

Colonisation – It's bad for your health: The context of Aboriginal health

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ABSTRACT: *Australia's history is not often considered to be an indicator of any person's health status. However, as health professionals we are taught the importance of taking and listening to our client's detailed history to assist us in our comprehension of the issues impacting upon their lives. This skill base is an important one in that it makes available valuable information that assists the health professional to be discerning of intimate and specific circumstances that could contribute to health related problems not previously diagnosed. It is a vital screening tool. I would like to advocate that history taking, that being Australia's colonial, political, social and economic histories be a course of action undertaken by all health professionals working with Aboriginal and Torres Strait Islander peoples. Health researchers of recent years have been able to clearly illustrate that there is a powerful relationship between health status and individuals or collectives; social, political and economic circumstances (Marmot, 2011; Marmot & Wilkinson, 2001; Saggers & Gray, 2007). This way of knowing how health can be affected through such social health determinants is an important health competency (Anderson, 2007; Marmot, 2011). As such this paper delivers a timeline of specific historical and political events, contributing to current social health determinants that are undermining Indigenous Australians health and well-being. This has been undertaken because most Australians including Indigenous Australians have not benefited from a balanced and well informed historical account of the past 200 and something years. The implication of this lack of knowing unfortunately has left its effect on the way health service providers have delivered health to Indigenous children, mothers, fathers, and their communities. Indigenous Australians view the way forward in improving health outcomes, as active partners in their health service delivery. This partnership requires health professionals to listen to their clients, with respect and a decolonising gaze.*

KEYWORDS: colonisation, decolonisation, social determinants, eurocentric, positivist, first nations, Indigenous, Aboriginal and Torres Strait Islander peoples

The aim of this paper is to provide the reader with:

- a context of why 'Indigenous Australians continue to suffer a greater burden of ill health than the rest of the population' (Australian Institute of Health & Welfare [AIHW], 2013, p. 1).
- and
- a decolonising gaze for reflecting on the political and historical events that have directly impacted on the lives of Indigenous Australians.

This paper is written by an Indigenous health professional and I have explored the actions resulting from laws and policies that have mainly been ignored and, at worst, denied by governments, historians, scientists and the broader non-Indigenous community. I have attempted to fill in the gaps of knowledge related to these circumstances and histories from an Indigenous perspective, providing the context of a trans-generational Indigenous Australian experience. I

have used a decolonising methodology to inform this approach.

DECOLONISATION

Decolonisation is the philosophy grounding the Indigenous informed conceptual framework I have used to review, critique and reflect on the sources and histories I have read and listened to. This methodology accepts that research is not impartial. Instead it recognizes that we all as researchers and health professionals bring our own worldviews and perspectives, as a lens to gaze and examine and explore what we read about, think about, research and discuss (Ranzijn, McConnochie, & Nolan, 2009; Rigney, Kunnie, & Goduka, 2006; Smith, 1999).

We have been influenced in Australia by the scientific method of positivistic research, informed philosophically through Western reasoning. This Western reasoning and viewing Australian Indigenous peoples became a significant and useful tool of Colonisation

(Thomas, 2004). It aided colonial activities and policies through its production of knowledge about the Indigenous Australian Other (Dodson, 2003). This development of colonial knowledge purposely misrepresented and dehumanised, Aboriginal peoples (Sherwood, 2009). It also produced and developed racial stereotypes that continue to be used within the Australian Western culture, the academy and the football ovals of today (Riseman, 2013; Said, 1995).

Since their first intrusive gaze, colonising cultures have had a preoccupation observing, analysing, studying, classifying and labelling Aborigines and Aboriginality. Under that gaze, Aboriginality changed from being a daily practice to being 'a problem to be solved.' (Dodson, 2003, p. 27)

Problematic constructions of Indigenous peoples, as the sole cause of their poor status, have been replicated through the decades since invasion (Sherwood, 2009). Guba and Lincoln have argued, that once constructions have been mentally formed they are very hard to shift (Guba & Lincoln, 1989). This is a significant point to consider, and it is why it is vital that we all employ a more open and decolonising gaze.

Since settlement and the usurpation of Aboriginal and Torres Strait Islander custodianship of their respective countries, Australia and those who lived and here have been colonized.

Deconstructing old myths and revealing practices used to problematize Australian Indigenous peoples in the past and currently are important tenants for why decolonising approaches are necessary. They also help us to examine hegemonic practice and policy that have been used to support initially Britain's attempts to legitimize the illegal ways of dealing with its problematic natives. Albert Memmi asserts, the colonizer 'endeavors to falsify history, he rewrites laws, he would extinguish memories – anything to succeed in transforming his usurpation into legitimacy' (Memmi, 1965, p. 52). This willful forgetting has been called 'colonial amnesia,' the inability to resolve an unpalatable past (Gandhi, 1998).

