Aboriginal health information bulletin, number 17, May 1992

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Aboriginal health information bulletin

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Editor: Dr Neil Thomson
Assistant Editor: Bruce English

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Guidelines for contributors

Articles which could be published in `Brief communications', `Selected reviews' or `Book reviews' are most welcome. Those suitable for `Brief communications' or `Book reviews' should not exceed 1,500 words.

The Editors would be grateful for any assistance in the compilation of the *Bulletin*, particularly with regard to `Current topics', `Recently published research', and `Recent reports, publications and theses'.

Authors are urged to write in plain English so that their works can be easily understood. They should follow the style used in the most recent issue of the *Bulletin*. In other cases the recommendations of the AGPS *Style Manual* should be followed. The Harvard system of referencing should be used.

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Contents

Editorial

This issue marks the tenth anniversary of the *Aboriginal Health Information Bulletin*. The *Bulletin* was initiated in April 1982 as part of the Australian Institute of Aboriginal Studies' (now Australian Institute of Aboriginal and Torres Strait Islander Studies—AIATSIS) Aboriginal Health Project—a major purpose of which was to collect, collate and disseminate information about Aboriginal health. The difficulties experienced by the Project in the collection of information from the many and varied sources led to recognition of the need for a publication like the *Bulletin*, which provides abstracts of recent research (including journal articles, monographs, other publications and theses), reference to current developments in the field, brief articles and reviews on issues of current interest, and major publications about Aboriginal health.

The *Bulletin* was published by AIATSIS until the completion in 1985 of the Aboriginal Health Project, after which there was a delay of production until August 1987, when it became a joint publication of the Australian Institute of Health (now Australian Institute of Health and Welfare—AIHW) and AIATSIS. This arrangement continued until May 1991, when, following a policy change within AIATSIS, the Institute of Health assumed full publication responsibility.

I am most grateful to my two co-editors over the 10 years—Dr Pat Merrifield (from number 9, February 1988 to number 14, November 1990) and Bruce English (from number 15, May 1991 to the present). I would also like to thank the many other people who have assisted in the production of the *Bulletin*—particularly the many contributors and people who have provided other information. Without their help, the viability of the *Bulletin* would have been less certain. I request your continued assistance as the *Bulletin* enters its second decade of publication.

Of the many changes that have occurred in Aboriginal health since the first edition of the *Bulletin* in April 1982, certainly the most significant has been the decision by all governments—Commonwealth, State and Territory—to implement a National Aboriginal Health Strategy. The key elements of the National Aboriginal Health Strategy and developments in its implementation are summarised in the *Selected reviews* section of this edition.

Another important development in recent years has been the formalisation by the National Health and Medical Research Council of ethical guidelines for Aboriginal health research. An important component of these guidelines is the need for researchers to provide the results of the research to communities and individuals. Ernest Hunter's paper in this edition summarises and analyses the feedback process used during, and subsequent to, research conducted in the Kimberley region of Western Australia.

To a large degree, the contents of the *Bulletin* provide a useful measure of the focus of Aboriginal health research. Peter Lake's content analysis of research studies (abstracts or full reports) in the 15 issues from April 1982 to May 1991 reveals major deficiencies in some areas and, as the author notes, `may serve to highlight future directions and priorities for Aboriginal health research'.

Reflecting on the 10 years of the *Bulletin*'s publication, I am grateful to the Australian Institute of Aboriginal and Torres Strait Islander Studies and the Australian Institute of Health and Welfare for the funds which have made its production and distribution possible. I repeat my thanks to my two co-editors (Pat Merrifield and Bruce English) and the many other people who have assisted over these 10 eventful years.

Neil Thomson

Current topics

Drug and alcohol initiatives as a result of the Royal Commission into Aboriginal Deaths in Custody

In its National Report, the Royal Commission into Aboriginal Deaths in Custody drew attention to the major impact of alcohol and substance abuse on Aboriginal health (and on a considerable number of the deaths in custody).

As part of its response to the National Report, the Commonwealth Government announced in March 1992 that it would provide an additional $71.6 million towards these areas over the next five years. The Aboriginal and Torres Strait Islander Commission (ATSIC) will be provided with $61.6 million to cover a wide range of innovative responses to substance abuse, including information and education, detoxification, rehabilitation and after-care. The remaining $10 million is to be provided to the Commonwealth Department of Health, Housing and Community Services for drug-related education and research activities in Aboriginal health.

Council for Aboriginal Health

The Council for Aboriginal Health (CAH), one of the key components in the implementation of the National Aboriginal Health Strategy, has been established and had its first meeting in April 1992 (for details, see article in *Selected reviews* section of this *Bulletin*).

Aboriginal health research workshop

On 28–30 April 1992, the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) convened a workshop in Canberra to examine the role of research in 'confronting the barriers to improvements in Aboriginal health'.

Around 70 representatives from Aboriginal health services and health researchers from around Australia participated in the workshop, which met in 10 working groups over three days. These groups considered the barriers and possible research responses in a number of areas: the physical environment; social factors; health service delivery; injuries (including motor vehicle accidents) and domestic violence; mental health and substance abuse; circulatory and nutritional disorders; respiratory, ear and eye disorders; and communicable diseases. There were also two Aboriginal-only sessions relating to specific issues in men's and women's health.

To seek community and other views, the recommendations adopted by the workshop were circulated for comment to ATSIC Regional Councils, Aboriginal health services and other Aboriginal community organisations, Commonwealth, State and Territory health authorities and State and Territory tripartite forums.

After the incorporation of this feedback, it is intended to present the recommendations to the Council for Aboriginal Health and publish the proceedings of the workshop.

Enquiries should be directed to Steven Wild, Conference Convenor, AIATSIS, GPO Box 553, Canberra, ACT 2601, telephone (06) 246 1111.

Recently published research

Bower C, Stanley F, Connell AF, Gent CR & Massey MS
Birth defects in infants of Aboriginal and non-Aboriginal mothers with diabetes in Western Australia
Medical Journal of Australia 1992 156:520–524

In a retrospective cohort study of all births occurring in Western Australia in the period 1980–1984, it was found that birth defects in infants of Aboriginal mothers exhibiting some form of diabetes was higher than in infants of non-Aboriginal women presenting with similar medical conditions. The study concluded that the excess of defects in infants of Aboriginal women with gestational diabetes may be due to non-insulin dependent diabetes that is undiagnosed and predates pregnancy. The authors suggest that, for Aboriginal infants, maternal diabetes may be the single most common known cause of birth defects that is amenable to change.

Cordner S
The Royal Commission into Aboriginal deaths in custody: aspects of medical interest
Medical Journal of Australia 1991 155:812–818

This review summarises the background, work and National Report of the Royal Commission into Aboriginal Deaths in Custody. It summarises the Aboriginal deaths examined by the Commission, and considers particular medical issues relating to police and prison custody, and to the post-death investigations.

Crawford DH, Shepherd R, Cooksley WG, Patrick M & Powell LW
Wilson's disease in an Australian Aborigine
Journal of Gastroenterology and Hepatology 1990 5(6):705–707

This paper reports on only the second case among Australian Aborigines of Wilson's disease—an autosomal recessive genetically-determined defect.

Creasey SA
Epidemic meningococcal meningitis in central Australia in the 1970s [letter]
Medical Journal of Australia 1991 155:725–726

This letter reports a review of the medical records of all patients with bacterial meningitis admitted to the Alice Springs hospital for the period 1971 to 1980, with particular reference to meningococcal meningitis.

Of the 105 cases of meningococcal meningitis, 90 cases occurred in 1971–1973. There were 80 Aboriginal and 10 non-Aboriginal cases. During 1971, 25 per cent of cases occurred in Alice Springs; in subsequent years, all but three cases occurred in rural settlements. In epidemic years, school-age children were the most affected group, followed by children under 5 years of age. The author concludes that the epidemic rates were more typical of a developing country than a developed country like Australia.

Flynn M
Supply of kava: is it another Aboriginal offence?
Aboriginal Law Bulletin 1991 2(53):10–11

Under new consumer protection legislation in the Northern Territory, people who supply and/or sell kava are liable for a fine of up to $20,000. The author argues that this legislation should not be used to address a social problem that is essentially targeted at the Aboriginal population. It is also argued that little notice has been taken of the role kava has come to play in certain communities in central Arnhem Land where it used to keep communities free of the violence and social disruption caused by alcohol.

Gilbert GL
New vaccines for *Haemophilus influenzae* type b disease
Medical Journal of Australia 1992 156:518–520

This article summarises recent developments in vaccines against *Haemophilus influenzae* type b (HiB), a bacterium which can cause serious infection in early childhood, particularly for Aboriginal children in some areas of Australia. The author reviews the conjugate vaccine, and considers the implications of administering Hib vaccines.

