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**Race and Culture in
Health Research:
A Facilitated Discussion**

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July 2003



First published in 2003 by
the Cooperative Research Centre for Aboriginal and Tropical Health
PO Box 41096
Casuarina NT 0811

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Kowal, E. and Paradies, Y., 2003, Race and Culture in Health Research: A Facilitated Discussion, Cooperative Centre for Aboriginal and Tropical Health, Darwin.

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ISBN X XXXXXX XX X

Foreword

The Cooperative Research Centre for Aboriginal and Tropical health has aimed to transform the way that Indigenous health research is conducted. It is fitting, then, that one of the last activities of the CRCATH (before it makes way for the new Cooperative Research Centre for Aboriginal Health) was the *Race and Culture in Health Research* workshop.

This workshop was, to my knowledge, the first of its kind. More than a cross-cultural workshop, and more than an anti-racism workshop, the presenters did not portray themselves as the experts providing the answers, or even suggest that answers are always possible. They succeeded in doing something much more exciting – creating a space for non-Indigenous researchers to honestly examine what they do: their motives, their aspirations, their limitations, and the political and historical structures that shape them.

This kind of learning is often subtle, and may not immediately change the behaviour of researchers. However, any changes that do occur are likely to be more honest, and more lasting, than any level of mere compliance with guidelines can achieve. And the feedback received indicates that self-reported behaviour, at least, is already changing.

Many non-Indigenous researchers working in Indigenous health try hard to conduct their research in a way that benefits Aboriginal and Torres Strait Islander people. Even for those that genuinely try, all sorts of personal and structural barriers get in the way. Workshops such as this give researchers the space and inspiration they need to appreciate the nature of those barriers, and perhaps begin to address them better.

This report is intended as a resource for others working in Indigenous health; a resource for people interested in developing a similar workshop, or a workshop with a similar audience; and a record of the workshop for participants.

The CRCATH is proud to have supported this workshop, and we hope that you find this report is stimulating, challenging and useful.

Terry Dunbar
Deputy Director
Cooperative Research Centre for Aboriginal and Tropical Health

June 2003

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Executive Summary

The *Race and Culture in Health Research: A Facilitated Discussion* is a workshop designed to create a space for people working in Indigenous health to consider the ways that they approach Aboriginal ill-health, and the differing uses of race and culture in these approaches. It was first held at the Menzies School of Health Research, Darwin on May 20-21st 2003. There were 21 participants from Menzies, the Northern Territory Department of Health and Community Services, the Northern Territory University and other organisations, and was facilitated and presented by Yin Paradies and Emma Kowal.

The workshop was prepared over the preceding 11 months, drawing from a number of disciplines including the psychology and sociology of race, Whiteness studies, critical Aboriginal studies and anthropology. The design aimed to present challenging material in a non-threatening way using a variety of media and predominantly small group work. Rather than arguing the facts of Indigenous health, the workshop asked participants to analyse the way we construct the very problem of 'Indigenous ill-health'.

The content was presented in six sessions over two days. After the 'Startup' session, where we discussed the aims of the workshop and ground rules for discussion, we presented the 'Groundwork' session, which explored the definitions and meanings of identity, race, Whiteness, racism and culture in an interactive format.

The 'Explaining Health Inequalities' session asked participants to think of all the possible reasons for various health problems, using this exercise to explore the types of explanations that researchers and others are more or less comfortable with. In 'The Cultures of Health Research' section, guest speakers gave presentations on the history of Indigenous health research, and contemporary practices of public health professionals, stimulating reflection on the nature of our work in Indigenous health.

On the second day, the workshop began by looking more closely at how 'culture' is used in various ways in 'The Use of Culture in Health Research' session. In the 'White Identity Theory' session, we asked participants to choose one of a number of statements about White identity. The discussion that resulted, and the explanation of the theory from which the statements were adapted, stimulated reflection on how non-Indigenous people interact with Indigenous people, and how they approach the task of helping to solve the problems faced by Indigenous people. In the final session, recommendations for using 'race' and 'culture' in health research were presented.

There were a number of recurring themes in the workshop discussions, including tension over emphasising either the structures that shape Indigenous people's choices, or the agency of Indigenous people to make choices. Other issues were the tensions over understanding Indigenous people as either the same as, or different to, non-Indigenous people, and the dissonance that sometimes occurs between moral principles and lived experience.

The workshop was generally very well received. Most participants felt that the workshop was well presented, well organised, and successful in presenting challenging material in a safe environment. There were mixed views about whether the workshop would have been better with Indigenous participants. Some participants thought that the workshop should be available to other people, and we have already received interest in presenting the workshop to other audiences.

1. Background & Process

Race and Culture in Health Research: A Facilitated Discussion was a workshop held at the Menzies School of Health Research in Darwin on May 20-21, 2003. The workshop was sponsored by the Development Division of the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH) and was designed and conducted by the two authors of this report.

Rationale and aims

The impetus for this workshop can be traced back to a previous workshop conducted by the CRCATH entitled *Research partnerships: Yarning about research with Indigenous peoples* which was held in Darwin on April 10-11, 2001 (Franks et al. 2002). This workshop brought together both Indigenous and non-Indigenous health researchers to ‘yarn’ about key factors in improving Indigenous health as well as the major impediments and best practice approach to communicating about research.

In one part of the workshop, participants were split into Indigenous and non-Indigenous groups and asked to consider what research projects had been effective within their own ‘cultural group’. Several responses to this exercise were illustrative of the difficulties posed for this group of non-Indigenous researchers. One participant said “I’ve only ever researched in other cultures, I have to dig deep to look at my own”, whilst others commented that “we are not very good at seeing our own culture,” and “a lot of non-Indigenous people will say they have no culture” (Franks et al 2002).

These sentiments are not unique, but are echoed in a burgeoning field of ‘Whiteness studies’ (Frankenberg 1993; McIntosh 1990). This multi-disciplinary area of study seeks to examine how being identified as a ‘white person’ within a society has “tangible, if complex, effects on systems, institutions and also individual peoples’ sense of self, experiences, and life chances” (Frankenberg 1993). One of the elements of Whiteness is that it tends to be “unmarked, unnamed, and invisible” (Frankenberg 1993), as highlighted by the above comments.

Using this as a starting point, a proposal was put to the CRCATH to conduct a workshop for non-Indigenous researchers that would allow further exploration of these notions of Whiteness. This proposal was accepted by the CRCATH Development Division in June 2002.

Soon after the concept proposal was accepted it was realised by the authors that an exclusive focus on Whiteness may be too confronting, and would not seem relevant enough to researchers to justify their attendance. As a result the workshop shifted in its focus from an explicit discussion of Whiteness and instead widened out to encompass notions of race and culture more generally, and planned to use materials and theory of direct relevance to research practice wherever possible.

Several studies from the literature have suggested that workshops and classes on topics of race, racism and culture can be beneficial to participants (Baron 1992; Cohen 1995; Gamble 1999; Jakubowski 2001; Kobayashi 1999; Lawrence & Tatum 1997a; Lawrence & Tatum 1997b; Locke & Kiselica 1999; Wilson 1999). Elements and approaches that have been found to work best have included valuing flexibility and diversity, avoiding an authoritarian style, and addressing emotional issues (Cohen 1995; Kobayashi 1999). It is also important to create a safe space of trust, support, acceptance and respect (Baron 1992;

Kobayashi 1999; Locke & Kiselica 1999), use multidisciplinary (Gamble 1999), action-oriented (Jakubowski 2001) approaches and multimedia formats (Cohen 1995; Gamble 1999), remain neutral (Gamble 1999), use free discussion (Gamble 1999; Jakubowski 2001), critique, analysis (Jakubowski 2001; Wilson 1999) and self exploration (Locke & Kiselica 1999).

Taking into account this evidence from the literature, we decided that it would be best to use a self-reflective, experiential, and participant-focused approach to learning in the workshop rather than a didactic, presenter-focused, one-way pedagogy. In this way participants could use problem-based and experiential learning techniques to reach their own conclusions through exploring and critiquing appropriate materials, as well as self-reflection.

There was some concern that recruiting people for the workshop would be difficult given the confronting nature of 'Whiteness' as a subject. However, broadening out the scope of the workshop to include issues of race, racism and culture and the construction of Indigenous health as a discourse is thought to have decreased recruitment difficulties which did were not significant in practice. It was also envisaged that workshop participants would have considered issues of 'race' and 'culture' to some extent as part of their work or personal lives and that the workshop could help increase understanding of these complex issues, rather than simply introduce them to people for the first time. As one advisor to the workshop put it, this was unrepentant 'navel-gazing.'

The overall aims of the workshop were two-fold: (i) to encourage researchers to consider the ways that they approach Aboriginal ill-health, and the differing uses of race and culture in these approaches and; (ii) to examine the implications of these different constructions of Aboriginal ill-health for research practice.

Workshop Planning

A broad-ranging literature review was conducted within the fields of Whiteness studies, anti-racism, education, critical Aboriginal studies, and sociology of race and culture from July 2002 to March 2003. During this time the authors also consulted with a number of social scientists and staff at the CRCATH to obtain their ideas as to the best approach and content for the workshop (see *Acknowledgements* for a list of people consulted).

