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REPORT

ABORIGINAL HEALTH*

Late in 1979 the House of Representatives Standing Committee on Aboriginal Affairs released its report, Aboriginal Health. In its foreword to the report the Committee states:

> The standard of health of Aboriginals is far lower than that of the majority of Australians and would not be tolerated if it existed in the Australian community as a whole.
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> The Committee found that the low standard of health apparent in the majority of Aboriginal communities can be largely attributed to the unsatisfactory environmental conditions in which Aboriginals live, to their low socio-economic status in the Australian community, and to the failure of health authorities to give sufficient attention to the special health needs of Aboriginals and to take proper account of their social and cultural beliefs and practices.

The Committee has undertaken an analysis of cultural factors implicated in the health status of Aboriginal people. We believe that teachers will find this discussion of considerable interest and that they will find much of relevance to them in their teaching role. We have therefore, with permission, reproduced this section of the report.

The fact that we have not presented that section of the report dealing with physical environmental factors should not be taken as implying our lack of very real concern about the adverse environmental conditions of Aboriginal communities. For instance, the Director of Health, Northern Territory, in the foreword to a recently published environmental survey of Aboriginal communities, 1977-78, writes -

> Certainly in the Northern Territory and I believe largely in the rest of Australia too, Aboriginals live in an "Oliver Twist" world of blinding poverty

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* *Report from the House of Representatives Standing Committee on Aboriginal Affairs*. AGPS, Canberra, 1979.

> with 19th century demographic patterns of high birth rates, high population growth, high mortality rates both adult and infant, as well as high levels of illiteracy and unemployment and a high incidence of morbidity largely of an infectious nature - trachoma, leprosy, tuberculosis, otitis media, bronchitis, pneumonia, and gastroenteritis are the order of the day.
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> This study shows that not only have Aboriginals a Dickensian pattern of vital statistics but that this is naturally matched, as should be expected, by a Dickensian environment. (Gurd, 1979)

8. CULTURAL FACTORS

164. An effective health care program for Aboriginals requires a recognition by non-Aboriginal health personnel of those Aboriginal beliefs and practices which affect health and the use of health services. It is important that the cultural factors which influence Aboriginal attitudes towards health and health care be fully appreciated not only by those directly involved in the delivery of health services, but also by governments in the allocation of funds and determination of priorities, by policy and decision-makers involved in the planning and administration of programs, and by the various learning institutions in the instruction and training of medical personnel. A few hospitals, health centres and staff are already aware of these factors and take them into account in the provision of services. The majority do not.

165. One reason for the emergence of Aboriginal Medical Services is the failure of conventional services to take account of cultural differences and to accept the importance of Aboriginal beliefs and practices. Several cultural factors were identified during the Inquiry which particularly influence the use and acceptability of health services. The influence of these factors varies considerably from community to community.

Aboriginal Attitudes to Health and Illness

166 Aboriginal views of health differ in some respects from those of non-Aboriginals. For instance, the Committee was informed that, while the Pitjantjatjara wish to be healthy and want their children to be strong and happy, they do not view health as one of the inalienable rights of life. While they feel great sadness and grief at a death and seek to alleviate pain and illness, they view themselves as subject to spiritual forces outside themselves and thus accept illness, deformity and disability more readily than most non-Aboriginals.

They do not share the great value placed by Europeans on preserving each human life at all costs. This attitude is often evidenced in a stoicism about traumatic injury and pain. However, internal pain or symptoms (which do not have an immediately evident cause or may be thought due to sorcery) can cause distress and fear out of proportion to a Western medical assessment of the severity of the condition.

167 Attitudes to health and illness have also been affected by the Aboriginal experience of continuing sickness and poor health. People who suffer pain and discomfort more or less continually inevitably cease to complain about conditions which they feel cannot be alleviated and are part of the life experience.

168 In Arnhem Land the decline in health of past decades is clearly recognised by Aboriginals who link their ill health to consumption of alcohol and processed and stale foods, to the stress of life on crowded heterogeneous settlements and to an unhealthy environment. They explicitly contrast the good health of their children on outstations to the poor child health on settlements. They also maintain that the security of outstation life away from the dangers of sorcery and dangerous spirits is beneficial for health. Good health is seen as resulting from harmonious relationships with the physical, human and supernatural environment. Sickness results from disruption of these relationships.

