Challenging our own practices in Indigenous health promotion and research

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Introduction

The 2006 National Conference of the Australian Health Promotion Association was called ‘Health Promotion Dreaming: shifting the sands’ and was held in Alice Springs. A significant focus within the conference was on the health needs of Australia’s Indigenous population. One of several Indigenous keynote speakers at the conference, Māori academic and public health physician Dr Papaarangi Reid raised some hard questions for health promotion – and these apply equally to public health researchers and practitioners. Dr Reid said we need to challenge ourselves – to critique our own practice. Good intentions are not good enough. She pointed out that at a population level, health promotion is most successful among upper and middle class citizens (for example, screening programs, addressing tobacco use or healthy schools initiatives) and that the failure of health promotion among people from lower socio-economic status and diverse ethnic backgrounds is amplified in Indigenous communities.

In response to Papaarangi Reid’s challenge, we have been reflecting on our own practice as public health researchers and health promotion practitioners, and asking ourselves whether our research and health promotion interventions are challenging or reinforcing the very values that have led to the disadvantage, neglect and apathy experienced by Indigenous populations in the first place. As one Indigenous and two non-Indigenous researchers working within the Aboriginal community-controlled health sector, we believe that research – if carried out in ways that divulge power through respecting Aboriginal culture and community control – can provide benefits to the Aboriginal communities we work with. Although we are all engaged in collaborative projects aimed at improving health outcomes for Aboriginal people in Victoria, we have been thinking about the way in which raising health issues can serve to further ‘discredit’ communities or social (a) In this paper we use Indigenous or Aboriginal to refer to the Aboriginal and Torres Strait Islander peoples in Australia. We recognise the diversity of Australia’s Indigenous population and that different groups and communities within this population choose to refer to themselves by different clan, group or tribal names.

Abstract

At the 2006 National Conference of the Australian Health Promotion, Māori academic and public health physician Dr Papaarangi Reid challenged us to critique our own practice and asked whether health promotion needs to be de-colonised. In this paper, one Indigenous and two non-Indigenous researchers working within the Aboriginal community controlled health sector reflect on ways in which research and health promotion interventions with Indigenous populations challenge or reinforce the very values that have led to the disadvantage, neglect and apathy experienced by Indigenous populations in the first place. While our practice is framed by the principles of Aboriginal self-determination and community control, we suggest that de-colonising is not so much about the need to invent new research methods nor to search for research methods in traditional Aboriginal culture; it is much more about values, processes and relationships. We recognise the need to challenge the deficit model in health promotion and research, and we do not want to inflict any more damage to the community, through reinforcing stereotypes, creating fear, or contributing to further bad press. We argue for adopting a methodology that shifts power and enables Indigenous people to frame research in ways they want it framed, and for taking a holistic approach and focusing on community strength and resilience.

Key words: Indigenous, methodology, de-colonising, community control, Aboriginal

So what?

With increasing calls to ‘close the gap’ in health inequalities between Indigenous and non-Indigenous Australians, it is critical that health promotion researchers and practitioners reflect on the way we work with Indigenous communities and accept the challenges of a de-colonising approach to our practice.
groups who are already disadvantaged. Sociologist Deborah Warr has warned researchers that the risks of “drawing attention to the things that are going wrong… need to be weighed against the even greater risks of apathy and neglect in impoverished [and disadvantaged] communities”. There is no doubt that Aboriginal and Torres Strait Islander communities suffer from continuing neglect and apathy from governments and most segments of the mainstream community. And neglect and apathy continue to reinforce entrenched Aboriginal disadvantage. On the other hand, media attention almost always focuses on deficit and dysfunction in Aboriginal and Torres Strait Islander communities. Media portrayals of Aboriginal disadvantage at once highlight the critical situation for Aboriginal people in particular contexts but also reinforce entrenched stereotypes and obscure the historical, political and structural causes of disadvantage.

