CHAPTER 6 Issues related to urban or remote residence

AS THIS STUDY has shown, it is not easy to make overall comparisons between the health status of rural/ remote and of urban Aboriginal populations; even so, some researchers and regionally-based institutions are at least focusing on health matters – the larger Aboriginal health organisations, institutions such as the Menzies School of Health Research in Darwin, and so on. Surprisingly, in Australia as a whole,

> *there is an absence of large-scale research which focuses on rural-urban differences in the health status…Neither of the existing two most comprehensive health interview surveys allow for rural-urban comparisons in terms of health status* (Humphreys 1988, p.329).

Such research as exists for the Australian population as a whole does not make it clear whether the ill-health noted in rural populations is associated with *locational* or *social* disadvantage (ibid.) – surely a crucial distinction.

Health issues and remoteness

While it might appear to be stating the obvious, remoteness does affect a number of factors influencing overall health; these include the risks of experiencing certain health problems, difficulties of adequate servicing and access to specialist treatment, and also the issues related to socioeconomic status – educational opportunity, job opportunity and hence the level of income. At a WHO meeting in 1988, a spokesman for the Royal Flying Doctor Service referred to the general assumption among city dwellers that people living in the country generally enjoy a better standard of health than urban residents. In fact, rural Australians have higher rates of morbidity and mortality than urban people (McEwin 1988). When discussing Aboriginal health, it is important to stress that living in remote or rural Australia in itself confers a certain level of increased risk, associated with both certain categories of injury or illness, and access to treatment.

Compared with urban dwellers, both Aborigines and non-Aborigines living in the bush face higher rates of death and injury through car smashes, as well as greater risk of suicide, alcohol abuse, heart disease and communicable diseases such as tuberculosis and sexually transmitted diseases. McEwin pointed out that with new technology, rural stations could now be managed with a handful of people, whereas in the past up to 40 or so workers would have been required. "Due to the changing economic circumstances and also the improvement in technology," he said, "on such a station today there may well only be two people, the owner and his wife, and any children they may have" (ibid., p.19). From the perspective of Aboriginal employment, of course, the advent of award wages in December 1968 brought about the demise of large-scale employment of Aboriginal men and women on cattle stations which had hitherto been a major source of livelihood in certain areas of Central and Northern Australia.

We know that there is a heavy over-burden of infectious diseases among Aboriginal people and, as Gray and Atkinson point out,

> *a large part of this over-burden is due to poor environmental conditions…Of particular concern are inadequate and/or contaminated water supplies, poor or non-existent sewage or waste disposal facilities, and insufficient and/or inappropriate housing. These problems are particularly acute in rural and remote communities* (Gray & Atkinson 1990, p.32).

In some cases, traditional oriented Aboriginal people have made decisive moves away from settlements with housing, running water, electricity, refrigeration and septic tanks, to outstations with none of these facilities. In the case of Oak Valley, the homeland centre on the Maralinga Lands (South Australia), water for drinking has to be trucked north from the Transcontinental railway line, which has in turn transported a rail tanker of water from Port Augusta far to the east. Decisions to move away from the comforts (however minimal) of modern life available in settlements are made for a number of reasons, some of which are beneficial to health. People have access to bush foods, and the time to devote to their acquisition. Less available are ice creams, cakes and fast foods. They are separated by many hundreds of kilometres from the nearest source of alcohol which, as a consequence, rarely appears. Confronted with extreme heat and dust storms in summer (in some desert regions), or cut off by the Wet

(in northern areas) people are nevertheless on their own country and this sense of place makes people "feel happy" (as one person put it simply). So there are psychosocial health benefits from living on such an outstation, while the lack of water and fresh foods (in some cases) and diminished health servicing are the drawbacks. Emergency evacuations (for unexpected childbirth, heart attacks, severe dehydration and so on) must be accomplished laboriously by road or air. These points are not made to dissuade such moves to even more remote locations, but it is clear that there are risks involved and it is inappropriate to pretend otherwise. Nevertheless, the outstation movement has, in some cases, been the victim of a decided lack of government support.

