MONASH University

Indigenous Health

HEALTH KNOWLEDGE SOCIETY

Dr. Asika Pelanda

THEME II:POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

Table of Contents

Click the text to navigate to the desired page

MONASH University

Acknowledgement of Country

We acknowledge the traditional owners of this country and pay our respects to elders, past, present and future.

We also acknowledge the advice, collegiality and input of the Indigenous scholars in the Gukwonderuk Unit and Dr Pariece Nelligan at Monash University.

For more information please visit:
https://www.monash.edu/medicine/about-us/indigenous-health

PLEASE NOTE

This module contains names and images of Aboriginal and Torres Strait Islander people who have died. Material in this module contains words, descriptions and terms which reflect the views of those in the period in which the content was written/utilised, but are not considered appropriate today. The content may be distressing or traumatic for Indigenous people.

Introduction

The current module will use the term 'Indigenous' as a term which is inclusive of Aboriginal and Torres Strait Islander people. Throughout the discourse you will see the terms 'Indigenous' 'First Nations' and 'Aboriginal and Torres Strait Islander' used. Note that these terms should be capitalised.

This week we will be discussing the health of Australia's Indigenous people. We will begin by discussing the cultural richness and diversity of Indigenous people and then examine the health disparities which exist between Indigenous and non-Indigenous sectors of society. It is important for future health professionals to be aware of these health disparities but most importantly be able to interrogate why they exist. We will explain these gaps by interrogating the history of colonisation and structural discrimination in our country.

Kunmanara Mungkuri
Puṉu (Trees) 2020
acrylic and pigmented ink on linen
Puṉu (Trees) is one of a number of ink and acrylic on linen paintings, and works on paper, created by the celebrated senior Yankunytjatjara artist that acknowledge the significance of trees in Aṉangu culture. Used to make kiti (resin glue), spear throwers, nulla nulla (hunting sticks), kali (boomerangs) and kutitji (shields), or for windbreaks, shelter and fire, trees for Mungkuri 'are our culture ... Our ancestors—those who have passed—were using our trees. This is all our culture.' His paintings, like the trees he depicts, hold Tjukurpa (ancestral stories) and are a form of passing on the culture that he himself learned from senior men.

Learning objectives:

1. Explain the term ‘Indigenous people,’ in the context of the United Nations’ principles of self-identification and a strengths-based perspective.
2. Identify and analyse the unique health risks and determinants of health related to Indigenous populations
3. Compare and analyse the disparity in health status between Indigenous and non-Indigenous Australian population
4. Outline key government initiatives related to Indigenous health in Australia
5. Assess the progress of the targets (benchmarks) of the Closing the Gap strategy
6. Analyse the way in which health professionals and general societal behaviour, biases and attitudes affect access to health care for Indigenous people

KEY CONCEPTS:

- Social and structural determinants of Indigenous health
- Structural discrimination
- Cultural safety continuum

Diversity Within Diversity

The Indigenous people of Australia have the longest continuing culture of any people on earth with 50 thousand years of human settlement.

Furthermore, Indigenous people demonstrate huge diversity within the continent of Australia with approximately five hundred nations

and two hundred and fifty languages across the country.

Below is a map which shows many different and distinct groups, each with their own culture, customs, language and laws. It is not intended to be exact or have fixed boundaries.