Delivering balanced stories through the memories and narratives of the lived experiences of the colonized provides important evidence for the present circumstances. An understanding

of context is essential to the Indigenous health stories that are written today. Without the background data of balanced stories of history, the problematic nature of complex health issues can be disregarded. Here I attempt to remember the unpalatable past that is often ignored in an account of Australians Indigenous people's health.

ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

The Australian Indigenous population is estimated to be as of 30th June 2011 669,736 (MacRae et al., 2013, p. 1). NSW has the largest Indigenous peoples living in this state being 31% of the total Aboriginal and Torres Strait Islander population, with the Northern Territory having the greatest percentage of Indigenous peoples in its Territory being some 30% (MacRae et al., 2013, p. 1). From 2006 through to 2010 the leading causes of death for Aboriginal and Torres Strait Islander peoples reported by the Australian Indigenous HealthInfoNet were cardiovascular disease, neoplasms (almost entirely cancers) and injury (MacRae et al., 2013, p. 1). Importantly the classification injury includes death through suicide (intentional self-harm) and in 2010, this was 2.4 times more frequent amongst Indigenous Australians than non-Indigenous peoples (MacRae et al., 2013, p. 2). Outstandingly from 1991 through to 2010 Indigenous and non-Indigenous infant mortality has seen a noteworthy reduction in NT, SA and WA (MacRae et al., 2013).

In 2007 Aboriginal and Torres Strait Islander health was reported to be a crisis (NACCHO & Oxfam, 2007); an unacceptable situation in a country that has a 'world-class health system' (AIDA, 2008, p. 1). For at least 50 years, the status of Aboriginal Australian health has been described as appalling (Stanner, 1972). Even though there has been much hand-wringing and many descriptive accounts of the burden of disease, poor living conditions, and accounts of continuing injustices, Indigenous health remained, as the National Aboriginal Community Controlled Health Organizations (NACCHO) and Oxfam Report, *Close the Gap: Solutions to the Indigenous Health Crisis facing Australia*, states, 'a national scandal' (NACCHO & Oxfam,

2007, p. 3). This conceptualization of 'a national scandal,' suggests that the poor health status of Indigenous Australians is recent and this is not the case (AIHW, 2013).

In 2008 the Federal Government took up action to Close the Gap as encouraged by the campaigning of NACCHO and Oxfam.

The campaign's goal is to close the health and life expectancy gap between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians within a generation. The campaign is built on evidence that shows that significant improvements in the health status of Aboriginal and Torres Strait Islander peoples can be achieved within short time frames. By joining our efforts we can make sure that by 2030 any Aboriginal or Torres Strait Islander child born in this country has the same opportunity as other Australian children to live a long, healthy and happy life. (AHRC, 2013)

This burden of disease has been estimated to be 'two and half times greater' than for non-Indigenous Australians (AIDA, 2009, p. 1). The fundamental discrepancies in Indigenous health status justify comparative descriptions with third and fourth world positioning (Bhatia & Anderson, 1995; Cooperative Research Centre for Aboriginal Health, 2006). Disparities in health are indicators of a disproportionate affliction of disease within a population group (Adelson, 2005, p. 45). The causal agents of disparities are 'social, economic, cultural and political inequities' (Adelson, 2005, p. 45). They have developed through marginalisation created by colonisation (Murray, Bell, Grant, & Wronski, 2003) and they have taken a heavy toll upon individuals and their communities (Thomson & Ring, 2008). The incidence of co-morbidities, disability and premature deaths are further exacerbated by 'the collective burden of a history of discriminatory practices, unjust laws and economic or political disadvantage' (Adelson, 2005, p. 46).

Western health policy has focused upon the responsibility of the individual to control their personal health fate, with disease causation being largely attributed to high risk behaviours and proximate causes of diseases, such as hypertension and diet. These notions have largely ignored what puts people at risk (Link & Phelan, 1995). The causal agents are linked to people's social environment and, in most circumstances, are not individually

chosen. Hence, the fate of health status is not entirely a choice but the product of many historical-political-social determinants that are often not elaborated on within the discourse of medicine (Kelm, 1998, 2005; Saggers & Gray, 2007).