Many of these problems characterise the health servicing of others in rural Australia, not just Aboriginal populations:

> *Rural Australia is characterised by a small population scattered over a vast area. The small isolated communities and dispersed population result in a low level of demand for services and a limited local tax base from which to provide essential services (*Humphreys 1988, p.326).

This has resulted in a clear rural-urban imbalance in the availability of and access to health care services, and these disparities are becoming more rather than less marked (ibid., p.328). Rural dwellers do not only lack access to nursing-homes, women's health centres, drug and alcohol centres, psychiatric services, family planning clinics and specialist services, they also have higher populations for each general practitioner than in urban areas, populations that are far more dispersed. In the case of remote Aboriginal populations, the numbers of people are small, but the areas covered are vast. The Pitjantjatjara lands for example, in the north of South Australia, have a health service that must cover an area approximately the size of Tasmania, and have a population of approximately 2000 people.

Ambulance, transport and transfer systems are far more problematic in rural and remote areas, and difficulties associated with these services are the cause of much resentment and ill-feeling among Aboriginal people. In the recently released "Last Report" by the NSW Task Force on Aboriginal Health (Williams 1990), disturbing evidence was provided of racist and careless dealings with Aboriginal patients during transfers between health care services. For example,

> *the Task Force was told of patients, having being transferred to a base hospital from an outlying centre by ambulance, being expected to find their own way home in circumstances where use of an ambulance would have been appropriate...trauma patients are transferred, then discharged in towns many miles from home without money, sometimes dressed in hospital gowns or bloodied and torn clothes. The hospitals deny responsibility for return transport...* (Williams 1990, p.22).

While "tradition-oriented" Aboriginal communities of reasonable size in what is commonly thought to be remote Australia (WA, north-west SA, northern Queensland and the NT) have their own clinics *in situ,* it appears that rural populations sometimes have no easy access to services or equipment at all. The Task Force noted that

> *Aboriginal people from a number of isolated communities [in NSW], for example Tabulam, Tingha and Caroona, have asked for Primary Health Posts based in the community with basic medical supplies, staffed by volunteers from the community. Basic training, in first aid, could be provided by the Ambulance Service* (ibid., p.21).

It is not only Aboriginal children living in isolated communities away from quick health servicing who present poorly in terms of their overall health. A study of an Aboriginal community in "urban" Northern Territory (probably Darwin) found the

> *presence of malnutrition, burden of illness and poor immunisation status in an urban Aboriginal community. If this is the case, what is happening in the suburbs where Aboriginal children are less regularly checked by health workers?* (Evans & Powers 1989, p.72)

Street kids

The existence of "street kids" who are Aboriginal is obviously more marked in metropolitan and semi-urban areas than elsewhere. While there are at times "marginal" children without permanent carers or home camps in remote Aboriginal communities, it is in the cities that such youths are more noticeable.

In the Adelaide metropolitan area (as one example) some Aboriginal youths are now living in squats, but in general Aboriginal youths are living with relatives. Even those from bush communities (such as Yalata) usually have a relative with whom to stay. However, the homes for many of these urban Aboriginal youth are not stable, and young people are often in transit from one to another, with no consistent caregivers. This constitutes an important difference between Aboriginal and non-Aboriginal youth: Aboriginal youths may not be literally "homeless" but may suffer from the disadvantages of an uncertain and changing caregiving environment.

Urban Aboriginal and other youths in Adelaide have a diversion scheme in operation called the Youth Support Scheme; it is based in Banks Street, in close proximity to Hindley Street, which has perhaps the liveliest nightlife scene in the city. The scheme started in January 1989; it was initially a one-year project but was later extended, and is funded under state social justice funding. The scheme is a crisis intervention program: the police ring the service if they pick up young people and the staff try

to increase the level of cautionings in order to prevent incarceration and the taking of formal proceedings against kids. The service is also involved in co-counselling and liaison with the police, and even undertakes to do training days with the police. Workers also compile social background reports and participate in case conferences for the children's court. Teams of street workers (in pairs) cover the Hindley Street area on Thursday, Friday and Saturday nights from 7 p.m. to 1.30 a.m. There are approximately 500 individuals, Aboriginal and non-Aboriginal, on their files, but "the majority" of their case load is Aboriginal youth. The main presenting problems seen by the Youth Support Scheme workers are: threatened and attempted suicide; offending; street behaviour (potential offending); drug overdoses or reactions; and alcohol problems (Rosie Moyle, pers. comm.).