Gracey M
Nutrition and infections in Australian Aboriginal children
Australian and New Zealand Journal of Medicine 1991 21(6):921–927

This paper, which is an abridged version of the Annie B Currie lecture delivered at the Annual Scientific Meeting of the Royal Australasian College of Physicians in Perth in May 1991, examines the interaction of nutrition, infections and growth in Aboriginal children.

The author reviews the evidence of gastrointestinal and other infections, and summarises the patterns of growth of Aboriginal children living in the Kimberley region of Western Australia.

Gunzburg S, Gracey M, Burke V & Chang B
Epidemiology and microbiology of diarrhoea in young Aboriginal children in the Kimberley region of Western Australia
Epidemiol Infect 1992 108(1):67–76

This paper reports on a 12-month prospective study of more than 100 Aboriginal children aged up to 5 years living in remote communities in the Kimberley region of Western Australia.

Diarrhoeal episodes were common (173 specimens were taken at the time of an acute episode); particularly in the first 2 years of life, and were associated with the presence in stools of intestinal parasites, and bacterial and viral pathogens. Diarrhoeal disease was more common in the early wet season (November to January) than at other times of the year.

Hunter EM
Stains on the caring mantle: doctors in Aboriginal Australia have a history
Medical Journal of Australia 1991 155:779–783

The author uses historical instances drawn from northern Australia, particularly the Kimberley region of Western Australia, to show why medical practitioners are sometimes viewed with ambivalence by Aborigines. He concludes that for clinical and research doctors to contribute positively to Aboriginal health and to continue to be given privileged access to Aboriginal communities, they should be aware of the profession's history in Aboriginal Australia and that privileged access must be earned, not assumed.

Hunter EM, Ellis RG, Campbell D & Fagan PS
The health of indigenous peoples
Medical Journal of Australia 1992 156:575–577

This overview of the Public Health Association of Australia conference, held in Alice Springs from 29 September to 2 October 1991 (see *Bulletin* 16:4), covers a wide range of topics including substance abuse, diabetes, hypertension and mental health, and emphasises the importance of community control.

Matthias GSH & Morgan G
Aboriginal and non-Aboriginal perinatal deaths in Darwin: a comparative view
Medical Journal of Australia 1992 156:533–537

A retrospective review of 198 perinatal deaths of infants delivered in the maternity unit of Royal Darwin Hospital between 1984 and 1989 revealed that the perinatal, late fetal (stillbirth) and neonatal death rates for Aborigines were around three times those for non-Aborigines. There were no significant differences in the distribution of Aboriginal and non-Aboriginal deaths when classified by cause—with the exception of pre-eclampsia, which was associated 2.5 times more commonly with Aboriginal than with non-Aboriginal perinatal deaths.

McIntyre P
Invasive *Haemophilus influenzae* type b disease in Australia: the beginning of the end?
Medical Journal of Australia 1992 156:516–518

The article reviews the epidemiology and public health importance of invasive *Haemophilus influenzae* type b disease, and reviews the efficacy, safety and cost of available vaccines. It is pointed out that the incidence of the disease is at least five times higher for Aboriginal children in some parts of Australia than for non-Aboriginal children.

McMillan SJ
Food and nutrition policy issues in remote Aboriginal communities: lessons from Arnhem Land
Australian Journal of Public Health 1991 15(4):281–285

In this article, the author demonstrates how dietary habits can be altered by the food purchasing policy of the main supplier to remote Aboriginal communities. The influence of government policy on sales tax and private sector capital city pricing policies are also examined, as are the roles of supply and demand.

Munoz E, Powers JR, Mathews JD
Hospitalisation patterns in children from 10 Aboriginal communities in the Northern Territory
Medical Journal of Australia 1992 156:524–528

This paper describes the results of a retrospective analysis of episodes of hospitalisation for Aboriginal children living in ten communities and three outstations in the Northern Territory in 1976–1985.

Aboriginal children were admitted to hospital and stayed longer than did non-Aboriginal children. In contrast to Western Australia, where admission rates for Aboriginal children had declined, there had been an increase in rates in the Northern Territory. The main causes of hospitalisation were attributed to diarrhoea and respiratory problems. Admission rates were influenced by age, community of residence and calendar year from 1976 to 1985.

The authors suggest that intervention strategies aimed at modifying social, behavioural and environmental factors could result in a reduction in morbidity, and in hospitalisation rates.

Munoz E, Powers JR, Nienhuys TG & Mathews JD
Social and environmental factors in 10 Aboriginal communities in the Northern Territory: relationship to hospital admissions in children
Medical Journal of Australia 1992 156:529–533

The authors report the results from a specially devised scoring system to analyse the impact of social and environmental factors in the substantial differences between 10 communities in the Northern Territory in the hospitalisation rates of children. Based on a correlation of social and environmental factors with the degree of community development and the health of Aboriginal children, the authors suggest further studies to identify and quantify those factors that are most effective in improving health.

Prociv P, Luke R & Quayle P
Isosporiasis in the Aboriginal population of Queensland
Medical Journal of Australia 1992 156:115–117

This paper reports the results of a ten-year retrospective study of the endemicity of *Isospora belli* in children under 15 years of age from all Aboriginal communities of Queensland.

Microscopic examination of preserved faecal matter allowed the researchers to conclude that isosporiasis is endemic in the Aboriginal population of Queensland and, due to the difficulty associated with diagnosing the organism, is likely to be more common than indicated.

Schultz R, Read AW, Straton JA, Stanley FJ & Morich P
Genitourinary tract infections in pregnancy and low birthweight: case-control study in Australian Aboriginal women
British Medical Journal 1991 303:1369–1373

A retrospective study of births to Aboriginal women in Western Australia in 1985–1987 found a strong association between singleton births weighing less than 2,250 grams and the presence of genitourinary tract infections both during pregnancy and at the time of delivery. The authors recommend a community intervention trial of screening and treatment of genitourinary infections in pregnant Aboriginal women.

Smith RM, Spargo RM, Hunter EM, King RA, Correll RL, Craig IH & Nestel PJ
Prevalence of hypertension in Kimberley Aborigines and its relationship to ischaemic heart disease
Medical Journal of Australia 1992 156:557–562

Based on the results of a stratified random sample of 249 men and 241 women from the Aboriginal population of the Kimberley region of Western Australia, the authors conclude that the prevalence of both systolic and diastolic hypertension, and of probable ischaemic heart disease (IHD), was two to three times higher in Kimberley Aborigines than in the general urban population surveyed in 1983 by the National Heart Foundation. Particularly high blood pressures were found in young Aboriginal men, and for both Aboriginal men and women there was a relationship between IHD and systolic hypertension.

Smith RM, Spargo RM, King RA, Hunter EM, Correll RL & Nestel PJ
Risk factors for hypertension in Kimberley Aborigines
Medical Journal of Australia 1992 156:562–566

Alcohol consumption was found to be associated with high blood pressure among young Aboriginal males and with diastolic hypertension in middle-aged males. The study also found a significant relationship between body mass index and blood pressure, and the authors suggest that overweight may account for the elevated prevalence of hypertension among Aboriginal women. They also suggest that the association between plasma cholesterol and blood pressure in both men and women may be relevant to the demonstrated link between systolic hypertension and ischemic heart disease.

Thompson JE, Sleigh AC, Passey ME, Barnes A & Streatfield RW
Ventilatory standards for clinically well Aboriginal adults
Medical Journal of Australia 1992 156:566–569

This study of 229 north Queensland Aboriginal adults without evidence of respiratory disease (as with most such studies, smokers were not excluded) found significant differences in ventilatory values between Aborigines and the general Australian population. Aboriginal values for FEV_1 and FVC were around 25 per cent lower than for the general population and fell much faster with age, though the decrease with age was less for smokers than for non-smokers.

van Buynder PG, Gaggin JA, Martin D, Pugsley D & Mathews JD
Streptococcal infection and renal disease markers in Australian Aboriginal children
Medical Journal of Australia 1992 156:537–540

This paper reports the results of a cross-sectional study of the association between markers of streptococcal infection and markers of glomerulonephritis in 180 Aboriginal children randomly selected from three communities in the Northern Territory.

Group A streptococci were found to be important causes of impetigo in Aboriginal children, and the authors conclude that streptococcal skin infection may contribute to glomerular haematuria, proteinuria and persistent glomerulonephritis in adult life. Public health programs are needed to reduce the prevalence of impetigo and group A streptococci, and the authors suggest that longitudinal studies are required to test the relationship between streptococcal skin infection in Aboriginal children and chronic renal disease in later life.

Watson DS & Clapin M
Ear health of Aboriginal primary schoolchildren in the Eastern Goldfields Region of Western Australia
Australian Journal of Public Health 1992 16:26–30

In 1989, 642 Aboriginal children aged between 3 and 15 years living in the Eastern Goldfields Region of Western Australia were assessed by audiometry, otoscopy and tympanometry.