As researchers and practitioners, we often respond either to the neglect and apathy, or to the media attention given to Aboriginal ill-health, or to government calls for research or intervention. A great many, if not the majority of health promotion and public health projects focus on the negative aspects of individuals or community health. This deficit model of health is illustrated in endless media reports of Indigenous disadvantage which tend to highlight communities where there have been reports of high levels of alcohol use, petrol-sniffing or family violence, and low levels of literacy or school attendance. We need to ask whether raising these kinds of health issues is good or bad for the Indigenous community: good, because the issues are being addressed and may lead to research or intervention; or bad, because it is reinforcing stereotypes or adding more stigma, and may lead to more descriptive research but nothing of benefit to the community.

We may feel pleased when we succeed in obtaining funding to carry out a research or health promotion project that we believe will benefit an Aboriginal population. But, as Dr Reid pointed out, since it is largely government that dictates the health promotion priorities, we need to be particularly discerning because part of the government’s discourse today is around blame, shame, deservedness, individual responsibility, and less government responsibility. The mere fact of funding an Aboriginal project around a specific health problem and not funding a mainstream project can send a message that it is an Aboriginal problem, that Aboriginal culture, Aboriginal practices or Aboriginal choices are to blame. The problem is more likely to do with poverty and social exclusion resulting from years of colonisation and ongoing discrimination. In other words, the causes of the problem are to be found in history; in past and present government policies and practices; in institutions such as schools, medical clinics and hospitals; and in public attitudes, yet the focus of the health promotion or research project converges on Aboriginal communities and individuals within them.

Writing about class inequalities, Beverley Skeggs has pointed out that state-funded research can often be an example of the state deflecting attention away from structural inequalities by focusing on individual behaviours such as the ‘young mother’ or the ‘heavy drinker’ or ‘smoker’, or community behaviours such as schools where the literacy levels are low, families who buy and eat fast foods, Aboriginal communities where there are high rates of alcohol consumption. In this way the state also draws a moral distinction between ‘worthy and unworthy’ recipients of state services and between the ‘socially responsible’ and those who can be excluded from benefits accorded to other citizens in the community.

What is the solution? Papaarangi Reid said ‘we have to put Māori first’ and because we work in Aboriginal health in Victoria we are guided by the need to put the Koori community first. We try to do this through our commitment to community control, adopting a de-colonising approach to research, and challenging the deficit model of health promotion and research.

Between us we have nearly 30 years experience working within Aboriginal health and attempting to deal with some of these challenges. We do not, of course, presume to have the solutions but we would like to offer some reflections from our combined experience and to contribute to an ongoing discussion of how health promotion can meet these challenges.

**Commitment to community control**

One of us is an Indigenous public health policy officer employed within an Aboriginal community-controlled health organisation (ACCHO), one is a non-Indigenous researcher-in-residence at the ACCHO and the third is a non-Indigenous PhD student who is ‘learning while working within the community’ at the ACCHO. The two non-Indigenous authors are fortunate that our university responsibilities are supported by an academic unit that has strong Indigenous leadership, a majority of Indigenous staff, and a program of teaching, research and community development that are underpinned by principles of Aboriginal community control.

The way we try to do public health research and health promotion is framed by the principles of Aboriginal self-determination and community control. Ideally, our research and health promotion projects are initiated by the community; we respond to issues that are raised within the community controlled health sector. The policy officer is directly responsive to the membership of the ACCHO; the researcher-in-residence works on research that is initiated by the ACCHO; the student is working collaboratively with the ACCHO to undertake a PhD on a topic that arose from within the Aboriginal community controlled health sector. The PhD student has three Indigenous supervisors, including two from the Aboriginal community-controlled health sector and has negotiated with her university to share with the ACCHO ownership of all data and findings arising out of her thesis. We
are all three accountable to our Aboriginal colleagues, to the CEO, and through her to the Board and to the member organisations (the ACCHOs) throughout Victoria. We are also accountable to the community through individual Project Agreements (or Memoranda of Understanding) and Project Steering Committees made up of Indigenous community representatives. Our research findings are submitted to the Project Steering Committees and to the Board for approval before any community dissemination or academic publication.

