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(2007)

The Meaning of Culture within Public Health Practice - Implications for the Study of Aboriginal and Torres Strait Islander Health.

In Baum, F, Bentley, M, & Anderson, I (Eds.) *Beyond Band-aids: Exploring the Underlying Social Determinants of Aboriginal Health*.

Cooperative Research Centre for Aboriginal Health, Australia, pp. 229-238.

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Bond, Chelsea and Brough, Mark K. (2007) The Meaning of Culture within Public Health Practice - Implications for the study of Aboriginal and Torres Strait Islander Health. In Anderson, Ian and Baum, Fran and Bentley, Michael, Eds. *Proceedings Social Determinants of Aboriginal Health Workshop*, pages pp. 229-239, Adelaide.

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## **The Meaning of Culture within Public Health Practice: Implications for the Study of Aboriginal and Torres Strait Islander Health**

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### **Introduction**

The purpose of this paper is to critically examine the conceptualisation of culture within public health practice, and consider its implications in our understandings of Aboriginal and Torres Strait Islander<sup>1</sup> health status. There is no doubt that culture is a popular concept within public health, particularly in describing health differentials between populations distinguished by race, ethnicity and culture. However, this popularity is not matched by critical self-reflection upon the ways in which the concept of culture has been constructed within this space.

Interest in culture has traditionally been the domain of anthropology, sociology and, more recently, cultural studies, rather than medicine and public health. Public health literature generally offers very little in the way of meaningful understandings of the culture concept. Instead, the idea of culture tends to be employed uncritically, with reliance on assumed understandings of culture and the cultural practices implicated in health.

Although arguments around definitions and explanations of culture persist, it is not the intention of this paper to enter the debate. Hall and Neitz (1993, 4) argue that efforts to define the term would reify culture and fail to acknowledge the broadness and complexities of the concept. Fundamentally, the term culture refers to a way of life of a group of people, or society, that is shared and learned (Abercrombie et al., 2000, 83). It is not a tangible or static entity, nor is it confined to what is observable, whether that includes behaviours or belief systems. Commonly, definitions of culture tend

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<sup>1</sup> Aboriginal and Torres Strait Islander people are at times referred to as 'Indigenous' within this article. It is acknowledged that Aboriginal people and Torres Strait Islander people reflect two distinctly different cultural groups.

to emphasise the shared meanings and understandings behind what is observable (Hall and Neitz, 1993, 4-5). For example, Haviland (2002, 34) defines culture as follows:

Culture consists of the abstract values, beliefs, and perceptions of the world that lie behind people's behaviour and that are reflected in their behaviour. These are shared by members of a society, and when acted upon, they produce behaviour that is intelligible to other members of that society. Cultures are learned, largely through the medium of language, rather than inherited biologically, and the parts of a culture function as an integrated whole.

Hall and Neitz (1993, 5) suggest that culture includes "(1) ideas, knowledge and recipes for doing things, (2) humanly fabricated tools, and (3) the products of social action that may be drawn upon in the further conduct of social life". Across different disciplines, it is evident that some of these elements of culture have been emphasised more than others, that is, an archaeologist may be more interested in recovering the physical materials of a society, whereas an anthropologist may be more concerned about uncovering their meaning (Hall and Neitz, 1993, 5).

It should be acknowledged that culture intersects with many different sources of identity including age, gender, sexuality, race and ethnicity, religion, lifestyle and occupation. This paper emphasises culture within the context of race and ethnicity as the foundation for public health's imagination of Aboriginal and Torres Strait Islander culture. Of particular interest here, is the use of the culture concept as an explanation, both stated and implied, of health and illness.

In thinking about the notion of ethnicity and culture, Fenton (1999) argues that what matters most, are the markers of culture that construct group boundaries. Ethnicity is described as a social process that is often articulated through ancestry, culture, dress and language. Here, he suggests that culture is not fixed, but instead is contested and variable so that one cannot "define the people in a way that says "this people" share "this culture"" (Fenton, 1999). Yet, public health's interest in Aboriginal and Torres Strait Islander culture rarely engages in these intricacies. Instead, public health literature tends to require a sense of fixedness enabling it to measure culture alongside other 'risk factors'. Here culture becomes essentialised in the interests of rationality (Peterson and Lupton, 1996, 34) and healthism (Richmond, 2002, 200). Ahmad (1996, 190) expresses the dangers of this restricted use of culture:

Stripped of its dynamic social, economic, gender and historical context, culture becomes a rigid and constraining concept which is seen somehow to mechanistically determine people's behaviours and actions rather than providing a flexible resource for living, for according meaning to what one feels, experiences and acts to change.