More than 40 per cent of children assessed by audiometry had a hearing loss of more than 25dB in at least one ear, and 11 per cent had a hearing loss assessed as moderate or severe. Most hearing losses were associated with perforations, which were found in 37 per cent of all children. The prevalence of perforations was much higher (67 per cent) in the Central Reserve areas than in Kalgoorlie–Boulder (14 per cent) or other regional centres (28 per cent).

The authors suggest that the lack of improvement in ear health since 1980 may be due to insufficient attention having been directed to the treatment of acute otitis media in the infant population.

Weinstein P
The Australian bushfly (*Musca vetustissima* Walker) as a vector of *Neisseria gonorrhoeae* conjunctivitis [letter]
Medical Journal of Australia 1991 155:717

The writer suggests that the role of *Musca vetustissima* Walker needs to be investigated as a possible vector in outbreaks of non-sexually transmitted gonococcal conjunctivitis in Aboriginal communities.

Yiannakou J, Croese J, Ashdown LR & Prociv P
Strongyloidiasis in North Queensland: re-emergence of a forgotten risk group?
Medical Journal of Australia 1992 156:24–27

This paper reports the results of a five-year retrospective study of the medical records of all diagnosed cases of infection with *Strongyloides stercoralis* in north Queensland. Of the 14 cases identified, nine were Aboriginal.

The authors conclude that poor social and/or unhygienic conditions are a major contributor to the spread of infection and that strongyloidiasis should be suspected in any person with unexplained abdominal pain, diarrhoea, cutaneous symptoms or blood eosinophilia.

Brief communications

A decade of Aboriginal health research[1]

Peter Lake.
Aboriginal Medical Service, 128 Wakefield Street, Adelaide 5000.

Introduction

This year marks the tenth anniversary of the *Aboriginal Health Information Bulletin,* the first issue of which appeared as the *Aboriginal Health Project Information Bulletin* in April 1982. The purpose of the journal has been to draw together summaries of recent research, commentaries on current topics, book reviews, and original articles on Aboriginal health. As the editor noted in the first issue in 1982, '..much relevant information fails to reach many of the people involved in Aboriginal health care ...' and '...useful information is either not published or published in a form which is not readily available... scattered through an incredible array of different journals' (*Aboriginal Health Project Information Bulletin* 1982:2). Over the past ten years, the *Bulletin* has sought to address some of these problems.

The following is a content analysis of research studies (abstracts or full reports) in the 15 issues of the *Bulletin* to May 1991. Hopefully, this may serve to highlight future directions and priorities for Aboriginal health research, and emphasise the necessity for continued production of the *Bulletin.*

Content analysis—results

State of origin of reported studies

The term 'studies' has been taken to include reports of clinical cases, laboratory-based experimental or scientific studies, reports of the effectiveness of programs or approaches, and epidemiological studies (descriptive and analytical).

In all, there were 404 studies over the 10-year period, with 32 per cent of studies relating to the 15 per cent of Australia's Aborigines who live in the Northern Territory[2], and 20 per cent to the 17 per cent who live in Western Australia (Table 1). In terms of studies reported in the *Bulletin,* the health problems of Aborigines living in the two States with the largest Aboriginal populations—New South Wales (26 per cent) and Queensland (27 per cent)—were relatively under-researched.

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[1] This is a slightly edited version of a paper presented at the Public Health Association conference 'The health of indigenous people', held in Alice Springs in September–October 1991.

[2] According to the 1986 Australian Census

Table 1: *Aboriginal health studies by State of origin*

State of origin	Proportion of studies (per cent)	Population as proportion of total Aboriginal population (per cent)
New South Wales	10	25.9
Victoria	2	5.5
Queensland	6	26.9
Western Australia	20	16.6
South Australia	8	6.3
Tasmania	<1	3.0
Australian Capital Territory	7	0.5
Northern Territory	32	15.3

Note: Fourteen per cent of studies were unclassifiable from the abstract.

Study populations

According to the classification used by the Australian Bureau of Statistics in the 1986 Census, about 24 per cent of Aborigines live in major urban areas (defined as centres with a population of 100,000 or more), 42 per cent in 'other urban' areas (defined as centres with a population of between 1,000 and 99,999) and the remainder in 'rural' areas (which include remote communities) (Australian Bureau of Statistics 1987). Although the health problems may differ significantly between these different types of locations, relatively few studies have focused on the health of Aborigines living in major or other urban areas (Table 2).

Table 2: *Aboriginal health studies by urban/rural location*

Location of study	Number and proportion of studies
Major urban	13 (3 per cent)
Other urban	44 (11 per cent)
Rural and remote communities	96 (24 per cent)
Other urban/rural/remote	63 (16 per cent)
State/nationwide	122 (30 per cent)

Note: Remainder of studies were unclassifiable from the abstract.

Relatively few studies focused on particular sub-groups of the population, with children being the sub-group studied most frequently (Table 3).

Table 3: *Aboriginal health studies by population sub-group*

Population sub-group	Number and proportion of studies
Children	73 (18 per cent)
Women	35 (9 per cent)
Older people	1 (<1 per cent)

Topics of studies

Recent evidence (Australian Institute of Health and Welfare 1992) has shown that the main causes of death for Aborigines are circulatory system diseases, injuries, respiratory diseases and neoplasms. In the 10-year period, only six studies focused on circulatory system diseases (Table 4), and only two on ischaemic heart disease, a major cause of premature death for both males and females. Only one study of injuries involving Aboriginal children was reported. Major risk factors (smoking and alcohol abuse) for the commonest causes of death have received little research attention.

There were no studies dealing with abuse of prescription or illegal drugs, a serious omission considering anecdotal evidence that these problems are common.

In remote communities where water supplies are often unreliable, skin problems can affect almost everyone. There were only two dermatological studies reported, one about leprosy and the other a case report of a rare variant of scabies. Venereal diseases are also prevalent, particularly in remote areas, but accounted for only seven studies (mostly concerning syphilis).

On the other hand, there were many reports of descriptive research using existing large databases (State or national trends in morbidity, mortality, fertility, etc). This sort of research has its place, but it should not be allowed to dominate the scene at the expense of intervention studies, as seems to have been happening. The same is true for the second largest category of research, nutrition and growth.

Table 4: *Aboriginal health studies by major study topics*

Study topic	Number and proportion of studies
Large population studies	58 (14.5 per cent)
Nutrition and growth	47 (11.5 per cent)
Gastrointestinal diseases	19 (5.0 per cent)
Mental health	17 (4.0 per cent)
Diabetes	17 (4.0 per cent)
Alcohol	14 (3.5 per cent)
Respiratory diseases	14 (3.5 per cent)
Ear diseases	13 (3.0 per cent)
Urinary tract disorders	11 (2.5 per cent)
Dental health	9 (2.0 per cent)
Aboriginal health workers	9 (2.0 per cent)
Eye disorders	7 (1.7 per cent)
Sexually transmitted diseases	7 (1.7 per cent)
Circulatory system diseases	6 (1.5 per cent)
Smoking	3 (<1.0 per cent)
Petrol inhalation	3 (<1.0 per cent)
Drugs—unspecified	3 (<1.0 per cent)
Kava	2 (<1.0 per cent)
Skin diseases	2 (<1.0 per cent)

Evaluations of programs or strategies

There were fifty-two reports (12.5 per cent of all studies) describing the effectiveness of health programs or strategies. Twenty-four of these appeared to be of a formal nature, four dealt with alcohol programs and three considered general health care delivery. Overall there were few evaluations of health promotion activities.

Field-proven standard treatment regimens and preventive interventions (for example, immunisation) are important components of primary health care services. There were only eight such reports (1.5 per cent of studies) over the 10-year period (Table 5).

Table 5: ***Aboriginal health studies of preventive programs***

Preventive program	Number of reports
Immunisation	4
Trachoma	1
Treatment of alcohol abuse	1
Rheumatic fever prevention	1
Fluoridation	1

The advent of Aboriginal Health Workers has been a most significant program advance in recent years. They have made primary health care possible, allowed Aboriginal people to participate in service delivery, and provided a powerful impetus for community development. Despite this, in the 10-year period there were only nine reports about Aboriginal Health Workers.

Conclusions

The studies reported in the *Aboriginal Health Information Bulletin* provide some clear insights into the emphasis in Aboriginal health research over the past decade. It is true that some studies may not have found their way into the *Bulletin*, either as abstracts or as full reports, but from the very wide spread of journals cited, this number would probably have been small for journal articles. However, this may not be true for government and other reports, research theses, etc. A different problem for a journal like the *Bulletin* is how to approach research in health-related areas like unemployment, housing and environmental issues. In general, reference to studies in these areas have not been included in the *Bulletin*.

