

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/292140373>

"We don't tell people what to do": An ethnography of health promotion with Indigenous Australians in South East Queensland

Thesis · December 2015

CITATIONS

0

READS

36

1 author:



[Karen McPhail-Bell](#)

University of Sydney

25 PUBLICATIONS 14 CITATIONS

SEE PROFILE

“We don’t tell people what to do”

**An ethnography of health promotion with
Indigenous Australians in South East
Queensland**

Karen McPhail-Bell

Bachelor of Behavioural Science, Honours (Public Health)

Submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy

School of Public Health and Social Work
Queensland University of Technology

2015

Key words

Aboriginal, Aboriginal Medical Service, Australia, colonisation, community controlled health service, critical race theory, cultural interface, culture, ethnography, Facebook, government, health promotion, identity, Indigenous, Instagram, mainstream, policy, postcolonial theory, public health, relationship, self-determination, social media, Torres Strait Islander, Twitter, urban, YouTube.

Abstract

Australia is a world-leader in health promotion, consistently ranking in the best performing group of countries for healthy life expectancy and health expenditure per person. However, these successes have largely failed to translate into Indigenous health outcomes. Given the continued dominance of a colonial imagination, little research exists that values Indigenous perspectives, knowledges and practice in health promotion. This thesis contributes to addressing this knowledge gap.

An ethnographic study of health promotion practice was undertaken within an Indigenous-led health promotion team, to learn how practitioners negotiated tensions of daily practice. The study was strengths-based, informed by a theoretical framework that privileged Indigenous knowledges, perspectives and experiences, drawing on three theoretical tools: postcolonialism and critical race theory positioned the researcher and health promotion discipline; whilst cultural interface theory enabled the analysis to shift beyond a critique of the Western, to uncover the practitioners' meaning-making in daily health promotion practice.

The practice revealed innovative, diverse, relationship-based approaches to health promotion that effectively shifted power from health promotion practitioner to Indigenous people and communities. Community choice and control were central to practice. Through a dialogical approach with Indigenous people and communities, Indigenous notions of health and healthy behaviours were embedded and Aboriginality was asserted as health promoting itself.

The study's findings converge with global health promotion discourse. This suggests that paradoxically, decolonising health promotion practice in Indigenous contexts requires we 'do things differently', while adhering to health promotion's philosophical foundations of empowerment and control. The study proposes four interrelated principles for decolonising health promotion, informed by the practice observed. The study concludes that decolonising health promotion practice requires a radical reworking of practitioner relationships with Indigenous people and

communities. Indigenous-led health promotion presents a way to bridge the rhetoric and practice of empowerment in Australian health promotion practice.

List of publications and presentations

Publications relevant to the thesis but not forming part of it

McPhail-Bell, K., Nelson, A., Lacey, I., Brough, M., Fredericks, B., & Bond, C. (under review). Maiwah as a framework for Indigenist research: Community control and decolonising health promotion research in Australia. In P. Liamputtong (Ed), *Doing Cross-Cultural Research in Health and Social Sciences*. Springer Publications.

McPhail-Bell, K., Bond, C., Brough, M. and Fredericks, B. (2015). “We don’t tell people what to do”: Ethical practice and Indigenous health promotion. *Health Promotion Journal of Australia*, 26(3), 195-199. doi: 10.1071/HE15048p;

McPhail-Bell, K. (2014). *Deadly Choices: Better ways of doing health promotion. Croakey – the Crikey health blog*. Crikey: Sydney.

McPhail-Bell, K., Fredericks, B. & Brough, B. (2013). Beyond the accolades – A postcolonial critique of the foundations of the Ottawa Charter. *Global Health Promotion*. 22(2): 22-29.

McPhail-Bell, K., Bond, C., & Redman-MacLaren, M. (2013) Skins for smokes and the use of cultural content and imagery. *Queensland Health Promotion Quarterly*, June, p. 8.

Presentations relevant to the thesis but not forming part of it

McPhail-Bell, K. & Appo, N. (2015, September). *Deadly Choices social media: Empowering our people to create change*. Population Health Congress: Hobart.

McPhail-Bell, K. (2014, June). *Deadly Choices or deadly choices? An ethnography of health promotion practice with Indigenous Australians*. IUIH/Lowitja Symposium – Innovations in Urban Aboriginal and Torres Strait Islander Health: Closing the Gap. IUIH: Brisbane.

McPhail-Bell, K. (2014, March). *We have a lot to learn yet: A postcolonial lens in health promotion*. AIATSIS National Indigenous Studies Conference – Breaking Barriers in Indigenous Research and Thinking. AIATSIS: Canberra.

McPhail-Bell, K. (2013, August). **Panel speaker** in: Potvin, L. and Larouche, A. (2013). *Symposium: Towards a recognition of health promotion as a specific research domain*. World Conference on Health Promotion. IUIHPE: Pattaya, Thailand.

McPhail-Bell, K. & Bond, C. (2013, August). *Culture in and culture of health promotion: Tensions at the interface of Australian Indigenous health promotion*. World Conference on Health Promotion. IUIHPE: Pattaya, Thailand.

McPhail-Bell, K. & Fredericks, B. (2013, August). *Beyond the accolades: A postcolonial critique of the foundations of the Ottawa Charter*. World Conference on Health Promotion. IUIHPE: Pattaya, Thailand.

List of acronyms

AAF	Aboriginal Advancement Fellowship
ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
AFL	Australian Football League
AHPA	Australian Health Promotion Association
AIDA	Australian Indigenous Doctors Association
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
ANPHA	Australian National Preventative Health Agency
ANTaR	Australians for Native Title and Reconciliation
APA	Aboriginal Progressive Association
ATSIC	Aboriginal and Torres Strait Islander Commission
CATSIN	Congress of Aboriginal and Torres Strait Islander Nurses
CCHS	Community Controlled Health Service
CDH	Commonwealth Department of Health
COAG	Council of Australian Governments
CRT	Critical Race Theory
CSDH	Commission on Social Determinants of Health
CTG	Close the Gap
CYWRT	Cape York Welfare Reform Trial
DAA	Federal Department of Aboriginal Affairs
EBM	Evidence-based medicine
GQT	Good Quick Tukka
HFA 2000	Health for All by the Year 2000
HLT	Healthy Lifestyle Team
HREC	Human Research Ethics Committee
HREOC	Human Rights and Equal Opportunity Commission
IAS	Indigenous Advancement Strategy
IDAA	Indigenous Dentists' Association of Australia

IUIH	Institute for Urban Indigenous Health
MATSICHS	Moreton Aboriginal and Torres Strait Islander Community Health Service
MPSS	Murri Places, Smoke-free Spaces
NACCHO	National Aboriginal Community Controlled Health Organisation
NAHS	National Aboriginal Health Strategy
NBHP	National Better Health Program
NEAF	National Ethics Application Form
NFL	National Football League
NGO	Non Government Organisation
NHMRC	National Health and Medical Research Council
NHS	National Health System
NIRA	National Indigenous Reform Agreement
NRL	National Rugby League
NTEHP	National Trachoma and Eye Health Program
NTER	Northern Territory Emergency Response
PHC	Primary Health Care
PHM	People's Health Movement
QAIHC	Queensland Aboriginal and Islander Health Council
QH	Queensland Health
QUT	Queensland University of Technology
RACO	Royal Australian College of Ophthalmologists
RCADIC	Royal Commission into Aboriginal Deaths in Custody
SDOH	Social Determinants of Health
SEQ	South East Queensland
SNSs	Social Networking Sites
SNTTS	Say No To The Smokes programs
TIGs	Traditional Indigenous Games
TVC	Television Commercial
WHO	World Health Organization

List of key terms

Behavioural accounts of health

Behavioural accounts of health are individualistic. This means such accounts operate at the individual level with a focus upon behaviour and risk factors (for example, smoking, alcohol consumption, exercise) (Baum & Fisher, 2014). Behavioural interventions tend to draw on theories of behaviour change and health behaviour, focusing on individual action and choice to improve health (Nutbeam & Harris, 2004).

Colonisation

Colonisation in Australia began with British imperialism to establish British control over land, resulting in dramatic change and destruction of Indigenous Australian peoples and their cultures (Dudgeon & Walker, 2015; Sherwood, 2010). Colonisation is both an historical and ongoing process and recognised globally as a determinant of Indigenous health (Commission on Social Determinants of Health, 2007; Smith, 2012).

Decolonisation

Decolonisation is a process that begins after recognition of colonisation (Sherwood, 2010). It is an approach and philosophy that accepts that research is not impartial and that as researchers and health professionals, we bring our own worldviews and perspectives (Sherwood, 2013a). Decolonisation requires the rewriting of history to include Indigenous perspectives (Smith, 2012). It also requires that each of us learn how we all contribute to ongoing oppression, systematic marginalisation and institutional privileging of some over others, to maintain Indigenous subjugation and the control held by dominating groups (Fredericks, Maynor, White, English, & Ehrich, 2014). Through resistance against the forces of colonisation, decolonisation purposes to overturn the colonial structure and realise Indigenous liberation (Waziyatawin & Yellow Bird, 2005).

Health promotion

This thesis uses the Ottawa Charter for Health Promotion definition of health promotion:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. (WHO, 1986b, p. 1)

Indigenous

In this thesis, the term Indigenous is used in reference to Aboriginal and Torres Strait Islander people, and global Indigenous populations more broadly. The words Aboriginal and/or Torres Strait Islander are used if they are contained within a quote, a government or organisational document, or in reference to a specific point. The use of the word Indigenous is discussed in Chapter One.

Indigenous health promotion

In this thesis, Indigenous health promotion is a term used to denote the field within health promotion that is applied to Indigenous health issues and refers to health promotion with Indigenous people and communities.

Indigenous-led health promotion

This thesis uses the term Indigenous-led health promotion to refer to health promotion practice led and controlled by Indigenous people, practitioners and communities. Indigenous-led health promotion may be in partnership with non-Indigenous practitioners, although not necessarily.

Mainstream

The term mainstream refers to the principal and dominant culture and social structures within Australia, primarily of Anglo-Saxon/Anglo-Celtic, European origin. In a health service context, mainstream typically refers to “not Indigenous-specific” (Scrimgeour & Scrimgeour, 2008, p. 1).

Neoliberalism

Neoliberalism is an economic policy agenda that appears to be the dominant theory for contemporary capitalism. Neoliberalism involves a ideological narrative that: the state “must reduce its intervention in economic and social activities”; “labour and financial markets must be deregulated in order to liberate” the market’s creative energy; and “commerce and investments must be stimulated by eliminating borders and barriers to the full mobility of labour, capital, goods, and services” (Navarro, 2009, p. 425). Research has found that smaller government is linked to higher inequality in the world’s richest nations (Bergh & Nilsson, 2010), of which Australia is one (Office of Economic Development, 2013).

Practitioner

In this thesis, practitioner refers to the range of population, health and nutrition professionals who in their everyday work have an opportunity to help empower individuals, groups and communities. The term refers to those working within the realm of public health and health promotion such as researchers, students, bureaucrats, or clinicians.

Structural accounts of health

Structural accounts of health refer to social conditions and the socio-political context that shape health (Commission on Social Determinants of Health, 2008). They tend to be ecological in approach, non-individualist and emphasise the various aspects of the environment including physical and social (Baum, 2008).

Top-down/bottom-up

Top-down refers to a hierarchical system of government or management in which actions and policies are initiated at the highest level, which is typically associated with disease prevention efforts, as opposed to bottom-up approaches, typically associated with empowerment – although the two are not mutually exclusive in practice (Laverack & Labonte, 2000).

West/Western

In this thesis, West and Western are terms used in reference to Euro-Australian people, nations, knowledge and so forth. I recognise that the use of such terms contributes to the essentialising of both Western and Indigenous cultures/perspectives, including by implying a simplistic intellectual and methodological similarity of traditions within each, which is not the case (Anderson, 1997; Ashcroft, Griffiths, & Tiffin, 2004). However, the terms are used broadly in this study to distinguish shared or unifying intellectual and cultural traditions of Euro-Australia to that of Indigenous Australians.

List of figures

Figure 1: Schema of Deadly Choices practice during this research.	16
Figure 2: “We don’t tell people what to do”... yet advise people how to live better, healthier lives: Health promotion's core tension.....	55
Figure 3: To reflexively engage with one's standpoint, the connections to other social positions and structures must also be examined	81
Figure 4: A bricolage framework informed this study by drawing on critical race theory, postcolonialism and the cultural interface, informed by my researcher standpoint. Together they enable a decolonised understanding of the workings of power and control in health promotion.....	83
Figure 5: Schema of methods: who I was with, where we went (internally and externally to UIIH) and how I did it.	106
Figure 6: Approximate time periods per structured engagement activity in fieldwork, which were in addition to the unstructured engagement activity in fieldwork..	107
Figure 7: A sample of Deadly Choices Facebook post, asking the Deadly Choices community what their deadly choice is.	131
Figure 8: The inductive-deductive process of data analysis and fieldwork.....	134
Figure 9: The Deadly Choices logo.	142
Figure 10: The home page of the Deadly Choices website	143
Figure 12: Seven session topics of the Deadly Choices program.....	145
Figure 12: Deadly Choices team.....	147
Figure 13: A Deadly Choices practitioner teaches some community members a Good Quick Tukka recipe.....	148
Figure 15: A Deadly Choices practitioner stands with a sign as part of the MPSS package.	149
Figure 15: Deadly Choices creates posters to promote upcoming community days, which are shared through social media.....	151
Figure 16: "Urban is the new black" is written on the back of Deadly Choices merchandise	153

Figure 18: A pregnant woman starring in an earlier television commercial. The narrative imprinted on this image for the Deadly Choices poster was that of the mother.	155
Figure 18: Poster of a man whose deadly choice was not to smoke to be around his family.	155
Figure 19: Image from the National Health Service 2013 anti-smoking campaign ..	156
Figure 20: Deadly Choices commercial #2.....	157
Figure 22: Deadly Choices posted a video on Facebook to showcase the prizes for an upcoming Community Day. In response, community members posted regarding the merchandise and their anticipation of the day.	160
Figure 22: After completing a term of the Deadly Choices Education Program, shirts were awarded to the students, as posted on Facebook.....	161
Figure 23: Community member posting on Deadly Choices Facebook page requesting the purchase of Deadly Choices merchandise	163
Figure 24: A community member enquires about obtaining a Deadly Choices hoodie and soon becomes an active member online.....	163
Figure 25: A community member posts their entry for a Deadly Choices Facebook competition.	165
Figure 26: The second repost by this social media user, again about her family.	166
Figure 27: A repeat visitor on Deadly Choices Facebook page posts another of her deadly choices.....	167
Figure 28: A Deadly Choices Facebook competition will award a “hoodie” as the prize.....	168
Figure 29: A partnership with Brisbane Broncos contributes to the shaping of the ever-evolving Deadly Choices brand.....	169
Figure 30: Deadly Choices students that completed the Deadly Choices Education Program were rewarded with the opportunity to run onto the field with one of the two NRL teams to open a home Broncos game.....	170
Figure 31: School Oztag Day.....	171
Figure 32: A Deadly Choices practitioner with a student who had just participated in the Deadly Choices Oztag Day	172
Figure 33: Deadly Choices team work with the local AMS to run the Oztag Day....	172
Figure 34: OzTag Day school participants	173
Figure 35: One Deadly Choices ambassador is an Aboriginal academic	184

Figure 36: One of the Deadly Choices ambassadors.	185
Figure 37: A Deadly Choices ambassador shares her journey moving towards competing in the Commonwealth Games and Olympics.....	185
Figure 38: Sam Thaiday, Deadly Choices ambassador, interacts with some youth participating in Deadly Choices on university campus.....	187
Figure 39: A sample of the Deadly Choices ambassadors.....	189
Figure 41: Deadly Choices promotes social choices - in this case, encouraging leadership behaviour.	190
Figure 41: Previous Federal Minister for Indigenous Health, the Honourable Warren Snowdon, with Broncos president, IUIH CEO and IUIH team at the launch of the Brisbane Broncos partnership in 2013.	193
Figure 43: One of the Deadly Choices ambassadors was awarded woman of the match.....	195
Figure 43: Deadly Choices celebrates the achievements of a female ambassador and staff member.	196
Figure 44: Two Deadly Choices ambassadors with their image displayed on the marquee.....	196
Figure 45: Deadly Choices participated in the Women's Netball Carnival with its own women's team in the game, as well as delivering Deadly Choices education sessions and facilitating health earlier in the day.....	197
Figure 46: Some of the Deadly Choices practitioners	204
Figure 47: Cricket players were required to undertake a health screen before playing	206
Figure 48: Participating in the Deadly Choices fitness training sessions after work.....	212
Figure 50: Deadly Choices Twitter shout out to their new followers.....	217
Figure 51: A parent shares their son's deadly choice: To obtain an education.....	218
Figure 51: A community member posts about their son's Deadly Choice to complete an apprenticeship.	219
Figure 53: A community member posts that their deadly choice is of "time with my family listening, watching and learning"	220
Figure 53: Community member alerts Deadly Choices to merchandise being worn by people undertaking behaviours incongruent with the Deadly Choices message.	221

Figure 54: A Deadly Choices ambassador preparing for his world title boxing match, where he would represent the Deadly Choices brand, shares the importance of being Aboriginal.	223
Figure 55: The IUIH/Deadly Choices medical van visits the State High School to provide the venue for health checks to take place.	228
Figure 56: Facebook Insights: People, Your Fans	237
Figure 58: One of the entries into the Deadly Choices Facebook competition	239
Figure 58: A community member provides an update on Twitter regarding their progress to their Deadly Choice to give up smoking	240
Figure 59: Providing a space to celebrate people and their deadly choices.....	241
Figure 60: The Deadly Choices team promoted the artwork produced by students who participated in their Deadly Choices program	243
Figure 62: “Name the three major chemicals in cigarettes” – This is a short video posted on the Deadly Choices Instagram account	244
Figure 63: Deadly Choice cooking video for Good Quick Tukka.....	245
Figure 63: Deadly Choices Facebook quiz regarding chronic disease	245
Figure 64: One entry into the Deadly Choices mental health competition involved mountain biking and eating healthy	247
Figure 66: Deception Bay Community Day Flier 2013.....	248
Figure 66: Deadly Choices tweet to thank their students for their thank you message.	249
Figure 67: Some positive conference participant feedback on the Deadly Choices presentation at AHPA 2013.	251
Figure 69: Positive reception for a Deadly Choices presentation at AHPA 2013.....	251
Figure 69: More conference participant tweeting about Deadly Choices at AHPA 2013.....	251
Figure 70: Deadly Choices tweet mid-workshop.....	254
Figure 71: The Deadly Choices tweet at the conclusion of my workshop.	254
Figure 72: A team lunch for National Nutrition Week; we each brought a dish in...257	
Figure 73: Article in The Australian regarding the success of Deadly Choices and IUIH	261
Figure 74: A NACCHO communiqué promotes the support of the acting Prime Minister of Australia	263
Figure 76: Close the Gap campaign image	277

Figure 76: Four principles to enable decolonising health promotion practice and their associated processes and outcomes.....	288
Figure 77: The Deadly Choices team gifted me with one of every piece of their merchandise and some magazines at our farewell party, held to celebrate the research journey.	313
Figure 78: Some of the Deadly Choices team members attended my PhD Final Seminar and wanted a photo together afterwards to post on Twitter.	314

Statement of original authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: [QUT Verified Signature](#)

Date: 7/12/2015

Acknowledgements

To my three supervisors, thank you. You are the finest supervision team. To my principal supervisor, Associate Professor Mark Brough – thank you for your constant, humble and encouraging support and direction, through the challenges and the successes. Thank you also for fostering a community of ethnographers in Brisbane and a community of peer-supported learning. Thank you to Dr Chelsea Bond for your sharp intellect, mentoring, guidance and endless inspiration. You somehow knew what to say to me and when. To Professor Bronwyn Fredericks, thank you for your friendship, guidance and for believing in me. You encouraged me to begin this PhD and I thank you for staying with me on the journey.

To the IUIH mob, thank you is barely enough to express my gratitude – and there are so many of you to thank! I know that in various ways, this thesis tells some of your stories too. Three names must be mentioned. Dr Alison Nelson: the PhD journey with IUIH began with you. Thank you for opening the way, your guidance, academic input, understanding and much more. Thank you to Adrian Carson for supporting this research, for the time and guidance you provided to teach me and shape the research. Ian Lacey, I thank you for your steadfast support of this research and of me. Your pragmatic and accepting approach gave me the courage to keep growing and learning.

Thank you especially to the Deadly Choices team and research participants – what a group of inspiring, positive, inclusive and supportive people you are. I wish I could name everyone, to acknowledge your special part but as we’ve talked about, I cannot do that. You accepted me as part of the team; you encouraged me, taught me, and shared. I am forever changed (for the better, I hope!) from my time with you. I hope I have reflected the dignity and sophistication of your practice in these pages.

To Professor Martin Nakata, Dr Reuben Bolt and the Nura Gili team at UNSW, thank you for the welcoming in the Nura Gili space when I relocated to Sydney. Professor Nakata, thank you for being a critical friend, for reading and discussing drafts of my work, for your generosity and encouragement. I have finally “put the sucker to bed”.

To the community of people who have stood by me and bolstered the somewhat isolating PhD journey – thank you, I could not have finished without you. Some special mentions must be made. To Connie Allen: thank you for your encouragement and practical support and belief in me during my recovery from my accident mid-PhD. Dr Michelle Redman-MacLaren, thank you for sharing this journey through our weekly check-ins. You brought joy and connectedness, and a safe space to swap PhD strategies and grow – which also helped me relearn how to structure my days, a skill impacted from the injuries of my accident. Thank you also to Dr Megan Williams and the Muru Mari team for your openhearted hospitality. You are all too deadly.

I have received professional advice from many who generously critically reviewed and proof read drafts of this thesis. Sincere thanks to Dr Katherine Doyle, Associate Professor Jon Willis, Dr Alison Nelson, Professor Julie Hepworth, Connie Allen, Mary Hunt, Usha Rao and of course my supervisors. Your critiques and feedback helped sharpen and improve this work.

Finally, to my family – I will always remember how you stood by me and I thank you. Usha, you are a dream mum-in-law; thank you for your encouragement and understanding the demands of a PhD. To Mum: no words can explain my gratitude but we both know this PhD would not have happened without you. And finally to my beloved husband, Mohit: you stood by me – and my PhD. You are patient and supportive, and I know that this PhD has become your life too. Thank you for everything.

Dedication

This thesis is dedicated to my stepfather Alan Bell. You were the father of my heart.

You taught me how to dream. You believed in me. You showed me to be true to myself. You left us too soon but your memory lives on.

This thesis is dedicated to you.

Table of contents

Key words	ii
Abstract	iii
List of publications and presentations	v
Publications relevant to the thesis but not forming part of it	v
Presentations relevant to the thesis but not forming part of it.....	v
List of acronyms	vii
List of key terms	ix
List of figures	xiii
Statement of original authorship	xviii
Acknowledgements	xix
Dedication	xx
Table of contents	xxi
1. Health promotion in Australia – Health for all?	1
Control in health promotion: Colonisation and the tensions of practice	1
Why me? Why this topic?	4
Research agenda.....	9
Research significance.....	10
Research site: IUIH and Deadly Choices.....	11
Why urban?	12
The Institute for Urban Indigenous Health – A new direction for community control... 13	
Deadly Choices: “Empowering Aboriginal and Torres Strait Islander people to make healthy choices”	14
This work’s relationship to the words ‘Indigenous’ and ‘mainstream’	17
Thesis outline	18

2. “Work with us not for us” – Indigenous health promotion in Australia	21
Time to make peace: The failure of health promotion.....	21
The Great Australian Silence – The colonial basis of health promotion	26
The Community Controlled Health Service movement and primary health care.....	30
The global and the local of Indigenous health promotion.....	35
Moral distress – The tensions of Indigenous health promotion	52
“We don’t tell people what to do”... or do we? Health promotion’s colonisation of bodies	53
Learning from Indigenous health promotion?	70
3. Conceptual framework and methodology	72
Research purpose and question	72
Researcher standpoint.....	73
Epistemology – My way of knowing	74
Ontology – My way of being.....	75
Axiology – My way of doing.....	77
Reflexivity: The link between positioning and theory	78
Theoretical framework	81
Postcolonialism.....	83
Critical race theory	88
The cultural interface	92
Critical ethnography	98
Ethnography	98
Ethnography involves power	100
Critical ethnography	101
Expanded ethnography – Incorporating the offline and online	102
4. Schema of ethnographic methods	105
My conduct of field work	106
Entry and exit.....	107
Participant observation	110
Ethnographic (conversational) interviews	114
Participant diary approach	116
Workshops.....	119
Field diary	122
Ethics	122

Where and how I spent time with Deadly Choices practitioners.....	130
Methods of analysis.....	133
Who I spent time with: Deadly Choices practitioners	137
Featuring participants.....	138
5. “Urban is the new black”: Engaging Indigenous people in health promotion ...	141
Deadly Choices as a health program.....	144
“Just bringing that community spirit” through Deadly Choices community events	151
“Urban is the new black”: Deadly Choices as a way of life	153
Deadly Choices merchandise: “A walking billboard”	160
Partnerships and sport: “We use sport as a vehicle”	168
Community promotion and an agenda of choice	175
6. “It’s all about empowering our people”: Innovation through leadership and relationship	177
Distributive leadership for creating change: “Everybody can be a leader”	178
Deadly Choices ambassadors.....	183
Strength, not deficit: The importance of role modelling	187
Deadly Choices as a transformative space: “Having a go”	191
Leadership is relationship	197
“We know how to talk to each other”: Relationship-based health promotion.....	203
“We’re doing it ourselves”: The Deadly Choices team	203
“What’s your Deadly Choice?” Community driven health and the Deadly Choices brand	216
A deadly choice is an identity choice: The unspoken curriculum	221
Talking <u>to</u> , not down: Depth over body/behaviour-checking.....	223
7. “It’s just thinking normal”: Community control and transformative governance	233
Social media – “It’s where they are”	234
“We’ve got so many likes”: Dialogue and engagement through social media	234
A welcoming and celebratory space	240
Health education and activity promotion.....	243
Connecting and partnering	248
“We’ve brought culture to social media”: The blurring of online and offline spaces...	252
Decolonisation and reverse colonisation: A non-Indigenous audience	257

Deadly Choices: A community controlled agenda	262
8. “We don’t tell people what to do”	264
“We do things differently”: Engaging with the tensions of health promotion practice	265
Distributive leadership as a model for change	265
Competing agendas	270
Inclusive and incentivised choice.....	271
Indigeneity as health promoting.....	275
Of the community.....	280
Theory and health promotion as colonisation.....	283
“We’re in, looking out”: Decolonising health promotion practice.....	286
“It was our way”: Community control as a measure of success.....	289
An agenda of choice	292
“It’s a feeling”: Empowerment as a health promotion goal	294
Relationship as an enabler.....	296
“Now that’s a deadly choice”: Moving forward	297
9. Conclusion: “We learn from each other”	300
“They see you leading by example, being accountable”: Summary of argument	300
Contribution	303
Implications.....	304
Limitations and future research	306
Research aims revisited	308
Reflection: “Everyone can be a leader”	309
References.....	315
Appendix A: “Beyond the accolades” – paper in Global Health Promotion	365
Appendix B: Participant information form	373
Appendix C: Participant consent form	375
Appendix D: Participant diary template	376
Appendix E: IUIH consent form – Deadly Choices Education Program.....	378
Appendix F: Samples of SimplyMeasured reports.....	379

1. Health promotion in Australia – Health for all?

In 2014, the Australian Journal of Primary Health released a special issue dedicated entirely to Indigenous health promotion. Despite decades of Indigenous health promotion practice in Australia, this issue was only the second dedicated by a mainstream Australian journal to Indigenous health promotion.¹ In that issue, the special editors called for health promotion researchers to focus on the possibilities inherent in a process of self-determination and of co-creating health and well-being, rather than on Indigenous² people's disadvantage (Arabena, Rowley, & MacLean, 2014). The editors' call resonates with the core values of health promotion (WHO, 1986b) and aligns with the essence of this thesis, that is: to learn from Indigenous community controlled health promotion practice.

Control in health promotion: Colonisation and the tensions of practice

The internationally recognised Ottawa Charter for Health Promotion defines health promotion as a "...process of enabling people to increase control over, and to improve, their health" (WHO, 1986b, p. 1). It follows that this thesis, which focuses on Indigenous health promotion, tells a story about choice and control. While health promotion emphasises equal opportunity and resources to enable people to achieve their full potential in and thus control over their life (WHO, 1986b), its practice has largely failed to engage with the context of Indigenous Australians. This thesis reveals the circumstances of this failure and thus tells a somewhat solemn story of control in Indigenous Australia.

To clarify, health promotion has undeniably brought success in Australia. Australia is regarded as a leader and pioneer in health promotion globally (Shilton et al., 2010), with an influential role in the development of global health promotion, including its charters (e.g. DCSH & WHO, 1988; WHO, 1986a; WHO & UNICEF, 1978). Despite Australia's success in health promotion, Indigenous Australians continue to experience

¹ The first issue specific to Indigenous health promotion in Australia was the Journal of Health Promotion Australia's special issue on Indigenous health, Volume 15 number 4.

² The use of the term 'Indigenous' in this thesis is discussed below in this chapter.

gross disadvantage (Baum, Fisher, & Lawless, 2012a), with a life expectancy 10.6 years less for males and 9.5 years lower for females compared to their non-Indigenous counterparts (ABS, 2013a)³. In an international context, the health gap between Indigenous and non-Indigenous Australians remains remarkably greater than that of Australia's counterparts in New Zealand, Canada and the United States of America (Cooke, Mitrou, Lawrence, Guimond, & Beavon, 2007).⁴ Hence, this thesis also tells a story of mainstream health promotion's failure to enable Indigenous Australians to increase control over their health.

Australia's success in tobacco control exemplifies health promotion's unequal treatment of Indigenous Australians in practice. Australia is considered an international leader in tobacco control, with the Australian Government lauded by the public health community for its resistance to the tactics of 'big tobacco' when introducing plain packaging legislation (ComLaw, 2012; Liberman, 2013). Australia's success is evident in the long-term health gains in the mainstream population, with a declining smoking rate of 16% (AIHW, 2014). Nevertheless, Indigenous Australians are 2.6 times more likely to smoke daily than non-Indigenous Australians (ABS, 2013b; AIHW, 2011b), with approximately 41% of Indigenous Australians smoking daily (ABS, 2013b). Despite some indication of a decline in intensity of smoking (Thomas, 2012), Indigenous Australians continue to experience high mortality and morbidity rates from conditions related to tobacco use and unequal support and service access (ABS, 2013b; Briggs, Lindorff, & Ivers, 2003; Clough, Robertson, & MacLaren, 2009; Power, Greal, & Rintoul, 2009). This scenario illustrates that while health promotion is not the cause *per se* of poor Indigenous health, it has generally been ineffective in engaging with the social, cultural and political context of Indigenous Australians.

Examination of the history of public health and health promotion in Australia reveals that these unequal outcomes are not new but rather, a continuation of colonial practices. In Australia, colonisation began with British settlement and the usurpation of

³ This statistic has been reported as a reduction of the life expectancy gap by 0.8 years for men and 0.1 years for women compared to previous periods (Australian Health Ministers Advisory Council, 2008; AIHW, 2011d). However, stakeholders in Indigenous health are yet to agree upon a specific estimate of the life expectancy gap and therefore magnitude of and progress regarding the gap (Rosenstock, Mukandi, Zwi, & Hill, 2013).

⁴ I acknowledge the technical difficulties of comparing data between these countries, related to concepts, data and methods (AIHW, 2011a).

Indigenous Australian custodianship of their lands according to *Terra nullius*⁵ (Sherwood, 2013a). Prior to this, Indigenous Australians had self-determined, healthy lives (Fredericks, Lee, Adams, & Mahoney, 2012). The establishment of the British penal colony in Botany Bay and subsequent “land grab” (Dudgeon, Wright, Paradies, Garvey, & Walker, 2014c, p. 7) involved many inhumane strategies. These strategies included massacres, rape, removal of children from their families, diseases and other serious disruption to traditional life that continue to have a profound impact upon Indigenous health and cause disadvantage (Fredericks et al., 2012; Fredericks et al., 2014; Mitchell, 2007; Sherwood, 2013a; Sherwood & Edwards, 2006). Consequently, colonisation is both an historical and ongoing process, recognised globally as a determinant of Indigenous health (Commission on Social Determinants of Health, 2007; King, Smith, & Gracey, 2009; Mitchell, 2007; Smith, 2012).

Health promotion is not separate to the process of colonisation and can be practised as an apparatus of control *over* Indigenous Australians, instead of working to increase Indigenous Australians’ control over their own health. In this way, a fundamental tension of health promotion is amplified, which is the focus of this thesis. In Australia’s postcolonial setting, health promotion practitioners must work to change Indigenous people and communities to live better, healthier lives while supporting increased community and individual control over their health. Consequently, although mainstream health promotion may aim to deliver effective and culturally safe practice, without genuine Indigenous community ownership of the process and outcome, the status quo may be the greatest beneficiary.

Fortunately, the Indigenous community controlled health service (CCHS) sector has substantial experience in Indigenous health promotion and primary health care (PHC), from which to learn. Indigenous people and communities have been practising health promotion since long before the Ottawa Charter was produced (Ward, 2014). Despite this experience, few health promotion studies exist that are positioned to learn from Indigenous community-led health promotion and that centres Indigenous knowledges, practices and perspectives. In fact, it appears that mainstream health promotion has largely ignored potential lessons from Indigenous organisations and practitioners. I

⁵ To enable occupation of Australia, the British settlers claimed *Terra nullius*, meaning “land belonging to no one”.

argue that mainstream health promotion could learn from and with practitioners at an Indigenous community controlled interface. Chapter Two discusses these issues further.

Why me? Why this topic?

...we, as health professionals, need to be prepared to place our own cultural practices under the microscope and examine their effect on the health of Aboriginal people. (Bond, 2005 p. 41)

Given this study is based upon a decolonising agenda, it is both vital and fitting that I introduce myself as the researcher early in this thesis. In accordance with Aboriginal protocol to declare my connection to this story (Anderson, 1997; Bond, 2007; Carey, 2008; Martin, 2003), I introduce myself here and discuss my positioning further in Chapter Three. I further intend that by introducing my positioning here, the contents of this thesis will be read accordingly, for what I write is derived from my own understanding of health promotion practice; it does not represent the collective Indigenous practice of health promotion.

I am a non-Indigenous health promotion researcher and practitioner who continues to benefit from the injustices of colonisation. My location intersects with the above-mentioned tension of health promotion practice. Accordingly, at the very least, to be an ethical researcher I must be aware and critical of my worldview for its influence on and application in this study; for knowledge is not produced context-free (May & Perry, 2011). As self-indulgent as this may feel or appear, the purpose of locating the researcher is to enable awareness of the researcher's self to contextualise and transcend it. Okely (1992, p. 2) reminds me that: "Self-adoration is quite different from self-awareness and a critical scrutiny of the self". With this in mind, in this research, I am both participant and enquirer.

I recognise the politics of endeavouring to decolonise my positioning and the limitations associated with the way people privilege different selves (consciously or otherwise). Likewise, this study's methodology, ethnography, has a remarkable history of colonial endeavours and associated harms, including with Indigenous Australians (Moreton-Robinson, 2000). Nonetheless, my intention is to respect Indigenous people and not

misappropriate Indigenous knowledge – a problematic intention in light of my researcher position. I also recognise that relationship is methodology (Nicholls, 2009) and my social positioning is part of naming my methodology (Moreton-Robinson & Walter, 2010).

I am Karen Rao (nee McPhail-Bell), eldest of four children. My maiden name is significant, for it symbolises my biological heritage as well as heritage of heart: McPhail being my father's surname and Bell the surname of my mother and stepfather who raised me. I am a non-Indigenous Australian with Irish, Scottish and English ancestry, born on Noongar land (Perth). I moved when I was 9 to be raised on Mununjali land (Beautesert). My childhood experiences shaped my sense of justice early on, where I gained personal insight into the direct link between justice and health. My passion for people's health matured and in time, my conceptualisation of health was founded upon a belief in the importance of having control over one's health and ability to improve it. Becoming a health promotion practitioner, with its disciplinary emphasis upon advocacy, enabling and mediating (WHO, 1986b), seemed a natural fit for me.

My career in health began when I was 13 years old in the aquatic and fitness industry. I progressed to the field of public health and development after completing an undergraduate degree in behavioural science and public health. I followed opportunities as they presented and melded with my values, and gained international experience at the interface of advocacy, policy and community health. I worked in roles across the Queensland Government health department, non-government organisations (Oxfam Australia, ADRA Solomon Islands, Queensland Council of Social Services), the World Health Organization (Geneva) and academic agencies (Queensland University of Technology and Griffith University), based predominantly in Australia and the Pacific Islands (particularly Papua New Guinea and Solomon Islands). Such experience arguably provided me with an introduction to the wider system I am now positioned in as a public health professional, and accordingly, an increasingly critical view.

I questioned my profession's actions and ethics: how was it that for so many years, our efforts to address the root causes of illness and disease (namely, poverty and vulnerability) led to little or no change for those who most needed it? How could we be so successfully busy with individualistic-focused strategies and biomedical and

behavioural explanations for issues we knew (the evidence showed us) were structurally caused? Were our efforts all rhetoric, serving only the dominant powers of the time? Across various assignments from Solomon Islands to Geneva, from Ireland to Melbourne, I began to realise how deeply rooted inequalities are in neoliberal power and White privilege. Further, as a non-Indigenous, Western-trained health professional, I could in fact be part of the “problem”. The romantic view of what I could achieve as an international health and development professional was transitioning.

I sought ways to connect and contribute more meaningfully and beyond rhetoric, to challenge implicit agendas that seemed most fitting for White Australia’s interests. I engaged with the People’s Health Movement, of which I remain supportive, and was an executive member of the Queensland branch of the Australian Health Promotion Association (AHPA) until I recently relocated to Sydney. I endeavoured to learn more about Indigenous perspectives and White privilege. I remained critically reflexive regarding the approaches of the work in which I was involved. These included HIV and AIDS where I found that despite 25 years of evidence, political agendas and ideology seemed more influential for driving action in developing nations. I also came to see that noble health promotion efforts quite easily racialised and “Othered” (Bhabha, 1983) its target groups by way of generalised portrayals and narrow behavioural explanations of illness among poor people.

This lesson in an Australian context was crystallised for me in 2007 when the Australian Government released its Northern Territory Emergency Response, apparently to enact recommendations of the *Little Children are Sacred* report (Wild & Anderson, 2007). However, the Howard Government selected only two recommendations of the 97 outlined in the report. I worked at Oxfam Australia at that time, where the subsequent Close the Gap report was published in response (NACCHO & Oxfam, 2007). Amidst the excitement and outcry, I decided to return to an Australian perspective in my work, in hope of being an active part of a solution to the injustice experienced by many Australians, especially Indigenous Australians and others affected by inequality.⁶

⁶ I realise that to have this choice and to write about it in my own PhD thesis is a further indication of the privilege I carry into this research.

After returning to Brisbane, I was employed by Queensland Health to support the Queensland Indigenous Alcohol Diversion Program (QIADP) in 2009-2010, which was part of the Queensland Government response to the *Royal Commission into Aboriginal Deaths in Custody* (RCADIC) (discussed in Chapter Two). My position was in the same Queensland Health team that carried some of the cross-department responsibility for the Alcohol Management Plans (AMPs). These AMPs mean that alcohol restrictions exist that only apply to Indigenous people or Indigenous communities. These laws contribute to many Indigenous people coming into contact with the criminal justice system due to public consumption of alcohol (Cunneen, 2008), which acts against the RCADIC recommendations⁷ (Royal Commission into Aboriginal Deaths in Custody, 1992) (discussed in Chapter Two).

As a public servant implicated in this government response, I was confronted time and again with the amount of investment required for government departments to simply “partner” on a whole-of-government initiative, while the fundamental issues – such as those clearly identified in the RCADIC – remained unaddressed. The RCADIC resulted in the expansion of Indigenous justice interventions, including Murri Court (Cunneen, 2008). However, while these service developments were small but positive changes, in Queensland, Indigenous people remain 10.7 times more likely than other Queenslanders to be in prison and represent approximately a quarter of Queensland’s prisons population (Project 10%, 2010). Furthermore, Queensland’s Indigenous incarceration rates are higher than the national average, despite commitments of the *2001 Aboriginal and Torres Strait Islander Justice Agreement* to reduce these (Queensland Government, 2000).

I recall a moment with Bronwyn Fredericks (my associate PhD supervisor), discussing the prospect of undertaking a PhD in Indigenous health. I was cautious of the negative and harmful history of Eurocentric research and practice in relation to Indigenous people, yet hopeful to draw upon participatory and decolonising research methods (Braun, Browne, Ka‘opua, Kim, & Mokuau, 2013). Bronwyn’s words presented an opening for me in research:

⁷ For example, number 87, which is to only arrest people when no other way exists for dealing with a problem.

This is where you can make some difference to what happens here in your home country... we (Aboriginal people) need good people working with us, not around us and over us... if you do it well then it helps us. If you work with us it helps us. If you look at issues that Aboriginal and Torres Strait Islander people want you to look at then it helps us. If you work in good solid ways with integrity and honesty and ways that respect Aboriginal and Torres Strait Islander peoples then it helps us. If you work in ways that can lead to change then it helps us. To do nothing also maintains the inequities! To do something else and avoid the realities in this country around inequities and injustice maintains the inequities and injustice this is what I get upset at some folks for, like if they really wanted to address inequities in Australia they would put a lot more effort into Indigenous health, Indigenous housing, Indigenous employment, Indigenous education etc... and into their own and other peoples relationships with Indigenous peoples in this country... to leave alone leaves the issues alone and unaddressed... like 'if I don't look at it, do anything may be it'll go away' attitude or 'someone else will pick it up so I don't have to'. Problem is too many people act in this way and then it doesn't get picked up and no one else picks it up and Aboriginal people are left to do it on our own, the sickest are left to do, the poorest are left to do it, the most disadvantaged are left to struggle once again. So go for it Karen, it won't be easy but it will be worth it!! (Bronwyn Fredericks, personal communication, 11 September 2009)

It was from this base that relationships were built in preparation for the commencement of this PhD research. It is also from this base that my understanding of health promotion is that it is ultimately about control. The reality of increasing people's control over their health is informed by a history where health and welfare served a colonial agenda – and arguably continues to do so under the guise of White privilege and neoliberalism. As health promotion professionals, it is our responsibility to interrogate our practice, individually and collectively, in order to be accountable to whose control is in fact being increased over people's health; to “speak... truth to power and open... up areas of social silence to critical examination” (Baum & Fisher, 2014, p. 221). This thesis serves as a contribution to this endeavour.

Research agenda

The aim of this research is to contribute to the decolonisation of health promotion practice and accordingly, to recognise Indigenous knowledge, skills and experience in health promotion. To achieve this aim, this research enquired into the daily practice of a cross-section of Indigenous and non-Indigenous health promotion practitioners, in an urban setting. The overarching research question was *“How do health promotion practitioners in an urban Indigenous setting make sense of and navigate the tensions inherent to health promotion in daily practice?”*

I drew on a number of sub-questions to guide my response to the overarching research question, in terms of research process and data focus:

- What does contemporary daily health promotion practice look like in an Indigenous community controlled urban setting? Is there a difference between Indigenous-led and mainstream-led health promotion practice?
- How do health promotion practitioners approach the inclusion of community concerns and issues in their daily practice?
- How do urban health promotion practitioners negotiate the tensions of practice, including the challenge of behavioural versus structural accounts of health?
- How are urban health promotion practitioners incorporating Indigenous worldviews into their practice?
- What are the barriers and enablers experienced by urban-based health promotion practitioners to meet the needs of and work with the strengths of community?

Using an ethnographic approach, this research learned from practitioners of health promotion practice, led by and for Indigenous Australians. This study aimed to centre Indigenous perspectives and practice, rather than measuring how they met mainstream criteria and agendas. Accordingly, the study is interested in describing health promotion practice controlled by Indigenous people and communities in an urban setting.

A bricolage theoretical framework underpinned the research, drawing on postcolonialism (Bhabha, 1983;1994; Said, 1978;1993), critical race theory (CRT) (Ladson-Billings, 1998; Solorzano & Yosso, 2001; Solórzano & Yosso, 2002) and

cultural interface theory (Nakata, 2002;2007a). Postcolonialism and CRT positioned me as the researcher, as well as the health promotion profession and discipline, and provide a way of thinking about health promotion; whilst cultural interface theory enabled the analysis to shift beyond a critique of the Western, to uncover the practitioners' meaning-making in daily health promotion practice. Chapter Three further discusses the bricolage as the conceptual framework for this thesis. The bricolage informed the use of an expanded form of critical ethnography. Critical ethnography presented an invaluable research methodology for addressing the research gaps (discussed below), while practising the principles of empowerment within health promotion and centring Indigenous perspectives, knowledge and practice (Cook, 2005; Jamal, 2005; Thomas, 1993). Participant observation, the signature method for ethnography, is detailed in Chapter Four.

Research significance

This research makes an important knowledge contribution to health promotion by describing health promotion practice with Indigenous people in urban settings, while acknowledging Indigenous knowledge and skills. Given the research gap regarding health promotion practice in an urban context, this research contributes to the documentation of what an Indigenous perspective may look like for Indigenous people in an urban area. Additionally, the research process embedded relationship, self-reflexivity and mutual research capacity building between the involved practitioners and me as the researcher. This process supported the moulding of this research to contribute to the host agency by assisting the team of practitioners to develop an evidence-based health promotion framework for its practice, at their request. Beyond this study, the research has wider implications for health promotion in terms of how health promotion works with any group, particularly those groups marginalised or excluded from health promotion.

More broadly, Australia is currently involved in a search for better relations with Indigenous people – a process usually referred to as reconciliation⁸ (Chartrand, 2009).

⁸ The term “reconciliation” is fraught with unfinished business related to but beyond the scope of this proposal, such as claims that “reconciliation” is a euphemism for denial because “most Australians want the reconciliation part without the truth of history upon which it must be based” (Phillips, 2007).

In this context, this research has explored health promotion as a culture-bound practice. Accordingly, this study endeavoured to recognise the epistemological and ontological assumptions within health promotion, and to identify alternative epistemologies that might be at work within Indigenous communities. Ultimately, this thesis rests upon the recognition of the entwining nature of liberation for Australia, for both Indigenous and non-Indigenous people:

If you are here to help me, then you are wasting your time. But if you come because your liberation is bound up in mine, then let us begin. (Lily Walker p4 cited in Labonte, 1994; Lilla Watson cited in Riggs, 2004)

Research site: IUIH and Deadly Choices

The research site of this study is the Deadly⁹ Choices team within the Institute for Urban Indigenous Health (IUIH), based in Brisbane, the capital city of the state of Queensland in Australia. IUIH has been selected as the site for this study in light of a number of factors. Firstly, health promotion is part of IUIH's core business, with a range of programs, policy and advocacy activities working together to achieve its vision of equitable health outcomes for urban Indigenous peoples. Secondly, IUIH operates in a context that traverses the range of tensions of interest to this study, including corporate and mainstream health system requirements, a community-based reality and Indigenous frames of reference. IUIH thus represents fertile ground to explore practitioner narratives and practice, in their navigation of the tensions discussed within health promotion practice. It also presents an important opportunity to gain greater understanding of the operationalising of an Indigenous health promotion agenda within the greater context of a Western health system.

When identifying potential study participants, consideration was made regarding the ongoing discussion and debate regarding the professionalisation of the health promotion profession (e.g., Harris & McPhail-Bell, 2007; Sadgrove, 2012; Shilton, Howat, James, & Lower, 2001). However, due to the decolonising research aim to acknowledge Indigenous knowledge, skills and experience in health promotion, this study does not intend to engage in these debates. Further, this study does not set out to evaluate whether the practitioners involved meet the relevant core competencies for health

⁹ The term 'deadly' is explained in Chapter Five.

promotion (e.g., AHPA, 2009; Queensland Health, n.d.-a; Queensland Health, n.d.-b), nor enter into the international debate as to what constitutes health promotion core competencies (Allegrante et al., 2009; Barry, Allegrante, Lamarre, Auld, & Taub, 2009; Madsen & Bell, 2012). This is largely because much of the establishment of health promotion has excluded Indigenous knowledge, perspectives and practice, so is therefore not accountable to Indigenous agendas.

Why urban?

When we live in a city or town, we don't become any less or more Indigenous... The blood of my ancestors still flows through me, as it does through other Aboriginal people, and we breathe, walk and live on Country that is occupied by cities. (Fredericks, 2013, pp. 4, 5)

Indigenous Australians living in cities and towns represent 74% of the total Australian Indigenous population (ABS, 2012), contribute 65% of the overall Indigenous disease and injury burden, and experience 59% of the Indigenous health gap – of which, 70% is explained by preventable non-communicable diseases (Vos, Barker, Begg, Stanley, & Lopez, 2009; Vos, Barker, Stanley, & Lopez, 2007). In other words, the majority of the health gap affects Indigenous residents of non-remote areas (Vos et al., 2009). This is important to note because 28% of Indigenous Australians live in Queensland, of which 26.9% live in greater Brisbane (ABS, 2012) and more broadly, 38% in South East Queensland (SEQ) (IUIH, 2013d). To put these demographics into a Queensland health context, research found a 13.1 year deficit in the Health Adjusted Life Expectancy (HALE) in Indigenous people compared to non-Indigenous people (Begg, Khor, Bright, Stanley, & Harper, 2008).

Urban-based Indigenous people are also exposed to complex socio-political tensions associated with urban Indigenous identity. Aboriginal women have written about the contradictions and struggles they face when living in urban environments (Fredericks, 2013). Studies have found that the dominant Australian culture at times regards Indigenous Australians with darker skin colour as being “more Aboriginal” and authentic in terms of their Indigeneity (Ivanitz, 1999). Indigenous people who are successful in the ways governments want them to be, or who do not live in a ‘traditional’ manner, may also be seen as having no culture (Reconciliation Australia, 2010). Often Indigenous Australians do not ‘fit’ the pre-conceived notion of

Indigeneity, particularly urban-based Indigenous Australians who may not behave according to mainstream imaginations and ideals of the ‘traditional’ Indigenous person (Behrendt, n.d.; Bolt, 2010; Bond, 2007;2014; Brough et al., 2006; Fredericks, 2004;2013; Nelson, 2010). Given the tensions involved regarding Indigenous urban identity and health (Bond, 2005;2007; Bond & Brough, 2007; Bond, Brough, & Cox, 2014; Brough et al., 2006; Fredericks, 2004), as well as the limited research regarding Indigenous health in urban areas (Eades et al., 2010), this thesis is concerned with urban Indigenous health promotion practice.