From the time the first draft of the workshop plan was written in January 2003, twelve versions were produced before the final plan was used. During this process of expansion and revision, the document went from 4 to 20 pages, and the final document cited 49 references (although the workshop booklet and the materials used drew from many additional sources).

All sessions were devised in the first plan, apart from Session 4, which was added in around March 2003, when we realised that discussion of the cultural explanations for ill-health were too complicated to cover as a part of Session 2. About 6 weeks before the workshop, we planned in detail the timing of the parts of each Session, at the same time as clarifying the content in detail. Due to the particularly sensitive nature of issues around 'race' and 'culture', the order of sessions was designed so that material we considered to be more confronting was covered in the latter part of the workshop.

Workshop Audience and Recruitment

During the planning of the workshop it was implicitly assumed that those attending the workshop would be non-Indigenous (and also White), and the workshop content was pitched accordingly. Others have noted that workshops with members exclusively from the 'dominant group' allow participants to focus on issues of their group and accept responsibility for it; explore their own attitudes and behaviours in an atmosphere of openness, trust and support; and not run the risk of embarrassing or offending 'minority' group members, or exploiting them as teachers (Chambers & Pettman 1986 p. 42).

From our reading of the literature and our experience, we knew that a deliberately 'cross-cultural' mix would result in a very different type of workshop. Although a 'cross-cultural' workshop is very important and useful, it would also increase the risk of non-Indigenous people looking to Indigenous people as the 'experts' on culture and race, and so not say anything they thought might be interpreted as racist or offensive. These elements would have detracted from the purpose of this workshop.

Having noted this evidence from the literature, however, we nevertheless couldn't justify the deliberate exclusion of Indigenous people from the workshop, and we advertised it as open to all CRCATH core partner employees.

In Feb 2003 an advertisement for the workshop was distributed via the CRCATH network seeking expressions of interest from people involved in Indigenous health research to attend the workshop. By the middle of April, 25 people had returned their expressions of interest. All of them were non-Indigenous (although not all of them were White).

Close to the time of the workshop itself, a few Indigenous people did express interest in attending, however by that time it was clear that all the other participants would be non-Indigenous. Those Indigenous people were briefed by the Indigenous facilitator (YP) to inform them of the current make-up of workshop participants and in the end, those people did not attend the workshop.

A two page workshop program outlining the aims of the workshop, and a brief summary of what would be covered in each of the sessions, was sent to potential participants (see the next section for further details of the workshop program). We also offered to brief individuals who had further questions about the workshop, but no participants requested a briefing (although three of the participants had been consulted about the content during the development of the workshop plan).

Resources

As a result of our literature review, we were able to select a range of different resources to include in the workshop resource book and to utilise during the workshop. A variety of media formats featured in workshop materials including newspaper articles, videos about health promotion and the history of Indigenous health research, interactive computer exercises, play readings, as well as pictures and diagrams (see References and Appendix for some examples).

Each of the two authors were paid for 25 full-time equivalent days in which to design, develop and conduct the workshop, including consultation with key stakeholders and writing of this workshop report. This allocation of time greatly underestimated the actual time taken to complete all these activities,

which was at least 3 months full-time each.¹ The cost of the workshop including development of materials, catering and staff costs (as budgeted for) was approximately \$8,000.

Facilitation

A month before the workshop was conducted, it was suggested to the authors that a facilitator and/or rapporteur should be recruited to assist the two authors as the ‘presenters’ of the workshop. A total of nine senior health social science academics were contacted in a bid to find somebody both able and willing to fulfill this role.

Unfortunately, due to the short notice and high commitment levels of such people this was not possible. The roles of presenter and facilitator were therefore rotated between the two authors such that both spent about equal amounts of time in each role. During the course of the workshop, especially towards the end, these roles became somewhat blurred due to the dynamic and interactive nature of the workshop.

For each session, the role of the presenter was to provide the didactic components of the workshop, including information on topics, explanation of exercises and answers to content questions. The role of the facilitator was to keep time, identify and accept questions from participants, answer process questions, clarify points and arguments, diffuse excessive conflict or distress and uphold the ground rules.

It was conveyed to participants that neither of the authors wished to position themselves as ‘experts,’ but instead hoped to stimulate and guide discussion of the workshop topics as peers. It was also noted that the workshop was not designed to provide ready-made solutions, but rather intended as a space to explore the complex issues that researchers confront in their work.

The ability of the facilitators to present potentially confronting material in a non-threatening way was seen as crucial to the success of the workshop. Strategies used by the presenters included use of ‘we’ statements, that is, always including ourselves in discussion of what we do as researchers. We also tried in other ways to reduce our distance from participants, such as starting with one of the presenters as an example for the identity exercise (Session 1), and having one of the presenters perform the role of a ‘failed anti-racist’ in the skit (Session 5).

Where we made comments, we tried to use language that minimised any judgements (phrases such as ‘it has been said that...’) rather than express a firm opinion, and we tried to present a range of views. This was not particularly difficult, as the main interest of the authors (EK in particular) was to discuss and analyse the range of views that exist, rather than present any particular view.

Conduct of the workshop

The workshop was free of charge and, at the outset, was attended by 21 non-Indigenous researchers, clinicians, students and bureaucrats from the Menzies School of Health Research, the Department of Health and Community Services, Northern Territory University as well a student researcher from the University of Sydney. The majority of participants were known by the authors prior to the workshop. It

¹ As most of the literature review and program planning was done out of regular work hours, the actual time taken is difficult to quantify.

should be noted that there was significant attrition during the workshop due to other commitments of participants over the two days, with only nine people being present at the conclusion of the second day.

The workshop itself was split into seven sessions. Morning tea, lunch, and a workshop dinner were provided. At the outset of the workshop, participants chose to sit at one of four tables, each of which was allocated a group number. These tables formed the basis of the 'small group activities' which occurred during the workshop. There was some attempt by the authors to mix up the composition of each table as the workshop progressed so that different groups of individuals could stimulate more varied discussion.

Permission to record the plenary discussions directly onto a laptop computer was obtained from participants (discussion within the four small groups was not recorded), and minutes were taken by Jenny Brands and Amica Adams. Rather than verbatim transcripts, they recorded summarised versions of what was said, with an emphasis on discussion rather than the didactic components of the workshop. Consent was also separately sought for the minutes and other material arising from the workshop activities to be used by the one of the authors (EK) for her PhD research. A set of ground rules was suggested by the authors and accepted by participants without addition or amendment.

During the introduction to the workshop, participants were made aware of 24 quotes that had been placed around the room. These quotes presented a variety of opinions about notions of race, culture, identity, and public health. We asked that participants read them during the scheduled breaks, and be prepared to choose a quote to discuss during the last session of the workshop.

As the workshop progressed, it was found that there was insufficient time to cover all the material as initially intended. In response to this, the second to last of the seven planned sessions was skipped. Details on this session are omitted from the 'synopsis' section of this report but, in brief, consisted of a debate whereby each table was given a particular position that they were asked to argue for. These positions were intended to illustrate various issues, covered up to that point, in the workshop.

2. Workshop Synopsis

In this section we summarise what was presented in the workshop as well as some of the discussion that followed each exercise. The stated objectives for each session are shown in a box. The issues raised in this section will be discussed further in *Section 3: Themes and Issues*.

Session 1: Groundwork

- To create a safe space for honest consideration of complex and difficult issues for health researchers in Aboriginal health.
- To introduce and problematise key concepts of race, culture, ethnicity, Aboriginality and identity.

In this session a number of concepts, which underpin the issues presented in later sessions, were debated. These included notions of identity, race, racism & culture.

Identity exercise

People have multiple identities (Robinson 1999), and we bring all of these identities to our work in Indigenous health. We asked people to find a partner, ask them about their different identities, and report back to the group about their partner's identities. As they reported back, the identities were written up on a whiteboard. In reviewing the incredible range of identities, we explored the three levels of identity: self-ascribed (e.g. I am a vegetarian), ascribed within the group (e.g. other vegetarians recognising you as a vegetarian or not), and ascribed externally (e.g. non-vegetarians recognising you as a vegetarian, or having other labels for that identity, such as 'lettuce muncher') (Chambers & Pettman 1986).

Whiteness as an identity

One type of identity that White people may or may not self-ascribe to is that of a White person. While a non-White person will commonly identify with their non-White identity, Whiteness is often invisible, in that people do not think of themselves as 'white'. However, one's Whiteness clearly has important effects on our position in society, what we do and how others see us. It is important to note that Whiteness and non-Indigeneity are not synonymous, and many people in Australia today are both non-Indigenous and non-white.

We presented the four groups with two resources: an NT News article attacking affirmative action for Indigenous people on the grounds that it disadvantaged White people; and a list of "privileges of Whiteness" from an academic article (McIntosh 1990). In the discussion that followed, people debated whether White people were privileged or whether Indigenous people are disadvantaged, exploring how these two concepts relate to one another.

Definitions of race, racism and culture

The four groups were provided with the same three definitions of race, or racism and of culture (Table 1). We asked the groups to discuss which definition they liked the best and why. People discussed the difficulties of defining these terms, particularly the biological or physical aspects of race. 'If race is not about biology, what is it about?' was an important question asked by a participant.

