The painting on the cover has four parts, from top to bottom.

The first part tells how Aboriginal people lived before white people arrived. The culture, the Dreaming and family life were strong: the tjukurpa was wiru. People gathered good foods from their lands and hunted emu and kangaroo. They practised their religious ceremonies to keep the Law of the land and life.

The second part tells how white people came and made their camp. Some visited Aboriginal groups and gave them new things to use: flour, sugar, alcohol and petrol.

The third part tells how these things are used today in ways that harm Aboriginal people. They get diseases such as diabetes, and die from drinking alcohol or sniffing petrol. They mix with white people, sometimes gambling or having sex. They may catch AIDS or other STDs. Families break down and the Dreaming and the Aboriginal Law are not passed on to the young people.

The fourth part tells about a future of healthy Aboriginal life. It will not be the same as it was before white fellas came. Aboriginal people are thinking and talking about ways to solve their own problems. They will keep their culture and their family life and use new Western things in healthy ways.
LIVING MALE

Journeys of Aboriginal and Torres Strait Islander Males
Towards Better Health and Well-Being

A discussion paper
prepared by Hinton J Lowe and Frank M Spry
Published by the Northern Territory Male Health Reference Committee 2002
ACKNOWLEDGEMENTS

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PREFACE

This document has been written by the Male Health Policy Unit, in Department of Health and Community Services.

It tries to reflect information, ideas and perspectives of Indigenous males in the Northern Territory about their health.

These have been reported, expressed and advocated in many discussions: at conferences, conventions, meetings and workshops; as well as a multitude of informal conversations.

Some information has also been included from other publications where it is relevant, and might be interesting or useful.

The knowledge in the paper belongs to you.

Readers may agree, disagree or want additions or other changes to be made.

If the paper contributes to further discussion, including debate, of the issues, it will achieve one of its main purposes.

Your feedback will also ensure that the process towards good health and well-being continues to be owned and controlled by Indigenous males.
SUMMARY

This Discussion Paper defines and explores issues about Aboriginal and Torres Strait Islander male health.

It argues that Indigenous male health requires a distinct policy response and the development of a specific framework for action to address the issues.

The paper traverses concepts of health, the history of the Indigenous male health movement in the Northern Territory, its relationship with women’s health, the issues raised and defined by Indigenous men and their initiatives, and many suggestions to address them.

Concepts and experiences of different Aboriginal and Torres Strait Islander ways of ‘living male’ (masculinities) are also described and explored; and some ways they relate to health outcomes are suggested.

Data and information which prove the disaster of Indigenous male health in the Northern Territory are presented.

The principal issues which Indigenous men in the Northern Territory have identified, ever since the Conference at Mataranka in 1993, are control and integration: their empowerment in defining their own health agenda and managing its implementation; and an integrated response which recognises the interrelationships between health, culture, education, income, living conditions, criminal justice and employment issues.

Indigenous male health in the Northern Territory is a catastrophe which raises questions of social justice and human rights.

It must be addressed urgently by a whole-of-government response, and intersectoral collaboration; and engage Aboriginal organisations in partnerships.

The following is a detailed summary of the information, issues and ideas in each section of the Discussion Paper.

Some Suggestions for Action are also included here. They are not recommendations. However they take into account formal recommendations such as those made at the 1st National Indigenous Male Health Convention held at Ross River in October 1999; and the NT Indigenous Male Health Conference in Tennant Creek last year.
1.0 The Discussion Paper

This section introduces readers to the paper. Its main purposes are stated and explained; and some guidance is offered about different ways the text may be used. Readers are invited to respond to the paper, and information is provided about how to do this.

2.0 Why Indigenous Male Health?

Reasons why the health and well-being of Aboriginal and Torres Strait Islander males in the Northern Territory must be addressed by specific policies and programs are argued and explored in this section.

Research should be conducted to gather, review, collate and interpret all data relevant to Indigenous male health in the Northern Territory: in order to establish baseline information, and track whether intended improvements are achieved, or not. Indigenous males should define, and wherever possible, carry out and manage this research.

3.0 Concepts and Understandings of Health

Ways Indigenous people have expressed and represented their understandings of health are cited and explored. Comparisons with different, Anglo-European ways of thinking about health are made. And some new directions for the philosophy of health are signposted.

Critical exploration of different concepts and philosophy of health should be included in all health education curricula: at both school and tertiary levels; and in professional development in all relevant fields and occupations. Curriculum should include different perspectives of diverse groups and communities, including gender. Mutual understanding, while respecting difference, should be the main purpose of such education and training.

4.0 Indigenous Experiences of Masculinity

This section explores some of the variety of ways Indigenous males grow up and construct a variety of forms of ‘masculinity’: of their many possible journeys. And how they can affect their health and well-being.

Research should be supported and carried out by Indigenous males about the varieties of Indigenous ways of ‘living male’: and their health implications.

5.0 History of Developments in Male Health

Outlines a history of Indigenous males taking initiative to define, advocate and address their own health issues; and places this in context of the wider men’s health, and women’s health movements.
6.0 Principles and Values
The cultural values and historical experience of Indigenous males suggest a number of principles which must underpin, inform and govern policy and program responses to their special issues.

7.0 Key Issues
Health related issues which have been identified by Indigenous males in various consultations are identified in this section.

Since there is a high incidence of chronic hepatitis and liver cancer in Aboriginal and Torres Strait Islander males in the Northern Territory (Selva-Nagayam et al. p. 111), this issue should be explored further and addressed by a specific strategy.

8.0 Relations between Indigenous Males and Females
Explores Indigenous constructions of gender differences and relationships. And their implications for ways of addressing Indigenous male health issues. A whole social and cultural response is advocated.

9.0 Recent and Current Initiatives and Activities
Indigenous males have taken the initiative to respond to their own health issues. Some examples of these activities are listed in this section.

10.0 Employment, Education and Training
Employment, education and training, funding, facilities and information resources which are necessary to address Indigenous male health issues are identified and discussed.

Occupations and particular jobs in health and related fields should be defined in terms which accommodate Indigenous men’s interests; and their roles and responsibilities in their families and communities.

Increasing effort and improving recruitment strategies and conditions to attract more Indigenous males into the public sector workforce, in all fields, at all levels

Including awareness of Indigenous male health issues, information and possible responses in in-service training in all Departments which have responsibilities related to Indigenous male health. Cross-Departmental training for these purposes should be considered to rationalise the resources required for training, and facilitate networking and co-operative work practices

Modifying employment conditions (duty statements etc.) to encourage cooperative work between Indigenous male employees across different Departments and their programs: to facilitate coherent and inclusive approaches to Indigenous male health issues.
Indigenous males must be attracted to work in the health field; and barriers to this occurring must be identified and addressed: eg., female nurses and Indigenous health workers, ‘white’ doctors, predominant women’s issues and interests, ownership and control; privacy and shame, inhibitions, usurped community and family roles, limiting ‘constructions’ of ‘masculinity’; focus on clinic based and medical practices in health work; inflexible conditions. Similar considerations also contribute to low rates of retention in the workforce.

The Aboriginal Cultural Awareness Program (ACAP) for Department of Health and Community Services employees should be improved and extended to ensure participants gain understanding of both male and female gender issues related to health; and the program should be made available to employees of other Departments and Agencies.

All providers of education and training related to Indigenous male health issues should be encouraged to include awareness of the issues, information and approaches; in both accredited and informal (eg., in-service) courses: including Department of Health and Community Services, the Departments of Education, Correctional Services and Local Government; Batchelor Institute of Indigenous Tertiary Education (BIITE), the Faculty of Aboriginal and Torres Strait Islander Studies (FATSIS), the Institute for Aboriginal Development (IAD), Aboriginal Health Services, Aboriginal Legal Services and Land Councils etc.

All formal (accredited) courses in health work should include male health as a particular field of issues and practice - at all levels of the Australian Qualifications Framework (AQF) : ie., TAFE Certificates and Higher Education.

Particular effort should be made to attract Indigenous males in the Northern Territory to undertake tertiary education which can prepare and support them to take up management positions in the health field. (See Courtney, M et al., 2000; Wakeman, J et al., 2000.)

Resources should be applied to develop curriculum for a new Male Health strand in the Batchelor Institute Diploma and Advanced Diploma courses.

Courses at the required levels which are suitable for Indigenous males should be made available; in order to achieve Goals identified in Department of Health and Community Services’ Aboriginal Employment & Career Development Strategy Implementation Plan (1996), especially 1, 6, 7 and 8.

Goal 4 of the Plan should be amended to recognise the particular interests, needs and disadvantages of Indigenous males.

The Health Promoting School Framework should continue to be implemented in Northern Territory schools. Where necessary, it should be enhanced or extended to include particular attention to male health issues; and to include male Aboriginal teachers and health workers in its implementation.

Research should be undertaken to discover specific learning, social and cultural issues and needs of Indigenous male children and youths in primary and secondary education; and their health impact.
In the school curriculum all students should become aware of the particular health issues of Indigenous males; and of gender, and other historical, social, economic and cultural differences between groups of people.

Indigenous male health issues should be included in both primary and secondary school curricula, including information about occupations in the health field in later years of schooling.

Occupational counselling by adult Indigenous male health and allied workers should be made available to Indigenous male students in secondary school about opportunities to study further and work in the health field.

11.0 Resources
Some resources which are necessary to address Indigenous male health issues are identified and discussed.

Facilities should be established in Aboriginal communities for Aboriginal Male Health Places where male-specific services are provided, as well as preventive communication and education, and learning how to manage chronic diseases.

Specific funding should be allocated for initiatives to address Indigenous male health issues. This should not be at the expense of Indigenous female health.

The Male Health Policy Unit, within Department of Health and Community Services, should be mandated and resourced to support and facilitate communication of information relevant to their health amongst all Indigenous males in the Northern Territory.

12.0 Structures
Some institutional and organisational structures which can be used, or created, as vehicles to support and facilitate ways of addressing Indigenous males’ health issues, are described.

13.0 Research
The need for more, and better data collection and research which will be relevant to Indigenous male health issues, and the responses to them, is advocated. Barriers to this are identified and discussed; and ways to overcome them are suggested.

Indigenous males should be encouraged and supported to take up occupations as researchers.

Indigenous males, in all occupations related to health, should be encouraged and supported to include research activity in their work.
14.0 Communication

This section raises and explores some communication issues which are relevant to the improvement of Indigenous male health.

Cross-cultural communication education and training programs for both non-Indigenous and Indigenous workers in health and related fields should be further developed; and evaluated in a research project, with particular regard to communication efficacy; eg., by Northern Territory University, Batchelor Institute and the Cooperative Research Centre for Aboriginal and Tropical Health. They should include attention to particular male and female gender, and generation, issues.

15.0 Strategic Directions

This section signposts some possible directions for planning and action to address the issues relating to their health which Aboriginal and Torres Strait Islander males in the Northern Territory have identified.

- Whole-of-government, inter-sectoral, interdisciplinary approaches: structures and processes for constructing and maintaining partnerships and collaboration in response to Aboriginal male health issues; at all levels
- Education, training, employment and support of Aboriginal male health workers
- Support research by Aboriginal male workers in health related fields to develop models for responding to Aboriginal male health issues which are congruent with values, beliefs and cultures of their families and communities.
- Improve access of Indigenous males to mainstream services
- Increase awareness within all institutions and organisations of the particular issues of Indigenous males which are relevant to their health and well-being; and engage them in cooperative processes to address them.
- Increase the awareness of Aboriginal males of health and well-being related issues.
- Support Aboriginal males to increase their ownership and control over programs and services which address their own identified health issues, at all levels and in all phases of their development and implementation (delivery).
- Increase the numbers (participation rates) of Aboriginal males in the health workforce, at all levels, and in all sectors.

References

A list of publications which have been consulted or referred to in the Discussion Paper. It can also be used to guide further reading.
1.0 THE DISCUSSION PAPER

The paper is a document which tries to summarise ideas and information about Indigenous male health; and suggest some directions for action to address the issues which have been identified and defined by Indigenous men and youth.

It can be read as a whole; or some readers may prefer to go straight to the sections in which they have particular interest. For example, some readers may wish to explore ideas discussed in theoretical or historical parts of the paper. Others may want to go straight to sections which define the health issues of Indigenous males and possible strategies and actions to address them; or to the section on research; or to the discussions about inter-relationships between Indigenous male health and education, or criminal ‘justice’, or employment.

The content page will assist readers to make their own choices about how they want to read the document.

References to other documents such as books and reports have been included. This is for two reasons.

- They acknowledge the ideas and quotations of their authors.
- They assist readers to locate and access the books, papers and reports if they are interested in further reading.

In addition to some strategic directions suggested in s. 15.0, many others suggestions for more specific actions are included throughout the paper. They are printed in bold italics and boxed.

Your comments are invited about any of these suggestions

A further feature of the paper should be mentioned here. The terms Aboriginal and Torres Strait Islander and Indigenous have been used in the document except where Aboriginal alone seems appropriate in a particular context.

Your comments about this usage and your own preferred term/s will be welcome.
1.1 **Purposes of the Discussion Paper:**

- Disseminate ideas and information which Aboriginal and Torres Strait Islander men have raised and discussed in consultations in the Northern Territory and elsewhere.

- Advocate issues which have been identified by Aboriginal and Torres Strait males, and their interests in improving their health.

- Continue the process by which Indigenous males are determining their health priorities and the kinds of responses which will lead to improvement.

- Increase and extend the commitment of all sectors and organisations which have responsibilities related to Indigenous male health to cooperate in the development and implementation of responses to improve Aboriginal and Torres Strait Islander male health.

- Use feedback from the paper to inform a Northern Territory Indigenous Male Health Policy.

*It is also hoped that this paper will contribute to the wider national conversation about male health.*

The paper has been prepared in the Male Health Policy Unit (MHPU), which is based in Department of Health and Community Services. The Unit is providing executive support for the processes of consultation amongst Aboriginal males to identify and prioritise their own issues related to their health.

It will be distributed as widely as possible to everyone who has interests and responsibilities related to Indigenous male health.

Your comments on the paper are needed to ensure that all relevant information and ideas are considered and reflected in the development of a policy for Aboriginal male health in the Northern Territory.