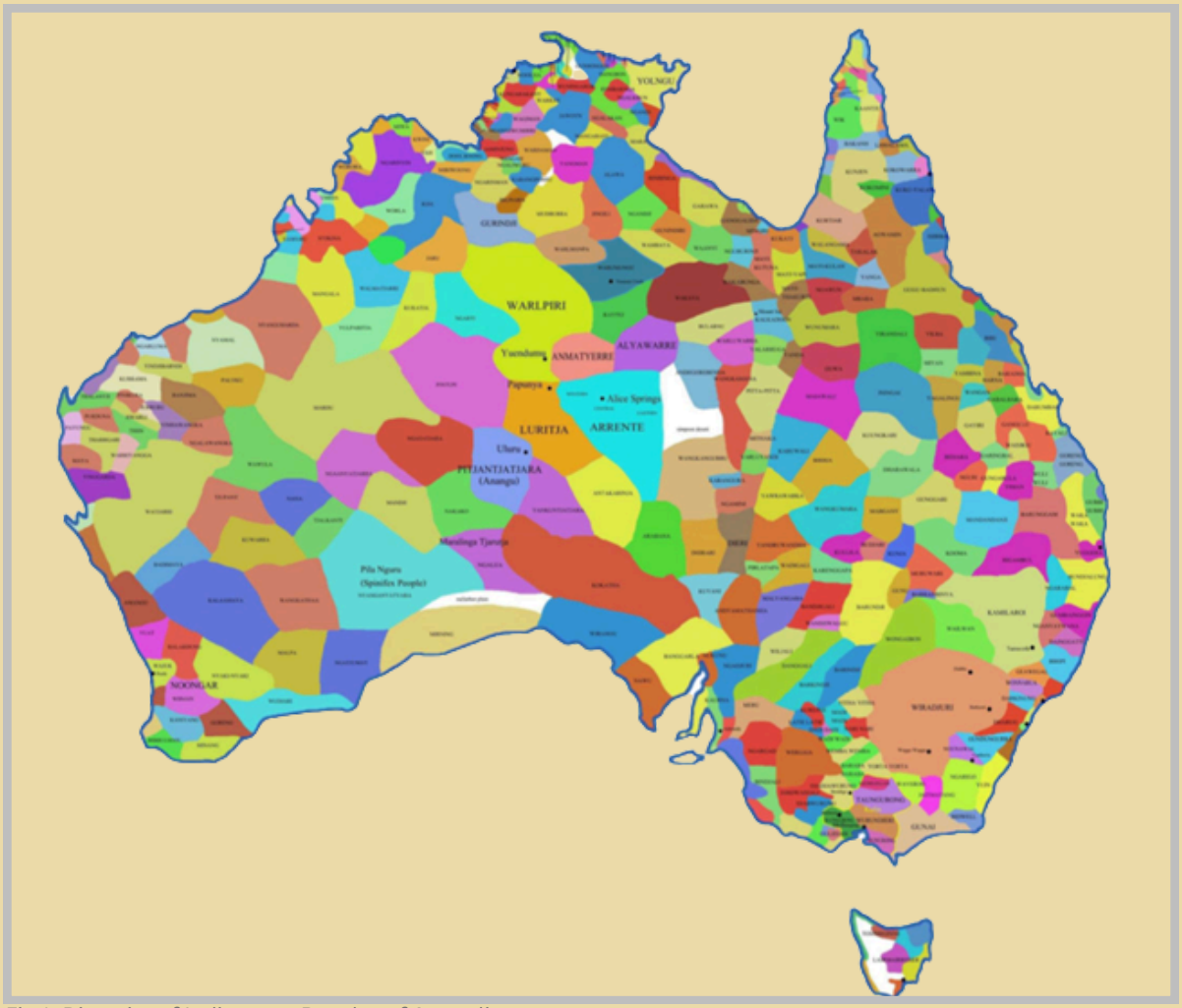


Fig-1: Diversity of Indigenous Peoples of Australia

Cultural exchange also occurred between and within nations in the form of “Songlines”. In **Songlines** (also called dreaming tracks) are living, oral knowledge systems that link people to their Country, ancestors, and community identity.

Songlines are a source of knowledge-keeping that are maps or routes of cultural exchange instructing on social behaviour, gender relations, trade and the importance of Country.

Watch the following video on Song Lines:
https://www.youtube.com/watch?v=kVOG-RKTFIo

Indigenous peoples have a longstanding tradition of oral history, in which knowledge, laws, cultural practices, and histories are passed down through storytelling, song, ceremony, painting, and dance. These forms of expression are central to the transmission of law, identity, and collective memory across generations.

Unlike written records, oral histories preserve the Indigenous worldview and lived experiences. In many cases, the “record books” present a dominant version of history that omits, marginalises, or distorts Indigenous experiences. Indigenous voices and interpretations of historical events are still striving to be recognised and validated within mainstream education, media, and historical scholarship.

Understanding this context highlights the importance of **truth-telling**. Truth-telling is a process that seeks to provide a more accurate and complete account of Australia’s history, recognising both the strengths and contributions of Aboriginal and Torres Strait Islander peoples and the injustices they have endured. It acknowledges the ongoing impacts of colonisation, including social, economic, and health inequities, and is essential for advancing reconciliation, justice, and self-determination.

This bark painting depicts Garraŋali, a sacred site of the Maḏarrpa clan where the ancestral Bäru (crocodile) nests. The artwork encodes ancestral stories, showing the events in which Bäru was scarred by fire after an argument with his wife, Dhamiliŋu. These events explain the distinctive skin of the crocodile, its fear of fire, and its habit of wallowing in water. As an important ancestor of the Yirritja moiety, Bäru also named areas of land and established social and spiritual connections for the Maḏarrpa people, linking people, Country, and sacred sites.

The painting incorporates elements of fire and water, reflecting the coastal and inland landscapes of Garraŋali, where freshwater springs meet tidal surges to create fertile brackish waters. These waters are considered sacred, containing the souls of the Maḏarrpa, and the site itself is protected through ancestral presence and the continuing power of Bäru.

As with other bark paintings, this artwork is a repository of knowledge, encoding the social, cultural, and spiritual structures of Maḏarrpa life. It communicates rules for relationships, ancestral law, hunting and harvesting practices, and the locations of sacred sites, all of which continue to be maintained and respected today. In this way, the painting exemplifies how Aboriginal art functions as both a historical record and a living source of cultural knowledge, linking past and present.

Complex Social Organisation and Kinship Structures

Indigenous people have complex forms of kinship and social organisation as shown in Fig-2 on this page.

In some areas knowledge of constellations or star formations reflect patterns of social relationships. Fig-3 depicts Arrente and Luritja 'skin groupings' – which determine marriage lines – based on constellations of Southern Cross.

