Social determinants of health, rural Indigenous men and participatory action research

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ABSTRACT:
Aboriginal and Torres Strait Islander people experience higher levels of illness and premature death than the rest of the Australian population. They are also more likely to be incarcerated, experience family violence, have lower levels of education and employment, and suffer from excessive use of alcohol and other substances. Within the Indigenous population, men are faring worse than women as age-specific death rates for men are higher than for women in every age group and between the ages of 15 and 24, the rates are four times higher. For Indigenous people living in rural and remote settings, the situation is even more serious due to inadequate services, isolation, lack of employment opportunities and endemic alcohol and other drug misuse. Despite efforts to improve the situation over the last 30 years, evidence suggests deterioration in many aspects of Aboriginal health and wellbeing. Consequently, Aboriginal community leaders and activists have called for more innovative and empowering interventions that enhance people's capacity to take greater control and responsibility for their situation. This paper analyses a participatory action research (PAR) process which aims to engage and support the members of a rural Aboriginal men's health group in Yarrabah, north Queensland to, in their own words 'take their rightful place in society'. The paper highlights the potential of participatory research approaches to enable Aboriginal men develop common understandings of their social circumstances as a basis for taking action to improve their situation. The findings of the study have important implications for: a) health promotion interventions in rural and remote Aboriginal settings; and b) the roles that academic researchers can play in supporting and adding value to community-driven initiatives to the mutual benefit of both parties.

INTRODUCTION

There are 460,140 Indigenous people in Australia (2.1% of the population), with approximately half being male (ABS 2002). Current mortality and morbidity data suggest that the health of the Aboriginal and Torres Strait Islander male population is the worst of any population in Australia (Wenitong 2002). Males have a life expectancy of 56.3 years (21 years less than the Australian average) and die at three times the rates of other males from all causes and at all life stages. This compares with a life expectancy of 62.8 for Indigenous women, almost 20 years less than the Australian average (Australian Indigenous Health InfoNet 2004).

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The health of Australian Indigenous people has not improved to the extent of that of other Indigenous populations who have suffered similar colonisation and loss of traditional ways. The gap in life expectancy between non-Indigenous and Maori people in New Zealand, for example, is only 8 years, and in Canada and the United States, it is even less at between 5-7 years, and 4-5 years respectively (Ring & Brown 2003). The relatively poor health status of Aborigines and Torres Strait Islanders (compared to both other Australians and other Indigenous populations) suggests there are Australian-specific factors at work.

While there have been marked improvements in the health of the Australian population as a whole in recent decades, Indigenous people still experience poverty and welfare dependence, and the health gradient between the haves and have nots continues to widen, rather than narrow (Mathers et al., 2000). For Indigenous people, between one-third and one half of the gap in the health status between Indigenous and non-Indigenous people has been ascribed to differences in socio-economic status. The remainder can be attributed to disparities in access to health services and in health behaviour (Booth & Carroll 2005). Underlying this analysis is a historical experience of dispossession of traditional lands, destruction of culture and erosion of customs, oppression and racism which has sapped the dignity and self respect of Aboriginal people (Bonner, 1982 in WPATSIMHWRC, 2004).

Despite the difficult and oppressive history and social circumstances of Indigenous Australians and evidence suggesting deterioration in many aspects of Indigenous health and wellbeing; Indigenous community leaders have suggested that such history should constitute sources of strength and inspiration for change, rather than disablement (Pearson, 2000). Consequently, they have called for more innovative and empowering interventions that enhance people's capacity to take greater control and responsibility for their situation. Empowerment has been defined as a process through which people reduce their powerlessness and alienation and gain greater control over all aspects of their lives and their social environment (Mullaly, 1997). It provides people with resources, opportunities, knowledge and skills - critical among these skills are the capacity to reflect and analyse one's situation (Ife, 1999).

This paper analyses a participatory action research (PAR) process which aims to engage and support the members of a rural Aboriginal men's health group in Yarrabah, north Queensland to, in their own words, 'take their rightful place in society' by developing empowerment strategies such as a men's support group and advocacy to influence structural determinants such as employment, education and access to traditional cultural practices.

The paper is structured into three parts. A summary of Indigenous men's health literature provides a broad context for the micro-level initiative. We then provide background information on the Yarrabah Men's Group PAR process in the context of Yarrabah's colonial history and associated social problems. Finally we describe a 'strengths-based' evaluation methodology that enables Yarrabah men to monitor and reinforce the changes that they have been making as a result of participating in the PAR process.