We acknowledge the political complexities of representations of Aboriginality, and in particular the shifting ways in which categories like 'race' and 'culture' have been used within both academic and

popular discourses. Like Anderson (2003, 47), we fear the policing of Aboriginal authenticity, whether via an 'old' biological essentialism or a more recent cultural essentialism. Such essentialisms are woven into Australia's colonial history, exemplifying the unique political positioning of Indigeneity within the multicultural landscape of Australian society. The goal of this paper is not to assert a morally acceptable definition or use of Aboriginal and Torres Strait Islander culture, nor is it to demonstrate a definitive way in which culture might matter to Indigenous health. Instead, we wish to encourage a more critical discourse within public health around its engagement with Aboriginal and Torres Strait Islander culture.

## **Method**

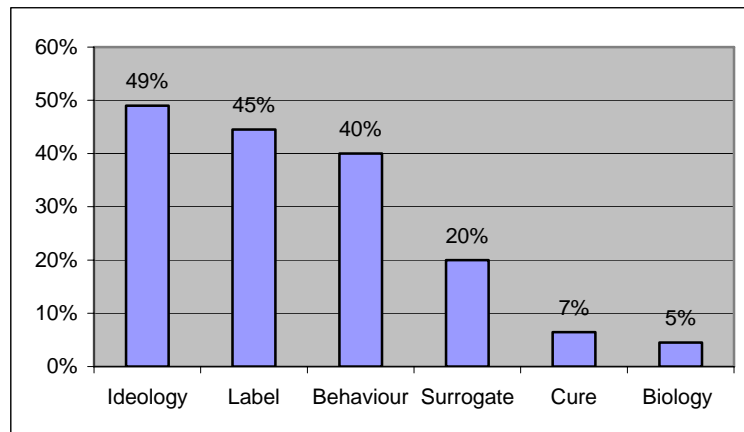
As part of this analysis, a recently constructed EndNote database of 4722 Indigenous health research papers<sup>2</sup> was searched for journal articles that explicitly used the term 'culture' in keywords, title and/or abstract. A total of forty-five papers were identified, although we reviewed many more that may contain discussions relevant to culture and health. However, for the purposes of this review we were keen to analyse only those papers that explicitly identified the term 'culture' as a keyword. These papers were analysed qualitatively to develop six themes that were then used to classify how public health research uses the concept of culture in Indigenous health research. The six broad themes are culture as biology, as label, as behaviours, as ideology, as a surrogate, and culture as cure. A discussion of each follows. Papers often invoked more than one theme area, but it appears from this analysis that Indigenous culture is most commonly referred to as either a label within epidemiological studies, as a set of belief systems or as a predicator of health behaviours (see Figure 1). This is an exploratory analysis only and further work is required to produce a more detailed study of so many research papers. Our goal here is to open up a line of inquiry, rather than to produce definitive findings.

### **Figure 1: Applications of 'culture' within Indigenous public health and medical journal articles 1994–2004<sup>3</sup>**

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<sup>2</sup> The database was collected as a preliminary project for the Burden of Disease study in Indigenous Australians by the School of Population Health at the University of Queensland. The original database was compiled by searching for publications (journal articles, reports, etc.) containing the terms 'Indigenous', 'Aboriginal', 'Torres Strait Islander', 'health', and 'disease' from the period 1994–2004 from Australian Indigenous HealthInfonet, Curtin University and databases such as PubMed, Science-Direct, Informit, Proquest, and Blackwell Synergy.

<sup>3</sup> Of the 45 articles collected, 19 were classified according to more than one theme. The most common combination was articles that were classified as both 'ideology' and 'behaviour'.



## Culture as biology

Although only 5 per cent of articles reviewed used the culture as biology theme, historically, biological explanations for health inequalities among different populations have been significant (Lee et al., 2001). Today, their significance remain, not in the validity of the practice, but rather in how the assumptions inherent within such thinking still feeds current discourses of ethnic health inequality.