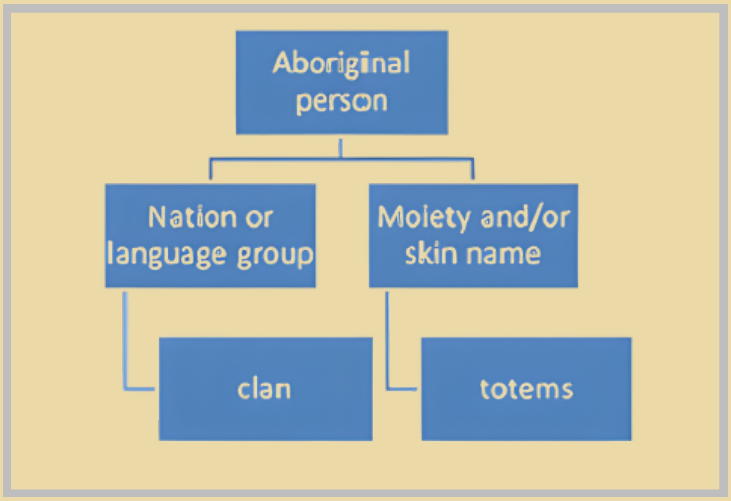


Fig-2: Social Organisation and Kinship Structures

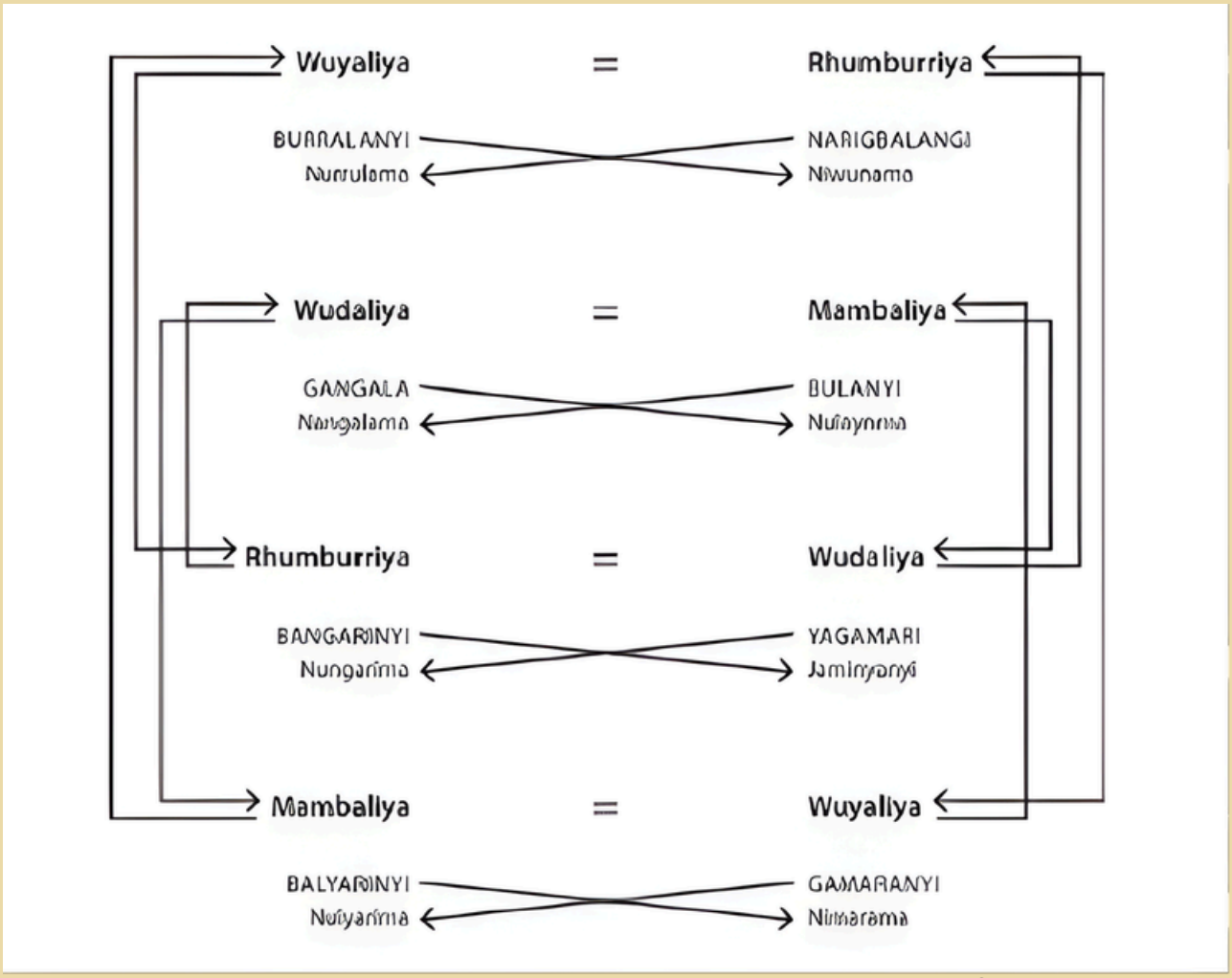


Fig.3: Arrente and Luritja 'skin groupings' which determine marriage lines based on constellations of Southern Cross