Prior to European invasion and settlement, Aboriginal Australians enjoyed a non-sedentary life-style that concentrated upon maintaining and sustaining their Country, relationships and ecosystems. 'Pre-contact health care systems' (Anderson, Anderson, Smylie, Crengle, & Ratima, 2006, p. 4) were focused upon the inter-relationships of land, people, the living and non-living entities and creator beings. If the land was not cared for, it got sick, and so would all other beings related to the land, including the people (Yunupingu, 1997). Tenure of management was dictated by Law, passed down through the Dreaming and Ancestors, and was practiced to ensure balance and to maintain health. The balance ensured a variable access to nutritional diets high in protein and complex carbohydrates (Mackean & Watson, 2004). Lifestyles limited the spread of endemic diseases or injury related to mental distress (Saggers & Gray, 1991b; Trudgen, 2000). Documentation of the First Fleeters highlighted that Aboriginal people were in 'good health and free from disease' (Franklin & White, 1991, p. 3).

THE CONTEXT OF ONGOING COLONISATION

Today the burden of disease, poor socio-economic status and severe disadvantage of the Indigenous Australians is a testament to a history of colonisation and its continuation (Mitchell, 2007). The practice of colonisation targeted Aboriginal people in a 'deliberate and calculated' manner which aimed to 'displace and distance people from their land and resources' (Sinclair, 2004, p. 50). To achieve this aim, Aboriginal culture had to be destroyed, firstly through hostilities and in more recent times through 'mainstreaming' policies. Canadian First Nation researcher, Raven Sinclair, argues 'almost every contemporary social pathology or health issue in Aboriginal communities' (Sinclair, 2004, p. 50) is a result of colonisation. Colonisation is a determinant of health and requires appreciating that it is not a 'finished project' (Czyzewski, 2011, p. 10).

Colonisation has been practiced for millennia but in this context, it refers to the period of European expansion from the 1500s to the 1900s, in which Britain and its European neighbours invaded and subsequently settled or exploited large proportions of the rest of the world (Smith, 1999). The philosophical underpinnings of colonisation 'provided the means by which concepts of what counts as human could be applied systematically as forms of classification' (Smith, 1999, p. 25) utilised through political action and informed by science 'to shape relations between imperial powers and Indigenous societies' (Smith, 1999, p. 25). This colonised and colonising mindset continues today.

The current status of the health of Australian Indigenous peoples is directly linked to this history of harmful policy (Kunitz, 1996; Mitchell, 2007; Reid & Lupton, 1991; Ring & Brown, 2003; Siggers & Gray, 1991a). The health of Aboriginal and Torres Strait Islander peoples is far worse than other Indigenous peoples living in Canada, the United States and New Zealand (Kunitz, 1996; Murray et al., 2003; Ring & Brown, 2003). Although their health is still poorer than many of the non-Indigenous populations, these First Nation peoples have benefited from somewhat more effective health measures and appropriate policies (Murray et al., 2003) and through self-determined advocacy and government investment, than have Indigenous Australians.

Aboriginal Health Policy in Australia has failed to improve Aboriginal peoples health and well-being, as evidenced by an increase of comorbidities fuelled by chronic disease and depression and the flourishing of fourth world diseases (Murray et al., 2003) such as: Failure to thrive, otitis media, rheumatic fever/heart disease, leprosy, tuberculosis and trachoma (Brewster, 2003; Couzos & Carapetis, 2003; Couzos, Metcalf, & Murray, 2003; Couzos & Taylor, 2003; Krause, 2003; Zweck, Roche, & Couzos, 2003). All of these are diseases of poverty and are endemic and preventable but continue as a result of a lack of effective political, social and medical intervention.

Dispossession 1770–1885 and 1885–2007

Terra nullius (land belonging to no one) was a European doctrine used to extinguish the sovereign

rights of First Peoples. British Law enabled Australia to be occupied by British citizens, dispossessing original owners without compensation (Reynolds, 1987a, p. 4). This practice led to the multitudes of injustices suffered by Aboriginal and Torres Strait Islander peoples who held customary ownership of the Countries of some 500 Nations throughout the continent. The conception of Australia as *terra nullius* became deeply intertwined with the constructions of Indigenous Australians as inferior and problematic, necessitating the notion of a superior race taking up an empty and untitled land (Reynolds, 1987b).