A key feature of the culture as biology category, is the intersection between the terms ‘race’, ‘ethnicity’ and ‘culture’ and the associated political and intellectual climates that their use occupies (Marks and Worboys, 1997, 4-5). Historically, the term ‘race’, rather than ‘ethnicity’, was used to distinguish particular populations. Here the concept of race was thought to be biologically determined, and therefore health inequalities between different populations could be unproblematically attributed to biological differences and deficiencies (Williams, 1999a). Within Australia, biological notions of race underpinned the colonisation process. Health problems could go unnoticed or ignored, and Indigenous people could be treated as experimental objects of public health and medicine (Bhopal, 1998). Indigenous health problems were expected and legitimised upon the premise that Aboriginal people were destined to die out (McGregor, 1997).

The terms ethnicity and culture have since emerged to replace the term ‘race’ in order to avoid the “past abuses and biological connotations’ that ‘race’ often invokes” (Marks and Worboys, 1997, 5). Ethnicity and culture both draw distinctions within the human population, not by perceived biological differences, but through social, economic, religious, political and cultural points of departure (Lee et al., 2001, 38). While the terms race, ethnicity and culture have been used interchangeably, they clearly elucidate two very different meanings. However, Lee *et al.* (2001, 39) accuse epidemiological and health service research of supplementing the terminology of race, with ethnicity and culture, while still retaining biologically derived meanings in explaining ethnic health inequality.

Critics of biological explanations of ethnic health inequality also suggest that genetic factors are not significant in explaining the observed ethnic/racial variations in health (Mays et al., 2003, 85),

particularly when other possible explanatory factors are taken into account, such as social, behavioural and environmental factors (Lee et al., 2001,). Importantly, Lee *et al.* (2001:39) note:

Arguing against the legitimacy of race as a category of biomedical research is not meant to suggest that the social category of race is not real, or that race as a key dimension of stratified societies does not exist... Race is socially, not biologically meaningful; it is 'real' because we have acted as if certain people at certain points in time, were inferior.

Indeed, today, we talk less about race, and more about culture and ethnicity. But we should still question whether or not the causal pathways we now rely upon still invoke racist and/or ethnocentric assumptions about 'us' and 'them'. Certainly, by continually emphasizing how the culture of the 'other' determines ill health (Ahmad, 1996, 192), we have perhaps supplemented biological determinism with a cultural determinism that is no less oppressive in its ability to assert ideas of inferiority among already marginalised populations within our society.<sup>4</sup>

### **Culture as a label**

Culture has become a standard feature of epidemiological inquiry that sits seemingly uncontested beside 'traditional' health risk behaviours of diet, substance use, physical activity and weight (McKenzie and Crowcroft, 1994). However, in recent years the use of race and ethnicity as an epidemiological variable has been seriously challenged because of its methodological flaws and destructive consequences (Bhopal, 1997, Bhopal and Donaldson, 1998, Senior and Bhopal, 1994, Anand, 1999, Aspinall, 1997, Shim, 2002, Pfeffer, 1998, Wright, 1997).

One of the most potent arguments is that using cultural identity to explain health inequality amounts to what is termed 'black box epidemiology'. That is, despite demonstrating an association between ill health and cultural identity, epidemiological studies have still largely failed to articulate precise causal pathways (Bhopal, 1997, 1752). Instead, epidemiology trades off old assumptions around "innate characteristics related to "ethnic" or "racial" difference" (Karlsen and Nazroo, 2002), thus fuelling racial prejudice and imaginings of the uncivilised, unsanitary and contagious 'other' (Lupton, 1995).

In this instance, Shim (2002, 130) argues that epidemiology participates in racial identity formation by constructing "particular knowledge claims about the health effects of racial, class and sex/gender differences". Peterson and Lupton (1996, 55) note, that the construction of them and us, as normal/abnormal and healthy/unhealthy enables the low risk group to project their fears about "social order, death and disease" upon those deemed as high risk.