---

*Please make your comments to the Male Health Policy Unit as soon as possible by visiting the office at Health House in Darwin, contact by phone, e-mail, facsimile or post.*

**Address:** PO Box 40596 Casuarina NT 0811  
Health House 87 Mitchell St, Darwin NT 0800

**Telephone:** 08 89992424, 08 89992936  
**Facsimile:** 08 89992955  
**E-mail:** mens.health@nt.gov.au
1.2 Towards a Northern Territory Policy on Aboriginal Male Health

It has been written that:

“... social policy is a contest about personal experiences which become collectively defined as social issues, about what social directions will be taken, and whose interests will be served.”
(Dalton et al. 1996, p.7)

This way of thinking about policy understands it as both a process of communication (consultation, debate), ie. a conversation; and also a commitment to action to achieve its defined, and hopefully agreed, purposes.

These commitments are usually written in an official document which can be used to signpost directions for actions, including allocating resources; and for reference to evaluate whether they have been carried out.

As Wes Miller, a speaker at the NT Indigenous Male Health Conference in Tennant Creek in August 2000 put it:

a “policy framework is needed to keep departments’ actions on track.”

In the same session at the Conference discussion then ensued about who the policy was for, where the policy will go and what level of control Indigenous males would have over it. It was proposed that “men as leaders should develop the policy”; a policy that “reinstates men’s rights and roles as leaders”. (Department of Health and Community Services, 2000, (2) p 21)

Therefore it is essential that all of the participants in the policy process are satisfied with the purposes defined in the document, so that they share the commitment to achieve them.

Your feedback to this paper is necessary to ensure that an Indigenous Male Health Policy framework will engage all participants and stakeholders in its implementation: including government, organisations, communities and families.

It might also be helpful to read the following four documents in considering your responses to this discussion paper:

1. Report to the Office for Aboriginal and Torres Strait Islander Health (OATSIH) on the National Indigenous Men’s Health Policy Forum, 16 to 17 August 2000, Yanba Sports Club, Canberra.


You can access these documents by request to the Male Health Policy Unit in Department of Health and Community Services.
2.0 WHY INDIGENOUS MALE HEALTH?

“When any group of people lose control of the basic things in life, the result is disaster.”
(Trudgen, 2000, p. 59)

“... nothing is more likely to ensure the perpetuation of inequality than the equal treatment of unequal individuals.” (Gray & Saggers, 1999, p. 72)

Aboriginal males recognise that health is a whole-of-life state and process of growth. This understanding was expressed in the theme for the 1st National Indigenous Male Health Conference: ‘Growing up as an Indigenous Male’.

In addition to lower life expectancy than other groups in the NT, Aboriginal males also experience worse rates of a number of diseases, injuries, harm from alcohol and other drug use, imprisonment and suicide.

The role of males in Aboriginal society has been significantly diminished as a result of the process of colonisation. This has contributed to the breakdown and collapse of Aboriginal society and community life. The impact on Aboriginal males has been devastating.

Aboriginal males recognise the significance of the loss of their authority, self-esteem and self-respect through alienation, loss of culture and country, and spiritual well being. They have also recognised the importance of returning to, and reviving the cultural and spiritual values which ground a sense of identity and strength.

The empowerment of Indigenous males is crucial to the raising of self-esteem, quality of life, health status and spiritual well-being. They must lead in improving their own health status and that of their families and communities. Community involvement, consultation and the engagement of Aboriginal males to define and take control of the issues that affect them is paramount in achieving positive and sustainable outcomes.

In the closing session of the 1st National Indigenous Male Health Convention at Ross River in October 1999, Mick Adams made the following statement:

“The clear message from the Convention was that Indigenous men should take greater responsibility themselves to improve the status of men’s health and play their rightful role as leaders, fathers, uncles, husbands and grandfathers.”
2.1 Why Male Health?

It is now beyond argument that male health issues must be addressed by specific policies and programs.

Males alone suffer some clinical conditions, such as testicular and prostate cancer, erectile dysfunction, impotence and male infertility.

They also suffer a number of other adverse health outcomes at higher rates than those suffered by females.

Death is one of them.

A recent report from the Australian Bureau of Statistics (ABS) states that:

“… Australia’s estimated life expectancy at birth in the year 2000 [is] 76 years for males and 82 years for females …” (ABS, 2000, p.5)

The report also states that the overall age-adjusted death rate of males is 60% higher than the female rate; and that “males were more likely to die than females at every age”. (ibid)

In one of these age groups (25 to 39 year olds), the report states:

“In 1999 the leading causes of death … were intentional self harm (21% of all deaths), malignant neoplasms (cancer) (15% of all deaths), accidental poisoning (13% of all deaths), and transport accidents … (12% of all deaths). For each of these except cancer, the death rate for males was considerably higher than that for females …” (ibid, p. 60; our italics)

Such information unarguably justifies particular attention to male health issues in policy, programs and services.
2.2 Why Indigenous Health?

The House of Representatives Standing Committee on Family and Community Affairs has recently published a report: *Health is Life: Report on the Inquiry into Indigenous Health*. It quotes the following statement made over twenty years ago by The Hon. P Ruddock:

“When innumerable reports on the poor state of Aboriginal health are released there are expressions of shock or surprise and outraged cries for immediate action. However the report appears to have no real impact and the appalling state of Aboriginal health is soon forgotten until another report is released”.

The Standing Committee comments further:

“Despite this, the continuing poor state of Indigenous health in Australia over the last twenty years, and the difficulties associated with isolating the underlying causes, has generated a continuous flow of further reports about the problem. The Committee has identified at least 20 further reports into aspects of Indigenous health which have been undertaken since 1979”. (House of Representatives Standing Committee on Family and Community Affairs, 2000, p. 7-8)

It is beyond argument that Australia wide, Indigenous health, both male and female, is still far worse than the health of other Australians: to the extent that it constitutes a national disaster. It raises serious issues, even internationally, about Indigenous rights and justice in this country.

There are many statistical indicators of this extreme disadvantage. This is not the place to include them all. However the following information is sufficient to prove the extreme disadvantage, inequity and injustice suffered by Indigenous peoples in Australia in their health.

At the national level, the recent ABS Report referred to above states that:

“The … death rate for the Indigenous population was 14 deaths per 1000 population compared to 6 deaths per 1000 for the total population”. The report also says that these “estimates of the disparity between Indigenous and non-Indigenous mortality are likely to be conservative”. (ibid, p. 73)

It also states that after adjusting for age differences:

“Differences in Indigenous and total [Australian] mortality are also reflected in significantly lower life expectancy among Indigenous people. … [It] is estimated that Indigenous males born in 1997-1999 could be expected to live to about 56 years, 20 years less than life expectancy for total [Australian] males (76 years), while Indigenous females could be expected to live to about 63 years, around 18 years less than the life expectancy for all [Australian] females (82 years)”. (ibid, p.73: our italics)

(See also Gray & Saggers, 1999, p. 57-74; House of Representatives Standing Committee on Family and Community Affairs, 2000, p. 3-5)

Of course similar differences exist between the health of Indigenous and non-Indigenous Territorians. (Tilton, 2001, p. 143-150)
2.3 Why Indigenous Male Health?

Some of the information in the preceding sections justifies particular attention to Indigenous male health in policy, program and service development in the Northern Territory. Indigenous males are evidently grossly disadvantaged in terms of their life expectancy and mortality rates across Australia. In view of the high population of Indigenous males in the Northern Territory, specific attention to their interests and needs in health policy, programs and services is evidently necessary.

Department of Health and Community Services has reported that male Aboriginal Territorians had a death rate 2.6 times that of all male Australians; and 2.8 times higher than the death rate for non-Indigenous male Territorians. (Dempsey, K & Condon, R. 1999, p.2)

The following graph shows changes over the period 1981-1997 in life expectancy of Indigenous and non-Indigenous males in the Northern Territory.

![Figure 1: Life Expectancy at Birth (NT Males)](image1)

It shows a much larger increase in the life expectancy of non-Indigenous males than Indigenous males. The following graph shows the difference.

![Figure 2: Improvement in Life Expectancy at Birth (NT Males)](image2)
Between the early 1980s and the late 1990s, Aboriginal male life expectancy increased by 2.4 years, whereas the life expectancy of non-Aboriginal males increased by 4.8 years. The gains of non-Indigenous males over the period were twice those gained by Aboriginal males. (Dempsey & Condon, 1999, p. 10)

This difference proves the serious inequity suffered by Indigenous males in the Northern Territory, especially given the large difference in the absolute levels between them.

The ABS report cited above estimates life expectancy of Indigenous males in the Northern Territory at birth 1997-1999 as about 56 years, compared with Indigenous females at about 61 years. (ABS 2000, p. 74) A similar discrepancy between the gains in life expectancy of Aboriginal and non-Aboriginal females is also evident. (Dempsey & Condon, 1999, p.11)

A large amount of other data exist which are relevant to Indigenous male health, including comparisons with data about the total Northern Territory population, both women and men; Indigenous females, various age groups; usual places of residence; etc. A great variety of information is relevant: including, in addition to mortality and morbidity, data about education, impact of criminal justice, engagement in commercial enterprise, employment, income, living conditions, participation in all levels of government, and governance and management of organisations – ‘quality of life’. These data are gathered and held by a variety of government departments, (eg., Department of Health and Community Services, Department of Education, Correctional Services etc.); and in other organisations and agencies, such as Aboriginal Medical Services (AMS).

It is beyond the scope of this discussion paper to review and interpret all of these data. However it is suggested that

Research should be conducted to gather, review, collate and interpret all data relevant to Indigenous male health in the Northern Territory: in order to establish baseline information, and track whether intended improvements are achieved, or not. Indigenous males should define, and wherever possible, carry out and manage this research. (See also Sections 11.3 and 13.0)
2.4 Interpretation of Data about Indigenous Male Health

The following is a story made out of some data and their interpretation.

Indigenous death rates are very high amongst Indigenous males between the ages of 25-39 years. (ABS, 2000, p. 62). The three leading causes of death are intentional self harm, heart disease and accidental poisoning. This is an age group which is likely to have special responsibility for parenting, especially growing up boys and youths: as fathers grandfathers and uncles.

Figure 3: Comparisons between Indigenous and non-Indigenous Male and Female Populations in the Northern Territory

Source: d’Espaignet et al. 1998

The proportion of Indigenous men in the NT in this age group to children and youths aged 0-19 is much lower than the proportion of other men in the same age group to children and youths. (d’Espaignet et al. 1998)
These graphs show that “every 100 Indigenous adults of working age were responsible for 66 children compared with 32 in the non-Indigenous population”.

They care for more than twice as many children as do non-Indigenous adults. (d’Espaignet et al, 1998, p.2)

Indigenous children and youths suffer high rates of illnesses, malnutrition, injuries and mental disorders. Unhealthy environments, including poor food supply, dust, overcrowding in bad housing, poor water; lack of education, information and communication technology; dangers in transport (condition of vehicles and roads), limited clinical services etc. all contribute to bad health outcomes.

They are all consequences of underlying political, economic and cultural problems including injustice and racism.

Hospital admissions of children and youth were higher at all ages than for the non-Indigenous population. For example the rate of admission for Indigenous young people aged 5-14 years was 81 admissions per thousand; whereas the non-Indigenous rate was 53. (d’Espaignet et al., 1998, p. 35)

Evidently hospitalisation separates these children and youths from parental care and interrupts their social and cultural education.

Detention of youths under criminal justice measures also evidently separates them from parental care and interrupts their social and cultural education.

The Department of Health and Community Services report cited above states:

“Although Indigenous young people aged 13-17 years made up for about 35% of young people in the Northern Territory, they accounted for 72% of all youth detentions in the Territory [in the period 1995-1997]. Their rate of detention …was four times that of non-Indigenous young people …” (ibid, p. 22)

More young Indigenous males suffer detention than others.

For example in 1998/99, 41 Indigenous males aged 16–17 years were received into custody. Only 6 non-Indigenous males were detained in the same period. (Northern Territory Correctional Services data)

A further serious problem faced by Indigenous parents is the practice of petrol sniffing in some communities. In a recent report it is stated that:

“Aboriginal petrol sniffers are more commonly male than female.” (d’Abbs & MacLean, 2000, p.6)
Marcia Langton has written:

“Petrol sniffing is perceived as being both a symptom and cause of the breakdown of traditional family structures, and many individuals feel helpless to counter it”.
(Langton, 1900, p.214)

And

“… petrol sniffers form a ‘drug culture’ within the wider community …”
(ibid, p.217)

Again, one of the consequences of this destructive activity is separation and interruption of parenting: of the processes of ‘growing up male’: and the impairment of the roles of fathers, grandfathers and uncles. (Japarte, 1997; and Department of Health and Community Services (2), 1999, p. 9-10)

All of these problems create great pressures in parenting: not least the anxiety, sorrow and loss of confidence of parents.

This information implies severe difficulties for Indigenous people - both males and females - in raising and parenting their children.

Indigenous adult males face enormous challenges and pressures in their parenting, in particular of male children and youths, who are their special responsibility: whether as fathers, grandfathers or uncles. Their low levels of employment, educational disadvantage, poverty, high rates of illness and injury, and imprisonment, all reduce their parenting capacity.

The historical dispossession and disempowerment of Indigenous men, including undermining their particular male cultural and social roles and authority, have impaired their self esteem and confidence to carry out their parenting and teaching responsibilities.

The ABS report (Deaths Australia: 1999) says this:

“Indigenous persons (in the 25-39 age group) also had relatively high death rates for mental and behavioural disorders due to psychoactive substance use which was the fourth leading cause of death among Indigenous 25-39 year olds.” (p. 62)

Alcohol and other drug use is also often a response to mental and emotional suffering, such as anxiety and depression (Najman, p. 7), which arise from the stresses of the lived realities of poverty, disempowerment and hopelessness. Use of alcohol and other drugs, including cannabis, is sometimes referred to as ‘self-medication’ for such experiences.

Suicide can be an even more tragic way of ending them.
Once dependence on alcohol is established, drinkers tend to reduce their performance of social and cultural roles, including parenting. They are sometimes entirely removed and alienated from their communities and families. (Langton, 1990, p.31-32) In turn, this impacts adversely on children and youth. For example, drinkers often gravitate to Alice Springs - a town which a recent report has said is “awash with alcohol” (Hauritz, McIlwain & Finnsson, 2000, p. 76); in part due to easy availability and inadequate regulation. The impact on Indigenous males is indicated by the vast disproportion in alcohol related offences (ibid, p.79) and admissions to the Alice Springs Sobering-up Shelter. (ibid, p. 86)

Another way men are removed from their families and communities is imprisonment.

On 1 September 2000 there were 369 Indigenous males in prison custody in the Northern Territory. (ABS, 2001, p.21) Together with the 14 Indigenous females in prison on that date, they comprised 62% of all prisoners: the highest proportion in the country. (ibid, p. 5)

The following Table from NT Correctional Services shows numbers of prisoners received according to prison, sentence status, Aboriginality and gender, 1998/99.