AUSTRALIAN INDIGENOUS MALE HEALTH- AN OVERVIEW
Most Indigenous men die from cardiovascular disease (28% deaths), injuries (16%), respiratory disease (9%), cancer (8%) and endocrine diseases including diabetes (9%) (ABS and AIHW 2003 in NWPATSIMHRC 2004). Health risks factors include low socioeconomic status; poor living conditions; poor nutrition; high rates of tobacco use; the harmful use of substances; and violence (NWPATSIMHRC 2004).

Throughout Australia, Indigenous males live their lives on a background of emotional distress that is characterised by enormous loss, trauma and grief including loss of land; loss of traditional ways; loss of roles as hunter/providers/warrior/teacher of young men; loss of health; lack of recognition of human status (by Terra Nullius); loss of freedom; culture undermined; loss of control over their lives; and removal of children (Indigenous Youth and Men's Health Conference, 1997). These and other issues such as unemployment and racism make Indigenous males more vulnerable to mental illnesses (Hunter 1993). It can result in acting out (such as child neglect, sexual abuse, emotional abuse and physical abuse) or self-medicating with alcohol or other substances (Swann and Raphael 1995).Up to 54% of Indigenous males over 14 years are smokers. Those who drink alcohol tend to do so at harmful or hazardous levels (ABS 1999). Marijuana is the most popular illicit substance and petrol sniffing is a significant problem for young males, particularly in remote communities.

On a wide range of social and economic indicators, Indigenous Australian men fare less well than their non-Indigenous counterparts. Indigenous males have lower educational achievements than both non-Indigenous males and Indigenous females. In the 2001 Census, only 19% of Indigenous males reported a non-school qualification compared with 46% of non-Indigenous males (ABS 2003 in Australian Indigenous HealthInfoNet 2005). Only 27% of those over 15 years were employed in non-CDEP (Community Development Employment Projects or 'work for the dole') jobs, 20% in CDEP jobs (which often involve very basic and non-productive work) and 22% were unemployed (ABS 2003). Finally, the Indigenous average gross household income was $364 per week, 38% less than the average of $585 for the total population (ABS 2003).

Because of their severely disadvantaged social, economic and cultural position, Aboriginal and Torres Strait Islander people are also over-represented among both victims of crime and offenders (Fitzgerald and Weatherburn 2002) and at increasing rates (ABS 2003a). Contact with the criminal justice system starts early and there is a continuing high level of contact, especially for young males (Mackay 1996). The longer-term consequences include the likelihood of adult incarceration. Indigenous people are incarcerated at 15 times the rate for the non-Indigenous population and represent 20% of the prison population but only 2.1% of the Australian population (ABS 2003a in InfoNet 16). There is little national data available about the health of Indigenous prison inmates (Wenitong 2002).

Indigenous men are not a homogeneous group. The health needs and profiles of remote, rural and urban men can be slightly different. Traditional men in remote areas may require more strict gender-specific health services (men's business), and in urban areas, issues such as illicit substance misuse can be more prevalent. Indigenous gay and transgender males also have unique needs. Anecdotal evidence suggests that men who have sex with men make up a significant proportion of the Aboriginal male

population and male adult to youth rape occurs in some communities, with it's associated sequelae.

Despite these needs, there has been a lack of attention given to the development of appropriate health services and models of service delivery. Although Indigenous males do not necessarily want a complete isolationist approach and regard Indigenous women and family as a significant support, a "gendered approach" to health may lead to better health access and outcomes for Indigenous males. But cultural issues, inadequate resourcing, and failures of health systems to identify and address the specific needs of men, mean that access to appropriate health services is poor and access to specialist and specific services worse. Commonwealth, States and Territories are developing policies and strategies for both mainstream and Indigenous male health (WPATSIMHRC, 2004). There are several models of Indigenous male health programs, based on the principles of accessibility; affordability; accountability; acceptability; appropriateness; flexibility, holistic approach; and focus on education, health promotion and screening, but few have been rigorously evaluated. Initiatives include discrete men's clinics; men's programs within Aboriginal Health Services; men's business camps; sobriety groups; sports initiatives; parenting projects; and men's support groups such as the Yarrabah Men's Health Group which is the subject of the present paper.

BACKGROUND
Yarrabah Men's Group
Yarrabah is a north Queensland rural Aboriginal community of some 3000 residents located on the coast 54 km south of Cairns. The traditional owners are the Kunkangi people but the community is now made up of 80% stolen generation (people who were forcefully removed from their families and brought up by church and government institutions) from about 40 different tribes. The availability of welfare payments, unlimited amounts of leisure time, alcohol and other drugs and a generally permissive alcohol and drug culture in mainstream Australian society have all combined to create an 'alcohol epidemic' with devastating effects (Pearson 2000).