Table 1: Definitions of culture used in the workshop

1. A learnt system of behaviours, including language and other systems of meaning, ways of organizing society, preferences for food, dress, leisure, aesthetics, all forms of production, and forms of cultural reproduction – what people think, what people do, and what people make.
2. A ‘template’ of behaviours within a group of people, shaping behavior and consciousness within a human society from generation to generation. Culture is bigger than the people in it. Although people can change their culture, the ways in which they can change it are determined by culture.
3. A constantly changing system of meanings negotiated between the members of a given group.

Adapted from

<http://www.wsu.edu:8001/vcwsu/commons/topics/culture/culture-definitions/bodley-text.html>

Session 2: Explaining health inequalities

- To generate a critique of the various explanations of Aboriginal ill-health which are used in research.

In this session, we asked the four groups to consider one of four health problems that afflict Indigenous communities at higher rates than non-Indigenous communities:

- 1) Chronic diseases, due to high rates of non-healthful behaviours like smoking, lack of exercise and eating fatty foods;
- 2) Renal disease;
- 3) Poor housing and environmental health; and
- 4) Poor antenatal care, obstetric and infant outcomes.

We asked the small groups to think of all the reasons that Indigenous Australians suffer these problems at higher rates than non-Indigenous Australians. We specifically asked people to include ‘politically–incorrect’ reasons, and we used examples from newspaper articles to start people off. Reasons were written on large post-it notes by each group.

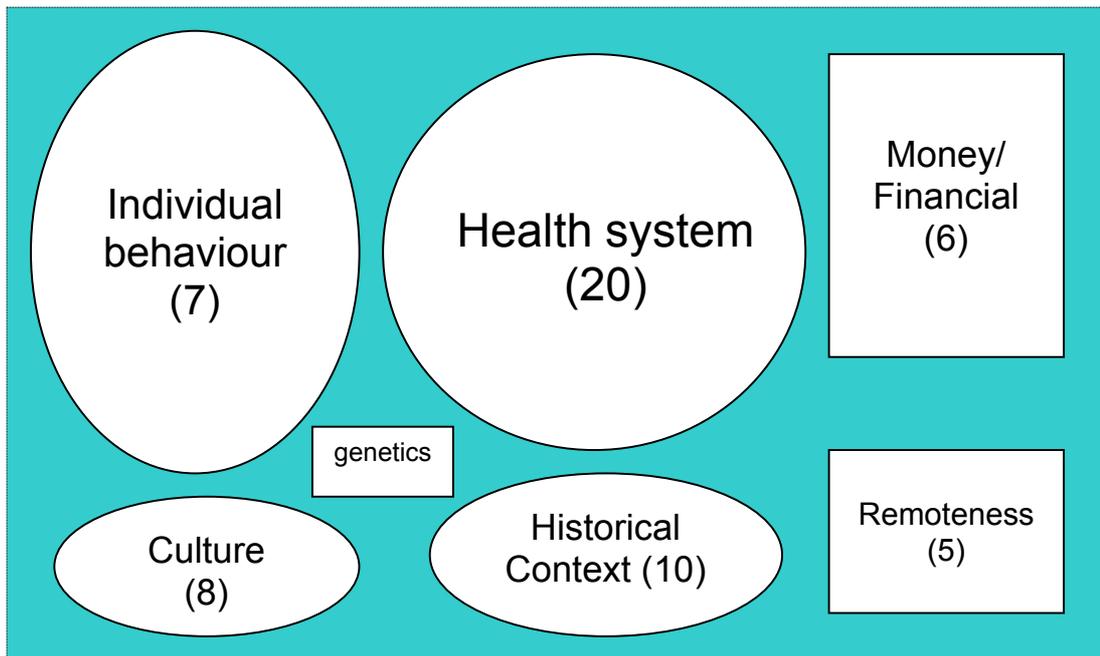
After generating many different reasons we asked the groups to come together and arrange their reasons into categories (Figure 1). Examples of reasons in each category are given below (Table 2). Non-politically-correct examples were identified by the groups that wrote them. In the table below they are marked with an asterisk.

Table 2: Reasons given for excess Aboriginal ill-health by category

<i>Category</i>	<i>Number (non PC)</i>	<i>Examples</i>
Individual behaviour	19 (12)	Having kids too young*, want to share in a non-healthful behaviour identity (such as “drinking culture”)
Culture	9 (1)	Community dysfunction, different beliefs about health behaviour.
Health system	20 (0)	Culturally-inappropriate interventions,

		poor choice of health services, cycle of disadvantage, lack of interpreters, institutional racism, lack of control
Historical Context	10 (0)	Past and present discrimination, forces changes in ways of living
Money/Financial	6 (0)	Poverty, welfare dependency
Remoteness	5 (0)	Expensive to provide care, problems with maintenance of health hardware

Figure 1: Diagram of explanations for ill-health from Session 2, non PC reasons excluded



The results showed that researchers were more readily able to discuss ‘structural’ reasons for poor health, and were less comfortable with ‘individual behavioural’ reasons (indicated by the high numbers of politically-incorrect reasons in this category). That is, they were more likely to blame the system, and were reluctant to nominate people’s actions as a cause of their ill-health. We discussed this in terms of the ‘structure versus agency’ dualism.

We then explained four categories of explanations of ill-health derived from the literature² :

- Biogenetic

² Many examples of these explanations appear in the literature on Indigenous and other ‘minority’ populations. The thrifty gene hypothesis is a contemporary example of a biogenetic explanation (Boullu-Sanchis et al. 1999; Busfield et al. 2002; Hegele et al. 1999). For examples of socio-economic explanations of health see Kaufman, Cooper, & McGee 1997, Lillie-Blanton et al. 1996, and Williams 1999. For examples of socio-cultural approaches see Kelleher & Hillier 1996, James 1993, and Salant & Lauderdale 2003 and for socio-political critiques see Bird & Bogart 2001, Krieger et al. 1993, and Paul 2002. For details of a similar conceptual model see Dressler 1993.

- Socioeconomic position, including education and ‘remoteness,’ and essentially all aspects of disadvantage not associated with Indigeneity
- Socio-cultural, which includes a number of conflicting conceptions of culture explored further under Session 4
- Socio-political, including colonisation, racism, and inadequate governmental response to Indigenous ill-health

We also discussed a study that asked the same question of American college students (Muntaner, Nagoshi, & Diala 2001), and found that they were most likely to nominate lifestyle (socio-cultural), followed by bio-genetic, and least often social (socio-political/economic) causes for health inequalities. This contrasted with the results from the exercise in this workshop, where researchers were most comfortable with socio-political and socio-economic causes, least comfortable with socio-cultural causes, and barely mentioned bio-genetic causes.

In the light of our discussion, we looked at different causes proposed in various diagrams and flowcharts about Aboriginal health.

Session 3: The cultures of health research

- To introduce the history of Indigenous health research as a tool for self-reflection on current practice, and to generate a critique of the current practices of health researchers.

We started the session with a screening of the short video, “Spencer and the King: A Tale in Two Laws” (2000), used with the kind permission of the Melbourne Museum, which presented a reconstructed conversation between Baldwin Spencer, prominent anthropologist of the early twentieth century, and ‘King Charlie’, an Arrentre elder.

David Thomas then presented a talk entitled “More than Just the Fish: An overview of the history of how Australian health researchers wrote about Indigenous people before 1970.” He started his talk with a description of the surgeon Tobias Lempriere (from the novel *Gould’s Book of Fish*, Flanagan 2002) whose character is the archetypal racist scientist of old. He then discussed the way present-day researchers tend to distance themselves from past researchers and think that they have little to learn from the past. He suggested that the past should be important to current researchers, even if only because of the importance of this history of research to Aboriginal people.

He described how interest in health research in Aboriginal populations was minimal until the 1950s. Before that time, dominant thinking was that Aborigines were ‘a doomed race’, and actions of kindness toward them were done in the name of ‘palliation’. Biological notions of race and the inferiority of Aboriginal people underpinned these ideas. Early research concentrated on blood groups in an attempt to find a biochemical marker of racial difference. There was a sense of urgency to collect data before the race died out, and an assumption that analysis could wait.

He went on to talk about the discrediting of notions of race in the aftermath of World War II, and the subsequent tendency for researchers to use terms like ‘ethnic constitutional factor’ to avoid talking about race. Science was used to support assimilationist notions of ‘biological absorption,’ reflecting the emerging view that research should be ‘useful’ for policy. It was not until the 1960s that researchers like

John Cawte proposed that Aboriginal people should be involved in, and benefit from, research involving them. However, there was strong resistance from the academy where the prevailing view was that science should be 'above' politics. Although science is implicitly saturated with politics, there persists a distaste for explicit discussion of politics, or acknowledgement of its role in the conduct of research.

In the discussion that followed David's talk, the question was raised of whether we could learn from the past sufficiently to avoid being judged negatively by researchers of the future. David commented that he was consistently asked this question every time he presented this work from his PhD research (Thomas 2001). He commented that we should approach the study of history in the same way as we approach cross-cultural research, that is, by appreciating the differences in context and world view of the past researchers.