The Institute for Urban Indigenous Health – A new direction for community control

In 2009, the four Community Controlled Health Services (CCHS) in South East Queensland¹⁰ (SEQ), with the leadership and support of QAIHC¹¹ (AMA, 2011; IUIH, 2013c), established IUIH. IUIH’s establishment was a strategic response by these bodies to the growth and geographic dispersion of Indigenous populations within SEQ and their associated under-servicing (IUIH, 2011c); they recognised that a new direction for the CCHS was needed. The 2009 establishment of IUIH arose through QAIHC’s regionalisation strategy regarding health sector reform (QAIHC, 2010), with IUIH being the first Institute for Indigenous Health proposed for Queensland (QAIHC, n.d.). Since that time, IUIH has expanded from six staff members in 2009, to over 350 employees across IUIH and the clinics it established, such as Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS¹²) in 2014.

IUIH is positioned to provide support for Indigenous health service development and coordination across SEQ (IUIH, 2011b, p. 6). It is also positioned to support the implementation of Closing the Gap initiatives and other strategic developments, through partnerships and integration with mainstream health services (IUIH, 2011c). IUIH is governed by a board, which comprises four directors nominated by each of the four member CCHSs, as well as four independent skills-based directors appointed by those

¹⁰ The four AMSs are: Aboriginal and Torres Strait Islander Community Health Service (ATSICHS); Kalwun Development Corporation (Kalwun); Yulu-Burri-Ba Aboriginal Corporation for Community Health (Yulu-Burri-Ba); and Kambu Medical Service (Kambu).

¹¹ QAIHC is the Queensland Aboriginal and Islander Health Council and, as the peak CCHS body for Queensland, is a NACCHO affiliate. QAIHC was established in 1990 and currently represents 26 community controlled health services.

¹² At the time of writing, IUIH was responsible for the operation of MATSICHS, with an established plan for the eventual transition of the clinics within this service to Brisbane ATSICHS (IUIH, 2013d).

four nominee directors. The chairperson of this eight-member board is appointed from amongst the four CCHS-nominated directors (IUIH, 2011b). For its operations, IUIH has a number of business units to implement its strategic priorities and those of its member CCHS, in an effort to meet the needs of Indigenous communities in SEQ (IUIH, 2011c). At the time of writing, there were six business units, in addition to MATSICHS: Preventative Health; Clinical Services; Research and Evaluation; Allied Health and Workforce, Corporate Services, and Operations and Communications (IUIH, 2014e).

IUIH maintains that its model for operation is the only one of its kind in urban Australia (IUIH, 2013e), providing a way for Indigenous communities to have a voice in improving health outcomes in an urban setting (IUIH, 2012). With an emphasis upon tangible outcomes, IUIH has worked with SEQ AMSs to drastically increase the number of clinics and facilities available to Indigenous Queenslanders in the SEQ region (IUIH, 2014g). Since 2009, these clinics have grown from five to 17, with more planned (IUIH, 2015).

Deadly Choices: “Empowering Aboriginal and Torres Strait Islander people to make healthy choices”

IUIH established Deadly Choices during 2010 in response to rising prevalence of chronic disease in Indigenous Australian communities. As one of a number of IUIH program areas, Deadly Choices was funded primarily through the Australian Government Closing the Gap initiative (IUIH, 2013c) - specifically, Australian Government tobacco and healthy lifestyle funding (IUIH, 2010b). That Deadly Choices was established in response to an external government agenda contrasts the grassroots beginnings of the CCHS sector (Best, 2005; Foley, 1982;1991; Gillor, 2011; Gillor, 2012; Waterford, 1982). The way Deadly Choices was established reflects the neoliberal environment within which the majority of Australia’s health promotion currently operates (Baum & Fisher, 2014), where “lifestyle drift” sees government commitment to address social determinants of health enacted through lifestyle interventions to change behaviour (Baum, 2011c, p. 405). However, as will be discussed in later chapters of this thesis, how a service begins is not necessarily how it continues. With this in mind, the story of Deadly Choices offers lessons about community-driven approaches in Australia’s neoliberal environment.

IUIH delivers health promotion through a number of its teams, including Deadly Choices. The Deadly Choices team¹³ is responsible for implementing relevant IUIH initiatives, including a social marketing strategy, the Broncos Deadly Choices partnership, and the Deadly Choices Education Program. The Deadly Choices Education Program includes community days, Good Quick Tukka (GQT), and tobacco action (IUIH, 2013d). The Deadly Choices team encourages community engagement online and offline (for example, Box 1). At IUIH's request, this research was framed to enable support for the (at the time, new) team to establish its framework of practice and develop its research capacity. Figure 1 provides an overview of the fields of practice covered by Deadly Choices during this research.¹⁴

This is something all Murry kids want to be apart of. As a kid, I always wanted to do deadly things and be called 'deadly'. Now, I live my life making Deadly Choices. I love this campaign. Props guys. Much love. Peace.

Good program delivered by passionate people.

Box 1: Two examples of community reviews of Deadly Choices, submitted to Facebook in March 2014 (URL: <https://www.facebook.com/deadlychoices/reviews> - Accessed 28/11/2014).

¹³ The nomenclature of this team has changed over time, having first been referred to as the Healthy Lifestyle Program (Fletcher, 2012), then the Healthy Lifestyle Team and its current name, the Preventative Health Unit. This study refers to the team as the Deadly Choices team for ease and consistency in the telling of this story.

¹⁴ Note that the IUIH and Deadly Choices staff portrayed in images within this thesis are not necessarily participants in this study.



Figure 1: Schema of Deadly Choices practice during this research.

The team of Deadly Choices practitioners is a young¹⁵ and vibrant one, involving many long-term relationships and friendships. At the time of writing, the Deadly Choices team comprised 16 staff members across three teams. This represents a rapid growth from its initial size of five staff in 2010 (Fletcher, 2012). The majority of the Deadly Choices team identify as Indigenous, with a small number of non-Indigenous people, and demonstrate a shared commitment to improving Indigenous health. The Deadly Choices team has a variety of backgrounds in terms of experience, family origins and educational qualifications. The team is mostly male and a number of its members maintain serious involvement with rugby league, professionally and semi-professionally. In fact, a number of the practitioners maintain strong and continuing links to National Rugby League (NRL), which appears to facilitate access to the NRL cultural capital and celebrity status for Deadly Choices' engagement mechanisms. Therefore, the health promotion background of a number of these practitioners is through their involvement with community, including for some, community

¹⁵ The majority of the Deadly Choices team members are in their twenties.

responsibilities associated with being a professional NRL player, and for most as ‘recipients’ of health promotion. Chapter Four introduces this team in detail.

This work’s relationship to the words ‘Indigenous’ and ‘mainstream’

In this thesis, I use the term Indigenous Australians to refer to both Aboriginal and Torres Strait Islander people. I use the words “Aboriginal” and/or “Torres Strait Islander” if they are contained within a quote, a government or organisational document, or in reference to a specific point. I have engaged and reflected much on my decision regarding the use of the word “Indigenous”, asking questions such as, “How do I define Indigenous?” and, “Am I using it in a way that is consistent with its definition?” This process of reflection involved speaking to Indigenous people, reading the work of Indigenous scholars and attention to whose knowledge I draw upon throughout this research. My use of the term Indigenous accordingly encapsulates this global body of knowledge and groups of peoples.

Such reflection illuminated the contentious undercurrent of this term’s use. For example, the word Indigenous has been co-opted politically by descendants of settlers who lay claim to an Indigenous identity simply by way of their occupation and settlement of land over several generations, or for being born in that place (Smith, 2012, p. 7). However, the aforesaid claims to Indigeneity are not matched with attendance at Indigenous peoples’ meetings or formation of alliances that support self-determination of Australia’s original landowners. Such people arguably do not struggle as a society for the survival of Indigenous languages, knowledges & cultures, given theirs lie somewhere else (Smith, 2005). I therefore use the term Indigenous carefully, aware of its limitations and hopeful that I have achieved a respectful use of it.

Likewise, I use the term mainstream to reference non-Indigenous Australians and systems, and more generally to reference the hegemonic norm shared by the majority of people and power brokers. Similarly, the term mainstream is one widely used in public health discourse and by Indigenous people to reference non-Indigenous services. I acknowledge there are groups who may experience disadvantage or marginalisation in Australian society within this group according to this definition. The distinguishing

difference in relation to Indigenous Australians is that mainstream society was not living on Australian land before colonisation; they came from elsewhere. Indigenous Australians thus face discrimination at individual and institutional levels that is unique to the colonial legacy of Australia, as well as disadvantage based on race, gender, and class. Furthermore, mainstream health services have been shaped by this colonial legacy, which continues to marginalise Indigenous Australians today.

I acknowledge that to suggest a binary of Indigenous/mainstream is an essentialising act of reducing populations and that the reality is far more complex. Given the rampant identity policing of Indigenous Australians in Australia's discourse today, I especially do not want to detract from the fact that Indigenous Australians comprise diverse Aboriginal and Torres Strait Islander nations, with their own language and traditions. However, for the purpose of distinguishing locus of control and genealogy of knowledge, particularly in a postcolonial society, this terminology aids the opening of discussion.

Thesis outline

This thesis provides my ethnographic account regarding a team of Indigenous and non-Indigenous health promotion practitioners based in an Indigenous CCHS organisation in SEQ. This thesis is divided into nine chapters. This introductory chapter has presented the context to this thesis, including the precarious nature of control in Indigenous health promotion. The research aim, significance, site and me as a researcher have also been presented in this chapter. In Chapter Two I discuss the current research regarding Indigenous health promotion and the impact this has had upon Indigenous health outcomes. I then trace the historical underpinnings of public health and health promotion in Australia, through to contemporary Indigenous health promotion practice according to global discourses and the CCHS sector in Australia. Importantly for this study, Chapter Two reveals the centrality and tension of control to health promotion, particularly within an Indigenous context.

Chapter Three provides details of the bricolage conceptual framework designed to inform this study. This bricolage includes my researcher standpoint and theoretical framework, based upon the three theoretical tools stated earlier: postcolonialism, CRT

and the cultural interface. The bricolage also incorporates the use of critical ethnography in online and offline fieldwork with Deadly Choices. Chapter Four then discusses the schema of ethnographic methods employed according to this bricolage and introduces the participants of this research involved through Deadly Choices at IUIH.

In Chapters Five, Six and Seven I present the findings of this study, based upon approximately eighteen months of ethnographic fieldwork. In Chapter Five, I introduce Deadly Choices as a health promotion initiative, providing details of its agenda and positioning in relation to mainstream health promotion. In Chapter Six, I discuss a range of strategies I observed the Deadly Choices practitioners undertaking, including the Deadly Choices model of distributive leadership. This model is underpinned by relationship-based practice, which is an enabler for much of the Deadly Choices practice, including the community-driven interactions via the various Deadly Choices social media platforms. Chapter Seven discusses in detail Deadly Choices' innovative use of social media for health promotion and concludes by unpacking the significance of community control for the success of the Deadly Choices practitioners' work. The impact of community control includes construction of Indigenous identity in health promotion by Indigenous people, and a non-Indigenous following that shifts the colonial undertones of health promotion.

In Chapter Eight I locate the findings in relation to the decolonising possibilities available to health promotion. This chapter discusses the findings in terms of how Deadly Choices practitioners navigate the tensions of health promotion practice. The discussion is particularly focused on how the Deadly Choices practitioners navigate health promotion's primary tension of working to colonise people's bodies to induce "healthy" behaviour and outcomes, while simultaneously working according to the goal of empowering people to have control over their lives (discussed in Chapter Two). I then introduce a model for decolonising health promotion, which was developed based upon the findings of this study and comprises four principles for practice, being: relationship (which underpins the remaining three); empowerment; choice; and Indigenous community control.

Chapter Nine concludes by articulating the thesis argument, its contribution and implications for health promotion. In Chapter Nine, I emphasise the opportunity and

imperative for health promotion to adhere to its own principles by listening to, and learning from and with, Indigenous people on Indigenous terms. I also discuss the limitations of this work and opportunities for future research and conclude with a personal reflection of how this research has taught and shaped me as a researcher and health promotion practitioner, in my endeavour to decolonise my own practice.

2. “Work with us not for us” – Indigenous health promotion in Australia

In his Social Justice and Native Title Report, Mick Gooda, the Commissioner for Aboriginal and Torres Strait Islander Justice called for the Australian Government to “work with us” (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2014). Gooda continued his call to “work with us not for us” beyond this report (Gooda, 2014a;2014b), cutting to the heart of the importance of and struggle for Indigenous control over their own health and affairs. This chapter addresses three overriding matters relating to this struggle. Firstly, the state of Indigenous health and associated Indigenous health promotion research is summarised and critiqued. Secondly, the historical basis covered in section one is built upon, to unpack the underpinning tension of the moral distress experienced by health promotion practitioners (Sunderland, Harris, Johnstone, Del Fabbro, & Kendall, 2015). This moral distress relates to the overarching tension examined by this thesis, where practitioners aim to change people’s behaviour to be “healthy”, while remaining non-coercive and empowering. Finally, the chapter concludes by highlighting the sparse evidence of mainstream health promotion learning from Indigenous-led health promotion, and the opportunity that this gap presents for the decolonisation of health promotion. This chapter is written from the overarching theoretical perspective of the thesis (discussed in Chapter Three), which draws on critical race theory, postcolonial theory and cultural interface theory.

Time to make peace: The failure of health promotion

Australia has a world-class health system and is considered a world leader in health promotion. Australia consistently ranks in the best performing group of countries for healthy life expectancy (currently ranked seventh in the OECD nations) and health expenditure per person (ranked thirteenth in the OECD nations) (Office of Economic Development, 2013). Yet despite this success, health promotion has largely failed Indigenous Australians.

While the claim that health promotion has failed may seem severe, it is based upon the minimal, if not absent, improvement in Indigenous health outcomes. The claim is not a charge of blame towards health promotion for poor Indigenous health outcomes, nor one against the many dedicated health promotion professionals working to improve Indigenous health. Rather, it is made in the belief that from health promotion's failure to engage with the social, historical, political context of Indigenous Australians, we can learn. In this way, the health promotion fraternity is presented with an opportunity to mature in its endeavour of Indigenous health promotion – to make peace with its failure.

Like many other fields in public health, the evidence-based movement influences the practice of health promotion (Potvin, Juneau, Jones, & McQueen, 2011), although exactly how is not completely understood (Juneau, Jones, McQueen, & Potvin, 2011). In the case of Indigenous health promotion in Australia, the evidence base remains limited regarding its effectiveness (Lee, Jagtenberg, Ellis, & Conigrave, 2013; McCalman et al., 2014; O'Donoghue et al., 2014; Power et al., 2009; Wise, Angus, Harris, & Parker, 2012a). Research primarily pays attention to a diverse range of behaviours, risk factors and disease. Substance use is a main feature in Australian health promotion research in relation to Indigenous health promotion (Lee et al., 2013), particularly alcohol (Brady & MacKenzie-Taylor, 2002; Conigrave et al., 2012) and tobacco use (Ardler, Booker, McLeod, & Mark, 2004; Bond, Brough, Spurling, & Hayman, 2012; Campbell, Finlay, Lucas, Neal, & Williams, 2014; Ford, Clifford, Gussy, & Gartner, 2013; Hearn et al., 2011; Ivers et al., 2005; Johnston & Thomas, 2010; Johnston, Thomas, McDonnell, & Andrews, 2011; Johnston, Westphal, Earnshaw, & Thomas, 2012; Marck et al., 2014; Mark, McLeod, Booker, & Ardler, 2005; Wise et al., 2012b). Likewise, research regarding Indigenous lifestyle programs and physical activity are prevalent (Aboriginal Health and Medical Research Council of New South Wales, 2009; Doran & O'Brien, 2007; Fredericks, Row Row, & Weazel, 2005; Hunt, Marshall, & Jenkins, 2008; Kiran & Knights, 2010; Nelson, 2009; Parker et al., 2006; Thompson, 2009), as well as sexual health (Arabena, 2006; Arabena & Mikhailovich, 2005; Crouch & Fagan, 2014; McEwan, Crouch, Robertson, & Fagan, 2013; Mooney-Somers et al., 2009; Stewart & Walsh, 2011; Ward, 2014; Whiteside, Tsey, Crouch, & Fagan, 2012).

Other health issues receiving attention in the literature include nutrition (Abbott, Davison, Moore, & Rubinstein, 2010; Aboriginal Health and Medical Research Council of New South Wales, 2009; AIHW, 2012; Colles, Maypilama, & Brimblecombe, 2014; Dawson, Richards, Collins, Reeder, & Gray, 2013; Gilchrist et al., 2004; Murray et al., 2014; Viola, 2006), hearing (Adams, Dixon, & Guthrie, 2004), eye health (Atkinson, Boudville, Stanford, Lange, & Anjou, 2014; Boudville, Anjou, & Taylor, 2013), and mental health (Clelland, Gould, & Parker, 2007; Cox et al., 2014; Sheehan, Ridge, & Marshall, 2002; Stacey et al., 2007). In terms of diseases, diabetes and chronic disease appear to receive the majority of research concentration (Abbott et al., 2010; Browne, D'Amico, Thorpe, & Mitchell, 2014; Dussart, 2009; Schoen, Balchin, & Thompson, 2010).

Beyond this, researchers have raised the importance of health equity, human rights (Awofeso, Brooklyn, & Williams, 2010; Couzos, 2004), and reconciliation (Jackson-Pulver & Fitzpatrick, 2004) for Indigenous health promotion in Australia. Social determinants of health also feature in Indigenous health promotion research (Awofeso et al., 2010; Commission on Social Determinants of Health, 2007; Ferdinand, Paradies, Perry, & Kelaher, 2014; Gallaher et al., 2009; Hunter, 2010; Marmot, 2011; Purdie & Buckley, 2010; Thomas, Briggs, Anderson, & Cunningham, 2008; Willis, Pearce, McCarthy, Jenkin, & Ryan, 2006). A handful of practitioners and researchers advocate for and present alternative approaches in practice (Brough, Bond, & Hunt, 2004; Brough et al., 2006; McLennan & Khavarpour, 2004; Murphy, Kordyl, & Thorne, 2004; Pyett, Waples-Crowe, & van der Sterren, 2008), and researchers beyond Australia have proposed Indigenous models (Chino & DeBruyn, 2006; Durie, 1999;2004) and decolonising models of health promotion (Mundel & Chapman, 2010).

Some Western models of health promotion, such as the PRECEDE/PROCEED model and Hygiene Improvement Framework (HIF), have been identified as suitable for use in remote Indigenous communities for their ecological and comprehensive approach (McDonald, Bailie, Grace, & Brewster, 2010). An ecological model has likewise been presented as suited for adapting to local models of health and wellbeing, with its recognition that social inequality is a failure of institutional systems, policies and perspectives (Chino & DeBruyn, 2006; Department of Health, 2005; Reilly et al., 2011). However, the use of Western models comes with caution to consider Indigenous

perspectives (Nelson, 2010). Other examples of effective health promotion recognise principles of cultural security, social connections, community development and capacity building (Department of Health, 2005; McLennan & Khavarpour, 2004; Thorpe, Anders, & Rowley, 2014).

There have been some successful public policy interventions in Australia¹⁶ and success in HIV prevention in Indigenous communities, where HIV rates between Indigenous and non-Indigenous Australians remain very similar (Nakhla, Middleton, McDonald, Guy, & Ward, 2014; Ward, 2014). Other improvements in Indigenous health are evident. The gap mortality rates for Indigenous children under five since 1998 has reduced by 35% (Australian Government, 2015). The gap in Year 12 attainment has reduced by 11.6% for Indigenous Australians aged 20-24 (Australian Government, 2015). There are also examples where health promotion specifically has positively impacted Indigenous health. For instance, the Family Well Being Program (FWB) is an empowerment program initially developed by Indigenous leaders to empower Indigenous people and communities to support, develop and build Indigenous wellbeing (Tsey & Every, 2000). The FWB has since expanded through a partnership between universities, government and non-government service providers. The FWB is holistically grounded in Indigenous Australian knowledge (Tsey et al., 2007) and has led to enhanced capacity in participants to exert control over factors shaping their health and wellbeing (Tsey et al., 2009). There are many other health promotion processes and practices that have positively impacted Indigenous health, including social media to recruit and retain Indigenous clients in AMSs (Hodgson & Bennett, 2014) and initiatives that endeavour to engage community in empowering ways for health improvement (e.g., Aboriginal Health and Medical Research Council of New South Wales, 2009; AHPA, IUHPE, CRCAH, & QAIHC, 2009; ANTaR, 2007;2010; Fletcher, 2007; Malseed, Nelson, & Ware, 2014a; Malseed, Nelson, Ware, Lacey, & Lander, 2014b; Nelson & Hall, 2013).

This thesis acknowledges these successes in Indigenous health promotion, as well as the ongoing, genuine support of a workforce of health promotion practitioners. However, health promotion involves a wide-ranging continuum of processes and practice (as

¹⁶ One example is South Australia's Health in All Policies work (Baum, Newman, Biedrzycki, & Patterson, 2010; Buckett, Williams, & Wildgoose, 2011).

discussed in section two of this chapter) and so it is beyond the scope of this thesis to review and evaluate all Indigenous health promotion initiatives. Furthermore, this thesis posits that despite these successes, the majority of health promotion approaches have shown little impact upon the burden of disease in Indigenous communities (Garnett et al., 2008; McLennan & Khavarpour, 2004; Mikhailovich, Morrison, & Arabena, 2007; Vos et al., 2010). This claim is evidenced by the lack of overall improvement, and at times regression, in Indigenous health outcomes.

Indigenous Australians suffer grossly disproportionate rates of disadvantage against all measures of socioeconomic status, including health (Baum et al., 2012a). Differences in health outcomes between Indigenous and non-Indigenous Australians are most stark in relation to chronic and communicable diseases, infant health, mental health and life expectancy (AIHW, 2011c; Calma, 2006; Scrimgeour & Scrimgeour, 2008; Vos et al., 2009). The incidence of end stage renal disease among Indigenous Australians has more than tripled in the past decade (AHMAC, 2008), more than six times as high as non-Indigenous Australians (AIHW, 2007). While almost non-existent in the non-Indigenous population, male Indigenous deaths from rheumatic fever are 15 times that of non-Indigenous males, and female Indigenous deaths 23 times higher than non-Indigenous females (Australian Government, 2012). Australia is also the only developed country on the World Health Organization's (WHO) list of trachoma endemic countries, because trachoma is endemic in Indigenous Australian populations (Department of Health, 2011). Rates of overweight and obesity are steadily increasing, with Indigenous Australians nearly twice as likely to be obese as non-Indigenous Australians (AHMAC, 2008; AIHW, 2011c). Indigenous Australians are also exposed to additional pathways to inequality through the influences of colonisation, racism, loss of land and the Stolen Generation (Anderson, 2007b; Bailie, 2007; Carson, Dunbar, Chenhall, & Bailie, 2007; Clapham, O'Dea, & Chenhall, 2007; Dunbar & Scrimgeour, 2007; Gray, 2007). These inequalities, stemming from structural disadvantage, manifest themselves in poor health outcomes for Indigenous Australians.

While the statistics regarding poor Indigenous health outcomes are often used to justify mainstream health promotion policies and programs¹⁷, they more pointedly provide evidence of lack of effective action to address poor Indigenous health. This leads to the question of why the general health promotion fraternity – with some exceptions (e.g., Bond, 2007; Bond & Brough, 2007; Bond et al., 2012; Brough et al., 2004; Pyett et al., 2008) – has generally not queried its own failure with Indigenous Australians. I argue this speaks to the working of colonial imaginations in health promotion.

The Great Australian Silence¹⁸ – The colonial basis of health promotion

Health promotion may be a relatively new discipline in the public health landscape yet it was founded in a historical, social and political context of colonisation that continues today. These colonial processes have contributed to the failure of health promotion to forge genuine partnerships with Indigenous Australians to enable them to control their own health. To understand contemporary health promotion practice, this thesis first traces health promotion's historical basis in colonisation and the silencing of Indigenous Australian voices.

The process of colonisation continues to position Indigenous Australians as prehistoric and has influenced the way the Western disciplines of anthropology, history and literature came to understand Indigeneity¹⁹. This impacts Indigenous people in many ways, including urban-based Indigenous people who face a particular set of contradictions and struggles (Behrendt, 1994; Bolt, 2010; Fredericks, 2013) (discussed in Chapters One and Nine). Understanding of Indigenous people in the human sciences occurs within cultural frameworks, positioning them as primitive and inferior in a colonial (and post-colonial) setting (Nakata, 2002).²⁰ This mainstream public health “knowing” of Indigenous Australians is based upon the way that Indigenous Australians have been talked about in the past (Bond, 2007). This results in Indigenous health being bound to old imaginings of Indigenous people (Brough, 1999;2001; Fredericks, Adams,

¹⁷ For example, many Indigenous health government project cases and policies include a background section outlining poor Indigenous health outcomes as justification for that particular project or policy.

¹⁸ “The Great Australian Silence” is a term coined by W.E.H. Stanner in his 1968 ABC Boyer Lecture (Gunstone, 2012).

¹⁹ To claim Indigeneity involves self-consciously recognising particular cultural traits (such as language, religion, ancestry) as important emblems in representing one's self. To mobilise these emblems as signifiers of Indigeneity is to make a political statement of solidarity with others who identify as Indigenous (Harris, 2013, p. 10).

²⁰ Though more recently celebrated as different (Nakata, 2002).

& Edwards, 2011a; Gillor, 2011; Mitchell, 2007), generating a discourse largely based upon deficit and lack of acknowledgement of the history of vibrant Indigenous resistance (Foley, 2010).

In response to colonisation, Indigenous Australians entered a frontier war involving widespread dispossession (Donovan, 2002; Foley & Muldoon, 2014). Soon after, in the protectionist era²¹, missionaries and government determined that Indigenous Australians were doomed and progressed their policy approach to “smooth the dying pillow”²² (HREOC, 1997). When it was clear the population of Indigenous Australians continued to increase – rather than die out – the colonial agenda shifted to merging and assimilation²³, where the forcible removal of Indigenous children from their families to be held by the State was amplified, creating the Stolen Generation²⁴ (HREOC, 1997). For that reason, the State assimilation agenda became “the aim of ‘native welfare measures’” (HREOC, 1997, p. 2).

The health system is heavily implicated in the State’s damaging colonising practices (Kowal & Paradies, 2005; Thomas, 2004). Public health before 1950 was a form of colonial control over Indigenous Australians, entangled with the politics of a White Australian identity, which the health system was to protect (Thomas, Bainbridge, & Tsey, 2014, p. 51). Prior to the 1980s, there was little epidemiological evidence on Indigenous health, apart from occasional measurement within the context of a contagious or polluted Other (Brough, 2001). Historical notions such as social Darwinism, assimilation, and “dangerous other” are all evident in the historical public health interest in Indigenous health (Brough, 2001). From this, commentators have concluded that the various governments’ main interest in Indigenous health was that

²¹ In the late nineteenth century, to address “native uprisings” and gain control over colonial settlements, the Australian Government introduced protection laws to allegedly save the “dying race” of Indigenous Australians (Fredericks et al., 2014). These laws enabled the Australian Government to control where Indigenous people lived and worked, what they could do and whom they could meet or marry, as well as the forcible removal of Indigenous children from their families, beginning the process that created the Stolen Generations.

²² The aspirational goal of “smooth the dying pillow” was for Indigenous Australians to die out.

²³ The policy of assimilation required all Indigenous people to attain the same manner of living as non-Indigenous Australians, to live in the same community with the same rights and privileges, customs and beliefs.

²⁴ The Stolen Generation comprises those people who were forcibly removed as children from their families by the Australian Government and state and territory governments, to be placed in institutions, missions, foster homes and with adoptive families. Indigenous people of mixed heritage were targeted as part of the assimilationist policies. The practice of removing children from their families continued until the 1950s and 1960s under child welfare legislation in most states (Fredericks et al., 2012).

disease might spread among Whites and thus required containment – not treatment – of Indigenous populations (Brough, 2001; Rowley, 1978; Thomas, 2004).

Despite Indigenous health becoming a federal issue in 1918, the Queensland Government continued to use health policy as a form of control over Indigenous Australians. During the policy approach of “isolation and segregation”²⁵, the State “Protector”²⁶ could order compulsory medical examinations for Indigenous people (RHTU, 1997). The State routinely ordered the removal and quarantining of Indigenous people suspected of illness (Parsons, 2010). The twentieth century leprosy management policies of Queensland illustrate this, where the Queensland Government combined its Indigenous management with its leprosy management. During colonial expansion, leprosy became labeled as a disease of non-White people – of colonial subjects (Gussow & Tracey, 1971) – which situated leprosy within the discourse of colonial medicine (Parsons, 2010).²⁷ These policies were implemented in island-leprosiums, such as Fantome Island, which housed Indigenous leprosy sufferers (Parsons, 2010). Police-assisted leprosy raids of Aboriginal communities, such as those led by medical practitioner Sir Raphael Cilento, enabled health professionals to implement policies of the Queensland Chief Protector of Aboriginals to capture and remove “troublesome Aborigines” to government institutions, such as those in Cherbourg and Palm Island (Parsons, 2010, p. 89).

In the 1950s, new drug therapies became available to treat leprosy. Despite the new treatments making a high number of patients in leprosariums eligible for discharge, this largely did not happen. In the case of Fantome Island, the Department of Native Affairs determined that all former ‘lepers’ be sent to Palm Island settlement, instead of their home districts (Parsons, 2010). Soon after, the Department of Health transferred

²⁵ Isolation and segregation was a protection and palliative care policy approach to “smooth the dying pillow of a dying Aboriginal race” (Loos, 1982).

²⁶ When Indigenous Australians were ruled as wards of the State, State Protectors were appointed whose role was to “protect” Indigenous Australians from cruelty and injustice and to protect their rights. In practice, the State Protector was controlling of Indigenous Australians with powers to move Indigenous people onto reserves, control marriage choices and prohibit family visits, and manage Indigenous people’s wages, bank accounts, wills and debts (RHTU, 1997).

²⁷ For example, Cecil Cook’s work positioned leprosy as a sexually transmitted disease from ‘racial mixing’ between White men and Aboriginal women, while Cilento positioned it as a racial susceptibility, with the negative impacts of colonisation and poor nutrition as an explanation for high incidence in Indigenous populations (Parsons, 2010). Leprosy presents an example of the way a racialised understanding of disease influences medical knowledge.

responsibilities for these patients to the Department of Aboriginal and Islander Affairs, formalising the Government's connection of its approaches to Indigenous management and leprosy management (Parsons, 2010). In this context, the health workers and police officers alike were representatives of colonial authority, as Fanon articulated in his work:

...going to see the doctor, the administrator, the constable or the mayor are identical moves. The sense of alienation from colonial society and the mistrust of the representatives of its authority, are always accompanied by an almost mechanical sense of detachment and mistrust of even the things that are most positive and most profitable to the population. (Fanon, 1965, p. 139)

Somewhat ironically, this coincided with the founding of the World Health Organization (WHO) in 1948, a defining moment in the global history of health promotion for its introduction of a human rights agenda to health. States party to the 1946 Constitution, including Australia (Australian Government, 2001), agreed to conform to a number of principles based upon happiness, harmonious relations and security of all people, including:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. (WHO, 1946, p. 2)

Despite Australia's apparent commitment to health as a human right "without distinction of race" (WHO, 1946, p. 2), Indigenous Australians continued to experience "notoriously bad" conditions and an "appalling state of... health" (Foley, 1982, p. 13; 1991). World Health Organization experts conducted a study in 1967 in Brisbane and condemned the appalling health conditions of Indigenous people as being on par with the most deprived African village (Best, 2005; Watson, n.d.). European apathy about Indigenous wellbeing was widespread, based upon a belief that improving Indigenous health was a waste of time, with mainstream health care often closed to Indigenous people (Mitchell, 2007). This attitude was also evident regarding the provision of appropriate living standards, with stories of Indigenous homes being burnt down by non-Indigenous groups (Howes, 2009). White Australians' expectation of Indigenous extinction reinforced the view that Indigenous poverty and death was a natural evolutionary order. The "doomed race theory" permitted White Australians' cruel and inadequate treatment of Indigenous Australians (McGregor, 1997). This harmful and unjust mainstream treatment of Indigenous Australians provided the incongruous

backdrop to the global developments in health promotion (see Table 1). The juxtaposition of global health promotion discourses and Indigenous social policy is discussed further below.

Table 1: The paradoxical milestones of health promotion and Indigenous health in Australia (adapted from Richmond & Germov, 2009)

Indigenous health milestones in Australia	Global health promotion milestones
1971 Redfern Aboriginal Medical Service established	1974 The Lalonde report – A new perspective on the health of Canadians
1976 National Aboriginal and Islander Health Organisation (NAIHO) established	1978 Alma Ata Declaration for Primary Health Care
1989 National Aboriginal Health Strategy	1986 Ottawa Charter for Health Promotion 1988 Adelaide Recommendations on Healthy Public Policy
1991 Royal Commission into Aboriginal Deaths in Custody (RCADIC)	1991 Sundsvall Statement on Supportive Environments for Health
1997 Bringing them Home Report on the Stolen Generations	1997 Jakarta Declaration on Leading Health Promotion into the Twenty-first century
2003-2013 National Strategic Framework for Aboriginal and Torres Strait Islander Health	2000 Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action; Framework for Countrywide Plans of Action for Health Promotion
2007 Northern Territory Emergency Response (NTER) & Cape York Welfare Reform Trial (CYWRT)	2005 Bangkok Charter for Health Promotion in a Globalized World
2008 Closing the Gap (CTG) policy	2008 Commission on Social Determinants of Health (CSDH) 2011 Rio Political Declaration on Social Determinants of Health
2013 National Aboriginal and Torres Strait Islander Health Plan (NATSIHP)	2013 Helsinki Statement on Health in All Policies

The Community Controlled Health Service movement and primary health care

A growing protest movement for Indigenous health continued building, in which activists situated poor Indigenous health and living standards within a broader political discourse, particularly colonial oppression (Foley, n.d.-a; Mitchell, 2007). The Aborigines Progressive Association (APA) called for equal civil rights and emphasised the link between physical illness and colonial genocide (Foley, n.d.-b). Similarly, the Australian-Aboriginal Fellowship (AAF), founded in Sydney, acted as a vehicle for political education and organisation. The AAF created a partnership between

Indigenous and non-Indigenous people in a campaign against state government policies of assimilation, while educating the wider community regarding issues affecting Indigenous people (Foley, 2010).²⁸ For example, the Charles Perkins Freedom Rides through rural New South Wales highlighted alarming examples of poor Indigenous health, as well as the power of popular discourse of racial health and hygiene as mainstream justification for the continued exclusion of Indigenous Australians (Foley, 2010;n.d.-b).

The CCHS movement

Mainstream health system failure of Indigenous Australians remained pronounced. Indigenous Australians faced poor health conditions, for which many could not afford treatment, caused by White prejudice, racist attitudes, suppression and alienation (Briscoe, 1974, p.167; cited in Gillor, 2012). At that time, the Aboriginal Legal Service in Redfern had recently been established and soon found it was “being swamped by people with a whole range of social and medical problems” (Hollows & Corris, 1991, p.99; cited in Gillor, 2012). In response to this ongoing mainstream denial of health care and exposure to disease, Indigenous people took their health into their own hands and created Aboriginal Medical Services (AMS) controlled and run by Indigenous people (Watson, n.d.). These AMSs formed the beginning of the community controlled health service (CCHS) movement. The first of these was the Redfern AMS, established in 1971, based upon the philosophical principles of “self-determination through community control” (Foley, 1991, p. 2). Since then, over 150 AMSs have been established across Australia, represented by a peak body known as the National Aboriginal Community Controlled Health Organisation (NACCHO), established in 1992. Prior to this, NACCHO operated as the National Aboriginal and Islander Health Organisation (NAIHO), established in 1976 (NACCHO, 2014b).

The CCHS movement represented the first of Indigenous health promotion in Australia (Ward, 2014) and holds a strong place in the history of resilience and control over health by Indigenous people (Gillor, 2012). The “crucial ethic” of the CCHS movement

²⁸ The AAF became associated with a number of trade unions and the Australian Union of Women and in doing so, brought members of the AAF to the attention of the Australian Security and Intelligence Organisation (ASIO), which was concerned about Communist involvement in the Indigenous movement (Foley, 2010). Later, in 1982 when NAIHO was encouraging people to join protest action at the Commonwealth Games in Brisbane, the Redfern AMS Newsletter reported ASIO harassment and alleged frame-ups of Aboriginal activists (Gillor, 2012).

was (and remains) to provide an all embracing and holistic approach to the health needs of all Indigenous clients (Watson, n.d., p. 2). The CCHS movement is based upon a model where the most important people are the patients – the Indigenous people – who run the service through an elected Indigenous board of directors (Foley, 1982). This Indigenous community control continues despite Australian Government attempts to exercise control over the work of CCHS sector (Foley, 1982), while remaining reluctant to provide funding (Fredericks & Legge, 2011).

The establishment of CCHS movement was significant for health promotion, in part because Indigenous views of health differ significantly to the Western biomedical perspective (McLennan & Khavarpour, 2004). Perhaps more fundamentally, the CCHS sector considers community controlled services, culture, self-determination and health equity to be the guiding principles for action to promote Indigenous health (NACCHO, 2013b). In effect, Indigenous control as the underpinning factor for the CCHS sector is not only effective (Gajjar, Zwi, Hill, & Shannon, 2014; Panaretto, Wenitong, Button, & Ring, 2014), but a demonstration of the endeavour of health promotion to increase people's control over their health, as first imagined in the Ottawa Charter (WHO, 1986b).

The Lalonde Report

While the CCHS movement was being established, significantly for health promotion globally, in 1974 the landmark document for health promotion, the Lalonde Report, was released (Lalonde, 1974). This report coined the term “health promotion” and identified four key fields that influence individuals' health (Baum, 2008; Lalonde, 1974; Richmond & Germov, 2009):

- The physical and social environment (over which individuals have little control)
- Human biology (physical and mental health)
- Lifestyle (over which individuals allegedly have control)
- The nature and resourcing of health care services.

The Lalonde Report was one of the first major governmental statements to recognise that maintaining the status quo in health care delivery would not be an effective long-term strategy – even if this were primarily due to financial concerns (Parish, 1995).

Although the Lalonde report has been criticised for too little attention to the social aspect or environmental impact upon lifestyle, it broadened the international debate beyond medicine and treatment and provided the major impetus for global health promotion initiatives (Richmond & Germov, 2009). This global development contrasted with the continuing struggle of Indigenous Australians to attain access to basic health care, to treat illness and disease caused by avoidable conditions to which the Lalonde Report drew attention.

National Trachoma and Eye Health Program

The *National Trachoma and Eye Health Program* (NTEHP) presents an example of the conflict for “authentic Aboriginal control” over their health (Gillor, 2012, p. 143), and the failure of the health system to partner with Indigenous Australians. The NTEHP was launched in 1976, less than a decade after the 1967 Referendum²⁹ and the introduction of the 1972 Whitlam Labour Government policy of Indigenous self-determination (Maddison, 2009). The NTEHP was a Commonwealth-funded program to address the high rates of preventable blindness-causing Trachoma (RACO, 1980), resulting largely from colonisation (Jones, Smith, & Briscoe, 2006, p. 63). The NTEHP resulted from lobbying led by Professor Fred Hollows with the Royal Australian College of Ophthalmologists (RACO), which received the Australian Government funds for the program (Jones et al., 2006).

A team of filmmakers joined the NTEHP team and created a 45-minute documentary. Produced in 1977, the documentary was originally called “Out of sight out of mind”. Upon the insistence of the Australian Broadcasting Commission (ABC) that the title was too contentious, the film was renamed to “They used to call it Sandy Blight³⁰” (Jones et al., 2006). The Commonwealth Department of Health (CDH)³¹ considered the documentary controversial and tried to censor it prior to screening on ABC to conceal the extent of ill health in Indigenous communities (Jones et al., 2006). The documentary eventually aired in 1978 as intended (Anonymous, 1978) and resulted in demonstrations of public support and donations to the NTEHP (Jones et al., 2006).

²⁹ The 1967 Referendum established Indigenous Australians’ full citizenship under the Commonwealth. This resulted in powers given to the Commonwealth Government to legislate for Indigenous Australians and for the inclusion of Indigenous Australians in the census.

³⁰ Sandy Blight is another name for trachoma.

³¹ The CDH was responsible for funding the NTEHP.

Discussions regarding who had control of NTEHP continued into the 1980s, until eventually NAIHO passed a vote of no confidence in the Department of Aboriginal Affairs Minister (Gillor, 2012). However, the lifespan of the NTEHP was much shorter in Queensland, when in 1987 then Premier Joh Bjelke-Peterson promptly ended it:

...Mr. Bjelke Peterson kicked Fred Hollows and his trachoma team out of Queensland for fighting against the inequalities in our health. It was seen as threatening and undermining the National Party line on Aboriginal health and was therefore dealt with effectively. (Watson, 1998; cited in Best, 2005, p. 49)

The Queensland premier's decision to end NTEHP is a telling sign of the political nature of Indigenous health. The Queensland Government continued to contravene federal laws of self-determination with a policy approach of assimilation. Despite this, the Commonwealth Government did not utilise its power to determine better service provision for Indigenous Australians, instead choosing not to "intrude unnecessarily" in State affairs (Best, 2005, p. 48). One of the Indigenous workers on the NTEHP team was fired based upon accusations his team was encouraging Indigenous people to vote in upcoming Queensland elections:

As our reputation grew and we combed the states, Queensland was the last to really tackle. We employed Clarrie Grogan and Mick Miller and they prepared the Cape and the Islands for our arrival. Joh Bjelke-Peterson and his party got wind of it and accused Clarrie and Mick of electioneering for the state elections. I didn't know what was going on, but I did receive my termination notice and it really rocked me. I was absolutely stunned to think the FACO or the Federal Health Department did not have the courage to stand by us. It was a big shock. I had never been sacked before or since. My political naiveté went out the window. (Jones, Buzzacott, Briscoe, Murray, & Murray, 2008, p. 37)

To this day, the use of legislation to control Indigenous people remains a signature part of Queensland's history (RHTU, 1997).

Alma Ata Declaration for Primary Health Care

In the same year that the NTEHP ended in Queensland, the Alma Ata Declaration was created (WHO, 1978). The Alma Ata Declaration was the first internationally recognised emphasis upon wellbeing as the centre point for improving health (Venediktov, 1998). The Alma Ata Declaration emerged in a new political context that included the presence of a decolonising Africa and the influence of a global anti-

imperialist and leftist movement (Cueto, 2004; Venediktov, 1998). It espoused a model of primary health care (PHC) that grew out of community-based health programs pioneered during the 1960s and 1970s, such as China's barefoot doctor program (Cueto, 2004; Massachusetts Society, 1974; Zhang & Unschuld, 2008) and the CCHS movement in Australia (which was represented by NAIHO) (Fredericks & Legge, 2011). Thus, while NAIHO was advocating for basic access to health care for Indigenous Australians, it was also contributing intellectual property that shaped global discourses regarding comprehensive primary health care (CPHC).

The development process of the Alma Ata Declaration was reportedly inclusive, with the Alma Ata Conference in Kazak attended by delegations from 134 national governments and representatives of 67 United Nations organisations, specialised agencies and nongovernmental organisations (NGOs) (WHO & UNICEF, 1978). The conference was preceded by a number of national, regional and international meetings throughout the developing and industrialised world, with a conference committee representing both developing and industrialised nations (WHO & UNICEF, 1978). The "official" list of Alma Ata participants, though, may not be entirely accurate with at least one NGO, NAIHO, present (Fredericks & Legge, 2011) but not recorded in official records (WHO & UNICEF, 1978). This is an unfortunate omission in light of the fact that the CCHS model foreshadowed and exemplified the Alma Ata Declaration, with AMSs being 'strategic sites' for Indigenous community development and empowerment (Bell et al., 2000). It also leads to the question of what other NGOs may have been present but excluded from the participant list, leaving their intellectual property and contributions to policy, frameworks and subsequent action ignored.

The global and the local of Indigenous health promotion

As the global movement of health promotion began to establish itself, Australia was a key player³² and continued to reinforce a parallel space for Indigenous health where – contradictory to the principles of empowerment, participation and control espoused by the global health promotion movement – Indigenous knowledge and voices remained marginalised and suppressed. Alongside hope-inspiring milestones such as the Ottawa

³² Australia provided a representative, Heather MacDonald, for the Ottawa Conference planning committee, who subsequently organised the 1988 Adelaide Conference where the Adelaide Statement on Healthy Public Policies was developed (Macdonald, 2012).

Charter for Health Promotion and the Commission for Social Determinants of Health (CSDH), Australia has enacted legislation and policies that effectively disempowered Indigenous Australians and perpetuated their poor health. The following section traces these global and local developments, highlighting the inconsistency of health promotion in relation to Indigenous Australians.

Ottawa Charter for Health Promotion

While Indigenous Australians were experiencing their first access to appropriate health care through the CCHS movement, the first International Conference on Health Promotion was held in Ottawa in 1986. The Conference was held in order to act and achieve WHO's *Global Strategy for Health for All by the Year 2000* (HFA 2000) (WHO, 1981), in recognition of both the fact that it was not being adopted in industrialised countries, and the limitation of the lifestyle and behavioural approaches (Baum, 2008; WHO, 1986b). The resulting Ottawa Charter remains the key influence and guide for the concept of health promotion, establishing health promotion as a field of public health practice while shaping public health practice more broadly (Dooris, 2006; Nutbeam, 2008; Richmond & Germov, 2009; WHO Secretariat, 2005).

Where the Alma Ata Declaration acknowledged health inequalities, the Ottawa Charter affirmed that health promotion maintains the goal of action to reduce those differences (Ridde, Guichard, & Houéto, 2007; WHO, 1986b). The Ottawa Charter was an inspiration to many to adopt a comprehensive model of promoting health that did not blame individuals and instead focused on creating environments and policies that made the healthy choice, the easy choice (Baum, 2005). To secure this approach, a combination of advocacy, community mobilisation, capacity building, organisation change, financing and legislation were called for (Sanders, 2006). This positioned health promoters as taking a holistic view of health by addressing social, economic and ecological environments as well as individual factors (Burrows, Nettleton, & Bunton, 1995 p. 2; Labonte, 1993; Navarro & Shi, 2001; Raphael, 2008; Shiell & Hawe, 1996; Syme, 1998). To achieve this, the Ottawa Charter identifies five interrelated principles:

1. Strengthen community action
2. Develop personal skills
3. Create supportive environments
4. Reorient health services

5. Build healthy public policy.

The genius of the Ottawa Charter is said to lie in the way it integrated a range of differing perspectives with social and public health movements, including-nineteenth century public health, feminism, the green and consumer movements, and experiments in community development from the 1950s (Baum, 2008). Importantly, the Ottawa Charter challenged the individualism that was taking root in health promotion and continues to provide a blueprint for the “new public health” (Baum, 2008). The Ottawa Charter took the understanding of health beyond this, to a complete state of wellbeing and resource for everyday life – that is, an “input” (Kickbusch, 2007) and an indicator of society’s overall development (Kickbusch, 1987). The Ottawa Charter also shifted the language of public health professionals from an educational tone to a community development tone (Wenzel, 1997). Perhaps the most important contribution to health promotion was the Ottawa Charter’s highlighting of the influence of societal structures and public policy on the health of populations, particularly the more vulnerable (Kickbusch & Payne, 2003).

While the Ottawa Charter led to ground-breaking changes in health promotion practice and research, the continued reverence for the Ottawa Charter risks deflecting the possibility of much needed critique. The Ottawa Charter remains a dominant influence over health promotion, being referred to as a “mantra for health promotion workers” (Baum & Sanders, 1995) and “the new public health³³ bible” (Baum, 2008). Yet, the Charter has been critiqued for its top-down and WHO-dominated process of development (Raeburn & Peters, 1987). Some participants reported “intense dissatisfaction” with the limited process of collaboration (Raeburn, 2007; Raeburn & Peters, 1987). Moreover, research by my colleagues and I found that the Charter’s principles of collaboration and empowerment were not reflected in its own production in relation to Indigenous peoples and developing nations (McPhail-Bell, Fredericks, & Brough, 2013b).

³³ The new public health is defined as “a social model of health linking ‘traditional’ public health concerns about physical aspects of the environment (clean air and water, safe food, occupational safety), with concerns about the behavioural, social, and economic factors that affect people’s health” (Richmond & Germov, 2009).

The Ottawa Charter's focus on wealthy countries alludes to the colonial context of its production. The Ottawa Charter was created by "a primarily privileged 'club' of 38 predominantly wealthy nations", which by its very nature excluded developing and Indigenous nations and their knowledge (McPhail-Bell et al., 2013b, p. 24; Raeburn, 2007). In terms of Indigenous representation, there were but two: an Indigenous consultant from the First Nations Confederacy, in her capacity as an educator; and a participant from Research and Development in Health and Welfare Canada who referenced Indigeneity in their professional background³⁴ (WHO, 1986a). This is a substantial shift away from the globally inclusive agenda promoted by the Ottawa Charter and the Alma Ata Declaration before it. Yet acknowledgement of this is lacking within the health promotion literature. The Ottawa Charter's development demonstrates that health promotion is in fact not culturally neutral, as is so often assumed. For a document so revered and founded on principles of community ownership, it is extraordinary that it was based on a privileged first world voice.

National Aboriginal Health Strategy

Soon after the Ottawa Conference and years of lobbying by Indigenous health organisations and people, the *National Aboriginal Health Strategy* (NAHS) was developed (National Aboriginal Health Strategy Working Party, 1989). Significantly, the NAHS development process was the first time that representatives from Indigenous communities were involved with the Commonwealth, state and territory governments to collectively work on a national policy regarding Indigenous Australians (Fredericks et al., 2012). Commissioned by the Hawke Labour Government in 1987 and endorsed by state and territory governments in 1989 (McCallum, 2012), the NAHS was developed through a comprehensive and open process (Gillor, 2012). Based upon a principle of Indigenous self-determination, the NAHS is debatably the most comprehensive document regarding Indigenous health to date (National Aboriginal Health Strategy Working Party, 1989). Unfortunatley, the NAHS was never properly implemented, arguably due to the failure of government coordination and its emphasis upon selective

³⁴ This participant identified his expertise as being in the "... development, management and provision of primary health care programs for... Indian and Inuit peoples in Canada... as well as the Third World" (WHO, 1986a).

PHC³⁵, and immensely inadequate funding (Aboriginal and Torres Strait Islander Commission, 1994; Boffa, 1993; Fredericks et al., 2012). Therefore, while health promotion was endeavouring to establish itself in Australia, including being host to the second International Conference on Health Promotion (the Adelaide Conference for Healthy Public Policy) (DCSH & WHO, 1988; WHO, 1988), the Australian Government continued to intervene in the health and wellbeing of Indigenous Australians, with little health improvement to show for it. Nonetheless, the NAHS definition of health continues to be the bedrock for Indigenous health promotion, and Indigenous health more broadly:

Health is not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life. (National Aboriginal Health Strategy Working Party, 1989, p. ix)

Royal Commission into Aboriginal Deaths in Custody

In 1991, the same year the Sundsvall Statement on Supportive Environments for Health was produced (WHO, 1991), the *Royal Commission into Aboriginal Deaths In Custody* (RCADIC) was released in Australia. Like the NAHS, the RCADIC adopted a model of Indigenous health promotion based upon the principle of Indigenous self-determination and comprehensive PHC (Boffa, 1993). Again like the NAHS, the RCADIC was commissioned in 1987 in response to a sustained campaign by Indigenous groups and organisations (including the Aboriginal Legal Service), families of people who died while in custody, and supporters (Cunneen, 2008; Gillor, 2012). The Commission found over-representation of Indigenous people in prisons, a high number of deaths in custody and failure of custodial authorities to exercise proper duty of care, which at times caused or contributed to the deaths in custody (Cunneen, 2008). At the heart of the problem was the issue of over-representation of Indigenous people at all stages of the criminal system (Royal Commission into Aboriginal Deaths in Custody, 1992).

