CHAPTER 5

Social factors in overall health

IN MY DISCUSSIONS with health workers and other health staff at community health centres in towns and Aboriginal communities, a variety of social and cultural issues which influence the ongoing nature of Aboriginal ill-health were raised. This section draws together some of these observations. Some are social factors which, together with historical and environmental influences, exacerbate ill-health, and others are factors which militate against the resolution of health problems. Some of these issues may sound mundane to the uninitiated reader – daily, grassroots problems that affect Aboriginal people and those working to improve their health – but combined with the overall high rates of morbidity and mortality, even very basic daily practices are influential.

Priorities

It needs to be stressed that health matters are not everyone's priority. This may seem an obvious statement, but today's preoccupation with healthy lifestyles, diet, exercise and the prevention of disease is one to which only certain sections of the population can turn their attention. For others, the struggle for existence and the overwhelming nature of the stresses and crises that characterise daily life mean that health issues retreat into insignificance. In addition, many practices (smoking, heavy drinking, taking no exercise) may be detrimental to health, and people are aware that this is so. These are matters of personal priorities and choices and the social benefits of these practices, or the exigencies of life, may outweigh the health arguments.

Washing

In one Aboriginal-controlled health service in a remote community of desert people, I asked the local administrator what health practice he would most like to see his clients undertake. "Take showers" was his reply.

The first item on a list of healthy living practices in the Strategy for Wellbeing report on the Pitjantjatjara Lands in South Australia (the UPK Report; Nganampa Health Council et al. 1987) was washing people. Washing children every day, the report states, is likely to reduce the prevalence of the four most common childhood illnesses (diarrhoeal and respiratory diseases, pneumonia, skin infestation and trachoma) as well as many others, including otitis media. An opthalmologist working at Yalata, SA claimed that if mothers could wash their childrens' faces in as little as half a cup of water each day, this would assist in the prevention of trachoma. The issue is, of course, how to educate women to perform this simple act on a regular basis. If it was that easy to change behaviour, then this would surely have been accomplished by now. Environmentally, the presence of water (for swimming in) is beneficial both to trachoma and otitis media. Skin diseases such as scabies are apparently minor complaints, but the itching and discomfort they cause produce intense personal discomfort and sleeplessness. Children with itchy scalps scratch them so that heads become encrusted with sores, which in turn are very hard to keep clean especially in bush communities.

For adults washing can reduce the level of scabies, the prevalence of kidney disease which occurs as a result of skin infection, and diarrhoeal disease which is transmitted by organisms between adults and children. The report points out that the change of behaviour to regular washing of children "will only occur if at least, young adults also change their behavioural patterns" (1987, p.8).

While the provision of adequate running water and ablution facilities is still poor in some areas, all major remote Aboriginal settlements have these facilities to varying degrees. Conditions in fringe camps on the outskirts of rural towns, which are usually on informal leasing arrangements with local councils, are generally much worse. In the "town camps" of Alice Springs, which are on formal leases and whose residents are represented and administered by an Aboriginal Council, Tangentyere, conditions are much improved.

Showering can, however, be disliked for a number of reasons. At Yalata, South Australia, for example, until recently the public showers had little privacy; there was one shower in the clinic which was private, and an ATCO ablutions block located behind the clinic. While the showers themselves are partitioned, the shower block

itself was starkly visible. Young men in particular are embarrassed to be seen going for a shower. One young man of 20, already with acute trachoma, took showers in the house of a member of staff with whom he was friendly, rather than use the public facilities. He is aware of what will happen if he does not wash his eyes regularly (and treat himself), but has become too ashamed to shower at this house. Should this man become blind, which is likely, his ability to fulfil his traditional responsibilities to the land will be severely curtailed. As it happens, he is the son of a recently-deceased senior traditional owner. One solution to problems such as these is simply to facilitate greater privacy by having screened entrances to ablution blocks, and adequate privacy within shower blocks themselves.