The Dreaming

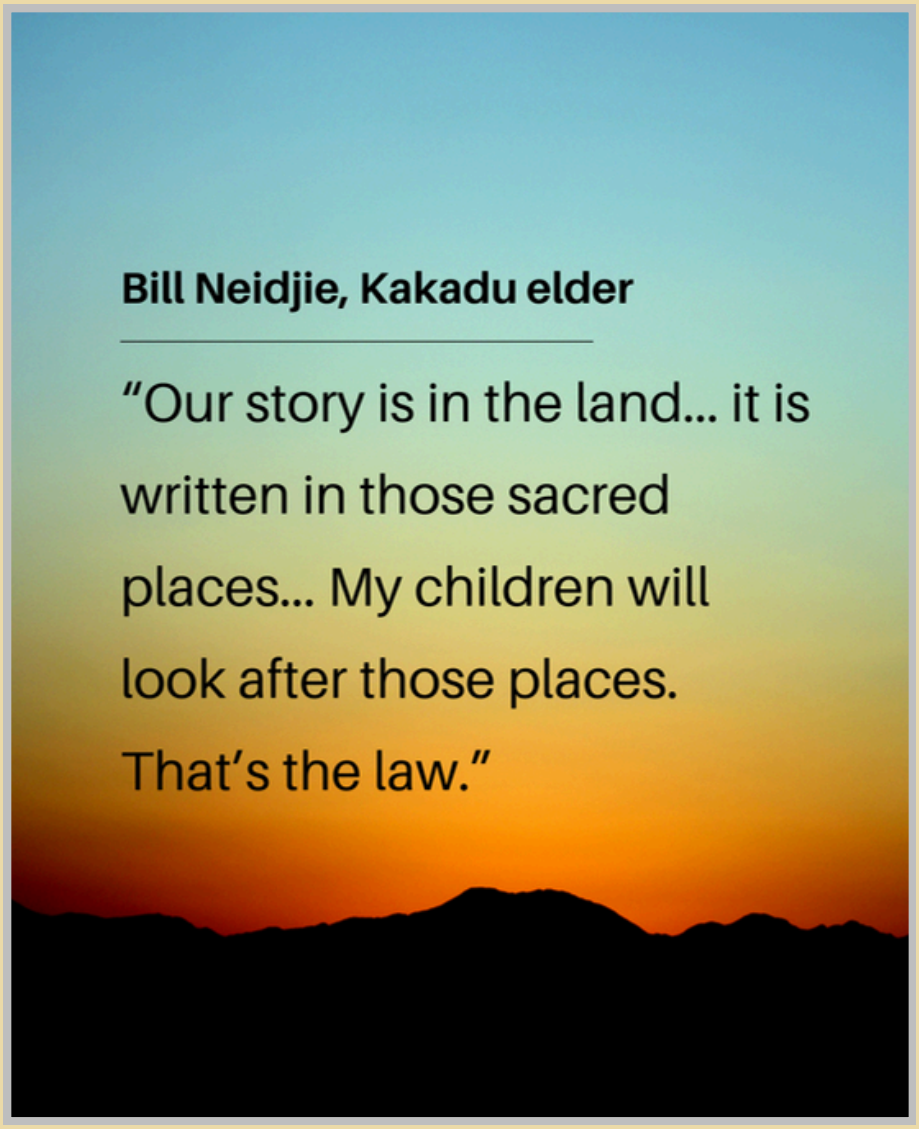
The Dreaming is a comprehensive and ongoing Indigenous world view that sees an intimate inter-connectedness between the natural and spiritual world, past and present, ancestors, people, stars and land.

The Dreaming' or 'Dream Time' is an oral history of the world and its creation as told by Aboriginal and Torres Strait Islander people. Indigenous spirituality is deeply affected by these sacred stories about ancestral beings which moved across the land and created life and significant geographical features.It explains how the land, living beings,

language, customs, laws, ceremonies, and social relationships came into being through the actions of ancestral spirits who emerged from the earth, sky, and waters and shaped the continent as they travelled.

These ancestral beings also established the rules for how people should live, interact, hunt and gather, and maintain Country. The land itself, including its rivers, mountains, and sacred sites, carries the imprints of these ancestral journeys and is understood as alive with spiritual life force.

This knowledge guides everyday practices, social roles, moral behaviour, resource use, identity, and connections between people, animals, and the environment. Learning about The Dreaming is a lifelong, structured process that builds responsibility, authority, and cultural belonging, illustrating how deeply it informs law, kinship, spirituality, ecology, and the ethical foundations of Aboriginal life.



Dream time sisters by Colleen Wallace Nungari
Colleen's most renowned artworks depict the 'Dreamtime Sisters' (Irrernte-arenye), ancestral spirits of the Eastern Arrernte people who are believed to protect significant areas of land, including sacred and ceremonial sites. Colleen's country, Arnumarra, lies northeast of Alice Springs in Central Australia and is her grandfather's country. She explains that the Dreamtime Sisters were once living people, her ancestors, who now watch over the land and its people. Through her paintings, Colleen uses the traditional dotting techniques of the Central and Western Desert combined with delicate linework to show the sisters dancing the awelye (women's ceremony) as they hover above and guard sacred sites. Her artworks are highly valued for both their cultural significance and artistic skill, serving as a visual expression of her people's knowledge, traditions, and ongoing connection to Country.

Indigenous Health Disparities

A health disparity describes a preventable difference in the burden of disease or opportunities to achieve optimal health. It is used to describe a health situation which is not equitable.