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<sup>4</sup> The intersection between racism and public health 'authority' has been shown elsewhere to be highly influential in public policy. For example, the USA 1990 General Social Survey revealed that more than half of all white people believed black people to be prone to violence, to prefer a dependence on welfare and to lack

In Canada, and elsewhere, epidemiological portraits of Aboriginal sickness and misery act as powerful social instruments for the construction of Aboriginal identity. Epidemiological knowledge constructs an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganised communities can be used to justify paternalism and dependency (O'Neil et al., 1998).

Epidemiological studies formed a predominant feature of Australian Aboriginal health discourse in the 1990s, and account for approximately 45 per cent of all Indigenous health journal articles that explicitly use the term 'culture' (see Figure 1). Despite the successes in achieving greater social and political awareness of Indigenous health inequality, Brough (2000, 80-81) has argued elsewhere that pervasive epidemiological descriptors have made it more difficult to imagine Aboriginality beyond the labels of disease and dysfunction. These depictions, while grounded in certain quantified 'facts' about Aboriginal health, are presented as uncontested truths about Aboriginal people, families, cultures and communities. Here, we can see Aboriginality constructed as pathogenic and deviant through a largely behaviourist health promotion agenda (Richmond, 2002, 198, Nettleton and Bunton, 1995, Brough, 2000).

### **Culture as behaviours**

Culture as behaviours refers primarily to the way in which health promotion and health education programs understand culture. Invoked through the discourses of risk, 'healthism' and rationality, culture here often refers to a series of unhealthy behaviours (Richmond, 2002). Understanding culture as behaviour is a common approach within Indigenous health research, accounting for 40 per cent of cultural interest (see Figure 1). It is an approach that tends to be criticised for ignoring the broader structural forces that contribute to health inequalities in favour of an individualised approach that encourages victim-blaming, and further marginalisation (Nettleton and Bunton, 1995). Nettleton and Bunton note the irony of health promotion rhetoric, which purports to empower the disadvantaged yet often benefits the privileged, a group more likely to be able to take up healthy behaviour messages. Moreover, as Jones (1994) argues:

In focusing exclusively on modifying cultural practices in black and minority ethnic groups, they both imply that such culture is deficient and also ignore wider structural deficiencies and barriers, including racism.

Pearson (1986, 53) suggests that such constructions enable the causes and solutions to health inequalities among cultural minorities to become depoliticised and individualised. Here, culture, behaviour and lifestyle become blurred, hence behavioural 'remedies' can run dangerously close to cultural 'remedies'. Jones (1994), for example, describes the varying public health responses to rickets

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motivation and will power to get out of poverty. Four out of five respondents rejected biological explanations for

in the United Kingdom amongst Asian women and the general population. He noted that when it was found to be a problem among Asian women, attempts were made to change their diet, yet when it was a problem across Britain decades earlier, vitamin D was added to margarine. In Australia, we see Aboriginality constructed largely in terms of risk, and an emphasis on associating behaviours such as smoking, drug and alcohol use, violence, nutrition and self-harm with Aboriginality (Alati et al., 2003, De Costa, 2002, Sweet, 2002, Sutton, 2001, Widders, 2003, Busch, 1998). Rarely is Aboriginal culture examined or defined in a way that highlights the positive or desirable behaviours and attributes associated with Aboriginality (Brough et al., 2004). Curiously here, the benefits of the broader health promotion rhetoric of empowerment (WHO, 1986) seem to be denied to precisely those groups within society who could most gain from it.

### **Culture as ideology**

Described as a culturalist explanation for health inequality, culture as ideology emphasises how different belief systems impinge upon interactions within the health care setting (Julian, 2003). This popular approach challenges the ethnocentricity of the biomedical model of illness by examining the different meanings and associations attributed to issues such as health service access, communication and diagnosis, and perceptions of health, illness and treatment by different ethnic populations. Durie (2003) notes that cross-cultural understandings are required because misdiagnosis and non-compliance is said to be greater in situations where the doctor and patient have different cultural backgrounds.<sup>5</sup> Chu (1998) argues that greater awareness around the differences of language, illness explanatory models, and illness management are vital to enhancing the level and quality of health care service access among ethnic minorities.