The final recommendation of the RCADIC was to initiate a formal process of reconciliation between Indigenous people and the wider community (Royal

³⁵ For example, the National Better Health Program (NBHP) reportedly took a selective PHC approach, which meant that NBHP funds were being used in ways contradictory to recommendations of both NAHS and RCADIC (RCADIC is discussed below in this chapter) (Boffa, 1993). A case in point is that the NBHP could fund the establishment of a cervical cancer screening program but not of an Indigenous community controlled women's health services as per the NAHS recommendation (Boffa, 1993).

Commission into Aboriginal Deaths in Custody, 1992). Debates regarding relations between Indigenous and non-Indigenous Australians ensued and in 1991, the Federal Parliament of Australia voted to establish a Council for Aboriginal Reconciliation. This Council was to create:

...a united Australia that respects this land of ours, values the Aboriginal and Torres Strait Islander heritage, and provides justice and equity for all.
(Council for Aboriginal Reconciliation, 1999, p. 1)

Despite the publicity, most of the RCADIC recommendations remain not fully acted upon, the main custodial, societal and cultural issues persist unresolved (Cunneen, 2008). While the rate of Indigenous deaths in custody since the 1992 report has fallen, the number of deaths remain higher due to the over-representation of Indigenous people in custody (Lyneham & Chan, 2013). Unsurprisingly, Indigenous resistance and advocacy continues (e.g., Clark, 2014; DICWCWA, 2014; Project 10%, 2010).

Jakarta Declaration on Leading Health Promotion in the 21st Century and the People's Health Movement

On the global stage, health promotion discourses continued to evolve with the Jakarta Declaration produced in 1997 (WHO, 1997). The Jakarta Conference focused on partnerships for health and strongly endorsed the health promoting settings approach (Dooris, 2006). Controversially, the organisers sought to involve representatives of large corporations, such as pharmaceutical and multinational companies including Coca-Cola, Guinness and Smith Kline Beecham.³⁶ Regardless, the Jakarta Declaration promoted the importance of a global health promotion alliance that emphasised the breaking of barriers within government sectors, and between government and non-government organisations and the public and private sectors (O'Byrne, 1998).

To set the scene for this conference, one needs to consider the period of time between the Ottawa Charter and the Jakarta Declaration. During the 1990s, the WHO seemingly receded its leadership role in the shadow of the World Bank. The World Bank's influential report, *Investing in Health* (World Bank, 1993), was particularly significant,

³⁶ The argument for doing so was that the activities of these companies significantly influenced health. The counter-argument to this was the limitations their presence placed upon opportunity to discuss ethical and other dilemmas raised by involving these players, the manner in which they were involved, and the lack of robust scientific and ethical debate on the way in which the private sector should be involved in health promotion (Baum, 2008).

facilitating the view of health as part of economic development rather than a human right (Baum, 2005) and promoting cost-effective packages that ignored the SDOH (Labonte et al., 2008). These approaches have been criticised for harming the health of poor people (Baum, 2007b) by cutting public sector social spending and weakening the capacity of many developing country governments to intervene on SDOH (Solar & Irwin, 2006). In time it was evident that global distribution of power (particularly amongst some of the more powerful players³⁷) determined the work of the WHO, reinforcing and reproducing the dominant neoliberal ideology (Navarro, 2008).

As globalisation and neoliberalism advanced, so too did the People's Health Movement (PHM), which draws inspiration from Alma Ata and is committed to HFA 2000. In response to the increasing power imbalances associated with neoliberalism, the first People's Health Assembly was held in 2000 in Savar, Bangladesh, in an effort for the voice of civil society to be heard. This meeting was seen as an alternative to the World Health Assembly (the governing WHO body) and although no senior WHO staff chose to attend, the previous WHO Director-General and Alma Ata champion, Halfdan Mahler, was present and strongly endorsed the PHM and its People's Health Charter³⁸ (Baum, 2007b). PHM held a second People's Health Assembly in 2005 in Ecuador where the status of the Alma Ata Declaration and associated WHO documents were discussed. From Australia, Indigenous delegates included Bronwyn Fredericks, Lisa Jackson-Pulver and Peter Waples-Crowe, and other Australians including Fran Baum and David Legge (Legge, 2003). Further work regarding revitalising HFA emerged from these discussions and is continuing today.³⁹

Bringing Them Home Report

Despite its social justice and human rights orientations, health promotion continued to be largely absent from the advocacy efforts for Indigenous health and wellbeing in Australia. In the same year the Jakarta Declaration was produced, the first Australian Reconciliation Convention was held to review the reconciliation process up to that time. This Convention coincided with the tabling in Federal Parliament of the *Bringing Them*

³⁷ For example, the United States establishment is seen by some as the dominant power, not only for its military force but also the dominance of its neoliberal ideology (Navarro, 2008).

³⁸ This People's Health Charter embeds each Alma Ata ideal and calls for a people-centred health system based on CPHC (People's Health Movement, 2000).

³⁹ For example, see http://www.globalhealthequity.ca/projects/proj_revitalizing/index.shtml (Accessed 28 November 2011).

*Home Report*⁴⁰ (HREOC, 1997), which was hugely significant not only for bringing the stories of “gross violation... of human rights” (HREOC, 1997, p. 27) of the Stolen Generation into the public consciousness, but also for its recommendations, particularly the reparation entitlements for those affected by the forcible removals (HREOC, 1997, p. 29). Despite this, at the Reconciliation Convention, then Prime Minister John Howard made his controversial speech signalling his opposition to the HREOC Report recommendations, while justifying his refusal to apologise on behalf of Australia to the Stolen Generation⁴¹ (Augoustinos, Lecouteur, & Soyland, 2002). The Howard Government approach became known for its rhetorical emphasis upon “practical reconciliation” and Indigenous responsibility, with no statistical evidence that policies of that Government improved outcomes for Indigenous Australians compared to their predecessors (Altman & Hunter, 2003). The result was that the reconciliation process was critiqued for being symbolic, without the dialogue needed between Indigenous and non-Indigenous parties (Altman & Hunter, 2003).

While this was happening, the Australian Government commissioned the National Health and Medical Research Council (NHMRC) to conduct a review of health promotion projects and infrastructure in and with Indigenous communities in Australia (Angus, 1997; Angus & Wise, 1997). In the words of the NHRMC Chair of Health Advancement at that time, the purpose of the review was “listen to what Indigenous people of this country have to say about what is needed to advance their future health” (Holman, cited in Angus & Wise, 1997, p. i). The review was perhaps the first on Australian record in relation to Indigenous health promotion, where a mainstream agency sought to learn from Indigenous-led health promotion (Angus, 1997). Based on the lessons learnt from these reports, the *Sydney Consensus Statement on Principles for Better Practice in Aboriginal Health Promotion* was produced (NSWHealth, 2004). However, the reports were rescinded by the NHMRC in 2004 with little explanation as to why. Furthermore, the current Australian Health Promotion Association draft ethical framework makes no mention of the Sydney Consensus Statement (AHPA, 2009)

⁴⁰ The *Bringing them home* report examined the Australian laws, practices and policies which resulted in the forcible separation of Indigenous children from their families, and the effects of those laws, practices and policies. These practices were reported as continuing until the early 1970s (HREOC, 1997).

⁴¹ One of the Report’s recommendations was for reparation consisting of: acknowledgement and apology; guarantees against repetition; measures of restitution; measures of rehabilitation; and monetary compensation (HREOC, 1997). Prime Minister Kevin Rudd later delivered an apology to the Stolen generations (Rudd, 2008).

despite the implications of its principles for the way health promotion is practiced (McPhail-Bell, Bond, Brough, & Fredericks, 2015).

Bangkok Charter for Health Promotion in a Globalized World

The CCHS movement continued to grow and play an increasing role in primary health care for Indigenous Australians, while at the global level, in 2005, the WHO held the 6th Global Conference on Health Promotion in Thailand, where the *Bangkok Charter for Health Promotion in a Globalized World* was endorsed – the first health promotion Charter since the Ottawa Charter. Compared to the process of creating the Ottawa Charter, which focused upon developed countries, the Bangkok Charter allowed for more global input. WHO initially received public comment on the draft Charter in July 2005. Two members of PHM commenced a conversation on its list server and provided feedback to WHO. This feedback may not have been heeded, because in August 2005 the ratified Bangkok Charter was released and was soon after attacked by PHM as “an inadequate and timid document” (Porter, 2006, p. 72), that “take(s) a ‘neutral’ view on globalization” and “uncritical view of private-public partnerships, many of which advance corporate interests at the expense of people's health” (Werner, 2005). In relation to Indigenous people, the Bangkok Charter noted that the increased vulnerability of Indigenous people was a “further challenge” but identified no principles or approaches for addressing this.

In the same year of the Bangkok Charter's development, the Howard Government in Australia abolished the Aboriginal and Torres Strait Islander Commission (ATSIC). ATSIC was established by the Hawke Government in 1990 as a step towards Indigenous self-determination. Advocates of Indigenous autonomy argued that ATSIC did not provide a mechanism for self-determination and many Indigenous Australians did not recognise ATSIC as an Indigenous-representative body or as an avenue of self-determination (Gillor, 2012; Maddison, 2008). ATSIC also initially had responsibility for Indigenous health, including funding for AMSs but Indigenous community health organisations criticised ATSIC's function in this portfolio (Anonymous, 1994). Therefore, in 1995 when the Federal Government resumed responsibility for the Indigenous health portfolio, Indigenous self-determination had yet to be trialled in Indigenous health (Cunningham & Baeza, 2005). Regardless, media and government continued to blame ATSIC for failures of other agencies and governments (Cunningham

& Baeza, 2005) and John Howard announced that ATSIC had become “too preoccupied with... symbolic issues” and most profoundly, that ATSIC was a demonstration that self-determination was “a failed experiment” (Gunstone, 2006). Arguably, the Howard Government abolition of ATSIC is a decision that also reflects the lack of self-determination through ATSIC (Gillor, 2012). Throughout this process, the struggle of Indigenous Australians to control their own health continued, remarkably without visible support from the health promotion fraternity.

Commission on the Social Determinants of Health

In the same year, 2005, the WHO launched the *Commission on Social Determinants of Health* (CSDH), a vehicle to revive the Alma Ata agenda (Baum, 2008).⁴² The CSDH report was a watershed document in public health’s history, representing an unequivocal endorsement by the health sector of the importance of addressing inequalities in social conditions in order to address health inequalities (Braveman, Egerter, & Williams, 2011). The CSDH report took the moral argument that HFA is a matter of social justice and made three overarching recommendations (Baum & Fisher, 2010; Commission on Social Determinants of Health, 2008, p. 2):

1. Improve daily living conditions in which people are born, grow, live, work and age
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of daily living conditions – globally, nationally and locally
3. Measure and understand the problem of health inequities and assess the impact of action.

Northern Territory Emergency Response

On 21 June 2007, the Australian Government announced the Northern Territory Emergency Response (NTER) (Brough, 2007), referred to most commonly as the Intervention (Fredericks et al., 2012). While the global health promotion and public health fraternity were advocating for governments to address the social determinants of health, the Australian Government introduced a series of measures in Indigenous communities across the Northern Territory. It claimed these were in response to the

⁴² In March 2005, Dr JW Lee, the former World Health Organization Director-General (WHO DG), created the CSDH with a three year directive to gather and review evidence on what needs to be done to reduce health inequalities within and between countries and report this to the WHO DG (WHO, 2014).

Little Children are Sacred report (Brough, 2007; Wild & Anderson, 2007). These measures included compulsory child health checks⁴³, compulsory income management, alcohol restrictions, banning of pornography, suspension of the *Racial Discrimination Act 1975*, land acquisition and appointment of community business managers (Brough, 2007). The NTER also legislated changes regarding Cape York in Queensland through special measures to the *Racial Discrimination Act 1975* (HREOC, 2007). This involved passing Cape York trial legislation to establish and endow with special powers the Queensland Commission⁴⁴ in Cape York as part of the four year Cape York Welfare Reform Trial (CYWRT). The CYWRT was different to the NTER in some ways, including discretionary rather than blanket use of income management, and applied in a specific target community of the Council of Australian Governments (COAG) Closing the Gap (CTG) policy (discussed below). Regardless, researchers found that considerable investment in the NTER and CYWRT was made based on unproven assumptions regarding a link between social dysfunction, child neglect and substance misuse, and ‘passive’ welfare (Altman & Johns, 2008; Evans, 2012). Both reforms made Indigenous welfare conditional upon government-defined behaviour, while limiting income expenditure on alcohol and restructuring the labour markets through rule changes in labour market programs (Altman & Hunter, 2003). These measures were a far cry from the CSDH recommendations released internationally at the same time.

The Howard Government positioned the NTER as part of “practical reconciliation”, which relied upon a morality of intervention to justify the nature of its controlling, racist⁴⁵ practice (Stringer, 2012). To do this, the Australian Government promoted a narrative of emergency in Indigenous communities by alleging an epidemic of child sexual abuse; quoting in part *Little children are sacred* (Wild & Anderson, 2007):

The immediate nature of the Australian Government's response reflects the very first recommendation of the *Little Children are Sacred* report into the protection of Aboriginal children from child abuse in the Northern Territory which said: ‘That Aboriginal child sexual abuse in the Northern territory be designated as an issue of urgent national significance by both the Australian and Northern Territory Governments...’ (Brough, 2007, p. 1)

⁴³ After widespread concern regarding compulsory child health checks, the Australian Government introduced non-compulsory health checks instead (ABC News, 2007).

⁴⁴ Also known as the Family Responsibility Commission.

⁴⁵ In order to implement the majority of the measures, the Australian Government enacted provisions to prevent challenges to the Intervention measures under the *Racial Discrimination Act 1975*, being: that the Northern Territory National Emergency Response Act is a ‘special measure’ under the RDA; and suspension of Part II of the RDA, ‘Prohibition of racial discrimination’ (Edmunds, 2010).

Indeed, in its first recommendation, *Little children are sacred* did call upon governments to urgently prioritise child sexual abuse prevention initiatives in the Northern Territory, as Mal Brough, the Minister for Families, Community Services and Indigenous Affairs correctly outlined. However, Minister Brough based his response upon only part of the recommendation and the Australian Government has been criticised for ignoring the second part, which was (Edmunds, 2010):

It is critical that both governments commit to genuine consultation with Aboriginal people in designing initiatives for Aboriginal communities.
(Wild & Anderson, 2007, p. 22)

Instead, the majority of the Australian Government's proposed measures were implemented by enacting new legislation within 10 days of the bills being introduced to parliament. Consequently, there was limited time to produce details for discussion or a considered analysis (Fredericks et al., 2012; HREOC, 2007). The Government-appointed NTER review board later found this failure to engage constructively with Indigenous people impacted the potential support for the NTER measures (Northern Territory Emergency Review Board, 2008, pp. 9-11). The Human Rights and Equal Opportunity Commission, amongst others, also criticised the Australian Government for creating and exacerbating divisions and mistrust between the governments and Indigenous communities, and more broadly for its human rights implications and concerns⁴⁶ (Edmunds, 2010; HREOC, 2007). The NTER was also found to be assimilatory in its goals, rather than supporting self-determination (Evans, 2012); quite the opposite of the global health promotion discourse focusing on increasing people's control over their own health. The United Nations Special Rapporteur on the Rights of Indigenous Peoples also reported that the NTER discriminated against Indigenous Australians, infringed on their right of self-determination and further stigmatised already stigmatised communities (Anaya, 2010).

The Labour Government came into power in 2007 and chose to continue the NTER as part of its Stronger Futures package. This was despite not one person being prosecuted

⁴⁶ These concerns included Government action on a land reform agenda that apparently was unrelated to the NTER (in fact, this agenda was already underway in 2006 with legislative changes passed to negotiate 99-year headleases over townships on Indigenous land) or to address child abuse specifically (Dillon & Westbury, 2007). Indigenous Australians in the Northern Territory had comprehensive land rights for decades prior to the NTER.

for child sex abuse in the five years from the NTER until the introduction of the *Stronger Futures in the Northern Territory Bill 2011* (Pazzano, 2012). This was also despite the Australian Government signing a Statement of Intent with Indigenous Australians to work together to achieve equality in health status and life expectancy by the year 2030 (Australian Government, 2008).⁴⁷ The continuation of the NTER was in the face of the Aboriginal Peak Organisations of the Northern Territory calling for the Australian Government to recognise the NTER approach was “fundamentally flawed” (APONT, 2011, p. 3). More recently, a Parliamentary Joint Committee on Human Rights expressed concerns that the Stronger Futures package may not comply with Australia’s human rights obligations (Parliamentary Joint Committee on Human Rights, 2013). The Parliamentary Joint Committee on Human Rights is currently reviewing the Stronger Futures package (Ferguson, 2014), while the current Coalition Government⁴⁸ is revising associated funding (Parliamentary Joint Committee on Human Rights, 2014b).

Closing the Gap policy

The *Closing the Gap* (CTG)⁴⁹ policy was designed and implemented in response to a concerted advocacy campaign, Close the Gap, led by a partnership between NACCHO, Oxfam Australia and other supporting agencies. In 2005, the HREOC recommended that the governments of Australia commit to achieving equality of health status and life expectation between Indigenous and non-Indigenous people within 25 years (HREOC, 2005). In 2006, the National Indigenous Health Equality Campaign, known as Close the Gap, was developed, which released their report, *Close the Gap*, in 2007 (NACCHO & Oxfam, 2007) – just prior to the Government announcement of the NTER. The campaign steering committee continues to operate, led by its Indigenous members and funded by its membership, with Oxfam Australia a major financial supporter. The Close

⁴⁷ At the 2008 National Indigenous Health Equality Summit, key stakeholders signed the *Statement of Intent* for Closing the Gap (Australian Government, 2008). The signatories were: representatives of the Australian Government; NACCHO; CATSN; AIDA; IDAA; and Aboriginal and Torres Strait Islander Social Justice Commissioner.

⁴⁸ The current Coalition Government comprises the Liberal party, The Nationals, the Country Liberal Party and the Liberal National Party. The Liberal party originally formed from a merger of the Protectionist and Free Trade parties in 1910 and has governed Australia since 2013 under previous Prime Minister Tony Abbott and current Prime Minister Malcom Turnbull. The Nationals is a rural-based party, whose representative Warren Truss serves as Deputy Prime Minister. The main members of the Coalition at national level are The Liberals and the Nationals.

⁴⁹ Note that the Government agenda of Closing the Gap is distinct from the Indigenous-led Close the Gap campaign introduced above, which is based upon a human rights framework (Holland, 2014).

the Gap campaign has been an effective policy driver (Fredericks et al., 2012), with more than 190,000 people having signed the pledge to Close the Gap demanding Indigenous health equality. Thousands of Australians have written to the Australian Government demanding action and tens of thousands participated in National Close the Gap Day (Holland, 2014; Oxfam Australia, 2014). While these advocacy efforts reflect the nature of health promotion according to the Ottawa Charter, mainstream health promotion agencies remain absent in this partnership.⁵⁰

In response to this advocacy, in 2008 the Australian Government endorsed *Closing the Gap* (CTG), which is a strategy that aims to reduce Indigenous disadvantage. COAG then determined measurable targets to monitor the improvements in Indigenous health and wellbeing, which are (COAG, 2009a):

- Close the life expectancy gap within a generation (by 2031)
- Halve the gap in mortality rates for Indigenous children under five within a decade (by 2018)
- Ensure access to early childhood education for all Indigenous four year olds in remote communities within five years (by 2013)
- Halve the gap in reading, writing and numeracy achievements for children within a decade (by 2018)
- Halve the gap for Indigenous students in year 12 attainment rates (by 2020)
- Halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade (by 2018).

Subsequently, COAG committed \$4.6 billion for 2009-2013⁵¹ across early childhood development, housing, economic participation, remote service delivery and health. Commitment of all levels of government was formalised for the specified outcomes of this period through six *National Partnership Agreements*, including one for Indigenous health outcomes (COAG, 2009b).

⁵⁰ There are a number of mainstream health agencies that are members of the Close the Gap Campaign and while some include health promotion as part of their broader focus, none identify explicitly as a health promotion agency. The member mainstream health agencies include: the Public Health Association of Australia, Australian Medical Association, Australian Medicare Local Alliance, Australian Physiotherapy Association and The Heart Foundation.

⁵¹ Subsequently extended by the Australian Government by 12 months.

A discrepancy exists between the Australian Government claims of commitment and its domestic actions in relation to Indigenous Australians. While some minor improvements have been evident, the pace for Indigenous health improvement has been slow in some areas, with no changes in others (Productivity Commission, 2014). Most recently the Australian Government has implemented detrimental “deep cuts” to Indigenous health funding (Holland, 2014). Since the Abbott Government came into power, all of the COAG National Partnership Agreements lapsed and the Australian Government is yet to commit to their renewal (NACCHO, 2014c). Furthermore, the Australian Government’s Indigenous Advancement Strategy (IAS), designed to progress CTG, has received wide public backlash with many politicians and organisations claiming the IAS funding process was unfair and confusing (Henderson, 2015). As a result, a parliamentary inquiry is currently underway (Parliamentary Joint Committee on Human Rights, 2014a), through which it was revealed that under half of the funded organisations are Indigenous organisations (Henderson, 2015). Such a finding contrasts with the Government’s own advice that external authorities imposing change and interventions, without local Indigenous community control, do not “work” (Yaman & Higgins, 2011). The most recent Closing the Gap report notes that most CTG targets are not on track to be met⁵² (Australian Government, 2015), while the future of CTG remains uncertain.

Critiques of CTG exist beyond those regarding its limited progress on CTG indicators. Commentators have criticised the Australian Government’s emphasis upon neoliberal principles of individualism and economic growth, rather than valuing diversity and resistance to transformation and homogenisation (Altman, 2009). Some critics claim the CTG agenda is incompatible with human rights commitments, based upon the longstanding polarisation of Indigenous policy debate between accommodating Indigenous cultural difference and self-determination, to fostering an equality approach based upon Indigenous assimilation into the mainstream (Cooper, 2011). This argument highlights that the equality approach is reflected in the CTG health indicators and their inattention to Indigenous Australians’ sense of control over their health or cultural dynamism (Pholi, Black, & Richards, 2009). In this way, CTG is based upon an

⁵² One of the challenges faced by local and regional bodies, such as IUIH, is to demonstrate their impact upon CTG indicators, when local success is absorbed into national averages. This is discussed further in Chapter Nine.

underpinning philosophy that Indigenous people must become like non-Indigenous people. Such a philosophy justifies ongoing Government intervention in Indigenous Australian's lives; a contrast to the self-determination espoused by health promotion.

...the pursuit of statistical equality for Indigenous Australians... is also an approach that reduces Indigenous Australians to a range of indicators of deficit, to be monitored and rectified towards government-set targets. This illustrates a substantial imbalance in power and control over the Indigenous affairs agenda in Australia, which is the 'gap' that must be addressed for the health and wellbeing of Indigenous Australians to improve. (Pholi et al., 2009, p. 1)

Recent milestones in the global health promotion discourse

Since CTG was introduced, two more global milestones in health promotion were achieved, yet arguably they feature minimally, if not at all, in the current struggle for Indigenous community control over their own health in Australia. In 2011, the WHO held the *World Conference on Social Determinants of Health* in Rio de Janeiro, in recognition of the stilted progress on SDOH and a continuing narrow focus on educating people to change their lifestyles (Richmond & Germov, 2009). This conference resulted from a 2009 World Health Assembly resolution to follow up the work of the CSDH in order to provide innovative solutions on the "how-to" for addressing SDOH. The result was the *Rio Political Declaration on Social Determinants of Health* (WHO, 2011), which includes five building blocks considered essential for action on SDOH (Krech, 2011): governance; participation; the changing role of the health sector; the need for global action; and how to monitor progress.

The Rio Declaration is said to express global political commitment for the implementation of SDOH approaches to reducing health inequities and to achieving other global priorities (Friel, 2011). However the Declaration has been criticised for not setting a clear agenda for future action by the WHO and for lacking accountability regarding action to address the CSDH's recommendations – not to mention a consultation process that excluded civil society movements (Alames et al., 2011). The five action areas have been referred to as "prime examples of the bland sanitised language... (and) do nothing to push forward the progressive agenda of the CSDH" (Baum, 2011b). PHM's analysis of the draft Rio Declaration found it to be so far off the mark that they drafted an alternative declaration which includes key omissions such as: curbing power of transnational corporations to engage in activities detrimental to health;

and the importance of growing global people's movements to ensure a voice regarding distribution of power and wealth and the attack on systems of social protection (People's Health Movement, 2011).

In 2013, the 8th Global Conference on Health Promotion was held in Helsinki, which focused upon "Health in All Policies", resulting in the Helsinki Statement (WHO, 2013). In the same year, the tripartisan Senate Community Affairs Committee released its report on Australia's domestic response to the CSDH (Community Affairs References Committee, 2013). Its first recommendation was for governments to ratify the WHO CSDH. This ratification is yet to happen, as is action on the Senate Community Affairs Committee report's remaining recommendations. The struggle for Health for All continues today.

National Aboriginal and Torres Strait Islander Health Plan

Currently in Australia, through the *National Aboriginal and Torres Strait Islander Health Plan* (NATSIHP), health promotion is an identified goal within the Federal Government's framework for policy and programmatic responses to improve Indigenous health (Australian Government, 2013). NATSIHP's emphasis on health promotion is within the context of mental health and social and emotional wellbeing, while acknowledging the call for "A comprehensive approach to primary health care... that takes into account the social determinants of health, health inequalities, health promotion, illness prevention, treatment and care of the sick, community development, advocacy, rehabilitation, inter-sectoral action and population health approaches" (Australian Government, 2013, p. 48). Nevertheless, NATSIHP's status is thus far unknown, with the Abbott Government indicating it will update NATSIHP to reflect its priorities⁵³ (Nash, 2014b) and develop an implementation plan (Australian Government, 2015; Nash, 2014a). It remains unclear what these priorities will be⁵⁴. The current Australian Government exhibits a lack of commitment to shape a national positive direction in terms of Indigenous health in partnership with Indigenous Australians and

⁵³ This proposed change is based upon the premise that the current Australian Government came into power one month after the previous Government released NATSHIP.

⁵⁴ I contacted the office responsible for NATSIHP a number of times requesting information regarding the status of NATSHIP but have received no responding emails or phone calls. Information available on the Australian Government website provides no further clarity than the political announcements I have referred to.

their self-determined representative bodies.⁵⁵ Fundamentally, it has produced a “lack of clarity and muddled narrative (that) is deeply worrying” to many, including Indigenous Australians (Aboriginal and Torres Strait Islander Social Justice Commissioner, 2014, p. 17).

Perhaps now more than ever, health promoters are experiencing a contradictory policy and practice environment, favouring top-heavy approaches (Jolley et al., 2014). NATSIHP’s approach to health promotion is nested within a context of government control and an assumption that improved administrative and policy coordination will enhance access and uptake of government services, which will in turn improve health outcomes (Anderson, Baum, & Bently, 2007; Close the Gap Steering Committee, 2010). This viewpoint is particularly apparent given the major changes being implemented and proposed by the Australian Government, without consultation of key stakeholders (NACCHO, 2014c; The Senate, 2014). Likewise, there are many examples of Australia’s continued systemic preference for selective primary health care and lifestyle health promotion (Baum, 2008; 2011a; Baum & Fisher, 2014; Richmond & Germov, 2009), from initiatives in the late National Preventative Health Strategy (National Preventative Health Taskforce, 2009) that demonstrated “lifestyle drift” over addressing the SDOH (Baum, 2011a), to the subsequent Government’s abolition of the coordinating preventative health agency (Sweet, 2014) and resistance to addressing specific impacts on disadvantaged groups (Douglas, 2015). The effect of this environment is that many health promotion professionals are constrained in their work to truly address the fundamental health determinants. It also leaves Australia in a position of failing Indigenous Australians.

Moral distress – The tensions of Indigenous health promotion

The second section of this chapter builds upon the historical basis discussed above regarding the failure of health promotion with Indigenous Australians. This section acknowledges that the daily practice of health promotion is one comprising tensions, where practitioners must balance a range of competing agendas and allegiances.

⁵⁵ For example, Indigenous bodies and community organisations recently called on the Australian Government to not proceed with implementation proposals under the Forrest Review (NACCHO, 2014a). The Forrest Review is led by Andrew Forrest, a notably wealthy, non-Indigenous mining magnate, and has been criticised for ignoring ‘what works’ in Indigenous policy (e.g. Cox, 2014).

Therefore, while health promotion as an institution may have failed Indigenous Australians, practitioners must navigate a difficult terrain in their practice that requires a series of judgements, for which competing agendas may exist but little or no evidence-base, or theoretical and ethical frameworks, to guide those judgements. This means that health promotion's moral endeavour to contribute to a "good society" remains incredibly varied and constrained in practice (Carter, Cribb, & Allegrante, 2012a), creating a level of moral distress amongst health promotion practitioners (Sunderland et al., 2015). This section aims to identify and discuss a number of the practice tensions involved in this moral distress. While these tensions are common to mainstream practice of health promotion, they tend to be amplified in Indigenous health promotion where ongoing colonial processes of control over Indigenous Australians continue to operate. Overarching all of these tensions is the central tension of this thesis, which requires practitioners to "not tell people what to do" while also advising people how to live better, healthier lives.

"We don't tell people what to do"⁵⁶... or do we? Health promotion's colonisation of bodies

Health promotion practitioners occupy an antagonistic reality. On the one hand, practitioners are required to change people – their knowledge, attitudes and behaviours – to improve their health (Duncan & Cribb, 1996). On the other hand, practitioners are to endorse community autonomy and choice (Bond et al., 2012). This tension is an exquisite manifestation of health promotion's colonial foundations (McPhail-Bell et al., 2013b), where health promotion aspires to colonise the bodies of its subjects (Hughes, 1997). No one is safe from this endeavour, with populations regularly exposed to state-directed advice and regulation regarding how to eat, exercise, have sex and enjoy our recreational time. This tension is amplified in an Indigenous context, where the health system is implicated in the disastrous effects on Indigenous health from historical and contemporary colonial processes (discussed earlier in this chapter).

Commentators argue that health promotion can be understood as a normative ideal, derived from its origins in the Alma Ata Declaration, HFA 2000 and the Ottawa Charter (discussed above) (Carter, 2014; Carter et al., 2012a). This normative ideal emphasises

⁵⁶ "We don't tell people what to do" is a quote from this study's findings (Chapters Five, Six and Seven) and discussed further in Chapter Eight.

a just society as health promotion's goal, where citizens are active participants with equity in opportunity to be healthy and live the life they choose (Carter et al., 2012a). In this essentially political and moral vision (Carter, 2014), health promotion is a "reform movement" that advocates the redistribution of resources and reduction in health inequity (Yeo, 1993, p. 225). In other words, the project of health improvement requires various forms of intervention.

In light of health's holistic nature – not only according to the WHO (WHO, 1978;1986b) but also Indigenous notions of health (National Aboriginal Health Strategy Working Party, 1989) – health promotion has a broad gamut of mechanisms before it (including but beyond the biological) to employ in its project of improving health (Commission on Social Determinants of Health, 2008). However, in practice health promotion typically involves social marketing, educational or behavioural interventions, with state-defined health outcomes and the presumption of individual responsibility and opportunity to change (Baum & Fisher, 2014; Carter, 2014). Despite its conflict with the value that health promotion practitioners place upon health promotion's normative ideal (Carter et al., 2012b), this practice connotes the constrained environment in which practitioners operate (Sunderland et al., 2015).

The conundrum of practising empowerment while intervening in people's lives is a health promotion practitioner's daily reality. Intervention, it is argued, can be justified for certain ends for the public good (Calman, 2009; Jochelson; Lupton, 1995; Yeo, 1993). Yet, this raises ethical issues, such as who decides what outcomes are 'worthy' enough for contravention of health promotion's 'golden rule' of citizen autonomy and participation. How is the cost of intervention weighted with its benefit, given some harms and burdens are not measured (Carter, 2014) and citizen resistance to intervention for the sake of self-empowerment is an established phenomenon (e.g. Bond et al., 2012; Crossley, 2001; Hughes, 1997; Rofes, 2002)? While this thesis does not seek to cover the expanding literature regarding health promotion's ethical concerns, it does underscore the complex tensions faced by health promotion practitioners in their endeavour to improve people's health. Health promotion as a profession must acknowledge its own contradictions and dialogue towards establishing consensus in how to navigate this overarching tension. To contribute to this discussion, the following

section unpacks six tensions observed in the literature (see Figure 2) that together reinforce health promotion's overarching colonising tension.

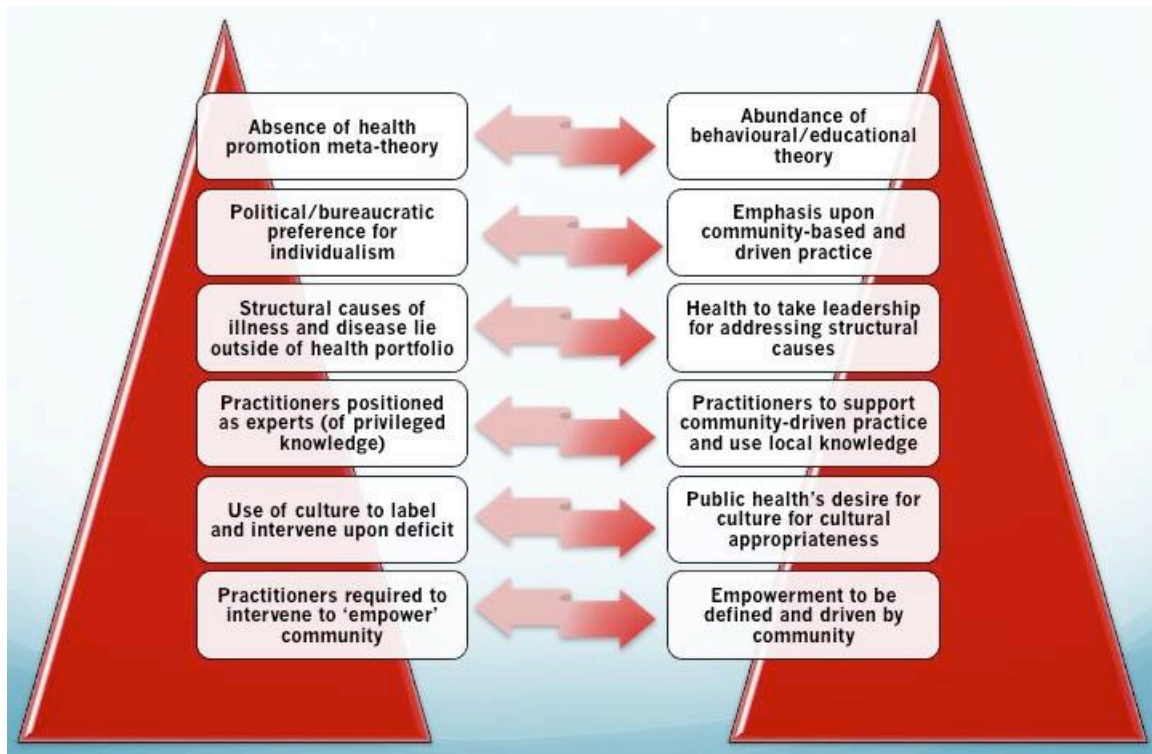


Figure 2: “We don’t tell people what to do”... yet advise people how to live better, healthier lives: Health promotion's core tension, which is the focus of this thesis, encapsulates a number of tensions in day-to-day practice, including the six displayed here.

Absence of meta-theory in health promotion

With the awkward tension of health promotion's endeavour to colonise people's bodies while “not telling people what to do”, a practitioner may look to theory to guide their approach. While the health promotion profession regards itself as having social theories guiding its practice, in reality an absence of meta-theory leaves practitioners eschewed in undertaking to support people's choice while improving their health. Perhaps because of this, there is an abundance of psychological and health education theories used in health promotion, which provide tangible frameworks for practitioners and lead to concrete processes and outcomes for health promotion interventions. Consequently, while practitioners intend for their health promotion practice to be socially oriented, in reality, without its own meta-theory, health promotion most visibly becomes individually-based behavioural change initiatives.

For some time now, health promotion has been wanting of a theoretical grounding (Burrows et al., 1995; Eriksson & Lindstrom, 2008b; Lindström & Eriksson, 2006; Lundy, 2010; McQueen, 1989; Stevenson & Burke, 1991), with commentators cautioning that without a theory, it can be no more than an “attractive concept, bright ideas... (that) generates enthusiasm, but cannot become a cumulative basis for understanding which would guide action” (Antonovsky, 1996, p. 12; Lundy, 2010). Certainly health promotion receives guidance from the Ottawa Charter. Nonetheless this is arguably moral rather than theoretical guidance. To establish this theoretical grounding is no easy task given the complexity of the “wicked problems” health promotion endeavours to address, requiring more than the traditional behavioural change models and risk reduction (Beurden & Kia, 2011; Gardner, 2011). More recently, with its theoretical roots in social sciences (Potvin & Balbo, 2007), pointers towards a theoretical foundation for health promotion include Ken Wilber’s Integral Theory (Lundy, 2010), complexity science and complex adaptive systems (Jayasinghe, 2011), critical social science perspective (Eakin, Robertson, Poland, Coburn, & Edwards, 1996)/critical social theory (Stevenson & Burke, 1991), salutogenesis (Antonovsky, 1996; Eriksson & Lindstrom, 2008a; Eriksson & Lindstrom, 2008b; Mittelmark & Bull, 2013; Silva, de Mendonça, & Vettore, 2008) and participatory action research (Baum, MacDougall, & Smith, 2006).

Nevertheless, despite – or perhaps because of – health promotion’s lack of a meta-theory, it continues to use behaviourist theories to underpin its techniques. For example, Prochaska’s model of behavioural change (the transtheoretical model) (Prochaska, DiClemente, & Norcross, 1992), the health belief model (Becker, 1974; Janz & Becker, 1984; Rosenstock, Strecher, & Becker, 1988), theory of reasoned action (Ajzen & Fishbein, 1980), and Bandura’s theories of social learning (the health belief model) (Bandura, 1977;2004) frequently inform health promotion approaches, exemplified in efforts regarding tobacco, diet, exercise and weight (Blue Moon, 2007; Hyndman, Libstug, Giesbrecht, Hershfield, & Rootman, 1993; Rosenstock et al., 1988). Together these theories empower an individually-based orientation in practice, presenting a dilemma for a practitioner to determine which theory to draw upon, or perhaps overlook.

The unclarified theoretical positioning of health promotion is of particular importance to Indigenous health promotion, because an underlying epistemology exists behind health promotion actions, even when it is not stated or fully understood by the practitioner (McQueen & Kickbusch, 2007). Recalling the colonial foundations of health promotion's global genesis (McPhail-Bell et al., 2013b), the ramifications of an unarticulated epistemology – with its roots in Western knowledge – are that health promotion itself may inflict the “hidden injuries” of Whiteness through its epistemological privileging (Moreton-Robinson, 2007). This in part may account for the failure of health promotion described earlier, with Indigenous Australians.

What exactly is health promotion? (The rise of individualism)

As it stands, the field of health promotion is “a type of social science” with a somewhat frustrated yet futile ability to define itself (Catford, 2004; Goodson, 2010; McQueen & Kickbusch, 2007, p. 1; Tannahill, 1985). Beyond the WHO descriptions discussed earlier, there is no one agreed definition of health promotion (Arabena et al., 2014; Crouch & Fagan, 2014; Labonte, 1997). Perhaps unsurprisingly, in practice there are many varieties of health promotion, ranging from attention on individuals and their relationships, to that of seeking explanations in the material conditions of people's lives (O'Hara, 2014; Whitelaw et al., 2001). In this somewhat unhinged environment, health promotion may legitimately be practised according to a colonising creed of “healthism” (Hughes, 1997), while imagining itself to be empowering.

Since the 1986 Ottawa Charter, the concept of health promotion has been criticised for focussing mainly on changing behavioural components of health, such as smoking and physical exercise (Baum & Fisher, 2014; Mooney & Ataguba, 2009; Wenzel, 1997). While the language of health promotion appears to be social, it is at best rhetoric when its actions are behavioural (Nettleton & Bunton, 1995). Biomedical constructions of health remain influential in practice, translating health promotion philosophy into an imperial form of oppression, particularly for those already marginalised (Baum & Fisher, 2014). Health promotion claims to support control in terms of people's “control

of destiny”⁵⁷, yet in reality, it has been unable to resist the dominant ideology of individualism (McQueen, 1989).

Western governments across the globe are reportedly “stuck” at promoting individual lifestyle change (Alvaro et al., 2010; Raphael, 2014), despite evidence of the inadequacies and ineffectiveness of this approach (Baum & Fisher, 2014). Australia is no exception, with its emphasis upon “emergency prevention” for Indigenous health, including plans of compulsory health checks (Anderson, 2007a) and the assumption that all Indigenous people need to know more about key risk factor messages (“don’t smoke”, “be more active”, “eat 2 fruit and 5 vegetables a day”) so that they would take concrete steps to change their behaviour. Indeed, health promotion in mainstream Australia has at times been defined and measured in terms of doctors, clinical treatments and disease management, or mass media campaigns (e.g. AIHW, 2008; AIHW, 2013). The by-product of this individualist approach is that, regardless of good intentions, the “target group” (in this case Indigenous Australians) can be further stigmatised and blamed for their unhealthy behaviour (Bond, 2002). Subsequently, researchers and policy makers may be limited from seeing the valuable resources and resilience brought by Indigenous populations to health promotion activities (Nelson, 2010). More profoundly, the structural causes of poor health remain unaddressed and overlooked.

Consider for example the Queensland Health guide, “What to Eat” (Queensland Health, 2008). This booklet aims to raise awareness amongst Indigenous people of the importance of healthy eating and physical activity. Using text alongside illustrations of Indigenous people and food, the book discusses food: what to choose, how much to eat, how to read food labels, healthy cooking, and physical activity. The information contained within the book is aligned to Queensland Health’s agenda to “address modifiable risk factors that contribute to chronic disease through... improved nutrition... (and) participation in physical activity” (Queensland Health, 2010, p. 7). The booklet therefore reflects a strategic agenda of the state, to intervene in relation to the behaviour – the lives – of Indigenous Australians.

⁵⁷ That is, the ability of people to deal with the forces affecting their lives, regardless of whether they decide not to deal with them (Syme, 2004).

Although this Queensland Health strategic directive acknowledges the importance of addressing socio economic factors that underpin Indigenous health, the responsibility for this effort is parked squarely within the National Indigenous Reform Agreement (NIRA)⁵⁸ (Queensland Health, 2010, p. 47). The NIRA has been critiqued for: being unbalanced and overly focused on remote area service delivery, despite 74% of Indigenous Australians living in towns and cities (ABS, 2012); brevity in terms of core agreement across governments, and; ambivalence regarding Indigenous involvement through its principles for service delivery and investment (Sullivan, 2011). The aim of increasing Indigenous people's awareness around what to eat appears to have more impact for enabling governments to overlook the fundamental socioeconomic factors impacting upon health, than positively influencing Indigenous health as intended.

Politics and the structural causes of illness and disease

Global health promotion discourses do offer hope. With its social conceptualisation of health, health promotion is positioned well to address the international recognition of the need to address social determinants of health and reduce health inequalities (ANPHA, 2012; Baum et al., 2010; Commission on Social Determinants of Health, 2008; Davison & Smith, 1995; Golds, King, Meiklejohn, Campion, & Wise, 1997; Owen & Westoby, 2011; Raphael, 2012; WHO & Government of South Australia, 2010). The government health sector is frequently identified as responsible for providing leadership and evidence of program impact upon social determinants on health and equity (Commission on Social Determinants of Health, 2008; Lynch, Kaplan, & Salonen, 1997; Newman, Baum, & Harris, 2006; Wilkinson & Marmot, 2003).⁵⁹ However, the empowerment and social justice underpinnings of health promotion are often overridden by contradicting constructs and discourses of control, management and marketing (Gould, McEwen, Watters, Clough, & van der Zwan, 2012), as well as unarticulated colonial uses (Allen, 1998;1999; McPhail-Bell et al., 2013b). Therefore, while a practitioner may advocate for a structural approach to health promotion, they may also be required to balance the agendas of particular stakeholders and departments that contradict this.

⁵⁸ The NIRA was established as part of the CTG policy through COAG, discussed earlier, and recently expired. The NIRA is pending a performance assessment by the Australian Government Productivity Commission.

⁵⁹ The health sector's responsibility for provision of leadership does not suggest the health sector alone is responsible for addressing the SDOH.

Health promotion is especially vulnerable to politics, given that health professionals, officials and ministers cannot implement a holistic policy on their own. Politically, Ministers of Health who understand the SDOH are in an awkward position, as the SDOH lie largely outside the control of their own Ministries (Wolff, 2011). Evidence of effectiveness has not been sufficient on its own to sway community preferences and political decisions (Raphael, 2013;2014; Wise & Nutbeam, 2007). Instead, the difficulties faced by health promoters in achieving a SDOH approach are thought to be not a problem of evidence but of political will (Raphael, 2006).

At the 6th *Global Conference for Health Promotion in Bangkok*, Michael Marmot said health promoters need to take action on the “causes of the causes... as though people matter” (Ritchie, 2005, p. 167). This requires dispelling the myths that neoliberalism has brought faster economic growth from which benefits have trickled down to the poor; it also requires leadership in resisting today’s efforts to rebuild the neoliberal economic system that is at the root of inequality and poverty (Mooney & Ataguba, 2009). Indeed, the Ottawa Charter purports the intention that health promotion would question the dominance of economic rationalism in public policy (Labonte, 1997). For this, practitioners must reflect upon their relationship to the structures within which they work and how that shapes their practice (Burkett, 2007; Young & McGrath, 2011). As Halfan Mahler once said, HFA "...means that health should be regarded as an objective of economic development and not merely as one of the means of attaining it” (Mahler, 1981, p. 6).

The neoliberal environment of Australia and beyond provides a powerful force requiring a behavioural focus of practitioners. While practitioners may endeavour to design and implement initiatives to address structural causes underpinning health issues and to work with community on community-defined terms, a practitioner’s employer or funder, for example, may predefine particular outcomes that contradict such an approach (Sunderland et al., 2015). The irony is that while health promoters may be working to the advantage of the disempowered in society (which includes Indigenous Australians), the advantaged and powerful (which includes the White, middle class) continue to be engaged in active struggles to maintain and increase their control and privilege (Stephens, 2010).

Take as an example the recent series of actions in Australia, which undermine effective public health and health promotion activity. As of June 2014, the Australian National Preventative Health Agency (ANPHA) was abolished, with little public debate or barely an announcement.⁶⁰ Although the ANPHA priorities reflected the political attention of the time to behaviours – namely obesity, tobacco and alcohol (ANPHA, 2012) – it was still an important, independent body for progressing nationally coordinated disease prevention and health promotion efforts, based upon debated policy. Similarly, the COAG Reform Council⁶¹ has been disbanded, as have a range of other important bodies (Sweet, 2014). A senate enquiry into Australia’s health policy, administration and expenditure has revealed the fallacy of this Government’s claims regarding unsustainability of the health system, as well as its lack of consultation with key stakeholders when announcing structural changes to the system (The Senate, 2014). In Queensland, significant cuts to preventative and health promotion services have led to commentators cautioning these are likely to rapidly reverse health gains (Binns, Howat, & Jancey, 2014). There is an anticipated long-lasting, far-reaching impact on the Australian health system – and thus upon the health of Australians, particularly for disadvantaged and marginalised groups (Goldie, 2014; NACCHO, 2014c) – from the Australian Government’s health agenda (The Senate, 2014).

Experts, evidence and local knowledge: Whose knowledge counts?

Health professionals committed to Primary Health Care and health promotion are often faced with the difficulty of serving two masters: their respective agencies and the community. (Kickbusch, 1994, p. vii)

A striking tension inherent to health promotion’s enterprise of ‘colonising people’s bodies’ is its perpetuation of the need for experts and particular Western knowledge, along with local knowledge and involvement. Here, practitioners are positioned in a paradoxical space (Warr, Mann, & Kelaher, 2012). On the one hand, practitioners are required to have particular professional and technical skills and competencies (AHPA, 2009; Allegrante et al., 2009; Barry et al., 2009; Harris & McPhail-Bell, 2007; Madsen

⁶⁰ One had to visit the ANPHA website to learn of its closure, where the Australian Government released its public notice of closure (URL: <http://www.anpha.gov.au/internet/anpha/publishing.nsf> - Accessed 3/12/2014).

⁶¹ The COAG Reform Council played an important role in monitoring Closing the Gap initiatives, with its membership including Federal, state and territory governments.

& Bell, 2012; Queensland Health, n.d.-a;n.d.-b; Sadgrove, 2012; Shilton et al., 2001). These requirements position the practitioners as experts who can work with evidence-based policy and practice, and form interdisciplinary partnerships with other specialists by framing public health problems according to a professionals audience (Warr et al., 2012). On the other hand, practitioners must also be responsive to, and engaging and respectful of, the community they work with, appreciating local wisdom and collaborating with local people (Smith, 2010). This latter requirement is particularly important for working with Indigenous communities, where researchers claim that health promotion must be driven from the community upwards, or else risk failure (Demaio, Drysdale, & de Courten, 2012; MAC & WHGNE, 2008; O'Donoghue et al., 2014; Wise et al., 2012a; Yaman & Higgins, 2011).

The nature of the dominant education models of individual behaviour and the holy trinity⁶² (Porter, 2006; Raphael, 2006) require a professionalised industry of health “experts” familiar with the type of biomedical knowledge required (Smith, 2010). Quantitative performance measures are typical in this results-based environment (Berry, Murphy, & Coser, 2014; Smith, 2010), where governments have a preference for “better” evidence⁶³ that can oversimplify or disregard the reality of practice in the community (Bond, 2002; Brough et al., 2004; Rychetnik & Wise, 2004). The paradox of the professionalisation of health promotion means that practitioners are to negotiate their practice with the community they work with, while implementing an imposed agenda, typically from their funding body or employer, such as government.

Given the centrality of social justice in health promotion, health promotion practitioners naturally have an interest in evidence to support advocacy. For instance, the successful Close the Gap campaign discussed earlier (Close the Gap Steering Committee, 2010; NACCHO & Oxfam, 2007) led to public support and political will to act. Yet this evidence can also be problematic by presenting a sick, hopeless and dying Indigenous population, devoid of strength, resilience, pride, wellness and determination, which are known to exist (Bond, 2005;2009; Brough et al., 2004). Similarly, evidence can make

⁶² The holy trinity of public health is a term coined by Sarah Nettleton to refer to the individual risk factors: nutrition, physical activity and substance use (tobacco, alcohol and other substances) (Nettleton, 1997).