Settlement occurred from 1788, not as a single event but as a staggered assault throughout the continent over a period of 100 years (Goodall, 1996), beginning on the south-east coast (Goodall, 1996) and ending in the Northern Territory around 1870–1885 (Haebich, 2000; Trudgen, 2000). NSW was initially founded as a penal colony, which led to an enterprise of farms, housing and expanding settlement. It has been documented that within a year of initial contact, epidemics of smallpox had wiped out large numbers of Aboriginal people from within the Eora Nation (Sydney) (Reynolds, 2001, p. 36). Diseases became the key explanation for the decline in numbers of the Aboriginal population, considered to have been between 750,000 and 1,000,000 people across Australia, prior to the invasion (Franklin & White, 1991; Siggers & Gray, 1991a). This explanation of demise fits with an ideology of primitive and backward races, effectively whitewashing the impact of 'warfare, dispossession, and demoralisation on health and social organisation' (Anderson, Ian, & Humphrey, 2007; Mitchell, 2007).

Settlement expansion and encroachment by non-Indigenous people, using many strategies over Indigenous Countries (Bird Rose, 1991; Reynolds, 1987b), reduced Aboriginal peoples' access to Country and their ability to maintain societal, legal and religious obligations. European occupation resulted in loss of land, critical to the health and well-being of Aboriginal peoples and limiting their access to nutritional resources, leading to malnutrition and the lowering of resistance to infectious diseases. Epidemics of smallpox, measles, influenza, tuberculosis, whooping cough and venereal

diseases (Mitchell, 2007, p. 43); a decrease in fertility (Bird Rose, 2004; Rowse, 2002) together with an increase in deaths, lead to a dramatic reduction in population. The destruction of social and political infrastructures, critical to a sense of community well-being, was equally important.

Conflict and violence 1788–1928

Settler encroachment of lands met with Aboriginal resistance. The consequences of resistance were violence from both the military and settlers, acknowledged as a sustained period of warfare from 1788 to 1838 (Connor, 2003). As the British claimed 'Aborigines were British subjects,' they were able to define hostilities 'as civil disorder rather than as a war against a foreign enemy' (Connor, 2003, p. 58). This ensured that a treaty would not result. Martial Law became a standard tactical response during this era, enabling the military to mount attacks without legal retribution (Connor, 2003) in NSW, Tasmania and Western Australia (Reynolds, 1999), where many lives were lost. In Tasmania, from 1824 to 1831, the population was culled from 1,500 to 350 (Reynolds, 1999, p. 71). The frontier warfare escalated once the military had been withdrawn (Connor, 2003, p. 120), and there were numerous reprisals against Aboriginal people, acknowledged as massacres, throughout the country from 1837 (Reynolds, 1987b).

A number of inhumane strategies were used both by settlers and the police to demoralise Aboriginal communities. Abduction, rape and the murder of women and children (Woods, 2002, p. 88) resulted in hostile retaliation from tribal bands (Reynolds, 1987b). The poisoning of water holes, poisoned food, along with shooting, stabbing and forcing large numbers of Aboriginal people, including children, to jump to their deaths, (Elder, 1988; Schlunke, 2005) were also employed. Massacres, starting not long after invasion and continuing into the 20th century, occurred throughout the nation and resulted in the murder of hundreds of Aboriginal people. The most infamous of these were: The Myall Creek Massacre, NSW, in 1838, (Elder, 1988; Goodall, 1996, p. 31); the Bluff Rock Massacre, NSW, 1844 (Schlunke, 2005); and the Coniston Massacre 1928, Northern Territory (Elder, 1988; Haebich, 2000).

The scientific community, as part of the colonial administration, developed constructions of 'primitive, savage natives,' who were not long for this world (Wolfe, 1999). These constructions supported the 'doomed race theory,' encouraging settlers to be active in Aboriginal people's early demise (McGregor, 1997; Thomas, 2004). Anthropologists, in particular, promoted a European blindness to the human status of Aboriginal Australians (Stanner, 1972). This premise fed 'the psychological disposition to hate and despise those whom the powerful had injured, or wish to injure' (Stanner, 1972, p. 108); the instances of massacres highlight this abhorrence. In the wake of such acts, the challenge for Western researchers was to ensure they captured every aspect of the dying race, to be preserved in their writings, as specimens for observing and to be pursued for overseas interests. Prior to the Protection Era, this was achieved through shooting, and later, by grave robbing (Turnbull, 1997). With these homicidal activities carried out in the name of science, research understandably gained a bad name in Aboriginal communities.