**Figure 4: Number of Prisoners by Aboriginality and Gender 1998/99**

<table>
<thead>
<tr>
<th>Prison</th>
<th>Sentenced</th>
<th></th>
<th>Unsented</th>
<th></th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Male</td>
<td>1998/99</td>
</tr>
<tr>
<td>Alice Springs Correctional Centre</td>
<td>109</td>
<td>573</td>
<td>3</td>
<td>29</td>
<td>29</td>
</tr>
<tr>
<td>Darwin Correctional Centre</td>
<td>143</td>
<td>682</td>
<td>21</td>
<td>218</td>
<td>18</td>
</tr>
<tr>
<td><strong>Total 1998/99</strong></td>
<td>252</td>
<td>1255</td>
<td>24</td>
<td>247</td>
<td>47</td>
</tr>
<tr>
<td><strong>Total 1997/98</strong></td>
<td>196</td>
<td>1148</td>
<td>29</td>
<td>274</td>
<td>45</td>
</tr>
</tbody>
</table>

These data should be considered alongside information from the recent NT Correctional Services Annual Report 1999/2000. The report states that:

“The average number of [juvenile] detainees fell from 26.9 in 1998/99 to 15 in 1999/2000, which is the lowest for more than 10 years”. (NT Correctional Services, 2000, p. 31)

It also states that in the Alice Springs Correctional Centre:

“The daily average [adult] prisoner numbers were 275, a modest decrease from the previous year which had a daily average of 290”. (NT Correctional Services 2000, p. 23)

and that in Darwin:

“The daily average number of prisoners was 340, a small increase from the previous year in which the daily average was 333”. (ibid, p. 27)
The Annual Report provides more detailed statistics in Part Five (p. 87-122), including specific data about rates of imprisonment and detention.

The following are some significant quotations from this Part of the Report which are particularly relevant to Indigenous male health.

“There continues to be a disproportionate number of Indigenous people in custody, in that the daily average number of Indigenous people in custody during 1999-2000 was 410 persons, which represented 67% of the daily average. This proportion is lower than the previous years due to a large number of non-Australian citizens in custody from overseas for ‘people smuggling’ offences.” (ibid, p. 90 – our emphasis)

“Of the 171 receptions of juveniles in 1999-2000, 119 (68%) were Indigenous.” Of the others, a significant number had a last known address overseas “of whom most were received because of an immigration order.” (ibid, p. 93)

The vast majority of these Indigenous persons who were caught up in the criminal justice system were male.

These data indicate the great negative impact of the criminal justice system on the lives of Aboriginal men and the availability of Indigenous fathers, grandfathers and uncles in growing up Indigenous boys and youths.

Again, the resulting separation of Indigenous males from their families and communities reduces and impairs the male parenting available to Indigenous children and youth from their fathers, grandfathers and uncles – ‘growing them up male’.

All of the factors mentioned here, plus many others, interact to produce and sustain the disastrous health status of Indigenous males in the Northern Territory.
3.0 CONCEPTS & UNDERSTANDINGS OF HEALTH

“Effective coordination can only be achieved if there is collaboration between Indigenous communities, community controlled organisations and government institutions. This can only be achieved if the premises on which coordination are built are shared by all parties. Some of these premises include:

- definitions of health
- equitable sharing of power and decision-making
- respect for varying patterns of organisation and planning
- collaboration in setting performance indicators and evaluation procedures”.

(Associate Professor A-K Eckerman, quoted in *Health is Life: Report on the Inquiry into Indigenous Health*, House of Representatives Standing Committee on Family and Community Affairs, 2000, p.3. Our emphasis.)

In 1988 a National Aboriginal Health Strategy Working Party was established following a decision of the Commonwealth, State and Territory Ministers for Health and Aboriginal Affairs. It was charged with developing a national policy on Aboriginal health. The Chair was Naomi Mayers and the majority of other members were Aboriginal. The Working Party completed its work early in 1989 and then published its report.

The Report included a section about Aboriginal Peoples’ Concept and Perception of Health (p. ix-x). It stated:

“‘Health’ to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely the provision of doctors, hospitals, medicines or the absence of disease and incapacity. ...

“In Aboriginal society there was no word, term or expression for health as it is understood in western society. It would be difficult from the Aboriginal perception to conceptualise health as one aspect of life. The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as ‘life is health is life."

“In contemporary terms Aboriginal people are more concerned about the quality of life....”
This Working Party therefore sees health as:

“Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life”.

There are also other ways in which Aboriginal concepts and understandings of health have been expressed.

In Central Australia, the paintings and posters of Kumantjayi Japaljarri Spencer represent a concept of health in terms of relationships between individual persons, their membership of communities, their histories and their shared meanings of country and place.

In the book Anangu Way, many artists in the Pitjantjatjara lands represented their understandings of health in the medium of the same symbology. Reading the paintings reproduced in the book and the transcriptions and translations of the artists’ own interpretations, is the best way to learn these understandings. However the introduction tries to summarise them in this way:

“In this book we encounter an Anangu concept of health: a concept that is rich in its embrace of a totality of personal and social existence. Its core metaphor is the journey ...”

“[The paintings] incorporate references to diet, the misuse of introduced substances such as alcohol and processed sugars; parenting; traditional food gathering and hunting patterns; the categories of foods; spiritual rituals; ceremonial celebrations of life and grieving for death; the re-enactment of original creation in the cyclical regeneration of life; and the kinship of all species of life with the land they inhabit: all kindred, expressed in the kindness of countrymen for one another, and the sorrows of parting.”

“They also affirm the integrity and autonomy of the person: self-ownership of the story-line of an individual’s life is inviolate.” (H.A.L.T., 1991 p. 2-3)

No doubt there are many different understandings of health amongst Aboriginal people, constructed from their different histories and experiences in diverse families and communities.

However the various expressions of Aboriginal concepts referred to here seem to share a common understanding: that health includes good relationships between people and their environment: a sense of the integrity of the individual and her or his whole life world.

This understanding of health differs categorically from the still dominant bio-medical model of health: which focuses on individual pathology: injury and disease; and its corollary of individual treatments such as medication and surgery; and preventative treatments such as vaccination. In this model, there are ‘professional’ ‘providers’ and the rest are ‘patients’ or ‘target groups’ - or more recently, ‘consumers’. (Knight, p. 139).
The Public Health model shares this theatrical stage with the medical model: with its concerns about water supply, garbage disposal, hygiene and pollution - all factors over which individuals and families have little control.

Individual responsibility for healthy/unhealthy behaviour, supposedly chosen wilfully, such as low exercise, poor diet, smoking, unsafe use of alcohol or other drugs, or driving under their influence, or unprotected sex, is the frame of reference for the Health Promotion model of health. Attributing individual responsibility for the behaviours which increase risk of diseases related to these individual behaviours; and methods which are supposed will change them, such as media campaigns, education and counselling are the ‘strategies’ which are typically used in this model of health ‘service’. (Knight)

It cannot be denied that the application of these models has produced some benefits. However those benefits are evidently not enough; and are not evenly distributed throughout Australian (or any other) society.

There must be other considerations or factors which might produce better health for all. Another model is needed.
3.1 New Directions in Thinking about Health

In recent years some critics of the conventional and dominant health paradigms have proposed a new model: now often referred to as the New Public Health (e.g. Knight, 1999, p. 145-146; Baum, 1998). It is informed by an ecological understanding of health, and referred to by some philosophers of health as the ‘human ecosystem’ model. (Knight, p. 146-147)

One of its proponents, Ilona Kickbusch, has defined it this way:

“the science and art of promoting health. It does so based on the understanding that health is a process engaging social, mental, spiritual and physical well-being. It bases its actions on the knowledge that health is a fundamental resource to the individual, the community and to society as a whole and must be supported through sound investments into conditions of living that create, maintain and protect health.”
(Quoted in Knight, p. 148)

Of course this expands vastly the field and conditions of health. And research supports the expansion - such as the research which relates the ‘control factor’ to incidence of some diseases: ie the degree to which people feel they control aspects of their lives (Marmot et al. 1997); and other socio-economic conditions. (Wilkinson & Marmot)

What is significant for this paper is that the concept of the New Public Health, a relatively recent development in Western ways of understanding health, shares much with the Aboriginal understandings of health which were described at the beginning of this section of the Discussion Paper.

The challenges are also similar: a fundamental shift in the orientation of health services and action towards changes which will optimise the chances of good health for all, by eliminating the structural disadvantages of some sections of the population and increasing their power and control.

Perhaps Western, ‘white’, Anglo-European thinking about health is catching up with Indigenous understandings at last!

There is no doubt that thinkers in the health field, both Aboriginal and others, understand the necessity of this shift, if health is to be achieved for all. It is an ideological, political and economic issue.

However this philosophical shift in the health field is far from changing the lived realities of workers and users in health services.

Thus one writer has claimed:

“... community health services operate within the biomedical paradigm, providing treatment on an individual basis. Prevention strategies tend to focus on specific interventions aimed at changing individual behaviour ...” (Knight, p. 144)
There is a long way to go to transform the roles of health workers and the expectations of users of health services to shift to Aboriginal models of health and the New Public Health paradigm in their attitudes and practices.

There is an even greater distance to travel to accept and accommodate Indigenous knowledge and practices within health care systems. They are not easily described and explained in terms of the dominant health discourse, nor incorporated into bureaucratic or corporate structures and language.

Independence and autonomy of Aboriginal health workers in defining and enacting their roles in their families and communities is therefore a paramount consideration in achieving health care in Aboriginal societies. Measures of ‘success’ must be defined in terms of Aboriginal and Torres Strait Islander knowledge of health and the values of their families and communities.

**Critical exploration of different concepts and philosophy of health should be included in all health education curricula: at both school and tertiary levels; and in professional development in all relevant fields and occupations. Curriculum should include different perspective of diverse groups and communities, including gender. Mutual understanding, while respecting difference, should be the main purpose of such education and training.**
4.0 INDIGENOUS EXPERIENCES OF MASCULINITY

This section explores some of the variety of ways Indigenous males grow up and construct their ‘masculinities’: of the many possible journeys of Indigenous males. And how these ways can affect their health and well-being.

The idea that ways of being male are ‘constructed’ suggests that growing up and becoming an Aboriginal man is not something inevitable, uniform and ‘natural’. It is suggesting that manhood is made: not something that just happens to men (eg. a biological necessity, or cultural inheritance which replicates the past).

Here is an analogy: an illustration of this meaning of construction.

In some ways it is like building (constructing) a house.

The kind of house will depend on the materials and technologies available, the environment and terrain (it is a cold climate, and the site is a steep slope on a mountain), the purposes (there must be a large area for storing food and sheltering domestic animals during winter months, separate from the areas for the human beings to cook and sleep and entertain), and be pleasant and comfortable. The design of the house will probably be similar in some ways to others in the neighbourhood, which have been built the same way for many generations; but also include special features which suit this particular family: including some decorations which will add pleasure to their lives and express their special feelings and family traditions. However sometimes a family will design and build a house which suits the environment better than others in the neighbourhood - perhaps it is better insulated and ventilated; and includes facilities for outdoor living, such as barbecues, in the warm months - and a good open view over the valley. In any case, the climate has changed over the last few years (there is a longer warm season), and so outdoor living is preferred. However the neighbours in the village dislike this new, different house. They complain and object: until perhaps they see that it is a better place to live in this environment than their own houses - and perhaps they will then accept it and make some changes to their own houses.

This was a Western story about construction: building a house, perhaps somewhere in Europe. It might be an office block, or a museum, or Parliament House. These constructions are all containing and confining: they keep something inside; and exclude everything else: they create boundaries: who is inside, and who is outside; the spaces which are enclosed, and those which are beyond; the people who are ‘us’ and those who are ‘them’. Our bit of turf! An idea of owning a space! Of Property!

An Indigenous way of thinking about construction is the creation of a wilytja - a bush shelter, in some Central Australian languages. It is a shelter, which is open to the country: made to protect a family from wind or rain or cold along the way of a journey. It does not mark any boundary. It will be made from the bushes and trees in that place: and be positioned to fend
off the special winds, rain or cold there. It serves the purposes of the journey. Another shelter will be made at the next stop along the way. It is a moment in a journey - not a claim to a bit of property with definite boundaries. But it also marks a claim and right to a tract of country.

[Even in English, a tract may be either a written text, or an area of country!]

The journey is the idea, which shapes this paper. An Indigenous understanding of journeys is that travelling through the country is creating the landscape: imbuing it with meanings. It is not only finding places that are already there. It is a construction of ever renewing meanings.

So, constructing masculinity is not only an individual male’s choices and effort. There is a complex interaction here of history, traditions, forms of social organisation and their rules and norms (eg. families and communities), resources and opportunities; and the wider historical, physical, social, cultural, political and economic environment, in the construction processes. And places where we belong.

There can also be conflict and experiences of dissonance in the construction process. These are the ways individuals experience the conflicts of feelings and beliefs when they are shifting their values and identities in a changing world: when they can no longer conform to the norms of the past, and the expectations of their communities, families and peers.

Many Indigenous males are constructing a variety of new identities in these personal journeys: while keeping themselves deeply rooted in their ancient sources of Indigenous identity; in country, Indigenous law, relationships, language, history and culture.

Others are floundering: feeling lost in the confusion of competing and conflicting pressures; cut loose from their cultural and historical bearings. Alienated, and without connections to any past, or possible future. No stable identity or sense of relationship. No prospects of realising the illusions of ‘success’ promoted in the media. Nor wanting to constrain their futures by the prescriptions of the past.

This is a recipe for despair.

And there is at least one more, mysterious factor: an individual’s choices and efforts: which are valued, probably in all cultures, by all human beings, as individual, personal autonomy: perhaps the source of all invention and creativity.

Aboriginal males are undertaking a process of reconstructing, redefining and re-inventing their male identities in contemporary social, political and economic conditions. In doing so they are taking up positions and roles in a wide range of institutional and social domains which often include a great majority of other, non-Indigenous, men or youths. There is not only one, uniform way of defining and becoming an Aboriginal man. There are many possibilities, depending on a multitude of factors and preferences: including, personal, family and community history; upbringing, living environment, opportunity; and, no doubt, genes, according to modern biological science.
There is a variety of ways in which Aboriginal males might express their masculinity: through, for example: education, training and employment; participation and achievement in sport, music, art, fashion design, writing, dance and theatre; creating and managing commercial businesses; participation and leadership in political action and governance or management of organisations; and as fathers, grandfathers, uncles, sons, grandsons, nephews, husbands and friends; and countrymen; as well as living and carrying out more specialised Aboriginal cultural roles and responsibilities.