As shown in Figure 1, this approach constituted almost half of all ‘cultural’ interest in Indigenous health. It is not without its critics, however, particularly for its somewhat ironic failure to acknowledge the heterogeneity of populations (Peberdy, 1997). For example, Morgan’s (*et al*) (1997) discussion of Aboriginal philosophy and its impact upon health outcomes draws on the sweeping generalisation of ‘*the* Aboriginal perspective’. Critics suggest that these approaches rely too heavily on ‘traditional’ or ‘authentic’ representations (Brady, 1995) as well as the capacity to promote stereotypical representations and victim-blaming. As Pearson observes: “Potted guides to culture, rarely written by minorities themselves, have become a vital source of instant ‘expertise’ on these cultures, which are thought to cause so many health problems” (Pearson, 1986, 53).

These depictions often result in “a catalogue of checklists of cultural stereotypes which are regarded as essential characteristics of particular cultural/racial types” (Ahmad, 1996, 195). In this instance, health

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such phenomenon in favour of motivational and cultural differences (Williams, D. 1999).



care providers are thus enabled to engage in policing the boundaries of ethnic or cultural group membership within the health care setting according to one's compliance to the imagined checklist. Evidence also suggests that such understandings influence health care providers in a way that may result in inequitable health care treatment, which thus contributes to and/or compounds health inequality (M van Ryn and Fu, 2003, Bowler, 1993).

Rather than suggest that culture does not matter, Kelleher (1996, 83) argues that there is a need for cross-cultural discourses to engage in the "complexity of identity formation" and the interplay of both agency and structure.

[P]eople from any ethnic background will have a number of structures giving relevance to their lives, with their culture and ethnicity being only one such structure which people utilise in making decisions about how to live and how to cope with problems of illness (Kelleher 1996:84).

Certainly, there has been little attempt within Indigenous health research to elaborate possible connections with other social structures.

### **Culture as a surrogate**

The category of culture as a surrogate refers to the research literature that seeks out structuralist explanations for health inequality, often using culture as a surrogate for socio-economic status, and applying these explanations to cultural spaces as if economic processes act independently of culture (Shim, 2002). For instance, disproportionate rates of work-related injury among migrant populations might be attributed to the over-representation of migrant groups in hazardous working-class occupations (Julian, 2003, 148). Here, culture as a surrogate accounted for 20 per cent of publications collected (see Figure 1), and often emphasised the importance of socio-economic and environmental conditions upon health outcomes for Aboriginal Australians.

Theoretically, this position is often most favoured among 'anti-racists' who view public health's interest in culture as a decoy diverting attention away from the more profound issues of racism, poverty, educational disadvantage and unemployment, to name but a few (Pearson, 1986, Ahmad, 1996). Poverty is perhaps the single greatest determinant of ill health, with racism serving the cause of economic and health inequality among minority populations globally (Bhopal and Donaldson, 1998, Harrell et al., 2003, McKenzie, 2003, Sherman, 2003, Bhopal, 1998). However, there still remains a large gap in how we conceptualise the intersection between culture and poverty without having to draw on pejorative 'culture of poverty' ideas. Lacking in Indigenous health research is any substantial

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<sup>5</sup> See Humphery *et al.* (2001) for a critique of the ethnocentric assumptions embedded in the compliance notion as used in Aboriginal and Torres Strait Islander health.

theorisation or testing of the extent to which Indigenous health inequality is the product of class and/or culture variables, and particularly how these two perspectives might contribute to each other.

Williams, D (1999a) notes that while socio-economic status can explain a large proportion of racial differences in health status, race and ethnicity still have an independent effect upon health outcomes. Hunter (2000) has found that Aboriginal Australians do not witness the associated improvements that the general population experiences with increased income. Julian (2003, 148) argues for a more sophisticated approach in which we “view social location as a function of the intersection of a range of factors such as class, ethnicity, gender, age and immigrant status”. This kind of sophistication has yet to substantially reveal itself in Indigenous health research.

### **Culture as cure**

The category of ‘culture as a cure’ refers to texts that seek to demonstrate how the notion and/or practice(s) of culture may be employed to produce better health outcomes. Although culture is the most popular concept within global Indigenous/First Nation health discourses (Brady, 1995), culture as a determinant for *better* health remains unexplored in public health research, representing only 6.5 per cent of journal publications examined (see Figure 1). This limited use of culture as a health resource, rather than as a barrier to health, reflects the dominant deficit model of public health inquiry.