Also aimed at street kids in the centre of Adelaide, is The Second Storey, a drop-in and health centre (it was located in Rundle Mall at the time of my research), which is used primarily by 14 to 17-year-old teenagers. The centre has a half-time doctor and full-time nurse and its clinics are booked out for three to four weeks ahead. There are also youth workers, one of whom focuses on drug and alcohol issues, and family planning clinics are conducted. The place has a relaxed atmosphere, with coffee available and table tennis. However, very few Aboriginal youths now make use of The Second Storey, although this was not the case when the centre first opened. For this reason, the Aboriginal drop-in centre in Hindley Street now has a part-time community health nurse.

In Perth, the Aboriginal Child Care Agency is providing services to street kids, and estimates that over half of the street kids in Perth are Aboriginal, some as young as eight or nine years old. Choo reported:

> *the community needs rehabilitation programs, recreation facilities, a drop-in centre for young Aboriginal street kids, and education for their families, in order to change their lifestyles to exclude drug and alcohol abuse and chronic gambling* (Choo 1990, p.65).

In Darwin, facilities for street kids and other Aboriginal children in need were under some pressure. Casey House, a refuge, provides short-term crisis accommodation for up to three months, housing up to ten at a time. There is also another refuge for young pregnant women. The clientele of Casey House always includes some young Aboriginal people. Between July 1989 and June 1990, for example, Aboriginal residents comprised 14% (n=18) of the total (n=132); and in the four months July to October 1990, Aboriginal residents comprised 26% of the total. Some youngsters ask for help from Casey House without becoming residents (it was said that some dislike going to bed by 10 p.m.). Staff at Casey House help their residents with contraceptive advice, taking them to the Family Planning Association, and act as advocates on their behalf with social security, schooling and legal issues. They stressed, however, that unless their clients actively want to stop using alcohol or drugs, there is little they can do. There are no outreach health workers or legal workers for young people in Darwin – the available assistance is all crisis-oriented. As in other locations, the absence of Aboriginal workers was said to hinder effective contact with the Aboriginal population.

Sport, play and recreation

Sport and recreation facilities are often seen as a panacea for a variety of social ills among young people. They are mooted as part of the "solution" to drug and alcohol use and juvenile crime in particular. A critique of earlier policies which proposed youth movements (of various kinds) as a means of producing happy and non-threatening youths is provided by Cahill and Ewen (1987). They observe that the notion of one small population group "rescuing" another much larger group has produced timidity in addressing new issues affecting young people such as homelessness, unemployment, and sexuality. Further, they point out that youth inevitably implies orientation to the future, and yet the history of youth policy is full of "responses to today's problems with yesterday's solutions".

In a review of the impact of sport and recreation on juvenile crime, Gail Mason and Paul Wilson comment:

> *it cannot be concluded…that sports, recreation and wilderness programs are the new answer to high rates of Aboriginal and non-Aboriginal delinquent behaviour. However, we are now in possession of sufficient facts upon which to base the conclusion that sport and recreation do have the ability to play a role in the reduction of offending behaviour* (Mason & Wilson 1988, p.131).

The RCIADIC National Report devotes a chapter to 'Breaking the Cycle: Programs for Aboriginal Youth' (Commonwealth of Australia 1991, Vol.4, pp.165-210).

The impact of sports and recreation on the health of young Aboriginal people has not been measured; indeed it would be difficult to do so. But the indirect influence of participation in social or sporting activities is undoubtedly positive, and "keeping up the side" is a useful persuasive lever to use in educational programs about the ill-effects of petrol sniffing, and drinking among young Aborigines. Several remote communities with keen basketball and football teams use these arguments in attempts to reinforce the view that sniffing petrol (for example) makes the muscles weak and the brain slow and thus adversely affects an individual's sporting activities. Access to recreation facilities is also used in some communities as a "reward" for not using drugs. Sport and recreation are also classic diversions from the obsessions of group sniffing or drinking. In Arnhem Land a Christian revival which incorporated mass choreographed movement to modern spiritual rock music attracted large numbers of young

people, diverting many from their previous participation in sniffing groups.