There is also a variety of ways which mark, and celebrate, the journey of growing up as an Indigenous male.

An example of inventing and performing a way of marking such significant points in growing up was created recently in Alice Springs.

“To provide a meaningful rite of passage event for young Aboriginal males currently undertaking education, members of the ICAIMCH arranged and conducted a Young Males Rites of Passage BBQ at Yirara College ...”

“There is also a variety of ways which mark, and celebrate, the journey of growing up as an Indigenous male.

An example of inventing and performing a way of marking such significant points in growing up was created recently in Alice Springs.

“With the help of some students, the men’s group prepared the food prior to the official program. Ken Lechleitner and Frank Curtis made short presentations and after the meal the older students were invited into a recreation room for further presentations and discussions with the committee members.

“The ICAIMHC believes that it is essential to celebrate steps along the way in each student’s educational career with a rite of passage event to encourage longer and better participation in education. If appropriate role models use the occasion as an opportunity to share their thoughts, beliefs, experience and wisdom the event has the potential to influence educational, employment and health outcomes in the long term”. (Report on a young Males Rites of Passage BBQ, Yirara College 18th Nov 2000)

There are many other ways which mark achievements along the way in growing up male: the sports arena, especially football, and music, are also favoured opportunities.

But these are not the realities of the lives of many Indigenous males.

Many young Indigenous males experience interruptions and disruptions in their experience of parenting and education which effectively prevent them from growing up well. They may have few if any experiences of such achievements and their validation by Indigenous elders: few experiences of positive rites of passage, if any. For many male youths, negative experiences, such as introduction to using alcohol or other drugs, including injecting them, or inhaling intoxicants such as the fumes from petrol or glue; or engagements with the criminal justice (sic) system, such as convictions in courts for offences, and detention or imprisonment; constitute their principal experiences of rites of passage to adulthood. They are unprepared for a healthy life as an adult Aboriginal male by the ways they grow up.
Many adult Aboriginal and Torres Strait Islander males have also experienced separation from their communities and families in early life: because of sickness, imprisonment or removal under government policies. As well as the suffering from such separations, these experiences have interrupted and impaired their cultural processes of growing up as Indigenous males: resulting, for many, in uncertainty and lack of confidence in their cultural roles of parenting; as fathers, grandfathers and uncles.

Detailed information, stories, interpretations and theories about such problems in growing up as an Indigenous male, and their consequences, have been written in many publications.


There can be no doubt that growing up as an Indigenous male is usually hazardous, and frequently disastrous.

For example, a recent report has stated:

“In general terms petrol sniffing is marked by a majority of male participants …”

“Aboriginal petrol snuffers are more commonly male than female….”

“Most petrol sniffers are between 8 and 30 years of age.”

(d’Abbs & MacLean, 2000, p.6)

Early uptake of drinking alcohol is a widespread concern in Indigenous families and communities. (See, eg., Langton, 1990; Mitcalfe, 1994)

Use of other drugs, including cannabis and intravenous use of amphetamines by Indigenous youth, especially in urban centres, is also a major concern of families, communities and health workers. Some Indigenous parents and other relatives perceive an association between such drug use and mental and behavioural problems. It is also believed that it has been associated with child and youth suicides.

Incarceration and detention rates of Indigenous male youths is high relative to Indigenous females and others.
At least four interpretations of these disproportions between males and females in such self-destructive behaviours have been suggested. They are not necessarily mutually exclusive or ordered in priority.

1. They are ways in which Indigenous youths express and relieve their despair for their life prospects: their disempowerment and confusion in constructing their male identities; and their experience of alienation/exclusion from both their Indigenous heritage and the new cultural imperatives of the wider society with which they also engage (media, personal contact etc.): consumerist, marketed, competitive, individualistic, materialistic etc.

2. They are ways which enact revolt against authority which they experience as oppressive and negating their masculinity.

3. They have been constructed as new ‘rites of passage’ to manhood.

4. Doing these things feels better than the available alternatives. For example some informants in a research project made the following comments about their experience in a juvenile detention centre:

“I like it better here”.

“It is more fun here”.

“There is more to do”.

(Mitcalfe, 1994, p. 199)

Whatever the interpretations of such destructive behaviours of male youths might be, it is certain that they interrupt, impede and damage the journey of growing up as an Indigenous male: with disastrous effects on their health.

There are also diverse ways Aboriginal males - both youth and adults - express their sexualities in various relationships and activities. Heterosexuality, homosexuality and sexual ambiguity (bisexuality and trans-sexuality), are possible aspects of different Aboriginal masculinities - different ways of being a man.

All of these possibilities of being an Aboriginal male occur in a context of wider societies, both national and global, in which ways of being male are constantly challenged, conflicting and changing.

It has been said:

“Like it or not, men must deal, on some level, with gender as a problematic construct, rather than as a natural, taken-for-granted reality.” (Messner, 1997, p. 2)
There is no inevitable, uniform or ‘natural’ way of being male in this society. As the same writer states:

“There are a myriad, often contradictory expressions of masculinity.”

Indigenous men, youths and boys encounter a similar multiplicity of forms of masculinity, and the conflicts between them, daily in the media and in their personal encounters with other males.

They experience the promotion of some ways of becoming or being a man as ‘successful’; and of others as ‘failures’. The value of boys’, youths’ and men’s lives is constantly represented in terms of status: wealth, a narrow range of physical appearance (‘good looks’, ‘good body’) and prowess related to sexual excitement; power and possessions; both personal and material. For most boys and men, whether Indigenous or other, much of this is not realistically attainable. Many then question the value of their own lives against the standards and stereotypes set by such images.

The modern process of Aboriginal and Torres Strait Islander youths and men creating their own forms of masculinity in ways which sustain their Indigenous identity, whilst also claiming equity in Australian society and taking opportunities to express their masculinity in diverse ways, is a process of rapid change: with great uncertainty, high expectations, constant challenges and testing, and conflicts of value and social/cultural norms.

It is a recipe for stress of a very high order indeed. And stress is a well established factor in ill-health, including increased risk of disease, injuries and early death. (Wilkinson & Marmot, 1998)

Research should be supported and carried out by Indigenous males about the varieties of Indigenous ways of ‘living male’: and their health implications.

(See also s. 13.0)
5.0 HISTORY OF DEVELOPMENTS IN MALE HEALTH

5.1 Aboriginal Male Health

Aboriginal men have taken the initiative in defining and asserting their own health issues for many years.

Their claims for special attention, facilities and services for men have been asserted ever since Aboriginal people began the creation of their own health organisations and agencies.

The failure of government controlled programs and agencies, such as local clinics, to respond to their concerns, has contributed to the alienation of many, if not most, Aboriginal males from the institutions and agencies which define their core business as health care. Their alienation is reflected in low levels of use by Aboriginal men of services; and engagement in education, training and employment in the health field.

Such concerns shared by Aboriginal men from a multitude of locations throughout Australia, and a great diversity of life histories, have had a long history of discussion, advocacy and activism. This has lead to broad solidarity amongst Aboriginal males, both nationally and in the Northern Territory, in developing and pursuing a male health agenda.

In the Northern Territory Johnny Briscoe and Uncle Jack Little became pioneers and leaders in raising awareness of Aboriginal male health.

They were both eminent health workers, amongst other Aboriginal males who became Aboriginal health workers at that time. They were strongly supported by Dr. John Hargreaves and Dr. Dayalan Devanesen, who were then medical officers in the NT Department of Health.

An early major public event in this history was a three day Conference in 1993 at Mataranka. A senior Aboriginal officer in Department of Health and Community Services, Brian Dixon, instigated and managed the Conference: which is believed to have been the first Aboriginal male health conference in Australia.

The Conference was reported in the NT News on 7 May by John Loizou under the headline: NT’s Aboriginal men take action.

The report quoted Jack Little:

“Well I think it’s about time the men did something because the men have been dragging a big chain”.

“The women folk took the lead and the men have been hanging around behind”.

“We want to pass on some information to the young ones”.

“We want them to listen to older people more … the father, the mother and the uncles”.

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Since then there have been gatherings and participation of Indigenous men at the mainstream national men’s health conferences in Melbourne (1995), Fremantle (1997), and in Alice Springs (1999).

Meanwhile, in 1997 Maurie Ryan and Frank Spry created a male health initiative within Department of Health and Community Services and commenced holding regional workshops throughout the NT as a way of heightening the awareness and promotion of male health as a gender-specific issue. The enthusiasm and motivation generated by those workshops culminated in the successful bid to hold the 1st National Indigenous Male Health Convention at Ross River, near Alice Springs, in October 1999.

Major achievements and decisions from the Convention included the establishment of the National Indigenous Male Health and Well-Being Reference Committee (NIMHRC), the recognition and promotion of Male Places, an agreement to hold annual State and Territory conferences and a national Convention every two years. The Convention provided a boost to the 150 Indigenous males who attended and to the health movement generally. There was unanimous agreement at the Convention of the need to empower males so that they could take greater responsibility themselves to improve the status of men’s health and play their rightful role as leaders, fathers, uncles, husbands and grandfathers. (Report from the 1st National Indigenous Male Health Convention, 1999.)

The ideas and commitments from the Convention were powerfully expressed in a march by Aboriginal men as well as women and children and other supporters, from the centre of Alice Springs to the venue of the 3rd National Men’s Health Conference on 6 October 1999. Delegates from the march delivered a manifesto, in the form of a Statement of Principles, to the opening session about the claims of Aboriginal men for attention to their particular health concerns. The Conference willingly and formally accepted the manifesto.

This initiative and further participation of Aboriginal men throughout the Conference were recognised by many participants in the closing sessions as an example to other men of directions which can be followed to improve men’s health more generally in Australian society: in particular, the formation of a sense of community amongst groups of men in pursuing their interests in improving their health. They issued a challenge to the wider Australian male population to construct communities of interest which will be inclusive of diversity and strengthen their claims to improvements in the conditions of better health.


Further significant public events in this history of Aboriginal male health have been an NT Indigenous Male Health Conference, held at the Tennant Creek Showgrounds from 29 to 31 August, 2000. There were between 150 and 200 participants, including some from interstate.
A number of significant observations and recommendations (17) arose from the conference. Included amongst them was a reaffirmation of the need for separate ‘male places’ in communities; a call for greater collaboration between key stakeholders to work towards improvements in male health outcomes; the provision of more effective male health promotion campaigns, and the need to develop strategies to increase the number of Indigenous males in the health workforce.

It was especially noteworthy at this conference that a large number of young males attended the opening day. There were also a number of students from the local high school.


A National Reference Group has formed to contribute to developing national Indigenous Male Health policy. This is indicative of the strong political drive of Indigenous men to develop and drive community based programs and take responsibility for their health and well-being.

OATSIH sponsored and funded a two day Forum of the Reference Group in Canberra on 16 and 17 August 2000. Prior to the Forum, NIMWHRC developed a Vision Statement:

| Our Vision is to be the vehicle to highlight, promote and address issues associated with Indigenous Male Health and Well-Being, by Males for Males. |

The Forum identified issues in four broad areas, or categories:

- Emotional and social well-being
- Cultural
- Structural
- Physical

It also worked to define principles and key result areas for Indigenous male health; and associated strategies, actions, roles and responsibilities.

(Report to the Office for Aboriginal and Torres Strait Islander Health (OATSIH), 2000)
5.2 The International and Broad Australian Context

Aboriginal males have initiated and driven the awareness of their own health issues and taken action independently to address them.

However they have also engaged with the more recent emergence of awareness and action about men’s health in the broader society.

A prominent example of this engagement was evident in the powerful impact of Aboriginal men in the discussions at the 3rd National Men’s Health Conference in Alice Springs in 1999.

It is also inevitable that Aboriginal males’ constructions of their own masculinity and their understandings of health issues are influenced by exposure, eg. in the media, to other shifts and possibilities of living as a male.

Mainstream writers on the emergence of an awareness of men’s health issues and problems in broader societies, both in Australia and overseas, note that it is a fairly recent phenomenon. It has been recognised that this has come much later than the recognition of a particular field of ‘women’s health’ issues (Luck, Bamford & Wilkinson, 2000, p.6). An Australian expert in gender health issues, Dorothy Groom, has estimated that focus on men’s health has lagged behind women’s health by about 20 years. (Groom, 1999, p. 52)

In a recent Australian publication: Men’s health: a Research Agenda and Background Report, it was said:

“In recent years there has been increasing concern with issues that have come to be called ‘men’s health’. Two national conferences, heightened media interest and a parliamentary investigation are signs of this concern. This follows, by about twenty years, a somewhat differently framed public discussion on women’s health. The two debates reflect an increasing awareness by health workers that gender is an issue that matters in health care, disease and injury prevention, and health education.” (Connell et al., 1999, p.1)

Since then the further national conference referred to above has been held in Alice Springs.

The same writers go on to state:

“We take seriously the point, emphasised by many writers in the field, that health issues about men are rarely narrowly biomedical problems, but typically involve broad questions about men’s lives and gender relations ... the general import is clear when health and community workers talk about ‘lifestyles’, ‘men’s roles’, ‘family issues’, ‘machismo’, ‘male identity’, ‘male socialization’, etc., as sources of health and safety problems. (ibid, p.3)
They also note the diversity of the Australian male population and the “health problems emerging in different groups of men” ... [such as] ... “Aboriginal men, elderly men, boys and youth, homeless men, and men of specific immigrant groups.” (ibid, p. 34) There are also “… certain health issues specific to gay men, and other issues specific to heterosexual men ... These patterns, of course intersect. Thus, a particular man may be gay, young, a metal worker, and of Italian immigrant background; or straight, rural, elderly and Anglo; or many other combinations”. (ibid, p. 35)

They conclude that:

“There is, then, no single pattern of men’s health problems: and it is extremely unlikely that any ‘one size fits all’ policy or education approach would be helpful. Rather, gender issues are inter-woven with other familiar influences on health: poverty and affluence, work and unemployment, ethnicity, generation.” (ibid, p. 35)

Aboriginal males engage and interact with all these conditions and changes in the wider Australian society.
6.0 PRINCIPLES & VALUES

The following principles have been widely recognised and discussed by Indigenous males. They underpin all efforts to improve their health.

- Indigenous males have the right to self-determination in defining and addressing their own issues.

- Issues and interests of Aboriginal and Torres Strait Islander males in health and well-being are inter-related eg. equity, employment, mental health and the use of alcohol and other drugs are not distinct. They are inter-related by common factors which arise from the historical, political and economical conditions of Indigenous masculinity or the lived realities of Indigenous males.