In your careers you will have a look at a lot of numbers which describe health and disease (quantitative data). This data is useful in understanding which diseases affect which populations disproportionately so that we can create focused interventions to improve health outcomes. Importantly, every time you see data, you should always consider systemic and structural factors at play which contribute to this data.

Across many health indicators, Indigenous Australians remain disadvantaged compared with non-Indigenous Australians.

Aboriginal Australians have a life expectancy 8.8 years lower for males and 8.3 years lower for females than non-Indigenous Australians.

Health inequities exist across a broad range of communicable and noncommunicable diseases including: diabetes, ischaemic heart disease, trauma, cancer, TB, HIV and Pneumococcal disease.

Rheumatic heart disease (caused by Group A streptococcus) is 37 times higher in Indigenous populations in the Northern territory, 167 times higher for Indigenous populations in Queensland and 630 times higher in Western Australia.

Other important issues include eye disease like trachoma; ear disease (e.g otitis media); asthma and infectious diseases such as TB, Hepatitis B and C, Haemophilus influenzae, pneumococcal disease and meningococcal disease which all occur at significantly higher rates within Indigenous populations.

While there have been improvements in the health and wellbeing of Aboriginal and Torres Strait Islander populations in recent years and some incredible initiatives by Indigenous people to improve health (more on this shortly), there remains some long-standing challenges which are important for you to understand.

Historical Accumulation of Inequities

When looking at the previous data, we hope you started to consider the systemic and structural factors which would lead to this difference. The gap in Indigenous health has arisen from the accumulation of biosocial inequities over the last two hundred years.

It is useful to consider important features of historical time periods for understanding the emergence of the Indigenous health gap:

1. Displacement and colonisation
2. Segregation and frontier violence
3. Forced assimilation and stolen generations
4. Structural discrimination

Watch the following video to understand how the above factors contribute to ongoing health inequities experienced by Indigenous people today:
Chapter 1: Working with Aboriginal People: Enhancing Clinical Practice in Mental Health Care (youtube.com)

We appreciate that Indigenous history may have been taught differently in schools and some students may not have grown up in Australia so the following chapters aim to provide a historical context for these ongoing inequities.

Displacement (1788 – 1837)

At the time of the arrival of British settlers, Australia was inhabited by a diverse group of Indigenous people numbering close to 1 million.

The 'doctrine of discovery' was a European law which sanctioned the colonisation of other countries. If a country's population was:

- not Christian and
- did not demonstrate European understandings of civil behaviour, they were 'amenable' to colonisation (in other words, they could be colonised under European law).

In 1778 Arthur Phillip formed a penal colony in Sydney cove. Unlike many other colonised nations, no treaty or legal agreement was ever entered into with the Indigenous Australians.

Disease

European settlers brought communicable diseases with them, to which Indigenous people were not immune. These diseases included Smallpox, TB, sexually transmitted diseases which devastated local Indigenous communities.

Sexual violence and trafficking of Indigenous women (as sex slaves) occurred frequently which allowed for the transmission of STI's like chlamydia and gonorrhoea to women.

These diseases when untreated can lead to chronic inflammation (pelvic inflammatory disease) and often lead to infertility meaning a further decrease in Indigenous populations. In combination with the widespread sexual and physical violence these events had serious mental health consequences for Indigenous women and their families.

Physical Displacement

Land theft meant that Indigenous people were displaced from their land as well as sources of food and water. Connectedness with the land is a source of spiritual and cultural integrity for Indigenous people and this connection was violently disrupted by displacement.

Introduction of Addictive Substances

European settlers introduced substances such as tobacco and alcohol to which Indigenous populations had never been exposed.

Frontier Violence

Thousands of Indigenous people were murdered during the period of white settlement.

Segregation (1837 - 1937)

In the early 1800's after frontier violence and diseases had decimated Indigenous populations, the prevailing view among European settlers was that Indigenous populations would die out. This perspective was bolstered by belief in 'racial hierarchy' and inferiority of non-white populations.

There was also a fear that diseases which Europeans had transmitted to Indigenous communities would begin to re-enter the non-Indigenous population.

Between the ages of 1837 and 1937 each Australian State Government appointed a 'protector' of the

Indigenous people. Whilst claims were made that this was an attempt to 'palliate' a dying population, in reality during this time Indigenous people experienced state sanctioned segregation into missions and reservations. In the name of 'protection' Indigenous people were subject to near total control.

During segregation into missions and reservations Indigenous people lost freedom of movement and labour; custody of their children; control over their own property; their own names (given western names); were forbidden from speaking their own language and forced to become Christian. Indigenous people lost their identity, their culture, their community and the connection to their land.

Ideology of Assimilation (1937 - 1960's)

In 1937 at the National 'Conference of Aboriginal Welfare', Australia adopted an ideology of forced assimilation of Indigenous people into the non-Indigenous population. Despite extraordinary government sanctioned restrictions on their personal liberty, Indigenous people were expected to 'become' like other Australians.

Internationally scientific racism and in particular eugenic science was prevalent and in Australia the idea of 'breeding out the black' came to prominence. This involved 'diluting' the amount of Indigenous blood across generations by the systematic introduction of 'white skinned' sexual partners for Indigenous people.