Hospitalisation of Aboriginal Patients

169 It became apparent during inspections of hospitals which admit a significant number of Aboriginal patients that they are, in many respects, poorly adapted to Aboriginal needs.

170 Aboriginal patients may abscond from hospitals because of enforced isolation, poor communication by staff, attitudes of medical staff towards Aboriginals, fear of medical procedures, unfamiliarity with the hospital environment, and cultural beliefs such as fear of dying far away from their home or birthplace and fear of spirits of people who have died in hospital away from their traditional lands. The Committee found that the majority of large hospitals were not designed for the special needs of Aboriginals. They are particularly forbidding to Aboriginal patients for whom they are alien and lonely places. While cultural and linguistic barriers are greatest for Aboriginals living in remote areas, Aboriginals living in fringe and urban communities are also often intimidated and anxious when admitted to hospital.

171 There is an urgent need in many areas for live-in facilities for patients and kin (particularly for mothers and babies) in the hospital itself, for greater sensitisation of European staff to

Aboriginal needs and fears, and for the employment of Aboriginals as hospital staff in far greater numbers than is presently the case. There is also an urgent need for limited inpatient facilities to be provided in large settlements and staffed preferably by Aboriginal health workers so that only serious cases need be evacuated to distant hospitals.

172 The practice of evacuating pregnant women before the birth of their babies, beyond the reach of daily family visits, should be abandoned except where actively sought by the patient or where complications are anticipated. At least one midwifery sister should be appointed to each isolated community or health centre, Aboriginal health workers should be given training in midwifery and the services of traditional midwives be utilised wherever possible. Counter arguments are most strongly expressed by professional obstetricians based on perinatal death and morbidity statistics which derive from mainly urbanised communities.

173 Similarly, every effort should be made never to separate an infant or child from its mother, as occurs in some areas, because disruption to the mother-infant bond at birth and during early separations is of serious concern and may cause inadequate mothering and behavioural disorders later on. Other consequences of such separations, such as the interruption or termination of breast feeding and subsequent need for bottle feeding, greatly increase the risk of further infant illness. While it is important to minimise perinatal deaths, it may be far more important to minimise the much higher disparity between Aboriginal and non-Aboriginal mortality and morbidity in later months and years with strong social disintegration a frequent factor.

174 Spiritual ties to the land strongly influence the attitudes of many Aboriginals, particularly those in traditionally oriented areas, towards health and hospitalisation. Infant deaths are doubly traumatic for a mother and family when the child dies away from its home territory, especially if, as in some areas, it is believed that the child's soul remains in its tribal territory to await rebirth at a more propitious time. When a baby dies in a hospital many miles from home its spirit cannot find its way to its homeland and is thus lost to mother and community forever.

175 While the death of a baby in hospital is often a tragedy to its mother, the death of an aged person in hospital can be a severe blow to the whole community, especially if it is a man or woman who has been a repository of tribal law and knowledge which gives meaning to the past, present and future of the community. Such people die

'away from their dreaming' or spiritual continuity. Their life force is then separated from their country and the strength of the 'dreaming' is weakened to the eternal loss of all survivors.

176 The policy which prevails in many parts of Australia of not returning Aboriginal bodies to their home communities after death is deeply distressing to their families and shows a bureaucratic insensitivity to Aboriginal traditions and concerns. The Committee was informed by representatives of some Departments of Health that they do not take responsibility for returning bodies to communities and that community members themselves are expected to make appropriate arrangements and to bear the cost of having the body brought home by road or air. There is an urgent need for State health authorities to establish a procedure by which the bodies of patients who die in hospital can be returned immediately to their families.

Traditional Healing

177 The apparent high rates of utilisation of health services and hospitals attest to the confidence which many Aboriginals have in Western medicine. However, many traditionally oriented Aboriginals may also seek treatment by the Aboriginal practitioner, male or female, (known by such terms as *ngangkari*, *maban* and *marrnggitj*) particularly if an illness is perceived as chronic or serious, or if it does not respond to Western medical treatment. The healer often specialises in treating sicknesses which have resulted from the actions of sorcerers and spirits. The healer is believed to have the power to remove the cause of illness which has resulted from the actions of sorcerers such as 'pointing the bone', and 'singing' a person or spirits which have travelled from other sick people, from a deceased person's home, from an old camp site or spiritual homeland.