Protectionism 1838–1970s

Protection was a 'policy of limiting rights and separating Aboriginal peoples from society in order to protect European interests' (Grant & Wronski, 2008, p. 3). Although the Bill was passed in England, in 1838, 'to protect the natives' 'just rights and privileges as subjects of Her Majesty the Queen' (Ella, Smith, Kellaher, Bord, & Hill, 1998, p. 29), it was not enacted throughout the colonies immediately or uniformly. However, The Act did found the position of 'Protector of Aborigines' (Ella et al., 1998, p. 29). Due to ongoing settler massacres of Aboriginal people, the NSW Government, under the pressure from concerned citizens, appointed its own protector in 1882, heading a 'Board for the Protection of Aborigines' (Ella et al., 1998, p. 30). The Board acted without legislative powers initially, sanctioning the enforcement of Aboriginal peoples onto reserves, as well as punishing non-compliant Aboriginal families (Ella et al., 1998, p. 30). This program of management and control was replicated throughout the country (Haebich 1988; Gray, Trompf, & Houston, 1991).

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Protectionism mandated total control over Aboriginal peoples. It controlled where they could live and enforced restrictions on mobility, marriage, employment, education, and nutrition. The bureaucracy and its public service, inclusive of protectors, health professionals, police and welfare officers (Haebich, 2000) absorbed Aboriginal wages and entitled allowances (Kidd, 2000). This imposed poverty on Aboriginal people and established the exploitation phase of fraudulent activities by governments and their public servants, and the starving of communities of essential funds for survival (Kidd, 1997). The bureaucracy also prevented the purchase of land and the development of economic cooperatives by Aboriginal people (Attwood, 2003). Importantly, under this Act, Natives were no longer considered British Citizens; they were now Wards of the State. Those who survived 'the killing times' were rounded up onto missions and reserves for 'protection' (Reid & Lupton, 1991). This enforced incarceration ensured that there was no resistance to further encroachment on Aboriginal Countries (Haebich, 2000).

Mission/reserve life dictated and enforced welfare dependency (Newfong, 1995). Rations consisting of flour, sugar and tea were distributed to adults weekly, a colonial strategy (Rowse, 2002, p. 5) promoting 'dependency and demoralisation' (Rowse, 2002, p. 7). Poor health conditions, caused by malnutrition, were exacerbated by crowded living conditions, and deplorable shelters increased the rates of morbidity and mortality (Mitchell, 2007). Government underfunding in the area of Indigenous health and housing had become entrenched (Kidd, 2000, p. 10).

Health research promoted a 'doomed race theory,' with Dr Bruce Cleland, in 1928, prophesying the extinction of full-blooded Aboriginals (Mitchell, 2007, p. 52). Those suffering leprosy, smallpox and syphilis were chained up by the neck and walked great distances to 'lock-up hospitals' throughout the country (Grant & Wronski, 2008), as they were considered dangerous distributors of diseases to white communities (Franklin & White, 1991, p. 24). This resulted in Aboriginal people being left to die in these lock-up hospitals (Wolfe, 1999) as health provision was mainly in the form of segregated isolation

(Anderson, 2002). Meanwhile, health researchers focused on descriptive accounts of disease; carried out photographic studies of infected women and men for publication; promoted notions of a disease-ridden population and created the label 'black pox' (Thomas, 2004, p. 23) to explain *donovanosis*, a genital disease. Thomas comments that the photographs are still in circulation, although taking them was an 'abuse of power' that caused those suffering from this disease 'a loss of dignity' (Thomas, 2004, p. 23).

Injury through the removal of children 1814–1980s

From 1814 onwards, Aboriginal children were removed from their families 'to be educated and civilised' (Ella et al., 1998, p. 10), although prior to this period they had been kidnapped and exploited as slaves and guides (Ella et al., 1998, p. 29). From the 1890s, the Protection Board of NSW sanctioned the removal of children to 'training homes,' institutionalising their lives (Ella et al., 1998, p. 31).

In 1937, a Commonwealth Protectors' meeting, held in Canberra, shifted the agenda of removal for training and civilisation to miscegenation, a scientific rationalisation for breeding out the colour, a policy and practice supported by Protectors Dr Cecil Cook of the NT, A.O. Neville from WA and J.P. Cleland from SA (Anderson, 2002; Haebich, 1988), to solve the 'half caste problem' (Thomas, 2004, p. 63). Protector Neville was concerned with the growing numbers of half-castes, believing Australia would be taken over by this group (Thomas, 2004). The Protectors proposed a eugenics policy focusing on biological absorption aimed strategically at having 'them disappear.' It was believed this could only be achieved by the children's removal and a Western education (Anderson, 2002, p. 237, 19; Haebich, 2000). This policy was inhumane and irrational, yet it led to future Western political and social constructions that would perpetuate removals through a punitive system of incarceration. These irrational concerns, of half-castes taking over the country or running an Indigenous agenda, were dealt with as recently as the early 2000s, by Prime Minister Howard, who abolished

ATSIC, mainstreamed Aboriginal Affairs, and enforced the 'Emergency Intervention' upon Aboriginal Territorians, under the guise of 'protecting the children.'