- Responses to these health issues must also be broadly focused and integrated: holistic, rather than compartmentalised and narrowly targeted.

- Responses must be defined/planned/designed by Indigenous males. They must control all fazes of such responses; from defining interests and issues, devising and initiating responses, carrying out projects and activities and their evaluation.

- All participants in these processes should be engaged in mutually supportive partnerships which ensure that the Indigenous male participants retain control.

- Aboriginal and Torres Strait Islander male health must not be defined in ways which exclude Indigenous women and their interests and issues. This principle recognises the inter-dependence of Indigenous men and women in family and community life and achieving a more equitable future for Aboriginal and Torres Strait Islander communities as a whole.

- Recognise that Indigenous males have suffered from a long history of trauma and loss; and are undertaking a process of reconstructing, redefining and re-inventing their male identities in contemporary social, political and economic conditions. This process is fundamental to the achievement of better health and well-being.

- Relationships are not only structural, but also qualitative: they include dimensions of respect, trust, emotion, affection, kindness and care. But they are depreciated in bureaucratic institutions and their discourses.
7.0 KEY ISSUES

There can be no doubt that the principal, overarching, and fundamental health issue identified by Aboriginal and Torres Strait Islander males is of control.

A multiplicity of very diverse issues and concerns have been expressed by Aboriginal males in consultations and discussions over recent years. Some of the history of these discussions is recounted in section 5.0 of this paper.

At least two very broad themes are prominent amongst all these specific issues:

- **Control**

  Clear recognition is expressed throughout the discussions that control by Aboriginal males over all conditions which affect their health and well-being is a principal and overarching issue. And that their wide-spread disempowerment, including alienation from health services and resources, has had a disastrous impact on their health and life expectancy. This disempowerment has included their loss of authority and roles in their communities and families.

  A major issue in improving health, therefore, is re-claiming and re-creating authority and roles in contemporary life.

- **Inter-relatedness, Inter-connection and Inter-dependence**

  Generally the way in which health related institutions, agencies and their services operate are not congruent with Aboriginal holistic understandings. For example issues which are defined separately and independently such as high levels of alcohol and other drug use, mental health, diabetes, sexual health are all inter-connected and inter-related. They all share the underlying problems such as dis-empowerment, dependency, poverty, dysfunctional families, unemployment, racism, alienation, loss of country, and institutionalisation.

  This understanding was expressed at a National Indigenous Policy Forum in Canberra, in August 2000:

  “Of particular interest is how the identification and discussion of key health issues did not focus primarily on physical health issues. While a number of these were acknowledged as very important there was a particular focus on the inadequacies in the operation of the current health system (structural issues) and on emotional, social and cultural issues as determinants of poor physical health. When physical issues were discussed they were often addressed in a more holistic context as they relate to issues of emotional well-being.” (Report to the Office for Aboriginal and Torres Strait Islander Health (OATSIH), 2000 p. 8)

  The forum framed and structured the many specific issues that have been raised at various conferences and other consultations under four broad themes, or categories:
Emotional and social well-being issues

- Incarceration has a profound effect on individuals and their relationship with their communities when they are released.
- The need for men’s support groups
- Stigma of going to AMS/shame of what people think and confidentiality
- Parenthood skills and responsibilities
- Adhering to negative male stereotypes
- Youth suicide
- Sexuality
- Anger/Trauma/Grief management

Cultural

- Land/sea ownership/cultural and language
- Gender specific protocols/policies to help providers
- The need for separate male places/clinics
- Male business and associated regional variations

Structural

- Males to be resourced to assume control of their health and well-being
- Health and well-being of males need to be a part of a holistic approach including social, emotional and cultural aspects. Likewise Primary Health Care needs to be holistic addressing full range of target groups and issues including:
  - screening programs
  - prison health
  - gay health
  - chronic diseases
  - aged care
  - substance misuse
  - public health
  - youth
  - environmental health
  - mental health
  - social well-being

- Need more males in the health sector
- Need appropriate funding
Men’s Health Secretariat body to have input through to the Health Council and Minister
Identify and promote best medical practices
Male issues not receiving same attention as women’s health/gender equity
Legal systems/rights
Need for an audit of current men’s programs nationally and a literature review
Identifying access barriers to health agencies by Indigenous men/males (culturally appropriate)
Identifying performance outcomes (indicators)
Improving access to secondary and tertiary health care - development of cross-cultural understanding
Unemployment needs to be addressed as it is linked to substance misuse and youth suicide
Skilling of health professionals - both training for Indigenous health workers and cultural sensitivity training for non-Indigenous service providers

**Physical issues**

Preventable lifestyle illness such as heart disease and diabetes
Substance abuse
Living skills
Reproductive/sexual health

The health agenda which has been expressed by Indigenous males in the Northern Territory has not been ‘disease driven’. A number of health related issues have been identified strongly. The men who have defined them have shown an understanding that they all have historical, social, cultural-spiritual, physical-biological and economic aspects and conditions. They have all been identified and defined from an Indigenous male perspective and frame of reference. They include:

- High rates of death and low life expectancy
- Injuries and deaths from vehicle and other accidents; or violence
- Suicide
- Chronic diseases
- Food, nutrition and exercise
- Alcohol and other drug use
- Family violence
Sexual and reproductive health
Education and training
Employment, including management
Crime and justice, including circumstances and rates of detention and imprisonment, and their causes.

One of the principal issues which has been identified, and which should guide strategies to address all the others is:

- Barriers to Indigenous males accessing health related resources and services; and their employment in the health field, at both service and management levels, to define their issues and needs; and to make decisions and control the ways they are addressed.

Underlying all of these is the deeper and wider issue of:

- Political, economic and cultural dispossession and disempowerment of Aboriginal and Torres Strait Islander males.

Another issue which remains to be taken up more strongly by the Indigenous male health movement in the Northern Territory is chronic hepatitis. It has not yet become prominent in the Indigenous male health agenda.

Chronic hepatitis B infection is high amongst Aboriginal and Torres Strait Islanders in the Northern Territory (Selva-Nagayam et al. 2001, 111-112). Whilst hepatitis C (HCV) infection is probably not widespread in these communities in the Northern Territory, it occurs at epidemic level in the wider Australian population. A National Hepatitis C Strategy has been established to address the epidemic (Commonwealth Department of Health and Aged Care, 2000). It includes reference to Aboriginal and Torres Strait Islander communities, particularly regarding the issue of prejudice and discrimination (ibid, p. 49). HCV is spread principally by unhygienic practices in intravenous drug use, especially sharing needles (Crofts, Thompson & Kaldor, p. 11-13), which occurs in Northern Territory urban centres, and is said to be increasing (anecdotal). Another way it can be transmitted is by unhygienic tattooing. It is probably not transmitted by sexual contact. It is not transmitted by other social contact; such as kissing, embracing or sharing cups, plates or cutlery. However sharing razors for shaving or toothbrushes is risky, because blood can be transferred.

Cirrhosis and liver cancer are known to be caused by both of these forms of hepatitis (Lowe & Cotton, p. 4-5; Crofts, Thompson & Kaldor, p. 68-76). It is usually fatal. It is believed that high alcohol use increases the risk (ibid, p.77-80). It is also believed that good nutrition can reduce the risk of progression to cirrhosis and cancer.

Hepatitis can be a chronic condition: with long term symptoms of disabling fatigue and pain, and potentially fatal outcomes. In some interstate mainstream services it is addressed by support for learning self-management and lifestyle change - as for other chronic diseases. In the Northern Territory there has been little development of such services - especially for Aboriginal and Torres Strait Islander people.
Since there is a high incidence of chronic hepatitis and liver cancer in Aboriginal and Torres Strait Islander males in the Northern Territory (Selva-Nagayam et al. p. 111), this issue should be explored further and addressed by a specific strategy.

(See also Correll, MacDonald & Dore, 2000)

The current Northern Territory Preventable Chronic Diseases Strategy addresses “type 2 diabetes, renal disease, hypertension, ischaemic heart disease and chronic airways disease” (Department of Health and Community Services, 1999): because “they have common underlying factors, most notably poor nutrition, inadequate environmental health conditions, alcohol misuse and tobacco smoking”. (ibid) The Strategy does not include hepatitis.

In addressing these conditions, the Framework for the Strategy states that:

“The PCDS [Preventable Chronic Diseases Strategy] approach is innovative in its unremitting commitment to integration - an integrated theoretical framework that encompasses social and medical determinants of health; an integration of client, clinical (individual level) and public health (population level) perspectives; an integrated approach to the underlying risk factors for chronic disease; integration at the level of guideline development, care plans and standards of care for both individuals and their families; and an integrated approach across the continuum of need from health to illness, and across the continuum of , and between health and other government sectors.” (ibid)

The framework also recognises that health is a lifetime process, from birth to death; and that control and other social conditions are crucial in preventing and managing chronic disease.

These understandings and commitments of the Strategy are congruent with the insights of Indigenous men about their health: that the issues and conditions are interrelated; and require a holistic response.

The approach to chronic diseases must recognise the cultural and gender differences between people and their experiences who acquire and live with them; and their implications for preventing and managing them. They must also recognise the economic and education inequities suffered by Indigenous peoples; and their contribution to the rates and histories of chronic diseases amongst them. Integrated responses must address these; as well as the impact of the criminal justice system on Indigenous males.

Integration does not imply uniformity, or homogeneity!
Another issue which has been discussed amongst Indigenous males (including the Ross River Convention and the Tennant Creek Conference) is the different ways in which sexuality is expressed by Aboriginal and Torres Strait Islander males, and the implications of same-sex relations and activity between men. Questions arise about social and cultural acceptance of such different expressions of sexuality; and how homosexual or transgender Indigenous men, as well as those men who experience ambiguous, varying sexuality, can be included in the wider Indigenous male health agenda. There are special risks to health in the sexual activities between Indigenous males in living any of these possibilities.

HIV and AIDS, or other sexually transmitted infections, are perhaps less important here than the harmful effects of stereotyping and prejudice: which demolish the sense of value in any person’s life. This process is painfully familiar to most Aboriginal and Torres Strait Islander people.

Persons who suffer rejection, discrimination, ostracism and alienation; or shaming and hostility within their families or communities; and perceive themselves as powerless victims, are likely to become self-destructive (suicide or self-mutilation); or to engage in unhealthy or risky behaviour, such as poor diet and little exercise, misuse of alcohol and other drugs, or unsafe sex. These behaviours can also affect others in their families and communities adversely: the stress of sorrow and worry; modelling unhealthy and dangerous behaviour, or transmitting sexual diseases.

It would be ironic, and perhaps hypocritical, if some Aboriginal or Torres Strait Islander men condemned, excluded or punished other Indigenous men for living these alternative ways of being male. It is also dangerous. Youths, while they explore their sexualities, which might not conform to their family’s or community’s expectations, experience uncertainties, alienation and despair: because they cannot trust anyone to accept their ‘different’ experiences of becoming an Indigenous man. They need trust and unconditional acceptance (not merely tolerance) from their fathers, grandfathers and uncles while they live through the difficult process of constructing and discovering their own special male identities. They are all someone’s son, brother, nephew or grandson.
8.0 RELATIONS BETWEEN INDIGENOUS MALES & FEMALES

Indigenous peoples have their own ways of relating across gender and generations: personally, socially, culturally and politically. They differ from the structures and forms of interaction in non-Indigenous societies.

Indigenous males and females have different domains of knowledge, responsibilities and authority. However while each gender has its own autonomy, both are also inter-dependent.

The ways Indigenous males and females inter-relate across these gender domains constitute the integrity (wholeness) of Indigenous family and community.

Many if not all of the issues which Indigenous males are defining as their principal health concerns inter-relate with the issues of Indigenous women.

Outsiders must understand that both Indigenous males’ and females’ perspective must be included in all responses to Indigenous health: be it nutrition, alcohol and other drug use, sexual health, chronic diseases, family violence; or the underlying issues of education, employment, income or criminal justice.

Both in the Northern Territory and throughout Australia Indigenous males are defining and advocating their own issues. This is a necessary expression of their autonomy. It is also an expression of their own initiative to reclaim and re-construct their masculinity: after their long history of dispossession and disempowerment. However both Aboriginal males and females understand that this process of recovery requires support and partnership with each other.

A powerful example of this partnership and support between Indigenous males and females occurred in the march in Alice Springs to the 3rd National Men’s Health Conference, September 1999. Indigenous women and children joined their men to present their issues and claims to the conference.

Another example of ways in which Indigenous males and women cooperated to address a common health issue occurred at a remote community in the Western Desert in 1986.

A visitor who had friendships with several men in the community was asked by a group of young men to give them information about AIDS, of which they had heard. They evidently believed they were at risk of contracting this new disease, which they believed had been introduced by whitemen from overseas. They understood already that men were predominantly at risk because of sexual practices. They said that they only trusted this visitor to tell them the truth about this new disease. And that they knew that they had been deceived, or kept ignorant, about other dangers to their health in the past by others. The visitor then obtained
and prepared information and after some general discussion, asked the men to make the arrangements for its discussion. The men decided, at this stage, to exclude women from the discussion. However they also arranged for a female visitor - who was also trusted to bring knowledge about the new disease - to provide and discuss it with local Aboriginal women, separately. Later the men and women joined in a discussion of ways the new disease could affect both males and females in the community; and ways they could work together to reduce the risk.

This is an instance where new information was introduced and could be discussed only because of the existing relationships of mutual trust and care, and basic understandings of the primary languages and cultural permissions and constraints of the participants.

It was therefore possible to introduce and discuss information about HIV and AIDS with both men and women in the community in ways which respected gender differences and relationships.

These and many other examples show how Indigenous males and females can work together, while maintaining their gender autonomy.

The autonomy, and special social and cultural responsibilities, of Aboriginal females have been enacted in the NT Strong Women, Strong Babies, Strong Culture Program (SWSBSC). This initiative of Aboriginal women has resulted in benefits to their babies. (Department of Health and Community Services, 1999 (2), p. 7) Whilst support by Aboriginal men for women in their care for babies is no doubt necessary, it is not primarily their business. This is a female domain.

On the other hand, whilst the issues of Aboriginal family violence were defined principally by Aboriginal women in a report by Eileen Cummings and Mai Katona the need to engage men in addressing them was also recognised (Cummings & Katona, 1995). Indigenous men have also identified violence as a prominent issue and responsibility in their male health agenda; and committed themselves to addressing its conditions: eg., at the National Convention at Ross River in 1999; and the Conference at Tennant Creek in 2000. This issue evidently extends across both male and female domains of authority and responsibility: and requires cooperation between men and women in defining, understanding and addressing it; and including both male and female experiences, understandings and perspectives.