Stolen Generations

Between 1910 and 1970 ten to thirty percent of Indigenous children (approximately 50,000 children) were forcibly taken from their mothers and fathers. This was intended to eventually lead to 'mixed lineage' children and ultimately the disappearance of the Indigenous population, culture and traditions altogether.

It is important as future doctors to have an understanding of the effects of trauma on a patient and intergenerational trauma.

Listen to the story of Sheila Humphries, a Nyoongar elder and acclaimed educator and storyteller, as she speaks of her stolen childhood, her experience of the

health system and her strength and resilience despite living within systems and structures that discriminated against her.

Please note that Sheila Humphries mentions suicide, child labour and child abuse.

My stolen childhood, and a life to rebuild | Sheila Humphries | TEDxPerth (youtube.com)

The Healing Journey - Riki Salam.

Riki Salam is an Indigenous artist who was born and raised in Cairns on Yidinji Land connected to the Torres Strait and Yalanji Country on his Fathers side and Ngai Tahu, South Island of New Zealand on his Mother's side. This artwork 'The Journey of Healing' - is based on the story of the Stolen Generations. It depicts the enduring hurt, pain, trauma and great loss, loss of identity, culture and family which continues to this day.

The ‘Aboriginal Health Problem’ 1960’s

In the 1960’s the so-called ‘Aboriginal health problem’ became a point of discussion within the public discourse. Disparities between Indigenous and non-Indigenous Australians were recognised in regards to adult and child mortality, rates of both communicable and non-communicable disease as well as a gap in life expectancy. It was only in 1967 that Indigenous people were given voting rights and in 1969 government sanctioned removal of children was repealed in all states of Australia.

The Indigenous health gap can be understood as the accumulation of inequities across 200 years of systematic displacement, violence, forced assimilation and ongoing structural discrimination.

Structural Discrimination (1960’s - ongoing)

Structural discrimination refers to a network of practices, rules and structures within society which systematically disadvantage a particular group of people whilst assisting the dominant group.

Watch the following Q&A segment where rapper, Adam Briggs, A Yorta Yorta man, talks about systemic discrimination and racism. Take note of his response and the ways in which the facilitator and other panellists respond - how could this discussion could have been better structured?

Briggs on Indigenous Disadvantage and Racism on Social Media | Q&A (youtube.com)

One form of structural discrimination is cultural blindness by health care providers. Cultural blindness refers to ignoring or dismissing the impact of cultural or structural factors which may impact an individual’s access to optimum health care.

Despite the atrocities committed against the Indigenous people, Indigenous people’s spirit and resilience prevails through the ongoing determination to continue culture, support communities and promote health and wellbeing.

Addressing Social Inequity to Improve Health Outcomes

Analysis of national health survey data shows that health inequities between First Nations people and non-Indigenous Australians are driven largely by social and structural factors, rather than biology or individual choice. Approximately 35% of the health gap is explained by social determinants of health such as income, education, employment, and housing, while a further 30% is linked to health risk factors, including smoking. The remaining 35% of the gap is unexplained, likely reflecting factors that are harder to measure, including access to culturally safe health care, racism, and connection to Country, language, and culture. First Nations people often experience reduced access to health services relative to need, due to barriers such as cost, service availability, geographic location, and a lack of culturally appropriate care. These challenges are particularly pronounced in rural and remote areas, where rates of chronic disease, preventable hospitalisation, and premature death are higher than in urban settings.

Some **key determinants as outlined by the Australian Institute of Health and Welfare** include:

- Socio-economic factors: education, employment, income
- Environmental factors: access to quality housing, healthy food and health care services
- Cultural factors: connection to Country, cultural identity, family and kinship, language and participation in cultural practices
- Historical and structural factors: colonisation, past policies of child removal in context of present rates of contact with child protection system, justice system involvement
- Health risk factors: obesity, tobacco smoking, alcohol consumption

Children in out-of-home care	Housing
In 2021-2022, 57,975 First Nations children came into contact with the child protection system (a rate of 170 per 1,000 population) - of these 13,553 children were the subjects of sustained maltreatment. The rate of substantiated maltreatment in First Nations children was 7 times as high as in non-Indigenous children (39.8 compared with 5.7 per 1,000 population).	First Nations people have less access to affordable or secure housing than other Australians and are considerably more likely to live in overcrowded conditions, or to experience homelessness. In 2021, 81% of First Nations people lived in appropriately sized (not overcrowded) housing - this was an increase from 75% in 2011. However in 2018-2019, 1 in 3 (33%) of First Nations households were living in housing with one or more major structural problems - this was a similar proportion in 2013-2014.
Employment Rate	**Adult Incarceration**
In 2021, the employment rate (the number of employed people as a proportion of the working age population) was 56% for First Nations people aged 25-64. Over a 5 year period, this is a 4.7% increase however, the employment rate remains considerably lower among First Nations people than non-Indigenous Australians (56% compared with 78%).	First Nations people experience contact with the criminal justice system, both as offenders and victims, at much higher rates than non-Indigenous Australians. As at 30 June 2022, 12,902 First Nations adults were in prison at a rate of 2,330 per 100,000 population, with 78% having experienced prior adult imprisonment. First Nations prisoners made up 32% of all prisoners.