In NSW, the Protection Act of 1909 gave the Board the right to take custody of an apprentice that is 'any child of an Aborigine' (Ella et al., 1998, p. 41). Simply being Aboriginal entitled removal under the premise of neglect (Haebich, 2000). Numbers of removals from 1910 to 1970 are estimated to be 'between one in three and one in ten' Aboriginal children, creating the Stolen Generations (Anderson, 2002, p. 239). Neglect was used as the basis for removal, another construction, developed through policy that would have a terrible legacy (Haebich, 2000, p. 37). Child removal continued in the NT, specifically in Alice Springs, long after the 1970s. Initially used as a strategy to break up Town Camps, the children were offered back to the family if the family left town (Haebich, 2000, p. 35).

The direct impact of this policy was the death of hundreds of Aboriginal children in residential care, due to physical, nutritional and psychological neglect (Kidd, 2000, p. 61). Of those who survived their 'care,' many self-medicated with alcohol, had their own children taken, lived with violence or suicide, and were further incarcerated (Kidd, 2000, p. 61). The Royal Commission into Aboriginal Deaths in Custody (RCIADC), 1991, found that 43 of the 99 Indigenous men who died in custody had been removed from their families (Ella et al., 1998, p. 163). From an Indigenous perspective, this removal policy and practice has been considered a genocidal act, which perpetuated injury trans-generationally (Tatz, 1999, 2001). It is another part of white Australian history which has been ignored and denied, but which continues to injure and scar Aboriginal families. The child removal policy and practice, however, failed to make Aboriginal people disappear. The aim of removing Indigenous children, to breed the black out, had not taken into account the nature of Aboriginality, which is not about skin colour but about the identity of the individual, identification by the Indigenous and non-Indigenous community, and the spiritual and physical connections to people and place.

Assimilation 1937-1969

... all aborigines and part-aborigines are expected to attain the same manner of living as other Australians and to live as members of a single Australian community enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs, hopes and loyalties as other Australians. (Hasluck, 1961, p. 2)

Although this policy aimed to have Indigenous Australians behave as non-Indigenous Australians, government policy continued to control their lives, deny equal wages and employment rights (The Fred Hollows Foundation, 2005, p. 2). Aboriginal men, women and children contributed extensively to the growing economic base of the nation (May, 1994), but without recognition or remuneration. The Pastoral and Cattle Industries of Australia were built on the back of cheap Aboriginal labour (Rowse, 2002) and the enforced labour and slavery of stolen children (Kidd, 2000, p. 18).

The health research focus of this era was on collecting data on diseases and deficits without intervention (Thomas, 2004). Epidemiological research in the 1960s identified that infant mortality was four to six times greater than that of non-Aboriginal infants; and for children under four, mortality was 13 times greater than for non-Aboriginal Australians (Kidd, 2000, p. 12, 32). Malnutrition was the cause of death for 50 per cent of children under three and 85 per cent of children under four on Palm Island in Queensland (Kidd, 2000, p. 33). During the 1960s and 1970s, Central Australia was reported to have had the highest infant mortality in the world (Haebich, 2000, p. 29).

Governments failed to act on substandard conditions and apprehended maternity allowances and child endowment payments from 1912 (Kidd, 2000, p. 40, 47), enforcing poverty and malnutrition. Substandard conditions continued with overcrowded shelters, lack of access to clean drinking water, sewerage and cleaning facilities, all of which contributed significantly to poor health status (Torzillo & Kerr, 1991), as did the lack of access to health care, which, until the 1960s, was denied on the grounds of being Aboriginal (Saggers & Gray, 1991a, p. 388).

From the 1930s to the 1950s and beyond, biochemical definitions of race focused upon

research of blood types of Aboriginal Australians to determine origins and support racial differentials (Thomas, 2004, p. 66). Scientific hypotheses were used to explain death tolls and the burden of disease for Aboriginal Australians. These included explanations such as genetic factors, inability to cope with civilisation and poor hygiene (Torzillo & Kerr, 1991). Health research data collection continues to be used as a tool for blaming the victims for their disease burdens (Mitchell, 2007; Mobbs, 1991).