A further example of an issue which extends across both Indigenous male and female domains of authority and responsibility is food and nutrition. Both men and women can take roles in improving the quality and range of foods which are available and used in Aboriginal communities. However they may do so in different ways. Men may take responsibility for getting and providing some kinds of food; and women for others. These differences have their roots in ancient distinctions between responsibilities and meanings of categories of foods: eg., of men for kuyu, or kuka (meats) and of women for mangari (mainly vegetables and grains). [Some Central Australian languages] And different practices in getting and preparing them. Today other issues also arise, such as control of food marketing, processing, preparation and consumption. Stores and take-away outlets must be managed and staffed. Profits, losses and
the GST must be administered! Staff must be recruited, trained and supervised. And hygiene, health and safety measures must be implemented. Both men and women may take roles in these local businesses: and so increase their control over the selection of foods and their distribution. However men and women may prefer different roles and responsibilities, and ways of discharging them. Some of these issues are being addressed in the implementation of the Northern Territory Food and Nutrition Policy. (Department of Health and Community Services, 1996; and Department of Health and Community Services (1), 2000)

At the 3rd National Men’s Health Conference in Alice Springs in 1999 Dorothy Broom, a keynote speaker, called her address: Finding Common Ground. In her conclusion she spoke of the need to abandon the language of “winners and losers, and villains and victims”. She suggested that doing so “might enable us to identify more opportunities for collaborative projects, or sharing resources in parallel but related projects”

In her address to the Conference, Dorothy worried about the idea of finding common ground. She said that “we must all take responsibility not simply for discovering but creating common ground. Perhaps we do not so much find as produce mutual understanding …”

In journeying we not only find the places which are there already. We also create them: by making new meanings in, and from them.

This is surely the way forward.
9.0 RECENT & CURRENT INITIATIVES & ACTIVITIES

Indigenous males in the Northern Territory have taken many initiatives to define, advocate and address their health related issues. Some of them have been supported, with both funding and encouragement, from Department of Health and Community Services and other agencies. Many other initiatives have been taken at community and family level by Indigenous males without seeking or obtaining any such support.

However, Indigenous Male Health as a social action movement for change, has been driven by Indigenous men themselves; with very little financial support.

This demonstrates their commitment, initiative and effort in addressing their own issues.

The following initiatives are examples of what has already been achieved:

- Recognising past contribution by communities and individual males to address issues: eg. petrol sniffing, the AIDS story by Kumantjai Japaljarri Spencer, Johnny Briscoe, Jack Liddle and reaffirmation of roles and obligations of Uncle-Nephew relationships.

- Organising and facilitating the First National Indigenous Male Health Convention; and the 3rd National Men’s Health Conference

- Conducting regional workshops Alice Springs, Darwin, Nhulunbuy and Tennant Creek

- An Aboriginal male health conference in 1993

- Establishment of Aboriginal Male Health Places and special services

- Well men’s checkups by Health Promotion (Greg Smith, Richard King and John Morgan)

- Establishment of the Male Health Policy Unit within Department of Health and Community Services

- Development, trialing and evaluation of the Male Healthy Lifestyle Program

- Tennant Creek Conference: a joint initiative of the NT Indigenous Male Health Committee and the Male Health Policy Unit

- Kigaruk Project: a Department of Health and Community Services and Office of Commissioner for Public Employment initiative developing leadership and management skills for Indigenous males working across government departments and agencies.

- Maintaining input into recent national developments in Indigenous male health

- Tiwi Islanders have recognised the need to establish their own male centres/places

- Danila Dilba separate Men’s Health Clinic established
Initiatives to respond to HIV/AIDS and sexual health: Eg.

− Danila Dilba conducts HIV/AIDS and sexual health education in schools in Darwin, and at the Don Dale Centre. It also conducts similar initiatives in Katherine, in collaboration with Wurli Wurlinjang. The Aboriginal Student Support and Parent Awareness (ASSPA) Committees are also involved.

− At the Male Health Centre in McLachlan Street, Darwin, individual counselling is offered about HIV/AIDS and other sexual health issues.

− The Men’s Health Centre within Danila Dilba is planning both a Male Camp and a Youth Camp, to be conducted in May. Support Committees have been established for both these activities: the latter comprising local Indigenous youth.

Jabiru – Djabulukgu and the community have recently opened a men’s centre

In Central Australia Indigenous males have formed the Interim Central Australian Indigenous Male Health Committee

Formation of the Darwin Indigenous Male Health Committee

At the Tennant Creek Conference in 2000, it was proposed by Frank Ansell that the Northern Territory Indigenous Male Health Committee (NTIMHC) become a Sub-committee of the Northern Territory Aboriginal Health Forum. The Forum comprises representatives of Department of Health and Community Services, the Aboriginal Medical Services Alliance Northern Territory (AMSANT), Office of Aboriginal and Torres Strait Islander Health (OATSIH) and the Aboriginal and Torres Strait Islander Commission (ATSIC). This structural change should ensure that the Forum consistently recognises and addresses Indigenous male health issues.

A proposal to build a specific purpose male health centre at Yarralin, an initiative of the Yarralin community
10.0 EMPLOYMENT, EDUCATION & TRAINING

This section raises issues which are relevant to the employment of Indigenous males in both the public and community sectors, in a range of fields, who can contribute to improvement in Indigenous male health. Some strategies to address them are also suggested.

10.1 Employment

Lack of employment opportunities is a major issue in Indigenous communities. This contributes to poverty and powerlessness: which in turn contribute to bad health. The problem is especially severe in bush and remote communities, and a highly prominent local concern. (eg. Mitcalfe, 1994; Trudgen, 2000)

Indigenous males face particular difficulties in gaining employment in occupations which are congruent with their interests, roles and responsibilities in their families and communities.

*Occupations and particular jobs in health and related fields should be defined in terms which accommodate Indigenous men’s interests; and their roles and responsibilities in their families and communities.*

Increasing employment opportunities for Indigenous men in health and other related fields could address this issue to some extent.

It can also ensure a wider engagement of Indigenous males in addressing their own health issues: in decision making processes, organisation, and services.

A range of departments and their agencies - both Commonwealth and Northern Territory - have related responsibilities: especially Department of Health and Community Services, Education and Correctional Services.

All Indigenous male employees in the public sector necessarily have interests in both their own and the general improvement in Indigenous male health.

They already make a contribution through their occupations; and can be engaged and supported to become even more effective agents in the process. Evidently Indigenous male workers in Department of Health and Community Services, the Department of Correctional Services and the Department of Education have great opportunities for engagement in this commitment. However employees at commonwealth and local government levels can also be engaged to make valuable contributions.

Due to a number of reasons and circumstances, Aboriginal and Torres Strait Islander men are under-represented in the Northern Territory Public Service (NTPS), particularly at senior levels.
One of the many reasons for the under-representation is that established mainstream career development programs are not being accessed. Given the success of programs for specific groups, Department of Health and Community Services (THS) and Office of Commissioner for Public Employment (OCPE) are designing a program that will provide the opportunity for Aboriginal and Torres Strait Islander males to gain the skills, knowledge and confidence necessary to win merit-based promotions.

The medium-term outcome of the program is Aboriginal and Torres Strait Islander men will be in positions to influence the formulation of relevant government policies and shape the delivery of services. In the longer-term, the program will contribute to the improved health and well-being of Aboriginal and Torres Strait Islander people in the Northern Territory.

Processes to engage and support the involvement of Indigenous men should at least comprise:

- Increasing effort and improving recruitment strategies and conditions to attract more Indigenous males into the public sector workforce, in all fields, at all levels.
- Including awareness of Indigenous male health issues, information and possible responses in in-service training in all Departments which have responsibilities related to Indigenous male health. Cross-Departmental training for these purposes should be considered to rationalise the resources required for training, and facilitate networking and co-operative work practices.
- Modifying employment conditions (duty statements etc.) to encourage cooperative work between Indigenous male employees across different Departments and their programs: to facilitate coherent and inclusive approaches to Indigenous male health issues.

The aim of the Aboriginal Employment Career Development Strategy (AECDS) is to improve the employment status of Aboriginal and Torres Strait Islander people in the Northern Territory Public Sector by providing a range of appropriate recruitment and career development programs. The Strategy also aims to facilitate the development of individual Agency Strategies.

Increasing the number of Indigenous male health workers in the health field would reduce the barriers to males accessing health services which are created by their reluctance to approach and consult with female health workers about their special concerns. Greater confidence in accessing health services would result.

Encouraging and supporting Indigenous males to take up management positions, both in the government sector and community health service organisations, would empower them to engage in decision making processes about their own, their families’ and their communities’ health issues. (Courtney, M et al., 2000; Wakerman, J et al., 2000.)
Occupations in other fields, such as education and criminal justice, can also be reconstructed to make a greater contribution to improving Indigenous male health: eg., by including awareness of Indigenous male health issues in their training and professional development; and the requirement to work in partnership with male health workers in the field.

Senior Indigenous males can contribute their specialised traditional knowledge, authority and leadership to improving male health. They should be encouraged and supported to work with Indigenous male health workers, and male workers in other related fields, as mentors and consultants. This is an application and extension (‘adaptation’) of the Indigenous Uncle-Nephew concept of relationships between males in contemporary conditions.

> Indigenous males must be attracted to work in the health field; and barriers to this occurring must be identified and addressed: eg. female nurses and Indigenous health workers, ‘white’ doctors, predominant women’s issues and interests, ownership and control; privacy and shame, inhibitions, usurped community and family roles, limiting ‘constructions’ of ‘masculinity’; focus on clinic based and medical practices in health work; inflexible conditions. Similar considerations also contribute to low rates of retention in the workforce.

For some years Department of Health and Community Services has conducted an Aboriginal Cultural Awareness Program (ACAP) for staff.

ACAP has had an important role to play in raising people’s awareness and understanding of Aboriginal culture. It has also played a useful role in developing greater understanding and challenging entrenched negative attitudes towards Aboriginal people, cultures and circumstances.

> The Aboriginal Cultural Awareness Program (ACAP) for Department of Health and Community Services employees should be improved and extended to ensure participants gain understanding of both male and female gender issues related to health; and the program should be made available to employees of other Departments and Agencies.

### 10.2 Education and Training

Generally, Indigenous people in Australia “have been disadvantaged in all sectors of education, including higher education.” (Encel, 2000)

There has also been a large disparity between male and female participation. For example, nationally:

“In 1996 there were 4352 female Indigenous students in higher education: this was 4.5 per cent of the female Indigenous population in the 17-64 age bracket. In comparison, there were 2604 male Indigenous Australian higher education students, 2.9 per cent of the male Indigenous population in the same age bracket.” (ibid, p. 4)
It is believed that similar disparities continue, and also exist in the Northern Territory.

Good education and training at all levels to address male health issues is necessary to ensure engagement of Indigenous males in all occupations which can contribute to improving Indigenous male health.

### 10.2.1 Tertiary Education and Training

Tertiary education and training programs for Aboriginal health workers appear, overall, to attract and retain more Aboriginal females than males.

Education and training for other occupations which have potential to contribute to improving Indigenous male health do not include specific content about male health and possible contributions and approaches to its improvement.

All providers of education and training related to Indigenous male health issues should be encouraged to include awareness of the issues, information and approaches, in both accredited and informal (eg., in-service) courses: including Department of Health and Community Services, the Departments of Education, Correctional Services and Local Government; Batchelor Institute of Indigenous Tertiary Education (BIITE), the Faculty of Aboriginal and Torres Strait Islander Studies (FATSIS), the Institute for Aboriginal Development (IAD), Aboriginal Health Services, Aboriginal Legal Services and Land Councils etc.

All formal (accredited) courses in health work should include male health as a particular field of issues and practice - at all levels of the Australian Qualifications Framework (AQF): ie. TAFE Certificates and Higher Education.

Particular effort should be made to attract Indigenous males in the Northern Territory to undertake tertiary education which can prepare and support them to take up management positions in the health field. (See Courtney, M et al., 2000; Wakerman, J et al., 2000.)

For example, Batchelor Institute of Indigenous Tertiary Education (BIITE) now offers Higher Education courses at Diploma and Advanced Diploma level in the health field.

They comprise a core of generalist health studies; plus options of a number of specialist strands: including environmental health, mental health, nutritional health, renal health, and general health.

A new specialised strand (course) should be developed by Batchelor Institute in Indigenous Male Health, which may be chosen by male health workers. Awareness of particular male health issues and ways to address them should be included in all courses.
At this higher education level, the specialised strand of the course (curriculum) should include, at least:

- History and analysis of male health issues: including imperialism, invasion, colonisation, racism, genocide, power and control; and Indigenous resistance: and their special impact on Indigenous males

- Contemporary political, social, cultural and economic issues; including: maintaining an Indigenous male identity. (What is it to be an Indigenous male? Who are we?): cultural and communication issues: including, ‘constructions’ of new and various (‘different’) Indigenous masculinities; the continuities, tensions and conflicts between past, recalled, identities and new ways of living in contemporary conditions. How the conflicts are felt: as powerlessness, dissonance, and stress. How these experiences can cause physical, social and cultural damage. And how males adapt, sometimes well, and sometimes self-destructively, to the situation. The rejection of ‘different’ ways of being an Indigenous male - social norms and sanctions that enforce ‘conformity’. The alternative ways of accommodation and inclusion - with care and compassion - sharing the variety of Indigenous male identities with other males ... a common humanity. What is ‘the Indigenous way’?

- Specialised clinical skills

- Management of organisations and their services

- Research and evaluation, eg., about needs and interests (‘issues’), policy implementation, services and resources.

Such a course could contribute substantially to the attraction of Indigenous men to work in the health field.

Consideration should also be given to ensuring that different male and female health issues and responses to them arise in the core curriculum, at least in general terms: so that all students acquire an understanding of gender difference as a prominent consideration in health work.

The award which would be conferred by Batchelor Institute on completion of the course might be:

Advanced Diploma of Indigenous Primary Health Care (Male Health)

Resources should be applied to develop curriculum for a new Male Health strand in the Batchelor Institute Diploma and Advanced Diploma courses.

At the same time curriculum should be developed at other levels of the AQF: ie. Certificates at levels which may be necessary to qualify for employment as Indigenous Male Health Workers; or to gain entry and prepare for undertaking higher level courses such as the Batchelor Diploma and Advanced Diplomas.
Awareness of the need to differentiate male and female health in training health workers was expressed by an informant at Nyirripi, in Central Australia, in a research project to find out local community interests and issues, as follows:

‘Several people said that they need more health worker training:

“one for women and one for men”.’ (Mitcalfe, 1994, p 119)

Research should be conducted to find out the interest and demand for male health oriented training in Indigenous communities in the Northern Territory.