⁶³ “Better” evidence refers to experimental research designs that demonstrate immediate- and short-term intervention outcomes.

for sensational media attention. This presents an additional layer of complexity and injustice, given the way an issue is framed in the media influences political agendas and public perceptions, and reflects elite agendas (McCallum, 2012). In this way, evidence and its professional interpretation construct a moral imperative for health promotion practitioners, and mainstream actors more broadly, to act *on* Indigenous Australians' health, rather than work *with* communities, as health promotion claims to do (WHO, 1986b;1998). Despite the continued failure of government health and social policies (e.g. Anaya, 2010; Durey & Thompson, 2012; Steering Committee for the Review of Government Service Provision, 2014), the evidence is used to support government intervention to “fix” a problematic Indigenous population.

Health promotion's evidence base – its “thorniest issue” (McQueen, 2000) – is situated within a broader context of evidence-based medicine (EBM). In an environment where EBM discourses have colonised health (Poland, Lehoux, Holmes, & Andrews, 2005), given its interdisciplinary nature, health promotion can only be proven effective by its disciplinary subcomponents (McQueen, 2001). Thus, the dominance of the EBM movement has had a pervasive impact on the ability to provide evidence of health promotion's effectiveness (Broucke, 2012). Subsequently, health promotion has experienced failure in convincing decision-makers to invest in health promotion (Binns et al., 2014; Wise & Signal, 2000).

What is rarely asked is “whose evidence?” and according to “whose rules?”; this has been a long term concern for Indigenous communities in particular (Monk, Rowley, & Anderson, 2009). A vicious cycle exists, where research investment privileges biomedical and politically attractive options in health promotion, according to the preferences of funders and decision-makers. It is not surprising then that some decision-makers maintain the view that health promotion cannot improve Indigenous health and

so thus is not a worthy investment⁶⁴ (Wise & Signal, 2000). Yet such a view is far-removed from understanding health promotion's historical and political context.

EBM's methodologically poor fit to the complexity accommodated by health promotion, is symbolic of a health system preoccupation with quantitative evidence. This preoccupation permeates the mainstream approach to overcoming Indigenous disadvantage (e.g. see Yaman & Higgins, 2011). Although initially health promotion (through the Ottawa Charter) did not prioritise evidence and effectiveness (Evans, Hall, Jones, & Neiman, 2007), the Western-derived terms *evidence*, *effectiveness* and *evaluation* are now commonly found in the health promotion literature (McQueen, 2001;2007). Today there is an inescapable focus upon evidence as the basis of health promotion practice (Arabena et al., 2014; Baum, Laris, Fisher, Newman, & MacDougall, 2013; COAG, 2011a;2011b; DoHA, 2011; Potvin et al., 2011; World Health Assembly, 1998). In doing so, health promotion has built a professional foundation based upon an extended period of "dismissal and disintegration" of Indigenous knowledge and more recently, Western interest and commoditisation (Nakata, 2002, p. 2; Rigney, 2006). A strong cultural and geographical bias exists, where the relevance of the evidence debate to health promotion outside of the West has been questioned (McQueen, 2001). Correspondingly, logical positivism continues to dominate, generating evidence that must be able to be verified through rigorous observation and experiment.

The paradox of knowledge and expertise is a particularly problematic conundrum in Indigenous health. Expert opinions abound about how to improve Indigenous health. Yet, the majority of health promotion initiatives in Australia have been produced from a Western cultural perspective, reflecting Western values. There are frequent examples of a mainstream health promotion program having been "adapted" to suit Indigenous people by use of artwork and logos, or without the fundamental understanding of the

⁶⁴ I reflect back to when I was told by a state senior policy executive that the ACE Prevention report (Vos et al., 2010) provided evidence that health promotion was not a wise investment for Indigenous health due to the fact it was "too late" for most Indigenous Australians to improve their health; rather, this executive officer claimed treatment was all that is required. This conversation to me was an echo to the 'smooth the dying pillow' policy era (Foley, 1999). Note that from the same report, the Queensland Aboriginal and Islander Health Council derived that the evidence base was strengthened for the effectiveness of community control to improve Indigenous health. This example points to the central importance of the way values have direct impact on the funding, development, interpretation and use of evidence in Indigenous health promotion.

impact of epistemology (Bond, 2002; Fredericks & Anderson, 2013). The dominant Western health system funding approach in Australia means that attempts to operationalise an Indigenous approach to health promotion may be reframed in accordance with a Western, linear epistemology – known to dissect knowledge and health into compartments and categories or boxes. Not only is such an approach incongruent to the values of Indigenous people (Kreuter, Lukwago, Bucholtz, Clark, & Sanders-Thompson, 2003; Nelson, 2010), its unchecked epistemological assumptions tend to privilege the voice of the expert and silence that of the community it aims to empower. Health promotion with Indigenous people thus involves much more than simply adapting mainstream health promotion programs in an effort to be more culturally appropriate. Instead, it requires a fundamental questioning of the nature of health promotion (Brough et al., 2004).

Culture *of* and *in* health promotion: Desiring culture

The biased imagery of Indigenous Australians presented by the evidence reveals that public health and medicine are themselves cultural practices, heavily influenced by colonialism (Bond, 2005). In a public health context, culture provides the ability to describe health differentials between populations according to ethnicity, race and culture (Bond & Brough, 2007). Therefore, culture enables health promotion to identify Indigeneity and accordingly, to link cultural identity to health inequality (Bond, 2007). Likewise, health promotion's use of culture enables it to attribute poor health to the unhealthy behaviours and ideology of a particular culture (Bond & Brough, 2007). It follows that in health promotion, Indigenous culture is largely marked as illness-producing – a remarkable contrast to the implied strengths-based approach of health promotion, through which communities are to participate in and take ownership of health promotion initiatives.

Health promotion has potential to utilise “culture” as a concept in a superficial way, particularly when explaining unhealthy behaviours (Brough et al., 2004). Although health promotion aims to empower (WHO, 1986b), in practice, Indigenous people are frequently constructed negatively – as “a group of people who just don't know what is good for (themselves)” and with “nothing to bring to the table” to improve their own health (Bond, 2005 p. 40; Brough, 1999). Likewise, funding processes tend to allocate to an “Indigenous problem”, serving to reinforce stereotypes and notions that

Indigenous people/culture/practices/choices are to blame, rather than the structural causes. Indigeneity is constructed by epidemiological descriptors that unquestioningly afford labels regarding risk and poor behaviour, offering a surrogate for inequity (Bond, 2007; Bond & Brough, 2007). This is contrary to the strengths of Indigeneity in relation to pride, strength, determination and survival (Bond, 2005; Vickery, Faulkhead, Adams, & Clarke, 2007).

It is perhaps unsurprising to find that public health continues to pathologise Indigenous identity as a public health threat, when recalling its colonial underpinnings (Parsons, 2010). Health promotion and public health more broadly denote Indigenous status as a risk factor and in doing so, devalue culture and view it as illness-producing (Brough et al., 2004; Guthrie & Walter, 2013). Indigenous scholars have discussed the ramifications of this, including the use of identity to “manage” Indigenous people (Bolt, 2010; Jordan, 1986) and perpetuate racist stereotypes in health promotion (Bond, 2005). Although unlikely the intention of health promotion, its use of Indigenous status often produces (rather than protects against) health inequality through behaviourist rationalisation (Bond, 2007), by implying that illness is inevitable and normal, rather than structurally caused (Bond & Brough, 2007). Mainstream services and processes have used Indigenous status to determine when to include or exclude Indigenous people (Brough et al., 2006). Fundamentally, through its use of culture, health promotion enables the execution of a controlling agenda over Indigenous people to continue.

These are significant considerations for today’s CTG policy era, which emphasises socioeconomic equality for Indigenous people, while also inherently detracting from recognition of difference, choice and self-determination, and more broadly from the unfair and avoidable differences arising from poor governance or cultural exclusion (Altman & Hunter, 2003). Paradoxically, Australia juxtaposes its objectives for Indigenous people in terms of sameness with non-Indigenous people, while Indigenous people frame their future in terms of difference – cultural, values, spiritual, community control and self-determination (Houston, 2006). Consider the words of one Aboriginal commentator:

If Aboriginal people value the good that we find in country, kin and culture more than the good that we find in a quarter acre, individualism and middle class aspiration, do we give up the right to fairness and justice at the hands of health services and systems? And in order to achieve

greater equity in the health system and in its services, do we need to give up the good we find in country, kin and culture? Will this make us healthier? (Houston, 2006, p. 209)

In reality, the range of expressions of Indigeneity goes far beyond, if not contradicts, the narrative of deficit.⁶⁵

Empowerment as a problematic positive

The only empowerment of any importance is the power seized by individuals or groups. (Labonte, 1994, p. 256)

That “increased control over” is a core tenet of health promotion, and thus essentially about empowerment, is well established (Labonte, 1993). Yet, assumptions underpinning mainstream practice about “giving” power to people for control over their health position the community as weak and powerless and the practitioner as expert. This speaks to the colonial contradiction of health promotion, for although health promotion claims a theoretical basis of empowerment and social justice, in practice, health promotion has failed to produce Indigenous health outcomes that validate this claim.

By definition, empowerment means to “make (someone) stronger and more confident, especially in controlling their life and claiming their rights” (Oxford Dictionary, 2014b). In health promotion practice, empowerment is a process by which people, organisations and communities gain mastery over their lives (Labonte, 1994). Implicit to this process is participation and accordingly, participation plays a key role in health promotion as a strategy for empowerment. Participation changes based upon power relations and historical/social contexts. This means that while participation is a recognised health promotion principle for community engagement and inclusion (Llewellyn-Jones, 2001), participation arguably means more than this. Rather, participation means the sharing of control over the health promotion process with the people who are impacted by it, from start to finish. With its locus of control based with the community, this type of participation is uncontrollable (Wallerstein, 2006). As an example, the CCHS

⁶⁵ As one example, local to the location of this PhD study, consider the South East Queensland study that found a number of strengths in the Indigenous community, many of which contrasted stereotypes regarding Indigenous people: extended family; commitment to community; neighbourhood networks; community organisations; and community events (Brough et al., 2004).

movement discussed earlier is one such model that enables the embedding of community control into health promotion as a genuine empowerment strategy (Fredericks & Legge, 2011; Gillor, 2012).

Inherent to empowerment is relationship, through which the verb ‘empower’ involves the subject acting upon an object (transitive verb), or upon itself (intransitive verb) (Labonte, 1994). As follows, relationship is a mechanism for the distribution of power and thus carries potential for the subject to control the object. This is a pertinent point: if a health promotion practitioner is endeavouring to be ‘empowering’, in order to empower a community/member, the practitioner remains the controlling actor. While the practitioner, no doubt, aims to increase people’s control over their health, it is the practitioner’s control that is effectively increased over others. Associated with this, in practice, empowerment tends to be a state bureaucratic tendency rather than a movement against the state as intended in health promotion (Labonte, 1993). This dynamic involves the health practitioner doing “things” to “other things” through an imagined exchange of “wisdom” that allegedly empowers people (Labonte, 1993, p. 6). While this top-down conceptualisation of empowerment is prominent in mainstream practice, such an exchange is not empowering at all for those it claims to empower and instead, reinforces the expert professional status of the health promotion practitioner.

Specific to Indigenous health promotion in Australia, the theoretical guidance regarding empowerment in health promotion is limited but developing. Researchers recognise that in this context, empowerment is about increasing people’s control over factors that influence their lives, acknowledging the ongoing impacts of colonisation (Fredericks, 2008; Tsey, Whiteside, Deemal, & Gibson, 2003). As one researcher commented, “...any sense of what empowerment means to Aboriginal peoples or the effects that empowerment strategies have in working with Aboriginal peoples needs to come from the understanding that we were once sovereign peoples” (Fredericks, 2008, p. 9). In this way, empowerment is a matter of equity and resonates powerfully with Indigenous self-determination (HREOC, 2007). Re-empowerment thus also has a place in empowerment in Indigenous health promotion, from the viewpoint that Indigenous Australians once had control of their life and colonisation subsequently disempowered them (Fredericks, 2008).

Accordingly, aspects of empowerment must be defined by Indigenous people themselves (Tsey et al., 2009). Observers distinguish that the Indigenous community impacted by a health initiative must be the ones who define the problem and solution (Campbell, Pyett, & McCarthy, 2007). This makes empowerment in Indigenous health promotion both a process and the end change itself, for which community control of resources and decision-making processes is necessary (Tsey et al., 2009). It follows that empowerment is about Indigenous voices being heard and enacted, leading to a shift in the dominant culture (including within health systems) so that these systems become supportive and facilitate change (Fredericks, 2008).

For this reason, the agency of Indigenous people is an ingredient of empowerment, tied to choice and the significance of Indigenous people's roles in health (Bainbridge, 2011). Actions for empowerment may involve strengthening cultural, social and emotional wellbeing of individuals, families and the community (Dudgeon et al., 2014a); it may also involve unique characteristics such as "spiritual sensibility, and ethics of morality and the notion of cultural competence" (Bainbridge, 2011, p. S29). Whatever the process and outcome, the underpinning theme of empowerment in Indigenous health promotion is that of Indigenous control.

Unfortunately, in practice, health promotion can be a disempowering experience, including for practitioners, rather than the empowering practice it espouses itself to be. What we see instead is health promotion's inability to effectively engage with the social, cultural and political context of Indigenous Australians, and a narrative of mainstream health professionals with regard to living better, healthier lives. Mainstream/government approaches to Indigenous health tend to promote an agenda of control *over* Indigenous people – in contrast to health promotion's stated values of people's control over their *own* health. There are uncomfortable colonial undertones here, where the expert voice is privileged while the voice of those supposedly being empowered is silenced. However, with convergence between Indigenous concepts of health and the narrative of health promotion, and the CCHS sector experience with health promotion that pre-dates the Alma Ata Declaration and the Ottawa Charter, opportunity exists to learn from Indigenous-led health promotion.

Learning from Indigenous health promotion?

In summary, the colonial underpinnings of health promotion continue to influence its practice today. While Australia is a world-leader in health promotion, it has exhibited a remarkable failure to Indigenous Australians, in terms of health outcomes, partnership and supporting genuine self-determination. This is a bitter irony in light of the global health promotion developments advocating for social justice and people's control over their own health that occurred in parallel with the struggle for Indigenous health in Australia. Evidently, the daily practice of health promotion is not a straightforward endeavour, marked by its aspiration to colonise people's bodies for the objective of health. Because of this, practitioners themselves face a series of tensions to navigate, for which a limited, if not absent, evidence-base and meta-theoretical framework exists.

It is astounding that there is a scarcity of health promotion research premised on learning from Indigenous organisations and practitioners. The CCHS movement continues to deliver Indigenous health results, where mainstream services fail (Alford, 2014; Gajjar et al., 2014; NACCHO, 2014d; Panaretto et al., 2014). Furthermore, the CCHS movement had experience in Indigenous health promotion long before the Ottawa Charter was produced. Despite this, while state and federal governments continue to struggle to deliver on their promises of improved Indigenous health, there is minimal evidence of governments listening to, working with and learning from Indigenous community-led health promotion. This chasm reflects the colonialism of a mainstream system teaching Indigenous people how to practice health promotion, while disregarding Indigenous knowledges and practice.

Indigenous community-led health promotion presents an opportunity to address the inequalities between Indigenous and non-Indigenous Australians. It can bring Indigenous and non-Indigenous people together by means of a relevant and meaningful framework to potentially overcome cultural and institutional barriers (Chino & DeBruyn, 2006). Indigenous approaches to health promotion are considered holistic in nature and intercultural in setting, providing opportunity to identify ways to overcome the dynamics working against the principles of health promotion, such as medical reductionism and market consumerism (Durie, 2004; Labonte, 2005a; Lea, 2008; MAC & WHGNE, 2008). Indigenous approaches arguably go beyond the biomedical model

of health, to incorporate key foundations of cultural identity, family and community kinship, wellbeing and healthy lifestyles, spirituality and land (Brough et al., 2004; Durie, 2004; McLennan & Khavarpour, 2004; National Aboriginal Health Strategy Working Party, 1989). Indigenous approaches thus present a way to create new bridges for intercultural understanding and respect (Labonte, 2005a; Lea, 2008), drawing on Indigenous strength for progressing negotiations through dialogue (Hearn, 2004).

Fundamentally, researchers have found that core capacities for making progress in Indigenous health promotion are Indigenous leadership, autonomy and governance (Durie, 2004; McCalman et al., 2014; Wise et al., 2012a, p. 142). At the core of this is Indigenous peoples' control over the health promotion process, rather than the practitioners' or the health service's control over Indigenous people and communities (NAIHO, n.d., p. 21). In this way, Indigenous community-led health promotion works with community-identified needs, harnessing the pivotal roles of Indigenous health workers working with communities and establishing partnerships (McLennan & Khavarpour, 2004; Rose & Pulver, 2004).

A range of tools exists to guide and support effective Indigenous health promotion practice (McCalman et al., 2014; Wise et al., 2012a). Yet, beyond this, the practicalities of operating at a community-based level in an empowering way are difficult and complex. Furthermore, little exists in the literature to inform the practice level, and knowledge deficits continue to exist regarding effectiveness of Indigenous health promotion in practice (McCalman et al., 2014). This is particularly the case for Indigenous health promotion in an urban context.

It is time for a different kind of evidence of a decolonising nature, where mainstream health promotion learns from and with practitioners at the interface of Indigenous-led health promotion, working with Indigenous people and communities rather than intervening. Mainstream practitioners have an important role in this, by acknowledging existing Indigenous perspectives, capacities and richness in culture (Brough et al., 2004; Durie, 2004). For this, a decolonising approach is required, to guide both Indigenous and non-Indigenous researchers and practitioners to develop strategies for devolving or sharing power with the participating communities (Pyett et al., 2008; Smith, 2012). This PhD study endeavoured to contribute to addressing this knowledge gap.

3. Conceptual framework and methodology

Little research exists to guide actual health promotion practice, particularly of a decolonising nature that acknowledges and learns from Indigenous-led health promotion practice. This chapter discusses the theoretical tools used to address this knowledge disparity, to broadly contribute to the decolonisation of health promotion practice. Firstly, the chapter restates the research purpose and clarifies how my researcher positioning informed this study. Secondly, the chapter outlines the three theoretical tools that guided the research to understand the reality of practitioners navigating the tensions of health promotion practice. The first two tools, critical race theory (CRT) and postcolonialism were employed to position health promotion as a discipline and practice, and myself as a practitioner and researcher. These tools are useful for unsettling presuppositions about Western-Indigenous relations in health promotion and research. However, alone, they risk creating a structuralist binary regarding the way the study participants practised and positioned themselves. Such an outcome would arguably not be decolonising for its imposition of assumptions about truth and participant agency. Therefore, the third tool applied is the cultural interface, which enabled analysis to more openly inquire into the practice studied, as positioned in a “complex ‘middle-ground’” of the Indigenous and Western (Nakata, Nakata, Keech, & Bolt, 2012, p. 143). The chapter then concludes with an explanation of the use of critical ethnography in an expanded manner, informed by this theoretical framework, to traverse the fieldwork spaces online and offline.

Research purpose and question

The purpose of this research was to contribute to the decolonisation of health promotion practice in an urban setting. To do this, the study enquired into how a cross-section of Indigenous and non-Indigenous health promotion practitioners navigate their daily practice. The overarching research question was:

How do health promotion practitioners in an urban Indigenous setting make sense of and navigate the tensions inherent to health promotion in daily practice?

As a non-Indigenous health promotion practitioner, my own positioning is of central relevance to decolonising health promotion practice and research. Like other health promotion practitioners, I too face the tensions discussed in Chapter Two and carry the White privilege endowed upon me through the inequitable, ongoing impacts of Australia's colonisation. Accordingly, I acknowledge that my researcher standpoint directly influences my approach and interpretation in this study. Therefore I describe my standpoint below.

Researcher standpoint

An Indigenous woman's standpoint is informed by social worlds imbued with meaning grounded in knowledges of different realities from those of white women. (Moreton-Robinson, 2000, p. xvi)

In theoretical terms, standpoint refers to a method of inquiry, "a distinct form of analysis" (Nakata, 2007c, p. 214) and research paradigm (Moreton-Robinson, 2013) that recognises claims and knowledge as being socially situated.⁶⁶ Standpoint requires that these situations must be examined (Harding, 2002; Pohlhaus, 2002), for the social position of the knower is epistemologically significant, making possible and delimiting the knower's knowledge (Pohlhaus, 2002, p. 4). A researcher's positioning informs the goals of their research, which means that my own values and morals were not detached from this research (Moreton-Robinson, 2013). Philosophical assumptions and investigator worldviews (paradigms or sets of beliefs) inform the conduct of research, which is then further shaped by interpretive and theoretical frameworks. These assumptions, worldviews and frameworks frequently overlap and support each other (Graham, Brown-Jeffy, Aronson, & Stephens, 2011, p. 81). Identifying my researcher standpoint therefore contextualises the purpose of this research and my choice of theoretical frameworks, and serves to unsettle and resist the hegemony of White

⁶⁶ I acknowledge the large and growing body of literature regarding standpoint theory. I do not intend to contribute to that body of knowledge but rather, highlight the social positioning of my own way of knowing and the way that influenced this research process.

privilege and entitlement (Nakata, 2004) inherent to health promotion practice and research.

Epistemology – My way of knowing

I am a middle-class, Christian woman of Irish, Scottish and English heritage. The historical context of my privileged positioning is not lost on me; I am aware that non-Indigenous interest in Indigenous welfare has been part of the civilising role prescribed for early twentieth-century Australian White women (Bishop, 2008). I am also aware that White women continue to be involved in gendered racial oppression of Indigenous people, while self-representing according to an Australian society norm of Whiteness (Moreton-Robinson, 2000). Given the power dynamics at play in these social relationships, it is safe for me to say who I am – which may not be the case for others (Max, 2005).

My social positioning means that experiences of oppression and colonisation position me differently to others, including Indigenous Australians. Indeed, culture and bodies matter in discourses about Indigeneity (Sefa Dei, 2008) and skin colour is a powerful marker that attaches privilege to White skin and punishes dark skin through a social hierarchy of pigmentocracy (Akom, 2011).⁶⁷ As an ethnographer, my body was key in this study, where *I* was the primary research tool (Madden, 2010). I brought what Bourdieu described as a “habitus”; that is, an embodiment of society deposited in forms of capacities and structures for thought, emotions and behaviour (Bourdieu, 1990).

As Ryde recognises (2009), my connections with my ancestors are subtle and deeply held. Because of this, coexistent attitudes towards Indigenous Australians shape me at quite a fundamental level, originating from colonial times – times from which I continue to benefit by the advantage colonisation has afforded me. Anne Barton, the great-granddaughter of Sir Edmund Barton⁶⁸, reminds me that there is an obligation accompanying my White privilege:

A robust and honest reflection on my racialised identity aims to show that, as a white Australian, I can only become part of the solution when I recognise the degree to which I am part of the problem, not because I am

⁶⁷ Akom explains that pigmentocracy “refers to a system of advantages or disadvantages based on various phenotypes or skin pigmentations within a racialised hierarchical society” (Akom, 2011, p. 127).

⁶⁸ Sir Edmund Barton was Australia’s first prime minister.

white, but because of my investment in white privilege. (Barton, 2010, p. 1)

To unsettle the hegemonic nature of my Western way of knowing, I engaged with the work of Indigenous scholars, particularly Aboriginal and Torres Strait Islander scholars. This engagement is reflected in my selection of theoretical tools for this study. My choice to engage with Indigenous scholarship demonstrates the fundamental power of Whiteness: that because of the White privilege from which I benefit, I could choose when and if I engaged with Indigenous people and their work (Moreton-Robinson, 2006). My choice also demonstrates the ease with which non-Indigenous people can easily appropriate Indigenous knowledge for their own agendas, which remains an uncomfortable tension for me, particularly given how few guides there are for non-Indigenous people to respectfully utilise learning from Indigenous people (Carnes, 2011b; Cross-Townsend, 2011). I acknowledge the critical nature of unsettling White privilege and listening to Indigenous voices, if I am to be an allied activist accountable to my White privilege (Carnes, 2011a;2011b). In this way, this study is a work of resistance to the hegemony inherent to health promotion practice and research in the mainstream institutions.

Ontology – My way of being

My ontology – or, as some Indigenous scholars clarify, “way of being” (Martin, 2003; Moreton-Robinson & Walter, 2010) – is influenced by my Christian-guided spirituality, which also provides me with a particular form of moral code. Admittedly, I have struggled with mainstream interpretations of Christianity and on occasion found the church experience to be at odds with what I consider was the original intention, enforcing a (typically White, Western) culture in the name of Christianity. Christianity has played a clear role in colonisation in Australia and beyond, with the missionary movement leaving a traumatic impact on many Indigenous people and communities (Adam, 2009). However, my Christianity also galvanises me to an agenda of reconciliation (Mostert, 2010), Indigenous land rights and social justice⁶⁹ (Ross, 2006). I believe in reconciliation, which includes apology as well as bringing truth to light, restitution, retribution and forgiveness (Seiple, 2004) – much more than what is evident

⁶⁹ I acknowledge that social justice is a concept based on a Western epistemology, which may heighten epistemic concerns regarding my thesis. As discussed later, this research accepts that knowledge is a contested space (Nakata, 2007b).

in the Australian agenda for reconciliation.⁷⁰ These facets of my Christian spirituality present another layer to scrutinise in terms of my positioning as “the coloniser” in this study.

My passion for social justice and the centrality of love as a tenet for life is interwoven with my Christian positioning, which inspires me to stand for human rights.⁷¹ I take the view that to identify health inequities involves a value judgment premised on one’s views of: social justice; how society is organised; and, the root causes underlying health inequalities (AHS Tri-Project Glossary Working Group & Population and Public Health, 2001). These differences systematically place vulnerable populations at further risk of poor health outcomes and thus, I believe addressing these differences must be prioritised, rather than an individual focus as so commonly evident in health promotion practice. My values of empowerment and justice have an associated responsibility and possibility for resistance, activism and the use of my position to effect positive change. I agree that:

If we aspire to social justice for Indigenous people, especially in the area of health, then we must undertake appropriate research that addresses the needs of Indigenous people as they perceive them in a way that fits within their frame of reference. (Gorman & Toombs, 2009, p. 4)

My predominantly Western socialisation and disciplinary training have informed my stated agendas and values, and located me as a researcher within the mainstream discourse of Australia. This positioning is significant, given many non-Indigenous people have little or no knowledge of the impacts of colonisation – and nor did they ask⁷² – and thus perpetrate stereotypes about Indigenous communities (Kendall & Wickham, 1999a). Further, as an ethnographer, I am mindful that my work of representation is a political act, historically contextualised and implicated by intersecting notions of race, gender, sexuality and place, situated and contingent on particular material and imaginative boundaries (Wahab, 2005). Thus, I have shaped this

⁷⁰ I also acknowledge that the reconciliation process and “Recognise” movement in Australia are not representative of the views of all Indigenous Australians (or non-Indigenous Australians for that matter, perhaps for different reasons). For example, Indigenous writers argue that Recognise is a “government-sponsored ad-campaign removed from grassroots Indigenous opinion” (Liddle, 2014); similar arguments were mounted regarding reconciliation (Foley, 2010). Furthermore, researchers have found that the reconciliation efforts to educate the wider community regarding Indigenous and non-Indigenous history were restricted by a nationalist framework (Gunstone, 2012).

⁷¹ I acknowledge human rights as being a Western concept (Moreton-Robinson, 2000).

⁷² One must consider too, why do only some non-Indigenous people ask back and not others?

research to examine power imbalances and oppressive histories pertaining to Whiteness as well as to apply a critical lens to my own work as a non-Indigenous researcher.⁷³

Axiology – My way of doing

My axiology – or way of doing (Martin, 2003; Moreton-Robinson & Walter, 2010) – brought extrinsic and intrinsic values to the research process, which led me to choose this topic, this aspect, inspired by a particular interest (Moreton-Robinson & Walter, 2010). I write from the position of someone who has been involved in the practice, policy and research of health promotion for some time. My experience positioned this thesis as one of passion for health promotion's possibilities and concern that health promotion has not been what it claims to be. I believe deeply in health promotion's aim to enable people to increase control over their health (WHO, 1986b) and accordingly value privileging the voice of the oppressed.⁷⁴ The call for equality and equity, including "health for all" (WHO, 1981) and my history in advocacy continue to influence my approach. Perhaps this is because I am an optimist (albeit a pessimistic one at times) which, like Labonte (2005a), I consider to be an act of political resistance and empowerment.

Could I ever consider myself one who supports an Indigenous cause of being a "warrior using ink, my mouth, spirit and mind... as my weapons" – one of the non-Indigenous warriors walking along side Indigenous warriors (Fredericks, 2007)? I ask this with caution because good intentions alone are inadequate and have been harmful. I am in uncertain territory, operating in a cultural site (academia) that has perpetrated the obscuring of Indigenous worldviews and realities for years (Rigney, 2006). I carry a sense of responsibility to contribute to equity and equality in society, particularly while too many Indigenous people and communities live within political and social conditions that perpetuate poverty, disadvantage and poor health (Walter, 2005).

As my standpoint exposes, ethnographers begin with preconceived notions about how people behave and what they think; "...the choice of what problem, geographic area, or

⁷³ I also acknowledge that elements of my personality may influence the way I present scientific enquiries and methodologies (Trigger, 1992).

⁷⁴ I recognise the tension in using terms such as "marginalised" and "oppressed" in that they serve to Other particular groups of difference in relation to the hegemonic norm, while denying them their voice and not naming the dominant group. However, for the purpose of opening a dialogue in this space, I use the term, albeit cautiously.

people to study is in itself biased” (Fetterman, 2010, p. 1). Acknowledging my positioning does not extinguish the possibility for my prejudices in this study, nor is this my intention. Rather, just as knowledge is socially constructed, my prejudices remain engrained in political, social and historical structures, able to evolve but not crudely removable. Thus, acknowledging my positionality does not dissolve its inherent tensions but rather exposes the terrain I was to respectfully traverse in this study. By its very nature, my positioning as a non-Indigenous researcher, researching Indigenous-led health promotion practice while endeavouring to counter the colonial power structures, meant I embodied the privileges that I sought to challenge. Consequently, this work is of a very personal nature.

My intention for this research – the topic, research question, aspects, process, analysis and interpretation – was to privilege Indigenous perspectives and interests (Rigney, 1999b) and to work for (not against) the protection and safeguarding of Indigenous practices, customs and beliefs (Fredericks, 2007). This was not to downplay or mask the awkward gain and benefit I would acquire in obtaining a PhD. Rather, I endeavoured to frame and continually reframe this research in a way that privileged and embedded Indigenous values and perspectives. For example, I aspired to think about the primary values that exist in Indigenous communities, asking myself how I could change the institutions within which I reside, and actively reproduce Indigenous core values (Sefa Dei, 2008). I was cautious of reducing participants to data or objects when I analysed and reported (Toll & Crumpler, 2004), being cognisant that traditional research processes have marginalised and misrepresented Indigenous ways of understanding and knowing (Rigney, 1999a). My regard for people’s control over their own health – and accordingly, for the community controlled health sector – informed the development of research questions that considered the local Indigenous research agenda and goals. In this way, I approached this research process with a politically active agenda: to honour the call for research to make a positive difference for those being researched (Smith, 2012).

Reflexivity: The link between positioning and theory

There are variations to reflexivity in terms of who, what and how it is done. Reflexivity is arguably a guard against the assumption of an unproblematic relationship between the

social scientific text and its valid and reliable representation of the ‘real’ world (May & Perry, 2011). Certainly, reflexivity risks centring the researcher in text and thereby legitimising knowledge claims of professions, rather than questioning them (D’Cruz, Gillingham, & Melendez, 2007). However, a decolonising approach requires reflexivity and enables acknowledgement of White privilege (Redman-MacLaren et al., 2012; Smith, 2012) and support of culturally safe practice (Booth & Nelson, 2013).

Foley explicates four types of reflexivity: confessional, theoretical, textual and deconstructive (Foley, 2002). I aimed to create an ethnographic text that is of a reflexive realist narrative style (Foley, 2002, p. 469) by spanning across these forms of reflexivity. For example, confessional reflexivity enabled me to be emotionally open as an observer and interpreter, while theoretical reflexivity enabled me to make transparent how I produced “truth claims and facts” and “knew” reality (Foley, 2002, p. 476). Intertextual reflexivity led me to reflect upon the foundation documents of the institution of health promotion to understand differences of interpretations (e.g., McPhail-Bell et al., 2013b) (see Appendix A), and deconstructionist reflexivity prompted me to deconstruct my reflexivity and embrace the tensions of my positioning in research practice (Foley, 2002).

I chose to start from a position of reflexivity in acknowledgement that it is from here that our critiques of the academy could hold sway (May & Perry, 2011; Sefa Dei, 2008). Academia – one “home” for this PhD research – has concealed racial privilege in many of its tools and epistemologies (Moreton-Robinson, 2003b). Ethnography – this study’s methodology – is no exception, where representation is a political act that is historically contextualised. I chose to problematise research as a power struggle between researchers and the researched (McCarthy & Martin-McDonald, 2007). Thus, throughout this research I sought to maintain reflexivity regarding the process, including my approach to knowledge, representation, my positioning and how this influenced my approach to the research, such as the application of a decolonising approach⁷⁵ (González y González & Lincoln, 2006; Racine & Petrucka, 2011; Smith, 2012).

⁷⁵ Although this research is not explicitly decolonising in nature, I have drawn on decolonising methodologies as part of my researcher positioning, being aware that my personal positioning is connected to the macro and vice versa. The decolonising approach is discussed below.

My Whiteness and gender have been a central part of my research undertaking, where as a White ethnographer I carried power to choose what becomes data and how data would be represented. My positioning remains unstable, for middle-class White feminist academics who advocate for decolonising practice – such as myself – have a history of unconsciously and consciously exercising their race privilege (Moreton-Robinson, 2000, pp. 126-127). The weight of my supervisor's words pressed upon me: "Sometimes the strategies of non-Indigenous feminists can act as new forms of colonizing practices" (Fredericks, 2010, p. 546). Postcolonial theory and critical race theory have raised issue with the history of unequal power relations within research: as a White researcher it was me who carried the weight of power.

Therefore, to engage reflexively with my standpoint I had to be concerned with power. However, to be critically reflexive regarding my position involved more than an autobiography to locate me as a researcher – although this was also important. I engaged with the personal (for example, my personal location in the research) and the macro (for example, the history and practice of health promotion, or structures through which I am bestowed and enact my privilege) (Figure 3). As part of this, I examined the health promotion literature to understand how my profession demonstrates an awareness of power, including its own. What I found was that despite its grandiose statements regarding empowerment, health promotion as a profession is blind to its colonial foundations and because of this, risks replicating colonial power structures in its practice. For example, the development of the Ottawa Charter was embedded in a colonial context that normalised a Western view of health, while excluding and silencing non-Western views (McPhail-Bell et al., 2013b):

It is alarming that in the development phase of an international movement led by the WHO and in the wake of the Alma Ata Declaration, a primarily privileged 'club' of 38 predominantly wealthy nations was fashioned to create a movement for addressing health inequality. A colonizer's imagination was clearly at work here, though this has remained unacknowledged in the history of health promotion... In this way, the process did not reflect the ideals of the Charter itself, reflecting instead the established global order of inequality. (McPhail-Bell et al., 2013b, pp. 24-25)

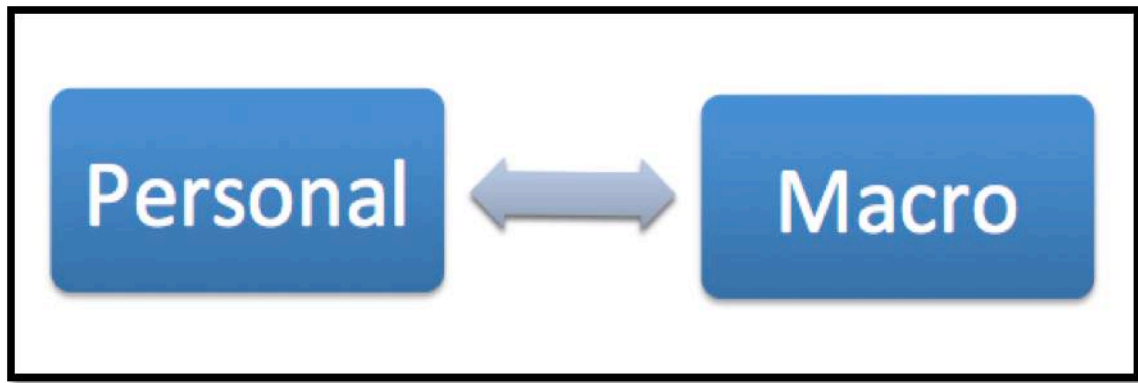


Figure 3: To reflexively engage with one's standpoint, the connections to other social positions and structures must also be examined. Consideration of one will strengthen understanding of the other.

The implications of the somewhat uncritical use of the Ottawa Charter today are that the health promotion profession may be perpetuating inequalities and inequities due to the White ignorance of, “not just not knowing but not knowing what one does not know and believing that one knows” (Applebaum, 2010, 6; cited in Moreton-Robinson, 2011, p. 413).

Theoretical framework

It is with the abovementioned concerns in mind that I turned towards mainstream health promotion to examine its practice. With the lack of an overarching health promotion theory (discussed in Chapter 2), I drew on a bricolage of theoretical tools (Kincheloe & McLaren, 2005) to examine the body of health promotion rather than its subset of techniques, while deepening the epistemological reflection on how health promotion positions itself. These theories enabled me to theorise about health promotion in a manner that supported a decolonised space of practice.

That said, this study was not concerned to establish an absolute theory for health promotion. Instead, the concern was regarding the practical issue of power and control in health promotion practice and research, particularly given people’s control is a core principle of health promotion (WHO, 1986b). Control matters for the decolonial endeavour regarding health promotion because decolonisation shifts the locus of control over health promotion knowledge and practice. The logical progression to apply this

understanding to health promotion was for this study to examine Indigenous-led and community controlled health promotion practice (Smith, 2012).

While this research does not claim to be entirely decolonising in nature, it has drawn upon a decolonising approach to contribute to the decolonisation of health promotion. Decolonisation is an event and a process whereby concerns and worldviews of the colonised Other are centred (Chilisa, 2012; Smith, 2012). Specific strategies are created through decolonisation to liberate the “captive minds” of both the colonised and the coloniser from oppressive conditions that silence and marginalise the voices of the colonised (Chilisa, 2012, p. 14). Decolonisation values the integration of knowledge systems (Chilisa, 2012) and therefore involves suspending foregone conclusions generated through an anti-colonial critique, to engage with and integrate knowledge and agency at the interface of Indigenous analysis, resistance, practice, knowledge revitalisation and futures (Nakata et al., 2012, p. 135). To align with a decolonised approach, the chosen theoretical tools in this work first critique the Euro-Western paradigm dominance and subsequently inquire how knowledges converge and evolve through their daily enactment, to expand assumptions underpinning existing health promotion theory and practice.

The decolonising approach of this research was conceptually based upon a bricolage framework involving three theories (see Figure 4), each bringing an important angle to richly explain the data, when on their own each one was insufficient for this project (Kincheloe & McLaren, 2005). This bricolage enabled the research to provide cross-referencing and expansion of understandings not previously undertaken in health promotion research of this nature. These tools also enabled consideration to the workings of power in health promotion practice and research. The following section details these theoretical frameworks as they relate to this study.

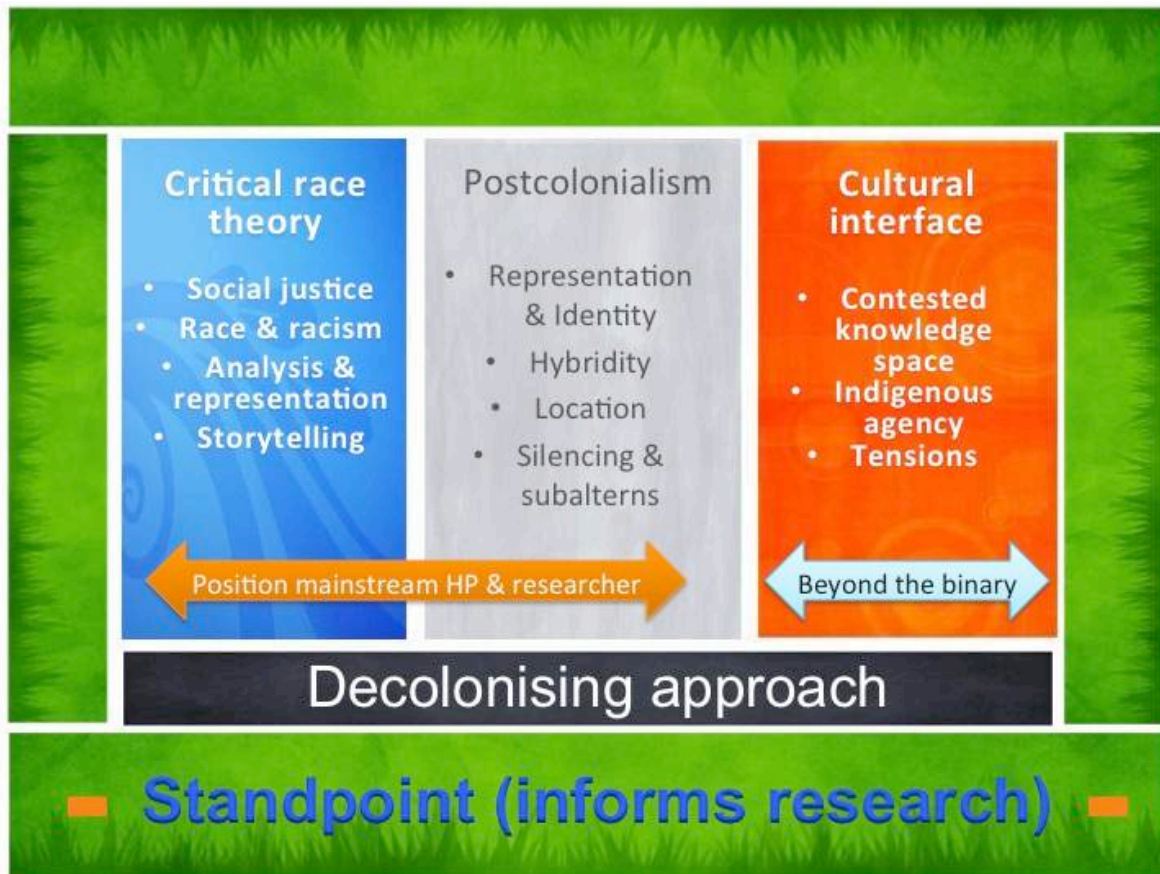


Figure 4: A bricolage framework informed this study by drawing on critical race theory, postcolonialism and the cultural interface, informed by my researcher standpoint. Together they enable a decolonised understanding of the workings of power and control in health promotion.

Postcolonialism

Postcolonialism is a theoretical tool⁷⁶ that recognises many of the assumptions underlying the “logic” of colonialism still active today. In this way, the ‘post’ of postcolonial is not an historical marker but rather represents a form of historical resistance to colonialism (Ashcroft, Griffiths, & Tiffin, 2007). In its focus upon combatting the residual effects of colonialism, postcolonialism provides a focus upon power and control of and over people, providing a direct link to this study’s interest in people’s control over their health. Accordingly, postcolonialism was suitable to my standpoint and intention to prioritise the creation of mainstream space for voices of marginalised people (Bhabha, 1983;1994; Gandhi, 1998; Morton & Procter, 2009; Spivak, 1995). The following section discusses some key postcolonial concepts as they related to this study.

⁷⁶ I use the term ‘theoretical tool’, acknowledging that postcolonialism is not a theory in the strict sense of the term but rather a set of conceptual resources (Young, 2001). Likewise, my use of theory is practice-oriented rather than a strict theoretical endeavour.

“The West and the rest”⁷⁷ – Representation and identity

Postcolonial theory provided a framework for this study to destabilise dominant Western discourse and power (Gandhi, 1998). The West is more than a geographical construct, but rather a historical one that functions in a number of ways to describe a set of ideas, historical events, and social relationships (Hall, 1996). The concept guided my postcolonial analysis of health promotion’s foundation and my position, helping to identify how and when the West characterised and classified societies into binary opposites of coloniser/colonised, first world/third world, and Western and non-Western. Hall’s work regarding “the West and the rest” demonstrates the way these binary positions empower the West to produce its self-defined uniqueness through contact and self-comparison with other non-western societies (1996). These perceived differences then shape the discourse of “the West and the rest” and influence public perceptions and attitudes. This effect remains evident in the way national cultures acquire their strong sense of identity by contrasting themselves with other cultures. For example, in Australia, a sense of nationalism has been nurtured through dominant group behaviour that resists the Other within this country. A case in point is the Cronulla riots, where the dominant group protested against its imagined marginalisation and provocation (Cowlshaw, 2007). Similarly, White commentators have been involved in ongoing naming and claiming of what and who can be Indigenous (Bond, 2014; Moreton-Robinson, 2003a). Regardless of the position of power asserted by the dominant group in this process, they also face damaging effects of colonial ideas on self-identity – the coloniser is not more free or liberated in their power and privilege, because their minds are colonised too (Fanon, 1967).

To identify the production of these binaries in health promotion, I examined essentialising techniques that created an Other. Essentialising condenses an image/set of images of different characteristics (including complex descriptions of other societies) into a ‘sameness image’ (Hall, 1996). The created Other can then be judged against the Western idea. These Othering and essentialising ideologies work to marginalise and suppress knowledge systems and ways of knowing of the colonised and of other disadvantaged groups on the basis of gender, ethnicity and social class (Hall, 1996). The

⁷⁷ This is a phrase coined by Stuart Hall (Hall, 1996).

West's representation of the Other then provides a basis to rank societies, around which powerful positive and negative feelings cluster. In this way, non-Western societies may be conjured as being under-developed and thus bad and undesirable (Young, 2001).

As Chapter Two demonstrated, health promotion is complicit in the identity struggle regarding Indigenous Australians. Postcolonialism enabled this study's reclamation of pre-colonial forms of history and culture, and the construction of new national identities based on specific and local knowledges and histories, by debating and recognising the problematic nature of cultural identity (Ashcroft et al., 2007). As part of this focus upon cultural identity, this study examined representation and identity in health promotion to uncover racial classifications serving to control the colonised through a hierarchical division between Europe and its Others according to fixed genetic criteria. Attention to ethnicity⁷⁸ also enabled this study to view identity as an expression of a positive, beneficial self-perception (Ashcroft et al., 2007).

The postcolonial turn: Hybridity

Hybrid notions influence national and cultural identity. Hybridity is a strategy to weaken the colonial power that involves the combination of elements of colonial culture with various others. By doing so, the coherence of colonial discourse is fragmented and challenged (Allen, 1999). Like colonial mimicry⁷⁹, hybridity involves a doubling, dissembling image of the Other in more than one place, which in effect reduces the visibility of the colonial authority (Bhabha, 1994).

As a decolonising technique, hybridity enabled me to examine Indigenous agency in health promotion practice in contrast to the colonial foundations of health promotion. Likewise, hybridity revealed the colonial ambivalence inherent to health promotion (McPhail-Bell et al., 2013b), whereby the colonists desire one thing – Indigenous people in this case, in order to deliver Indigenous health promotion – while wanting its

⁷⁸ The term “ethnic” tends to refer to geographic origin as opposed to “race” which tends to refer to biological inheritance (Jamal, 2005). While ethnicity involves how people choose to identify themselves, it is also defined by a society and accordingly can, like race, still be used as a basis for discrimination (Jamal, 2005).

⁷⁹ Homi Bhabha wrote of colonial mimicry as an “ironic compromise”, using ambivalent discourse, whereby the Other is reformed as a subject of difference that is almost the same as the colonial power, but not quite. Bhabha wrote of colonial mimicry as one of the most elusive and effective strategies of colonial power and knowledge (Bhabha, 1994).

opposite – for example, Indigenous self-determination (Ashcroft et al., 2007). Such ambivalence is typical of a colonial relationship of attraction to and repulsion from a person or object, while never actually being opposed (Young, 1995).

The hybrid embrace-exclusion relates to the dominating belief in European power, with the possibility that the colonised also desires the superficiality of “modern” civilisation. This leaves the colonised and the coloniser locked in a struggle that empowers the master-slave relationship, with one conquering the other the only way forward (Gandhi, 1998, p. 16). Hybridity revealed the way dominant and marginalised knowledge sets remain as binary opposites in the discourses of health promotion. While this analysis is important for identifying power and control, such an arrangement perpetuates their binary existence as homogenous entities, demonstrating postcolonialism’s limitation in relation to this study’s agenda.

Location: “The colonials did not go home”

The hybridity of cultural identity can aid understanding of cultural location. In Australia, the postcolonial remains based on Whiteness given that “the colonials did not go home” (Moreton-Robinson, 2003a, p. 30).⁸⁰ In other colonised locations, umbrella labels such as the “Third World” or “developing nation” are common for homogenising Western discourse. In contrast, postcolonialism allows for the demonstration of heterogeneity within colonised locations through analysis of the uneven impact of Western colonialism on different places, peoples and cultures. Given the historical and ongoing dispossession of Indigenous peoples from their lands, cultural location was an important concept for my standpoint and analysis of the power structures with which I engaged.

The postcolonial concern is with the non-geographical aspects of cultural location such as social, cultural, religious and linguistic processes that constitute cultural identity, rather than with a particular geographical area (Ashcroft et al., 2007). For example, Indigenous Australians are not Other or non-Other, but rather always maintain “a subject position that can be thought of as fixed in its inalienable relation to land” (Moreton-Robinson, 2003a, p. 31). Indigenous relationship to land is a key concept for

⁸⁰ This author suggests an alternative term, “postcolonising”, for the associations of ongoing process it implies (Moreton-Robinson, 2003a).

enabling analysis of Indigenous control in health promotion, in relation to which the struggle for self-determination in Australia continues. Appreciation of Indigenous health promotion practice on Australian soil enables openness to the heterogeneity of postcolonial cultural identity, and its constructed and unstable nature (Young, 2001). Such an analysis leads to possibilities of moving beyond colonial control, towards a place of mutual respect (Said, 1978).