The **Health Performance Framework (HPF)** highlights the critical role of comprehensive, culturally safe primary health care, particularly when delivered through Aboriginal Community Controlled Health Organisations (ACCHOs). Strengthening access to such services is essential for reducing the burden of disease, avoidable hospitalisations, and preventable deaths.

Importantly, the HPF recognises that health and wellbeing for First Nations people are deeply connected to self-determination, culture, family and kinship, Country, language, and participation in cultural life. These factors are protective determinants of health and central to strengths-based approaches.

Over the past decade, there have been meaningful improvements in several areas, these include

- Reduced smoking rates (including during pregnancy)
- Improved antenatal care attendance
- Higher immunisation coverage
- Improved chronic disease management
- Reductions in deaths from cardiovascular and kidney disease

However, progress has been uneven. Little or no improvement has been seen in key outcomes such as

- Infant and child mortality
- Diabetes mortality
- Avoidable deaths
- Preventable hospitalisations

Some indicators have worsened, including **suicide rates, cancer mortality, family violence-related hospitalisations for women, children in out-of-home care, and adult incarceration**.

In order to improve health outcomes for Indigenous patients and communities it is vital that social inequity is addressed. It is vital that non-Indigenous people work together with Indigenous populations to address social inequity and provide healthcare services that are tailored for Indigenous people. There have been some significant advances in healthcare provided by Indigenous people for Indigenous people. The Indigenous Australian's Health Programme (IAHP) is a central funding mechanism by the Australian government which supports culturally safe primary care initiatives, preventative services and community-led activities to improve health access and outcomes. Some programmes funded by the IAHP include Aboriginal Community Controlled Organisations (ACCOs) and Birthing on Country.

The government also supports the **Closing the Gap Framework** and the **Indigenous Health Workforce Program** which supports First Nations peoples into healthcare careers.

Closing the Gap

In 2005, the Aboriginal and Torres Strait Islander Social Justice Commissioner, Professor Tom Calma AO, urged the Australian government to commit to achieving equality for Aboriginal and Torres Strait Islander people in health and life expectancy within 25 years. The Close the Gap Steering Committee first met in 2006 and in 2008 the first targets were set. The Closing the Gap report has tracked these targets (and added new ones), releasing reports yearly since 2009.

Take some time now to examine the **2025 Closing the Gap Report** - be prepared to discuss in your tutorial.

Here is an important resource which tracks the outcome areas of the Closing Gap initiative - note the legend in the top right corner with symbols highlighting which outcomes have had good improvement and are on track, improving but not on track, no change from baseline, worsening or assessment unavailable.

As future clinicians, it is important for you to be aware of how, in particular, health related outcomes are tracking, including:

- Life expectancy
- Healthy birthweight
- Early childhood education
- Proportion of Aboriginal and Torres Strait Islander people aged 25-64 who are employed
- Rate of incarceration of Aboriginal and Torres Strait Islander adults
- The rate of Aboriginal and Torres Strait Islander children in out-of-home care
- The rate of suicide among Aboriginal and Torres Strait Islander people

Timothy Cook
Kulama 2018
earth pigments on linen120 x 120 cmMonash University Collection, Purchased by the Monash Business School 2019Accession No. 2019.29
Timothy Cook paints exclusively with natural ochres and crushed charcoal, inspired by the 'old designs' that he learnt from his elders. His paintings are strongly connected to Tiwi ceremonial practice and, in recent years, he has focused on the kulama (or yam) ceremony: a coming-of-age ritual coinciding with the harvest of kulama yams and involving a circular fire-pit and dancing circle. The circular motif that appears in Cook's Kulama paintings has further echoes in Tiwi culture. 'Kulama time' is indicated by the halo that appears around the full moon towards the end of the wet season (March – April). The moon is a potent metaphor for life and death in the Tiwi Islands.

Activity: Have a look at the dashboard and note how each of the above are tracking.

- Life expectancy: improvement but not on track
- Healthy birthweight: improvement but not on track
- Early childhood education: good improvement and on track
- Proportion of Aboriginal and Torres Strait Islander people aged 25-64 who are employed: good improvement and on track
- Rate of incarceration of Aboriginal and Torres Strait Islander adults: worsening, not on track
- The rate of Aboriginal and Torres Strait Islander children in out-of-home care: worsening not on track
- The rate of suicide among Aboriginal and Torres Strait Islander people: worsening, not on track

Aboriginal Community Controlled Organisations

An Aboriginal Community Controlled Organisation (ACCO) is a service which has been initiated and operated by the local Aboriginal community. A locally elected Board of Management oversees the service and ensures that it delivers holistic, comprehensive and culturally appropriate care. An Aboriginal Community Controlled Health Organisation (ACCHO) often has a GP, a nurse and Aboriginal liaison officer, but also can include allied health services, a paediatrician or other specialists. If you're interested in finding out more information on the Victorian Aboriginal Community Controlled Health Organisation please visit their website: **VACCHO - Victorian Aboriginal Community Controlled Health Organisation Inc**.