Adopting a de-colonising approach

Māori academic Linda Tuhiai Smith has famously observed that the term ‘research’ is “inextricably linked to European imperialism and colonialism”. Smith argues that Western research “is research which brings to bear, on any study of [I]ndigenous peoples, a cultural orientation, a set of values, a different conceptualisation of such things as time, space and subjectivity, different and competing theories of knowledge, highly specialised forms of language, and structures of power”. However, Smith does not call for a total rejection of Western research, theory or knowledge. She explains that “Indigenous methodologies tend to approach cultural protocols, values and behaviours as an integral part of methodology… as ‘factors’ to be built in to research explicitly, to be thought about reflexively, to be declared openly as part of the research design, to be discussed as part of the final results of a study and to be disseminated back to the people in culturally appropriate ways and in a language to be understood”.

We suggest that de-colonising is not so much about the need to invert new research methods nor to search for research methods in traditional Aboriginal culture; it is much more about values, processes and relationships. Whether Indigenous or non-Indigenous, any researcher who is committed to a de-colonising approach must develop strategies for devolving or sharing power with the participating communities. If we are genuine about including communities in the research endeavour, and if we go about things respectfully and with patience, taking the necessary time to develop relationships of mutual trust and shared understanding, we are contributing to the process of de-colonising research.

Numerous academic and community guidelines now require researchers to obtain approval in an appropriate form from the relevant community before commencing any research. The NHMRC now allows time and funding for this process. Most properly constituted ethics committees now demand written documentation of the approval process. Before our research begins, we inform the Indigenous community through a range of avenues such as community newsletters, community forums and ACCHO executive meetings. Community members are thus informed about the nature of the research or health promotion project before we visit their organisation to commence any intervention or data collection.

Having a community-controlled reference group, or better still, a steering group with power to steer rather than merely advise the project team, is almost mandatory under ethical guidelines for Aboriginal and Torres Strait Islander research. We want to stress the importance of establishing a steering group early in the project. People are often anxious about who should be on the group, how to make sure it is representative. We have found it best to start with two or three key Aboriginal people and ask them to nominate others onto the steering group. That’s what community control means – the community will nominate their own representatives.

The language of research and health promotion is the language of the colonisers. Aboriginal people quite reasonably object to many words that carry a history of oppression and discrimination. Words like ‘research assistant’ echo the many ways in which they were forced to assist the colonisers in schools or health services, but never allowed to take on the real role of teacher, nurse or doctor. ‘Training’ sounds like something that is done to animals, or domestic servants, while real education was only available to white people. We need to think about language and to use culturally appropriate and respectful language — referring to our Aboriginal co-researchers as Researchers, Research Officers or Project Officers. Rather than offering training, we need to think about the two-way learning process possible through capacity exchange or sharing knowledge and experience.

Smith has talked about the importance of what Māori call Kanohi kitea or the ‘seen face’ for developing and maintaining credibility within the community. In order to gain an understanding of what an Aboriginal model of public health would look like, the PhD student’s project involves a process she has termed “learning while working within the community”. This process has been developed in an attempt to de-colonise the conventional anthropological method of participant observation. Its focus is on practical skill-sharing rather than mere participation and on learning from and with the Indigenous community rather than observing and note-taking. Reciprocity, respect and capacity exchange are key characteristics of this method. Part of the process of working with Aboriginal communities is to share community life, join in the NAIDOC celebrations or the Sorry Day march and, when you are invited, to attend celebrations and funerals. As an Aboriginal colleague explained to one of us recently, “Remember, if we let you in to our community and make friends with you, it’s for life. We have shared the births of your babies, we know you, you belong to us.” This is a privilege that is not available to most researchers. And the obligations that come with that relationship are ongoing.

Reciprocity can take many forms, and we recognise that researchers can offer many skills to community organisations.
We can read lengthy ethics applications or policy documents that come across the desks of busy health workers and managers, we can help write funding submissions, we can do literature searches for useful up-to-date information, we can help supervise students on placement, and we can build capacity within the organisation while we do it and we can also make cups of tea and wash up when there’s a meeting or a big event in the organisation.

Ethical guidelines stress how important it is that consultation and feedback are ongoing throughout a project, and that research or health promotion interventions need to have tangible outcomes that the community wants. Outcomes may be posters and booklets for the community, or may be videos. Or it may be the development of a new course for Health Workers, or a school-based healthy eating program. We try to produce community reports written in a style and format that is attractive to Aboriginal Health Workers and community members. This means writing clearly, avoiding jargon, and producing a booklet that looks attractive and relevant (see for example 13-16).