Once again, it seems that remote-urban factors can be influential. While there are better equipped and functioning sports and recreation facilities available in urban areas, they are not specific to Aboriginal youth, and this may serve as a deterrent, particularly if instances of racist abuse or discrimination have occurred. In remote communities on the other hand, while hardware and supervising staff may be limited, the discreteness of the community may reinforce the popularity of a particular activity. Obtaining funds to purchase and maintain equipment, and to hire supervisory staff, is difficult for many remote communities. The YMCA no longer has a formal role in the provision of workers to Aboriginal communities, as these functions have been taken over by state or territory departments. Communities have to think ahead, apply for funds by the appropriate dates, and often must take responsibility for the employment of recreation officers. Often too they must raise the money themselves for specific items.

In the Northern Territory, for example, there are 16 communities with Aboriginal recreation officers funded by the relevant territory department; all but one are male. Training is non-existent or sporadic, though, and supervision difficult. There are two field staff (funded by the YMCA in Darwin) who offer support to these communities, and one is based in Alice Springs (Leon Zagorskis, pers. comm.). In Central Australia, however, several quite large communities have no youth worker or recreation officer, and the responsibility to run and supervise out-of-school activities often falls on the community adviser, or the teachers. Already stretched by their other responsibilities, these people often baulk at the extra work involved. I found that in some remote communities (particularly in Western Australia, and in Arnhem Land) the adults dominated the distribution of funds and resources and the control of access to some buildings within settlements. Their priorities took precedence over those of young people – despite the fact that in many communities over half the population is under 19 years old. In some communities heavily influenced by fundamentalist Christian beliefs, for example, adult Christians refused to allow the use of public or church-owned buildings for events such as roller-skating, play, or band practice (documented in Brady, in press). In these cases, some pointed consciousness-raising is required to enable the youth of the communities to lobby for resources and facilities.

Rural towns are often flash-points for Aboriginal-white confrontation, and local town councils often take alarming decisions which have poor outcomes in terms of race relations. In Port Augusta, South Australia, for example, an uproar among the Aboriginal community followed a proposal to impose a 10 p.m. to 6 a.m. curfew for city residents aged 16 and under (Adelaide *Advertiser*, 28/11/90, p.3). Aboriginal people perceived the curfew to be discriminatory and believed that Aboriginal, not white, children would be victimised by it. The town is not atypical, in that a local survey found that only four out of 123 17-year-old Aboriginal youths interviewed were employed. Of the 99 individuals interviewed in the 17 to 21 age group, only 11 had jobs. The town has no games centres, bowling alleys or amusement arcades; Aboriginal youths amuse themselves by swimming off the jetty, going to Friday night movies and playing football.

Broome in Western Australia is probably not a typical example of a rural town, with many visitors from bush communities. It has an active Police Youth and Citizens Club, well equipped with indoor sports, an oval, gym shed, roller skating rink, a canteen (for blue light discos), BBQ, pool, and ablution blocks. A committee of 15, of whom four are Aboriginal, run the PYCC. A "healthy" proportion of users of the club are young Aborigines, but there is a membership and use charge for the facilities. Also in Broome is a drop-in centre used by Aboriginal children and teenagers (Broome Youth Support Group). This is housed in a tin house, and operates in a low-key way as a place for youngsters to listen to rock music, play pool, and table tennis, and watch videos. Because the building is basic and homely, and the coordinator well known to the kids, the centre performs a valuable function for town dwellers, and has some visiting children from communities such as Lagrange and Derby as well. The place runs on a minimal budget of $40,000 per year; the building was donated by Lord MacAlpine, the pool table is second-hand, and the truck used to take kids out on weekend camping trips is borrowed from a local college. The girls are raising the $6000 needed to visit Perth for basketball by having raffles (Mal Mason, pers. comm.). Teenage Aboriginal boys in Broome said that they would like discos for their age group and more frequent trips out camping.