Other training providers, both institutional and private, should be engaged to ensure that awareness of male health issues is included in their courses.

Courses at the required levels which are suitable for Indigenous males should be made available; in order to achieve Goals identified in Department of Health and Community Services’ Aboriginal Employment & Career Development Strategy Implementation Plan (1996), especially 1, 6, 7 and 8.

The 4th Goal of the Plan (Equity and Merit) is:

“To address the particular needs of Aboriginal people with disabilities, Aboriginal Women, and Aboriginal people for whom English is a second language”.

Goal 4 of the Plan should be amended to recognise the particular interests, needs and disadvantages of Indigenous males.

The compelling reasons for doing so are spread throughout this Discussion Paper. If this Goal were appropriately amended to recognise the particular inequities Aboriginal males suffer in regard to employment in the health sector, then the curriculum developments proposed here could contribute to achieving its purpose.
10.2.2 Pre-Tertiary Education

In a recent report on Indigenous pre-tertiary education in the Northern Territory it has been written:

‘A central recommendation of this review and the PAC [Public Accounts Committee] is that there must be high level support by Government departments and Government itself to inextricably link education and health in Indigenous communities. The two are synonymous. Failure to recognise and respond effectively to this reality results in an endless loop of poor outcomes in both.’


Increasing participation in tertiary education and training in the health field by Indigenous males requires innovations and improvements in the primary and secondary schooling curriculum. This would increase their engagement in health and related occupations.

Schools are also places where there are opportunities to learn information and life skills which can improve immediate and longer term male health.

“In a recent report, the National Health and Medical Research Council (NHMRC) concluded “the available evidence indicates that school health programs which are comprehensive and integrated, and include the curriculum, the environment and the community, are more likely to lead to advancements in the health of school children and adolescents”.

The report then commends a ‘Health Promoting School Framework’ which could guide curriculum development and teaching practice; as well as relationships and partnerships with other stakeholders in education and promotion of good health.

(Men’s Health Promotion Strategic Framework, North East Health Promotion Centre. 1999, Melbourne. p. 29)

Department of Health and Community Services and the NT Department of Education currently collaborate in a Health Promoting Schools program.

The Health Promoting School Framework should continue to be implemented in Northern Territory schools. Where necessary, it should be enhanced or extended to include particular attention to male health issues, and to include male Aboriginal teachers and health workers in its implementation.

The special situations and experiences of Indigenous male students at primary and secondary school and their particular difficulties and challenges must be addressed.
Evidence of disadvantages of boys and youths in mainstream education has led to increasing public concern: expressed, for example in a Life Matters program on ABC Radio National on 12 February 2001. Changes in classroom practice and culture, teaching styles and gender of teachers, curriculum and methods of assessment, are all possible reasons for this shift from past disadvantage of female students, to recent male disadvantage.

Indigenous male students are likely to be doubly disadvantaged, with undoubtedly adverse effects on their health.

The Standing Committee on Employment, Education and Workplace Relations, of the House of Representatives, is currently conducting an Inquiry into particular issues of male students. Amongst other matters they will

‘… inquire into and report on the social, cultural and educational factors affecting the education of boys in Australian schools, particularly in relation to their literacy needs and socialisation skills in the early and middle years of schooling’.

(Terms of Reference, 2000)

The submission from the NT Department of Education to the Inquiry does not provide specific information, or raise or address specific issues of Indigenous male students.

(NT Department of Education, [n.d.] Submission by the Northern Territory Department of Education to the House of Representatives Standing Committee on Employment, Education and Workplace Relations. NT Department of Education, Darwin.)

However it does state, more generally, that:

‘It appears that boys as a defined group do consistently less well on most school-based English literacy tests and other aspects of schooling …’

‘Even though gender appears to be an important factor, other factors such as economic status, ethnicity and location interplay with gender in different ways to produce ‘success’ for some boys and girls and not others.’ (p. 1)

And that:

‘… social and economic resources available to children through their homes and communities also impact significantly on their achievement, and so do location and ethnicity. As educational performance correlates with socio-economic status gender gap widens. Thus the real question is not whether girls as a group are more disadvantaged or boys as a group, but which boys and which girls’. (p. 7)

It is reasonable to infer from these statements, together with other knowledge and common sense, that Indigenous boys are significantly disadvantaged in their schooling.
The recent Collins Report: Learning Lessons; focussed principally on literacy and numeracy issues.

(Northern Territory Department of Education, 1999)

It made 151 recommendations. Of these, only recommendations 124-127 directly addressed health issues. They are that:

- infant health interventions are introduced within the multipurpose early childhood centres recommended by this review.
- health objectives are incorporated within school action plans and principal performance management agreements, to ensure the links are maintained in practice as well as theory.
- community service agreements are established between the school and the community health centre.
- teachers are trained and supported for their health and community development role.

Some other recommendations address issues of hearing impairment of students.

In the Recommendations to address data deficiencies, (p. 131-138) the need to differentiate and compare quantitative data about male and female attendance and participation, and qualitative data about the different learning experiences of Indigenous male and female students, is not addressed.

However, some relevant data are provided in the report.

For example, it is shown that in 1994, 6 Indigenous males and 19 females completed year twelve in the Northern Territory. In 1998, 11 males and 26 females completed their schooling at this level. (Collins, 1999, p. 31)

Research should be undertaken to discover specific learning, social and cultural issues and needs of Indigenous male children and youths in primary and secondary education; and their health impact.

In the school curriculum all students should become aware of the particular health issues of Indigenous males; and of gender, and other historical, social, economic and cultural differences between groups of people.

Indigenous male health issues should be included in both primary and secondary school curricula, including information about occupations in the health field in later years of schooling.

Occupational counselling by adult Indigenous male health and allied workers should be made available to Indigenous male students in secondary school about opportunities to study further and work in the health field.
11.0 RESOURCES

Specific resources must be allocated to address Indigenous male health issues. They include the following.

11.1 Facilities

In most, if not all, consultations amongst NT Indigenous males about their health issues, they have identified a need for special places and facilities in their communities where they will be able to discuss and address their own health issues. Many men have expressed their alienation from existing health services and the places where they are conducted. They often feel that these places and facilities are dominated by women - both Indigenous and others; and that their core business is principally the concerns of women. This situation is aggravated by the usual employment of women in health centres, and of few, if any, male health workers. And even when there are male health workers, they are usually subordinate to female non-Indigenous nurses or doctors. Many Indigenous males express lack of confidence and embarrassment in using existing health services in their communities to present and discuss their health concerns, and get treatment for them, at their local clinic or health centre.

The consequence of this situation is that many Indigenous males do not access health services, care and treatment when they need them: and do not engage in the conversation about Indigenous health (discourse). They are excluded from this discourse: especially its professed concern with prevention and health education.

One of the ways to address this issue has already been discussed in this paper: ie. attracting and keeping Indigenous male health workers.

Another, which is continually demanded by Indigenous males, is the establishment of special male health places and facilities.

Ideas about these places range from facilities for special clinical services, through special places for discussions and education, to places and facilities where males pursue their health and other interests: such as recreation, training and work.

An example of the former is the male health Centre established at Gapuwiyak.

In consultations at Nyirripi in 1993, men said they wanted a place where they could work on their cars, get training and talk about health and other issues. (Mitcalfe, 1994) Many functions might be served by such male health facilities.

The Indigenous males in each community must define their own concept and purposes of such a facility; and be engaged in planning its establishment; and the activities which will take place; including the ways and extent of collaboration and cooperation with generic or female oriented health facilities and services.

Facilities should be established in Aboriginal communities for Aboriginal Male Health Places where male-specific services are provided, as well as preventive communication and education, and learning how to manage chronic diseases.
11.2 Funding

Implementation of a new program to address the health issues of Indigenous males will necessarily require specific funding. This is justified by the extreme need, and urgency, to address the evident crisis in Indigenous male health.

Advocates of this allocation of specific funding sometimes face strong opposition.

There is a perception amongst those who have strong commitments to health programs, such as women’s health, that allocations of funds to male health will inevitably result in decreases in the resources for such programs.

Few, if any, advocates for Indigenous males in improving their health would want to do so at the expense of equally necessary programs in Indigenous female health.

Funding debates are typically beset by what has been called ‘zero-sum’ thinking.

This way of thinking about the distribution of funding is also expressed in the ‘shared cake’ metaphor.

These ways of thinking about funding maintain an assumption that one allocation of funding will inevitably be at the expense of another. If you get a larger slice of the cake, then I will get less!

However there are other possibilities.

- We might share our portions of the cake, so that we each get enough to satisfy our appetites.
- If we complain enough to the cook, she/he might make a bigger cake.
- Even if we don’t increase the size of the cake, we might improve its nutritional quality: add some dried fruits and nuts.
- If the cake that we make together is very good to eat (eg. by government ministers and senior bureaucrats), then more ingredients for a bigger, and more nutritious, cake will be provided.

Competition for funding, and the conflicts which result, are not always inevitable.

Nevertheless it should be recognised that very little funding has been specifically allocated to addressing Indigenous male health issues.

Specific funding should be allocated for initiatives to address Indigenous male health issues. This should not be at the expense of Indigenous female health.
11.3 Information

It is sometimes said that the world is divided between the ‘information rich’ and the ‘information poor’. It is also widely understood that the information rich are more powerful. “Knowledge is power!”

Information poverty correlates with socio-economic disadvantage, cultural/racial prejudice and discrimination, location of residence, language competence, education, and so on.

Many Indigenous males are information-disadvantaged; especially with respect to information related to their health.

Even when research has produced information which is relevant, it is often not accessible: either because it is not presented in forms which are readily understood, or is unavailable through existing communication networks and processes. Sometimes the technology to access the information is not available, or people do not know how to use it. For example, e-mail and websites on the Internet are only accessible to people who have the equipment and know how to use it; and library resources are not accessible to many Indigenous people. Many Indigenous males lack sufficient literacy competence to access information which is only available in print: such as this Discussion Paper!

The Male Health Policy Unit, within Department of Health and Community Services, should be mandated and resourced to support and facilitate communication of relevant health information amongst all Indigenous males in the Northern Territory.
12.0 STRUCTURES

“Effective coordination can only be achieved if there is collaboration between Indigenous communities, community controlled organisations and government institutions. This can only be achieved if the premises on which coordination are built are shared by all parties. Some of these premises include:

- definitions of health
- equitable sharing of power and decision-making
- respect for varying patterns of organisation and planning
- collaboration in setting performance indicators and evaluation procedures.”

(Associate Professor A-K Eckerman, quoted in Health is Life: Report on the Inquiry into Indigenous Health, House of Representatives Standing Committee on Family and Community Affairs, 2000, p.3)

Achievement of the aspirations and purposes of Aboriginal males in the Northern Territory to improve their health requires appropriate organisational resources. The forms of organisation and their ways of operating must be congruent with Aboriginal structures and processes of organisation. They must ensure that Aboriginal males control their health agenda: both its definition and implementation.

It has long been recognised that Aboriginal ways of organising their social and economic life differ from, and often conflict with, other forms of organisation; especially those which have bureaucratic characteristics, such as government departments and corporate bodies. (eg. House of Representatives Standing Committee on Aboriginal Affairs, 1990; Peaarson, 2000 Trudgen, 2000)

More effective ways must be developed to enable Aboriginal males and their communities to engage with them and influence their processes, decisions and operations.

One way to facilitate this is to increase Aboriginal participation in employment within such institutions and organisations. This has been discussed elsewhere in this paper.

Department of Health and Community Services has facilitated this interaction by establishing a Male Health Policy Unit (MHPU). The MPHU is based within the Department, and located in its offices at Health House in Darwin. Members of the Unit are Aboriginal males.
The Unit aims to contribute to improvement in the health and well-being of males in the Northern Territory by identifying priorities and responding to their needs and issues. The MPHU advocates and supports the aspirations of males and endeavours to provide a ‘male perspective’ in defining the health related issues of themselves, their families and communities. Developing partnerships with other program areas within Department of Health and Community Services, government and non-government agencies and communities is an important function of the Unit: including cooperative/collaborative approaches to issues such as family violence, alcohol use, high incarceration rates and youth suicide.

The MHPU is in the process of developing an NT Indigenous Male Health policy framework. The Unit also has a support function to the operational implementation of other programs and initiatives within Department of Health and Community Services, ensuring that they address Indigenous male health issues and concerns wherever possible. For example Indigenous male perspectives need to be incorporated in programs dealing with nutrition and physical exercise, family violence, alcohol and other drugs, chronic diseases, environmental health, health promotion and sexual health.

The MHPU also provides secretarial and logistical support to the NT Indigenous Male Health Committee (NTIMHC) and the National Indigenous Male Health Reference Committee (NIMHRC).

Linkages are also extended and maintained with other government departments, which are necessary if a whole-of-government response to Indigenous male health issues is to be established and sustained.

The MPHU also works collaboratively with Aboriginal medical services; their peak body (AMSANT) and the Office for Aboriginal and Torres Strait Islander Health (OATSIH).

The following diagram shows some of these relationships.
This structure will change again once the draft terms of reference for the male sub-committee are endorsed by the NTAHF and the sub-committee becomes fully operational.

Department of Health and Community Services and NT Department of Education have established a Memorandum of Agreement and a framework for inter-agency cooperation: Healthy, Educated Territorians (the HET Framework).
13.0 RESEARCH

A lot of data exists about the status of Indigenous male health. It has been gathered and published over many years. It certainly proves that health problems of Indigenous males constitute a disaster which requires particular attention in the national and Northern Territory health policy agenda.

However most of the data are about ‘end-stage’ problems: illnesses, injuries and deaths: they are about the health outcomes of other disastrous conditions.

With few exceptions, research has not focussed on the initial social, cultural and economic conditions, as the lived realities of Indigenous males within their families and communities, which lead to their disastrous health outcomes. And it is here that the important information is to be found upon which strategies to improve Indigenous male health must be based.

So it is here that change is necessary to reduce the poor health outcomes of Indigenous males.

However, the systems and infrastructure do not exist to determine baseline information about initial conditions, and the changes that follow implementation of policies and strategies to improve male health.

For example, disempowerment has been identified by Indigenous males as a principal condition underlying their disastrous health outcomes.