A critical step in the de-colonising process is giving proper acknowledgment to the co-researchers, the steering group and the participants in the project. How people want to be acknowledged should be discussed with the steering group and with the participants early in the process and again at the end. We need to consider who are really the co-authors on the project and ask if people want to be anonymous or want to be named, and how. Of course, we also need to make sure we include proper Acknowledgements in any publication. The way we acknowledge our participants, the communities we consulted, and the people who carried out the research is an important part of reporting the processes of consultation and community engagement. Failure to report these processes raises questions about the legitimacy and validity of the research. Far too few researchers do this as evidenced in a recent literature review. A systematic review of Australian Indigenous child health, development and well-being epidemiological studies conducted in 2006 found that of 214 studies identified, 71.5% of them did not report whether Indigenous people had been involved in the research process (other than as participants). Journals may need to consider developing guidelines for authors in order to address this gap.

Challenging the deficit model

To return to the main challenge raised by Papaarangi Reid: this is the importance of challenging the deficit model for health promotion and research. As other Indigenous leaders and researchers have noted, we need to focus on communicating the positive stories from communities. As Indigenous and non-Indigenous researchers, we do not want to inflict any more damage to the community through reinforcing stereotypes, creating fear, or contributing to further bad press. While acknowledging that we can have little impact on mainstream media representations of the deficits in Aboriginal communities, we try to focus on the positive aspects, drawing on people’s strength and resilience. We adopt the holistic view of health as defined by the National Aboriginal Health Strategy Working Party: health is “not just the physical well-being of the individual, but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life.” We understand the importance of taking into account the structural causes of Indigenous health inequity, particularly those related to colonisation and oppression, and of developing interventions that avoid victim-blaming. An example of how we applied these strategies is a project that was funded to address alcohol use during pregnancy in the Victorian Aboriginal community. Acting on the advice of our project Steering Committee, we adopted a holistic approach for the development of resources that stressed the positive aspects of a healthy pregnancy, avoided any blaming or shaming of the individual woman, and focused on the responsibility of a whole community to support women to be healthy during pregnancy.

Conclusion – challenges within the challenges

Resisting the deficit model is often difficult because, as we have already pointed out, media and government so often draw attention to health needs through stigma and lack. Research and health promotion funding often dictates or results from such attention. If we are concerned about the health problems that have been raised, and the funding to address them is available, it is hard to ignore the opportunity that is presented. However, there are positive ways of addressing health issues that have been framed as deficits, and we have argued above for taking a holistic approach and focusing on community strength and resilience. Furthermore, there is a real need for health researchers and health promotion practitioners “to reflect critically upon the purposes that our research may serve, and the way in which our concepts and methods feed into these purposes”, and we have also argued for a methodology that shifts power and enables Indigenous people to frame research in ways they want it framed.

The second challenge is how to maximise academic rigour without causing any harm to the community. While compromises in research design are inevitable in collaborative participatory research, documentation of such compromises is necessary for academic rigour. We believe that if we are serious about community control, and if we are serious about research doing no harm, then we are going to find ourselves faced with situations where we have to compromise academic expectations. We may not be able to complete our rigorous sampling plan; our steering group may find it difficult to meet...
as a group and we may be given different advice by different members of the group each time we meet; the language used in the validated interview schedule may be completely inappropiate and have to be radically changed. But we believe that flexibility of method is a critical component in a de-colonising approach, and we would argue that data quality and the interpretation of results can be greatly improved by the level of community engagement.

Finally, we recognise that academic training encourages autonomy and leadership and many health researchers and practitioners will not find it easy to relinquish or share control. Other researchers have acknowledged their desire to retain control of the research, fearing the disruption of their research agenda, methods or time frame, and recognising that power sharing is a ‘messy process’.27 Putting ideals of equality into practice is not easy, despite the best intentions of researchers.28-30 Mason Durie has pointed out that although non-Indigenous health professionals have important roles to play in addressing health disparities, they should respect the leadership that already exists in Indigenous communities.2 Durie also notes that non-Indigenous practitioners of health promotion will be challenged by Indigenous perspectives. The failure of so much health promotion and research that has been based on western models calls for us to follow Paparang’s Reid’s advice, to challenge ourselves and to give de-colonising methods a chance.

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