178 The Aboriginal healer may be consulted before, after, or in conjunction with Western medical care. In some cases he alone is consulted. Sometimes both are used in the hope that one or both will prove effective. Treatment by the Aboriginal practitioner usually consists of external massage, the apparent removal of harmful objects or substances from the body, or the use of powerful objects to alleviate the effects of the illness. Ministrations are, however, directed not only towards ameliorating the physical signs of the illness but towards removing its spiritual or other cause. The Aboriginal healer thus promotes healing and has a powerful and usually beneficial, psychological effect on the patient.

179 Treatment involves not only the healer and his patient, but everyone in the patient's immediate family group. When an individual has become ill as a result of falling out of harmony with his spiritual

or social environment, the concern and attention which his suffering evokes often overrides intra-community tensions and draws the community together. The healer is a catalyst in this process, using his diagnostic abilities and healing powers to focus attention on the patient and to highlight the great importance of community solidarity and mutual support. Thus the practice of medicine in traditional Aboriginal society is not merely a matter for the sick person and the practitioner, but is the concern of the whole community. It is therefore not surprising that many Aboriginals prefer to be attended by the healer before, or instead of, attending a clinic or hospital. Nor is it surprising that they are reluctant to be taken out of the community and evacuated to distant hospitals for treatment.

180 Aboriginal women have, particularly as they grow older, significant ritual and healing roles and act as midwives in many traditionally oriented communities. These roles have been eclipsed by non-Aboriginal interest in traditional practitioners and by the activities of Western health services, and are at present under-utilised by Western health services. Their knowledge, authority and experience could profitably be mobilised by involving them in decisions concerning health care and upgrading their existing skills in home treatment and midwifery. In this regard Australia is behind many developing countries in adding to the skills of those who have indigenous health roles and giving them an expanded role in the changing social system. The practice, for instance, in some Asian, African and South American countries of upgrading the skills of traditional midwives (or 'birth attendants') has not yet been adopted in Australia despite a clear endorsement of this strategy by national and international agencies.

181 In general, there is little or no evidence that the activities of traditional healers conflict with those of medical services provided that there is open communication and co-operation. Most of the evidence to the contrary stems from non-Aboriginal professionals who state only what they see as unacceptable practices such as lack of sterility.

182 The involvement of Aboriginal healers in the delivery of health care is further considered in paragraphs 328 to 330.

The Differing Health Needs and Roles of Aboriginal Men and Women

183 In many Aboriginal communities, particularly those traditionally oriented, there is a clear demarcation between 'women's business' and 'men's business' and all gynaecological and obstetric matters are dealt with by women with the greatest privacy and propriety. Many Aboriginal women avoid seeking gynaecological treatment and family planning advice because of their apprehension and embarrassment about

approaching an often strange non-Aboriginal male doctor. The Committee was informed that Aboriginal women are rarely treated with sensitivity, understanding and sympathy which non-Aboriginal women expect when consulting doctors about these matters. There is a great need for Aboriginal female health workers to receive training in the diagnosis of common gynaecological complaints and in family planning techniques and for female doctors to be available to Aboriginal women for consultation on a regular basis.

184 Men are often reluctant to seek medical care from female nursing sisters and Aboriginal health workers, particularly for uro-genital illnesses. Their reluctance is compounded by the fact that settlement health centres are generally patronised by women and children and run by women. Each community should have at least one male Aboriginal health worker and separate visiting times should be made available for male patients, or separate rooms or entrances be provided for males and females.