Such difficulties notwithstanding, the most significant findings of this content analysis of the *Bulletin* are that in the past ten years:

- the major causes of Aboriginal morbidity and mortality and their associated risk factors have been under-researched;
- little research has been directed at any area of health concerning the large populations of Aboriginal people living in and around capital cities;
- health promotion programs either have not been evaluated or evaluations have not been reported; and
- relatively few intervention studies have been undertaken (or reported).

A brief review of these topic areas in another publication, *An annotated bibliography of Aboriginal health* (Thomson & Merrifield 1988), shows a similar absence of research in these key areas over the previous decade—1971 to 1980.

The recent emergence of community-controlled Aboriginal health research ethics committees, and the new National Health and Medical Research Council (NHMRC) guidelines (1991) should help Aboriginal communities ensure that research is better directed in future. Part of the reason for the fragmented and inappropriate pattern of Aboriginal health research so far may lie in poor communications between Aboriginal communities, field health staff and researchers. To address these problems, Aboriginal health research committees need to become more proactive, suggesting or even contracting out topics to researchers, assisting in procurement of funds, and mediating between researchers and communities. For their part, researchers must respect due processes by following NHMRC guidelines, and working through Aboriginal research ethics committees.

Finally, the value of the *Aboriginal Health Information Bulletin* is beyond dispute, but needs re-emphasising. Its funding base should be protected, the research community ought to support it, and any attempts to subject it to 'cost recovery' from its readership resisted.

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Feedback: towards the effective and responsible dissemination of Aboriginal health research findings

Ernest Hunter

Introduction

The process of feedback, or the return of information to people or communities that have been the subject of health research, is a key element in the ethics of such research. In the past, there has been little feedback of the findings of Aboriginal health research, and certainly too few studies that have provided information in a form that could be understood by many Aboriginal people.

Since the mid-1980s increasing attention has been directed towards the special ethical issues involved in Aboriginal health research. This culminated with the adoption by the NHMRC (1991) of 'Guidelines on ethical matters in Aboriginal and Torres Strait Islander research'. These guidelines emphasise the importance of feedback—the return of information to the subjects of research and to relevant communities and agencies.

This paper summarises the feedback process used during, and subsequent to, research conducted in the Kimberley region of Western Australia in 1988 and 1989. It also reports the results of a brief survey, conducted in October 1991, analysing the penetration of feedback to workers in Kimberley health agencies. The results of a similar survey of the research subjects themselves, carried out by Kimberley health workers, has been published elsewhere (Kimberley Aboriginal Health Workers 1992).

The primary research

The research involved a stratified random sample survey of 516 Aborigines throughout the Kimberley region of Western Australia. The survey, conducted over a period of nineteen months, aimed to:

- examine the prevalence of hypertension and heart disease and the associations with lifestyle factors (Smith, Spargo, Hunter et al. 1992; Smith, Spargo, King et al. 1992); and
- delineate the patterns and correlates of alcohol consumption (Hunter, Hall & Spargo 1991).

A description of the research methodology and a discussion of the ethical issues arising from the work is contained in the alcohol research monograph (Hunter, Hall & Spargo 1991).

The process of feedback

Different levels of information arising from the research were fed back to:

- the Aboriginal subjects of the research;
- members of the communities in which the research was conducted;
- the Aboriginal population of the Kimberley; and
- relevant Aboriginal and non-Aboriginal agencies.

The dissemination of the research findings outside the Kimberley is not considered in this paper.

Prior to the commencement of the study it was decided that comprehensive feedback was an essential component of the research rather than a separate endeavour, and would be carried out by the researchers during the study. Ultimately, feedback occurred in six main ways:

- face to face with each person interviewed;
- a personal written report provided to all participants;
- reports on the aggregate results to community councils and health workers in the communities involved;
- a region-wide tour of the Kimberley in May 1990;
- a comprehensive simple language document disseminated through the region; and
- descriptions of the findings in the local media.

Individual

Following each interview and examination the basic results were presented to the research subjects. When areas of concern were obvious, advice was offered and, where appropriate, medical treatment was instituted (at times including hospitalisation). About a month later, following the examination of laboratory results, a letter was written to each participant outlining in detail all findings (including laboratory values and normal ranges), with some comments regarding their general health status and issues they could consider (for example, suggestions regarding diet or exercise).

No attempt was made to differentiate the subjects in terms of their level of comprehension or understanding, as it was felt that every participant had the right to have access to complete information. Participants whose level of literacy was considered inadequate for the complexity of information to be provided were advised at the time of the interview that they could take the letter to a suitable health worker (community health worker, nurse or doctor) for clarification.

For those participants where medical problems were discovered, permission was obtained to send a copy directly to the responsible health care provider.

Community

During return trips to each community (most being visited on numerous occasions during the research), emerging findings were discussed with health workers and available community members. This gave the opportunity to follow up on letters that had been brought to attention from earlier examinations.

Regional and agency

More comprehensive feedback of the results from the completed surveys was provided during a Kimberley-wide tour in May 1990. Twelve pre-publicised public talks were delivered using simple summary diagrams (in Broome, Derby, Fitzroy Crossing, Halls Creek, Balgo, Turkey Creek, Wyndham and Kununurra). These meetings were attended by more than 500 individuals, about two-thirds of whom were Aboriginal. Discussion of the results was also broadcast from Kununurra via the local Aboriginal radio network. Talks were also delivered to medical workers during that tour, and to regional health administrators during a subsequent tour in October 1991.

Written

The response to the May 1990 tour was overwhelmingly positive (in contrast to some stereotypes suggesting that Aborigines are not interested in health information), and resulted in requests for documentation. As a result, a 90-page simple language document containing all material presented during the Kimberley tour was produced and disseminated (Smith, Hunter, Spargo & Hall 1990). In 1991, 300 copies were distributed throughout the region—to communities, health and social service agencies, regional and State Aboriginal agencies, relevant State and Federal Ministerial offices, and to key Aboriginal and non-Aboriginal individuals. Following requests during the October 1991 tour, a further 300 copies were produced and distributed. Some 60 copies of the primary research monograph (Hunter, Hall, Spargo 1991) were also distributed in the region.

Feedback survey

While considerable effort was expended, the researchers involved remained at most cautiously optimistic about the results of this feedback process. Comments from the Kimberley suggested that most of the first batch of the simple language document had been collected by individuals, rather than being made more widely accessible. As a result of this experience, and anticipating future follow up of the research, two feedback surveys were carried out.

The first involved the administration by health workers in each of the major centres of the Kimberley region of a short questionnaire to participants in the original survey (Kimberley Aboriginal Health Workers 1992).

The second survey, the results of which are reported here, involved the administration of questionnaires to participants at a conference of medical administrators in Broome prior to the presentation of information about the study, and to those attending talks given to local medical and health workers in Broome, Derby, Fitzroy Crossing, Halls Creek, Wyndham and Kununurra. The aims were to:

- assess the awareness of those surveyed that the research had been conducted and knowledge of how to access the results if necessary;
- assess the means by which workers had become aware of the research;
- assess whether the results of the research had been used and, if so, how; and
- collect comments regarding the processes of the research and feedback.

The 105 respondents included 19 Aborigines and 84 non-Aborigines (2 did not specify race), of whom 85 per cent worked in government health services, 11 per cent in Aboriginal Medical Services and 4 per cent in non-health agencies. There were 18 community health workers/health aides, 63 nurses, 10 doctors, 5 workers in allied fields and 7 administrators.

Of the 56 respondents (53 per cent) who had been in the Kimberley at the time of the research, 70 per cent were aware of the survey. In contrast, only half of all respondents had heard of results of the work. For the 50 individuals who were aware of the research results (from one or more sources), the sources of this information were:

- 1990 regional tour—24;
- community or agency talk during the research—18;
- simple language document—18;
- letter to informant—17;
- newspaper article—11;
- radio broadcast—6;
- research monograph—5; and
- other—5.

For the four most commonly nominated sources, the distribution by occupation was roughly similar to the breakdown of the overall sample except that doctors and administrators were more likely to have heard of the results through the 1990 tour or the feedback document, whereas community health workers/health aides (thus Aboriginal informants) more frequently nominated a talk during the research or the informant letter.

Of the 50 respondents with knowledge of the research, 34 attempted to briefly describe the aims of the research—30 gave relatively clear descriptions. Nineteen of these had had cause to use the information, most commonly for teaching (5), personal education (5), program development (3) and client care (3). Fifteen respondents indicated they had heard comments about the process of the research or feedback. Only one respondent was clearly critical—a nurse commented that the participants didn't understand the research, and that insufficient information had been given to health staff at the local level prior to the study being carried out. Of the 58 who answered as to how they would find out more information regarding the survey, 48 gave a reasonable and appropriate course of action.