Some Aboriginal children in Central Australia (maybe elsewhere too) are so concerned about privacy that they often shower wearing their underwear. The extent of this practice is not known. It means in effect that washing is incomplete, and the wet clothes serve to foment irritation and infection (Peter Tait, pers. comm.). The UPK Report (Nganampa Health Council 1987) included videos and cassette tapes as part of the feedback of information to the participating communities. The video of the Shower Block Song features a song in Pitjantjatjara about showering, and shows children going to the store, buying soap and towels and then showering. Ironically, because they were being filmed, some of the children featured in the video are themselves wearing underclothes in the shower. However, the Shower Block Song on the UPK cassette has become something of a hit in itself – probably hundreds of Aboriginal children know the words.

Schools in major bush settlements have their own showering facilities, but the logistics of their use often causes disagreement. Some schools insist that children shower every day before class, provide towels and soap, and launder their uniforms. Other schools assert that this service is paternalistic, that it is the responsibility of parents to ensure that children come to school washed and dressed appropriately, and do not enforce showering.

Shyness and embarrassment are major factors in the underuse of showers. Older boys will not undress in front of younger boys, and there are rarely separate facilities for secondary students. Shower blocks may lack doors, curtains and cubicles. Showering, perhaps because of its association with schools, and memories of mission days, is sometimes viewed as being the province of children, rather than of adolescents and young adults. Showering can also be associated, disparagingly, with being “like whites”.

Eating

Health problems associated with nutrition are primarily those of young babies and children (loss of weight during weaning and growth failure), tooth decay among children and adults, and adult diseases such as obesity, hyperlipidaemia, hypertension, diabetes mellitus and cardiovascular disease. We know that Aboriginal children in remote areas are lighter and shorter than children who live in towns, that unsatisfactory growth is related to nutritional deficiencies, and that these are exacerbated by repeated infections (Gracey & Spargo 1987; Cheek, et al. 1989). In a report on Aboriginal Child Poverty, Choo recommends (among other suggestions) that governments should commit funding to reduce the incidence of malnutrition among Aboriginal children, and asserts that this malnutrition is associated with poverty and with lifestyle factors (Choo 1990, pp.40-41). Among young town Aborigines (for example, in Alice Springs) there is now an emerging problem of obesity (Peter Tait, pers. comm.).

Poor nutrition among children or adults is not always related simply to poverty or lack of access to fresh food, however. With so many people reliant on fortnightly social security payments, money and food supplies are depleted towards the end of each period unless people budget carefully and avoid situations in which they must give their money away to relatives. Children are loved and indulged and are not, on the whole, socialised in an authoritarian manner. This means that their desires are gratified without question, because the ethic of generosity and looking after others requires that this be done. Children learn from a very young age that they may have this independence and gratification; they ask for money or food without embarrassment. Very young children in bush communities can be seen going to community stores to buy themselves chips, cool drinks and lollies according to whim, and indeed these items are enjoyed by all age groups. No one would dream of taking such items from a child on the grounds that they were poor health choices. Saturating a community with nutritional information, together with education of store managers so that they maximise the provision of wholewheat bread, salad rolls instead of fried foods and so on, can have startling results. The Menzies School of Health Research in Darwin has been involved in such an approach, the first part of their program is reported in Lee et al. (1989).

The taste for sweet things begins early then and is reinforced, once a child starts to drink tea, by the excessive amounts of unrefined sugar added to billies of tea. Because of the manner in which tea is prepared in bush communities, it is very difficult for individuals to minimise their sugar intake. Once the water in a billy is hot, both tea and sugar are added together; and because spoons may be in short supply, people literally add handfuls of both to the pot. The whole concoction is then brewed up together, before decanting and the addition of cold water (so that the tea is not too hot). Some children can be seen adding *more* sugar to their individual mugs. If someone does not take sugar, they must either boil their own billy, or persuade the tea-maker to pour their tea before sugar is added. The

Northern Territory health department is attempting to persuade people to minimise their sugar intake, by using sugar cubes as a way of demonstrating to people how much sugar they might eat in a day. Health workers show people the number of sugar cubes equalling the amount of sugar contained in a Mars bar, or a milk shake. The Nganampa public health survey found that in Pitjantjatjara communities, people added up to the equivalent of 66 teaspoons of sugar (per person per day) to tea, in addition to drinking an average of three cans of cool drink per day (1987, p.67). These are astonishingly high levels of sugar intake.