In the mid 1980s, a series of violent suicides were completed by young Yarrabah men, several of them in custody. Through the early 1990s, a second cluster of suicides occurred. This tragedy served as the catalyst for a range of locally driven initiatives including the formation of a health council in 1988, some improvements in access to mainstream services, a decision to close the alcohol canteen in 1997, the development of a feasibility study for a multi-purpose health care service in 1997, and the establishment of a men's support group in 1998.

The Yarrabah Men's Group started as a voluntary group undertaking activities such as weekly health education sessions, counselling, men's health clinics, and social activities. By 2000, the community had acknowledged the benefits of the men's group and called for extension of activities, particularly to men that were most in need. Those at particular risk of suicide include heavy drinkers, those with a history of violence and men in the corrections systems.

Auspiced by Gurriny Yealamucka Health Service, the Men's Group successfully secured a two-year National Suicide Strategy grant from August 2001. This allowed

two local men to be employed to coordinate and support the activities of the Group. As part of the funding agreement, the University of Queensland (UQ) was contracted to evaluate the project using a participatory action research (PAR) process. A three-year follow-up funding has been provided by the National Health and Medical Research Council (NHMRC) from January 2004.

Some of the key PAR activities and developments are listed in Table 1.

Table 1

> - Development of a Strategic Plan focusing on employment, education and training, tradition and culture, a place for men, leadership and personal development, and a health service for men
> - Weekly education meetings, bonding activities, hunting and fishing trips
> - Referrals from the local magistrate courts
> - A small business feasibility study
> - Detailed business plans for 3 discrete potential business initiatives, namely cultural dancing, landscaping, and stone masonry
> - Extension of the PAR process to one other Indigenous men's group
> - Support for a group of young men to transform their church-based dance group for commercial purposes - the nucleus of the proposed Cultural Dance Business
> - Systematic review of the literature regarding the pitfalls and opportunities involved in business enterprise development in Indigenous communities
> - Partnerships with an Indigenous dance group in Canada

EVALUATION METHODOLOGY AND FINDINGS
Participatory action research (PAR) has been widely promoted as a potentially effective tool for working with Indigenous Australians in order to achieve better health outcomes. It has emerged as an alternate methodology to conventional research practices which have been perceived, in some contexts, as acts of colonisation whereby research and policy agendas were imposed on a local group or community from management, or agencies far removed from local concerns or interests (Kemmis and McTaggart, 2000).

- PAR has been defined as *…inquiry by ordinary people acting as researchers to explore questions in their lives, recognise their resources, and produce knowledge, and take action to overcome inequalities, often in solidarity with external supporters* (Dickson, 2000). As such an approach views people as the experts in their own lives, and considers that they should necessarily be actively involved in decision making, planning and then both implementing and reviewing change (Tsey et al., 2002).

This paper addresses an important gap in the PAR and community development literature, namely, the need to develop innovative evaluation methodologies that enable participants to monitor and reinforce changes they have been making as a result of participating in PAR processes.

The original vision statement of the men's group in 2001 was: 'to restore men's rightful role in the community' encompassing spiritual, mental, physical, emotional and social aspects of life. The men visioned and described the characteristics and behaviour by which a Yarrabah man who plays his 'rightful role' could be recognised.

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These were categorised into sets of **Do's** and **Don'ts** as described in Table 2.

Table 2: Do's and Don'ts

Do's	Don'ts
• Be loving, kind, compassionate, forgiving, respectful, honest and truthful; • Support family by working and paying bills; • Have employment; • Role model for wife and kids; • Practice what you preach; • Share household responsibility; • Be an example, role model; • Have goals; • Communicate with kids and wife regularly; • Spend time reading to your kids; • Look at spiritual needs and values; • Resolve conflict by talking not fighting; • Be actively involved in finding positive solutions to community conflicts, for example land issues; • Show positive leadership in family and community; • Teach your kids to read; • Instil CONFIDENCE in your family; • Learn to be a mediator; • Respect yourself and others; • Admit when wrong; • Make sure food is in the cupboard.	• Argue and fight in front of kids; • Abuse wife or kids; • Gamble money away; • Be slaves to alcohol, drugs, gambling and pleasures of the self; • Hate, reject and put down people; • Become 'Mr Moms' (Solely responsible for household chores); • Take side with others in community disputes; • Be lazy and expect everything like a king; • Be macho about certain jobs; • Be ashamed of who you are; • Be violent to others and families; • Be selfish.

Source: Tsey, Paterson, Whiteside, Baird and Baird, 2002

As well as giving the men a clear identity and values to which they aspired, the **Do's and Don'ts** provided criteria against which to monitor and evaluate their activities over time. In February 2004, a series of small focus groups involving 34 local men were run. Each group was given a simple scale from 0-10 to rate individual performances and behaviours against the **Do's and Don'ts**, zero being very poor and ten being excellent. Details of the findings are reported elsewhere (Tsey, Wenitong, McCalman, Whiteside, Baird, Patterson, Baird, Fagan, Cadet-James and Wilson in print). What follows is a brief summary of the key findings.

