the core of indigenous kinship systems which is essential to their culture. Kinship helps to define roles and responsibilities for raising and educating children and provides the structure systems of moral and financial support. In indigenous society, family ties are healer to emotional and physical wellbeing.

Indigenous people had a healthier lifestyle, had pride in their identity and their culture heritage was passed through generations. Their traditional cultures helped them to survive for thousands of years. The crisis indigenous people face today is the consequence of continuous years of inequality, disadvantage, discrimination and disenfranchisement. To close the gap

between indigenous and non-Indigenous health, health providers need to consider the determinants of health, including socio-economic and political issues and their impact on indigenous people. It may remind non indigenous Australians to apply some self-criticism: to remember that they equal to us and all can enjoy the right to be free and exercise self-determination.

Conclusion:

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