Silencing and subalterns

Central to postcolonialism's concern with providing a counter-hegemonic practice is the clearing of space for multiple voices, particularly those previously silenced by dominant ideologies. In postcolonialism, these voices are known as "subalterns" (Ayoob, 2002; Spivak, 1995). The generally accepted goal is that such a space must first be cleared in academia, which is a location of power in past, present and likely future contexts where knowledge is produced and re-produced (Spivak, 1995). This goal stems from Said's point that Orientalists⁸¹ can disregard the views of those they actually study, relying instead on their own "intellectual superiority" and that of their peers, while leaving Orientals positioned:

...as silent shadows to be animated by the Orientalist, brought into reality by them, or as a kind of cultural and international proletariat useful for the Orientalist's grander interpretive activity. (Said, 1978, p. 208)

The creation of intellectual space for the subaltern to speak is to balance the binary power relations inherent to the colonised-coloniser subject (Ayoob, 2002; Spivak, 1995). Critiques of these essentialist representations argue they negate the heterogeneity of the subaltern masses. Because of these critiques, some social scientists felt paralysed and accepted it must be impossible to represent the Other. Spivak rejected this position outright, arguing that to not represent a cultural Other is only "soothing one's own conscience" and "allowing one to not do any homework" (Spivak, 1995). Instead, retreating from criticism enabled the authorising power of those intellectuals to remain concealed (Alcoff, 1991) – a claim where I see parallels to the choice with which I was faced, discussed in Chapter One, in conversation with my supervisor BF. Instead, Spivak argued that in response to (and to fight) silencing of voices, "strategic essentialism" is required, to speak on behalf of a group while using a clear image of

⁸¹ Orientalists are colonists (Gandhi, 1998).

identity to fight opposition (Spivak, 1995). Spivak argued that this strategic essentialism would be more powerful to challenge dominant knowledge (in academia or active protest) on the basis being an organised voice. In light of health promotion's emphasis upon participation and empowerment of recipients of health promotion, along with its general failure of Indigenous Australians, creation of such space has been a key endeavour and tool of this research analysis. However, this strategy is one amongst a suite of others, in recognition of the boundaries of these binary relations and essentialist representations.

Critical race theory

Critical race theory (CRT) brings to this research an ability to analyse the raced nature of health promotion and my own Whiteness (Ford & Airhihenbuwa, 2010; Graham et al., 2011). CRT is an extension of an earlier legal movement known as critical legal studies – a leftist legal movement that challenged the traditional legal scholarship focused on doctrinal and policy analysis (Ladson-Billings, 1998). CRT emerged from this due to the omission of racism in its critique of mainstream legal ideology (Gandhi, 1998, p. 16). As such, CRT is concerned with racial subordination, prejudice, and inequity, accentuating the socially constructed and discursive nature of race (Darnell, 2007), with a transdisciplinary basis in a broad literature from law, sociology, history, ethnic studies, and women's studies, as well as poststructuralist and postmodern perspectives (Ladson-Billings, 1998).

Given CRT's desire to deconstruct and unpack structural conditions that disadvantage people, there is alignment between postcolonialism's emphasis upon Othering, oppression through discourse, and the ongoing workings of colonialism in modern oppression, including the historical silencing we see today in Australia⁸² and in health promotion (McPhail-Bell et al., 2013b). While I acknowledge the limitations of a focus upon race⁸³, I found CRT to be essential for analysis of the highly personalised issue of

⁸² As one of many examples of the silencing of Australia's colonial history, the Australian Government is proposing a diluted focus in education curriculum on the way the colonisers treated Indigenous Australians in order to promote the benefits of Western civilization (Foley & Muldoon, 2014).

⁸³ The problematic nature of markers of race include: tendency to homogenise and universalise the experience of all Black people; denial of the multitude of diverse cultures within the "Black" community; and privileging of Black people as being the only victims of racism or colonialism (Ashcroft et al., 2007). I use the term 'Black' in accordance with the language used by many postcolonial and critical race theorists, which references Blackness (as for Whiteness) as a social construction.

Whiteness for me. I cannot separate myself from my upbringing, Western disciplinary training in public health and development, and the way I know, behave and do in the world as a non-Indigenous woman.

The social justice underpinnings of critical race theory

In Australia, CRT is considered to be a transformative theory with potential to contribute to the wider struggles for rights and recognition of Indigenous peoples and communities (Hart, 2003). This relates to CRT's clear commitment to social justice, which translates to its insistence on a critique of liberalism and incorporation of elements of liberation and transformation. CRT thereby clearly aligned with the social justice underpinning of health promotion, making CRT a suitable tool for this research to examine how health promotion adheres to social justice.

Like postcolonialism, CRT focuses on power relations, including attention to the privileged positioning of the Western paradigm and argument that the colonial condition remains. To do so, CRT recognises the connection of race and racism with other forms of subordination and oppression, such as gender, class, sexuality and poverty (Solorzano & Yosso, 2001; Solórzano & Yosso, 2002). CRT thus views racism as normalised, requiring unmasking through analysis that incorporates the various markers of Whiteness, beyond skin colour.

CRT positioned racism and the disproportionate distribution of power and resources as central to this study's investigative lens, as opposed to the margins. Guided by CRT, this research was able to challenge traditional dominant ideologies regarding objectivity, meritocracy, colour-blindness, race-neutrality and equal opportunity (Graham et al., 2011; Ladson-Billings, 1998; Solórzano & Yosso, 2002). The way this was achieved was through foregrounding race and racism in all facets of the research process, and confronting conventional research texts and worldviews (Graham et al., 2011) – such as key health promotion texts and milestones, referenced earlier.

Race and racism contextualised

CRT departs from the postcolonial perspective by placing race and racism in both historical and contemporary contexts, with an argument for recognition of the history responsible for organising and naming the Black Other as problematic. The process of

problematizing the Other is evident in contemporary Australia today, where Indigenous people are continually positioned as the problem in such a manner that directs Indigenous Australians' energies into reminding – educating – the mainstream population that Indigenous Australians are not the problem.⁸⁴ The risk of not contextualising race is the removal of the need to name what it means to be non-Indigenous and a coloniser, thereby missing an analysis that articulates the power dynamics that require addressing (Hart, 2003).

This research project, with its focus upon Indigenous health promotion, acknowledges the rampant racism in Australia and its impact upon Indigenous Australian's health system (Durey, 2010; Gallaher et al., 2009; Krieger, 2000; Krieger, Williams, & Zierler, 1999; Larson, Gillies, Howard, & Coffin, 2007; Paradies & Cunningham, 2009; Paradies & Modra, 2008). The study context is also one where the process of challenging the dominant Western paradigm and ideological majority can be difficult, given the concerns of the marginalised do not comprise the popular majority of educators, administrators or policy makers (Hylton, 2005; Ladson-Billings, 1998). Instead, racism continues to survive (and thrive), with its resilient and flexible nature that aligns with discursive frameworks (re)affirming Europeans and those associated (Wilson, 2011, p. 14). Accordingly, CRT enables this study's analysis to progress an agenda to disrupt and change this discriminatory and harmful dynamic.

CRT informs analysis and representation

CRT reveals the possibility for the non-Indigenous academic to be positioned in a range of relationships with Indigeneity, without losing the power they hold from their positioning (Said, 1978). CRT helped to elucidate that this work was as much about my own positioning, as it was a focus on health promotion practice (Lampert, 2003). This recognition helped me as the researcher to articulate the morally and epistemologically double-bound nature for me as a non-Indigenous Australian (Hart, 2003), as I endeavoured to work supportively with Indigenous academics and practitioners. CRT guided me as an investigator to endeavour to be honest and forthcoming regarding my

⁸⁴ One example is when on the Q&A television show, Indigenous leader and activist Rosalie Kunoth-Monks responded to an audience question with her experience of the “ongoing denial of what is me”, emphasising that Indigenous people are “not the problem”: “Don’t try and suppress me and don’t call me a problem. I am not the problem. I have never left my country nor have I ceded any part of it” (Kunoth-Monks, 2014).

inter-subjective perspective in design, data collection, interpretation, and the research endeavour as a whole (Graham et al., 2011). Therefore, CRT led me to examine other sources of information, including collecting the context of data, the way I presented data in my writing, and the emotional nature of the work. In this way, my passions, concerns and purpose, the political aspect of this research endeavour and its call for action all enfolded into the analysis (Ford & Airhihenbuwa, 2010; Graham et al., 2011). Likewise, CRT enabled attention to the encounters that ‘produced’ racial knowledge and Whiteness (Darnell, 2007). This process supported the endeavour to eliminate racism, sexism and poverty, and empower subordinated minority groups.

The importance of storytelling

Like postcolonialism, CRT endeavours to clear spaces for marginalised voices. To do this, CRT centralises experiential knowledge through storytelling and counter-storytelling methodologies. Like postcolonialism, the effect is the provision of a counter-hegemonic praxis to counter the harmful representation of Indigenous people. “Race centred” research of this nature can arguably generate alternative or competing versions of the “truth” based upon the experiences of Black people (Ladson-Billings, 1998; Solorzano & Yosso, 2001; Solórzano & Yosso, 2002). These methodologies “...add necessary contextual contours to the seeming “objectivity” of positivist perspectives” (Ladson-Billings, 1998, p. 11). CRT uses parables, chronicles, stories, counter stories, poetry, fiction, and revisionist histories to illustrate the false necessity and irony of much of current civil rights doctrine.

CRT’s rich focus on centring the voice of the marginalised suited this study’s endeavour to share power with the research participants in data collection, analysis and representation, and centre participants’ voice. In this way, CRT provided an entry point to examine how to create spaces where multiple knowledges can co-exist in the Western academy and therefore in this research. Consequently, in the search of epistemological equity, I gave attention to the ontological and epistemological claims of Indigenous knowings (Jamal, 2005; Rigney, 1999a;1999b;2006). Likewise, CRT’s emphasis upon storytelling informed my approach to ethnography, to ask participants to “name your reality” (Ladson-Billings, 1998). Given that “reality” is socially constructed, stories were powerful for transforming the storyteller (in this case, participants) and listener (in this case, me), to affect and alter oppressive relationships at multiple levels (Ladson-

Billings, 1998; Solorzano & Yosso, 2001; Solórzano & Yosso, 2002). The use of storytelling in this research was therefore part of the broader aim to overcome the ethnocentric nature of health promotion, through developing a counter-narrative to the mainstream health promotion discourse.

The cultural interface

...the cultural interface provides a useful, discipline-based rationale for working beyond the Indigenous-western binary, and that his notion of standpoints encourages both the ongoing production of diverse, historically and politically informed scholarship, while preparing... a contemporary and ethically sophisticated grasp of Indigenous and non-Indigenous relations. (Carey & Prince, 2014, p. 2)

As one who occupies the space of the coloniser, postcolonial and CRT critiques provided me with a fundamental entry point to unsettle presuppositions about Indigenous-Western relations, including examination of my own positioning and of mainstream health promotion. However, these critical analyses – while in this case, essential for holding health promotion to account for its goal of increasing people’s control over their own health – led into a superficial, counter-productive Indigenous-Western binary that was difficult to move beyond (Carey & Prince, 2014; McGloin, 2009). Such binaries – Black/White, us/them, Indigenous/non-Indigenous, traditional/Western, and so on – may lead to “reversalist” solutions that demonise the Western other while romanticising notions of Indigeneity, as though the two are disentangled (Carey & Prince, 2014, p. 1). Likewise, these binaries can serve to reinforce Western knowledge systems by drawing on Western epistemologies,⁸⁵ while assuming knowledge systems remain static and unchangeable (Nakata, 2007b). Instead, the cultural interface provides the tools:

...to expand assumptions underpinning theory based on a reading of how Islanders⁸⁶ have been inscribed into Western systems of thought over the past century and more... (and) to draw into theory principles that give primacy to the Islander lifeworlds as a complex terrain of political and social constructs. (Nakata, 2007a, p. 197)

As follows, the cultural interface enabled this study to go beyond the assertion of an Indigenous presence, to a critical engagement with the idea of Indigenous knowledge and agency (Anderson, 2009). In his search for an epistemology that is liberating for

⁸⁵ For example, social justice and emancipatory theories.

⁸⁶ And in this case, Aboriginal Australians as well.

Torres Strait Islanders (and colonised people more generally), Nakata argues that there is a shared space in the intersection between Islander and non-Islander cultures (the latter also being known as Australian, Western, mainstream and so on) (Nakata, 2007b). Nakata talks to the complexity of this space as being much more than a ‘clash of cultures’ but rather an interface. In doing so, Nakata positions the cultural interface as multi-layered and multi-dimensional, constituting overlapping theories, narratives and arguments, as well as contradictions, ambiguities, practices and contestation (Nakata, 2007b). In this way, culture and knowledge were not static in this study, but rather evolving and dynamic. Consequently, the cultural interface guided me by providing a space for analysis of both possibilities and constraints regarding Indigenous health promotion and my positioning. Health promotion could thus be placed within both a critical space and dialogue in this study.

Nakata reminds researchers to choose a theory because it is useful for one’s purposes (Nakata, 2013). If this research had been based solely on CRT and postcolonialism, aspects of the Deadly Choices practice may have been discarded, potentially reducing their story to one that did not represent the Deadly Choices story in its fullest. This is because an analysis informed by postcolonialism and CRT requires that a marginalised, a disempowered, a racialised Other always exist in analysis. The binary invoked through “simplistic oppositional analysis between Indigenous and non-Indigenous” by its nature heightens, rather than overcomes epistemological concerns (Nakata et al., 2012, p. 127). Such a pre-supposition would have led me to view participants within an investigator-imposed judgement about their reality, perceiving their position and knowledge as unchangeable. So, while CRT and postcolonialism were essential for enabling me to destabilise Western power in research and health promotion, on their own they arguably would lead to a research process and outcome that would not be decolonising.

While I am committed to the critique of and resistance to the colonising agenda, it is a matter of ethics – and accordingly, decolonisation (Chilisa, 2012) – that the stories participants shared were not constrained to that agenda. Therefore, for this research to deeply listen to and create spaces for Indigenous voices, cultural interface theory was an

important tool in the bricolage. The deep listening⁸⁷ enabled through the cultural interface was important for a decolonising agenda, by permitting research that reinforced the agency and positive, creative aspects of research participants' practice, rather than hinging upon binary worldviews.

Nakata expands the concept of the cultural interface with his Indigenous Standpoint Theory (Nakata, 2007b;2007c). As a non-Indigenous researcher it is inappropriate that I base this research on an Indigenous Standpoint Theory. However, Nakata's expansion brings some insight into how various actors may be positioned at the cultural interface. In his Indigenous Standpoint Theory, Indigenous people are positioned as the knower, rather than the known (Yunkaporta & McGinty, 2009), based on the understanding that knowledge is a contested space, where non-Indigenous people have positioned Indigenous people as the subject to be known (Nakata, 2007b).

Nakata's three principles of knowledge production are relevant to both the cultural interface and his Indigenous Standpoint Theory. These three principles were also useful to understand the lived experience of research participants in this study, my position in relation to them, and more broadly of Indigenous health promotion as an interfaced ethnographic site. These three principles recognise (McGloin, 2009; Nakata, 2007b):

- The cultural interface as a contested knowledge space
- The continuities and discontinuities of Indigenous agency
- The continual tension that informs and limits what can and cannot be said and left unsaid in the everyday.

A contested knowledge space

At the centre of the cultural interface lie the interwoven importance of contested knowledge spaces and the locale of the learner (Nakata, 2002;2007a;2007c). Like postcolonialism, the cultural interface sees knowledge as a site of power relations. The cultural interface correspondingly reinstates the notion of Indigenous people having their own history – to look at the world as a whole instead of a sum of self-contained societies and cultures (Wolf, 2010) – to counter colonisation and the supremacy of

⁸⁷ Dadiri, or deep listening, provides an approach for the act of decolonisation (O'Donnell & Kelly, 2011). I acknowledge Aunty Jenny Thompson for introducing me to Dadiri in 2010 in her Dadiri Program at Junjarina Centre.

Western notions and theories (Nakata, 2002). Nakata speaks of the importance of forming a space that is recognisably Indigenous (as *Deadly Choices* is), as a way to resolve the contradiction of being included in, working in, and studying in the very system that has constructed ways of thinking about Indigenous people.

As an alternative, Nakata argues for a meta-knowledge to be a basis for interactions within the cultural interface, given the multitudes of intersecting and sometimes conflicting or competing discourses (Nakata, 2002). Certainly, knowledge is entangled with experiences that situate the space of knowledge production, distortion, complicity, reproduction, and exchange as being disembodied (Moreton-Robinson, 2007). Accordingly, the cultural interface has structuralist elements and effects, and recognises race, class, gender, history, sexuality, “abledness” and so forth. Likewise, the cultural interface intends for change and transformation in structures of institutional practice – such as health promotion (Nakata, 2007b).

As follows, the cultural interface’s approach to knowledge is aligned with this research’s decolonising agenda, for decolonisation also values the integration of knowledge systems (Chilisa, 2012). A decolonising approach permits that if something is effective and useful for the colonised (in this case, Indigenous Australians), it is desirable to adapt and assimilate it, whether it is “an artefact or an attitude of mind” (Alatas, 1974: 692; cited in Chilisa, 2012, p. 24). The cultural interface expands this idea by positioning the suite of theories available to researchers as the “domesticating” tools they are, designed to enable organised thought amidst chaos (Nakata, 2013, p. 6).

Hence, the cultural interface enabled me to seek to understand the meaning-making of participants within the complexities of their daily practice, at the interface of Indigenous health promotion. While facilitating conversation and negotiation of meaning, I remained mindful that the ontology of Western knowledge systems mediated Indigenous and non-Indigenous understanding (Nakata, 2006). The cultural interface enabled me to examine the presence of Indigenous and Western systems of thought and “their history of entanglement and (con)fused practice” (Nakata et al., 2012, p. 126) in health promotion. Such examination was useful to gain insight as to how *Deadly Choices* practitioners – both non-Indigenous and Indigenous – draw on Western,

Indigenous and other conditions of knowledge in their daily practice, not merely as separate knowledges but as knowledges that expand and integrate.

Indigenous agency

Nakata's second principle positions the cultural interface as "a site of active Indigenous engagement, of resistance, contestation, refusal and, as well, of assimilation of the new, of inclusion of other practices and understandings derived from non-Indigenous knowledge traditions" (Nakata et al., 2008, p. 105). Through everyday living, theoretical constructions position Indigenous Australians in a manner that either constrains or enables them (Nakata, 2007b). The cultural interface requires an understanding of this positioning in order to untangle from it, where Indigenous people are recognised as "active agents in their own lives – where we make decisions" (Nakata, 2002, p. 285). That is, Indigenous people are not passive but rather, position themselves in the best way possible according to the circumstances (noting that in many cases, those circumstances are restrictive) (Nakata, 2007b). For example, Rigney writes that Indigenous people's acceptance of science is not a symbol of embrace regarding the historical exclusion of Indigenous people from science but rather a demonstration of "love for the act of discovery and the valuing ideas that transform... the colonised world" that we share (Rigney, 1999a, p. 10). In this way, the interface is a "space of ongoing historical continuities and discontinuities as people discard and take up different ways of understanding, being and acting in a complex and changing environment" (Nakata, 2007b, p. 208).

The cultural interface principle of Indigenous agency was directly relevant for this research. Indigenous health promotion calls for recognition of, and respect for, Indigenous agency as a basic requisite for success in Indigenous engagement (Hunt, 2013) and health promotion with Indigenous people (MAC & WHGNE, 2008; Mundel & Chapman, 2010; NSWHealth, 2004). The cultural interface was fitting for this focus, enabling examination of agency in health promotion practice (mainstream and Indigenous), which (as discussed in Chapter Two) claims to employ empowerment as a strategy in practice as both a means and an end, while struggling to resolve its disempowering aspects (Labonte, 1994). The cultural interface's attention to agency was also fitting with this research's focus upon the CCHS model and Indigenous control in health promotion, which are embedded in self-determination.

Tensions

Just as there are tensions in health promotion practice (discussed in Chapter Two), there are tensions at the intersections of different knowledge systems and with the overarching narrative that frames and connects those at the interface (Nakata, 2006). These tensions arise from the tug-of-war of oppositions and positions. Because these tensions are physically experienced and tend to be expressed in behaviours (Nakata, 2007b), this research was able to observe the tensions in practice. Furthermore, these tensions are based upon deeper epistemological levels of knowledge – levels that this research also has an interest in – which are often not visible, conscious or reflected upon (Nakata et al., 2008).

The cultural interface therefore enabled this study to pay attention to the tensions in the daily experience of Indigenous health promotion, in Deadly Choices practitioners' constant pressure to reconcile contradictions and ambiguities produced in this space (Nakata et al., 2008). Through a methodology involving participant observation (discussed in Chapter Four), I observed, and to some degree experienced, the tensions faced by Deadly Choices practitioners as they informed and limited their daily practice. Likewise, I dialogued with participants about their experience and discussed and negotiated the meaning underpinning those tensions, so that together we shared understanding, in the context of the tensions at the Indigenous health promotion interface.

As alluded to in my standpoint, as a non-Indigenous health promotion practitioner and researcher, I experienced the cultural interface as a site of tension. Other non-Indigenous researchers have also grappled with ingrained tensions to their non-Indigenous position at the cultural interface, particularly in relation to how to balance a privileged positioning while working in Indigenous spaces or supporting Indigenous agendas (McGloin, 2009; Nelson, 2011; Thomas, Gray, & McGinty, 2011; Yunkaporta & McGinty, 2009). I found that the cultural interface enabled me to examine the way, as a non-Indigenous researcher and practitioner, I embed knowledges that are outside of my own frame of reference, while conscious of the multi-dimensional nature of their intersection in my practice. CRT and postcolonialism were useful to identify tensions in Indigenous health promotion and in my own practice, while the cultural interface

enabled me to articulate my standpoint in a historically, politically and ethically situated way, in relationship to Indigenous and non-Indigenous people, and to the health promotion profession (Carey & Prince, 2014). This is not to say the tensions in my positioning and practice are now removed, but rather that I have a contextualised frame of reference for examination of my positioning and practice.

In light of these considerations, the cultural interface provided an opportunity for this study to robustly approach cross-cultural encounters as the source of new sets of negotiated meanings in health promotion practice. With Indigenous people's agency and experience positioned as central to the navigation of the cultural interface, the dynamic of this space was able to provide an intellectual map for this work (Anderson, 2009). The cultural interface has already been found useful in health-related research for providing explanatory power in the way Indigenous people carry their cultural heritage while also negotiating a white Western cultural context on a daily basis (Minniecon, Franks, & Heffernan, 2007; Nelson, 2011; Thomas et al., 2011). More specifically, the interface offered opportunity for new insights and ways of understanding health promotion in this study (Durie, 2004).

Critical ethnography

The bricolage discussed thus far informed the way I employed critical ethnography. Not only was my use of critical ethnography appropriate to my agenda to examine and change power relations in favour of the oppressed, it brought with it permission for an interpretive account and requirement of self-reflectivity (Jamal, 2005). In this section I discuss the use of ethnography and its relationship to and execution of power. Given the field of practice of the Deadly Choices practitioners involved, I also discuss this study's use of expanded ethnography, which enables fieldwork to traverse the interconnected nature of offline and offline practice.

Ethnography

This study examined the depths and richness of the processes and context of health promotion delivered to Indigenous people. It aimed to understand and explore the narratives and meaning made in health promotion practice by Indigenous and non-

Indigenous health promotion practitioners working with Indigenous groups in urban environments. For this purpose, reductionist, quantitative methodologies were unable to capture the complexity necessary. Rather, I required a qualitative methodology that could accommodate the complex historical, political, cultural and personal contexts of health promotion work and thus illuminate lived experience rather than assume an absolute “truth” (Charmaz, 2006; Guba & Lincoln, 2005; Nicholls, 2009; Rychetnik & Frommer, 2002; Tsey, 2010). Ethnography is one such methodology that can achieve this.

In essence, ethnographic work involves going into a certain setting, to study certain phenomena occurring there, and then reporting what was found while connecting those findings to the work of other researchers and theory. Ethnography is defined as:

A family of methods involving direct and sustained contact with human agents within the context of their daily lives (and cultures) watching what happens, listening to what is said, asking questions producing a richly written account that respects the irreducibility of human experience that acknowledges the role of theory as well as the researcher’s own role and that views humans as part object/part subject. (O’Reilly, 2009, p. 52)

Ethnography’s emphasis is upon “telling a credible, rigorous, and authentic story... (that)... gives voice to people in their own local context” (Fetterman, 2010, p. 1). Such an emphasis enables the understanding of human behaviours within a culturally complex society, with attention to the needs of those people and their ways of meeting those needs (Fetterman, 2010). Ethnography is versatile and has been used with a range of approaches, such as Photovoice (Lenette, Cox, & Brough, 2013; Mitchell, Steeves, & Hauck Perez, 2014) and virtual spaces (Driscoll & Gregg, 2010; Hine, 2000; Pink, 2012). Through its versatility, ethnography can achieve a “sense of presence” that pays dues to the wider political and social importance of particular events (Cowlshaw, 2007). From a postcolonial and critical race viewpoint, the wider sensitivity enabled by ethnography provided a response to the general mainstream tendency for ‘master narratives’ of health promotion to homogenise complex local meanings. Ethnography offers more intimate and complex perspectives (O’Reilly, 2009).

Ethnography’s primary method is participant observation, which required me as the researcher to immerse myself into the natural social setting – the practice space of Deadly Choices – with openness to all potential connections and data leads

(Carspecken, 1996). Thus, ethnography provided me with an opportunity to gain intimate familiarity with the Deadly Choices team and its practices. With ethnography being iterative-inductive in nature, the design of this study evolved as the research progressed. Consequently, this research did not begin with a rigid hypothesis. Rather, instead of using prescriptive question lines, ethnography allowed for participants to reveal topics they found to be important and wished to explore and with this, the cycle of participant observation varied in focus, informed by dialogue and analysis with participants (O'Reilly, 2009, p. 52).

Ethnography involves power

Ethnographic studies are a means of producing knowledge. Consider that “knowledge is power and acquiring knowledge empowers individuals and societies” (Sefa Dei, 2005, p. 232). Thus, ethnographic studies can shift the balance of power in favour of those who initiate such studies (Sefa Dei, 2005). The 20th century shift from positivism to post-positivism, influenced by critical realism, highlighted the limitations of ethnography. Accordingly, recognition arose that all observation is fallible and has error, and that all theory is revisable (Chilisa, 2012).

Consciously or otherwise, the ethnographer adopts a cultural lens to interpret observed behaviour, ensuring that the behaviours are placed in a culturally relevant and meaningful context (Fetterman, 2010). As such, the ethnographic story will always be that of the ethnographer and limited by their researcher positioning. Because of this limitation, I carried a commitment to reflexive practice. By no means was this a panacea but, rather, such an approach can and did contribute to a mutually beneficial research experience (Redman-MacLaren et al., 2012) and to greater trust-worthiness and inter-subjective agreement regarding ethnographic accounts (Cardano, 2009; Jamal, 2005).

Ethnography's roots are Western in nature. Indeed, its classification system is predominantly framed around a Western worldview, where Western culture performs the naming and coding of difference (Ashcroft et al., 2004; Said, 1993). These Western roots are highly relevant to a study such as this one, which is concerned with the concept of the West and Western and power more broadly. Historically, observation was a key method in anthropology during the colonial period and has been used to transform descriptions of daily life of studied groups into theories that were often

shocking to those being studied (Chilisa, 2012). Such a research process became a powerful instrument for legitimising colonialism by way of justifying the agenda of the coloniser and perpetuating the dominance of one race over another (Moreton-Robinson, 2000). In light of these harms, there is debate around the way ethnography copes on a world scale in a globalised world and how or whether ethnography can help to achieve a better understanding of global processes (Lapegna, 2009).

Given the surrounding debates in relation to ethnography, I approached it with caution, guided by the tools of this study's bricolage. I adhered to an interpretive approach to ethnography, rather than the realist tradition of ethnographic writing (Hammersley & Atkinson, 2007). I acknowledge that what I have written in this thesis is just one interpretation – and my chosen representation – of the reality of people I have been involved with through this research (Hammersley & Atkinson, 2007). That is, ethnography provides a window into the lived realities of a group of health promotion practitioners involved in this research.

Critical ethnography

Critical ethnographers rely on the same sets of methods and methodology of conventional ethnographers. It is argued that the empowerment principles implicit within health promotion practice require a critical research methodology that can be used to facilitate action among those affected, while simultaneously providing rigorous and convincing evidence to decision-makers (Cook, 2005; Labonte, 2005b). It is also acknowledged that whilst empowerment is a central principle of health promotion, it is regularly at odds with state imperatives to affect population health according to a state driven agenda (Mendes, Plaza, & Wallerstein, 2014). Critical ethnography is useful for uncovering the lived reality of this tension, given it studies culture through analyses of injustice, and is overtly political and critical in order to expose inequalities to effect change (Cook, 2005; O'Reilly, 2009). Critical ethnography's concern with power relations suited my worldview and research goals: I am not content to merely understand the world but rather, I want to change it for the better.

Critical ethnography is a type of reflection that examines culture, knowledge and action (Thomas, 1993). With its underpinnings of critical theory, critical ethnography is concerned with empowering human beings to rise above the restraints placed on them

by race, gender and sexuality (Graham et al., 2011, pp. 81-81; Jamal, 2005). For example, a number of anti-racism studies have been based on critical ethnography in recent years (Akom, 2011; Jamal, 2005; Lederman, 2005). Critical ethnography is derived from a long tradition of social science, emerging in Britain as part of the interpretivist movement with a goal of freeing individuals from the sources of domination and repression (Thomas, 1993). More recently, there are instances where ethnography has been used postcolonially as “modern ethnographic methodologies” (Madison, 2005;2011). Claims also exist that ethnography could be the most effective research strategy for anti-racism research, given it examines power relations materially and historically (Jamal, 2005).

Critical ethnography and health promotion research share the mutual aim of challenging oppressive structures and addressing identified issues, by searching for “what can be done about it” (Cook, 2005). Rights and responsibilities are characteristic of critical ethnography, including the “responsibility and willingness to be unsettled... by our ethnographic partners in all contexts...” (Tengan, 2005, p. 253). This suited my intentions in which lie a politics of love and thus commitment to others through dialogue and participation to liberate oppressive situations (MacLaren, 2006). Similarly, this work’s location at the cultural interface involved the negotiated balancing of judgements regarding a complex array of social, economic, political and historical factors. In light of these factors, critical ethnography was suitable and appropriate for the range of qualitative methods required to meet this study’s decolonising aims and approach.

Expanded ethnography – Incorporating the offline and online

Early on during fieldwork, it became clear that the practitioners participating in this study operated in both online and offline spaces. I required an expanded ethnography to guide my fieldwork across the online sites and to understand the interconnected nature between the online and offline practice. I developed this approach by looking to examples of the practice of ethnography in online settings in other contexts. For example, online ethnography brought understanding of the political economy of the Internet in Trinidad and Tobago (Miller & Slater, 2000). Virtual ethnography was used to study the social aspects of information provision and consumption on the Internet (Hine, 2000) and expression of emotion (Sade-Beck, 2004). My approach was also

informed by the criticisms of the real-virtual dichotomy upon which virtual ethnography is centred. Such criticism was based on the way that today's social world takes place in both offline and online environments (Beneito-Montagut, 2011). Indeed, the Internet is now part of our offline culture (Lupton, 2013a; Lupton, 2014a). To research the broader online reality of Deadly Choices practice required an approach that could integrate online and offline methodologies (Nguyen et al., 2013; Pedrana et al., 2013; Sade-Beck, 2004; Wittel, 2000). Therefore I used the alternative, expanded ethnography, in this study.

Expanded ethnography goes beyond the online world into everyday communications and interactions carried out online but linked to offline communications (Beneito-Montagut, 2011). Such an approach expands and contests ethnography's traditional focus on boundaries, instead focusing upon connections and connectivity. For example, place (as opposed to locality) is a theoretical concept that can enable understanding of the configuration of things and processes through which they are formed (Geertz, 1973; Hammersley, 2008; Patton, 1990). Researchers argue that the virtual world is not in fact a different reality to our physical environment, but requires attention to multi-sensory purposes and experiences (Pink, 2012). My experience in this study mirrored the multi-sensory dynamic, where the practice I observed flowed online and offline, simultaneously and dynamically.

There is a growing emphasis in ethnography to move away from material spaces to cyberspace (Hine, 2000; Tunçalp & Lê, 2014). This shift in focus demands the revisiting of ethnography's aims to include the attendance by/co-presence of an ethnographer and the observed situation, and the revelation of context and complexity (Wittel, 2000). Ethnography has traditionally emphasised the thick description of behaviour in order to explain the behaviour as well as its context, to make the behaviour meaningful to outsiders (Pink, 2012). The online context expands and problematises the traditional ethnographic notion of "the field" as a geographically defined area and in doing so, repositions the role of participant observation (Wittel, 2000, p. 2). Long-held assumptions, such as the privileging of face-to-face relationships over more mediated interactions or permanent residence over movement, are being questioned (Wittel, 2000). Consequently, ethnography's core method, participant-observation, is transforming from its traditional sense to observation of a virtual field of study through

computerised communication (Sade-Beck, 2004). The transformed conceptualisation of participant observation was suitable for this field of study, which involved both the offline and online practice of health promotion practitioners. Rather than focus solely on place and locality, I could also concentrate on flow and connectivity (discussed in Chapter Four). Likewise, expanded ethnography enabled me to acknowledge the multiple sites from which research participants access social media, creating a melding of spaces and places in my ethnographic fieldwork.

With these expanded understandings of ethnography come challenges for use in the online environment. For example, online sites are dynamic and involve constant movement, which can make follow up on a regular and methodical basis problematic, particularly given observed users can choose to change their identities from site to site (Dominguez Figaredo, 2012; Sade-Beck, 2004). The rapid pace at which technology changes presents an additional layer of complexity to research in an online environment, requiring that the researcher be a “technologized” researcher (Beneito-Montagut, 2011, p. 720; Pink, 2012). This requirement arguably places the researcher in the paradox of needing to “speed up” to follow the fast-moving objects, while slowing down to understand them properly (Beneito-Montagut, 2011, p. 720). Similarly, the multimedia character of Web 2.0 presents both the opportunity and challenge of an abundance of data. Internet findings constitute a huge, non-concrete database, which can make data analysis incredibly complex.

In light of these challenges, the expanded form of critical ethnography provided me the flexibility to draw on a combination of qualitative data-gathering methodologies online and offline, to form the “thick description” so central to developing an ethnographic story (Geertz, 1973; Sade-Beck, 2004; Wittel, 2000). To guide my choices in fieldwork, I endeavoured to remain grounded in reflexivity and analysis informed by the conceptual framework discussed above. Expanded ethnography also provided space for research participants to shape the way I understood and analysed their work, and to negotiate meaning of their practice at the cultural interface. In the next chapter, I provide details of how I did this, including the manner of fieldwork through a combination of interviews, team feedback sessions, participant diaries, field notes, and online and offline participant-observation.

4. Schema of ethnographic methods

The conceptual framework discussed in Chapter Three informed my choice of methods. I conducted the research according to an expanded use of critical ethnographic methods, in order to blend face-to-face interactions with those online, allowing the field of participants’⁸⁸ practice to determine where I went. The methods I employed were interwoven and evolved according to the unfolding of fieldwork, as is the way of ethnography (Fetterman, 2010; Picken, 2009). The methods I adopted were: entry and exit strategies; participant observation; ethnographic interviews; participant diary; workshops; and a field diary. I approached ethics as a compass for the research process, to navigate the “messiness” involved in the daily practice of an ethnographer. Figure 5 depicts the schema of this study with Deadly⁸⁹ Choices practitioners across a range of spaces and places, online and offline, internal and external to IUIH. This chapter provides the detail of this schema of methods.

⁸⁸ I use the term “participants” rather than “informants” or “target group”, which are commonly used in qualitative research, in order to signify the active voice and two-way nature of fieldwork and analysis.

⁸⁹ The term “deadly” is discussed further in Chapter Five, as this term is an important part of the ethnographic story.



Figure 5: Schema of methods: who I was with, where we went (internally and externally to IUIH) and how I did it.

My conduct of field work

Deadly Choices practice in a range of settings and spaces in which I endeavoured to be present through participant observation, as outlined in Figure 5 (refer to the four left columns). My focus in fieldwork was the Deadly Choices practitioners themselves, making this study essentially an organisational ethnography, interested in a particular group of IUIH staff (Yanow, Ybema, & van Hulst, 2012). The flexibility of critical ethnography permitted me to employ relatively structured methods, such as interviews or focus groups, alongside more unstructured participant observation, which enabled me to respond to new data and insights as they arose (Babbie, 2004; Carspecken, 1996; Johnson, Avenarius, & Weatherford, 2006). Figure 6 represents an approximate timeframe associated with the various structured methods of participant engagement, although it does not represent other unique events and comparatively less structured activities of the everyday business of “being there” through fieldwork (Picken, 2009, p. 2).

Activity	No. (if applicable)	Date commenced	Date ended
Research design consultation with IUIH		September 2011	September 2012
Team meetings	25	December 2011	March 2015
Community/sports days	15	March 2012	July 2013
Presentations to team	13	May 2012	September 2014
Workshops	2	November 2012	July 2013
Social media fieldwork		November 2012	December 2014
Individual & group interviews	14	November 2012	August 2013
Team retreat	1 (2 days)	November 2012	
Team training	4	December 2012	July 2013
GQT sessions	10	December 2012	May 2013
Deadly Choices camp	1 (4 days)	December 2012	
Deadly Choices sessions: schools/other	19	January 2013	July 2013
Hot desk with team (occasional)		March 2013	November 2013
Tobacco sessions	5	March 2013	August 2013
Stakeholder meetings	5	April 2013	June 2013

Figure 6: Approximate time periods per structured engagement activity in fieldwork, which were in addition to the unstructured engagement activity in fieldwork.

Entry and exit

The entry and exit phases are critical for ethically establishing access to and relationship with the people of interest for the study (Hammersley & Atkinson, 2007). As outlined in Chapter One, I selected IUIH as the research site for the opportunity to gain insight into the operation of an Indigenous agenda in health promotion. However, I did not make the decision alone regarding the involvement of IUIH. A series of conversations took place in the initial phases of “entry” into the research site. As is often (but not always) the case with research in organisations, I first approached IUIH management for initial access negotiations. One of my supervisors (CB) already had a relationship with IUIH, which enabled the identification of one of the gatekeepers⁹⁰ for this research. One

⁹⁰ I use the term gatekeeper to refer to key personnel who could legitimately grant or withhold official permission for this study and my access (Hammersley & Atkinson, 2007).

member of IUIH management, Dr. Alison Nelson⁹¹, facilitated further discussions with other IUIH management staff. During these discussions IUIH requested that Deadly Choices be the focus of this study, as the umbrella to their health promotion work. Dr Nelson represented the proposed study to the IUIH board of management and the CEO, who provided written approval for me to discuss this prospect further with the Deadly Choices team.

Subsequently, I approached the Deadly Choices team and began to build relationships with its members. My approach to relationship was different to some traditional ethnography approaches that tend to emphasise differences, such as language and translation (e.g., Spradley, 1979;1980). My entry process reflected my belief that participants had the right to know me as a researcher and the way I would work with them, before providing consent. In practice this meant that I spent approximately 12 months after first connecting with IUIH to build relationship and inform potential participants about the research, including what a PhD would involve (see Figure 6). I volunteered in a range of roles at numerous IUIH community days and attended team meetings. I invested time in “being there”, understanding the importance of time with these practitioners in order to learn to understand their practice from an emic perspective (Picken, 2009, p. 2).

Negotiation formed an integral part of beginning the “doing” of ethnography (Madden, 2010). With IUIH support to continue and Dr. Nelson’s input and representation to the IUIH CEO, the Deadly Choices team and I explored and refined the study’s topic to align it to their work. This included trialling the proposed methods with the team, to collectively determine whether the methods did in fact suit our shared research objectives and the team’s workload. Participants were given the opportunity to select their own pseudonym, if they wanted to. I provided participants with an information form (Appendix B), which we discussed individually and at team meetings some months prior to fieldwork, to facilitate informed consent. These early interactions and discussions proved critical for establishing and building a respectful research

⁹¹ Dr. Alison Nelson played a key role throughout the research process by providing me guidance, and liaison with and provision of feedback to senior IUIH staff and board members regarding this study. As an academic, Dr. Nelson shares an understanding of academic demands inherent to a PhD and associated tensions in translating those requirements into ethical practice in an Indigenous context. Dr. Nelson also represented IUIH in the academic review processes associated with this PhD and its thesis, including membership on the confirmation and final seminar panels.

relationship, essential for a mutually beneficial research process and outcome (Chilisa, 2012).

Additionally, the entry phase permitted conversations with the team regarding the role I could take on as participant observer. To begin with, I was somewhat apprehensive regarding what role could be useful and non-intrusive to the team, while effective for fieldwork. I knew how important establishing a researcher role was to enabling me to participate with the team on a daily basis (Fetterman, 2010; Madden, 2010). I found that in time, simply being present and volunteering support in tangible ways led to my eventual acceptance by the team as a “normal” part of their daily experience.⁹² I also believe that the IUIH management support of this research and of my presence with the team was key for my entry and acceptance into the practice space of Deadly Choices.

Like my entry, I planned my exit. I emphasised to participants the time-limited nature of my fieldwork: that I would enter as a fieldworker, stay for a time, and at the conclusion of fieldwork, exit. This was the approach I had read of when learning about ethnography (de Laine, 1997; Fetterman, 2010; Madden, 2010; O'Reilly, 2009). However, I experienced fieldwork in an incredibly personal way; the “work” and relationships were much more than research “work” and spanned beyond this PhD. Thus, as fieldwork ended and I transitioned into the write-up phase, I became particularly anxious about the time apart from participants – even though the time apart was necessary and unavoidable if I was to produce this PhD thesis. I felt as though being away meant I was being untrue to the relationships, despite knowing that writing the thesis was being authentic to my promise of completing this PhD. This feeling was also despite IUIH and Deadly Choices practitioners demonstrating an understanding that this was simply the phase that I had informed them would come.

Eventually, I found that reframing how I viewed the impact of the exit phase on these relationships provided me with some inner resolution. After one particular communication with my supervisor (BF), I realised that I was not entirely bound by the ethnographic terms of entry and exit as a researcher, for these relationships are genuine,

⁹² There were many instances where participants expressed that I was “part of the team” and in fact, some staff of partner agencies shared with me that they viewed me as part of the Deadly Choices team, despite knowing that formally I was not.

evolving and changing. This conversation with my supervisor reminded me that relationships through “work” are not confined to work spaces. This view was consistent with my approach to relationships previous to and beyond the PhD, yet I had collected an understanding of ethnography where relationship boundaries were to be more rigid in their phasing. This particular conversation and the broader process of this research brought me to a deeper understanding of the meaning that relationships can change according to contexts and connections, to seasons (González, 2000); it also helped me to be at peace with being apart from participants during the write-up phase.

I suspect that my deepening understanding of relationship was also nurtured by my regular attendance at the Deadly Choices team meetings during the write-up phase. My attendance meant that I was present for the one time each month that the entire Deadly Choices team met and reported back to each other. The Deadly Choices team continued to allocate agenda time for me to update the team on progress and occasionally to deliver presentations regarding the thesis progress. In addition to the team meetings, I remained in contact with team members personally and regarding research progress. I shared findings chapters with participants and IUIH staff to review, question and provide feedback. Most recently, we held a celebratory farewell lunch, to signify the end of this phase of the relationship and acknowledge what we have achieved together through this research process. While I was solemn about the end of my regular visits with the team, because of our relationship, respect and affection I could also be proud and content in what the farewell signified. These relationships are continuing through change. As my supervisor (BF) said, the exit was not about withdrawal or going away, but rather, being “forever connected through experience, relationship, and obligation”.

Participant observation

Participant observation provided the umbrella for the range of methods I drew upon: participant diary, conversational interviews and workshops. Thick description provided the foundation for fieldwork, in which I endeavoured to describe how actions were undertaken in context and relation to other actions (Geertz, 1973; Hammersley, 2008; Patton, 1990). Thick description required me to describe what was seen and heard within the framework of the social group’s view of reality, to bring meaning to the behaviour and its context for an outsider (de Laine, 1997). In other words, an ethnographer’s aim is to be “in the thick of it all” (Picken, 2009, p. 2).

Using ethnography meant that I could flexibly choose methods as appropriate to the research process, as it unfolded. It also meant that I was able to adapt to the study site and agreements about access, involvement, reciprocities, and emergent relationships with participants – including when IUIH staff came or left their roles (Charmaz, 2006; Johnson et al., 2006). Relationality, which is key for research with Indigenous peoples and organisations (Kendall & Wickham, 1999b; Martin, 2008; NHMRC, 2003b; Wilson, 2001), supported my accountability (Martin, 2008). While IUIH management encouraged the team to involve me with their work, participants could choose to do so more or less in their practice, as they wanted or were comfortable with. While I continually (arguably perhaps more often than necessary⁹³) reiterated to participants they did not need to involve me or continue involving me if they changed their mind, many appeared to enjoy or appreciate the opportunity to have an extra person available for support and assistance when required. For example, I could support the facilitation of a conversation with Deadly Choices students⁹⁴, assist in setting up the Deadly Choices marquee or community/health events, run a health education station at a community day⁹⁵, administer evaluation surveys, and accompany female students to the toilet during class (male Deadly Choices facilitators were more limited in this task). Moreover, many research participants appeared to appreciate my continual feedback based upon participant observation, saying it helped to continue improving their practice – and I also suspect for its validating nature.

I was careful to balance the task of taking notes to assist me in my recall of observations, with being fully immersed and participating in the Deadly Choices team's social world (Atkinson & Hammersley, 2005). I initially began with loose frameworks to assist my note taking, such as Spradley's nine dimensions of observation (Spradley,

⁹³ I say this only because many participants would say to me that they knew they could change their mind regarding participation, adding, "You don't need to keep telling us". However, I was very cautious that I did not assume their consent continued throughout the research process over time.

⁹⁴ Chapter Five introduces the Deadly Choices campaign, where the context for student participation is explained.

⁹⁵ I noted that after some time had passed post fieldwork completion, the team had established tighter processes with role delineation to individual members for set up and running of community events. Perhaps had I commenced participant observation at that later phase instead, my contributions may have been more difficult for the team to accommodate.

1980)⁹⁶, which assisted me to develop a practice of observation and reflection. In practice, on some occasions, I would write notes while at other times I would record my verbal reflection using my iPhone with the app Audio Memos. Some occasions required a higher degree of my participation, such as when I oversaw a community event registration desk or education station to deliver health education (regarding chronic disease or nutrition, for example), in collaboration with a Deadly Choices staff member. At other times, I could fulfil the role of observer more fully. I found that being in relationship with participants supported me in my navigation of the tension of being both a participant and an observer – although for me, relationship also amplified the tension of deciding what was ‘data’ and what would be written in this thesis about the participants.

Although 20 people had signed consent forms to participate in this research (see Appendix C), some participants demonstrated comparatively higher engagement with data collection processes, to which I responded affirmatively and followed their lead. For example, some participants were enthusiastic users of the participant diary method (particularly by video), while others would request we meet to “have an interview”, and others wanted to yarn⁹⁷ about the photos they took at a recent event. Some participants chose to talk with me as a confidant, being one who was neutral yet understanding of the work setting. Less active participants were involved in the research in other important ways, if only by way of allowing my access to a site or observation of their practice.

I was interested in the mode of interaction taking place through participant observation, rather than place; I did not view fieldwork and the team’s practice according to an online/offline dualism where interactions had to be located in one or the other. Given the spaces of fieldwork spanned across online and offline realms, I sought to understand the way in which participants practised through the Deadly Choices social media

⁹⁶ Spradley’s nine dimensions of observation are: Space - layout of the physical setting; rooms, outdoor spaces, etc; Actors - the names and relevant details of the people involved; Activities - the various activities of the actors; Objects - physical elements: furniture etc; Acts - specific individual actions; Events - particular occasions, such as meetings; Time - the sequence of events; and Goals - what actors are attempting to accomplish (Spradley, 1980).

⁹⁷ In an Indigenous context, yarning is a recognised technique used by Indigenous Australians to connect, make meaning and pass on knowledge and history, socially or more formally (Bessarab & Ng’andu, 2010).

accounts, which I could observe participants do both offline as they “posted” and online via their posts. I also observed the types of deadly choices⁹⁸ community members posted and whether Deadly Choices practitioners solicited such choices. For example: was a community member’s post about the healthy meal they had just eaten in response to a Deadly Choices nutrition competition? (Many, but not all, were).

I collected screenshots of activity on social media for documentation in my field diary for the duration of fieldwork. I also developed a typology of health promotion uses for social media through a literature review, to deepen my understanding of what I was observing on social media. I did not predetermine which social media platforms to inquire about; instead, the practitioners determined which platforms they used for practice. Accordingly, I observed Facebook, Twitter, Instagram and YouTube (Deadly TV), of which Facebook and Twitter were the most active and interactive platforms (although Instagram activity appeared to be increasing). I was clearly identifiable when posting online, using my personal Twitter, Facebook and Instagram accounts.

I quickly found that a further challenge, as an experienced health promotion practitioner and doctorate research student, was to remain positioned as the “learner”. This is a recognised complexity for fieldwork, where in some cases ascribed characteristics and identities – be it gender, age, or other – may reinforce the ethnographer as being an expert (Hammersley & Atkinson, 2007). However, while I emphasised during the early phases of the research design and fieldwork that participants view me as a novice, I did not try to conceal my positioning. Rather, I was straightforward regarding my subjectivity, choosing to do so based upon an ethic of reciprocity, equality, integrity and trust (NHMRC, 2003b). In some way, this was contrary to traditional approaches that seek to commence fieldwork with a conscious attitude of almost complete ignorance (e.g., Spradley, 1979). Certainly, there were times when participants and the team deferred to me for my professional opinion and contribution to particular issues, which risked reinforcing my role as expert. However, I usually reciprocated such requests, mindful that the research process was to be one that contributed to Deadly Choices. That said, I was careful to shape and reshape my positioning as learner within this team, particularly at the start of the project.

⁹⁸ As discussed in Chapter Five, a deadly choice is a healthy choice.

I was also watchful of the complexity and “invisibility” of my Whiteness in this setting, wary of my potential to reconstruct power systems with my “arbitrarily-awarded power” (McIntosh, 1990). My reflexive practice involved attention to my approach to fieldwork, examining how my Whiteness could influence the data I collected, my interpretation of it and what I did with it. To do this, I regularly used my field diary and engaged with related literature, particularly by Indigenous scholars. I also conversed with supervisors and research participants about my positioning and its influence (known and unknown to me) upon me.⁹⁹ I strove to be accountable, while wary of expecting participants to do the work for me in terms of accountability for my (at times to me, perhaps, invisible) privilege and positioning (discussed in Chapter Three). I also checked in with fellow non-Indigenous peers and some participants, sharing our journeys of unpacking our positioning and unearned privilege. I was acutely aware of the power of ethnographic representation (e.g., Moreton-Robinson, 2000) and so actively shared with participants my write up progress throughout fieldwork and drafts of this thesis, building conversation around those documents in an effort to create a safe and open environment to discuss their contents. By no means is reflexive practice an end to the possibility of misusing of my White privilege, however, it was an important step towards being responsible for it.