Implications

This brief survey deals only with one level of feedback regarding Aboriginal health research—to workers in the field locally. Overall, nearly one in five of those surveyed had had cause to use the results of the primary study. For those who had some knowledge of the results of the research, the proportion was two in five.

The results of this survey suggest that reliance on one or a few methods of feedback will probably not result in substantial coverage of the range of workers. It appears that there is no substitute for the direct communication of such material—through discussions during the course of the research and by tours of the surveyed population soon after completion of the research.

The research participants' responses regarding the subject feedback letter will be addressed elsewhere. However, as one in six of the health workers surveyed reported having encountered one of these letters (presumably as a result of being approached by a participant or though a copy sent to the clinic), this appears to be an important conduit for health information that encourages positive interaction between the research population and the health-care system.

Conclusion

The feedback of information regarding Aboriginal health research is required ethically and needs to be a priority. The same scientific rigour that is applied to the research process itself should be encouraged in disseminating findings to the subjects of research and to those most likely to use the information. This requires acknowledging that the process of feedback is an integral part of the research. As such, it must be planned, properly executed and evaluated. It is likely and appropriate that Aboriginal groups will, as has been the case with Aboriginal health research generally, demand that researchers develop standards for feedback. It is thus essential for health researchers to give sufficient attention to this crucial element of the research process.

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Selected reviews

Development of the National Aboriginal Health Strategy[1]

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Background

In June 1990, the Commonwealth, State and Territory Ministers responsible for health and Aboriginal affairs agreed to implement a National Aboriginal Health Strategy. This historic agreement, reached at a combined meeting in Brisbane, represented the culmination of developments over a number of years—particularly those over the two-and-a-half years from December 1987, at which time a similar combined meeting of Ministers in Perth agreed to establish a Ministerial Forum on Aboriginal Health and appointed a working party to develop a national Aboriginal health strategy.

The working party, comprising 19 members (14 of whom were Aboriginal or Torres Strait Islander), was chaired by Ms Naomi Mayers, Administrator of the Aboriginal Medical Service in Redfern, Sydney (see National Aboriginal Health Strategy Working Party 1989: 1–6 for details of the working party's terms of reference and membership).

The working party's final report (National Aboriginal Health Strategy Working Party 1989), which was presented to a combined meeting of Ministers in Burnie in March 1989, incorporated the findings from consultations with Aboriginal and Torres Strait Islander people throughout Australia and numerous submissions from Aboriginal and non-Aboriginal organisations, government agencies and individuals.

The Ministers established an Aboriginal Health Development Group (AHDG) to assess the report and recommend priorities for implementation of a National Aboriginal Health Strategy. The AHDG comprised Ms Mayers (the Chair of the working party) and one representative from each of the Commonwealth Departments of Aboriginal Affairs and of Community Services and Health, the (then) Australian Institute of Health, and from each State and Territory government.

In response to considerable concern from Aboriginal communities that were not represented on the AHDG, the Commonwealth Minister for Aboriginal Affairs established an Aboriginal Health Advisory Group (AHAG) comprising

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[1] This summary has been derived mainly from information provided by the Aboriginal and Torres Strait Islander Commission's Office of Aboriginal Health. The term `Aborigines' is used generally to include both Australian Aborigines and Torres Strait Islanders.

representatives from Aboriginal health services. The AHAG developed a series of recommendations and comments (AHAG 1990), some of which were included in the AHDG's final report (1989). This report and the views of the AHAG were considered at a combined meeting of the Commonwealth, State and Territory Ministers for Health and Aboriginal Affairs held in Brisbane in June 1990.

The National Aboriginal Health Strategy

The overall aim of the National Aboriginal Health Strategy (NAHS) is to ensure that by the year 2001 all Aboriginal and Torres Strait Islander people should have the same level of access to health services and facilities as other Australians. The specific goals of the Strategy are:

- to improve health standards and raise life expectancy
- to provide better access to health services, including hospitals and health clinics
- to provide better housing
- to provide power, water, sewerage and roads in communities
- to provide a high level of participation in health decision-making processes, including representation on hospital boards and in national forums
- to provide training and employment for Aborigines and Torres Strait Islanders in health-related work
- to provide better support in the areas of information, education, training, research and evaluation
- to establish new community-controlled Aboriginal health organisations and upgrade existing ones
- to decrease the amount of substance abuse
- for State and Territory governments to provide culturally appropriate drug and alcohol and counselling services, complemented by Commonwealth initiatives in the prevention area.

In deciding to implement the NAHS, the Joint Ministerial Forum agreed to:

1 **The establishment of a Council of Aboriginal Health (CAH)** to be a standing committee of both the Australian Health Ministers' Conference and the Australian Aboriginal Affairs Council. This tripartite council—comprising representatives of Aboriginal communities, the Commonwealth Government and State and Territory governments—would have regard to the advice of State and Territory tripartite forums (see below), in:

- reviewing progress towards the implementation of the National Aboriginal Health Strategy
- recommending any necessary changes to the Strategy, paying specific attention to intersectoral collaboration
- developing appropriate short- and medium-term strategies to reduce the high morbidity and mortality rates of Aboriginal people
- advising on ongoing development of Aboriginal health policy and strategies

- continuing the process of setting goals and achievable, measurable targets in relation to specific Aboriginal health problems
- reviewing, in conjunction with State/Territory tripartite forums, the effectiveness of health services provided to Aboriginal people
- monitoring and evaluating the development of appropriate guidelines on research and statistics collection procedures
- monitoring and evaluating the development of a national database of Aboriginal health statistics
- liaising with other national health initiatives.

2 **The establishment or modification of existing arrangements to form a tripartite forum in each State and Territory** to:

- advise their State or Territory Government on implementation of the NAHS
- complement the activities of the CAH at State or Territory level, paying specific attention to intersectoral collaboration
- provide program and policy advice to their State or Territory Government
- develop appropriate short- and medium-term strategies to reduce the high morbidity and mortality rates of Aboriginal people.

3 **Endorse the need for a specialised Office of Aboriginal Health within** ATSIC.

This Office, with an appropriate level of staffing (including health expertise) would provide secretariat services for the CAH and have policy formulating, program administration and monitoring evaluation responsibilities at Commonwealth level. Establishment of the Office would be a matter for determination by ATSIC Commissioners.

4 **Note that there is recognition of the need for a national Aboriginal-controlled health body.**

This matter was referred to ATSIC Commissioners for consideration.

5 **Note that provision should be made for increasing resources to, and upgrading facilities of, existing fully Commonwealth-funded community-controlled health services**, where needs had been established.

The allocation of resources would be determined in conjunction with the State and Territory tripartite forums.

6 **Endorse the establishment of new community-controlled health services.**

This would be either in response to a community submission (in which case, funding would be subject to endorsement by the State or Territory tripartite forum and the relevant funding agency) or as determined by a State or Territory tripartite forum.

7 **Note that a high priority be given to the provision of basic services such as housing, clean water, safe waste disposal, roads, power and communications.**

The cost of addressing these issues was estimated to be $2.5 billion. Tripartite negotiations on funding for the provision of these services would be based on the findings of a detailed assessment of needs. These negotiations may need to include local government representatives.

8 **Note and refer to the State and Territory tripartite forums for action** (and also report on progress within 12 months):

- employment, where needed, of Aboriginal hospital liaison staff (with adequate resources)
- appointment of at least two Aboriginal community representatives to hospitals' boards in areas serving a significant Aboriginal community
- review of the provision of specialist services to Aboriginal communities
- development of appropriate procedural protocols for the interaction of mainstream government agencies with Aboriginal people
- rationalisation of the health services provided to the Torres Strait region
- provision by government substance abuse services of appropriate training courses, to be available to both government and non-government substance abuse workers
- provision of resources to Link-Up (or similar) services to re-unite Aboriginal families
- examination of alternative models for the provision of psychiatric services for Aboriginal people
- continue discussions addressing the education and training recommendations contained in the report of the National Aboriginal Health Strategy Working Party.

9 **Refer to the Council of Aboriginal Health for action:**

- consideration be given to establishing a National Aboriginal Substance Abuse Taskforce, as recommended by the Interim Report of the Royal Commission into Aboriginal Deaths in Custody.

10 **Immediately implement the following:**

- the National Campaign Against Drug Abuse (NCADA) give priority to funding Aboriginal community-controlled substance abuse education and prevention projects
- each State and Territory nominate a senior person in the relevant department to be responsible for the implementation of the recommendations of the 1985 National Taskforce on Aboriginal Health Statistics
- an appropriate level of resources be made available to the Australian Institute of Health (now Australian Institute of Health and Welfare) to enable comprehensive Aboriginal and Torres Strait Islander data collection, analysis and reporting
- the National Health and Medical Research Council (NHMRC) give priority to funding Aboriginal community-controlled health research projects.