Self-determination 1972–1996

The 1967 Referendum, finally establishing Indigenous Australians' full citizenship under the Commonwealth, raised hopes amongst Indigenous Australians that their status would change. In 1972 the Commonwealth established the Office of Aboriginal Affairs, directing and funding States and Territories to address Indigenous health priorities (Saggers & Gray, 1991a). Sadly, this policy had a 'top down approach to self-determination' (Maddison, 2009, p. 28), focused only upon 'organisational and community management' (Maddison, 2009, p. 28) and not the autonomy of Aboriginal communities. Aboriginal controlled health organisations, land councils and legal services were only established in the 1970s (Murray et al., 2003).

This was also the era that ran the first national inquiry into Indigenous affairs; the target in 1979 was Aboriginal health. The findings revealed 'low standards of environmental and housing conditions, socio-economic factors, and inappropriate health services' (The Fred Hollows Foundation, 2005, p. 2). These findings have not changed and are the result of a lack of government investment and goodwill. This is highlighted by the failure to implement the 1989 National Aboriginal Health Strategy (NAHS), the first national Aboriginal health policy (Murray et al., 2003; Anderson, 2007).

This political era also saw the documented rise of racial violence within the criminal justice system (O'Shane, 1992, p. 2), targeting Aboriginal communities. Indigenous incarceration rates escalated, as did suicide rates, a direct result of racial victimisation (Hunter, 2001; Tatz, 2001). Internalized injury led to a rise in family violence and alcohol misuse (ATSIWTFV, 1999; Brown & Brown, 2007). The era of hope was dashed

by the continuing irrational and inhumane acts of colonial systems along with the lack of health interventions, particularly in social and emotional well-being treatment (Cunneen, 2001).

Colin Tatz argues, 'Much in Aboriginal policy and practice is confusing, contradictory and ambiguous' (Tatz, 2001, p. 7), and suggests that ambiguity is a valuable political tool when attempting to assert power and appease calls for action. Policy responses that target Indigenous Australians have been reactive, politically contrived and have had 'serious consequences' (Tatz, 2001, p. 7) on their lives. In fact, white solutions for us have become our problems (Sherwood, 1999). Stanner's lecture, entitled the 'Great Australian Silence,' delivered in 1968, offers a reason for problematic government policy. He argued that the Government's lack of conscience was a direct result of failing 'to integrate the story of Aboriginal dispossession and its aftermath into their understanding of Australian history' (Manne, 2003, p. 1). There has been a willful forgetting of these tragic events, the policies and the injuries caused. Yet they impart an Indigenous context, not only of Australian history and its denialism, but of the causal agents that created the appalling Indigenous health status that continues unabated.

Howard Era and beyond: Intervention and apologies 1996–2010

In 1996 a Liberal Federal Government was elected with a new Prime Minister, John Howard. Immediately Howard employed denial, deception and ambiguity into Aboriginal policy. By claiming wrongs committed against Indigenous people in the past were not the responsibility of current Australians (Behrendt, 2003, p. 3), Howard appeased mainstream Australia's guilt. He chose a methodology, which Memmi described in his text, *The Colonizer and the Colonized*, of falsifying histories to imbue the coloniser with importance and superiority (Memmi, 1965). Right wing academic allies discounted the works of 'black armband historians,' who had chosen to balance the mainstream Australian history stories with Aboriginal accounts and factual archival evidence of unreported warfare (Connor, 2003; Manne, 2003). Conservative Australians were enthusiasts of these right wing accounts of Aboriginal fabrications of history.

This approach enabled Howard to dismiss evidence based accounts produced in the *Bringing them home* Report, tabled in 1997, that detailed the shocking consequences of the Indigenous child removal policy, denigrating and diminishing the impact this policy had on generations of Aboriginal children and their families (Tatz, 2001, p. 17). A further act of denial was his refusal to accept the recommendation from the report to offer a national apology (Behrendt, 2003; Broome, 2002). His successive policy approaches were just as damaging: the abolition of the self-determination policy, in 1996, and the abandonment of the collective Reconciliation movement, by shifting the agenda to a political funding program, requiring Indigenous communities to share responsibility of government inaction (Behrendt, 2003; Manne, 2003). He enacted the 1998 Native Title Amendments Act, as a result of pressure from mining companies and national anti-land rights sentiment (Altman, 2007).

The abolition of ATSIC, a democratically elected body, was supported by a bipartisan vote in 2005 (Altman, 2007) and effectively silenced Indigenous voices and our ability to represent ourselves (Maddison, 2009). His final and most destructive vote seeking policy was the implementation of the Northern Territory Intervention (NTI) in August 2007.