Ethnographic (conversational) interviews

I recorded fourteen ethnographic interviews during the course of fieldwork (see Figure 6) and conducted numerous informal, follow up conversations by phone, email and in person. Ethnographic interviews are best thought of as a series of casual, friendly conversations where the ethnographer introduces new elements to assist participants to respond as informants (Spradley, 1979). However, conversation between ethnographer and informant is less balanced than that between friends – “asymmetrical turn taking” means that the ethnographer asks most of the questions and the informant talks about activities and events that make up his lifestyle (Madden, 2010; Spradley, 1979). To ask ethnographic questions is to interrogate in a manner that draws out descriptive (how do you...?), structural (what’s the relationship between...?) and comparative (what’s the difference between...?) responses from an interviewee (Madden, 2010). At any time

⁹⁹ There were a number of conversations with participants that traversed an interface of practice involving, race, privilege, knowledge, and much more.

during an interview it is possible to revert back to a friendly conversation, so as to maintain rapport and avoid the interview feeling like a formal interrogation (Spradley, 1979). Ethnographic interviewing was thus a useful way for me to combine participant observation and directed one-on-one interviews with key informants, to build upon what I learned in participant observation.

Ethnographic interviewing enabled me to take my observations to a micro level – according to individual and local context – to understand the behaviours and processes of *Deadly Choices*. The flexibility of ethnography enabled me to conduct interviews when the need and opportunity arose, as a step towards democratising the research process and centring participants’ voice in the research process (Cook, 2005). I could draw on my participant observation to inform when, with whom and where interviews may need to have been conducted. For the pre-arranged interviews, I emphasised to participants I would meet them in a place convenient to them where they felt safe to speak with me. There were times when participants chose to keep it at the office workspace, other times in alternative locations including cafes and even car rides together. I also conducted ethnographic interviews as part of participant observation during health promotion activity in the “natural setting” while the tasks were performed, in order to bring to light details of behaviours as they occurred (Hammersley & Atkinson, 2007).

I commenced this study expecting to have many informal ethnographic interviews with participants and this certainly came to be the case. Interviews were arranged in different ways, with some participants requesting them with, “can we have an interview” while others sought to meet to discuss their chosen photos for their participant diary (see below); alternatively, some interviews evolved from conversations¹⁰⁰ while other interviews were invited by me. The line between formal and informal did not appear clear-cut, with the more organised interviews still maintaining a conversational format of an ethnographic context. I recorded most of the more formal interviews; in fact, some participants were familiar enough with the process to remind me to do this. I did not document written notes during the majority of interviews, feeling that interfered with the informal and personal setting I sought. However, I did take notes and write in my

¹⁰⁰ Note that I sought participant consent before proceeding to record any interview.

researcher journal after conducting interviews, documenting descriptive and reflective aspects of the experience. For those instances where I travelled immediately following an interview to the next location of fieldwork, I verbally recorded my reflections while in transit, to consider what I was learning and what to explore next.

Given the iterative-inductive nature of ethnography (O'Reilly, 2009), I had intended to ensure that I transcribed and analysed data from each interview before proceeding with the next, however, I found that some circumstances did not permit this. For example, numerous times when I was present at the Deadly Choices office for a pre-arranged reason, a participant would opportunistically request to meet with me afterwards, or even initiate a conversation that eventuated into a conversational interview. As I prioritised flexibility and allowed our relationships to drive the process, I would follow such opportunities.

Participant diary approach

The participant diary method provided an additional layer for this study to focus upon “everyday life” and “what happens in reality” for participants (Johnson & Bytheway, 2001, p. 183). Conceptually, the participant diary also enabled a focus on decolonisation of research practice through participation, recognition of human agency and participant expertise (Moffitt & Vollman, 2004; Wilkin & Liamputtong, 2010). In these diaries, participants could record their thoughts, feelings, behaviours and observations in both open- and closed-ended formats, according to their choice (Hyers, Swim, & Mallet, 2006). Research diaries enabled the capturing of characteristics and frequencies of mundane incidents and immediate responses to such incidents, allowing attention to the subtle, sometimes ambiguous and often forgotten aspects of experience (Hyers et al., 2006). The diary method also meant that participants could be participant observers in this study, together addressing the basic question, ‘What do these practitioners do all day?’ (Johnson & Bytheway, 2001).

I adapted the diary method with the input of participants, who I asked to *document their everyday lives as health promotion practitioners*. This meant that participants’ photos, videos and reflections were about their reality of health promotion practice, not the quality or artistic value of images. I designed the diary method to be flexible, with a

range of diary tools available to participants to maintain flexibility and accommodation of participants' various styles of reflection:

- Text diary (Hyers et al., 2006; Johnson & Bytheway, 2001; Juhila, 2009)
- Audio and visual diary (Monrouxe, 2009) (Davey & Goudie, 2009) (influenced by Photovoice (Moffitt & Vollman, 2004; Racine & Petrucka, 2011; Wilkin & Liamputtong, 2010)¹⁰¹).

Before fieldwork had begun, I piloted the participant diary over NAIDOC Week 2012, where I consulted participants regarding: diary structure; attention to context; and schedule for making a diary entry. This consultation enabled: development of an administrative process; building participant confidence in their data collection skills; and demonstration of the way fieldwork (including related analysis) could unfold. To prepare participants, I delivered two sessions regarding its administration (prior to and following the pilot phase) as part of the team meetings. These sessions appeared to facilitate a sense of collaboration between participants in the diary method and provide opportunity to discuss and question the diary keeping procedures. I also took the opportunity in these sessions to introduce the issue of consent regarding the images they would include in their diary entries: where their images identified people who had not consented for their image to be used by IUIH for research, those photos could not be included in this work. Additionally, I could reiterate the emphasis upon participants as “collaborators” in data collection, positioning participants as the researcher-observer of their own experience (Corti, 1993; Hyers et al., 2006). These sessions and the piloting enabled the method to be modified and improved to suit the Deadly Choices team preferences, including their request to use their work-provided iPhones as their data collection tools.

Participants could opt-in to record a diary entry if and when they chose to document their experience of health promotion practice. Initially, participants requested me to

¹⁰¹ See: <http://www.photovoice.org/> (accessed 13/04/12). Described as a participatory health promotion strategy for documenting participants' health and work realities (Wang & Redwood-Jones, 2001), Photovoice has three main goals: 1) to enable people to record and reflect their community's strengths and concerns; 2) to promote critical dialogue and knowledge about important community issues through large and small group discussion of photographs, and 3) to reach policymakers (Wang & Burris, 1997). Photovoice is also considered to be ethically appealing for its foundations in: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm (Wang & Redwood-Jones, 2001).

remind them to record their diary entries; the team manager also provided blanket reminders to the team (not knowing who had consented to participate). Participants could complete a diary entry at any time they chose and provide me their entries when convenient for them. Participants submitted their diaries to me in different ways: some arranged to meet at the office, others took the opportunity to ask when seeing me unexpectedly; and those with diary entries of a small enough file size would email them to me.

For those who wanted to use the diary method, it presented an additional way to centre their voices and respond to what participants wanted included as data in this study. I did not require participants to adhere to a particular structure. However, at the request of one participant, I crafted a generic structure for those who wished to use it; one participant provided feedback on this structure (see Appendix D). I emphasised the importance of participants reflecting upon moments that were important to them in their practice, moments that made them proud, key events or activities, the day-to-day matters, or particular issues they wished the research to explore in more depth. Although management encouraged the team to “do your diaries for Karen”, particularly using their IUIH-provided iPhones, not all participants did so. I hope the fact that not all participants completed their diaries is a reflection of choice and the spirit of the strengths-based approach I endeavoured to embed into this research.

I found that the text diary was the least popular diary format option. In contrast, photo and video were most commonly used, often with a number of images compiled together to form one entry that the participant requested to discuss with me. The option for participants to use their iPhones to photograph and share aspects of their practice appeared to be, as other researchers have found, a research tool of empowerment and artistic expression (Bond, 2007), that also enabled me as a researcher to co-create knowledge with participants. Some practitioners also referred me to their social media posts, requesting specific ones to be included as a contribution to their diary entry, with an explanation as to meaning behind this choice.

Many of the Deadly Choices practitioners (but certainly not all) were avid users of social media and were thus in some way accustomed to documenting their everyday experience. Those who were not so accustomed to this practice requested support to

engage in recording their diaries, including for some showing them how to use their iPhone to take photos and record videos. Some staff preferred to take photos and then meet with me to discuss those photos for their diary entry. A number of participants appeared to work together on recording their diary entries, sometimes interviewing each other to record video footage. The collective action between participants with the diary appeared to encourage participants to continue in their diary practice. This process created a strong link between the diary method and interviewing, with some participants seeking to discuss their diary entries with me and thus commence ethnographic interviewing. In this way, the “diary interview method” flowed from the participant diary entries (Corti, 1993, p. 1). Participants appeared to enjoy revisiting their photos and experiences with me.¹⁰² The diary entries also provided data that was useful and fun for the feedback presentations I regularly delivered to the team, where they could see their own faces and hear their own voices, telling their story.

Workshops

The flexibility of critical ethnography makes it characteristic to use relatively structured methods (such as workshops) alongside the comparatively unstructured method of participant observation (Babbie, 2004; Johnson et al., 2006). Unlike more structured methods such as interviews or surveys, the workshop does not have a defining feature, yet is recognised as a group approach that can benefit both research and participants, while providing “valuable, actionable information” (Freeman et al., 2013, p. 9). A strength of workshops relevant to this research is the interactivity of the group, whereby a specific set of topics can be examined (Freeman et al., 2013), while not limited to the smaller participant numbers of 5-10 participants, as is required of focus groups (Krueger & Casey, 2009).

I incorporated a workshop format as part of my data collection process for a number of reasons. Firstly, the Deadly Choices team (management and individuals) had requested that I facilitate a workshop with them, to support their objective of team building. This was achievable given that workshops are an effective method for team building and participation, by allowing the space for participants to work together in a group or

¹⁰² For example, one participant took photos and videos of two well-known Indigenous comedians delivering a comedy session at a community event. When this participant showed me the photos and videos, we spent time watching and laughing together and were soon joined by other team members who were laughing and sharing how funny that comedian’s session was for them.

groups. Secondly, the workshop format enabled me to explore central themes arising in fieldwork with participants, explicitly and collectively. Using workshops as a method allowed for participants to come together to consider various domains and themes, and come to some form of agreement about them (Labonte & Laverack, 2001). Workshops also provided opportunity for the team to consider where they wanted to be, compared to where they are on a particular topic. Together, these reasons meant the workshop format was an appropriate way to meet my fieldwork objectives and reciprocate the team's generosity to me, by providing their requested team-building opportunities.

I conducted two two-hour workshops during the data collection phase. The first of these workshops was at a team retreat, during the beginning of fieldwork. I approached this workshop as an opportunity to explore the team's views regarding health and how they saw their work relating to those views, as well as to establishing a reflective approach by participants to this research process. The workshop involved a warm up exercise based upon the question "What is health?" This was discussed collectively and tied back to the National Aboriginal Health Strategy definition of health (National Aboriginal Health Strategy Working Party, 1989). Following this discussion, the larger group split into four small groups and were given 25 minutes to discuss the following questions:

- What do you/your team do in relation to your chosen health theme?
- What makes your work unique?
- What are the strengths and areas to strengthen in your/your team's practice?

Each group then reported back to the large group with their responses written on butcher's paper, followed by a large group discussion. I drew upon the discussions and themes arising from this workshop in the following months to guide fieldwork and my feedback to the Deadly Choices team.

The second workshop was held 7 months into fieldwork as a stand-alone event at a time selected by Deadly Choices at their office. The focus of this workshop was leadership, which was an overarching theme I observed in fieldwork and wished to explore with the team collectively. One month prior to the workshop, I provided participants with a feedback paper I had prepared regarding leadership in their practice, for their consideration and feedback. I commenced the workshop first with a feedback

presentation that summarised this paper's contents. This was followed by a large group discussion based around the following three questions:

- Why is leadership “normal” in your health promotion practice? Why is it important?
- How do you know leadership is good practice?
- How does a leader know they are a leader?

Following this, two small group activities were held based around the following questions:

- How do you use leadership in your work? For example, encouragement, support, role modelling, community, existing leaders.
- What are some tensions and challenges in using leadership? For example:
 - What happens when a leader stops demonstrating the behaviour being promoted?
 - What happens when community members do not have a role model they relate to?
- What support do you need to be a leader?

Each small group reported back to the large group, presenting their discussion on butchers' paper. A large group discussion was then held, after which the workshop was closed.

Both of these workshops served the purpose of PhD fieldwork, including my agenda of reciprocity through research. During and after both of the workshops, participants indicated very positive support for this approach, publicly and privately. For example, at the conclusion of the leadership workshop, one participant commented to the whole group:

Personally, I thought that this was a very good exercise that we done today, as just an individual but obviously helping for your thesis. But it was a reflection as a group on what is leadership and how we can better instil this in the community and into our work practices as well. I've done a whole lot of leadership courses and that sort of stuff, but each one you still learn new stuff. And it's good to hear everyone's perspective, hearing from everyone else's as well, on what is leadership as well. So I think it was a very positive exercise that we've done. (Workshop transcript 1)

Field diary

I maintained a field diary as part of building a primary record of monological data (data collected from an outsider “researcher” perspective) (Cook, 2005; Hardcastle, Usher, & Holmes, 2006). The field diary links closely with participant observation and supports reflective practice (Hanrahan, 1998; Nadin & Cassell, 2006; Vaartjes & Goff, 2008) by enabling me to consider self-reflexivity, inter-personal reflexivity and collective reflexivity (Nicholls, 2009). The diary and its associated reflexive process was markedly important for methodological and analytical decisions I made during the research process, as well as for influencing the theoretical conclusions reached (Nadin & Cassell, 2006), given ethnography is necessarily representation of a culture from a particular point of view (Cardano, 2009). Moreover, documenting reflexive accounts enabled me to report uncertainty, which could be useful to the scientific community in assessing the plausibility of some or all of the assertions I make in this ethnography (Cardano, 2009).

As Wilson experienced (2009), to tell the story of this research project, I needed to search myself to derive a method of storytelling that fit with my paradigm. As informed by my conceptual framework outlined in Chapter Three, self-reflexivity involved a constant checking of my positioning. The field diary provided me with a practical tool to examine my observations, which are fundamentally theory laden and influenced by my biases and worldviews (Chilisa, 2012; Thomas, 1993). To maintain reflexive practice required the creation of dedicated times, spaces and contexts within which to be reflective, for which a research diary was beneficial (Nadin & Cassell, 2006). In this way, I used the diary to undertake critical reflection regarding my research practice and subjectivity, to record critical notes while reading, to deliberate on the research content and process, brainstorm and undertake critical incident analysis (Hanrahan, 1998).

Ethics

QUT provided me with formal ethics approval. When this study commenced, IUIH did not have its own Human Resource Ethics Committee (HREC) so instead provided written support for the research to progress according to the QUT HREC channels. I completed the NHMRC National Ethics Application Form (NEAF), which I made available to IUIH to comment and provide feedback on during the relationship-building and research design phases (accompanied by discussions), as well as the final submitted

version. QUT provided approval on 18 September 2012 (1200000425) with a variation approved on 17 December 2013 regarding my online participant observation (discussed below).

A number of important ethical guidelines have directed me, including the *Australian Code for the Responsible Conduct of Research* (NHMRC, 2007), the *NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research* (NHMRC, 2003a), *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (NHMRC, 2003b), the *Guidelines for Ethical Research in Indigenous Studies* (AIATSIS, 2011) and *Keeping Research on Track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics* (NHMRC, 2006). Further, I referenced the Australian Anthropological Society's Code of Ethics in the design phase of my research (Australian Anthropological Society, 2011, p. 1). I see ethical considerations as reasons to remain reflexive and critical – not as reasons to not conduct the research (O'Reilly, 2009). I unpack these ethical considerations further here.

Recruitment and informed consent

Ethics in ethnography is complex. I took a negotiated approach to consent, which is itself an ethical complexity, being dependant upon engagement between researchers and participants (Parker, 2007). As stated earlier, I prioritised building and nurturing respectful relationships from the outset of the research and only when I had obtained QUT ethical approval and completed the university confirmation process (where I ensured IUIH could be represented in the university review and feedback mechanisms), did I commence recruitment.

I aimed to ensure that research participants could be involved freely (as opposed to being coerced) after having been provided full and transparent information and opportunity to question me as the researcher (Czymoniewicz-Klippel, Brijnath, & Crockett, 2010). Recruitment involved my invitation, individually and collectively at team meetings, for potential participants to participate in this study. I made the Consent Form and Information Sheet (Appendices B and C) available to the team and relevant

IUIH staff,¹⁰³ highlighting that this Consent Form permitted participants to select particular, if not all research activities to consent to. The majority of participants consented to full participation, with a small number consenting to only particular research activities (for example, participant observation only).

I did not assume participant consent to be a continued given once fieldwork commenced. As a result of this, I checked in with participants as fieldwork progressed to confirm they still consented to be involved, particularly with new or more structured research activities. I emphasised frequently during and after recruitment that team members were under no obligation to consent; I felt doing so was even more necessary having observed the group encourage each other to consent. I also did not exclude people from research activities if they chose not to consent as research participants, although these individuals could choose not to participate in these activities. This approach was particularly important for protecting the anonymity of participants within the team,¹⁰⁴ as well as to support free and informed consent. The method also enabled those who chose not to consent to participate to contribute by providing feedback on the research interpretation and process.

I facilitated an additional process of consent for use of images that depicted community members. Typically, research participants provided me such images for their participant diaries; however, some of these images were from my participant observation on social media. Consent was gained for many images in the participant diary as part of the blanket IUIH consent process embedded into its education program, community events and other activities (for example, see Appendix E), but not for all images. For these particular images and those from my social media observations, IUIH contacted the relevant community members to obtain their consent for inclusion in this thesis.¹⁰⁵ Where community members could not be contacted, their images were excluded.

¹⁰³ I also consulted with IUIH regarding the Consent Form and Information Sheet, where constructive feedback helped to shape the documents to be accessible and appropriate.

¹⁰⁴ By having non-consenting team members included in research activities, it may not be apparent to other consenting team members that those individuals are not participants in the study. Any material that related to these non-consenting individuals was not used in this study.

¹⁰⁵ According to the ethics variation approval QUT granted me (see below), I did not require the consent of the individuals whose social media material I wanted to include in this research. However, I still deferred to IUIH before including such material in this thesis or other public spaces, knowing that IUIH may be aware of sensitivities or other issues relating to particular images that could require their withholding from this study.

Additionally, when I have included such images in work arising from this study in public spaces (for example, conference presentations or written pieces), I obtained IUIH consent for use of those images, even if consent had previously been granted, to ensure the consent remained current. Consequently, IUIH approval is in place for the images contained in this thesis and I continue to seek IUIH approval to use images and material from this study, before making it available in public spaces.

Confidentiality and anonymity

This research involved the risk that the anonymity and confidentiality of participants could not be guaranteed. IUIH and its Deadly Choices team is relatively small and well known in South East Queensland and in many parts of Australia. Because of this, some comments or images could be traced to particular individuals, potentially placing participant's professional or social reputations and employment prospects at risk. Likewise, community members may be identifiable in digital images and photographs taken by IUIH staff. Therefore, all efforts have been made to remove reference to key identifying factors of participants in public documents, including this thesis, along with comprehensive de-identification and secure data storage. This approach included the use of images of many IUIH staff in this work – not only research participants – so that the placement of staff images in this thesis does not imply their participation in this research. Likewise, IUIH granted approval to be identified in this thesis at the Final Seminar milestone in March 2015, which I consider to be a result of a process of respectful negotiation and feedback throughout this study.

Ethical considerations for social media

It is important to consider the new ethical issues that online research brings. Many Institutional Review Boards (IRBs) have yet to become accustomed to online research and thus become wary, even when advanced procedures are in place to secure participant safety (Moreno, Grant, Kacvinsky, Moreno, & Fleming, 2013b). The nature of researching social networking sites (SNS)¹⁰⁶ is akin to eavesdropping in a public space or drawing on newspaper personal ads for research content (Moreno, Fost, & Christakis, 2013a): the data is publically available but not published with intention for

¹⁰⁶ While much of the literature regarding research on social networking sites employ the term SNS, Deadly Choices practitioners referred to these spaces as social media. Accordingly, I use the term social media in the findings chapters.

research purposes. Researchers caution that the public nature of SNS does not justify secondary disclosure of such data in a presentation or publication; this is particularly the case for Facebook, given it has somewhat complicated privacy options of which many people are unaware (Moreno et al., 2013a).

There is limited research into participant experiences of online research, particularly in light of privacy and confidentiality concerns (Allison et al., 2012; Park & Calamaro, 2013). In fact, confidentiality is reportedly the number one priority researchers are to account for when researching SNSs, particularly with regard to vulnerable populations (Lau, Gabarron, Fernandez-Luque, & Armayones, 2012; Park & Calamaro, 2013). While my research focus was the Deadly Choices practitioners, given the nature of social media and participant observation, I inadvertently co-observed Deadly Choices community members (Bardus, 2011). In light of this, not all subjects I observed interacting with Deadly Choices on the Deadly Choices social media platforms could be informed of my surveillance.

The public nature of SNSs reduces anonymity (Pedrana et al., 2013). This means a key challenge for research with social media in health research is to ensure the safety of participants from inappropriate contact and exposure (Park & Calamaro, 2013). An additional challenge lies in the freedom participants have to tell others about their involvement in research in a public forum, which can detract from efforts to protect their confidentiality. Indeed, I experienced this challenge, where some participants tweeted about their participation in the research with me (discussed in Chapter Seven).¹⁰⁷ Yet, the online social spaces of interest to my work are public spaces: they can be accessed and seen by anyone, even without a Facebook/Twitter account. Research on SNSs clearly involves a blurry line between the public and private domains, riddled with complexities and the politics of “watching” (Ibrahim, 2012; Lupton, 2012).

In response to these online ethical concerns, I raised these issues with IUIH/Deadly Choices management and the Deadly Choices social media coordinator, as well as my

¹⁰⁷ That participants tweeted about me as the researcher studying them reflects the space provided in this research for participants to choose their level of engagement with the research, including how and when they identified with it, as opposed to a blanket ‘anonymity’ imposed and assumed by the researcher for the researcher’s needs.

supervisors and the QUT Faculty Ethics Advisor and Research Ethics Coordinator. IUIH provided consent for me to include the social media observations in this study and for my pursuit of an ethics variation request for the QUT Human Ethics Research Committee (the draft of which I discussed with IUIH). The strategies I proposed in this ethics variation aimed to protect individuals and groups involved with Deadly Choices online, included the following:

- I was not required to seek consent from the online Deadly Choices community. The QUT Ethics Unit advised that: 1. Obtaining consent from the entire online community I would observe was not required nor an endeavour considered reasonably achievable; and 2. The posts were already in the public domain and it is standard research practice to use such information without the user's consent.
- I would de-identify publicly sourced images and text used in this thesis wherever possible, including censoring names.
- I was to consult with Deadly Choices when intending to use data sourced through Deadly Choices SNSs, to identify and address possible concerns or participant safety issues. If not resolved, I would not use that data.
- I committed not to contact online Deadly Choices community members directly. In the instances where I wished to use an image which would identify an individual, Deadly Choices contacted these individuals to source consent, or otherwise.

I now provide further detail regarding how the *Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (NHMRC, 2003b) guided my approach to this research.

Reciprocity

My intention from the beginning of this PhD was that this research would demonstrate reciprocity. Reciprocity was a driving value in this research and influenced my choices to take on additional tasks within the research and for my concern with balancing being a researcher and a “helper” and even an “expert”, as discussed earlier. The initial relationship-building phase with Deadly Choices and IUIH enabled the research design to align with IUIH objectives and practice, and for the review and reflection upon the research design to see that it benefit those involved and affected by the research. One of

the products IUIH identified for this research was support for its development of evidence-based practice framework for Deadly Choices, which was achieved through the comprehensive feedback process throughout fieldwork, as well as the documentation of their practice in Chapters Five, Six and Seven. Furthermore, this research contributed to the strengthening of the team building and its critical analysis capacity, as IUIH staff have relayed to me throughout this research, suggesting that this study has added value to the work of Deadly Choices. I have also co-/delivered conference presentations (McPhail-Bell, 2014a;2014c; McPhail-Bell & Appo, 2015) and written pieces (McPhail-Bell, 2014b; McPhail-Bell, Bond, & Redman-MacLaren, 2013a) that constructively contributed to raising the profile of Deadly Choices. IUIH management have expressed interest and support for me to publish journal articles based upon findings from this research, subsequent to completion of this PhD in accord with an appropriate authorship process.

Respect

A respectful relationship is of utmost value to me, along with the trust and cooperation this can induce. My relational approach allowed for participants and IUIH management to become familiar with this research and me, and supported meaningful participation and feedback processes. I regularly provided feedback to IUIH regarding what I was learning through fieldwork. Similarly, I respected that there were some boundaries beyond which I could not go. For example, when attending a team meeting when the team wished to discuss an agenda item without the presence of observers, I would leave and return to the meeting only when invited back. I also discussed and consulted with IUIH and Deadly Choices staff regarding the Croakey blog piece (McPhail-Bell, 2014b) and conference presentations and posters (McPhail-Bell, 2014a;2014c) I wrote in relation to Deadly Choices. This was to ensure these reflected the spirit of Deadly Choices and respected IUIH's position and choice to be involved in this research, including its decision to endorse my representation of Deadly Choices or otherwise.

Equality

Mainstream ethics approval processes tend to privilege non-Indigenous forms of knowledge and ways of doing (Czymoniewicz-Klippel et al., 2010). In my efforts to democratise the research process, I drew on the flexibility of ethnography to share power over the research with research participants and IUIH, to make the process more

equal between me and research participants. For example, I provided feedback papers, presentations and thesis chapters to participants and key IUIH staff to question and discuss together and with me, so that over time a collective dialogue and understanding of this study's representation of Deadly Choices was gained. Furthermore, IUIH retained the control to be identified as an organisation – and Deadly Choices with it – and as Chapters Five to Seven reveal, the public display of much of this study's findings rested upon that consent to be presented.

This is not to say that I did not have control over the research process, but rather that where possible, participants and IUIH shared decision-making power in terms of process, design and data collection and representation. Such a process takes time and different participants and IUIH management engaged in different ways and levels. I sought to create spaces for participant voices to be equally included in this research, being mindful that inequalities can be exacerbated when already privileged voices are further privileged. This approach included deliberate strategies to meet (informally and on some occasions for interviews) with individuals or groups of individuals who were quieter when in the team collective, and seeking to participate in the full range of Deadly Choices activities. While I worked to create equal opportunity for each practitioner's voice in this study, I was aware of the tension in creating a scenario where participants felt coerced to engage more in this research than they wanted.

Responsibility

To be a responsible researcher, I aim to ensure that I do no harm and could be held accountable. I have sought guidance and undertaken induction and training when the opportunities presented. As discussed in Chapter Three, I approached my positioning within Deadly Choices in a reflexive manner; while this is by no means a “neat” tool or process, it enabled me to engage and check in with the ethical underpinnings of this research, which included reflection regarding my use of the specified guidelines above. Such an approach saw that I was positioned to respond ethically, particularly during more ambiguous moments or even being present during difficult dialogues amongst the team – as would happen with any workplace. I am responsible, ultimately, for ensuring I remain true to the agreed purpose and scope of this research both in practice and in its representation.

Survival and protection

A cornerstone for an ethical relationship with Indigenous peoples is respect for, and valuing of, cultural and language diversity. With respect to survival and protection, the foundation of this study and its overarching aim are centred upon exploring and sharing Indigenous-led health promotion practice in a manner that values and centres Indigenous knowledges. In consultation with IUIH, this research was designed to build upon strengths and bonds within the Indigenous communities with which IUIH is connected. The theoretical tools I drew upon also assisted me to prioritise and privilege Indigenous culture and identity. Overall, this study aims to learn from and with the vibrancy of Indigenous communities and cultures in an urban context – a context that as Chapter One described, is often overlooked in Indigenous health research. In this way, this thesis is a contribution in itself to the survival and protection of Indigenous peoples' culture and identity.

Spirit and integrity

I understand that the spirit and integrity of research can involve continuity between past, current and future generations; it can also involve behaviour to maintain the coherence of Indigenous values and culture. I recognise the sensitivity of conducting research in the realm of Indigenous health as a non-Indigenous person and endeavour to incorporate relationship and reflexivity into my research approach to contribute to building accountability. As part of this, I have sought the guidance of IUIH, mentors and my PhD supervisors (two of whom identify as Indigenous) for working with Indigenous participants and indeed, non-Indigenous participants. I hope that this has enhanced the spirit and integrity of this research and that this is reflected in the pages to come, where I shall now share details of the findings of this study.

Where and how I spent time with Deadly Choices practitioners

The concept of multi-sited ethnography informed the design of this study, to accommodate the diversity of places and spaces Deadly Choices operates in across community-based agencies, schools, public spaces, office locations and social networking sites (see Figure 1 in Chapter One). The online space is an integrated part of participants' reality and health promotion practice (for example, Figure 7). This is

consistent with other research, which has found that the Internet is situated in people's everyday lives (Hine, 2000; Wang, 2013). Interrogative boundaries informed me of research directions, where participants and the data led me, woven together into a single, broad-focused ethnographic field of enquiry (Madden, 2010, p. 53). Geographical and programmatic considerations were part of this decision making process, along with the IUIH objective that this research support the Deadly Choices practitioners in their development of a practice framework. This meant that I was present with Deadly Choices practitioners through a number of engagement activities, from being at the IUIH offices, to a range of sites for program delivery, including schools, community controlled health services, community-based organisations, public parks and fields, and more (see Figure 5 and Figure 6).

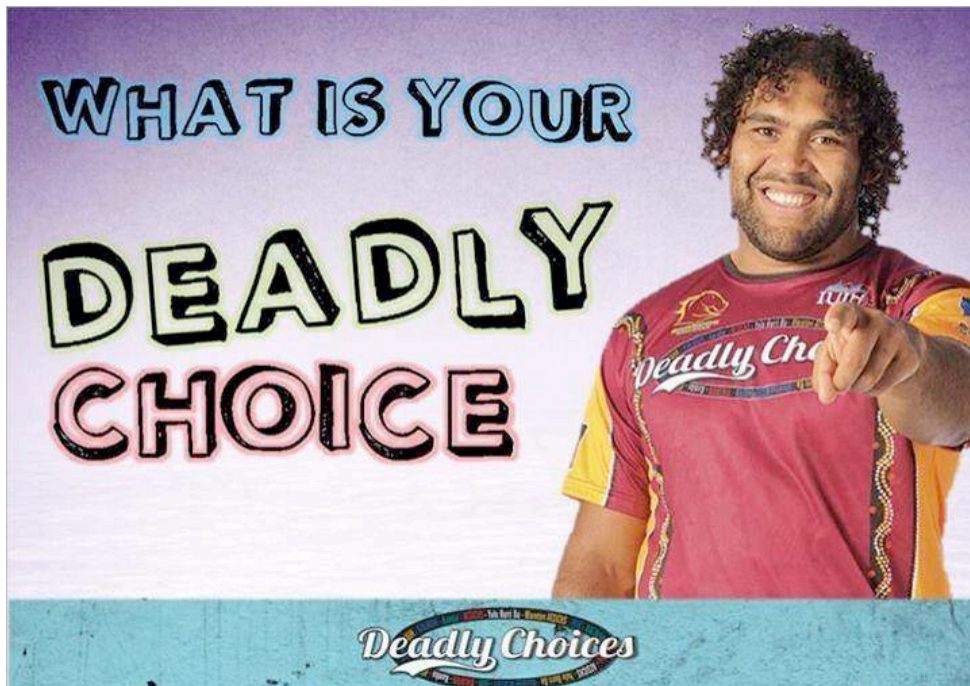


Figure 7: A sample of Deadly Choices Facebook post, asking the Deadly Choices community what their deadly choice is (Deadly Choices, 2014g).

I immersed myself into the working lives of the Deadly Choices team by observing their actions and trying to understand the intent behind their actions. At first, I felt as though I had to be in many places at once, with the team spread out across SEQ, plus social media platforms. Therefore, themes of interest guided where I focused my time, meaning that I spent more time with some practitioners than others, while remaining careful to keep the process equally accessible by participants. I attempted to follow

normative practices for interaction and self-presentation, which included wearing the Deadly Choices uniform, particularly when I joined participants in public places. I drew on ethnographic methods to produce thick descriptions and endeavoured to represent the social reality of these practitioners (Geertz, 1988). I was constantly trying to understand the actions of individual participants, their interactions, motivations, group life, and social relationships – all from an emic (participant’s point of) view (de Laine, 1997; Fetterman, 2010).

I began with the Deadly Choices practitioners for data oriented purposes but as discussed above, was soon considered part of the team. At times, I struggled with being welcomed as an “insider” while remaining a researcher who was an “outsider”. I was wary that participants might somehow forget I am there to research *them*. Perhaps I overcorrected at times¹⁰⁸ and this questioning of scenarios, while important, is a by-product of my analytical nature. To keep a balance during fieldwork and overcome too much self-introspection/self-reflexivity, I maintained regular contact with my research participants and supervisors, where we could explore ideas and help me to remain connected to the practice context.

With a wide variation of health promotion practice in play, I remained open to both traditional and non-traditional health promotion domains. For practitioners who wanted to meet with me personally, we would do so at their preferred location, sometimes at their office, cafes or the CCHS/community organisation where they were based. For fieldwork outside the office, I would usually meet the relevant practitioner/s at the Deadly Choices office and we would drive together to the relevant school or community controlled organisation where they would deliver their program or community event. On social media, I observed and interacted with Deadly Choices using my personal social media accounts. At times, I initiated interactions and at other times, Deadly Choices did, for example, by tagging me in a post.

Aside from my open personality, my previous experience with the agencies and communities that Deadly Choices works with, and our shared professional interest in

¹⁰⁸ For example, the team asked me to be part of team photos while they were being taken. When I declined, some participants said, “Come on, you’re part of the team!” Yet I considered it unethical to allow the insider-outsider boundary to be further blurred, by participating in photos that were to be used to represent the Deadly Choices staff, which I was not.

health promotion, being present (and listening) was perhaps the primary reason practitioners opened up to me. Over time, I was of the impression that participants related to me personally, not only as a researcher investigating their practice. I spent time with them; we took breaks together, travelled together, worked long days and ran youth camps together – sometimes one-on-one, other times as a group. As other ethnographers have experienced, I was a “vulnerable observer” in the sense of being willing to be vulnerable to personal transformation through happenings in the field (Behar, 1999; Wang, 2013): I felt and continue to feel strong connections to the participants, not just intellectually and personally, but with a heightened sense of responsibility to represent their stories in a respectful authentic way.

Methods of analysis

There is no one procedure to follow for ethnographic analysis but rather an “implicit understanding” shared by ethnographers of how to analyse data (O'Reilly, 2009). As one researcher teases, analysis makes clear what would have been most important to the study if we had only known beforehand (from Halcom's Iron Laws of Evaluation Research; cited in Patton, 1990, p. 431). According to ethnography's iterative-inductive nature (O'Reilly, 2009), ethnographic data analysis for this study was inextricably linked with data collection (Liamputtong, 2009). Figure 8 depicts my approach to data analysis, involving interconnecting loops of inductive and deductive analysis to “open up the data”. The reality of fieldwork and analysis was not as “neat” as what Figure 8 suggests, but rather, entailed continued comparison, coding and merging of concepts, creating some new ones, while renaming or modifying others (Thorne, 2000). My conceptual framework directed the process of data analysis.

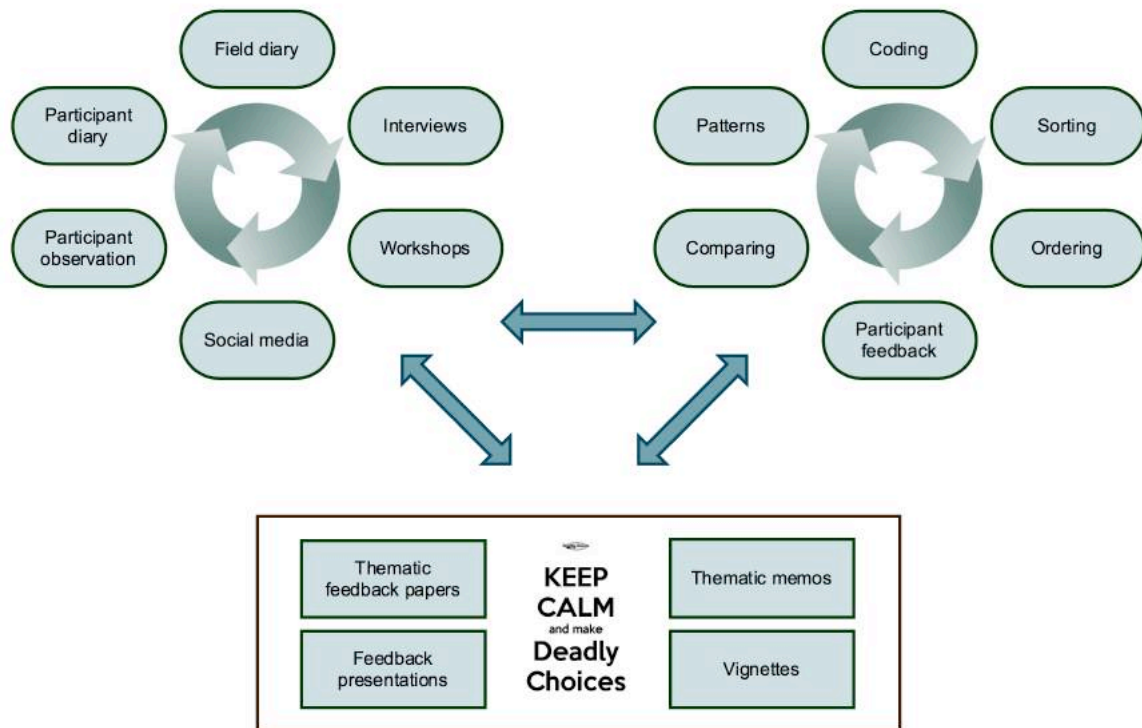


Figure 8: The inductive-deductive process of data analysis and fieldwork.

Although “official” data collection began in the study’s second year, I had already entered the field as a volunteer with IUIH prior to this. This meant that I had begun internal processes that would inform my data analysis – I had made observations and had personal conversations, reflected upon my research questions and the methods in light of my what I was learning (Glaser & Strauss, 1967). This iterative process continued into data collection, where at each stage, my analysis informed what I would next explore in data collection, such as who to ask questions of and where to do the next piece of participant observation or interview (O'Reilly, 2009). As a result, my understanding of Deadly Choices and its practitioners’ work was derived from a series of inferences, in my effort to seek a coherent account of what I had observed.

The analysis phase, although not a distinct division by any means, involved me writing things *down* (when information was gathered and stored) to writing things *up* (when I prepared the information collected in such a way as to present to others, most often research participants and supervisors, including thematic feedback papers) (O'Reilly, 2009). My core positioning was central to this process of data analysis and interpretation, thus making my research journal a key tool for analysis. Through this

process of writing, I organised the primary data and my interpretation of it into an ethnographic story (Madden, 2010).

Analysis built upon this chronological ordering, where I sorted data into categories (for example, descriptive or thematic categories). Typical of ethnography, these categories overlapped and changed as fieldwork and analysis progressed (O'Reilly, 2009). The sorting phase led me to look closely at my data, enabling me to see emerging patterns and to link themes together. However, the limitation to the sorting phase was that of my decisions as to what data to record; as I was the research instrument, it was possible I miss recording important occurrences along the way (O'Reilly, 2009). I found that sorting the data as I progressed through the research, combined with regular feedback to participants and IUIH, helped in some way to address this limitation.

As fieldwork advanced, I would have ideas about directions for analysis, while patterns and possible themes emerged, which is a recognised process of ethnography (Patton, 1990). I attempted to remain flexible and reflexive, mindful that my own personal identities spanning gender, ethnicity, social class, age, and religion could influence my access to and experience of fieldwork (Liamputtong, 2009). I reviewed my research questions and methods regularly, communicating to participants what I had been learning through the research about them and their practice (for example, see Figure 6 in reference to my regular feedback presentations).

As I analysed and collected data, I continually checked the data. I did this using a number of techniques: looking for consistencies and inconsistencies; checking people's reports of behaviour or other conditions against other accounts and sources of information; being open to negative evidence for a theory I may have been developing; seeking alternative explanations when I felt I had understood something; and endeavouring to fit extreme cases into my theory but not being quick to throw them out if cases don't fit (Bernard, 2006). I used my field diary to test my ideas against my observations, and to switch between emic (insider) and etic (outsider) perspectives to check "folk analyses" systematically (Bernard, 2006). My field diary was an important tool in the analysis process for facilitating the reshaping of summaries of field notes and associated notes while viewing the data in light of my researcher position. I shared some of these memos with my PhD supervisors and on a small number of occasions with

participants. The collective discussions we had about the memos and analysis further assisted me in analysing and clarifying meanings and understandings.

A major emphasis for me during analysis was also to provide ongoing feedback to participants – both formal and informal – to deepen my analysis and ensure space existed for participants to contribute and check on the narrative I was developing about them. I would return to examine themes evident from fieldwork, at times writing vignettes or thematic papers (which included thematic reference to relevant literature) to further develop my analysis of those themes. To deepen the analysis, while also providing support to Deadly Choices in building a monitoring framework for its social media, I obtained a two-week statistical report from SimplyMeasured for the Deadly Choices Twitter and Facebook accounts for the period of 24 September – 8 October 2013 (see Appendix F). I shared emerging findings regularly with IUIH during fieldwork – some in the form of thematic memos or vignettes, others as thematic papers and presentations. This feedback process supported checking the trust-worthiness of my analysis of data, while opening the analysis process for participants to contribute as well. Chapter Five, Six and Seven represent the cyclical analysis of these findings.

I used NVIVO 10 to store and sort data I collected. NVIVO 10 also had the ability to “NCapture” data from social networking sites, which was a central function for my online participant observation. Given the vast amount of data I had, typical of ethnography (Basit, 2003), NVIVO 10 was useful to provide a data warehouse function through its coding system and query functions, to easily retrieve information, as well as assign data to themes and cases (participants). NVIVO 10 enabled me to manage and analyse raw data, including coding according to themes and issues arising, and to examine relationships and model conceptual ideas. I transcribed and coded data with written summaries as data was collected, linking data together through codes and analytical memos. Furthermore, I was able to code data according to participant “cases” and to “node” themes as they emerged, which was useful not only for analysis but for data retrieval. I also applied this coding to my own field diary memos, enabling me to analyse and interpret my own field notes as part of the data. These functions, combined with text query options, ensured data was readily retrievable and accessible for analysis. Additionally, I generated visual representation of node trees, which assisted me to identify key themes.

Who I spent time with: Deadly Choices practitioners

Over the course of this research, 20 health promotion practitioners from the Deadly Choices team participated, during which time some participants left their positions with Deadly Choices, while new staff joined. Many of the practitioners had an affiliation with the SEQ community and/or CCHS sector in some way before their time with Deadly Choices, be it through employment or community. In terms of professional backgrounds and training, at the time of fieldwork, two practitioners had university level health promotion qualifications. Other practitioners held certificates of training, such as a Certificate in Aboriginal and Torres Strait Islander Primary Health Care, Certificate in Community Recreation, Certificate in Fitness, Certificate in Frontline Management, or Certificate in Training and Assessment. Many practitioners had also completed training courses, such as courses specific to tobacco (IRIS,¹⁰⁹ nicotine addiction, or Smoke Check¹¹⁰) and nutrition. As Chapter One outlined, the majority of the team is male and in their twenties. A small number of staff began with Deadly Choices as trainees, before later becoming IUIH employees. As the practitioner quote in Box 2 explains, the majority of the practitioners were not qualified in health promotion according to mainstream standards.

During fieldwork I also spent time with community members who participated in Deadly Choices events and programs, or were connected with Deadly Choices in some way, such as partner agency staff, students in the Deadly Choices Education Program, attendees at a community day, and IUIH staff more broadly. When I did this, there were times I informed these

Box 2: A Deadly Choices practitioner reflects on the Deadly Choices team's beginnings.

We had no health promotion or health education qualifications. There was no mainstream thinking of when we were doing it [*designing Deadly Choices*]. We spoke about leadership and education and covering those key things. We never had thinking from health promotion in a mainstream way. It was our way.

people I was a researcher with the Deadly Choices team, while at other times, it was not appropriate or relevant for me to disclose these details. Additionally, I observed user

¹⁰⁹ The IRIS (Indigenous Risk Impact Screen) was also accompanied by a brief intervention program and considered to be a culturally secure and validated screening instrument and brief intervention for use with Indigenous communities in Queensland and Australia.

¹¹⁰ SmokeCheck was an Indigenous smoking program developed by Queensland Health, aimed to reduce smoking rates in Indigenous communities.

postings on social media. Overall, my interest in these people was not so much a focus on them as a research participant, but rather to observe the way the Deadly Choices practitioners interacted with them. Thus, some community members appear (under a pseudonym) in material outlined in Chapters Five and Six in order to demonstrate the way Deadly Choices engages with community.

A consistent term I have heard used both by workers themselves and others to describe the team is “passionate”: the practitioners demonstrate a deep connection and caring for the community they work with, and

Box 3: Brendan reflects upon why he is a practitioner with Deadly Choices.

For me personally, it’s about closing the gap for everything so we can all be equal and all be one.

Indigenous people – “our people”, “my people” – more broadly (see Box 3). The practitioners appear to be proud of their work ethic (for example, Box 4). Likewise, I have observed a positive, connecting response by the community in relation to Deadly Choices. In fact, relationship with the community and each other is a feature of this team.

Featuring participants

Just as the research site requires an introduction, so too do the participants who feature in the chapters to come. Of the three Deadly Choices teams, the Healthy Lifestyle Team and Tobacco Action Team are based in the IUIH office, while the third team of practitioners is based across various CCHSs and NGOs in SEQ with a primary focus upon delivery of the Deadly Choices Education Program. Each worker is responsible for a portfolio, some according to output or health issue (for example tobacco clinic establishment) while others for geographical regions within SEQ.

Some participants feature more than others in the findings discussed in Chapters Five, Six and Seven. Those that feature in this thesis do so as a result of my decision regarding what data would be included in the findings chapters. Therefore, I introduce these participants here, to provide context to their appearance in those findings chapters. These participants are introduced by pseudonym and without detail in order to protect anonymity. I have also checked each introduction with the participant it represents and IUIH management and received consent for use as below.

Hunter is the first practitioner to feature in the coming chapters. I first met Hunter in 2012 when he joined the team. A vibrant yet quieter personality, compared to his male teammates, Hunter's role with Deadly Choices was his first in health promotion. However, Hunter was familiar with the community Deadly

Choices worked with, having served previously in other community agencies in the region. Hunter is a regular joker and often laughing – in fact, the whole team carries a humorous dynamic, which I believe contributes to its success. At the same time, Hunter struck me as somewhat serious when he wants to achieve a goal and perform well; this was most obvious to me in his efforts to succeed in delivering the Deadly Choices Education Program to the schools in his region. Hunter is based in an AMS for his region and is an Indigenous man.

Box 4: Bianca, a research participant, reflects upon the team's work ethic.

...a good thing about our team is that everyone's really motivated to work hard and everyone does work hard. They just go out and they do their best.

Shawn also features in the following chapters, being an avid user of the video participant diary method individually and collaboratively with his teammates – all undertaken with his trademark playful and creative approach. Shawn is well known for his creativity with multimedia for reaching a wider audience. In fact, his teammates would joke with him, and about him, regarding his love of being in front of the camera. Being an Indigenous man and a longer serving team member in Deadly Choices, Shawn was involved in the design phase of this research. Shawn had previously worked in youth and community oriented roles and appeared to take on an informal mentoring role within the team, where I frequently observed him working with newer team members to teach them the trade of working with community and delivering Deadly Choices.

Elenor is an Indigenous woman who joined the team at the same time as Hunter. She strikes me as incredibly committed to the community she serves locally through her host AMS, but also to Indigenous people more broadly. I recall many times when Elenor shared her visions with me to nurture excellence in the Indigenous community and she appears passionate to help Indigenous people lead and be the best they can be. Training – before or after work – would frequent conversation I heard involving Elenor, with sport and fitness appearing to be an important part of her life. Elenor is a generous spirit and incredibly considerate to the well-being of others.

Danielle is a non-Indigenous woman and a member of the Deadly Choices team. Danielle's demeanour is calm and positive and she appears to unite people. Danielle carries university level qualifications in a public health-related field and shares her knowledge and training with other Deadly Choices practitioners formally (for example, training workshops) and informally (for example, assisting staff when they request her content knowledge input). In fact, a number of practitioners commented to me regarding Danielle's support for them by sharing her knowledge. I too had observed and participated in team training delivered by Danielle and observed her contribution to updating and refining resources for the team in working with community.

Daniel is also a long-serving member of the Deadly Choices team, known for his tough approach arising from his passion for empowering the community. Daniel has been open about his upbringing in conversations with the team, which have exposed him to what he refers to as negative examples of parenting and family. From these experiences, Daniel appears to have gained inspiration to be different, to be better. Perhaps this experience also contributes to his emphasis upon discipline and rewards when working with community; or perhaps it his semi-professional sporting background that influences this approach. Despite this tough exterior, Daniel appears to have a soft heart and cares deeply to bring out the best in people.

There are many other participants who feature in the findings chapters, including (but not limited to) Braden, Ethan, Steven, Jolene, Bianca and Katie, who, with the broader Deadly Choices team and IUIH, work together to deliver smoking and nutrition/cooking programs, community events and the Deadly Choices Education Program. A common theme amongst the Deadly Choices practitioners is their emphasis upon engaging with the community (for example Box 5). Although not all of the practitioners involved in this research feature individually in this thesis, their influence and support is without a doubt present throughout. The following three chapters present the findings in which these participants feature.

Box 5: Shawn, a participant introduced above, reflects upon the Deadly Choices community engagement.

...we've always sort of tried to come down to their level, you know and not try and be that teacher - try and be like a cousin or someone in the community...

5. “Urban is the new black”: Engaging Indigenous people in health promotion

Deadly Choices is a program but it is also a brand. It is recognised in most of the Indigenous community and other parts of the state as well. (Deadly Choices interview on Brisbane Health radio, 27/03/2014)¹¹¹

This chapter provides an ethnographic description of the Deadly Choices brand and program and the associated engagement of Indigenous peoples and communities in their health promotion practice. While Deadly Choices is overtly a health promotion initiative aligned with the dominant healthy lifestyle approach, as the quote above explains, it is in fact a brand and a program with incredibly high engagement with and by the Indigenous people and community it serves. This chapter’s overarching purpose is to introduce the fieldwork revelations regarding Deadly Choices as a site of Indigenous community controlled health promotion practice in an urban setting. I begin with a description of Deadly Choices branding imagery and its nomenclature, through which the engaging nature of Deadly Choices is introduced. I then provide the context of Deadly Choices as a health program, including its various products and structures. In doing so, this chapter provides the setting for the ethnographic story that unfolds in the chapters to come.