Broome has five Aboriginal bands and numerous other solo and duo performing musicians – a keen interest in Aboriginal rock music is supported by the Broome Musicians Aboriginal Corporation (Granich 1990). Thirteen recordings have emanated from Broome musicians, although the band Scrap Metal is the only one with top sales. The corporation holds concerts and organises voice and music recording workshops; there are alcohol free family concerts as well. There are Aboriginal rock bands in communities throughout the Kimberleys, and four members of the cast of "Bran Nue Dae" (the rock musical from Broome) are under 18 (Ali Torres, pers. comm.).

Some concluding ideas

In many ways young Aboriginal people are no different from any other youthful segment of the general population. They quickly become obsessed with the ideas,

activities and preoccupations of their peers, learn quickly from the mass media, and are in the process of establishing their identities as adults. Their health is low on their list of priorities, and risk-taking is normal behaviour. They are the healthiest of the age groups among the Aboriginal population, having survived the high infections and mortality of early childhood, and having (for the most part) not yet developed the symptoms of chronic illness which cause premature death in middle-aged Aboriginal people. But they are vulnerable to violence, accidents and poisonings, the leading causes of morbidity and mortality among them.

As a result of the widespread popularity of rock music and the burgeoning availability of Aboriginal-made music through recording companies and Aboriginal media organisations, several Aboriginal health organisations have utilised music and cassette tapes in prevention efforts. While there is no hard evidence that the lyrics of songs change behaviour (or are even internalised) these techniques are obviously more appropriate and viable as a means of reaching the young than formal workshops or written material. The use of AIDS rock songs, the production of music and voice cassettes in prevention campaigns, and low-key work by trained fieldworkers together with the free provision of condoms, are all already techniques being utilised by Aboriginal health services. These approaches are slowly beginning to take effect and are in need of ongoing support.

The highly significant impact of maternal education on child survival, as well as on the utilisation of health services, has been highlighted by research in developing countries. While this association remains undocumented among Aboriginal people in Australia, it is likely to be similar here.

Particularly in urban areas, the provision of drop-in centres with some health servicing attached, specifically for Aboriginal young people, is urgently required. In some states they exist, albeit tenuously, often under the threat of "mainstreaming" which would subsume their particular qualities under state bureaucracies. While it is difficult to verify the economics and services involved, the impression remains that Aboriginal youth in metropolitan centres have fewer resources and services associated with health matters than their counterparts in the bush. Larger, more dispersed populations in urban areas make it more difficult to reach a discrete segment of the Aboriginal population, such as youth, with a specific program (AIDS information, for example). Local Aboriginal health centres in remote towns or settlements have better access to teenagers and young adults, but nevertheless these clinics operate largely for the benefit of babies, children and women. It is hard to see how these agencies could attract more teenagers, particularly boys, when the norms of the age group prescribe that one presents for medical help only under extreme duress.

While many young Aboriginal people are under enormous stress from a variety of factors, both from within their own families and communities and from the wider society, this is not to say that all is lost. A long-term study (30 years) of an island population in the Hawaiian chain has documented the resilience of "high risk" children in the face of the ill-health and social stresses they experienced. One of the researchers in the study reported that

> *...as our study progressed we began to take a special interest in certain "high risk" children who, in spite of exposure to reproductive stress, discordant and impoverished home lives and uneducated, alcoholic or mentally disturbed parents, went on to develop healthy personalities, stable careers and strong interpersonal relations* (Werner 1989, p.76).

Researchers followed up 698 individuals born on the island of Kauai in 1955, many of whom became casualties in one way or another over subsequent years. Two trends began to emerge: the impact of reproductive stress diminished over time; and the "developmental outcome of virtually every biological risk condition was dependent on the quality of the rearing environment" (ibid., p.78). The quality of the home environment, then, outweighed all other factors in terms of the ability of the children to overcome earlier setbacks.

The researchers then looked more closely at 201 individuals (30% of the sample) who were designated high risk because they experienced severe perinatal stress, grew up in chronic poverty, were brought up by parents with few years of education, or who lived in families experiencing discord, divorce, parental alcoholism or mental illness. Two-thirds of these children did indeed develop serious learning or behaviour problems (by 10 years), or had delinquency records, mental health problems or pregnancies before the age of 18. However, 72 of these individuals (one out of three) "grew into competent young adults who loved well, worked well and played well. None developed serious learning or behaviour problems in childhood or adolescence". These were what the researchers termed "resilient children", and the research endeavoured to understand this resilience, despite considerable physical, social and environmental odds.