Watch the video below which highlights the incredible work by ACCHOs.
Indigenous Australians avoiding mainstream health and aged care services, research shows | ABC News - YouTube

Birthing on Country

Structural violence refers to systemic inequalities embedded within social, political, and health systems that limit people's access to resources, rights, and opportunities, often invisibly. In the health system, this can manifest as policies, practices, or service designs that disadvantage certain populations without explicit intent, creating barriers to equitable care.

A note:
Structural violence = the harm that results from systemic inequities (emphasises outcomes).
Structural discrimination = the systemic rules, norms, or policies that create or maintain inequities (emphasises mechanisms/causes).

In other words, structural discrimination is a driver, and structural violence is a health consequence.

In the context of birthing, Aboriginal women often experience structural violence through:

- Limited access to culturally safe maternity services, especially in rural and remote areas.
- Healthcare practices and protocols that fail to recognise or incorporate Aboriginal cultural practices and knowledge about childbirth.
- Implicit bias and racism within health services, contributing to mistrust, poorer communication, and reduced engagement with care.
- Socioeconomic and logistical barriers such as transport, cost, and the need to travel far from family and community for birth.

These systemic factors contribute to disproportionately higher rates of maternal and infant complications among Aboriginal women, including preterm birth, low birthweight, and perinatal mortality.

Birthing on Country is an international initiative created by the Molly Wardaguga Research Centre. The late Molly Wardaguga, a Burarra Elder and Aboriginal midwife played an important role in the discourse of Birthing on Country.

This global movement addresses the impacts of colonisation on childbirth services, advocating for their return to Indigenous communities and control. It symbolises providing the best start in life for Indigenous communities, emphasising that childbirth occurs on lands never ceded by Indigenous peoples. These services, recommended in national policy, prioritise community-based governance, incorporation of traditional practices, connection with land, holistic health approaches, cultural competency, and collaboration with Indigenous communities. Birthing on Country facilities aim to establish dedicated hubs, including Indigenous-owned birth centres, in line with national frameworks.

To find out more information, visit **Closing the gap for Indigenous health | Birthing on Country**

Racism and Discrimination in Healthcare Practice

Culturally responsive health care aims to address structural discrimination embedded within health systems. In clinical practice, recognising that a patient's understanding of health, illness, and care is shaped by culture is essential for safe, effective, and ethical care.
When analysing whether a health system is culturally responsive it is important to consider the following:

- **Culture of self:** (majority culture): Implicit bias within non-Indigenous health providers and services.
- **Culture of other:** (minority culture): Ways in which Indigenous culture are represented and treated within a health service or institution.
- **Institutional culture:** Structures within health systems including relevant legislations, protocols and practices which can impact health outcomes.

Racism refers to beliefs, behaviours, or systems that create disadvantage or harm based on race or ethnicity. In healthcare, racism undermines trust, safety, and quality of care, and contributes to poorer health outcomes for Aboriginal and Torres Strait Islander peoples.

Forms of Racism

- Interpersonal racism: Racism occurring between individuals, such as discriminatory language, stereotyping, dismissive attitudes, or differential treatment by healthcare providers.
- Institutional racism: Racism embedded within policies, practices, and norms of organisations or systems that systematically disadvantage certain racial or ethnic groups, even without intentional prejudice. In healthcare, this may include service models that fail to provide culturally safe care or inequitable access to services.
- Structural racism: The broader system of social, economic, and political structures that collectively produce and maintain racial inequities over time. In health, this includes the enduring impacts of colonisation, segregation, and exclusion that shape access to care and health outcomes.

Recognising these forms of racism is essential to delivering culturally safe and ethical medical care.

Institutional discrimination is a broader term that describes systemic practices that disadvantage groups based on a range of characteristics, such as gender, age, disability, or sexual orientation. In health care, this can include systems that inadequately accommodate people with disabilities, marginalise older adults, or fail to meet the needs of LGBTQIA+ patients.

While institutional racism focuses on race-based inequities, institutional discrimination captures multiple forms of systemic disadvantage. Both concepts emphasise that health inequities often arise from the way systems are structured and operated, rather than from individual intent, and contribute to unequal health outcomes across populations.

Reporting Racism in Healthcare

In Australia, racism by healthcare professionals is both a human rights issue and a professional standards issue.

- **Australian Human Rights Commission (AHRC)**- Complaints about racial discrimination can be made to the AHRC under the Racial Discrimination Act 1975. This includes discrimination, harassment, or vilification in healthcare settings. The AHRC focuses on human rights and anti-discrimination law, and complaints are handled through a conciliation process.
- **Australian Health Practitioner Regulation Agency (AHPRA)**- Complaints about racist behaviour by doctors can also be made to AHPRA, which regulates health practitioners. Racism may constitute unprofessional conduct or professional misconduct, particularly where it affects patient care, safety, or trust.

These mechanisms reinforce that racism in healthcare is not only harmful but professionally unacceptable. Doctors have ethical and legal responsibilities to provide care that is respectful, equitable, and culturally safe.

The cultural safety continuum provides a framework for understanding how clinicians and health systems engage with cultural difference, moving from approaches that ignore culture to those that actively address power, equity, and outcomes.

Refer to the MUM eBook for information on the continuum of cultural safety.

MONASH University

Indigenous Health

HEALTH KNOWLEDGE SOCIETY

THEME II:POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1