Consider the Deadly Choices logo in Figure 9. Its imagery appears somewhat Americanised with its bold and simple use of space, in which the company brand name, Deadly Choices, is proudly displayed. The name Deadly Choices is itself conspicuous, for what does it actually mean?¹¹² While the message may not be clear to the average Australian citizen from this logo alone, there are clues. For example, an elongated circle comprising the names of Aboriginal Medical Services (AMSs) surrounds the words, “Deadly Choices”. The presence of the names of AMSs suggests that the Deadly Choices logo is an Indigenised one. If that is the case, this logo also presents as a creative variation to “traditional” concepts of Indigeneity evident in health promotion,

¹¹¹ URL: <https://www.youtube.com/watch?v=ymKQ14HkiWc&feature=youtu.be> (accessed 16/05/2014).

¹¹² The meaning of ‘deadly’ is explained below.

where health education resources are reportedly littered with Indigenous artwork (Bond, 2002).



Figure 9: The Deadly Choices logo.

Examination of the Deadly Choices home page (Figure 10) provides some additional signifiers of the business of Deadly Choices. The words, “Deadly Choices” are emblazoned across the screen, set against a field and a blue sky. To the right is the image of one of the Deadly Choices ambassadors, Sam Thaiday¹¹³, overlayed by the words, “ambassadors, find out more”. Thaiday smiles at the audience as he reaches his hand forward, finger pointed, individualising his appeal to each viewer of the page. The tone of Deadly Choices is set here, as one that personally acknowledges its audience as having the power to make its own choices.

The stylised image of a television appears directly below Thaiday, screening the words “Deadly Choices TV”. At the bottom of the page are Facebook and Twitter icons, demonstrating that Deadly Choices involves a range of media sources, with a message to share in an interactive way. The webpage directs viewers to the offline practice associated with Deadly Choices with links to its calendar of events, the Deadly Choices regions and contact information for AMSs across South East Queensland (SEQ). Consequently, Deadly Choices presents as accessible, available and approachable in both the online and offline spaces.

¹¹³ Popular in the South East Queensland Indigenous community, Thaiday is a Torres Strait Islander man and a professional rugby league player, playing with the Brisbane Broncos and Queensland’s State of Origin team.

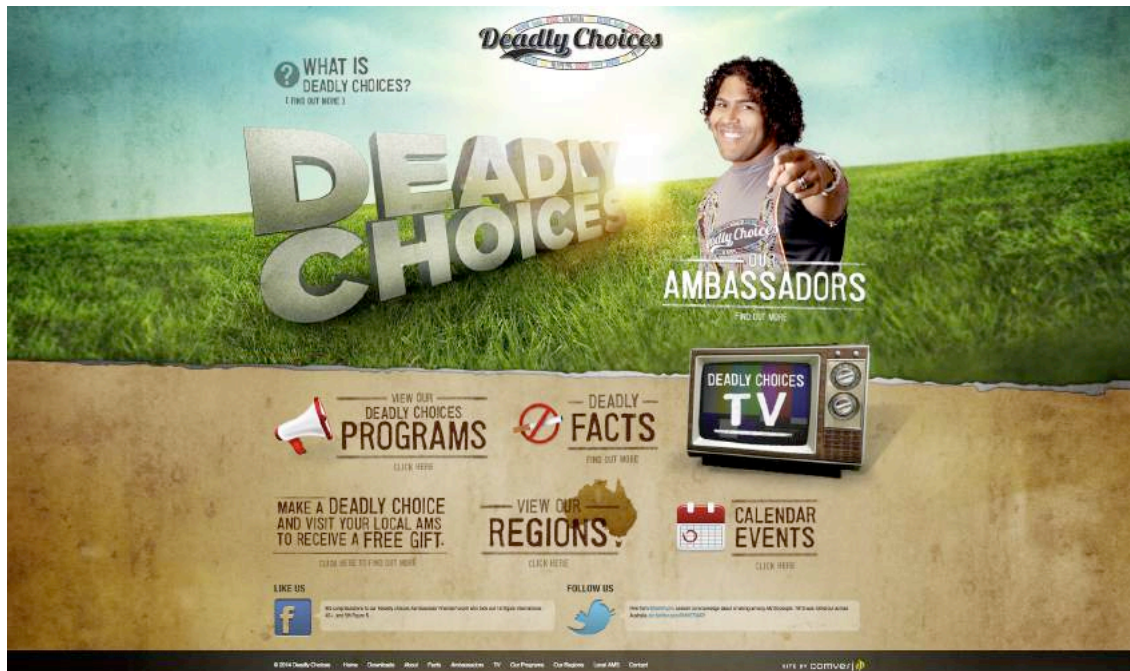


Figure 10: The home page of the Deadly Choices website (Deadly Choices, 2014d).

The page also offers a click-through to some “Deadly Facts” where viewers can “find out more”, accompanied by an anti-smoking symbol. It appears that Deadly Choices involves a health message, perhaps one of an education agenda to encourage people to avoid deadly illness-producing behaviour like that of smoking? Those familiar with an Indigenous health context would know that an AMS is an Aboriginal Medical Service. Subsequently, by encouraging viewers to attend an AMS to “receive a free gift” (“like a Deadly Choices jersey”) the Deadly Choices health agenda is exposed. Nonetheless, if Deadly Choices is a health initiative, why would it frame a health-promoting move such as attending an AMS as “deadly”? Why would Deadly Choices encourage people to “make a *deadly* choice” if they are promoting health? Why would Thaiday smile when the topic is “deadly”?

The name Deadly Choices is symbolic. The word deadly is a contranym. In public health terms, deadly means to cause or resemble death. However, in Aboriginal English, the term deadly means good or fantastic and is used in praise. Hence, in the Deadly Choices context, deadly signifies positivity to an Indigenous audience. During my

fieldwork with the Deadly Choices team, Donavon¹¹⁴ hinted at this disjuncture when retelling his explanation of deadly to his White friends and family.

While Hunter and I set up for the sixth session, Donavon chatted with us about his experience of trying to explain to some of his friends what Deadly Choices is. Donavon voiced that he found people thought ‘deadly’ was a negative thing: "Like deadly - you're gonna die", he said. Donavon acknowledged that his mum’s side is White, when describing where the confusion regarding the language was. Donavon asserted, “I explained to my friends that in Aboriginal culture, “deadly” means a good thing – it’s a good thing, it’s about eating and being healthy.” (Field notes, 28/05/2013)

Donavon provides an apt explanation of the culturally dichotomous nature of deadly. Donavon’s explanation also demonstrates that Deadly Choices is about *Indigenous* health.

The word “choices” also provides a signpost for the Deadly Choices approach to engaging Indigenous people and communities. To have a choice is to act “of one’s own accord”, to choose between two or more possibilities (Oxford Dictionary, 2014a). Those who engage with Deadly Choices are encouraged to *choose* their own healthy choices, rather than being advised and persuaded to comply with a health promotion agenda. That is, the Deadly Choices practitioners work according to their frequently stated philosophy that, "people don't want to be told what to do".

Deadly Choices as a health program

Deadly Choices is a health promotion program with a difference. Its own website describes Deadly Choices as:

...a campaign which aims to empower Aboriginal and Torres Strait Islander peoples to make healthy choices for themselves and their families – to stop smoking, to eat good food and exercise daily. (Deadly Choices, 2014b)

¹¹⁴ Donavon was a student of a Deadly Choices program run by Hunter, a Deadly Choices practitioner (introduced in Chapter Four).

At first reading, Deadly Choices could appear to be as any other health promotion program, working to educate participants to maintain healthy lifestyles. Deadly Choices is funded by the Commonwealth Department of Health and Ageing to focus on risk factors for chronic disease. Many program “ingredients” cross over with those typical of mainstream health promotion, including chronic disease prevention, physical activity, nutrition, and avoiding harmful substances and smoking (Figure 11); and these are indeed core to the Deadly Choices practice. Deadly Choices is also aligned with the Australian national framework for addressing obesity, and tobacco and alcohol misuse (ANPHA, 2012)¹¹⁵ and Queensland’s prevention approaches targeting disease and risk behaviours (Queensland Health, 2005)¹¹⁶. Similarly, Closing the Gap (CTG) funding structures are visible, with CTG priorities such as increasing physical activity and reducing tobacco use embedded in Deadly Choices. These factors help ensure that Deadly Choices remains strategically aligned with Australian and Queensland Governments’ chronic disease and Indigenous health strategies (IUIH, 2013c).

As the opening quote to this section indicates, Deadly Choices is based on a principle of empowerment (IUIH, 2014c), involving a suite of programs, activities and events that work together to create a “Deadly Choices” community. The Deadly Choices Education Program is delivered for Indigenous children, young people and adults, in high schools and primary schools, a detention centre and AMS-based men’s groups. The structure of

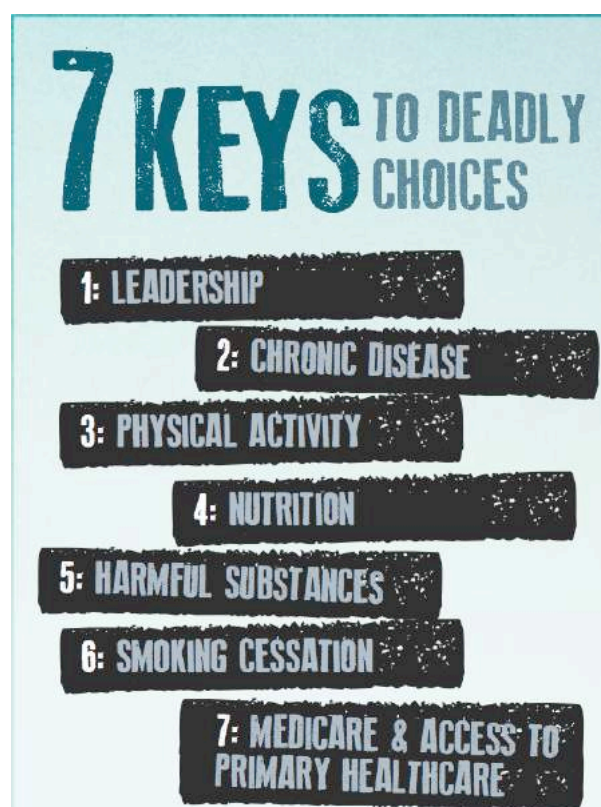


Figure 11: Seven session topics of the Deadly Choices program (IUIH, 2014).

¹¹⁵ It is likely this framework will be reformed due to the abolishment of Australian National Preventative Health Agency (ANPHA), with its website and services closed as of 30 June 2014 (URL: <http://anpha.gov.au/internet/anpha/publishing.nsf> Accessed 27/08/2014).

¹¹⁶ The Queensland Government approach is, however, undergoing a shift after recently experiencing “the greatest dismantling of public and preventative health services in recent Australian history” (Sweet, 2012).

the Education Program involves seven lesson topics: leadership; chronic disease; physical activity; nutrition; harmful substances; smoking cessation; and Medicare and access to primary healthcare (see Figure 11). Lesson plans provide a flexible format for Deadly Choices practitioners to deliver each session, which are generally conducted on a weekly basis over an approximate period of seven weeks in line with the school term. Participating students are provided with a workbook, in which to document their learnings and goals arising from each session. Each session involves an education component followed by a 30-45 minute session of physical activity, all facilitated by the Deadly Choices practitioner.

At the conclusion of the Deadly Choices term, the students undertake a health check, usually on the school premises inside the mobile Deadly Choices medical van with local AMS clinical staff. For students that participate in all seven Deadly Choices sessions and complete a health check, Deadly Choices rewards them with the exceptionally popular Deadly Choices merchandise (discussed below). Bringing the health checks to the schools, where students are based, is a strategic action for urgently enhancing access to health care.¹¹⁷ Plausibly, by promoting health checks through the health education program, competitions and merchandise (for example Figure 12), Deadly Choices encourages, legitimises and normalises Indigenous people's access to appropriate health care – which is low compared to other Australians (AIHW, 2008;2013).

The Deadly Choices Education Program is expanding rapidly. For the 2012-13 financial year, Deadly Choices reported operating in 28 high schools and eight primary schools (IUIH, 2013c), a dramatic increase from the three schools and detention centre reported for 2010 (Fletcher, 2012). The growth led to IUIH's development of a policy and procedures manual to guide the continued rollout and delivery of Deadly Choices. With a focus on building into the future, the policies and procedures manual includes a process of extended consultation with potential program hosts prior to program commencement (IUIH, 2014f).

¹¹⁷ Health checks for students of Deadly Choices would take place with the consent of the students' guardians or parents.



Figure 12: Deadly Choices team (Deadly Choices, 2014g).

Deadly Choices also delivers Good Quick Tukka (GQT), which involves education and demonstration of healthy cooking and nutrition. Developed by the Queensland Aboriginal and Islander Health Council (QAIHC) and based on the principles of Jamie Oliver's Ministry of Food, the Deadly Choices practitioners running GQT teach community members how to prepare healthy affordable meals in a short amount of time, at the invitation of the hosting agency (for example, Figure 13).¹¹⁸ Deadly Choices supports AMSs to integrate GQT into their work with clients, by training two to four staff at each participating clinic in GQT facilitation and donating a GQT kit with all cooking equipment and a facilitator manual (QAIHC, 2011). Deadly Choices also implement GQT at community events, festivals and on occasion staff training to provide catering while simultaneously teaching the skills of cooking and exposing people to GQT.

¹¹⁸ AMSs in South East Queensland have the option to participate in and deliver GQT with the support of Deadly Choices.



Figure 13: A Deadly Choices practitioner teaches some community members a Good Quick Tukka recipe.

In addition to GQT and its Education Program, Deadly Choices involves “tobacco action” activities, which appear to link back to CTG priorities (IUIH, 2011a;2014c). The tobacco practitioners describe their work as comprising three thematic areas: prevention; early intervention and treatment; and health promotion. The Deadly Choices “smoke-free workforce” undertakes a range of projects to reduce tobacco use, including supporting people to quit smoking during pregnancy, workforce training through the Mind Body Spirit package developed by the team, research (e.g., Ford et al., 2013) and education (IUIH, 2011a). A health promotion settings approach is evident in the tobacco activities (Chu et al., 2000; Dooris, 2006; Whitelaw et al., 2001), as illustrated in Deadly Choices’ development and delivery of the Murri Places, Smoke-free Spaces program (MPSS) for smoke-free workplaces (Figure 14). Deadly Choices delivers MPSS in 12 AMSs, two peak bodies and five other Indigenous community organisations in 2012-13 (IUIH, 2013c). Likewise, the Deadly Choices team developed Say No to the Smokes (SNTTS), a 6-week smoking cessation program delivered in a number of organisations and more recently piloted with young people through the Deadly Choices Education Program. Additionally, Deadly Choices practitioners train health and community workers to deliver SNTTS through their own work with community. Alongside these activities, the team works with a select number of AMSs to

establish and operate Smoke-free Wellness Clinics in the region, believed by the practitioners to be the first Indigenous clinics of their kind in Queensland.



Figure 14: A Deadly Choices practitioner stands with a sign as part of the MPSS package.

For all its synergy with mainstream frameworks and agendas, Deadly Choices comprises components that set it apart. For example, in the session topics outlined in Figure 11, leadership is positioned as the foundational session, above all other issues common to health promotion such as chronic disease and the holy trinity¹¹⁹. Deadly Choices positions leadership as a resource for health, promoting itself as a comprehensive health promotion program and campaign that “...build(s) strong *leaders* among Aboriginal and Torres Strait Islander communities to encourage healthy lifestyles and create a healthy future for Indigenous people” (IUIH, 2010a; italics mine).

¹¹⁹ As introduced in Chapter Two, the holy trinity refers to substance use (alcohol, tobacco and other drugs), physical activity and nutrition.

The emphasis upon leadership is indicative of its importance to the Deadly Choices health promotion approach, as well as a point of departure for Deadly Choices from mainstream health promotion approaches (discussed in Chapter Six).

All of the described Deadly Choices programs and activities, which occur online and offline, are interconnected. “Borrowing” of staff and program content commonly occurs between Deadly Choices portfolios, and practitioners attend the sessions of other practitioners regularly. For example, Tobacco Action Workers might attend the tobacco session of colleague’s Deadly Choices Education Program, while Deadly Choices Program Officers share their knowledge and local networks. These activities do not appear to operate in silos, but rather work to enhance their work in a holistic way.

At first, I observed staff attendance across sessions as part of the induction and orientation process for new Deadly Choices staff. For example, longer-standing staff attended the Deadly Choices Education Program sessions delivered by new staff that were undergoing training in Deadly Choices. Doing so was an act of support for the new staff, to share or lead the session delivery. Staff cross-fertilisation continues in other ways and management encourages staff to develop skill sets in each other’s program areas. Ethan explained the philosophy behind the staff “cross-fertilisation” at a team meeting:

We have to work as a team so that anyone can step in for someone else in the team if we need them to. Hunter should be able to cover David’s area if he’s away. You should all know how to do GQT to deliver that too. GQT is fun and good for engagement of the community. (Field notes, 14/03/2013)

By the end of that particular year, all team members had participated in GQT and completed Food and Hygiene Standards training to ensure they could deliver GQT. Furthermore, a process had been established to “book” staff with a particular skill or knowledge set, such as tobacco specialist knowledge or celebrity status associated with a sporting career, to make guest appearances in their programs. This process complements the team practice of working together to deliver programs, where typically a minimum of two staff members would attend most activities. The team, including its manager, reiterate this team-oriented approach regularly and continue to encourage each other to expand their program repertoire.

“Just bringing that community spirit” through Deadly Choices community events

Family fun days, community days, and sports days frequent the Deadly Choices schedule and provide a major platform for the Deadly Choices practitioners to engage with the community. These events are fun and family-oriented, involving sporting, cultural and nutritional activities to engage the community and raise their awareness regarding chronic disease, nutrition, physical activity and tobacco (for example, see flier in Figure 15). Partnering AMSs co-facilitate these days with Deadly Choices and typically provide health checks on site for community. Attendance has varied over the years and appears to be steadily increasing, with attendance of 100 people on some days, compared to 600 on others. Deadly Choices also provide lunch (often Kup Murri¹²⁰) for attendees.



Figure 15: Deadly Choices creates posters to promote upcoming community days, which are shared through social media.

¹²⁰ Kup Murri is Torres Strait Islander name for the method of cooking food in an underground oven, using heated stones and sand and soil to cook the food.

As one person posted in Figure 21 below, these days are about “good clean family fun”. The community events typically involve family entertainment including face painting, jumping castle, rock climbing, arts and craft and cultural activities. Additionally, physical activity “stations” are included from a selection of Zumba, Australian Football League (AFL) or rugby league drills – often with competitions held throughout the day to encourage people to play and dance. Deadly Choices uses a marquee to help structure its health education and interaction with the community. People commence on one side of the marquee and travel through by visiting education stations inside, and exit on the marquee’s other side. Stations are typically based around chronic disease prevention, tobacco reduction and nutrition. However, some community days are themed and when this is the case, stations are designed according to that theme.

In comparison, sports days are based around a specific sport, such as netball, cricket or OzTag, in partnership with a community organisation. In these cases, people are required to undergo a health check before participating in the sport; some days, such as the Men’s Cricket Day, include sexual health checks as well. Throughout the day, in between their rostered games, people participate in Deadly Choices education sessions. Once the games are completed, lunch is provided.

These community events “...signify many things for Indigenous people. They demonstrate solidarity among Indigenous people, but also project strength and pride to the wider population” (Brough et al., 2004, p. 218). And this appears to be the case with Deadly Choices. The community events are important not only for the health promotion agenda, but for the broader community agenda. One practitioner explained this when showing me a photo he took for his participant diary. He took this photo of a moment of which he was proud at a community day. His description explained that community days provide a positive reason for the community to come together:

What this photo means to me of the (*family name*) family: they had right from their grandchildren to their grandparents playing, and their mothers and fathers, nephews and nieces, younger cousins. And that’s what the day’s about: it’s about bringing the family together, in a positive environment, playing a sport, mingling with the rest of your community, just bringing that community spirit, because... the only time the whole community gets together is negative times, like funerals. So this is what I try and do is promote community days where people are getting active and

learning about health... and nutrition. This is what I try and promote.
(Interview, 22/11/2012)

“Urban is the new black”: Deadly Choices as a way of life

The activities of Deadly Choices are not the only drawcard for community involvement where the brand of the Deadly Choices social marketing campaign – its identifying mark – is conceivably what powers Deadly Choices’ popularity. The Deadly Choices slogan, “Urban is the new black” alludes to the brand’s emphasis upon positivity and positioning of urban Indigenous identity as “cool”, inclusive and healthy. To say “the new black” is to imply a new fad or trend of the moment, a term that originated in the fashion industry where black is arguably always in style. Thus, to say that something is “the new black” is to position it as ‘cool’ and fashionable. Therefore, to say “urban is the new black” is to declare that urban-dwelling is “in”. Similarly, the maroon colours used throughout the merchandise affirms its connection to the Brisbane Broncos, thereby maintaining a link to urban dwelling in SEQ specifically (for example, Figure 16).¹²¹



Figure 16: "Urban is the new black" is written on the back of Deadly Choices merchandise (Deadly Choices, 2014g).

¹²¹ Special edition merchandise is also released to mark particular events, people and issues including Torres Strait Islander colours, sports stars, breast cancer awareness and many more.

The brand is part of the Deadly Choices social marketing campaign involving positive messages and images to address “social abnorms”¹²² within Indigenous communities, in order:

...to empower Indigenous peoples to make healthy lifestyle choices and to be healthy role models and positive mentors for family, friends and broader community networks. (IUIH, 2013d, p. 78)

The power of the Deadly Choices brand is also evidenced by the fact that it can be purchased, for example by AMSs and Indigenous organisations. However, community members must still earn the merchandise; the merchandise itself cannot be purchased. A number of AMSs and other agencies had purchased the brand licence to deliver Deadly Choices in their own regions at the time of fieldwork. A purchaser of this licence is granted the following:

- Deadly Choices program, program materials and training
- Brand and marketing materials (for example, community days, or campaign materials)
- A locally tailored Deadly Choices shirt
- Access to branded merchandise.

As part of their social marketing campaign, Deadly Choices released a series of radio commercials, print and social media, as well as television commercials (TVCs) which have since been made available on Deadly Choices TV and the Brisbane Broncos website). These products feature Deadly Choices ambassadors and prominent local community leaders¹²³ (IUIH, 2014a), including Deadly Choices staff. Various health messages are conveyed through these media items. A holistic concept of health underpins these messages, affirming that being Indigenous means being proud and healthy, connected and belonging. In doing so, these media sources affirm Indigenous values. Take for example the posters in Figure 17 and Figure 18, which portray the value of family relationships as part of being healthy and well. The narrative inscribed on these posters is from the poster stars themselves, rather than an outside health promotion professional. This is a standard approach by Deadly Choices, which features

¹²² IUIH refers to social abnorms as having “developed within Indigenous communities around high smoking rates, poor nutrition and sedentary lifestyles” (IUIH, 2013d, p. 79).

¹²³ Chapter Six discusses the involvement of ambassadors and use of leadership in Deadly Choices.

people of the community – “real” people – as role models, for making their deadly choice.



Figure 17: Poster of a man whose deadly choice was not to smoke to be around his family.



Figure 18: A pregnant woman starring in an earlier television commercial. The narrative imprinted on this image for the Deadly Choices poster was that of the mother.

Compare Figure 18 to the recent National Health Service anti-smoking campaign imagery, which positioned pregnant mothers as harming their baby (Figure 19). The

condemning narrative in Figure 19 implies an assumption that the mother's smoking behaviour is irrational and amenable to persuasion through provision of information. The imagery is darkened to highlight the smoke exhaled through the mother's belly button against a stark background; the mother is voiceless and distant, viewed from the side as an undesirable Other (Hall, 1996; Young, 2001). Figure 19's underpinning message is that the mother is disgusting (Lupton, 2014b) and solely responsible for harming her baby.



Figure 19: Image from the National Health Service 2013 anti-smoking campaign (Virtual Genetics Education Centre, n.d.).

Compare the tone of the message in Figure 19 to that in Figure 18. Distinctively, although Figure 18 also locates the mother as responsible for her baby's health, she is portrayed in a positive manner, as being healthy and as having choice. The mother in Figure 18 is viewed front on, establishing a personal connection between her and the viewer in respect of the mother's agency and promoting a narrative of choice, rather than compliance. What's more, she is a member of the Deadly Choices community, whose voice and face is familiar to the Deadly Choices community. This poster's approach demonstrates Deadly Choices' profiling of the community as health promoters themselves.

Humour also performs a powerful role in the Deadly Choices brand, and enables centring Indigenous voices. Take for example the TVC starring ambassadors Sam

Thaiday, Scott Prince¹²⁴ and Steve Renouf¹²⁵, as well as a local respected health worker, Gordon Langton (Figure 20). The TVC begins with these stars stretching on the football field, while their coach walks next to them towards the camera, asking, “Which one of these professional rugby league players has not followed through with their Deadly Choices in the last 6 months?” Thaiday slowly points towards Renouf who retorts, “Really?” and after the group concurs, he walks away, frowning. As Renouf does this, we see Langton also pointing to Renouf. The humour of the situation is that it could very well have been Langton who was pointed out, being the one player not sporting an athlete’s body, nor a professional rugby player. Fuelling the humour of the situation, the coach calls out, “Gordy, looking good, brother”, who appears quite pleased with himself. The TVC ends with Thaiday and Prince walking together, joking about Renouf needing to wear headgear and that he should have known better.



Figure 20: Deadly Choices commercial #2 (Deadly Choices, 2013b).

The humour of the TVC is facilitated by the known relationships and community roles of the TVC stars. Langton is known amongst the SEQ Indigenous community as a health worker, rather than as a professional footballer as the other TVCs stars are known. This TVC plays on the standing of these stars in a light-hearted way to bring a

¹²⁴ Scott Prince is an Aboriginal man from the Kalkadoon tribe in the Mount Isa region and a recently (2013) retired professional rugby league player.

¹²⁵ Steve Renouf, also known as “The Pearl”, is an Aboriginal man and a former professional rugby league player with the Brisbane Broncos. Renouf was diagnosed with Type 1 diabetes at the age of 23 years.

health message to its chosen audience. Because of the community standing of the TVC stars, this TVC is able to carry a deeper message than what may be apparent at surface level. In a clip produced by Bush TV for the Australian Government, one Deadly Choices practitioner discussed the meaning of this particular TVC, saying:

Being in South East Queensland, we use sport as a vehicle and our number one sport is rugby league. So having Sammy Thaiday and some of the Under 20s boys and Scotty Prince in that ad, with Uncle Gordon, is just hilarious. Our people, we have a laugh, we joke, and that's what the ad's about. It's about being healthy, eating right and it's got that little spin on it as well. And to see Steve Renouf there as well, I can't wait to see the reaction of our community on it; it's just going to work. (Deadly Choices practitioner, Bush TV interview)¹²⁶

As this worker implied, this clip is as much about having fun as it is positive messaging regarding health. Humour has been a central element to the TVC's success. The TVC's context shows that the stories that build the Deadly Choices brand – even through its public TVCs – are personal. It is the personal that enables humour to be a tool for Deadly Choices to cover these issues sensitively. For example, perhaps unbeknownst to some viewers of the TVC above (particularly those outside of the SEQ Indigenous community), Gordon Langton had experienced a major life change as a result of his deadly choice.

Aboriginal health means more than just physical wellbeing. Its emotional wellbeing, everything connected to your family. So Closing the Gap, it does affect the whole family. We need the whole family's input to close that gap... For me it's a personal journey. People look at me now and see my physical stature but don't realise that in the past 18 months I have lost 18 kilograms. (Langton, Bush TV interview)¹²⁷

Beneath the humour of the TVC is a health message that is personal and empowering, using language and culture that has meaning for the Indigenous community of SEQ. The humour in these commercials contributes to making these TVCs culturally appropriate and somewhat an “insider joke”. Deadly Choices is not about attaining perfect health but instead, making better choices; and this is achievable for everyone, where anyone can be a leader. In this way, Indigenous humour enables Deadly Choices

¹²⁶ URL: https://www.youtube.com/watch?feature=player_embedded&v=7IEHYzEpqCU (Accessed 23/09/2014).

¹²⁷ URL: https://www.youtube.com/watch?feature=player_embedded&v=7IEHYzEpqCU (Accessed 23/09/2014).

to bring health into focus while cementing Deadly Choices as a brand to which Indigenous people personally connect.

Deadly Choices considers itself to be Australia's strongest Indigenous-created brand (IUIH, 2014h) – and the community response I observed would support this. I viewed people talking about Deadly Choices in many forums, online and offline, and connecting with the brand in their own ways. Take for example a Facebook conversation regarding an upcoming Deadly Choices community day (Figure 21). This conversation was in response to a video Deadly Choices had uploaded to showcase the prizes for the community day: Deadly Choices merchandise. People's comments here are like many others I have seen that exude positive anticipation of the event, and affirmation of the value of the merchandise – for example, “Deadly I’m going”, “Great stuff deadly choices. We’ll be there. Our community will luv the new hoodies and other wonderful prizes. See you Saturday” and “I’m going with my 7yr old and my 69yrs old mum should be good clean family fun ☺”. The photo posted at the conclusion of the conversation displays the winner of the merchandise on the day and reveals the pride people portray in being associated with Deadly Choices and having “earned” the merchandise.

I also observed that the Deadly Choices brand has infiltrated everyday language. Adults and youth alike would say, “That's not a deadly choice”, jokingly, but still meaning to hold each other accountable regarding behaviours and attitudes. I observed the Deadly Choices practitioners practice this behaviour with each other. This is notable because the practitioners themselves adhere to and reinforce the brand and despite being health promotion practitioners, generally do not employ the language of the Ottawa Charter and its associated discourse. The Deadly Choices community and practitioners alike use Aboriginal English in everyday language. Members of the Deadly Choices community know the meaning behind, “That’s not a Deadly Choice”. Through language, an inclusive Indigenous space exists, where people live and experience Deadly Choices as a way of life, performed in their everyday language and behaviours.



Figure 21: Deadly Choices posted a video on Facebook to showcase the prizes for an upcoming Community Day. In response, community members posted regarding the merchandise and their anticipation of the day (Deadly Choices, 2014i).

Deadly Choices merchandise: “A walking billboard”

The Deadly Choices brand has evolved over time, through IUIH’s strategy to incorporate and build upon what the community like and want. The first Deadly Choices jersey was designed at the request of the community for a football game, incorporating a logo with which the community could identify. The Deadly Choices practitioners continue to endeavour to keep the merchandise relevant and representative

of what community members want and associate with. However, Deadly Choices maintains that education must accompany the shirt; thus, if people wear it, most likely they have been involved with and “educated” through Deadly Choices in some way. For example, the students in Figure 22 had just completed their education program and displayed their new Deadly Choices jerseys awarded to them. As one practitioner described, the jerseys are “a walking billboard”, where its wearers are “proud, been educated and feeling empowered”:



Figure 22: After completing a term of the Deadly Choices Education Program, shirts were awarded to the students, as posted on Facebook: “Here are a few photos sent in by Deadly Choices Community Engagement Officer, the students from (*local*) SHS were over the moon to receive their DC school shirts” (Deadly Choices, 2014g).

Ethan explained that they always keep their merchandise current - they have 2013 on this year's jerseys, will have 2014 on next year's, and they have themes, like The Monster (Jessie Williams)¹²⁸ jerseys, pink jerseys for breast cancer, and they've moved on from the collared shirts. Steven added that now there are "shirts for babies" (in reference to shirts sizes for small children). The discussion gave me the impression that the

¹²⁸ Jessie Williams is the first Indigenous Australian to receive a scholarship to play college football in the United States of America.

practitioners were proud to see the kids participating in community day events with their jerseys on.

Ethan continued, “One challenge is that because people can get their Deadly Choices shirts by getting a health check at participating AMS people can get the jersey without even knowing what Deadly Choices is about, so they can be easily seen in their shirts doing things Deadly Choices aren’t about”.

In other words, such individuals could participate in “undesirable acts” while wearing the Deadly Choices gear.

“But,” Ethan said, “There is a flow-on effect - last year we had 4000 shirts, this year 6000 and that's excluding all the special ones. So this many people had health checks and were exposed in some way to Deadly Choices, which will start them thinking and learning about their choices. But what this shows is that the brand needs the education that goes with the Deadly Choices shirts.” (Field notes, 14/10/2013)

As Ethan explained, the Deadly Choices merchandise is associated with the rapidly increasing community following and performance of the Deadly Choices brand. The merchandise provided a tangible means by which the community could choose to identify with Deadly Choices and the strong and healthy Indigenous identity it promoted. As an indication of the potency of the Deadly Choices brand, consider the way people aspired to own and wear the Deadly Choices merchandise. In my fieldwork I observed community members wait in long queues and participate in a range of activities in order to be awarded their Deadly Choices jersey. People sought the Deadly Choices shirts frequently and I heard the Deadly Choices practitioners admit a number of times to being asked by a community member for a shirt. In fact, I encountered this myself when I wore the Deadly Choices jersey in fieldwork (for example, as a uniform at community days) where people frequently asked me how to get their own shirt, some even offering me money for mine.

Typically, the enquiry would begin with the somewhat innocent question (online and/or offline) by community members of Deadly Choices: “How do I get a hoodie?” or “How do I get a shirt?” Deadly Choices practitioners would then explain to the inquirers that people could obtain a shirt by making deadly choices, for example: “...you actually can’t buy them, the only way you can receive one is if you completed a full 715 health check at one of our local Aboriginal medical centres” (Figure 23). These initial

interactions position the merchandise as an integral part of the Deadly Choices brand formation regarding leadership and making deadly choices that are to be rewarded.



Figure 23: Community member posting on Deadly Choices Facebook page requesting the purchase of Deadly Choices merchandise (Deadly Choices Facebook page, 18 July 2013).

To obtain their own shirt, people would access social media, some becoming repeat visitors. Consider one community member whose motivation to post on social media was to win the merchandise. Their first connection with Deadly Choices began online on the Deadly Choices Facebook page in April 2013 (field notes, 07/09/2013). Here, this member sought to obtain a Deadly Choices hoodie. However, because these hoodies are not sold, Deadly Choices encouraged this community member to pursue alternative means to obtain one, by entering the Deadly Choices social media competitions or participating in their programs (Figure 24).

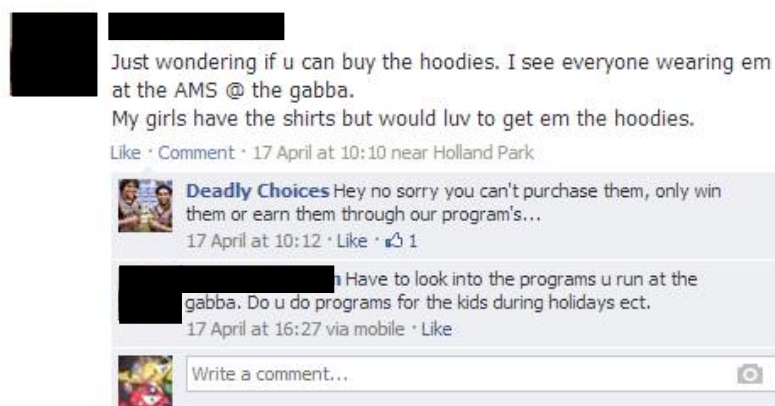


Figure 24: A community member enquires about obtaining a Deadly Choices hoodie and soon becomes an active member online (Deadly Choices Facebook page, 17 April 2013).

Immediately following this interaction – on the same day – this social media user posted their entry into the Deadly Choices Facebook competition, for which the prize was a hoodie (Figure 25). Their post displayed their deadly choice, which in this case entailed walking, swimming, bike riding, trampolining, and tennis with their cat – in other words, family time. The user indicated there were too many choices that would affect their kids so they could not choose only one. The sophisticated nature of community constructions of health is evident in this post, which was not simply a “snap” of a healthy meal with the hash tag #deadlychoices. Rather, Indigenous understandings of health were evident as “not just the physical well-being of the individual but the social, emotional, and the cultural well-being of the whole community” (National Aboriginal Health Strategy Working Party, 1989, p. x).

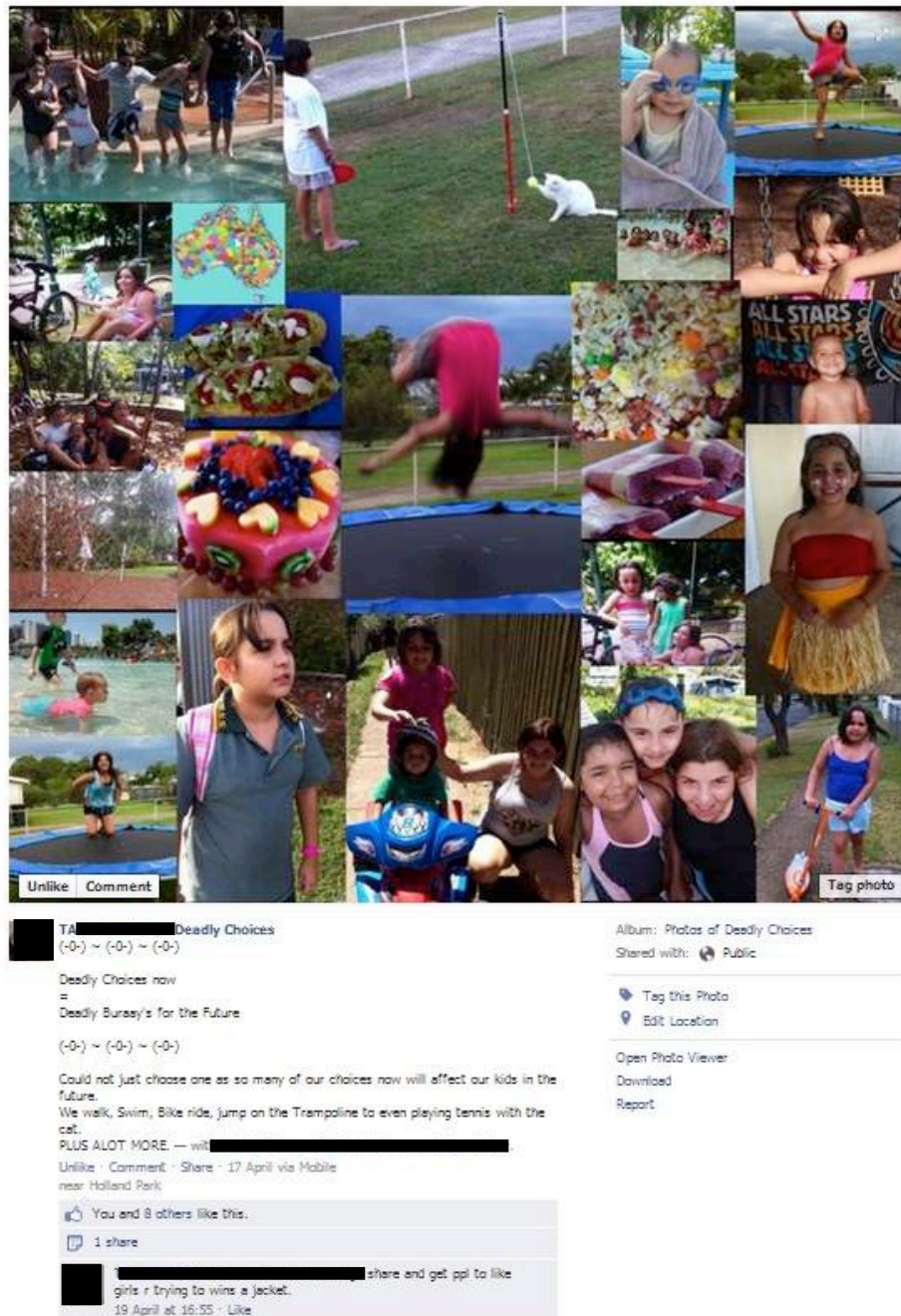


Figure 25: A community member posts their entry for a Deadly Choices Facebook competition (Name withheld for confidentiality purposes, 2013b).

This social media user's post did not win them the coveted prize. However, they became a repeat visitor. Their next post was aimed again to win the hoodie as a prize, by promoting what was important to her for making a deadly choice: her family (Figure 26). Over time, it appeared that the incentive of winning a prize had become secondary for this user, who posted again unsolicited when there was no competition to enter. As an example, refer to their post to profile their daughters' deadly choice to dance (Figure 27).

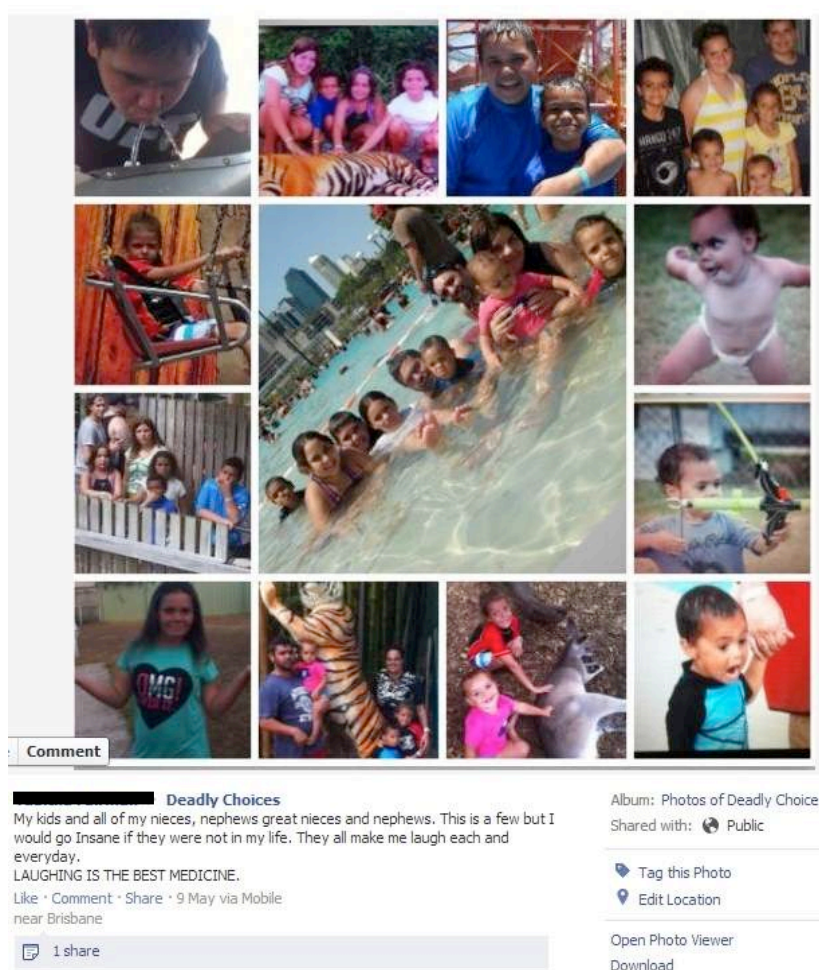


Figure 26: The second repost by this social media user, again about her family (Name withheld for confidentiality purposes, 2013e).

The pattern of this social media user's posts demonstrates the way Deadly Choices merchandise provides an entry point for an ongoing relationship with Deadly Choices. For this user, the merchandise was her reason for initial engagement. Deadly Choices affirmed her initial interactions and the value of Deadly Choices merchandise as something to earn, while offering another level of engagement for her to pursue. Despite not winning the merchandise, this user became a repeat visitor to Deadly Choices on social media. Perhaps it was the celebratory nature of Deadly Choices that enticed her to continue posting – Deadly Choices (and other online members) profiled and applauded this user's positive choices and "shared" her posts for Deadly Choices followers to see. These affirming online interactions are a regular characteristic in Deadly Choices social media, where community members themselves define what a deadly choice is and what health means to them, while Deadly Choices listen, affirm and promote those choices.

In this way, as people go about posting and sharing their deadly choices, they themselves are positioned as “health promoters”.

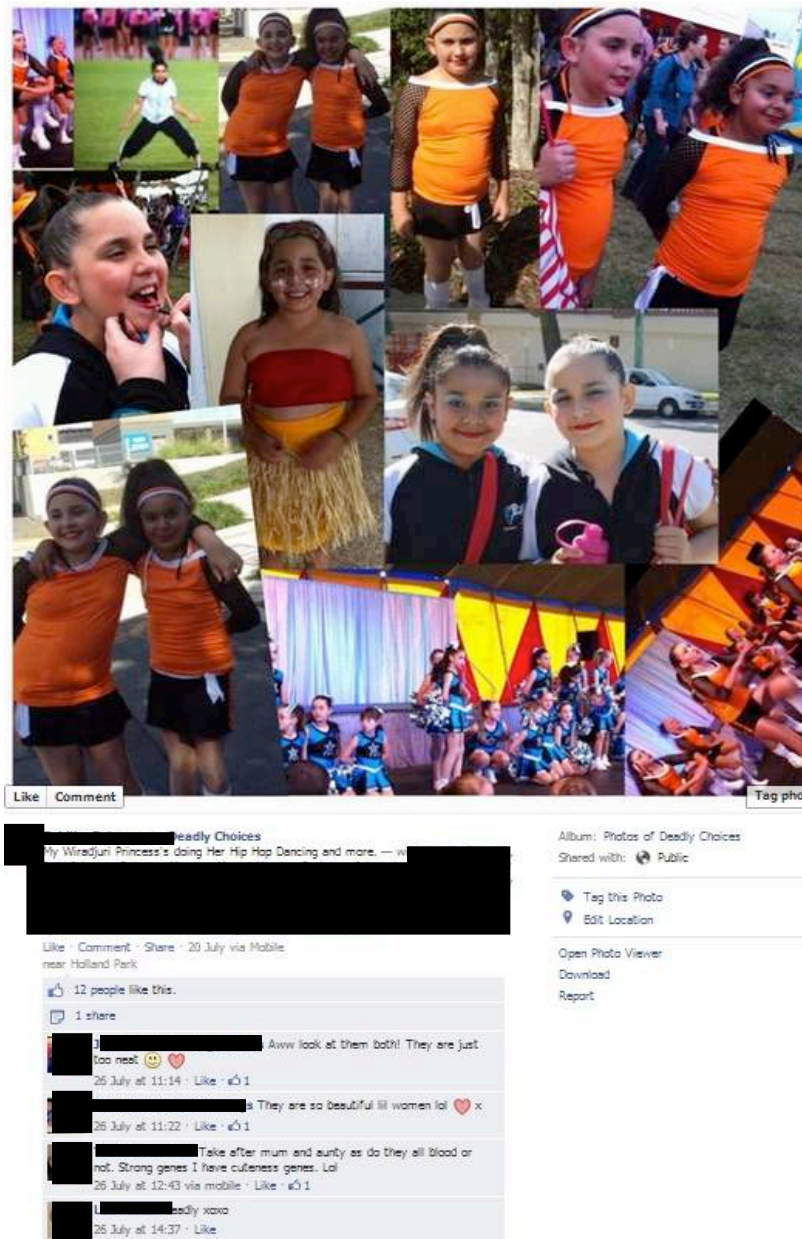


Figure 27: A repeat visitor on Deadly Choices Facebook page posts another of her deadly choices (Name withheld for confidentiality purposes, 2013f).

The example above exhibits the community buy-in of the Deadly Choices brand; to be associated with Deadly Choices is something to be proud of, as is having an Indigenous identity. Perhaps this is because the merchandise is clearly about more than a health promotion message. With the slogan, “Urban is the new black” (discussed above), and other identifying factors, such as Aboriginal and Torres Strait Islander flags, this

merchandise represents cultural strength and vitality, as being synonymous with urban Indigenous identity (see Figure 28). Thus, when engaged in Deadly Choices, Indigenous people and communities are repositioned from mainstream labels of deficit, to that of leaders and health promoters.



Figure 28: A Deadly Choices Facebook competition will award a “hoodie” as the prize (Deadly Choices, 2013h).

Partnerships and sport: “We use sport as a vehicle”

As stated in Chapter One, many of the Deadly Choices practitioners have a sporting background, some professional. Sport is strategically incorporated into the Deadly Choices Education Program and a range of activities, such as community events and sports days, and arguably into the Deadly Choices staff recruitment strategy. Sporting activities include netball, touch football, golf, Traditional Indigenous Games (TIG), OzTag and the Queensland Murri Carnival¹²⁹. Rugby league is the major sport in the work of Deadly Choices, which is amplified through a formal partnership with the Brisbane Broncos (see Figure 29). This partnership allows for the use of the Brisbane

¹²⁹ Sponsored by Deadly Choices, the Queensland Murri Carnival (QMC) is reported to be “much more than a rugby league event”, where players must undergo a health check and enroll to vote or ensure their voting enrolment details are current (Murri Rugby League, 2014).

Broncos logo on merchandise and material as well as involving a number of Broncos players as Deadly Choices ambassadors. Additionally, the Deadly Choices Schools Program and Brisbane Broncos Mentoring program work together to provide Indigenous students in Year 12 with support to complete their studies, and transition into further study, training or employment. Rewards are arranged through this partnership that provide community members with “an experience to remember”, such as tickets to a Broncos game, interviews with players at schools, training with the Broncos team or running onto the field with the players to open home games (see Figure 30). Deadly Choices also partners with other football clubs outside of SEQ, such as the Geelong Cats. High profile Indigenous players from the partner clubs and more recently, other sports including basketball, boxing and National Football League are involved as Deadly Choices Ambassadors (discussed in Chapter Six), which further strengthen the Deadly Choices brand.

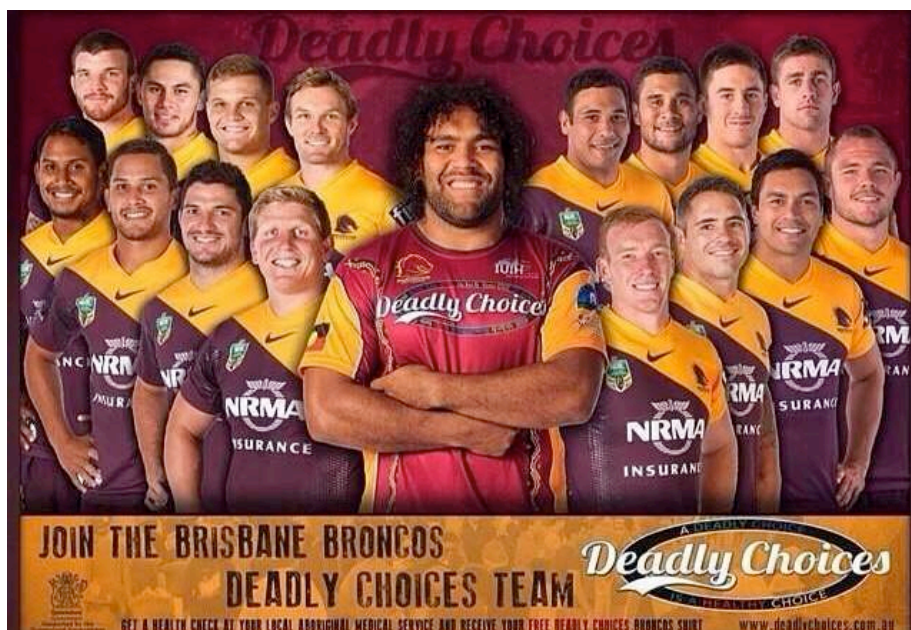


Figure 29: A partnership with Brisbane Broncos contributes to the shaping of the ever-evolving Deadly Choices brand (Deadly Choices, 2014e).