We then asked the group to list aspects of the relationship between the researcher and the researched in nineteenth and early twentieth century health research, and also list aspects of the contemporary relationship between the researcher and the researched (Figure 2). Discussion centred around the notion of a 'doomed race,' and that consequently the main aim of research was to further scientific knowledge, collecting as much data as possible before the Aboriginal race died out altogether. However, others discussed the good intentions of researchers in the past, the respect they had for Aboriginal people and their reliance on them, at times, for subsistence.

Participants stressed that we are not so different from our predecessors, in that we also have good intentions, and that researchers are still largely in control of the research agenda. It was also noted that the 'urgent need' of the doomed race was now the 'urgent need' of the national disgrace of the life expectancy gap between Indigenous and non-Indigenous Australians. The group agreed that the main difference is that today's research has the intention to improve the health of Indigenous people, and Indigenous participation is now sought and valued.

Tess Lea, who completed her ethnography of public health professionals in (the then) Territory Health Services in 2001, gave a short talk about her work (Lea 2002). She noted that the people who choose a career in Indigenous public health are the 'young Turks', the radicals, of any organisation. They problematise issues, are keenly aware of the structural causes of ill-health, and are endlessly self-reflexive. Why then, Tess asked herself, is the work of these progressives so repetitive and conventional? She found that auto-policing and mutual regulation were important devices whereby we constantly position ourselves as progressives (paradoxically) in a conformist way. She suggested that, as a result, work in Aboriginal public health is so difficult that people do interventions in the safest way they know.

She drew a parallel between contemporary practices and the history David discussed of researchers' relentless search for a biochemical notion of race, even when the 'evidence' continuously failed to support it. Today, the continued failure of interventions into Aboriginal communities, that is, the failure of people to 'respond' to the statistics and give away their cigarettes and fatty food, is directed into arguments for why more and better interventions are needed, rather than a questioning of the whole notion of interventions themselves.

Public health professionals she studied turn themselves into knots in an attempt to 'vortex out of the mire', to escape the difficulty of trying to help people while the ever-present sinking feeling remains that you are only further colonising them. Tess suggested that people stop trying to get out of the mire, and

admit that they are white and privileged, and try their best to ‘tweak around the edges’ in order to bring about some good in the world. These are very personal processes, and institutional processes like ethical review can work against this process by ‘putting more eggshells around,’ that we have to avoid crushing, hence increasing auto-policing.

The discussion that followed centred around the power of institutions and the ability of individuals to change them. Also important was the tension between analysing what we do and continuing to do it. Tess described her ‘anthropologist hat’ that did the ethnography, and the ‘bureaucrat hat’ that says ‘okay, what will we do about this.’

In the discussion of the ‘self-perpetuating’ nature of interventions, the question was raised as to whether an intervention from within a community was still an intervention. It was argued by some that an ‘intervention’ was by definition something generated from outside the ‘community’ (a term that was also critiqued by participants).

Session 4: The use of culture in health research

- To explore and critique different notions of culture which are used in health research and service delivery.

The concept of culture is clearly very important in understanding constructions of Aboriginal ill-health, and the role of these constructions in Aboriginal health research. In Session 2, the explanations of Aboriginal ill-health under the heading ‘sociocultural explanations’ were varied and complicated. In this session, each group was given a text, and asked to analyse the concepts of culture that were employed in the text.

As an example, we showed an excerpt from a video of a White remote area nurse talking about how a child’s death from petrol sniffing did not lead to a sustained reduction in the rate of sniffing on the community because the Aboriginal people attributed the death to sorcery rather than to petrol. She describes how other Whites on the community believed that the death would show the community the ill-effects of sniffing and lead to a reduction. We suggested that this extract emphasised cultural difference. In this model, culture acts a barrier to the community experiencing a ‘normal’ response to the child’s death.

The discussion that followed centred on the ways that we might have misinterpreted the speakers’ intentions, and on trying to understand the different responses to the death that White and Aboriginal people had. It was suggested that while White people were talking about petrol sniffing, Aboriginal people were talking about death. Similarly, it was suggested that White people talk about the general notion of petrol sniffing, while Aboriginal people are interested in the particular boy involved and how he came to be there. Another person suggested that the initial reduction of petrol sniffing in the week following the death may not have been a ‘normal’ response to the death (community elders stopping children sniffing), but instead could have been due to the petrol sniffers being distracted by funeral business. Another participant questioned whether a similar death in a White community would have led to a reduction in petrol sniffing.

The groups then analysed and reported back on four other texts that used different concepts of culture. Some of the texts emphasised the loss of culture as a result of colonisation, leaving a cycle of “grief-anger-despair,” with the solution being community control. People commented on the negativity of the representations, and the absence of resilience factors. They discussed the ambiguities of the terms ‘community’ and ‘community control.’

We then presented our work on the different models of culture that exist in representations of Indigenous peoples³:

1. *Cultural non-adaptation/ rigidity*: Aboriginal culture is stuck in pre-colonial time, and some features, like the non-accumulation of material resources, are no longer appropriate for the modern world.
2. *Cultural maladaptation/ Failed enculturation*: Aboriginal cultures have taken on the worst of western culture, such as alcoholism, domestic violence, gambling and fast food, and have failed to take on the positive aspects, such as Western education.
3. *Welfare dependency*: Aboriginal people have become dependent on government support, and have no ability or desire to become economically independent.
4. *Cultural loss/Culture as therapy*: Colonisation has robbed Indigenous people of their culture, and this vacuum is filled with intergenerational grief and depression that lead to existing social problems. We must encourage the restoration of culture as a means to solving the problems of Indigenous health.
5. *Culture as difference/ cultural fragility*: We have not taken heed of the cultural differences of Aboriginal people in the provision of services to them. This prevents improvements in health outcomes, and risks inflicting additional damage on communities.
6. *Universal human rights/ anti-alterity, culture as hobby/recreation*: Aboriginal people want the same things as the rest of us. We should stop being hamstrung by political correctness and go out there and give people the information and skills they need to live a healthy and happy life.

After the different models of culture were presented, discussion centred first on the notion of welfare dependency, and whether this was specific to Indigenous people or common to lower socio-economic groups in general. There was discussion about the use of culture in the ‘Strong Women, Strong Babies, Strong Culture’ program. Some people questioned the assumption that they attributed to the program, that making women’s nurturing roles ‘official’ would make a difference to health outcomes. Another participant said that their understanding was that strong culture came from men.

One participant thought that Indigenous people were tired of having to change all the time, and were suffering from ‘a burden of change’ whilst others thought that Aboriginal people were quick to adopt new things like cars, mobile phones and ATMs. We pondered over whether Indigenous people are

³ For literature that discusses models of cultural representation, see Muecke 1992, Cowlshaw 1998, Brady 1995, Weeramanthri 1995, Brady 1999, Myers 1992, von Sturmer 1989, James 1993, Lattas 1993 and Povinelli 1997. For interesting examples of cultural representation, see Sutton 2001, Tsey 1997, Gray & Smith 1995, Trudgen 2000 and Pearson 2000.

making a positive choice to take up aspects of Western culture, or whether they are weakened by the imposition of change.

Session 5: White identity theory

➤ To introduce the concept of White identity and consider how this may influence research.

In the break preceding this session, many participants completed the Implicit Association Test (<https://implicit.harvard.edu/implicit/>), a computer-assisted test that measures our implicit preferences towards European- or African-Americans. After some discussion, we then performed an extract from the play *Spinning into Butter* by Rebecca Gilman (2000).

It depicts the difficult and ambivalent journey of a White woman in her quest to escape from her implicit racism. The excerpt here describes how Sarah realised she was still racist despite having studied African-American culture for many years and actively trying to confront her racism.

And I was living in Chicago and I was taking the train to work and it would be the same thing on the train. There'd be a dozen black people sitting quietly, going about their business, but there'd be two incredibly loud, stinky, offensive black guys at one end of the car and they'd be the ones I'd notice. And I'd tell myself not to pay attention to them. That they weren't representative of their entire race. I knew that. I kept telling myself I just had to get used to them. It was just a matter of learning...

[Sarah then describes how she realised she had a hierarchy of who she wanted to sit next to on the train despite her best intentions.]

..I felt bad about it at first. I'd get on the train and I'd wonder, What must that poor black man think, I'm so obviously avoiding him. He's a perfectly nice person. Sitting there. I see his face. He's a perfectly nice person. But I didn't want to take a chance. And, after a while, it sort of slipped my mind to feel bad about it.

From 'Spinning into Butter', a play by Rebecca Gilman (2000).

The play performance aroused discussion of the conflict between what we think we believe, and our lived experiences. People talked about their experiences of seeing themselves adopt racist attitudes when confronted with particular events. Some thought that 'being non-discriminatory isn't realistic', and that we all treat other groups differently from our own. Some talked about how it is easy to maintain non-racist beliefs when, as middle-class white professionals (such as the workshop participants), you are distanced from difficult day-to-day lived experiences. An example given was of people that own a business where 'long-grassers' camp, and having to deal with 'difficult behaviour' on a regular basis.

Another participant commented that some behaviours and beliefs were inherently racist, while other behaviours were not racist, but were the product of a number of experiences that lead one to distance oneself from certain people. Someone else said that some people, particularly long-term Darwin residents, may express racist beliefs, but are non-racist in their behaviours. Others could identify this same effect with people from their own families.