Where were we in 2001?

Most participants rated themselves between 0-1 at the start of the **Do's** and **Don'ts** process in 2001. Reasons given for rating themselves poorly included 'selfishness' *Because I used to be selfish; I knew what was wrong but did not do the right thing; Being like a king and not doing much; and not taking family responsibilities seriously*, *Washing up but not doing other things.* For some men, the concept of the **Do's** and **Don'ts** was new. Two men performed poorly because of alcohol and drug problems while a third person went further to explain that in 2001 his life was one of a revolving door, *drinking, rehab in and out…*

Where are we now?
After two years of involvement in the PAR process, the majority of the men rated their performance against the Do's and Don'ts at 4-5, suggesting significant shifts on the pathway towards change. The main reasons given related to the personal development and growth of the men themselves and to responsibilities to family.

There was overwhelming consensus that the strategic plan and accompanying Do's and Don'ts checklist gave clear direction which had contributed to the men's development and growth. Participants also felt that the PAR allowed them to expand the range of men's group activities, which had increased their awareness of themselves and their needs and given them a greater willingness to seek help when needed.

Responses suggested that a lack of fairness in the distribution of housework between men and women is a major source of family conflict. The issue of sharing housework was important, and one man 'jumped' from 1 to 5 because of his increased involvement in *helping more at home, cleaning, etc, I have to cook because my wife is working.* However, a few people said that they had been trying to do more but their partners did not always appreciate it.

The two people with drug and alcohol problems had made little progress towards overcoming their addictions. One of them said he was still on level 1 because he was confused, while the other had only managed to move one step up the scale. Significantly, both expressed the desire to tackle their alcohol and drug problems more seriously, suggesting an opportunity for the men's group to refer people to specialist treatment and rehabilitation services.

What needs to happen for us to move to level 10?
In order to move towards level 10 and beyond on the **Do's** and **Don'ts** scale the men identified needs including a 'men's place' to give them space to organise and implement their objectives. *Men's shelter is important and this needs to be discussed with traditional owners; ...cultural activities; a place for men.* A second priority was the need for the men to take the **Do's** and **Don'ts** seriously and integrate them more into their day to day life. *Practicing each day, don't hate and put people down, the more I deal with it, I will move to level 9 and beyond.*

Another priority for the men related to employment and money problems. As one person aptly put it, *$275 for CDEP (work for the dole) doesn't help, biggest problem is money.* Most men reiterated their concern for greater opportunities for real employment. *To get good job and provide for the family; Having a good job can make a big difference.* Other priority tasks identified included promoting the men's group activities within the community, the need for men to become role models especially to younger men and boys, and more activities directed to families.

Significantly, the two people with serious drug and alcohol problems renewed their desire to address these problems. *Cut down on drinking, improve physical health. No putting money into poker machines and start working on all the pleasure issues; Give up dope smoking and save money.*

Conclusion

Few Indigenous men's health initiatives have been rigorously evaluated. This participatory action research approach provides an example of one attempt to adopting a systematic approach to evaluating the broad range of activities of the Yarrabah Men's Health Group.

Participation in men's group sessions over the two years significantly enhanced the men's capacity not only to discuss sensitive personal issues but also to give and accept help from each other. A few people even said that they might adapt the self-reflective evaluation technique for use in other settings including with family members. This clearly highlights the value of demystifying and making research more relevant to people's experience. Further, the research process itself can be used as a strategy for reinforcing and enhancing change. The findings indicate that the key elements of the men's group strategy plan - employment, a men's place, self help and support networks, a men's health service as well as cultural activities- remain as relevant for the men today as they were in 2001 when their strategy plan and the accompanying **Do's** and **Don'ts** were developed. The findings also indicate that traditionally 'gendered' approaches to housework may constitute major sources of conflict in the family and that opportunities needed to be created for men to dialogue and reflect on their domestic responsibilities in non-judgmental ways.

This research has demonstrated that participation in a structured empowerment initiative developed for Indigenous settings can enhance program participants' critical self-awareness and control and responsibility for the conditions affecting their health and wellbeing, and their sense of social inclusion. While we cannot demonstrate improvement in health outcomes within the timeframe of this research program, strong research evidence is emerging that such intermediate health outcomes are likely to influence health both directly through pyschobiological processes and through modified behaviours and lifestyles (Martikainen et al 2002; McEwan 1998).

We plan to fine tune and repeat the self-reflective rating exercise routinely so as to map out individual progress as part of a broader PAR evaluation strategy.

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