A study of Koorie children in several regions of Victoria (Anderson 1988, p.55) noted that Aboriginal diets commonly included:

Johnny cakes (flour and water fried in dripping)
Damper (unleavened bread of flour and water)
Heavily sweetened tea and coffee
Full cream powdered milk
Cheap cuts of meat (fried)
Ice cream
Potato chips
Alcohol including beer and fortified wines
Aerated soft drink

However, a detailed study of the dietary habits of rural Aborigines from Kempsey, NSW , showed that on the whole their diet was similar to that of typical working-class Australians. Food choices were certainly limited by financial means, but nevertheless people were not short of food to the extent of being hungry, and gave priority to purchases of meat, vegetables and cereals. Fresh fruit, cakes, desserts and "fast foods" were generally deemed to be too expensive (Sibthorpe 1988).

In both remote and rural Australia, choices about how to spend money often give priority to items other than food. Gracey documented that Aboriginal people in the Kimberleys spent generously, when money was available, on consumer items such as video machines, TVs, refrigerators and air-conditioners. He associates this with the poor health of children in the region. Sibthorpe, working with rural NSW people, found without doubt that consistent gambling decreased the amount of money available for all commodities, including food. However, as she points out, this is to do with

> *priorities attached to commodities and activities in the apportioning of total available income...In so far as gambling expenses were seen as a need, buying sausages instead of steak was a valid ordering of priorities* (Sibthorpe 1988, p.224).

She also documents the expenditure of large sums of money on petrol, on funerals and tombstones, and at the annual Easter Show. She argues that the way poverty affected diet was not related solely to income, but was associated with a complex of social conditions which were translated into "neglect (and abuse) of self and family, including diet" (ibid., p.226).

The feeding of infants is of significance to this study, partly because some mothers are young (within the age group under consideration) and partly because poor growth in infancy can have lifelong effects. While all health services encourage breastfeeding, bottle-feeding occurs too. In some remote communities bottle-feeding is synonymous with "a death sentence", as one local doctor put it, because of the unsanitary conditions and the impossibility of keeping bottles sterile. Even when an infant is breastfed, a weak undemonstrative infant may continue to be undernourished because, in some areas, mothers will not offer feed to a child: they wait for the child to demand it. A sickly baby is less likely to demand food forcefully from the mother, and reach spontaneously for the breast (Harrison 1986).

The diet of Aboriginal teenagers and young adults is poor in some cases – whether it is poorer than that of their age-mates from similarly depressed socioeconomic circumstances is impossible to say. At the Aboriginal Neighbourhood House in Elizabeth, in the northern suburbs of Adelaide, workers said that many Aboriginal school-leavers do not even apply for unemployment benefits; they lose their tax file numbers, and cannot deal with the paperwork involved. Their income is therefore minimal; their nutrition poor. This was confirmed by staff at a kids' refuge in Darwin, Casey House. Eighty per cent of their residents (including some Aboriginal children) were not on any benefits at all. The kids find it too troublesome; they do not like filling out forms or keeping appointments, they are apathetic and feel ashamed of asking for social security benefits. A study of the health of Aboriginal children in a Northern Territory urban community noted with alarm that 51% of young males aged between six and 16 years were malnourished (Evans & Powers 1989, p.72).

Health workers pointed out to me that petrol sniffers and alcohol drinkers often eat sporadically. Workers in urban areas have observed that some street kids and Aboriginal young people living in refuges are undernourished. In Darwin many survive primarily on iced coffee, according to workers at Casey House. At a drop-in centre in Darwin, the Tardis, with a primarily Aboriginal youth clientele, staff note that the majority of the children are underweight, are prone to infections, and neither eat nor sleep well. Nevertheless they are extremely active (Ann Buxton, pers. comm.), even hyperactive, an observation also made by workers in other, similar settings. (The possible association between eating "junk" food and hyperactivity was pointed out.)