We then gave each of the four groups a set of statements to look at, and asked them to choose one each that they felt strongly about. The statements were adapted from the White Racial Identity Attitude Scale (Helms 1990). Examples of statements were: "There is nothing I can do about racism" and "I express my honest opinion when an Aboriginal person is present without worrying about whether I appear racist."

Each person then reported back to the workshop as a whole and discussed their reasons for choosing their statement.

Two participants chose “I personally do not notice what race a person is,” both of them *disagreeing* with the statement. One of them explained that although in the past they have tried to treat all people equally, they now believe it is important to be aware of racial difference to avoid offending people by acting inappropriately.

Two participants also chose the statement, “I try to help Whites understand Aboriginal people.” Both of them talked about the ambivalence and difficulty they have had in trying to talk to people with ‘entrenched [racist] views’ about Aboriginal issues. One participant picked the statement “I think we should help Aboriginal people help themselves” (discussed further below), commenting that although the statement had a paternalistic aspect to it, s/he agreed with it in a pragmatic sense.

Another participant chose two statements: “Living in a multi-racial environment is a must for me”, and “I live or would live in a White neighbourhood.” In discussing the choice of these seemingly conflicting statements, s/he explained that while it was important to have contact with people from a variety of backgrounds, when you go home you want to feel safe, and don’t want to think or worry about things.

We then explained the theory from which the statements were derived – the stages of White Identity Formation (Behrens 1997; Block & Carter 1996; Helms 1992; Leach, Behrens, & LaFleur 2002):

Contact Stage: In this stage an individual has only a superficial awareness of being White. S/he denies, is oblivious to, or avoids anxiety-evoking racial information and experiences. People in this stage accept the racial status quo of society as normal and think of themselves and others as raceless or colour-blind.

Disintegration Stage: This stage is epitomised by feelings of disorientation, confusion and suppression of information due to racial moral dilemmas or experiences that highlight the racialised and racist nature of society.

Reintegration Stage: Information is interpreted in order to idealise what is White, and denigrate that which is not White. This stage is characterised by the belief that White people are superior to non-White people and there is a denial of the existence of racism by individuals in this stage.

Pseudo-independence: Racial experiences are interpreted to fit a “liberal” societal framework in this stage. There is a view that overt racism is not acceptable but that non-White people are in fact dysfunctional, culturally deprived and inferior through no fault of their own and they should be helped to be more like Whites. It is recognised that racism exists but no personal responsibility is taken for it.

Immersion/Emersion: In this stage a person has an outlook where s/he tries to understand the ways in which they contribute to, and benefit from White privilege. This stage is a process of re-educating yourself and other Whites whilst searching for internally-defined positive standards for being White.

Autonomy: This stage is characterised by active involvement in social change, a realisation of the benefits one has been entitled to due to Whiteness, and comfort with a White identity. People have an

understanding of the complexity of oppression, have flexible responses to race, and continually strive towards non-racist standards.

After these identity stages were presented, the group looked at where the statements they chose fitted in. The largest group of statements belonged to the Autonomy Stage. One person commented that this may be due to people being in the Autonomy stage, or alternatively that people knew what they were supposed to say (i.e. political correctness). We then considered a statement created by the workshop presenters, “I think we should help Aboriginal people to help themselves,” and discussed which stage we thought it should fit into. The consensus was that it was probably a ‘pseudo-independent’ statement (although with features of ‘autonomy’), and we discussed the implications of this.

We then asked the groups to consider how a hypothetical cross-sectional survey entitled: ‘Exploring women’s experiences of childbirth at Royal Darwin Hospital,’ might be done differently from the perspective of the various White Identity Stages. Table 3 synthesises the responses of the different groups and the authors’ to this exercise:

Table 3: Examples of research methodology for each Stage of White Identity Formation

Stage	Elements of research methodology	Intervention ideas
Contact	Take a random sample of women, do not record or account for racial difference in any way.	Not applicable.
Disintegration	Identify Aboriginal women and then exclude them so as not to bias the sample.	Not applicable.
Reintegration	Research each group identically using ‘White women’ as the norm. If Aboriginal women have worse experiences, this is because of genetics, language etc. rather than any system influence.	None offered.
Pseudo-independence	Have special questions for Aboriginal women. Explain that the worse experiences of Aboriginal women are because of their ‘culture’ which does not teach them about antenatal care or to speak English well.	Recognise Aboriginal disadvantage as unacceptable. Try to change Aboriginal women to fit better in the mainstream, e.g. hire an Aboriginal Health Worker to teach them about antenatal care and hospitals.
Immersion/Emersion	Interview health staff as well as mothers. Concentrate on understanding what has made non-Aboriginal women more advantaged. Conclude that Aboriginal women are disadvantaged because colonisation has destroyed their ‘culture’, and because of racism from hospital staff.	A Participatory Action Research project to encourage staff to reverse their racist attitudes.
Autonomy	Have Indigenous investigators on the team, and probably change the research question completely. Analyse both groups examining context, uniqueness and diversity within	Work with the hospital as an institution (if they are interested) to increase the accessibility of health care at the same time as working with

	groups. Conclude that Aboriginal women have different experiences due to a range of social, cultural, linguistic & political factors.	Aboriginal women (if they are interested) to see how they can better utilise health services.
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Following the exercise, there was discussion around the idea of ‘stakeholder-initiated’ research as opposed to ‘investigator-initiated’ research. A few examples of research ‘initiated by Indigenous organisations’ were given. People commented on the fact that these examples were of ‘sophisticated organisations’ where there were Western-educated Indigenous people who knew how to attract research funds.

We discussed how the source of funds can ‘taint’ research, and how Indigenous organisations can have a variety of motivations for being involved in research, other than the research itself. An example was given of a developing country that participated in vaccine research so as to access infrastructure development, as they would not be able to afford to use the developed vaccine itself.

We also revisited the notion of community and representation: when we work with an organisation like a Health Board, is this representative of the community? If only a few individual people benefit, rather than the whole community, is this okay?

Finally, we talked about what ‘identity stage’ health research might currently be in. One participant thought it was mostly in the ‘pseudo-independent’ stage, as it was mostly trying to change Aboriginal people. However, more recently there is a lot of institutional support, or at least rhetorical support, for changing the system, which would be the ‘immersion/emersion’ stage.

Session 6: Where to from here?

➤ To consider the implications of the workshop discussions for research practices.

In this session, we presented some recommendations on the use of race and culture in health research, summarising our findings from the literature. The table below shows the findings for race that were offered to the group (Gregory 2002; Hunt 2003; Jones 2001; Thomas 2001).

Table 4: Recommendations for the use of race in health research

- Always justify the use of race as a variable in health research and define it where used.
- Acknowledge that race is a social construct not a biological determinant.
- Allow individuals to identify in more than one race/ethnicity group and endorse self-identification as the primary mode of assessing race.
- Interpret all race-related findings instead of simply reporting them without comment or simply adjusting for race.
- Consider all four types of explanations for health differentials between groups defined by race (bio-genetic, socio-economic, socio-cultural and socio-political) and explicitly measure genes/biology, class/socio-economic position, culture and racism as required.
- Acknowledge racism within health research and other institutions and be mindful of the relation of past practices to current research.

- Be mindful that doing Indigenous health research does not necessarily mean studying Indigenous people. Also study why and how non-Indigenous people have better health than Indigenous people and what interventions targeted at non-Indigenous Australians could improve Indigenous health.

Discussion of this material centred around the problems of assuming people are or are not Aboriginal based on their appearance. Other people discussed the opposite problem of dark-skinned Aboriginal people being offended when asked if they were Aboriginal. We also discussed the notion of benefit, with people saying that while researchers will nearly always benefit from research they do, Aboriginal people will usually not directly benefit.

We then asked people to read out their chosen quote from those posted around the room, and discuss why they chose it. Two people chose a quote by Aden Ridgeway that questioned the real desire of non-Indigenous people to give up their power despite a strong rhetoric of reconciliation. One participant reflected that the workshop had helped them develop an understanding of their Whiteness and the privilege associated with that, and they felt that they were reluctant to give up that privilege.

Others chose a quote about health promotion (shown below). People discussed the tension between wanting to educate people about healthy choices, whilst also giving them the right to make choices we would consider unhealthy, such as a community deciding to put poker machines in their local pub. The discussion then moved to the ways that people are restricted in making healthy choices, like shop opening times, lack of choice of services, and even health services turning people off by pushing health promotion messages.

Lifestyle interventions and social engineering are disruptive to people's lives and raise the political question - do people want to be healthy? This is not a facetious question, as there is always a price to be paid for health. For some people health is not a top priority... we must ask whether people have a right not to experience interference, and whether health promoters are in danger of becoming a 'safety police'? (Kelly and Charlton, 1992, cited in Dressler, Bindon, & Neggers 1998).

We then closed the workshop. We asked all participants present to give feedback in the form of unstructured comments about their impressions of the workshop. We explained the processes for the collation of the workshop report, and thanked everyone for their attendance and active participation.

3. Themes & Issues

There was a great deal of discussion that occurred during the workshop. Some of the content of this discussion has been detailed in *Section 2: Workshop Synopsis* above. This section will provide an overview of some of the major themes that emerged over the workshop sessions. Note that the analysis presented here is the authors', and does not necessarily represent the views of workshop participants.