185 In traditionally oriented Aboriginal communities certain categories of people stand in avoidance relationships to one another. They may not, for instance mention each other's names, make eye contact, converse or otherwise interact directly with one another. These conventions vary from region to region. It is common for a brother and sister, and for a mother-in-law and her son-in-law, while having an affection and concern for each other's welfare, to avoid close physical or social contact. Situations can therefore arise in which it is inappropriate for Aboriginal health workers to treat members of the opposite sex. Under these circumstances they must delegate treatment to other health workers who stand in appropriate relationships. A lack of awareness of these conventions among non-Aboriginal health personnel can lead to acutely embarrassing and upsetting situations for Aboriginal health workers and those seeking health care. It is therefore important that non-Aboriginal health personnel be made aware of Aboriginal social conventions relevant to their work, that they are trained in Aboriginal culture, and, most importantly, that Aboriginals hold the responsibility for determining which people may or may not interact in the health care context.

186 It can similarly be inappropriate in some circumstances, for female Aboriginal health workers to treat elderly or senior men of the community. Such constraints may be overcome by the presence of male health workers or health workers who themselves are senior community members. Again it is only the Aboriginal health personnel, community leaders and patients themselves who possess the knowledge needed to determine which interactions are or are not appropriate.

187 It is therefore important that, as already happens in most areas, training bodies invite and accept the community's choice of health worker trainees whatever their age and whatever their level of literacy since these choices are made taking into account such cultural factors as those described above.

188 There are a number of other cultural factors which influence Aboriginals' perception of health and attitudes towards health care which should be considered in the treatment of illness and the provision of health care. Some of these are described below:

a) Many Aboriginals consider themselves cured once the pain has gone (the disturbing spirit has left the body) and they therefore do not complete medication which may be necessary for complete cure.

b) Many Aboriginals avoid pain and distress. This is considered more important than a person's long-term welfare. For example, although a mother is capable of carrying out certain therapeutic functions for minor complaints such as syringing and drying out of ears, she will desist from the practice if a child finds the treatment painful or unpleasant.

c) Aboriginal explanation of causes of serious illness often involve the malicious actions of sorcerers or spirits. They may therefore reject scientific explanations such as the concept of cross-infection which attributes the blame for a person's illness to a close relative.

d) Individuals and groups may be hesitant to seek help or may feel that their health care needs are not adequately met because Aboriginal health workers may be members of another family, clan or tribal group. The Committee found that most councils recognise this when selecting trainees and that health workers were generally drawn from several different groups.

e) Many Aboriginals are strongly opposed to surgery because :

- The sanctity of the body and the importance of maintaining its physical integrity are basic to Aboriginal concepts of treatment of illness. Surgery is believed to 'spoil the body'

and 'waste the blood'. Blood is regarded as powerful and, according to the context, a source either of strength or danger.

- Surgery is similar to sorcery where the removal of blood and vital organs is used to harm people.

- There is no corresponding treatment in the traditional medical system.

189 While most of the socio-cultural conventions discussed are strongest in traditionally oriented Aboriginal communities, the Committee received evidence that some conventions persist, often in an attenuated form, in urban, rural and fringe communities.

Conclusion

190 The Committee considers that health problems in all Aboriginal communities are exacerbated by the lack of knowledge among community members of the rationale for Western medical procedures and their lack of involvement in or influence over the health centre and its programs. It believes that this problem would be alleviated were more individuals of standing in the community actively involved in policy and decision-making and in the running of health programs at all levels. Denial of the legitimacy of traditional beliefs and refusal to acknowledge traditional practices will reduce the effectiveness of any programs designed to improve Aboriginal health. New and existing health care programs should, where possible, be based on existing Aboriginal community structures,and should be consistent with the culturally determined decision-making processes and beliefs and practices of community members.

191 The Committee further believes that it is essential to the success of any health care program that proper care be taken in the selection and training of non-Aboriginal medical personnel so that they are fully cognizant of the medical and social requirements of their position and are sensitised to the needs of the people.

192 While it is highly desirable that the cultural beliefs and practices of Aboriginals be recognised, understood and accepted by non-Aboriginal personnel, the Committee considers that only the Aboriginals themselves have the expertise and background which are the necessary prerequisites for the successful design of culturally congruent health care programs.

193 So that the delivery of health care to Aboriginals can be maximised, the Committee recommends that

Aboriginal cultural beliefs and practices which affect their health and their use of health services such as their fear of hospitalisation, their attitudes to pain and surgery, the role of traditional healers and the differing needs and roles of Aboriginal men and women be fully taken into account in the design and implementation of health care programs.

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