In the case of petrol sniffing, severe weight loss and muscle wasting follows chronic use, as it appears that sniffing acts as an appetite suppressant. Sniffers say that they can go for several days without eating. I have collected data from one region of Western Australia which shows that at least some young people are using petrol sniffing and its appetite-suppressing side-effects as a deliberate means of losing weight (Brady, in press). It

appears that among these teenagers and young people, leanness is valued over fatness. In its extreme form this type of self-imposed starvation is known as anorexia nervosa, a disorder known to occur particularly among white, high achieving young women (see Ben-Tovim & Morton 1990 for a discussion on prevalence). This is not the occasion to discuss the possible meaning among some (perhaps only a few) young Aborigines of the desire to be thin; but nevertheless this development, in association with petrol sniffing, should be cause for concern.

School

School can be a daunting experience for young Aborigines, quite apart from the issues of academic success or failure. Children attending urban schools with non-Aboriginal students often feel ashamed and embarrassed because of headlice and skin infections. Children with noticeable sores or scabies may be ostracised by others, who typify them as being diseased and infectious. This can precipitate problematic incidents such as an occasion at an urban school in which an Aboriginal child bit a teacher, who then requested tests for AIDS and Hepatitis B. In an Aboriginal community, where virtually all the students are Aboriginal, people accept that headlice and scabies are not remarkable.

Utilisation of health services

Utilisation of health services can vary dramatically between communities, and between remote-dwelling people (with an on-site clinic) and those in urban areas (with long bus rides to hospital). The director of one community-based clinic felt that the Aborigines in the community held a poor opinion of the health centre, simply because there were so few positive, notable outcomes associated with it. The staff merely patch people up, administer medication, arrange for hospitalisation – no major inroads into serious problems were seen to be made. Relief of discomfort was always temporary, with major ongoing problems such as diabetes or skin infections showing no obvious decline.

I have already drawn attention to the acute embarrassment felt by young men in particular about seeking any medical attention at all, let alone treatment for sexually transmitted diseases. Young men tend to deny injury and the need for treatment. There is often a feeling of bravado and immortality among adolescent and young adult males. Several Aboriginal health services observed that young men have to be very sick before they will seek help, (e.g. Choo 1990, p.64) and that the services basically cater for women and children rather than adolescent males. Among some desert groups, young men deliberately scar their bodies (in effect, self-mutilation) in order to show their scars as signs of strength and prowess. In Arnhem Land, boys wear bandaids on their faces in part to indicate that they have been in a fight and received cuts.

Hospitalisation

Predictably enough, young men also do not like staying in hospital. "Absconding" from hospital (a term with connotations of delinquency) is more frequent among Aborigines than among non-Aborigines, for all types of admission. Figures from South Australia show that 3.3% of male Aboriginal patients and 2.4% of female Aboriginal patients absconded from hospitals in 1986 (Divakaran-Brown & Honari 1990, p.50). The highest rate of absconding occurs for male Aboriginal patients admitted for "mental disorders", a category which includes alcoholic psychosis, alcohol dependency and non-dependent drug abuse. Staff at Kalgoorlie hospital in Western Australia reported that young men hospitalised for symptoms related to petrol sniffing frequently abscond and disappear into town. These boys and young adults have been evacuated by air from their home communities in the Central Reserves hundreds of kilometres to the north-east.

For younger Aboriginal children up to the age of 14, though, hospital stays are generally longer than they are for non-Aboriginal children. In Western Australia, Dibley and Waddell (1983) found that the greatest disparity between the races in terms of length of hospital stay was in rural regional hospitals, and in a Perth children's hospital. They concluded that

> *the remoteness of Aboriginal communities and the difficulties in transporting children back to these communities are contributing factors to their prolonged hospitalisation...[also] the attitudes of nursing and medical staff members play an important role in determining the duration of hospitalisation of these children* (Dibley & Waddell 1984, p.63).