The "protective" factors were found within the children themselves, in the families, and in their wider social networks. Some of the sources of resilience seemed to be constitutional, within the individuals, and associated with temperament; they included high activity levels, a low degree of excitability and stress, and a high degree of sociability. These were not particularly gifted children, but they were able to use whatever talents they had effectively; usually they had a special hobby they could share with a friend. The family environment also seemed to contribute to the children's ability to deal with stress. They tended to come from families with four or fewer children, and "in spite of poverty, family discord or parental mental illness, they had the opportunity to establish a close bond with at least one caretaker" who

gave them positive attention in their early years. If a biological parent was not available, the resilient children seemed to be adept at attaching themselves successfully to surrogate adults. Girls appeared to be positively influenced if their mothers were employed, and if they were responsible for younger siblings; resilient boys had "some male in the family who could serve as a role model" (Werner 1989, p.79).

> *When we interviewed them at 18, many resilient youths mentioned a favorite teacher who had become a role model, friend and confidant and was particularly supportive at times when their own family was beset by discord or threatened with dissolution...With the help of these support networks, the resilient children developed a sense of meaning in their lives and a belief that they could control their fate. Their experience in effectively coping with and mastering stressful life events built an attitude of hopefulness that contrasted starkly with the feelings of helplessness and futility that were expressed by their troubled peers* (ibid., p.80).

By the age of 30 these men and women "seemed to be handling the demands of adulthood well", although they reported more health problems than their low-risk peers. Despite problems in their adolescent years (such as teenage motherhood, delinquency and mental health problems), many individuals were able to bounce back in their twenties and thirties. Significantly, one of the most critical of influences was the reliance on informal rather than formal sources of support, "kith and kin rather than mental-health professionals and social-service agencies" (ibid., p.81). In conclusion, Werner and his colleagues state that "risk factors and stressful environments do not inevitably lead to poor adaptation". They suggest that it might be possible to shift the balance from vulnerability to resilience through intervention, and point out that individual differences among children living in adverse conditions mean that there is a need for greater assistance to some than to others.

For Aboriginal children in Australia, the process of identifying particularly vulnerable children who lack the "protective" factors that will assist them to withstand stress, is poorly focused. Even if such children were identified at an early age, the provision of appropriate support services is made extremely difficult as a result of inconsistent funding arrangements, federal-state squabbling, "mainstreaming" arguments, and insufficient sensitivity to Aboriginal ways of doing things. Distance and isolation compound the difficulties.

As usual, it seems, we must fall back on the requirement that the "Aboriginal community" marshal its own resources and networks to overcome the disadvantages that childhood ill-health, parental unemployment and discord, and societal disdain load onto young Aborigines. This, of course, is a circular argument: there may be no "community" at all, or the community may itself be embattled and unable to operate as a supportive environment in and of itself.

Recommendations and key issues deserving attention

- Improving the health of young Aboriginal people can only take place in the context of improvements in the health status of all Aboriginal people in Australia. In turn, the physical, psychological and spiritual health of Aboriginal people is dependent upon the degree to which they have control over their own lives and feel able to initiate change. The basis for this overall notion of "health" must be laid down firmly by the enactment of a treaty with Aboriginal people, and by the granting of land rights in those states which have so far failed to enact appropriate legislation.
- The outstation movement, which is undoubtedly a crucial factor in the avoidance of alcohol- and petrol-related morbidity and mortality, should be actively supported by federal and state/territory governments. Infrastructure and adequately resourced support services must be provided so as to offer outstation life as a realistic option to those who so choose.
- To improve the health of young Aborigines, it is essential that federal and state/territory governments fully support and act upon the National Aboriginal Health Strategy and its recommendations. These include the principles of community control of primary health care, with the states retaining responsibility for secondary level, and other, health services.
- ATSIC, now responsible for Aboriginal health at a federal level, should employ some staff in its Aboriginal Health Unit who hold professional qualifications in public health, medicine/substance abuse, and with practical experience of Aboriginal health.
- Both the National Aboriginal Health Strategy and the Royal Commission into Aboriginal Deaths in Custody stressed the special role of Aboriginal community controlled organisations. All levels of government should recognise and support these organisations and welcome their pivotal position both in policy and program implementation.
- Intersectoral collaboration was stressed in the National Aboriginal Health Strategy and some specific recommendations made. Once again, there is a need to emphasise the necessity of collaboration and coordination between government departments. Actions by one department have an impact far beyond their bureaucratic boundaries, and many actions not specifically targeting health issues do affect the health of Aboriginal populations.
- Aboriginal mothers, particularly young mothers,