Arguing facts and analysis

Health researchers work hard to try and discover facts about Aboriginal health and how to improve it. We are always trying to learn from failures to discover how to do things better, because we believe that there are solutions to the health problems of Indigenous people.

In this workshop, the presenters were asking people to *analyse* the way we think about Aboriginal ill-health, without worrying about what was right or wrong. In fact, worrying about what is right and wrong is often *detrimental* to clear analysis. Clearly, this is a departure from the ways health researchers usually function.

It was understandable, then, that participants had difficulty at times in analysing constructions rather than arguing about facts. This was particularly evident during Session 4, where the presenters asked people to analyse the way culture is constructed. After one of the presenters performed an example analysis on a video excerpt, some participants said things like "you are taking that out of context", and "that isn't what she meant." Other discussion centred on the topic of the video, petrol sniffing, and whether the interpretation given in video was correct or not. These statements try and correct misconceptions about the 'truth,' rather than analysing particular representations of, in this case, a community's response to petrol sniffing (whether that representation was 'intended' or not, and whether it is 'true' or not), and examining the effect of representations like these on the work we do.

It may be said that some of the examples used in the workshop were 'too close to home,' both in that the participants identified with the texts, and in some cases involved people who were personally known to them. It may have consequently been difficult for people to distance themselves from these representations sufficiently to analyse them (alternatively, participants may not have thought analysis was desirable). Thus, for example, when participants analysed the way an image used the concept of 'community control,' some people felt that the image was being unfairly criticised, and defended the diagram, saying it was done at a time when community control was a new idea.

Structure and agency

The notions of structure and agency arose frequently throughout the workshop. In this sense, 'structure' refers to the circumstances of our lives that we can't readily control, like government policy, availability of goods, and employment opportunities. 'Agency' refers to intentional actions or choices. Take, for example, the previous example of petrol sniffing. An explanation that emphasises structure would conclude that people who sniff petrol do not 'choose' to do it, but do it because of poverty, loss of culture, boredom, failure to provide effective education, etc. An explanation that emphasises agency would suggest that people choose to petrol sniff, and may give reasons like euphoric feelings, escape from the difficulties of life, and positive social aspects.

During Session 2, it became clear that participants were uncomfortable with attributing the causes of health inequalities to the agency or 'choices' of Indigenous people. They had to be encouraged to come up with the majority of reasons in the 'individual/behaviour' category. And among the seven reasons under 'individual/behavioural' category that were not "politically-incorrect" were tongue-twisters like 'wanting to share in a non-healthy behaviour identity.' This laborious phrase indicates the lengths to which we have to go in order to feel comfortable with the fact that Indigenous people may freely make 'morally-unsound' decisions.⁴

A further explanation of motives and definitions is called for here. In the workshop activity, the term 'politically-incorrect' was not defined, rather, its meaning was assumed.⁵ The implicit definition may have been: "A statement which would be seen by the mainstream left/progressives as racist or otherwise morally unsound." While people would have agreed that the reasons they cited were politically-incorrect, it is unclear whether all participants thought they were wrong, or were uncomfortable using them. It is likely that some participants thought the politically-incorrect reasons were not morally bad, and were not uncomfortable reproducing them. So, when we say here that people were uncomfortable with agency, we do not mean to say that all participants thought that the politically-incorrect reasons were morally unsound. What we are saying is that all participants recognised that *the (progressive/left) culture that has created these implicit definitions of political correctness and incorrectness is a culture uncomfortable with agency.*

Whether participants were participating in, or commenting on, the 'PC' culture that downplays agency, this culture is obviously in response to notions of 'victim-blaming', a term given to expressions of Indigenous agency that are generally seen as racist. Clearly it is very important to try to avoid being racist, however, this overemphasis on structure and denial of Aboriginal agency has other consequences. One participant put it this way: "in our attempt not to blame the victims we are *victimising* them."

These words are interesting for our purposes. Both terms have as their core the 'victim', one who is acted upon by structures and has little or no agency. The notion of 'victim-blaming' assumes that people are truly victims, while the term 'victimise' suggests that people's status as victims is created by external actors.⁶ Both terms accentuate structure, and minimise the agency of Indigenous people. This provides only a partial picture of the complex causes of what we call 'Indigenous ill-health.'

If we believe that Indigenous people make unhealthy choices entirely because of structural determinants, we are likely to conclude that if we are able to remove the appropriate barriers, people will naturally make healthier choices. It is more confronting to consider that Indigenous people may have the ability to freely choose, and still make the 'wrong choice' (when judged from the perspective of health researchers).

Juxtaposed against this discomfort with Aboriginal agency is the work that many public health researchers undertake, such as determining how to get people to give up smoking, wash their hands more, eat less fatty food, and do more physical activity. Although there is a great diversity in the work of public

⁴ In contrast, marginalised people themselves tend to use a complex and contradictory mix of explanations drawing readily on notions of both structure and agency (Bolam et al. 2003).

⁵ This implied definition appeared to be shared by the group as no-one appeared confused or requested a definition.

⁶ In fact, the word implies that people are 'double victims': they are victims of being labeled victims.

health researchers, it was suggested that interventions fundamentally tend to target individual behavioural and lifestyle factors (Baum 1998 p. 315-9; McMichael 1999), rather than the very 'structural' factors that were more acceptable, in explanatory terms, to workshop participants, such as poverty, racism and lack of education.

It is interesting to consider the relationship between the discomfort with Aboriginal agency and the fact that the agency of many researchers is directed at changing Aboriginal agency (i.e. behaviours/lifestyles). Are researchers particularly careful to avoid 'victim-blaming' because they, at some level, suspicious that their efforts to change Aboriginal behaviour might reinforce 'victim-blaming'? We do not attempt to answer this question here, and clearly there are many other equally plausible explanations.

One other observation of the workshop may shed light on this issue: the ambiguity with which participants approached their identity as people that try and help Indigenous Australians.

Ambiguity about researchers' agency

In the first session of the workshop, we asked participants to think of all the different identities they had. A few people talked about the fact that they worked in Indigenous health, and we tried as a group to think of a name for that identity. 'Indigenous helper', 'altruistic', and 'Southern pinko do-gooder' were all put forward (the last one facetiously), and later in the workshop the label WHIPS – White Helpers in Indigenous Projects was suggested (also at least partly in jest). The statement "I think we should help Aboriginal people to help themselves," included in the main exercise in Session 5, also aroused awkwardness with the "paternal aspect" of the sentiment.

There was a general level of discomfort about finding a label for 'us', "we whose job it is to 'do' something" {Ferguson 1990 p. 282}, an unease expressed in humour as well as the inability to come up with an adequate label. This could be interpreted as discomfort with the notion of *researcher* agency. This derives from the 'bind' that researchers in Aboriginal health find themselves in, that is, the tensions inherent in Indigenous health research.

Here we will mention just one aspect of this 'bind'. Many researchers believe they are working to benefit Indigenous people (indeed, 'altruistic' was one suggestion for the researcher identity). However, as one participant commented, "99 percent of the time researchers are going to benefit from research," as opposed to the more limited gains for research participants. There are many reasons for this (like short-term funding, lack of uptake of research findings, lack of professionally trained Indigenous researchers etc), but the effect is that some researchers may experience a *tenuous utilitarianism*, expressed as discomfort with their agency.

The discomfort with the 'helping' identity is also related to notions of Whiteness.

Whiteness

In the workshop, participants explored notions of 'Whiteness,' including intersections with class and other divisions of society. One participant talked about how they were from a "mixed race" background, and would resist being called White, as it implies an Anglo Celtic heritage.

Another participant suggested that the ‘privileges of Whiteness’ “should be called disadvantages of racism” instead, and that the list of privileges used in Session 1 was simply the way that everyone should be treated. Similar comments have been noted elsewhere in the literature (Frankenberg 1993; Lawrence & Tatum 1997b) and are thought to stem from an aversion to the guilt that can be associated with acknowledging an unfair advantage due to Whiteness. This interpretation was supported by participants who commented that you can’t call something a privilege if people aren’t aware of it, and that we shouldn’t be ‘blamed’ or considered ‘at fault’ for being privileged.

Aside from the issues noted above, people were readily able to engage with the notion of Whiteness. It was recognised that Whiteness is ‘invisible most of the time,’ and that “if everyone was white there would be a different measure for discrimination”, hence acknowledging the socially constructed nature of Whiteness as a phenomenon.

Whiteness came up again in Session 3, as we contemplated the culture of health research. We struggled with the figure of the health researcher of past and present as a White person with often good intentions, but working within a structure that gave them much power and oppressed others. One of the guest speakers suggested to the group that we need to ‘come to terms with’ our Whiteness: “admit, yeah I’m white, I’m powered, I own the discourse...not much I can do but try to tweak it, to do some little nudges and try to do good in the world.” This is perhaps an honest if lacklustre vision for White health researchers.

In another example of honesty, a participant noted in the last session that they had realised that they were “privileged because I’m white, and I don’t think I’d want to give up those things”. In our opinion, this uncommonly-expressed (but widespread) sentiment is a more useful starting-point for health researchers in general to consider their role than a denial of such privileges.