11 **Note and refer to the CAH the recommendation of NHMRC to establish a steering committee to:**

- maintain an ongoing review of priorities in Aboriginal health research

- assist in the dissemination of results of research in priority areas
- conduct a workshop on research skills for Aboriginal health workers and other health professionals working in Aboriginal health services
- provide training in research skills and professional enrichment for Aboriginal health workers
- evaluate the achievements of the strategy used by NHMRC to date of nominating Aboriginal health research as a priority
- commission specific research proposals and earmark special funds for Aboriginal health research
- advise on means of obtaining greater involvement of Aboriginal community representatives in assessing research applications.

Implementation of the National Aboriginal Health Strategy (NAHS)

Being such a wide-ranging Strategy, its implementation will occur in a number of ways.

Council of Aboriginal Health

One of the first areas to be acted upon was the establishment of the Council of Aboriginal Health, for which the ATSIC Commissioners allocated funds shortly after the June 1990 agreements had been reached. However, despite the early action to implement this agreement, the CAH did not first meet until April 1992—a delay which was partly due to differences of opinion about its membership. The report of the National Aboriginal Health Strategy Working Party did not specifically outline membership, but it is almost certain their intention was the same as the AHAG (1990), namely, that the 17 regional Aboriginal representatives (based on the ATSIC regions) should be elected by community-controlled agencies with health program responsibilities. The agreement reached in Brisbane by Ministers provided for the 17 representatives to be selected by `the Aboriginal or Torres Strait Islander community'.

Existing Commonwealth programs

A number of existing Commonwealth-funded programs are seen as part of the NAHS. These include the funds currently allocated by ATSIC for health, housing, substance abuse and infrastructure programs (totalling more than $275 million in 1992–93). As well, other Commonwealth agencies fund specific programs—an example is the Department of Health, Housing and Community Services program which allocates around $90 million each year to State and Territory governments to provide low cost housing for Aboriginal families.

Additional Commonwealth resources

The major new response by the Commonwealth Government was its announcement in December 1990 to contribute up to $232 million over five years for implementation of aspects of the NAHS. These funds (see Table 6) were allocated to:

- provide urgently needed housing, water supplies, sewerage systems, electricity supplies, communication systems, airstrips, roads and other basic infrastructure

- establish new, and upgrade existing, Aboriginal community-controlled health services
- establish an Office of Aboriginal Health (OAH) within ATSIC
- increase the effort by the Australian Institute of Health and Welfare in the collection, analysis and reporting of Aboriginal health statistics
- increase the projects targeted at Aboriginal people through the National Campaign Against Drug Abuse (NCADA).

New funds were allocated for the first three components, but the Commonwealth Health, Housing and Community Services portfolio was required to absorb the costs for the others. The Commonwealth funds for the first two components were dependent on the States and Territories making substantial contributions. As well, additional funds for health services were dependent on the development of specific quantifiable outcomes and performance indicators.

Table 6: *Additional Commonwealth allocations for the National Aboriginal Health Strategy, December 1990*

Program	Allocation ($million)					
	90–91	91–92	92–93	93–94	94–95	90–95
Environmental health[a]	2.10	18.38	33.57	58.96	61.00	174.01
Aboriginal health services	6.74	9.47	10.36	10.80	11.24	48.61
Office of Aboriginal health	0.17	0.36	0.38	0.40	0.42	1.73
NCADA projects	1.33	1.40	1.47	1.54	1.60	7.34
Australian Institute of Health and Welfare	0.10	0.11	0.11	0.12	0.12	0.56
All programs	**10.44**	**29.72**	**45.89**	**71.82**	**74.38**	**232.25**

(a) Housing and infrastructure

Office of Aboriginal Health

In early 1991, an Office of Aboriginal Health was established within ATSIC. In line with the agreements reached by the Ministers in Brisbane, the Office is responsible for coordinating the implementation of the Strategy. The Office also provides secretariat services for the CAH, and has a monitoring and evaluation role for Commonwealth sector activities in Aboriginal health.

The Office has played a key role in negotiations with the States and Territories in addressing the condition set by the Commonwealth Government that additional Commonwealth funds were conditional on the provision of 'substantial contributions' by the States and Territories. This process has been lengthy, but is understood that agreements have now been reached with all States and Territories except Tasmania.

OAH is also liaising with relevant sections of ATSIC in an assessment of the infrastructure and environmental conditions in Aboriginal and Torres Strait Islander communities (see *National housing and infrastructure needs survey* below).

State and Territory developments

To April 1992, tripartite forums have been established in New South Wales, Victoria, Queensland, Western Australia, South Australia and the Northern Territory.

As noted above, the Commonwealth funds allocated for environmental health improvements, and part of those provided for new or improved Aboriginal health services, were dependent on the States and Territories making substantial new contributions. Formal negotiations between the Commonwealth (represented by ATSIC and HHCS) and the States and Territories commenced in April 1991, and by May 1992 agreements were imminent with all jurisdictions except Tasmania.

Aboriginal health services

As a result of the 1990–91 Commonwealth allocation of $6.74 million, 67 additional health projects were funded. These projects included the establishment of nine new Aboriginal health services, nine new clinics providing basic health services, and the expansion and renovation of many of the existing Aboriginal health services. Other projects included dental and nutrition services, and surveys on the provision of health services.

Funds were also provided to the Aboriginal health services for the employment of additional doctors, nurses and Aboriginal health workers. The ongoing cost of these projects has been met in 1991–92 and 1992–93 through the NAHS funds.

National housing and infrastructure needs survey

To accurately assess the immediate and future housing and community infrastructure requirements for Aboriginal people, a national survey is being conducted as part of the Strategy.

The survey is being carried out in two stages: stage one, which examines the needs of remote and rural communities having an Aboriginal population of less than 1,000 people, is scheduled for completion in July 1992; stage two, which will look at the needs in urban areas, is scheduled for completion by December 1992.

National Aboriginal health goals and targets

The development of a plan specifying quantifiable outcomes and performance indicators was one of the criteria set by the Commonwealth Government in its funding of aspects of the Strategy.

As an initial step towards establishing quantifiable outcomes and performance indicators, a draft document entitled *Aboriginal and Torres Strait Islander health goals and targets (interim)* was produced. This document, which will be subject to extensive consultation with Aboriginal people, presents draft goals and targets in five areas:

- illness;
- health risk factors;
- environmental health aspects;
- education, employment and training; and

- resource allocation, access and appropriateness, intersectoral collaboration, decision making, health development support and research.

Government responses to the Royal Commission into Aboriginal Deaths in Custody

Another recent development of relevance to the NAHS is the response by the Commonwealth, State and Territory governments to the report of the Royal Commission into Aboriginal Deaths in Custody. Agreement was reached on most of the Royal Commission's recommendations and on 31 March 1992 the Commonwealth Government announced implementation of the first stage of a two-phase package. In the first stage, $150 million was allocated for immediate issues, including $71.6 million for the establishment of Aboriginal designed, controlled and staffed drug and alcohol services, and culturally appropriate services which respond to the needs of young Aboriginal people.

This first stage also included an allocation of $4.4 million for the Australian Bureau of Statistics to undertake a national survey of Aboriginal and Torres Strait Islander people covering a range of social, demographic, health and economic characteristics.

Monitoring and evaluation

Monitoring and evaluation are seen as important components of the NAHS, and specific funds have been set aside for a detailed and ongoing evaluation of it. This will enable an assessment of actual outcomes and permit targeting of initiatives after the 1994–95 financial year.

Conclusion

Implementation of the National Aboriginal Health Strategy and parallel developments in response to the Royal Commission into Aboriginal Deaths in Custody represent a new commitment to addressing the substantial health disadvantages experienced by Aboriginal people. However, these developments, and the steps leading to them, have not been without criticism.

Aboriginal people generally welcomed the establishment and work of the National Aboriginal Health Strategy Working Party, and had expectations that the recommendations of the Working Party's report would be implemented. In fact, the report is still seen by many Aboriginal people as *the* National Aboriginal Health Strategy.

As noted above, the task of assessing the report and recommending priorities for implementation was given to the Aboriginal Health Development Group (AHDG). The composition of the Development Group was a matter of concern to Aboriginal communities, in that it did not include Aboriginal community representation in partnership with Commonwealth, State and Territory governments. The report of Aboriginal Health Advisory Group (1990) notes that 'communities were gravely concerned for the future implementation of the Report if, despite being one of the principal tenets of the Report, community participation was passed over ... in the setting up of the Development Group'. The Advisory Group itself had been established in response to these concerns.