The idea that ‘culture’ acts as a resource for better health as been articulated in a number of different ways: from incorporating cultural symbols and meanings within health promotional material (Brady, 1995, Simmons and Voyle, 2003), asserting that a particular culture may be conducive to better health behaviours (Brook et al., 1998), that traditional cultural practices may remedy health conditions (Brady, 1995, Spicer, 2001), that strength in one’s own cultural identity may protect against or treat negative health behaviours (Chandler and Lalonde, Miller, 1999, Williams, 1999a, Yancey et al., 2002, Williams, 1999b), or that the process of examining and exploring one’s cultural identity might in itself be conducive to better health outcomes (Williams et al., 2003).

The concept of culture as treatment is most commonly found in the drug and alcohol literature regarding First Nation peoples (Spicer, 2001). Brady (1995) is critical of this approach, suggesting that it produces a “simplistic and static notion of culture”, that it fails to see culture beyond the ‘traditional’ past, that it supports common myths about Aboriginality and invokes essentialist ideas of authenticity, and that it serves to deny individual agency within alcohol treatment programs.

In his study of abstinence among First Nation Americans, Spicer (2001) noted that drinking was commonly associated with cultural degradation, and that a stronger sense of one’s own cultural identity was a common theme among those who became abstainers. However, within this study, there was not an argument for or against a specific mode of ‘culture’ or treatment, but a recognition of the

cultural meanings associated with particular health behaviours. Spicer (2001) criticises anthropologies of alcoholism amongst American Indian communities and calls for more attention to be given to cultural meanings around abstinence.

The influence of culture in positive health outcomes is being increasingly described in research among Hispanic, Mexican, and Asian populations in the United States of America. There, increased immunisation rates, and decreased drug use have correlated with cultural identity, rather than assimilated identities (Anderson et al., 1997, Guinn, 1998, Salant and Lauderdale, 2003, Brook et al., 1998). On a different tangent, in his analysis of African–American health, Williams (1999a) notes that negative conceptualisations of one’s own group have been linked with higher levels of psychological distress, alcohol use and poorer physical and mental health. Miller (1999) and Yancey *et al.* (2002) highlight links between positive racial socialisation and better health behaviours. This use of the culture concept in health research is yet to attract any real attention in understanding Australian Indigenous health.

Williams *et al.* (2003) present an interesting insight into culture as treatment by arguing that identity and culture are important individual and community resources for marginalised communities, engaging meaningfully, they suggest, with the empowerment agenda of health promotion. Here, culture is not measured according to quantifiable variables, but is instead recognised as a resource for the community; it is the process of enabling such communities to define, express and represent *themselves* that is empowering and conducive to better health outcomes.

## **Conclusion**

This rather brief overview of public health applications of ‘culture’ within Indigenous health research is not an attempt to argue for a particular version of the culture concept. Culture matters to Indigenous health because it matters to Indigenous people. Conceptually, research remains restricted to the study of cultures, and rarely engages in the culture concept itself and how it matters to health. Without this deeper reflection, culture is static and stereotypical, disguising as much as it reveals. Much of the public health rendering of Aboriginal and Torres Strait Islander culture is not concerned with how it matters to Indigenous people, but rather how it matters to risk-factor epidemiology. Culture then becomes little more than a branding device to denote research among cultural ‘others’. We have suggested a number of themes evident in the Indigenous health literature. We do not imagine these to be absolute categories and acknowledge there may be many other ways in which the culture concept is at work in Aboriginal and Torres Strait Islander health research. We are suggesting though, that Indigenous health researchers provide more critical reflection on how they use the culture concept in their work, so that a richer dialogue that resonates more fully with the lived experience of Aboriginal and Torres Strait Islander people may evolve.

Understandings of Aboriginal and Torres Strait Islander people, culture and health require an approach that acknowledges the fluidity, diversity, strength and vitality of Indigenous culture. Such an approach demands imaginings of Indigenous culture that extend beyond the stereotypical images of the ‘traditional’, the ‘dysfunctional’ and the ‘pathogenic’. Instead, we need both a deeper engagement in the concept of culture as well as a recognition of the intersections between culture and broader social, economic, environmental and political conditions that continue to entrench health inequalities.

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