Lived experience and moral principles

Another aspect of the honesty that arose in the workshop was the contrast between our moral principles and our lived experiences. The skit performed at the beginning of Session 5 provoked the most discussion around this issue. The example of Sarah, the dedicated anti-racist who found she was still a racist, had differing effects on participants. Some participants looked and felt uncomfortable, while others shared their stories.

One participant described how they took on the racist views of their colleagues after consistently experiencing particular behaviours from people of a single racial group. Another talked of the uncertainty and fear experienced when flagged down by a group of Aboriginal men on a remote road. We agreed that there was “a difference between intellectualising and being in the situation.”

The complexity of the relationship between one’s principles and one’s behaviour was discussed in reference to ‘racist’ people we knew. Some people talked about relatives and friends who frequently said racist things, but consistently acted in non-racist ways towards Indigenous and other people.

Are ‘racists’ who treat all Aboriginal people with respect better or worse than ‘antiracists’ who patronise them, or avoid sitting next to a black man in the train out of fear? It could be argued that some ‘racist’ people are conforming to the views of their subculture, just as we conform to the ‘antiracist’ subculture

of health research. And further, that their ‘racist’ views do not necessarily affect their behaviour any differently to the antiracist ‘views’ that we conform to. Any rigid way of looking at the world may be inherently limited in responding to the diversity of difficult situations we face in our work. It is possible that a systematic denial of lived experiences for fear of being ‘racist’ is personally unsustainable, and will be unlikely to lead to clear and honest thinking.

Sameness and Difference

As discussed above, workshop participants were more comfortable with structures imposed on Aboriginal people than Aboriginal agency. Despite this, we do make statements about Aboriginal agency all the time, and the workshop was no exception.

A recurring theme in discussions of what Aboriginal people do, don’t, should or shouldn’t do was notions of sameness and difference. Are Indigenous people the same as non-Indigenous people, but with different circumstances of living, or are they different? Or are they the same, but in a different way?

An example of discussion that explored these concepts is that which followed the petrol sniffing video mentioned in the first section above. The video excerpt argued that petrol sniffing did not decrease in a community after a child died because the community attributed the death to sorcery, not to petrol sniffing.

In response to the video, one person commented that sorcery was really about social relationships. Another said that the reason for blaming sorcery is because Aboriginal people are concerned with the particular reasons for that child’s death (why did that child in particular die when others also sniff petrol?), while White people prefer to generalise (all children who sniff petrol could die like that). Yet another person thought the initial week-long reduction in petrol sniffing was due to “funeral business”, not because the petrol sniffers in the community were initially shocked into stopping.

These are complex responses. Overall, their effect is to *make Aboriginal reactions understandable*, to show that their actions, while superficially illogical, make sense when you understand their different context. In the third comment about funeral business, the speaker is saying that even when the behaviour is the same (a decrease in petrol sniffing following a death), the logic behind it is different (funeral business rather than a realisation of the dangers of petrol sniffing).

In the development literature, this is called the *utilitarian* theory, where we explain different behaviour as ‘rational’ within its own context. A competing theory is the *dualist* theory, which says that people act irrationally⁷ because of their cultural difference (Ferguson 1990: 136-7). Take the example of the observation that cars are more quickly damaged and overused on Aboriginal communities.⁸ A dualist explanation of this may be that Aboriginal people place a different value on material goods, perhaps related to their perceived semi-nomadism. A utilitarian explanation may be that Aboriginal people have

⁷ Both ‘rationality’ (and ‘morality’ discussed below) are culture-bound constructs and hence it is not suggested here that they have some ‘universal’ meaning but that they have particular meanings (and associated value) to, for instance, health researchers.

⁸ Note that we are not commenting here on whether this observation is true or not, just that it exists as an observation made at times by, for example, White staff of community health centres commenting on the health centre vehicles.

to share resources with so many kin, that when they finally get their turn, they try and get the most use out of the resource while they still have it.⁹

An important aspect of the utilitarian theory (as opposed to the dualist theory) is that it maintains the *moral similarity* of the Aboriginal person to the observer. Thus actions that may seem immoral to us, like a petrol-sniffing mother, or even choosing to smoke cigarettes, are reframed by phrases like “want to share in a non-healthy behaviour identity” as understandable: we would do the same in the same circumstances. The tendency to emphasise structural explanations has the same effect of maintaining moral identification. It is not the fault of the mother who gambles her pension while the children go hungry, it is colonisation/lack of education/grief/addiction etc.

The work of preserving moral similarity is probably necessary for the ‘helping’ work of public health researchers. It is hard to tirelessly work for people whom you cannot understand in sympathetic terms or whom you consider to be ‘immoral’. Of course, we do not prescribe that researchers start to think of Indigenous people unsympathetically. We only suggest that researchers become aware of the ‘filters’ that they use when dealing with the issues they face in their work.

⁹ These examples both emphasise *agency*. Alternatively, a *structural* explanation may contend that poorly-maintained roads and poverty that preclude car repairs are to blame.

4. Feedback & Evaluation

At the conclusion of the workshop, participants were asked to provide unstructured written feedback. We asked them to reflect on how they found the workshop, what they had learnt and how we could improve it. Participants not present at the conclusion of the workshop were also approached in person or via e-mail and asked to provide anonymous feedback to one of the minute-takers (Jenny Brands). In total, responses were received from 15 participants. In this brief report format we are unable to reproduce the comments verbatim, or to discuss all the suggestions made by both participants and others involved in the workshop. Instead, this section will provide a brief overview of the general feedback from participants, the authors and the minute-taker.

Processes and facilitation

Overall, participants had a very positive response to the workshop. They described it as enjoyable, interesting, informative, valuable, worthwhile, productive, and terrific. Participants noted that the workshop was “appropriately confronting” and challenging but non-threatening, although others thought that some participants felt intimidated or insecure at times.

Many people commented that the workshop was evidence-based, used the literature effectively and was well organised. One noted that the aims and objectives were not always clear, and suggested that there be a process for summarising discussion and analysing emerging themes during the workshop sessions themselves.

Participants valued the frank and open discussion of complex issues, the balance of didactic and interactive learning, and use of group activities. They felt that most participants were willing to share and listen, and that they gained personal and academic insight. “The last couple of days have challenged my own beliefs and values, particularly talking about Whiteness” is an illustrative comment.

One participant emphasised that the need to avoid issues of ‘right and wrong’ was a key element of the workshop process, and that a more experienced facilitator should be employed to assist in this. The issue of a dedicated facilitator in addition to the two existing presenters is a matter of on-going debate. We feel that while for certain sessions more dedicated facilitating was needed, trying to ‘resolve’ things was not always possible or desirable, and that an extra person could make running the workshop unwieldy.

It was also suggested that the length of the workshop should be reduced, although one participant thought the time went quickly. Others suggested ways in which the format of the workshop resource book could be improved.

Audience and participants

Many participants commented positively on the range of people there – biomedical researchers, social scientists, operational staff and bureaucrats – and the varied discussion that resulted. Others thought the small size of the group allowed for more complex discussions.

The issue of whether the workshop should be for non-Indigenous people, White people or a mix of people was the subject of varying feedback. A number of participants felt that having a group of

exclusively non-Indigenous participants allowed them a safe space to discuss issues without fear of being labeled racist, or of offending Indigenous participants, and that having Indigenous participants there would lead to “less robust debate.”

However, an equal number of responses indicated that having Indigenous participants would be desirable. One person commented that “Indigenous health researchers could contribute enormously to increasing my understanding of race and culture.” Another thought that the diversity of society should be reflected in the workshop participants. One non-White participant indicated that the workshop didn’t cater well for her/his needs.

It was felt by the authors and minute-taker that the issue of workshop composition in terms of Indigeneity was a difficult issue to resolve. Adapting the workshop for a ‘mixed’ group is likely to be challenging, and the value of having culturally-safe spaces for both Indigenous and non-Indigenous participants is recognised. This issue could be further explored by conducting future workshops for ‘mixed’ Indigenous/non-Indigenous groups.

It should be noted that while none of the participants were Indigenous, one of the presenter/facilitators was. While the involvement of the Indigenous author (YP) is seen by the authors as vital to the legitimacy and success of the workshop, this author felt that his Indigeneity was not a significant feature of the interactions during the workshop. Thus the presence of an Indigenous presenter did not ‘constrain’ discussion as one might have feared. This may have been related to the fact that the author’s identities as an academic and professional researcher are strong, and may have shaped the participants’ reactions to him more than his Indigenous identity.

It was noted that the workshop was pitched very much at an academic audience and that catering for non-academic audiences would require further work in terms of workshop content. This would not imply a ‘dumbing down’ of the content, but some changes to language and style.

The authors were concerned about the levels of workshop attrition which seemed to be due to heavy workloads and other scheduled commitments. It was felt that having the workshop on-site (for most participants) and not charging attendance fees may have added to the attrition rate (although it is unclear whether the attrition rate was higher than one would expect for this type of workshop).

Content

There was generally positive feedback regarding the content of the workshop. Participants found most of the sessions interesting and effective. The sessions singled out for praise were the identity session that opened the workshop, and Session 3, which included David Thomas and Tess Lea’s presentations. A number of people found Tess’ talk particularly thought-provoking. The skit performed at the beginning of Session 5 was also seen by some participants as very effective in “open[ing] up space for some discussion of lived realities.”