The Development Group estimated that implementation of the National Aboriginal Health Strategy, as agreed in June 1990 by the Joint Ministerial Forum, would require more than $2.5 billion over 10 years. Implementation of the Strategy has involved substantial funds from different sources (as summarised above), but the Commonwealth Government's announcement in December 1990 to contribute up to a further $232 million over five years was seen as inadequate by a number of Aboriginal spokespeople. Reflecting this disappointment, the final report of the Royal Commission into Aboriginal Deaths in Custody noted that these new funds were `less than a fifth of that estimated as being needed by the Development Group ... Even then, the actual level of Federal funding will depend to some degree on the States and Territories making `substantial contributions'. Recommendation 271 of the Royal Commission's final report was:

> That the implementation of the National Aboriginal Health Strategy, as endorsed by the Joint Ministerial Forum, be regarded as a crucial element in addressing the underlying issues the Commission was directed to take into account, and that funds be urgently made available to allow the Strategy to be implemented.

In announcing the implementation of the NAHS, the responsible Commonwealth Ministers—Mr Robert Tickner for Aboriginal Affairs and Mr Brian Howe for Community Services and Health—noted that `a cornerstone of the strategy will be an unprecedented direct involvement for Aboriginal people in the formulation of Aboriginal health policy', particularly through the Council of Aboriginal Health, which would `advise governments on Aboriginal health policy and monitor the performance of the NAHS'.

Reference has already been made to the concerns about the membership of the Council of Aboriginal Health, and to the delays in its establishment. Given its central role in monitoring, changing and developing the NAHS, it is important that the CAH functions as intended.

The National Aboriginal Health Strategy is an historic development which provides, as noted by Mr Tickner, `the opportunity for dramatic and measurable improvements in Aboriginal health'. It is essential that implementation of the NAHS proceeds as rapidly and smoothly as possible for it is, again quoting Mr Tickner, `intolerable in a country such as Australia that one section of society is consistently disadvantaged in health matters'.

Book review

The health of Aboriginal Australia

Janice Reid and Peggy Trompf (editors)
1991, Harcourt Brace Jovanovich, Sydney (xxii + 436 pp; A$37.50)

Reviewed by Professor Anthony Radford, Department of Primary Health Care, Flinders University of South Australia

`Aborigines and Torres Strait Islanders comprise the least healthy identifiable sub-population In Australia' (p. 37).

This book concerning the health, or rather the ill health, of Aboriginal Australia is clearly the most comprehensive yet compiled on the topic and is `intended for students and graduates in the health and welfare professions...[written] within the conceptual framework...[of] the new public health...[and going] beyond the conventional paradigm of illness...to address the contribution of social justice, social action, power and access to resources...' (p.xii). After reading it no-one will be able to exclaim, like Douglas Gordon's honest confession as late as 1976, that they simply had `never thought about [Aboriginal] health' nor claim that they did not know that `the causes of their lower health statistics are complex, but the social and economic inequality are clearly of central importance'(p.37). For many Aborigines, `their concept of health and wellbeing is a sense of closely linked relationship to their land' (p.297), as well as `being happy', `feeling good', and in `having harmonious relationships'.

The book will become a major text for students of Aboriginal health. But it is not a primer. It is way beyond that, even though the editors have gone so far as to provide a teachers' guide as a companion volume.

The book is also well presented, and set out in nine very long (40–70 page) chapters which are broken up with effective interspersion of scenarios or vignettes (and some marvellous photographs). Each chapter is concluded with up to nine pages of references which will be of great assistance to research students, but are sometimes so extensive that they will virtually preclude the undergraduate from learning how to research literature!

While it is well presented, like many multi-authored volumes, it lacks adequate editorial control. Some authors appear to have approached their tasks with the in-depth thoroughness of someone preparing a reference book rather than a standard starting text. Several contributors, notably Harrison on nutrition and Reser on mental health, have provided an excess of technical detail in the former case, and an excess of theoretical framework(s) in the latter; in so doing, they may well lose many of their less advanced readers, for whom the book is targeted. Repetition is a feature of the book. For example, Gray, Trompf and Houston in Chapter 3 and Torzillo and Kerr in Chapter 8 stray from their topic and repeat much of the data provided in the Thomson chapter on illness patterns. Other deficiencies as a standard text can be assessed when considered from the direction on which the book is premised.

Two of the precepts of the `new public health' are community consultation and participation in the actual delivery of services, as well as an accent on health promotion and illness prevention. The book is markedly limited in reference to these areas, as well as to the level of access to and nature of Aboriginal health services, and any assessment of their effect apart from passing references such us `some programs have had positive effects' (p.208).

As the editors point out (p.xiii) 'Aborigines are not unique'. One aspect that does predominate in the book as a, or the, major factor in Aboriginal health status, or rather in their illness levels, is their entity as a so-called 'fourth world'. That is, their illness patterns, and the precepting factors which shape them, have many things in common with those other minorities who live under domination—'so invisible to most'(p.xii), dispossessed, dispirited, dispersed and, in common with most 'third world' communities, living in poverty, powerless ('concentrated in the ranks of the unemployed, the unskilled and poorly paid' p.xv), without education and without access to the resources they need. Furthermore, they are often discriminated against and/or physically victimised. Perhaps the book would have been better titled 'The illness of Aboriginal Australia'. One of the difficulties in writing about Aborigines is that non-Aborigines usually lump all Aborigines together as if they were an ethnic entity, rather than as over 100 separate cultures. It is comparable to talk about Europeans as if Scots, Swedes and Swiss were all the same—well they are all Caucasian! This book portrays something of that, perhaps because only two of its authors are Aboriginal. Such an approach may lead, as Robyn Mobbs points out (p.293) to cynicism and disillusionment in non-Aboriginal workers, rather than looking for other reasons for the lack of `success'.

The introduction provides an excellent overview of the social context of Aboriginal health, but health status is dependent on far more than one variable. As the editors wished their book to be a standard text, greater attention at the outset should, in this reviewer's opinion, have been given to the demographic profile of Aboriginal Australians vis-a-vis the country as a whole, and describe how this picture has changed over time. This could have been given not only as an age/sex comparison but also in terms of geographical distribution, pointing out the dynamism and diversity that exists between outstation and settlement centre, rural centre and rural town, rural town and rural city, rural city and urban city, as well as the major distribution patterns and the diversity of domiciles within cities.

Most chapters expand this theme of social context, though some, one feels, are woven with a thread of guilt complex. While perhaps understandable, it tends to result in a selective extraction of the literature which is in danger of distorting both fact and reality, as if to join the bandwagon of much contemporary writing related to Aboriginal history, wishing to indicate that all that happened in the past was bad. That is, there is a tendency to write with retrospective judgement, rather than assessment using the morés of the present rather than those of the period in which it was written/happened.

Neil Thomson provides a clearly written summary of the epidemiological picture of Aboriginal ill health. 'For almost all disease categories, rates for Aborigines are worse than for other Australians [usually 2–10 or more times worse, be they infectious diseases, injury or hospitalisation rates]; death rates are up to four times higher and life expectancy is up to 21 years less'(p.37).

However, little attempt is made in this or other chapters to explain the marked improvements that have occurred in several indicators such as fertility and respiratory infections. Nor is any attempt made to address those aspects which have worsened, such as young adult mortality and urban suicide rates.

Maggie Brady's chapter on drug and alcohol use and abuse stands out for its clarity of thought, though no mention is made of tobacco. The complexities of the issues in unravelling cause and effect are well described here, as are the ethnocentric approaches usually applied to assessing mental illness in the next, almost overwhelmingly comprehensive, chapter by Joseph Reser.

All health and welfare professionals working in the field 'with their contrasting concepts of [illness and] care' (p.315), would do well to internalise the material in Robyn Mobbs contribution entitled 'In sickness and health: the sociocultural context of Aboriginal wellbeing, illness and healing'. Indeed it should be required reading for them. Implementation of the paradigm of the `modern medical model' of health, illness and especially health care is doomed when applied en masse in an Aboriginal setting where belief is that illness results from bad interaction between individuals, groups or the supernatural, or by natural, environmental or introduced (European) factors.

If one did not know it before, Paul Torzillo and Charles Kerrs' chapter on 'Aboriginal public health' clearly portrays the complexities of public health issues and programs. Among the major factors identified are: the harshness (from a health point of view) of the settlement environment, the need for prolonged and patient participation with and by communities to determine and resolve the issues which most concern them, the necessity for adequate planning, financing and maintenance of appropriate 'health hardware' delivered in culturally appropriate ways, and the paucity of success stories (though there are some signs of movement in this direction using simple technologies). It will be a long story, in which Aboriginal health workers and community decision processes must be resourced and encouraged for success.