In November 2007 a Federal Labor Government was elected, with Kevin Rudd as Prime Minister. On 13 February 2008 the Prime Minister apologised to the Stolen Generations. This was a critical and historical event that gave Indigenous Australians a sense of hope that government policy and practice would become more humane and rational. However, the Federal Government has not revoked the NT Intervention. Instead it has stepped up its discriminatory acts, without any corresponding evidence that such actions are benefiting Aboriginal people. More recently, the government changed the name of the policy to 'Stronger futures.'

The United Nations' Special Rapporteur on Indigenous Human Rights, Professor S. James Anaya, reported in August 2009 that the NT Intervention 'overtly discriminates against Aboriginal peoples, infringing their right of self-determination and stigmatizes already stigmatized

communities' (ANTaR, 2009, p. 1). It can be observed that there is a pattern of such practices and outcomes from Government policy targeting Indigenous Australians. Although over 200 years have elapsed since the initial conceptualisation of this country as *terra nullius* we, the First Peoples, are still dealing with governments who aim to appease the mainstream and marginalise us through their policies and actions.

With this brief contextual exploration, I have attempted to illustrate the unrelenting injurious effects of colonial policy and its practice on the lives of Indigenous Australians. These effects have occurred over generations and they have been transmitted intergenerationally (Atkinson, 2002; Ella et al., 1998). This has resulted in social and emotional well-being co-morbidities that are directly linked to trauma and loss (mhfa, 2008). Trauma is a normal and predictable response to overwhelming distress resulting from an event which is left untreated or, at worst, ignored. It leads to intergenerational hopelessness and unresolved grief (mhfa, 2008, p. 2). Reviewing the evidence, it is clear that it has not been just one act; it has been a sustained and merciless process. Acknowledging the deeply etched impact the last 200+ years of colonisation has had on the health and well-being of Indigenous Australians, the significance of this process can begin to be appreciated.

The evidence provided here has illustrated that past and present policy decisions have created determinants that influence the health and lives of Indigenous Australians. These 'social and health ills' (Saggers & Gray, 2007, p. 5) are the direct result of 'economic and social exploitation' (Saggers & Gray, 2007, p. 5). Governments have been the causal agents that have produced the social gradients of health and created the social factors influencing good health outcomes (Saggers & Gray, 2007).

However this is not the story that has been told through health texts and research to explain the circumstances that have shaped Aboriginal people's health. Instead, the data focuses upon 'income, employment, education, parent-hood, diet and substance abuse,' utilising a Western model (Tynan, Atkinson, Bourke, &

Atkinson, 2007, p. 17) of social determinants. This approach promotes an Indigenous deficit model, leading to problematic constructions, rather than reflecting upon the successive 200+ years of trauma and injury. 'There is a real tradition in Australian culture of blaming the victim when it comes to Indigenous people' (Howard, 2009, p. 31).

Implications for health care practice, research and scholarship

The divergences between Indigenous and non-Indigenous ways of knowing are important to be reflective of in Indigenous health provision, research and scholarship. Appreciating that ways of viewing health for Indigenous and non-Indigenous Australians are divergent and are a result of differing worldviews is vital to working together respectfully, actively and effectively.

The context of Indigenous health is a vital story that needs to be examined and explored from all worldviews perspectives as it often a story that many health providers, researchers and academics have not had access to or cognition of. This general lack of knowledge does influence significantly the way Indigenous Australians are treated within the health system; how they are described in research projects and how they are taught about within the dominant western academy. The consequences of such ignorance have further corollaries for the health and well-being of Indigenous Australians.

Aboriginal people need the opportunities to tell their stories. Their ability to express their feelings and experiences however requires an emancipatory framework. The stories of racism and the ability to remain quiet while listening to the pain and the victory underpin healing in the broadest sense. (Lavalée & Clearsky, 2006, p. 5)

CONCLUSION

The purpose of this paper has been to provide a brief overview of some of the historical, political and societal circumstances that have impacted on the lives of all Aboriginal and Torres Strait Islander peoples since invasion, that Stanner espoused as 'the great Australian silence' (Stanner, 1979, p. 207). This history, the policies and their consequences have framed the

precipitous decline in Aboriginal health status. However they are often ignored or omitted in health discourses that use positivism as a method for knowledge production.

This paper has demonstrated that colonisation continues today both politically and through health service provision, research and scholarship. This is because the context of causal agents that have impacted upon the health of Indigenous Australians be they children, mothers, fathers and grandparents; they have been maintained through problematic constructions of Aboriginal people that were established when the concept of *terra nullius* was applied to this continent.

If we all take up an informed and active decolonising gaze we can shift this colonial context. It is time to make the change; the knowledge is out there, to stop blaming Indigenous Australians for their health circumstances, and to contribute to providing the very best health care, research and scholarship to the first Australians.

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