There was mention of the issue of ‘Whiteness’ in feedback from a number of participants. Some people felt that the introduction of the concept of “the privileges of whiteness” allowed them to reconsider issues that they have thought about “in a more coherent way.” Another participant felt the workshop “changed my perspective in thinking of what it means to be White.” It is interesting that the material on

Whiteness was seen as particularly effective, as it was a desire to bring this literature to health researchers that was the original impetus for the authors to develop the workshop.

The authors were both pleased and impressed by the engagement that participants had with the workshop topics, including their ability to pick up new concepts, freely express their opinions and engage in analysis and critique without necessarily arriving at firm answers. It was felt that the group exercises worked very well and that participants were having exactly the kind of conversations that it was hoped the workshop would inspire. One author felt that although letting the participants come to their own conclusions was important, it was sometimes difficult not to simply 'correct' perceived misconceptions when there was no time to explore them more fully.

The amount of material that was to be covered in the workshop was too much and this will need to be considered in the future, with a view to having different lengths and format (semester long course, 3-day, 1-day etc.). Both authors felt that the length of the workshop left them tired and exhausted and hence less able to assist participants on the second day. However, this exhaustion should be expected to decrease with greater experience of presenting and facilitating this workshop.

Perceived effect of the workshop

As discussed briefly in the first section, many people reported experiences of change such as "personal and academic insights," and that the workshop "challenged current thinking." Many participants described the workshop as useful.

A number of participants commented that they felt their practices would change as a result of the workshop. One person commented that it would generally "contribute to the quality and thoughtfulness of research in Indigenous health." Another person felt the workshop challenged them "to think through my research again, to think through my assumptions and how I define things."

While people may perceive at this time that their practices will change, it will be very difficult to assess this in any systematic way. Further, as the aim of the workshop was to encourage researchers to reflect on their practice, rather than to change researchers in any particular way, it would be difficult to both predict what changes may occur, or to attribute any changes that do occur to the workshop.

Suggestions for future workshops

A few participants suggested that the workshop should be an annual event, and should be offered to health department staff. Others suggested it should be used as part of an orientation course for new staff, and as a 'train the trainer' course for those who provide cross-cultural awareness workshops. It was described as an important companion to cross-cultural workshops, as while "those workshops are about unpacking Indigenous worldviews, this was about our world views and the influence of racism within it."

A few people noted the need for ongoing processes to deal with issues of race and culture, and suggested regular seminars as well as informal networks of like-minded people.

5. Recommendations and Future Directions

From the feedback received and the authors' reflections, the following issues would be revisited in planning for any future workshops:

Structural and processional issues:

- Investigate the use of a professional facilitator
- Investigate the use of a rapporteur to summarise discussions at the conclusion of each session
- Consider charging for the workshop
- Consider holding it at a venue outside Menzies (for future workshops in Darwin)

Audience issues:

- Revisit the issue of restricting the workshop to non-Indigenous participants
- Either revise the content to cater for non-White non-Indigenous people, or explicitly aim the workshop at White people
- Consider developing alternative workshop plans for mixed groups and Indigenous-only groups

Content issues:

- Revise the content and the workshop plan to incorporate more realistic amounts of material and timelines
- Develop a day-long version of the workshop
- Consider reworking Session 4
- Investigate how to present material that was presented by guest speakers for workshops held outside Darwin

Future Directions

Already, a *Race and Culture Reading & Discussion Group* has been set up. This group will meet monthly at the Menzies School of Health Research to discuss a short paper that will be distributed a week before each meeting. The papers to be covered will be drawn from a variety of sources, and will aim to present a range of stimulating views in an accessible way. For further information, please contact Jenny Brands at Jenny.Brands@menzies.edu.au.

To date, the individuals from the following organisations have expressed interest in bringing the workshop to them:

- The Diabetes and Related Disorders Urban Indigenous Darwin study (DRUID) have requested a day-long workshop for new staff in July 2003;
- Flinders University of South Australia;
- Murdoch Childrens' Research Institute, Melbourne.

The Development Division of the CRC for Aboriginal Health has also requested that the workshop be available at least annually to core partners of the Centre.

The authors would be happy to facilitate the workshop at other venues, and to assist others who may wish to develop a similar workshop.

Acknowledgements

Our thanks to the following people:

- CRCATH Development Division for supporting the concept and funding the workshop.
- Jenny Brands for her feedback during workshop planning, minute-taking, participation in post-workshop discussions, and assistance in writing and editing the report.
- David Thomas and Tess Lea for their guest presentations at the workshop.
- Jeannie Devitt, Tarun Weeramanthri, Beverly Sibthorpe, Richard Chenhall, Jenny Brands, Julie Brimblecombe, Terry Dunbar, Tony Barnes, David Thomas and Priscilla Pyett for their insightful comments during the workshop planning.
- Amica Adams for her minute-taking during the workshop and Yvonne Coleman for assistance with workshop logistics.
- Gary Foley at the Melbourne Museum for granting permission to use video material from the Bunjilaka exhibition.
- The workshop participants whose enthusiasm, courage and openness made the workshop a success.

Conflicts of Interest

This work was funded by the CRCATH, including consultancy fees paid to the authors for their time.

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Appendix– Materials included in the Workshop Resource Book

A range of published and unpublished materials were included in the workshop resource book as well as resources developed by the authors specifically for the workshop. Below is a list of articles and book chapters included in full in the resource book. A range of other excerpts and references, not detailed below, were also included.

Session 1: Groundwork

Chambers, B. & Pettman, J. 1986, *Anti-racism: A Handbook for Adult Educators*, Australian Government Publishing Service, Canberra, pp. 3-10.

Croteau, J. M. 1999, "One struggle through individualism: Toward an antiracist white racial identity", *Journal of Counseling & Development*, vol. 77, no. 1, pp. 30-32.

McIntosh, P. 1990, "White Privilege: Unpacking the Invisible Knapsack", *Independent School* pp. 31-36.

Session 2: Explaining Indigenous health inequalities

James, S. A. 1993, "Racial and ethnic differences in infant mortality and low birth weight. A psychosocial critique", *Annals of Epidemiology*, vol. 3, no. 2, pp. 130-136.

Krieger, N. 1996, "Inequality, diversity, and health: thoughts on "race/ethnicity" and "gender"", *J Am Med Womens Assoc.*, vol. 51, no. 4, pp. 133-136.

Reid, P., Robson, B., & Jones, C. P. 2000, "Disparities in health: common myths and uncommon truths", *Pacific Health Dialog*, vol. 7, no. 1.

Session 3: The cultures of health research

Anderson, W. 2002, *The cultivation of whiteness: Science, Health and Racial Destiny in Australia*. Melbourne University Press, pp. 180-215.

Humphery, K. 2001, "Dirty questions: Indigenous health and 'Western research'", *Aust N.Z.J Public Health*, vol. 25, no. 3, pp. 197-202.

Marshall, G. A. 1993, "Racial Classifications," in *The Racial Economy of Science: Towards a Democratic Future*, S. Harding, ed., Indiana University Press, pp.116-127.

Session 4: The use of culture in health research

Brady, M. 1995, "WHO Defines Health?: Implications of Differing Definitions on Discourse and Practice in Aboriginal Health," in *Aboriginal Health: Social and Cultural Transitions*, G. Robinson, ed., Northern Territory University Press, Darwin, pp. 187-192.

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Session 5: White racial identity theory

D'Andrea, M. & Daniels, J. 1999, "Exploring the psychology of white racism through naturalistic inquiry", *Journal of Counseling & Development*, vol. 77, no. 1, pp. 93-101.

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Session 6: Approaches to Indigenous health research – a debate

Davison, C. & Davey Smith, G. 1995, "The baby and the bath water: Examining socio-cultural and free-market critiques of health promotion," in *The Sociology of Health Promotion: Critical Analyses of Consumption, Lifestyle and Risk*, R. Bunton, S. Nettleton, & R. Burrows, eds., Routledge, London, pp. 91-99.

National Academy of Sciences 1993, "Methods and Values in Science," in *The Racial Economy of Science: Towards a Democratic Future*, S. Harding, ed., Indiana University Press, pp. 340-343

Trudgen, R. 2000, *Why Warriors lie down and die* Aboriginal Resources and Development Services, Darwin, pp. .

Henry, J., Dunbar, T., Arnott, A., Scrimgeour, M., Matthews, S., Murakami-Gold, L., & Chamberlain, A. 2002, *Indigenous Research Reform Agenda: Changing Institutions*, CRCATH, pp. 3-7.

Session 7: Wrap up and future directions

Corin, E. 1994, "The social and cultural matrix of health and disease," in *Why are some people healthy and others not?*, R. G. Evans, M. L. Barer, & T. R. Marmor, eds., Aldine De Gruyter, New York.

Gregory, R. J. 2002, "Research should not ignore the power of elite groups", *Aust N Z.J Public Health*, vol. 26, no. 1, pp. 6-7.

Jones, C. P. 2001, "Invited commentary: "race," racism, and the practice of epidemiology", *Am J Epidemiol.*, vol. 154, no. 4, pp. 299-304.