The book concludes with a review of 'Policy and practice in Aboriginal health' by Sherry Saggers and Denis Gray, which is concerned more with 'policy' than 'practice'. It was here at last one hoped (in vain) to find comprehensive descriptive examples of some successful progress and of Aboriginal input into them—not just a passing reference to the sixty-four Aboriginal controlled medical services and to Aboriginal Health Worker training. While there is no doubting that 'there have been positive changes in the health of Aborigines over the last twenty years there has been a slowing of such improvements ...' (p.417).

If this book is to become standard text, hopefully the next edition will address some of the issues raised above and will provide a less overall sociological approach (no doubt intentionally done here to redress the perceived imbalance of the past writings), provide less detail and a broader view. In so doing, health care providers, as distinct from reflectors and students who have interest in 'the social, economic and political factors' which shaped and continue to shape Aboriginal health, will receive a more balanced view of care provision issues—promotive, preventive and curative.

Recent reports, publications and theses

Aboriginal and Islander Health Worker Journal
Vol. 15, No. 4, August/September 1991

This issue includes: a review by Gary Foley of the Redfern Aboriginal Medical Services, which has been in operation some 20 years; a brief summary of the treatment of childhood diarrhoea; a review of access and equity for Aboriginal people with disabilities; and the first part of an overview of the challenges of AIDS for Aboriginal health workers.

Aboriginal and Islander Health Worker Journal
Vol. 15, No. 5, September/October 1991

The concluding part of the overview of the challenges of AIDS for Aboriginal health workers is contained in this issue, along with a review of health work among the indigenous people of the Philippines and a summary of Queensland's Biala Aboriginal alcohol counsellor training program (which closed in 1991).

Aboriginal and Islander Health Worker Journal
Vol. 15, No. 6, November/December 1991

This issue includes two articles from New South Wales: a review of the Aboriginal Health Promotion Program and a summary of work of the North Coast Aboriginal Health Committees in community development. It also includes a report from the New Directions Workshop, held in Brisbane in April 1991. This workshop drew on the experience of the Shuswap people of Alkali Lake, British Columbia, Canada, in considering approaches to controlling the impact of alcohol within Aboriginal communities.

Aboriginal and Islander Health Worker Journal
Vol 16, No. 1, January/February 1992

This issue includes articles on renal disease and disabilities, and a report by Judy Atkinson from the Indigenous Canadian Conference on Women and Wellness (this suggests that many of the problems faced by Aboriginal women are similar to those of other indigenous women).

Aboriginal and Islander Health Worker Journal
Vol. 16, No. 2, March/April 1992

The importance of feedback in Aboriginal health research is featured in this issue (see also Ernest Hunter's article in the *Brief communications* section of this *Bulletin*), which also contains articles dealing with Aboriginal deaths (including deaths in custody), and the impact of alcohol in Aboriginal health and culture.

Aboriginal Health Promotions Section, NSW Health
'We're looking good': an evaluation of the Aboriginal Health Promotions Program, 1986–1990
New South Wales Department of Health, Sydney, 1991

This report reviews the NSW Department of Health's Aboriginal Health Promotions Program, which was launched in 1986. The aim of the program was to improve the health of Aboriginal people using a variety of methods and resources and by emphasising prevention rather than treatment.

Community participation and consultation were key elements in the program which was targeted at ten Aboriginal communities: Baryulgil (North Coast); Caroona/Walhallow (New England); Collarenebri (Orana and Far West); Dareton (South West); Murrin Bridge (Central West); Redfern (Central Sydney); Tabulam (North Coast); Toomelah (New England); Wallaga Lake (South Eastern); and Wilcannia (Orana and Far West).

The report is set out in four sections covering the background, program, evaluation and future directions.

Fardon K, van Beurden E, Ferguson J, Christian J
North Coast Aboriginal nutrition feasibility study
Health Promotion, North Coast Public Health Unit, New South Wales Health Department, Lismore, 1991

This study looks at the role of nutrition in the health status of nine Aboriginal communities from the north coast area of New South Wales.

The premise of the study is that while the incidence of almost all 'lifestyle' diseases is greater among Aborigines than among the general population, the underlying cause is poor nutrition.

Information on nutrition education programs was collected and analysed together with the results of a questionnaire. The study concluded that while there have been a number of education topics presented, the more traditional role models such as dietitians, baby health staff, doctors and hospital nurses rated fairly poorly in the provision of nutrition information. The main providers of nutrition information were considered to be family, friends, community workers, and clubs and associations.

The report makes recommendations on how programs should be developed and implemented, what strategies should be implemented, and the structure and resources required.

Khoury P
Aborigines and the politics of alcohol
In: Kennedy R (ed.) *Australian welfare: historical sociology.* MacMillan, Melbourne:216–239, 1989

This chapter provides an historical and contemporary view of non-Aboriginal society's response to Aboriginal drinking. Myths and stereotypes surrounding Aborigines and alcohol are challenged by the author, who examines how these preconceptions have been used against Aboriginal people. The author argues that attempts to help Aborigines overcome alcohol abuse must look beyond treating the individual in isolation and must address the wider socioeconomic conditions and involve Aboriginal people.

'Let's beat the grog'
Connexions 1991, 11(6)
Journal of Drug and Alcohol issues, November/December 1991,

This article reports on the Public Health Association of Australia's annual conference which was held in Alice Springs 29 September to 2 October 1991. The role of alcohol and its impact on Aboriginal society was identified as a major issue and speakers identified various methods being used to combat the problem. Strategies ranged from direct intervention and community policing to influencing Government policy.

Lubliner M
Development and evaluation of the Northern Territory Aboriginal genital health (AIDS/STD) programme
Bachelor of Medicine thesis, Department of Community Medicine, Monash University, 1991

The Aboriginal Genital Health (AIDS/STD) Programme is an innovative attempt to integrate the issues of human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS) and other sexually transmitted diseases (STDs) into a health promotion program for Aboriginal people. The objectives of this study were to undertake needs assessment, develop a program plan and perform a pilot implementation and evaluation of the program.

The setting was a rural township and associated communities in the Darwin region. Extensive consultation and negotiation with community members and local organisations was undertaken. In response to the identification of a need, an AIDS/STD health promotion program was developed. Process evaluation indicated that goals and objectives of the program were appropriate and the strategies and methods were acceptable to the target group. A decentralisation of program control utilising the 'train-the-trainer' model is recommended.

McGrath M, Collins V, Zimmet P, Dowse G
Lifestyle disorders in Australian Aborigines: diabetes and cardiovascular disease risk factors—a review
Brolga Press, Canberra, 1991

As the title indicates, this publication summarises the results from numerous studies on the prevalence of diabetes, impaired glucose tolerance and selected cardiovascular risk factors (obesity, high blood pressure and high blood lipids).

Public Health Association of Australia
The health of indigenous peoples: the Public Health Association of Australia twenty-third annual conference, Alice Springs, 29 September to 2 October 1991
Australian Journal of Public Health, 1991 15(4):313–350

This article reviews the papers and posters presented at the above conference and covers a wide range of diverse and pertinent topics relating to Aboriginal health.

Rawlings L
Birthrights and landrights
In: *Homebirth reborn: 12th National Homebirth Conference, Book of Proceedings, July 12–15, 1991, Melbourne.* Mothers and Midwives Action Inc., Melbourne, 1991

The author argues that western culture, especially attitudes towards the provision of medical services to expectant mothers, has disrupted the social and cultural threads associated with childbirth in the Ngaanyatjarra lands of Western Australia. The removal of expectant Aboriginal mothers out of their homelands places undue stress on individuals because it impacts on the cultural traditions which play a crucial part in traditional Aboriginal life. The author suggests that authorities need to be receptive to the needs of Aboriginal women and develop appropriate strategies.

Thomson N
The implications for custodial authorities of Aboriginal health status
In: Kerr S, Cole C & Burt M (eds) *Corrections health: first national conference. Proceedings of the conference held 6–7 March 1991*: 136–145
Forensic Health Service, Health Department of Victoria, Melbourne
(Note: the publication incorrectly attributes authorship of this article.)

The article draws on the findings of the Royal Commission into Aboriginal Deaths in Custody. With the exception of the deaths assessed by the Commission as being self-inflicted deaths, the deaths occurring in custody generally reflect mortality in the general Aboriginal community. The generally poor health status of many Aboriginal people has special implications for custodial authorities.

Webster P, Mattick RP, Baillie A
Clients of treatment service agencies, March 1990 census findings
Australian Government Publishing Service, Canberra

In March 1990 the first national one-day census of clients of drug and alcohol treatment service agencies was undertaken in conjunction with a national survey of current treatment practices. Of the 549 agencies surveyed, 431 (85 per cent) of the 506 identified treatment agencies responded to the survey.

The census revealed that 6,175 people with a mean age of 34.4 years were receiving services for drug and alcohol problems on census day. Of these people, 90 per cent were primary substance users, two-thirds were male, and 10 per cent were Aboriginal or Torres Strait Islander.