For hospitalised children, distance from caregivers has other untoward consequences – again affecting remote area more than urban residents. These can affect diagnostic and treatment procedures; medical staff may have no relative to consult about the child, there may be language and communication difficulties, and a lack of knowledge of the child's circumstances (both emotional and physical) at home. While there are Aboriginal liaison officers in major metropolitan hospitals in most states, they are usually urban residents themselves and may have little knowledge of the home communities of patients. Dibley and Waddell recommend that there be programs to promote contact between hospital staff and Aboriginal parents, and more emphasis on their being involved in the care of their children while in hospital (1983, p.63). This would have other benefits as well. In the Northern

Territory, for example, when youths are evacuated to hospital with severe symptoms associated with petrol sniffing, neither their immediate family nor other community members ever see them, ill, in hospital. In one instance known to me, a community chairman happened to be in Darwin and visited a boy from his community in hospital. He was shocked to find him shaking, having convulsions, and restrained to the bed, and told me that he wished the family could have witnessed the severity of his symptoms so that they would comprehend the seriousness of his sniffing behaviour. Too often in these cases, the patients are airlifted out, disappear from the day-to-day life of the community for a time, and then reappear weeks later looking glossy-skinned and well nourished. The horrible reality of the more severe symptoms, and the painfulness of at least one treatment procedure (chelation therapy), remain hidden.

Aboriginal Medical Services

Aboriginal Medical Services offer at least the possibility of attracting more teenagers as regular clients than do state-wide non-specialist health services. While the medical staff are usually non-Aboriginal, staff are Aboriginal, the atmosphere is palpably different and the entire encounter between health professional and patient occurs in a far less threatening context. Comments by Aboriginal people were collected for a study of Adelaide Aborigines and their access to health care, and they reinforce this view:

> *"The local Centre is like a 'home' - it's more comfortable to attend."*
> *"I feel shame going to a white person clinic."*
> *"I trust them and they take their time and explain all details."*
> (Aboriginal Community Recreation & Health Services Centre of SA, n.d.)

Medical staff in AMSs often devote much longer to their consultations than do GPs in a normal practice: they are often confronted with a variety of other problems which are related in various ways to the presenting health problem. An example of the value of Aboriginal health services in dealing with complex psychosocial health issues was provided by one physician working for a city-based service. An Aboriginal woman had sought help from several doctors for insomnia and had been given sleeping tablets, which had not resolved her anxiety and sleeplessness. During a much longer consultation than her previous ones, at an Aboriginal health service, the doctor questioned her more closely and discovered that she was in fact acutely anxious about security because of disputes under way within the Aboriginal community in her street. She was worried that others might break into her house at night. The doctor was able to phone the Housing Commission on her behalf and ensure that locks on doors and windows were renewed, and this solved her sleeplessness. Doctors working in these services stress the multiplicity of problems they see. In one patient they may see several physical ailments such as diabetes or hypertension, together with a psychiatric problem (anxiety states), together with difficult social circumstances and poverty, heavy smoking, alcohol use and a poor diet. General practitioners are simply not so able to consult knowledgably on these issues, and often have no access to the Aboriginal networks of information and support. They do not have time to talk about diet and other preventive issues in the course of a normal consultation.

Not all Aboriginal people in towns and cities choose to utilise Aboriginal medical services. In Darwin, for instance, where there is an urban Aboriginal population of long standing, many from this population prefer to go to general practitioners. The NT Department of Health and Community Services runs a health centre at Bagot (an Aboriginal lease within the city area) in which Aboriginal Health Workers are in charge. This centre services not just Bagot residents but Aboriginal people from as far away as Palmerston (a new satellite development south of town). Certainly many urban Darwin people choose to use Bagot health service rather than their local (non-specialised) community health centres (Dr D. Devanesen, pers. comm.). An Aboriginal-controlled health service is being planned for Darwin.

In Adelaide the upwardly mobile segment of the Aboriginal population prefer to use GPs. The use of GPs by Aboriginal people probably also depends to a large extent upon whether the GP bulk-bills. Aboriginal medical services are undoubtedly the only way to reach the larger urban Aboriginal populations and to encourage the utilisation of health services by that elusive group, the teenagers and young adults. They will not, however, be able to succeed in gaining access to this age group unless resources are made available to them to employ counsellors, more staff to make visits to schools and staff to focus on the special needs of Aboriginal "street kids". The AMS in Adelaide has a city base, and branches in locations such as Port Adelaide and Elizabeth, suburbs with high Aboriginal populations. It provides a one night per week health sister at 61 Hindley Street (an Aboriginal youth drop-in centre) who provides informal counselling, and medical care. The drop-in centre is the only safe place open at night for Nunga teenagers in Adelaide and is helping to link these young people into the main Aboriginal medical service clinic in Wakefield Street. With sometimes 70 or 80 young people calling in each night, city-based facilities such as this are crucial first points of contact for health care among young urban Aborigines