should be targeted in education and child and health care practices. Support systems within the broad primary health care system could be developed which focus on the needs of the mothers, complementing existing "Well Baby" and women's health programs. Raising the educational levels and status of women has been shown to have far-reaching impacts on their children's health.

- Priority support is needed for children who appear to lack the social bonds and financial supports that buffer them from stress, particularly those hospitalised for long periods in childhood and separated from their families, and those in families where alcohol abuse provides persistent discord and tension.
- Particular support should be provided for children of very young mothers, and for the mothers themselves, when there appear to be insufficient or overstretched caretakers such as grandmothers.
- There is a need for the expansion and development of Aboriginal-run services which could stress the importance of antenatal care for Aboriginal women, especially for teenage mothers. The Congress Alukura in Alice Springs has pioneered this development, which is crucial if Aboriginal women are to relinquish, albeit slowly, their hesitancy about matters associated with childbirth.
- Mechanisms should be established and supported through which contact could be made with young Aboriginal people about their priorities, and their participation elicited in any processes being set up to improve their health and that of their residential group. A "Caravan for Youth" program for Canadian native communities proved to be one way of motivating young people to take more active roles in their communities.
- Aboriginal youth conferences could be convened, either nationally or on a regional basis. In Canada, young native people attend regional workshops and hold teleconferences on drug and alcohol abuse and suicide prevention.
- A complexity of issues needs to be addressed that impinge on the lack of meaningful activity and employment which is associated with much Aboriginal ill health among the young. In particular the problem of limited access by Aboriginal people to the mainstream educational system needs to be addressed. This affects their abilities to access future training and employment prospects. Programs such as Job Start and New Start need to be made even more flexible to fit with remote and rural area requirements.
- Alcohol use remains a key issue in many regions of Australia, with the prevalence of heavy consumption providing an ongoing negative learning environment for young people, as well as depriving them (through premature mortality) of the help, support and educative functions of mature adults. The initiatives and program-development emanating from Alice Springs (which has established a Central Australian Aboriginal Alcohol Planning Unit) should receive the full support of all government agencies. Professional training programs for Aboriginal alcohol workers in conjunction with a variety of treatment and rehabilitation centres, are a priority. The initiatives in Central Australia could become a model for similar training and treatment interventions elsewhere in the country.
- Specific funding to Aboriginal health services is needed for youth workers to concentrate on AIDS and sexually transmitted diseases, as well as for counselling and emotional support for adolescents.
- Ongoing support is recommended for locally-run, low-profile drop-in centres, youth groups and youth health services for Aborigines in country towns and urban centres.
- Aboriginal organisations should be encouraged, and financially supported, in the production of music cassettes, cartoons, comics, videos and rock bands as media for carrying health prevention messages.
- Consciousness-raising in remote communities should be promoted regarding the needs of young people for facilities, recreational hardware and staff support. At present adult-dominated councils pay scant attention to the requirements of (usually) 50% of their populations. Government departments and ATSIC also have a critical function here to promote the interests and well-being of adolescents and to direct resources appropriately.
- Church groups for Christian movements should be encouraged to relinquish hard-line fundamentalist approaches which alienate young Aboriginal people and discriminate against their interests in rock music, local bands and discos.
- Young Aborigines sould be involved and represented in formal and informal bodies where possible. In some communities or regions, the formation of youth councils might be feasible, in order to give young people some voice. While in some regions young girls and boys have little status, and no ritual status in religious matters, there is no reason why they cannot contribute their views on secular issues that concern them.