Research is necessary to establish current conditions in this respect: and to track changes and improvements related to the implementation of strategies to address this issue. Only then will it be possible to evaluate whether the strategies have been successful. Of course, monitoring health outcomes must also continue.

Indigenous male researchers will be in a better position to conduct such research than outsiders: because they will have better access to the information and be better placed, because of their cultural knowledge, to interpret it. For example, measures of the ‘control factor’, and the methodology, which were used in the famous ‘Whitehall study’ in England (Marmot et al.), might not be applicable in an Indigenous family and community context.

Conceptualisation and measures of ‘quality of life’ also probably differ between cultures, at least in some respects.

An Indigenous researcher will be well placed to invent and use measures of male empowerment (‘control’) and quality of life which are congruent with the culture, values and ‘lived realities’ of his family and community; and to know best how to discover and represent information from his research.
A powerful example of such a representation communicating an Aboriginal interpretation of information is a painting made by Kumantjayi Japaljarri Spencer in 1985. In Pintupi language, he called it: Petrolu ngaatja kuyarringipayi yanangu ngurra walytjangka; translated as This petrol destroys our people and our country. It was later reproduced as one of a set of six posters which have been widely distributed and used as innovative Indigenous representations of health issues. The painting was the result of inquiries and reflections by the artist and community worker on the practices of petrol sniffing and their impacts.

A note on the poster says that:

“The painting explains how petrol sniffing infects the whole system of relationships between people and spoils the Law and the country.”

It used the ancient system of symbols of Aboriginal communities in Central Australia in a new medium to communicate information about a disastrous contemporary problem in a way that could be understood immediately throughout the region. Explanations in both Indigenous language and English of the complex understanding of the problem expressed in the painting, strengthened the message. It was the foundation document of the Healthy Aboriginal Life Team (HALT) program, which continued until 1991 (Franks, p. 14-22; HALT: Lessons from the Clever Country, p. 4-7). Similar uses of the medium have since been made by many community and health workers about a wide range of issues in the lives of Indigenous people in Central Australia.

This is Aboriginal research! And Aboriginal health promotion!

The term *research* elicits mixed feelings for many Indigenous people. They are still suspicious that it means intrusion and control by others, and misappropriation and misuse of their own knowledge. At the same time, some information and discoveries of research are valued and used by some Indigenous people, including health workers.

Some recent approaches in doing research, including requirements of complying with ethical guidelines negotiated with Aboriginal communities, and contracts between research institutions and communities, have tried to resolve the problems of control and ownership of knowledge which have given research such a bad name.

Some of the principal concerns about research are that its institutions and discourse (language and other practices) continue to exclude Indigenous peoples and depreciate their knowledge; and is often contrary to their interests and rights.
This is for the following principal reasons:

- The positioning of Aboriginal people and communities as subjects of a research activity persists to this day in some research projects.
- There is not enough opportunity for Aboriginal people to gain access to education and training in research language and practice.
- Research institutions and discourse do not recognise specialised Aboriginal knowledge and ways of ‘finding out’ as legitimate practices and content for research.
- Research institutions, and perhaps many non-Aboriginal researchers, do not recognise the authority of Aboriginal participants in a research project; and maintain their own control over the research project.
- Outsider researchers sometimes benefit from the conduct and publication of their research at the expense of Aboriginal community participants; or without any benefit to them.
- Sometimes researchers fail to communicate their findings and interpretations, and check them with Aboriginal participants.
- Research projects often fail to serve the interests and needs of the Aboriginal participants.
- Issues or questions being researched have not been defined, or sometimes even informed, by Aboriginal participants.
- Evaluation research by outsiders of Aboriginal health initiatives often fail to recognise the values of the Aboriginal participants; and favour those of government or other funding agencies, in determining whether a program has been successful; and whether an intervention has had harmful/adverse consequences.

In a recent publication: *Men’s Health: A research agenda and background report*, the following research activities in men’s health have been proposed:

“# 12. action-research projects which employ community activists and professional researchers working side-by-side on the same projects;

# 13. training programs for community based researchers;

# 14. provision for community participation at the stage of research design, not just implementation and use, through a wider use of steering committees involving community representatives and health service workers;”

*(Connell et al., 1999, pp. 5 & 11)*

To some degree at least, implementation of these proposals would address the concerns listed above; and also increase opportunities for Aboriginal males to work as researchers, if the necessary educational and financial resources are allocated; and other support provided.

There are a number of issues which have been identified in Aboriginal male health which demand research to address them.
For example, the National Indigenous Men’s Health Policy Forum in Canberra on 16-17 August 2000 identified a key result area as:

Strategic research as to why services are not used and the reasons why men aren’t more active in improving their health.

(Report to the Office for Aboriginal And Torres Strait Islander Health (OATSIH), p. 9)

Approaches to research about this issue should engage Aboriginal researchers, using culturally appropriate methodologies; and will require provision of the necessary education, training and employment opportunities, funding and other support.

The Centre for Indigenous Natural and Cultural Resource Management (CINCRM), the Cooperative Research Centre for Aboriginal and Tropical Health, and Batchelor Institute of Indigenous Tertiary Education (BIITE) could be engaged to develop research education and training programs to implement these proposals.

Indigenous males should be encouraged and supported to take up occupations as researchers.

Indigenous males, in all occupations related to health, should be encouraged and supported to include research activity in their work.
14.0 COMMUNICATION

This section raises and explores some communication issues which are relevant to the improvement of Indigenous male health.

The engagement of Indigenous males in processes and organisations to increase their control over their living situations and improve their health will require good communication amongst all participants.

A procession of Indigenous males arrived at the inaugural session of the 3rd National Men’s Health Conference in Alice Springs in October 1999. They had marched through the town and were joined by many others along the way - Indigenous women and children, other non-Indigenous people; and even some bureaucrats from Department of Health and Community Services!

They presented a manifesto of claims of Indigenous males to the opening session, which had been developed by the 1st National Indigenous Male Health Convention at Ross River, which preceded the Conference.

The manifesto was accepted enthusiastically by the National Conference.

Participants had already been welcomed by Indigenous traditional owners of the site of the Conference in dances, song and speeches.

These powerful expressions of Indigenous males’ interests and concerns about their health set the tone of the whole Conference: in particular the potential sense of community amongst all males in defining and advocating their special health issues; including the many cultural, economic and sexual variations amongst them.

Everyone at the Conference heard and understood this message from Indigenous males. They were also stirred to stronger commitment to define and address their own issues.

Many other Indigenous men contributed their special experience and knowledge in their presentations and conversations throughout the Conference. Much was learned by all participants from one another.

At the closing session of the Conference Ken Lechleitner affirmed the unity of all males in pursuing an agenda to improve their health. He spoke of the possibility of men of all cultural backgrounds joining together in the journey towards better health: and their shared relationships to country. He recommended to the participants who would soon depart from Alice Springs that they read carefully the mural at the airport by the great artist Clifford Possum Japaljarri; and take home its message of the consequences of disharmony between men, their cultural law and their environment. Ken invited everyone at the Conference to join with Indigenous peoples to create a new unity amongst males and share the special knowledge of country and culture of Aboriginal men.
Ken’s address to the Conference inspired everyone present. Many spoke of their new insight and gratitude for the contribution of Aboriginal men to the conversation of the Conference.

At a public and political level, these events are examples of good communication: achieved by the initiative of Aboriginal men.

They used an opportunity created by a cultural event which was familiar to other non-Indigenous men (a conference), a form of protest and demand (a march), workshop presentations, and formal addresses at plenary sessions, to communicate their experience, interests and concerns to others. They did so in their own ways - ways which were congruent with the values and forms of their own culture: ‘adaptions’ to a new, contemporary situation.

It worked.

This was successful communication.

Many other forms of communication have been invented by Indigenous people to communicate their knowledge, issues and concerns to non-Indigenous people. They include theatre, dance, music, film, literature (biographies, histories, fiction and poetry), radio; and painting and graphic arts. The works of Kumantjayi Japaljarri Spencer, Les Mirrikkurriya, Lin Onus, Alec Minutjukur and many others have been powerful examples of the latter in successful communication. (Brady, 2000; HALT, 1991)

Non-Indigenous people have not generally been as inventive and successful in communicating their knowledge, issues and concerns with Indigenous peoples.

The problem is not so much about communicating to, as communicating with.

Good communication is not merely transfer, transmission or delivery of information; or exchange. It is a creative engagement in personal encounters to achieve a new mutual understanding. This is only possible in relationships of trust, respect, care and kindness; and a sense of ignorance; and compassion of each person for the other’s suffering. All of this is well understood in Indigenous cultures. (Myers, 1988)

In such relationships, the participants are interested in each other: they pay attention, they listen. In Central Australian Aboriginal cultures, and probably others also, listening well - expressed in one language as kulinyinpa - is the mark of intelligence, rather than talking well. It could be supposed that in Western cultures it is the other way around!

In a report of research in three Northern Territory communities about local issues, resources and services, one of the informants (at Nyirrpi) said:

“Sit down and listen to Yapa. We got ideas”.

(Mitcalfe, 1994, p.19)
Many linguists and others have concentrated on mis-communication and failures to communicate between people of different cultures. This has been useful in drawing attention to the problems, and sometimes disasters, which have resulted: such as miscarriages of justice, bad medical practice and education disadvantage.

Poor communication was identified as a prominent issue throughout Mitcalfe’s report, cited above.

Some reforms have been attempted to address the problems: such as use of interpreters, cultural mediators and Indigenous professionals in courts, hospitals and schools; and cross-cultural training for non-Indigenous workers.

The difficulties in communicating between persons who have different language histories and competence, and the world views which they encapsulate, encode and express, should not be underestimated.

However what we need to learn is how to communicate well. We should concentrate our attention on the conditions and ways this can be achieved: by thinking about examples of good communication; and about ways communication can fail.

Misunderstanding is not surprising.

The more remarkable fact is that, in spite of great historical, linguistic and cultural differences, and even old and continuing injustices and enmities, human beings all have the capacity to create understandings of one another, if they care enough to do so.

This is not to say that there are not enormous communication problems which must be addressed.

For example, in his recent book, Why Warriors Lie Down and Die, Richard Trudgen writes:

“The dominant culture of mainstream Australia - a culture with a foreign language (English) and legal, economic and social systems alien to Yolngu has now collapsed in on this ancient people. Balanda culture is as confusing to the Yolngu as Yolgnu culture is to Balanda. As Djiniyini once put it: ‘Balanda and Yolgnu do not understand one another. The Balanda are confused about how Yolgnu society works and Yolgnu are confused about Balanda society. They are missing each other all the time.’

“English is a fifth or sixth language for most Yolngu, and this leaves them severely intellectually marginalised in the dominant culture’s world. Communication fails miserably between them and almost all dominant culture personnel, including doctors, teachers and bureaucrats. This communication failure creates immense suffering for Yolgnu. In the areas of health, for example, some Yolngu wait years to understand what is making them sick. Many never find out.
“The root cause of these ‘diseases of development’ can be summed up in the words loss of control.”

(Trudgen D, 2000)

Other Aboriginal communities in the Northern Territory experience similar problems. They are reported in many other documents.

This is not only a problem of not sharing competence in a common language - English. It cannot be fully addressed by training and employing interpreters; or better education in basic English literacy and speech: albeit these programs are necessary to prevent, or at least reduce, some of the inequities and injustices suffered by Aboriginal people in the practices of institutions such as police, the courts and health services.

Even within the English language there are many specialised forms which are used in various institutions and organisations: which even many users of English as their first language often cannot access. These difficulties are aggravated for Indigenous people who use Aboriginal English as their primary form of communication.

The dominant institutions and organisations in the Northern Territory in fields such as health, criminal justice, government, the courts and legal systems, business, education, welfare; all have their own special discourses. Discourses are not only the specialised language used in various fields, institutions and organisations. They also include their specialised practices, such as procedures, protocols and processes of decision making; symbols, and systems for allocating status; and preference in rewards. All of these, together, also express particular world views and ideologies.

Within these discourses there are particular masculinist variations. Indeed they are often dominant. They express and maintain the values, identities and power of males; albeit under strong challenge from women, both white and Indigenous, for many years.

Indigenous communities and their cultures also have their own discourses; and variations within them. They differ from others of the dominant cultures.

In all languages, there are also variations both within and between different age groups. They reflect differences between interests, experiences and knowledge at different ages. Children, adolescents, and adults of various ages, all have some different interests and express them differently. And ways males, at any age, may express them differ in some ways from those of females.

The achievement of understanding (good communication) is vastly complicated by all of these differences between the languages and discourses of the wide variety of groups in the Northern Territory population.

Improvement in communication amongst them will be crucial in achieving better health for all.
Cross-cultural communication education and training programs for both non-Indigenous and Indigenous workers in health and related fields should be further developed; and evaluated in a research project, with particular regard to communication efficacy, eg. by Northern Territory University, Batchelor Institute and the Cooperative Research Centre for Aboriginal and Tropical Health. They should include attention to particular male and female gender, and generation issues.

See also:

15.0 STRATEGIC DIRECTIONS

This section signposts some possible directions for future planning and action to address the issues relating to their health, which Aboriginal males in the Northern Territory have identified.

The following are some suggestions for strategic directions towards improving the health of Indigenous males.

- Whole-of-government responses; ie both within and between departments and agencies
- Collaboration between government and non government agencies
- Partnerships with communities and families
- Education, training, employment and support of Aboriginal male health workers
- Research by Aboriginal male workers in all health related fields
- Develop models for responding to Aboriginal male health issues which are congruent with beliefs, values and cultures of families and communities
- Improve access of Indigenous males to mainstream services
- Increase awareness within all institutions and organisations of the health issues of Indigenous males
- Increase the awareness of Aboriginal males of health and well-being issues
- Support Aboriginal males to increase their ownership and control over programs and services, at all levels and fazes of their development, implementation, and evaluation
- Increase the numbers and participation of Aboriginal males in the health workforce at all levels, and in all sectors.

Some progress in these directions has already been made by taking the following initiatives:

Implementation and evaluation of Healthy Male Lifestyle Program (Department of Health and Community Services, May 2000)

Establishing Aboriginal Male Health Places: facilities, staffing and management by Aboriginal males.

These initiatives provide some models for further progress.

However many others will need to be devised and carried out.
16.0 REFERENCES

The following publications have all been consulted in thinking about the issues, and writing this discussion paper. Many of them have been cited in the Discussion Paper where they are specifically relevant. They may also be used to guide further reading.


Beresford Q and Omaji P, 1996. Rites of Passage: Aboriginal Youth, Crime and Justice. Fremantle Arts Centre Press, South Fremantle WA.