While the Aboriginal Medical Service in Adelaide has approximately 7000 urban Aboriginal people on its books, it nevertheless still has to convince the State government of its right to exist. The view of this, and of other state and territory governments is that Aboriginal medical services

merely duplicate existing services available through the state. Evidence collected by the Adelaide AMS, however, shows that Aboriginal people, on the whole, simply do not avail themselves of the state-run services; one of its reports documents the poor use of state-run health services by urban Aboriginal people (Aboriginal Community Recreation & Health Services Centre of SA, n.d.). The major South Australian state service for adolescent psychiatric and family problems, and the only child health service of its kind in Australia (Child Adolescent and Family Health Services, CAFHS), for example, does not even keep standard statistics which identify clients by race. Nevertheless, staff there reported that they see very few Aboriginal adolescents in their service, which is extraordinary, considering the obvious prevalence of mental health problems.

State health departments can also find it difficult to access Aboriginal populations – particularly those in rural areas – for the purposes of prevention and education campaigns. An example is a South Australian campaign aimed at educating health professionals, youth workers and secondary teachers about Pelvic Inflammatory Disease (PID). The significance of PID for Aboriginal women has been highlighted earlier in this report. The campaign was organised by the Health Promotions Branch in 1988 and involved two Aboriginal health organisations in Adelaide (the Aboriginal Medical Service and Aboriginal Health Organisation). PID charts were given to the AHO to distribute to Aboriginal health workers and audio tapes were made in Pitjantjatjara (produced by the Institute for Aboriginal Development in Alice Springs). A poster designed by an Aboriginal organisation in Victoria was used in South Australia, with the contact phone number altered appropriately. Altogether the budget for the campaign was $36,000 , of which only $500 was spent on material for Aboriginal health workers. It is hard to ascertain with certainty how broadly the PID campaign messages penetrate into Aboriginal communities or health services. Two hundred copies of the Aboriginal PID poster were distributed. According to the campaign evaluation report, a total of 330 individuals participated in metropolitan and country workshops across the state, but only 15 of those were from the Aboriginal Health Organisation and were therefore personnel working in Aboriginal community clinics (McColl, n.d.).

Drug and alcohol services

While it was not possible in the time available for this study to canvass thoroughly the availability of drug and alcohol services for young Aboriginal people, it is safe to say that both treatment and counselling services are almost non-existent for all age groups. A study conducted in Alice Springs compiled some recent data (Lyon 1990). Examining the disparity in the range of drug and alcohol services available in Darwin and in Alice Springs, the author noted:

> *Currently, there are no alcohol dependency or co-dependency services for young people in Alice Springs despite what appears to be a serious need, at least for co-dependency services* (ibid., p.150).

Lyon recommended that the local Alateen self-help group be re-established, and argued that a youth counsellor was required and that counselling services and other programs specifically geared to Aboriginal youth should be developed, especially in the town camps. She urged the government to support and expand existing youth crisis programs such as the youth Street Worker Program run by St Vincent de Paul (this service had ceased in 1990 due to insufficient funding; ibid., p.150). In Alice Springs, as elsewhere, the approach to Aboriginal drug and alcohol problems has been piecemeal, with the government funding different schemes on a short-term basis. This has resulted in “a succession of failures or near-successes which have seriously eroded Aboriginal confidence that anything can be done” (quoted in ibid., p.146). This is the case for Aboriginal substance abuse programs as a whole, let alone those rare instances focusing specifically on young people. Lyon considers it irresponsible that in Alice Springs there is no alcohol education program either in the adult jail or in the juvenile correctional institution, Giles House – especially in view of the fact that alcohol is a major factor in the incarceration of adult and some juvenile Aborigines (ibid., p.146).