Figure 30: Deadly Choices students that completed the Deadly Choices Education Program were rewarded with the opportunity to run onto the field with one of the two NRL teams to open a home Broncos game (Deadly Choices, 2014g).

Deadly Choices employs the use of “sport as a vehicle” for its practice with community. The importance of sport for engaging with the community is revealed in the participant diary of a Deadly Choices practitioner, who took photos of important moments for them at an OzTag Day, conducted by Deadly Choices in partnership with an AMS. As this diary entry shows, sport enables the Deadly Choices agenda to traverse a health promotion agenda of community connections and identity, where merchandise is a reward and signifier of belonging, partnership with health services, health checks and building relationships.

My first photo was (*workers’ names*) and some of the guys giving out the shirts (Figure 31) and I was actually on the mic at that stage... I had to call out different teams to go over there and line up to get their shirts... once they got over there, they were so happy to get the shirt and I think its because... they all knew what we stood for, and we were all wearing our shirts. So it sort of had that really good effect on the kids and with all of our guys picking up the kids in the morning we had all the kids looking up to us from the start. I think it was really important that the guys were really interactive with the kids, not just refereeing but also talking to them on the side, helping them out with lunch... it was good that they had someone to look up to and even though we only just met them on the day, I think it was good for them to see a Black face as well and have a yarn to us as well. That was our first photo and that line went back and they were just so eager to get their shirts, which was great.



Figure 31: School Oztag Day (photo courtesy of IUIH participant diary).

And this is a photo with (*worker's name*) (Figure 32). This young girl, she was just over the moon that she could get a shirt. I think its great that with the shirts, you got the Aboriginal and Torres Strait Islander flags on them as well, it gives them a bit of an identity as well and they're just really happy and really proud to wear the shirt... its a good feeling for us as well to see these kids wearing them and trying to get the same values out that we're trying to push as well... and the medical van in the background they did such a good job, they had an influx of kids at different times and got through em, so they were really, really happy. They were doing all the health screens...



Figure 32: A Deadly Choices practitioner with a student who had just participated in the Deadly Choices Oztag Day (photo courtesy of IUIH participant diary).

So that's just another photo (Figure 33)... They're ladies from (*local AMS*), the health service. So they came with the van and did all the health checks. They wear Deadly Choices shirts at the clinics as well, so they helped out...



Figure 33: Deadly Choices team work with the local AMS to run the Oztag Day (photo courtesy of IUIH participant diary entry).

This photo was of everyone pretty much Figure 34. Ah, some of the kids... the (*school name*) kids, they were one of the last to go through when our

sizing was sorted out, so they weren't able to get a shirt. But I just explained to them we'll get your sizes, we'll order them and get more this year and if not, organise it for next year... the good thing about it is that I think a couple years ago I think you would have had a lot of kids say, "Nah, that's crap", but you know, they saw that we are putting on this day for them and we did a lot for them as well. And I think I had that trust with them that I'm not going to lie to them, and they could see that, and I think was really good. And so we had a lot of trust there already and you could see they sort of, believed me, so.



Figure 34: OzTag Day school participants (photo courtesy of UIIH participant diary).

As this participant diary entry reveals, sport is a significant medium for Deadly Choices health promotion. In this case, an Oztag Day enabled deeper, relationship and identity work where the Deadly Choices practitioners could build trust with the participants involved. The positive relationship-based emphasis of the day amalgamated Indigenous perspectives, which were supported by the Deadly Choices merchandise and enabled the creation of an inclusive community and strong identity. This story is indicative of the interaction between Deadly Choices and the community: people want to associate with Deadly Choices in tangible ways and Deadly Choices makes this possible by providing a positive experience for the community.

While in many ways advantageous to the Deadly Choices agenda, the use of sport for community engagement is not a straightforward endeavour. While sport may successfully engage a broader group, it may do so at the exclusion of others. This exclusion may be influenced by various factors including gender, sexuality, race, ethnicity, social class or disability (Godwell, 2000; Macdonald, Pang, Knez, Nelson, & McCuaig, 2012; Ware & Meredith, 2013). An illustration of the way Deadly Choices

practitioners negotiate the tension of using sport to include people, while potentially excluding others, is their broadening of the variety of sports used and incorporation of sporting drills and games to increase the ease of participation for people. The intention behind Deadly Choices' use of sport is to embed Indigenous values, interaction, engagement and participation, as opposed to 'spotting talent' or building elite athletes.

The role of sport is such that session delivery is tailored to the specific group each time it is utilised. An example of this is found in a session Jolene, a Deadly Choices practitioner, conducted, and specifically her interactions with her Deadly Choices Education Program students (Field notes, 24/05/2013). After delivering the classroom education component of a session one day, Jolene directed the class to head towards the field where we were to play football, the planned physical activity for that day's session. As we walked, the students asked if we could play basketball instead, to which Jolene agreed and altered her plans. Jolene was carrying a sports bag full of equipment for a range of sports and games, so could easily accommodate this request. Once we arrived at the basketball courts, Jolene organised the class to play basketball-inspired games. Zac, one of the students, was experiencing shin problems and could not join in those games, so he and I began shooting hoops with another student, Kevin. Soon Jolene brought everyone together to play a modified, socially-oriented basketball game of "three on three" or "four on four", girls against boys, with certain rules that enabled everyone to play. The students appeared to enjoy this time playing together as I did; while we played we all chatted, laughing and smiling, and students shared about what was happening in their lives.

As this example shows, Deadly Choices uses sport as a vehicle not only to provide opportunities for physical activity, but to strengthen relationships and cultural networks, which has important physical and social health benefits (Clinch, 2010; Nelson, 2009). These health benefits are tangible for IUIH and its use of sport. IUIH found the Broncos Partnership to be "a key plank" in the Deadly Choices social marketing success, directly resulting in students completing the Deadly Choices School Education Program and an expanded range of Deadly Choices and Broncos branded merchandise (IUIH, 2014d). In fact, as a result of using the merchandise as incentives for completing health checks, the number of health checks increased 33% in between financial years ending 2014-2015. Deadly Choices shows us that by adapting health promotion activities such as sport, to

strengthen relationships and cultural networks, community engagement with the health promotion agenda can be elevated.

Community promotion and an agenda of choice

Deadly Choices provides an example of the way contested spaces can be approached through negotiated interaction (Nakata, 2007b), in which the community defines the meaning of “being healthy”, on their own terms. The case study shown in Figure 25, Figure 26 and Figure 27 is a demonstration of Deadly Choices as a health promotion program based upon community-driven concepts of health and health promotion practice. Deadly Choices is not based upon experts advising the community, as so frequently observed in mainstream practice. This is not to say that Deadly Choices does not deliver health messages, for health messages are embedded throughout the Deadly Choices program, as this chapter has established. However, the choice lies with the community to decide what their health choices are to be. In other words, for Deadly Choices, choice matters more than predefined health promotion outcomes.

The effect of a health promotion agenda of choice is creation of space for a multiplicity of healthy behaviours available to people. In practice this equates to Deadly Choices involving ongoing, daily decisions where people choose their behaviour. Because of this freedom, at times people may choose behaviours potentially deemed unhealthy. For example, a person could choose to reduce their smoking rate, rather than quit altogether and as a choice that is a *healthier* choice owned by that individual, Deadly Choices would celebrate and value this person’s agency (Nakata, 2007b). In other words, people can make a good choice and are not expected to be perfect or meet imposed ideals of what a healthy choice is.

Choice is prioritised over health messages, as part of a health promotion practice embedded in Indigenous community interactions in an urban and online setting. Deadly Choices employs various tools and products to achieve that, including merchandise, events, activities and programs. Rather than work to persuade individuals to conform to a health agenda, community members are rewarded and celebrated for defining and choosing their own healthy choice. Deadly Choices health promotion is in effect,

promotion of the community and of Indigenous identity as healthy. To achieve this, Deadly Choices practitioners listen and promote the community's deadly choices; these practitioners work to *not tell the community what to do*.

6. “It’s all about empowering our people”: Innovation through leadership and relationship

It’s all about empowering our people to be good leaders and mentors in their community. It’s them taking on their own health and taking that in regards to making their own lifestyle decisions. So that’s what Deadly Choices is all about. Once we give them the tools and the knowledge they go and make their own choices and lead healthier lives that way. (Video: It’s Deadly to be Strong, 2013)¹³⁰

This statement by a Deadly Choices practitioner is revealing in terms of how Deadly Choices practitioners navigate the tensions of health promotion practice explored in this thesis. The quote is taken from the Rural Health Education Foundation’s *Be Strong* series, in its program showcasing Deadly Choices. As this Indigenous practitioner explains above, first and foremost, Deadly Choices aims to empower Indigenous people and communities. What’s more, Deadly Choices views Indigenous people and communities as “our people”; the Deadly Choices practitioners are part of the community they are working to empower. It follows that Deadly Choices practitioners prioritise relationship with community. The above quote also evidences the role of people’s choice in the work of Deadly Choices, where empowered people “tak(e) on their own health and... mak(e) their own lifestyle decisions”. In other words, Deadly Choices acknowledge people’s agency to make choices that are health promoting and worthy of promotion as “good leaders and mentors in their community”. There are collectivist undertones in this approach, where the Deadly Choices health promotion agenda is to promote and work with the community. Thus, Deadly Choices’ health promotion agenda is not only about supporting individuals to be healthy, but also empowering people to influence change in their own communities. This chapter aims to unpack these processes further by examining the way Deadly Choices practitioners enact their health promotion principles of relationship and choice for an agenda of empowerment. First, the chapter begins by describing the unique model of leadership developed by Deadly Choices as a schema to enact these principles in their health promotion practice.

¹³⁰ URL: https://www.youtube.com/watch?feature=player_embedded&v=k6Du-Z523xw (Accessed 22/05/2015).

Distributive leadership for creating change: “Everybody can be a leader”

Deadly Choices is about building strong leaders among Aboriginal and Torres Strait Islander communities to encourage healthy lifestyles and create a healthy future for our people. (Deadly Choices [Facebook page](#) cover – April 2013)

As this Facebook banner states, Deadly Choices works to “build strong leaders” in order to promote health. The way Deadly Choices practitioners talk about leadership reveals a concept of leadership that is not directive. Indeed directive leadership would be ineffective given that “no one wants to be told what to do” (as Chapter Five discussed). As an illustration of the way leadership operates in Deadly Choices practice, consider the interactions between two Deadly Choices practitioners and a group of Deadly Choices participants, and the interpretation of these practitioners regarding leadership in that group (Field notes, 8/03/2014). This group of Deadly Choices students comprised female members of an academy that had requested Deadly Choices to deliver their Education Program to its students. The group was completing a Certificate 3 in fitness through the academy.

On this particular day, Daniel facilitated the physical activity component in the gym to open the session, with Brendon and I participating and supporting Daniel’s instructions. The physical activity component was high intensity compared to other Deadly Choices physical activity sessions in which I had participated, accommodating the fitness training emphasis of these students’ work at the academy. After the session, we moved upstairs to a room where Daniel delivered the Deadly Choices nutrition education session. At the conclusion of the nutrition session, while the students were completing the evaluation form standard to every session, Daniel informed the group that next week’s session would be their last in their Deadly Choices program. Daniel referred to Brendan, asking if he had arranged health checks for this group; Brendan indicated he had not. Daniel subsequently asked,

Girls, will you all get health checks within the next three weeks? Would you do that? If you do, I will give you a reward. I got some pretty good rewards for you.

A number of the students disclosed their fear of getting a health check. One referred to her dislike of needles, saying, “The doctor will come at me with a big long thing.” Daniel responded by expressing, “Having a health check is part of being responsible adults”, which appeared to stir a student into announcing she would get a health check. Daniel affirmed her choice: “That’s good. Would you tell your fellow students about this when you have had it done?” She agreed, to which Daniel responded positively. Daniel subsequently wrapped the class up and Brendan, Daniel and I departed, regrouping outside the front of the academy building.

I asked Daniel and Brendan where they saw leadership fitting into today's session about nutrition. Daniel responded with a reference to the structural location of leadership for this group.

A lot of these kids don't have that leadership. That's because their parents were taken out of their settings; they became depressed and drank as a result. So these kids don't have that leadership in their families; they don't know what healthy is - it isn't normal for them. So we come in and teach them that leadership. It's about knowing when you can reward yourself.

Brendan added,

That girl today who said she was going to get a health check, that's leadership. She's going to tell her classmates about what it was like to get a health check.

I disclosed to Brendan and Daniel my interpretation that Daniel was encouraging that leadership by asking her to share her experience in getting a health check with her fellow students. He agreed and Brendan added, “Leadership is a lifestyle thing”, clarifying that lifestyle means family and culture and much more than simply being physically healthy.

This vignette demonstrates that in the context of Deadly Choices, "healthy lifestyle" goes beyond the associated mainstream discourse to include Indigenous cultural values such as responsibility, "helping your mates out" (as practitioners would say) and nurturing family and relationships. In other words, Deadly Choices employs leadership to normalise “healthy lifestyle” in a package of identity, cultural values and strength. The versatility of leadership in this setting enables the Deadly Choices practitioners to discuss chronic disease prevention and treatment (for example) alongside other factors and values, such as family, responsibility, role modelling, time management and

confidence. Specifically, for Deadly Choices, healthy lifestyle incorporates Indigenous values and agendas, as well as the more recognised approach in mainstream practice.

This story also shows that for Deadly Choices, leadership is effectively a model for change based upon Indigenous knowledge, self-determination, being a positive role model, helping others, and more. In this case, leadership was about being responsible for one's health and sharing the experience of doing so with peers. Responsibility thus forms part of the Deadly Choices conceptualisation of being a leader. In fact, responsibility appears to tie together the values of collective/community health with individual health. I observed a conversation between two practitioners that illustrated this point where teaching a young person responsibility for their family's health was a possible basis for engagement about health behaviours. In this case, the two practitioners attempted to motivate a young person who does not smoke to help their family members to reduce tobacco use:

- Shawn: Somehow, everything relates to family. Everything relates, or we put it in a way or situation where its gonna affect them or their family, and why it's important for them to know it. I always ask a couple of them "why do you think it's important you know about smoking?"
- Brendan: And a lot of them say, "It's to tell my family".
- Shawn: Yep. And then you get some say "oh it's not for me, I don't smoke". That's not the issue - you don't smoke, but does someone in your family smoke? And they'll go "oh yeah, yeah." And there is. So it is important for you to know this because...
- Brendan: Yeah, it's your responsibility
- Shawn: Yeah, it's your responsibility to look after your family. He'll go, "Oh I'm the oldest boy" - exactly. You got all your little brothers and sisters looking up to you.

(Interview, 5/03/2013)

In other words, practitioners view leadership and the responsibility it entails as resources for young people to draw on in making positive health behaviour changes, for themselves and their families. Using these "resources", Deadly Choices practitioners exercise a form of inverted leadership where the community promotes the healthy outcomes, rather than health promotion practitioners pressing the community for compliance. The Deadly Choices philosophy that "everyone can be a leader" means that literally everyone in the community has a role in health promotion.

Noteworthy is the collective focus of the Deadly Choices approach to health promotion, where the community and the relationships that it comprises are “targeted”. This provides a contrast to the tendency of mainstream health promotion to target a particular group or individuals “most in need” of changing their behaviour, such as tobacco smokers. Instead, Deadly Choices works with the whole community, recognising the interdependencies and interactions between people. In this case, smokers and non-smokers alike are relevant, with their relational and family responsibilities to each other. By doing so, Deadly Choices is effectively repositioning the community as having agency for change and as health promoters.

This is not to say that the Deadly Choices practitioners perfectly balance the tension of not telling people what to do in health promotion. I observed times when this balance was skewed towards an emphasis upon compliance. In those moments, community backlash was evident, indicative of the accountability Deadly Choices held to the community agenda. For example, at one major sports event run and sponsored by Deadly Choices, its practitioners ran a health food van. The Deadly Choices food van and a fresh juice van were the only food and beverage options available at that event (aside from water), in accordance with the Deadly Choices sponsorship arrangement. This meant that attendees were not allowed to bring their own food into the event grounds. There was a reaction in the community almost immediately, including on social media, in response to the Deadly Choices impingement upon community choice regarding what they could eat and drink. I observed the Deadly Choices team listen to this feedback, including a team-debriefing meeting soon after the event. The community feedback and criticism were discussed at this meeting where responding strategies were identified to ensure future events would not repeat their error of impinging upon people’s choice.

As this example shows, while Deadly Choices upheld the principles of community control and choice, the practice of doing this was often a learning process for practitioners as well. The community resistance to Deadly Choices’ encroachment on their choice provides evidence for the importance of the Deadly Choices health promotion philosophy, “we don’t tell people what to do”. Instead of determining people’s choices for them, as Deadly Choices mistakenly attempted to do at the sports

event above, their health promotion practice is effective when they work to their stated aim of empowering people to make their own choices.

Oh, it's never, it's not easy, but yeah, and that's what we're trying to do is, you've gotta build leadership for you to change your nutrition. Or for a young person to actually say "I don't wanna smoke no more; where can I get help?" or "I drink too much". And we all have it; none of us is perfect, but if you do these things it might help here. (Interview, 22/11/2012)

For Deadly Choices, leadership in health promotion is not so much a theory as a way of thinking that shifts power from the health professional to community members. From the outset of my time with Deadly Choices, leadership was an obvious and essential ingredient of the Deadly Choices health promotion approach, and an initial sign that their approach is different to that of mainstream health promotion. When practising according to their stated values, Deadly Choices practitioners use a form of leadership based upon a distributive philosophy of inclusivity and strength, emphasising that "everybody can be a leader." That is, Deadly Choices endeavours to nurture leaders and role models, throughout the community, young and old; the Deadly Choices model of leadership is relational, collective and about the character and responsibility of individuals, who lead ("role model") by example.

In this way, leadership according to Deadly Choices is distinct from mainstream approaches to leadership, which are typically hierarchical and managerial in nature – although Deadly Choices uses hierarchal approaches, such as its team structure. Mainstream approaches to leadership generally emphasise accountability, growth and development, possibly without consideration to the impact of actions. For example, some perspectives of leadership styles explain them in relation to how the leader interacts with the team¹³¹, in which case the leader must drive to deliver results (Wee, 2008). From this perspective, "the leader's singular job is to get results" (Goleman, 2000, p. 78).

Similar to what I refer to as Deadly Choices' distributive form of leadership, research has recently turned to distributed leadership as a solution to overcome the problematic nature of the "heroics of leadership" (Spillane, 2005, p. 143), particularly in an

¹³¹ For example, competency (such as knowledge, drive, intelligence), behavioural (such as task-oriented, people-oriented), contingency (such as context driven) and transformational (such as how to transform teams) (Wee, 2008).

educational context (Jones, Hadgraft, Harvey, Lefoe, & Ryland, 2014; Spillane, 2005; Spillane, Halverson, & Diamond, 2004; Whitby, n.d.). Like the Deadly Choices approach to leadership, distributed leadership involves trust and respect of individuals' contributions (Jones et al., 2014) (and in the Deadly Choices case, agency). It also involves change and relationship, requiring collaboration towards identified goals (Anonymous, n.d.; Whitby, n.d.). However, while distributed leadership is seen to be a system of practice that is about people (both leaders and followers) and their interactions, it is understood according to an institutional environment where people have identified positions of employment (Jones, Harvey, Lefoe & Ryland, 2011, p. 27 cited in Jones et al., 2014). In contrast, Deadly Choices' distributive form of leadership operates in the context of community, which also involves the institutional environment of Deadly Choices by way of being within a community controlled organisation (that is, IUIH).

Deadly Choices ambassadors

Deadly Choices also employ leadership through their use of “ambassadors” to embed health promotion programs in community and institutions. The use of ambassadors is not a new approach to health promotion. For example, the Community Health Ambassador Program of North Carolina, USA, recruited community leaders to be ambassadors of health promotion regarding diabetes management and prevention as part of a lay health advisor model (Pullen-Smith, Carter-Edwards, & Leathers, 2008). In Australia, ambassadors have been used in Indigenous contexts, such as in the Trachoma Story Kit and its social marketing approach (Baunach et al., 2012) and for men's health (Smith & Bollen, 2009). However, the Deadly Choices ambassadors are unique for their versatility beyond promoting health according to terms of disease and risk behaviours, as well as their diversity in backgrounds.

While the majority of Deadly Choices ambassadors have a National Rugby League (NRL) background, others include music, film production, National Football League (NFL), softball, soccer, boxing, cooking, bodybuilding and academia/university. Each ambassador is characteristically profiled with their deadly choice, typically on the Deadly Choices website and/or on social media. These deadly choices range across various determinants of health. For example, one ambassador's deadly choice is “education” (Figure 35), while another's is to not consume alcohol or smoke while

remaining physically active every day (Figure 36). While the majority of ambassadors' deadly choices appear to be healthy lifestyle related, the role of ambassadors is much more than promoting a healthy lifestyle message (discussed further below). The ambassadors are also often profiled with a story about their background or promotion of their successes and milestones as they take place (for example, Figure 37).



Figure 35: One Deadly Choices ambassador is an Aboriginal academic (Deadly Choices, 2013c).



Figure 36: One of the Deadly Choices ambassadors (Deadly Choices, 2013l).



Figure 37: A Deadly Choices ambassador shares her journey moving towards competing in the Commonwealth Games and Olympics (Deadly Choices, 2014c).

As representatives of the Deadly Choices community, Deadly Choices ambassadors are embedded within a community controlled health agenda. Some have a celebrity status, which supports the Deadly Choices agenda to raise its profile and increase its following. For example, Sam Thaiday¹³² is a particularly prominent Deadly Choices ambassador with frequent appearances on Deadly Choices promotional material, Good Quick Tukka shows, school visits and community days. Celebrity ambassadors such as Thaiday tend to share their own “brand” with Deadly Choices by signing Deadly Choices merchandise, donating time with competition winners, tweeting/retweeting Deadly Choices tweets or being available to community (such as the Broncos autograph session at NAIDOC 2014). Deadly Choices draws on its official partnership with the Brisbane Broncos, from which a number of Deadly Choices Ambassadors come. Yet, even as celebrities, it is their interaction with community for which these ambassadors are valued. This is particularly the case when ambassadors share their own personal journey of transformation regarding their life choices.

Yeah, that was awesome, him (Sam Thaiday) coming along and just chatting to the kids and giving his story (Figure 38). He's such a perfect role model for us, an ambassador, because I think we talked about it on that day, you know, his experience growing up, his smoking and also his eating habits - they were in the paper, I remember reading about him having Hungry Jacks and dugong and stuff like that, how bad that was for him and he had weight problems at footy and he knew about them and he changed his life. And this is how good he's going coz he made these life changes. So he's perfect and the kids love him and I think it's good - they were just asking some funny questions too, they could relate to him and he could relate to them as well. He's good with the kids, very patient. (Interview; 22/01/2013)

¹³² As introduced in Chapter Five, Sam Thaiday is a Torres Strait Islander Australian and a professional rugby league footballer. He played for and captained the Brisbane Broncos during fieldwork. Sam Thaiday has also represented Queensland in the State of Origin.



Figure 38: Sam Thaiday, Deadly Choices ambassador, interacts with some youth participating in Deadly Choices on university campus (photo courtesy of UIIH, January 2013).

Strength, not deficit: The importance of role modelling

Deadly Choices promotes a transformative portrayal of Indigeneity, where people's choices are celebrated, particularly those who have positively changed their life on their own terms. Perhaps this is most emphatically displayed in Deadly Choices' promotion of NRL players with controversial histories (Bannerman, 2004; Brown, 2009; Doneman, 2009; Ferguson, 2009; Kogoy, 2009) as ambassadors, because of the players' subsequent positive behaviour. Thaiday is no exception to this controversy, yet he and his NRL colleagues have been deemed "perfect" role models of the type of behaviour Deadly Choices promotes.

At surface level, the Deadly Choices ideal and the histories of many NRL players involved appear to be at odds with each other. However, Deadly Choices promotes a model of leadership that involves change, including (and perhaps especially) choices made after having behaved "undesirably". In this case, rather than focusing on the imperfections of NRL ambassadors, Deadly Choices emphasises the positive choices these ambassadors made subsequent to their "poor" choices. In doing this, Deadly Choices has established a transformative space, where change is valued and supported. Thaiday, for example, is frequently referred to as having "changed his life" and it is

because of that change that many Deadly Choices practitioners regard him to be a “perfect” role model. As one practitioner reminded me in an email conversation, Deadly Choices believes that “everyone can be a leader”.

When I was at a session with Bradon earlier in the year, something that struck me was when he said to students “you are all leaders, whether you like it or not”. And I guess that is something the team really emphasises, from my experiences. That everyone is a leader at school, home or in the community - there is always someone that looks up to you. Even if you have made poor decisions (like some of the footy role models they refer to during the leadership module), you are still a leader; there is nothing you can do to change this. I’m not sure why it’s ‘normal’ but it seems like it’s something you can’t help but be. (Danielle email, 1 July 2013)

For Deadly Choices, role modelling is based upon a positive perspective of Indigenous people, whereby existing leaders are showcased and celebrated (for example, Figure 39). Everyone is encouraged to be a leader and people are affirmed and encouraged to lead in their sphere of influence (for example, Figure 40). This positive approach to leadership demonstrates an emancipatory, transformative construction of Indigenous health and identity, particularly when contrasted with health promotion’s history of leveraging “expert” advice to address deficit and “build capacity” (as discussed in Chapter Two).

It’s not too motivating when people are told they are likely to die 17 years before their peers, they are twice as likely to smoke (and to therefore suffer ill health or die), and they are twice to 14 times more likely to die from chronic disease. It’s obviously more helpful to focus on the positives... Like this: if you’re an Aboriginal or Torres Strait Islander rugby league player, you’re four times more likely than your non-Indigenous mates to achieve great things at all levels of the game! But only if you’re fit and make good choices about nutrition, physical activity and getting healthy. (IUIH, 2013e, p. 12)



Figure 39: A sample of the Deadly Choices ambassadors (image courtesy of IUIH, May 2014).

Social media (discussed in Chapter Seven) provides a dynamic platform for people to continually earn the leadership conferred to them by the community. The Deadly Choices model of leadership is aligned with an Indigenous conceptualisation of leadership as a process, rather than position within a hierarchy (Dodson, 2009). When people post their healthy meals and other healthy choices online, Deadly Choices classify that as a demonstration of leadership. For example, I observed many people posting about their deadly choices in relation to nutrition and physical activity. When I spoke to a practitioner about this particular focus, he responded with the following:

These (healthy meals and exercise) are the easiest to take a photo of. It's not easy to take a photo that shows leadership. However, in posting their deadly choices, they're showing leadership here. Any kind of interaction or promotion on our page is leadership. This has an effect on other people, who copy them. People have different levels of influence on others. Like, LeBron James, he is a celebrity; he inspires me. Compare him to my aunty, who probably has a greater influence on my behaviours and attitudes. (Interview, 5/12/2013)



Figure 40: Deadly Choices promotes social choices - in this case, encouraging leadership behaviour.

As this practitioner explains, leadership is demonstrated and built in the interactions between people, online and offline. While the content of the interaction may appear to be related to healthy lifestyle, such as nutrition and physical activity, it is the interactions and choices of people to positively influence each other that illustrate leadership in action. Furthermore, leadership is most powerful in relation to family and community networks; while Deadly Choices values and works with the celebrity status of many of its ambassadors, it is the collective “social capital” (Brough, Henderson, Foster, & Douglas, 2007) of the communities that has the most value and influence – the aunts, cousins, siblings and so forth. For Deadly Choices, “any kind of interaction on promotion... is leadership”, which translates to leadership involving the promotion of community by the community, be it self-promotion or of each other.

Role modelling also applies to the team of Deadly Choices practitioners. Deadly Choices practitioners appear to take pride in role modelling, done so with the philosophy, “We’re doing it ourselves.” The role modelling of positive and healthy

behaviours by Deadly Choices practitioners is significant in terms of a decolonising agenda, in that they provide an alternative narrative for empowerment to that presented in many mainstream initiatives. This alternative could have major health ramifications, in light of research findings that some Indigenous Australians resist mainstream health promotion initiatives as a form of self-empowerment. For example, researchers found that some Indigenous Australians chose to continue smoking in response to mainstream health promotion campaigns, effectively using their body as a site of resistance to paternalistic, neo-colonial messaging (Bond et al., 2012). In comparison, Deadly Choices employs role modelling of health and strength, which provides a contrasting and negotiated strategy for empowerment that simultaneously rejects the public health emphasis upon Indigenous illness and death and embraces Indigenous identity.

Deadly Choices as a transformative space: “Having a go”

The Deadly Choices approach to leadership involves an attitude of “having a go”, where participation is encouraged and expected of its leaders. The Deadly Choices practitioners employ an experiential approach to health promotion to drive towards transformation.

Because we can talk about nutrition and we can educate each other, we can educate our family, but if we're not acting... and that brings me back to us being more visual learners. Aboriginal people are very strong from learning from you doing something. When you take that into leadership, you can talk about anything as much as you want. For me, I was the same. If I'd seen it done several times, I can then try and do it myself and learn from my mistakes to get it right... So for us then we can educate, but drive it within itself, with leadership. (Interview, 16 July 2013)

As this practitioner explains, the Deadly Choices philosophy, *we don't tell people what to do*, translates the Indigenous cultural value of learning by doing, into practice. In this way, Deadly Choices practitioners navigate health promotion's tension of not telling people what to do, by the guidance of Indigenous values and knowledge. Deadly Choices therefore transcends health promotion's tension around control and instead becomes an endeavour of Indigenous agency (Nakata, 2007c).

Given that Deadly Choices uses leadership to create an inclusive health promotion practice, I was interested as to whether the masculine emphasis of NRL could be to the exclusion of those who do not associate with this imagery, particularly women. Some of

the practitioners explained to me their view that the NRL imagery held merit and authority due to the popularity of rugby league in the SEQ Indigenous community. This did appear to be the case for young males whose second most popular sport is rugby league (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 2013). Furthermore, the Close the Gap co-chair, Mick Gooda, noted that the NRL was the first sporting code to support Close the Gap, with many successful Indigenous players available to inspire young Indigenous Australians (National Rugby League, 2013). Putting aside the controversies of NRL players (indicated above) and the numerous NRL disciplinary actions enforced as a result, cross-overs between the discourse and approach of the NRL code with that of Deadly Choices is apparent, in terms of leadership and mentoring (House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, 2013, p. 83). Additionally, the NRL demonstrates support of Indigenous health through other means, including Close the Gap rounds¹³³ (National Rugby League, 2013) and more specifically to SEQ, through the formal partnership between IUIH and the Brisbane Broncos (see Figure 41). In light of this positive exchange and activities, some congruency exists between the Deadly Choices brand and its association with the NRL. However, the NRL's primarily masculine emphasis presents Deadly Choices with the capacity to promote an imagined space where Indigenous men are successful leaders.

¹³³ The NRL hold a number of games each year called "Close the Gap Rounds" as a call to action in tackling Indigenous health inequality. The rugby league sporting code is part of the Close the Gap campaign (discussed in Chapter Two).



Figure 41: Previous Federal Minister for Indigenous Health, the Honourable Warren Snowdon, with Broncos president, IUIH CEO and IUIH team at the launch of the Brisbane Broncos partnership in 2013.

While important, positioning Indigenous men as leaders presents Deadly Choices with the risk of being silent regarding Indigenous women’s leadership, and reproducing their inequitable positioning. The substance of such a concern could be, among other issues, the problematic relationship of the NRL players with women. For example, Thaiday and Inglis were reportedly involved in the abuse and assault of women (Doneman, 2009; Kogoy, 2009; SBS, 2009). Given Indigenous Australian women are the most socially and economically disadvantaged population group in Australia, with the poorest health status (Walker, Fredericks, & Anderson, 2012), Deadly Choices has the potential to contribute to further disadvantaging and excluding Indigenous women.

This tension associated with Deadly Choices’ emphasis upon NRL in its work continues. Yet, the Deadly Choices principle to “always be better” has enabled a transformation in their gender depictions over time. I observed the team explore ways to balance gender representations in its work, based upon community and practitioner feedback. In doing so, I observed the power of the team philosophy, “we learn from each other”. As an example, take Hunter’s approach to his manager, requesting that a stronger “female presence” be introduced through representation from sports other than

NRL that are known to have a strong female following. This particular conversation took place while the health checks for his school program were under way, at the end of term.

At one point, when Hunter, Braden and I were chatting, Hunter raised the idea of having an Indigenous female ambassador with Braden, his manager. At that time, no sporting female ambassadors were in place and in fact, I had suggested to the practitioners (in their meetings and informally in discussion) that they might consider some female ambassadors. Thus, I was pleasantly surprised when Hunter raised this proposition to Braden. Hunter said he knew an Indigenous female softball player, who was the captain of the Australian team at 22 years old. For a more quietly spoken man, Hunter appeared to press this matter with Braden, emphasising, "It would be good to have more of a female presence." Apparently, Hunter had been texting this individual who had already confirmed, "She is ok to be involved." (Field diary, 11 June 2013)

Since this conversation, at the time of writing, a number of women have been engaged as ambassadors from various backgrounds. Imagery of Deadly Choices ambassadors reveals an obvious shift towards gender balance. Women (including ambassadors) are showcased in a range of ways. These include starring in Good Quick Tukka cooking shows on Deadly TV¹³⁴, representing Deadly Choices on national news regarding their athletic achievements (for example, Figure 37), and by celebrating their achievements such as graduating with a Master of Public Health or being named top female rugby league player and women's player of the match (Figure 42 and Figure 43). Additionally, the Deadly Choices marquee has been updated to display female ambassadors (Figure 44).

The shift to include more women in Deadly Choices imagery is characteristic of the way Deadly Choices endeavours to build an inclusive identity and a transformative space. A conversation I had with a practitioner illustrates this point, regarding the means by which Deadly Choices practitioners include people who face participation barriers.

So we've got a slowly - like a totally different demographic. You were talking to me about a demographic of people who we've missed through the cracks; then there's a demographic of people we don't wanna miss who aren't just identifying with sport. You know what I mean? We gotta try and identify with people who are in the arts department, then on the medical side. So there's all these different groups of people who are on social media

¹³⁴ For example, see Deadly TV <https://www.youtube.com/watch?v=yonrKExeXL0> (Accessed 3 August 2014).

who we don't want to miss. So, we've gotta make sure we've got a mix of everyone. (Interview, 13/05/2013)



Figure 42: One of the Deadly Choices ambassadors was awarded woman of the match (30 September 2013).

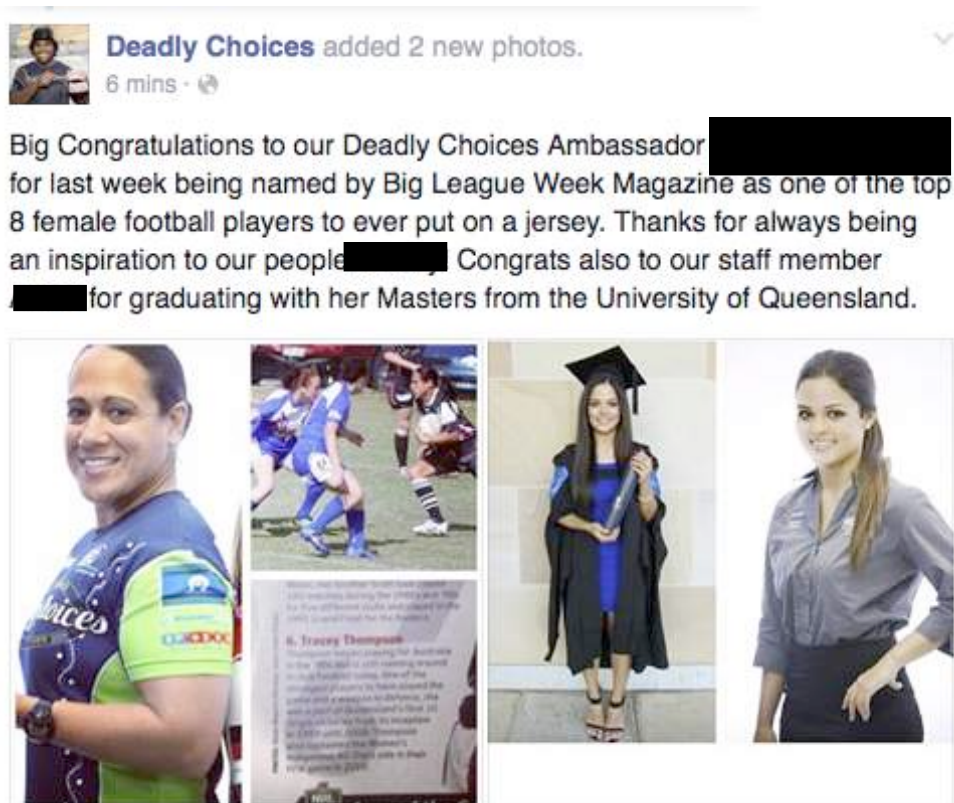


Figure 43: Deadly Choices celebrates the achievements of a female ambassador and staff member (30 July 2014).



Figure 44: Two Deadly Choices ambassadors with their image displayed on the marquee.

The community interactions and feedback, including criticisms of Deadly Choices and its practitioners, support the Deadly Choices drive for transformation not only within the community but within Deadly Choices as well. Through being accountable to a community agenda, outside solutions and experts are not required for Deadly Choices. Instead, Deadly Choices practitioners prioritise participation by everyone, including themselves (for example, Figure 45). In doing so, Deadly Choices is able to negotiate, experience and express the various tensions of their health promotion practice with community (Nakata, 2006).



Figure 45: Deadly Choices participated in the Women's Netball Carnival with its own women's team in the game, as well as delivering Deadly Choices education sessions and facilitating health earlier in the day.

Leadership is relationship

Deadly Choices affirms Indigenous cultural values through its health promotion practice. Arguably, the Deadly Choices deployment of leadership is interchangeable with culture. This can be seen in Daniel's recounting of the 2012 leadership camp, where kids were encouraged, disciplined and taught responsibility; in other words, they learnt about Indigenous values. The second year of the *Sport and Leadership Camp* was held in 2012 as part of the Deadly Choices Healthy Lifestyle Program (Floss, 2011). The Camp was designed to be a reward for students participating in Deadly Choices for the year to date and delivered with the support of the full Deadly Choices team, in

partnership with Indigenous teacher aides from local schools and other IUIH specialist workers for example, in oral health and nutrition. During the camp preparation phase, after one of the camp-staff meetings at the Deadly Choices office, Daniel (a Camp coordinator) and I discussed the camp. Daniel shared his enthusiasm and apprehension regarding the approaching camp, saying,

It's exciting and it's good because you just don't know. You got no idea, like, you don't know what's gonna happen, you know what I mean? It could be nothing; it could be something. Dunno how many's gonna turn up on the day... But most of the kids this year are pretty well, and the support of the schools this year is pretty good. And the support of our team will be great. (Interview, 22/11/2012)

When I asked Daniel who would attend from IUIH he responded, "There's about 20 of us and 50 kids..." and proceeded to illuminate his tough-love approach to working with the kids for instilling discipline.

...everyone that goes from our organisation, our team, knows how I operate: to have fun but give us a hand, pull people into line. You know like, there's a taxi there; you can get your own way home. People say when I do things that I'm a bit harsh or I'm a bit tough; well I'm not tough. I'm not tough. You have to be a bit tougher on these young people especially, and the older people, coz they always ask for something, for nothing. You don't always get something for nothing. It's terrible; it's a bad way to put things for young people: reward bad behaviour. You can't do it. Are you gonna get fired because you turn up to work every second day? You couldn't be bothered coming into work? Of course you are. So why would you let him come on a camp, or why would you let her do something? If I caught you smoking in the building, you get fired. You're not gonna reward that. It has to change; it has to be better. (Interview, 22/11/2012)

Daniel reflects a vision for his community: a positive space with clear boundaries to support people to always improve through relationship-based interactions. Such a vision is a regular feature in the discourse of these practitioners who actively and pragmatically endeavour to build relationship through their programs and activities. Daniel's continued reflection regarding the Leadership Camp's goal illustrates the practitioners' prioritisation of relationship:

See the other thing we're trying to get out of it is meeting people, especially Indigenous people from other areas and actually connecting, because you know, what Murris do in Brisbane is different to what Murris do on the Gold Coast; different lifestyles as well. They're still Murris, you know what I mean? ... We have... 13s-17... We try to build that leadership. Say, OK: here's your older group, here's your younger group; how do you support that? And how do you build different traits of cleaning up on the

camp? Looking after your area? You know, helping the little ones when you're doing stuff and building that team environment and that supportive environment in a way that they don't know that it's happening. (Field notes, January 2013)

Daniel's reflections elucidate the way relationship is a resource for leadership by enabling Deadly Choices practitioners to incorporate Indigenous values and principles into their health promotion practice, such as reciprocity, family and trust. In this case, leadership involved discipline to set boundaries and values for "helping the little ones... and building that team... and supportive environment". Those ground rules could only be applied and accepted because of the strength of relationship between Deadly Choices practitioners and the students. Discipline without relationship could be experienced negatively and resisted (as raised earlier in this chapter). In contrast to a controlling or judgemental intention, the discipline employed by Deadly Choices practitioners is based upon caring for and strengthening the community. A case in point is that rather than affirm mainstream Indigenous health policies (discussed in Chapter Two), the Leadership Camp affirmed Indigenous identity and values by building solidarity between "Indigenous people from other areas".

The Deadly Choices practitioners emphasised leadership as relationship and cultural value in their own team training regarding the delivery of the Deadly Choices Education Program. An example is found in training sessions Daniel facilitated at a team retreat, when most of the Deadly Choices practitioners were new to the team (Field notes, 8/11/2012). Daniel introduced the Deadly Choices leadership session as the first and most important session of the Deadly Choices Education Program and as described in the Deadly Choices handbook, "an opportunity for the facilitators and the participants to get to know each other." In Daniel's explanation, leadership was about choice, and the role of Deadly Choices practitioners was to build leadership in people to enable them to make 'deadly choices'.

Daniel highlighted that Deadly Choices focus upon young people in order "to get in early before the chronic diseases set in... (because) there are so many sick and dying Aboriginal and Torres Strait Islander people in the community." Deadly Choices was developed as a response to this situation, being a package "for the kids", "using simple information" and "about being positive, not negative". The imagery of Deadly Choices

supports this youth-oriented emphasis, along with the relatively young team of practitioners to deliver Deadly Choices.

Arguably, Deadly Choices' focus on young people is appropriate and strategic given the Indigenous Australia population has a relatively young age structure, with a median age of 21.6 years (ABS, 2014). Yet, community critiques exist about the emphasis on young people, particularly due to concern that older people may be excluded. I had heard, for example, comments by comparatively older people in the sector to the effect of "What about us? What about older people?" Nonetheless, these critiques appeared to be less forceful than those I observed regarding gender representation or the Murri Cup Carnival (discussed above). Perhaps this was because Deadly Choices do work with adults and older people, even if to a lesser degree than their work with young people. For example, older people are participants of Deadly Choices community events, education sessions, support groups, men's and women's groups and more. Additionally, Deadly Choices operates as part of "the greater whole" of IUIH's broader service and program delivery for adults. That said, the youth-oriented imagery depicted in Deadly Choices products may serve to camouflage its work with older people and in some way marginalise older people.

During this training, time was specifically invested in supporting practitioners to build connections with young people, as well as with community members more broadly. Daniel explained, staff "must always connect at the introduction and build that trust" with the students and community, suggesting practitioners could do this by, "ask(ing) them where their mob is from, what sport, generate the conversation..." (Field notes, 8/11/2012). Daniel's advice mirrored the Deadly Choices practice I observed where building trust and a connection was central and critical to most, if not all Deadly Choices activities.

Ice-breakers feature regularly in Deadly Choices activities and accordingly, Daniel included a practice session of various icebreaker exercises at this training. Shawn facilitated this training session, where together we practised a number of icebreakers – accompanied by a lot of laughs (Field notes, 8/11/2012). After the session we regrouped and Daniel emphasised that Deadly Choices is about making good choices to have better health outcomes. Therefore, he explained, the team's role is to provide

information to enable people to make their *own* decisions, as opposed to instructing people what to do: “no one likes to be told what to do”, Daniel said.

A core theme of this training for practitioners was building relationship with community members. Daniel frequently reiterated relationship in the context of building leadership. He encouraged practitioners to reflect upon cases when students are disruptive in their programs and work to understand "why are they behaving in such a way?" To support leadership, Deadly Choices practitioners were taught to reward effort and emphasise boundaries and so “don’t be afraid to send a kid out if they won’t change their behaviour, as rewarding bad choices isn’t what this is about”. Daniel explained that building relationships with the students also enables practitioners to "identify illiterate kids and those who need help." The structure of the training left me with the sense that a key attribute for a Deadly Choices practitioner is the skills to establish and nurture a variety of relationships (Field notes, 8/11/2012).

For Deadly Choices, supporting leadership provides a pathway to support cultural values and identity. While Deadly Choices does not overtly identify supporting cultural values and identity as an objective of its work, I observed students frequently experience Deadly Choices as a cultural program. Michelle’s story illustrates this, where she expressed her expectation to learn about culture, when Hunter presented Deadly Choices as a health education program. The following vignette begins at Hunter’s first Deadly Choices session on leadership with a new group of Deadly Choices students. In this particular session, Danielle also joined us to support data collection for Deadly Choices evaluation purposes.

Hunter began the session with a brief introduction regarding what would happen today and in the program over the coming weeks. Hunter accentuated this program was to “have fun” and “a chance for you to learn a bit about culture and heritage too”. When Hunter indicated we would “get to do some Traditional (Indigenous) Games” (TIGs), one student, Michelle, responded with such excitement, claiming she had not participated in TIGs before. Quickly, Christina, another student sitting with Michelle, reminded her they had played TIGs on camp. Michelle appeared to remember: “Oh yeah! But I’m still excited about playing Traditional Games. I want to learn more about culture”.

Later, once the session was completed and Hunter dismissed the students, Michelle waited. Once the other students had left, Michelle asked the three of us if she could ask some questions. Michelle began to share about her

journey of learning about her culture and forming her own identity. “Mum is my Aboriginal side”, Michelle disclosed, “and mum did a program like this in school but nothing after. So mum doesn't know much about our culture and so I don't know much about my culture. But I really want to learn.” Michelle revealed her dreams for the future: “Since I was eight, I knew I wanted to be a nurse and a midwife for Indigenous people. But, my grades aren't so good.” Danielle reminded Michelle, “Whenever you want to do something, there is always a way.” Michelle concurred, responding, “Mum and I are already looking into other ways I can get in.” Despite her young age (Michelle was in year 10), she struck me as decidedly certain about what she wanted to do for a career. Michelle expressed an eagerness to learn more about her culture and to do something to help Indigenous people. Michelle continued to talk to the three of us while we listened, occasionally affirming or encouraging her ambitions. It was interesting to me that Michelle's interpretation of this health promotion program so far appeared to be that Deadly Choices was a cultural experience. (Field notes, 9/07/2013)

This vignette highlights a few important matters. Firstly, the interactions between Hunter, Danielle and Michelle illustrate the way Deadly Choices practitioners work to deliver a health promotion agenda that incorporates and addresses the broader community agendas to which they are accountable. In Michelle's case, Deadly Choices was responding to the community agenda to affirm Indigenous identity and cultural values. Doing so illustrates that Deadly Choices practitioners value broader determinants of health, including culture, identity and community control. Furthermore, responding to community agendas enables Deadly Choices to address conventional lifestyle changes according to an Indigenous conception of health.

Secondly, Michelle's story clarifies that Deadly Choices practitioners operate with an unwritten curriculum of identity and cultural values. Although Deadly Choices is a health promotion program, its participants experience it as more than this. Michelle interacted with Deadly Choices with an expectation of a *cultural* learning experience; an expectation that she sustained in her conversation immediately following her participation in a *health* education session. Perhaps the presence of Indigenous practitioners in a traditionally White space – in this instance, the school setting – contributes to Deadly Choices being a cultural experience. Regardless, in Deadly Choices, its students *want* to learn about culture and identity; this is how they connect with Deadly Choices.

“We know how to talk to each other”: Relationship-based health promotion

“We’re doing it ourselves”: The Deadly Choices team

While the Deadly Choices practitioners take very seriously the way they engage with community members, youth and adults alike, their commitment to their work is matched by their humour and vitality. These workers are fun; they are *cool* and they are relatively young and active (for example, Figure 46). The culture of the Deadly Choices workplace is one where laughter and joking takes place while the work continues. The male practitioners, in particular, jab at each other with pranks and jokes, creating an energising environment that is often hilarious to be a part of. The humour often involves looking for the brighter side of challenging or serious situations, in some ways self-mocking when the team and its members stand out – which they often do, given the popularity of Deadly Choices. Take for example the way the practitioners reacted to seeing one of their colleagues on the large screen during one of my feedback presentations.¹³⁵

Karen: So... (I clicked to the next slide with the paused image of Shawn mid-conversation in a video).

(Outbursts of laughter)

Karen: It's actually a video, so I'm sorry...

(Louder laughter)

Shawn: I don't want to hear it.

Braden: Someone just got out of rehab.

(Bursts of laughter)

Brendan: He got too much soul, hey?

(More laughter; it begins to quieten down but then starts up again)

Shawn: This is supposed to be confidential. How do you know that's me?

(More laughter)

Braden: It's that cheerleader from the Broncos.

(Laughter)

Brendan: Karen, can you send me that photo?

¹³⁵ As discussed in Chapter Four, I delivered feedback presentations regularly during the research. To do this, I would incorporate data that had been collected about the team's practice, often from participants' diaries. Photos and videos provided a particularly powerful feedback tool but being identifying forms of data, I would ensure that the person being identified had seen the data item and consented to its presentation at the team meeting before using it.



Figure 46: Some of the Deadly Choices practitioners (Photo courtesy of IUIH, 2013).

This type of humour is common within the team and it enables the practitioners to laugh at themselves and their differences. Perhaps humour also enables the practitioners to make sense of their context from within a shared experience, as Indigenous humour has been found to do elsewhere (Behrendt, 2013; Holt, 2009; Nakata, 2007b). The use of humour is embedded in the practitioners' way of working, which means that the humour could be experienced as light-hearted and fun, in a safe way. Additionally, by incorporating humour in their practice, Deadly Choices practitioners are able to take on a non-authoritative tone when working with the community. Humour therefore plays an important role in how the practitioners work, as one practitioner explained to me:

I think I use that (humour) a lot. I always use humour. I love having a joke with the kids... I guess it would be very tough if you can't find some common ground or relate to these kids coz a lot of them are gonna go, once we try to push some health information to 'em, they'll be like, "I don't want to listen to you, why should I listen to you?" And I think that's for a lot of people... It only takes one bad issue in the community and you're tarred; that's your reputation gone. It's very tough and everyone has to be on well behaviour all the time and I think a lot of our guys, a lot of the team, they know that. It's so embedded in the community and they already know how it works and they know that they can't talk about things to some people, and they can have a joke with these people because they're so close to them, they've been around for so long. I think that kind of stuff is just so important. (Interview, 22/11/2013)

By using humour, Deadly Choices practitioners can connect with and embed their work in the community. Humour is a resource for Deadly Choices practitioners to build their

credibility in the Indigenous community they work with – not that this is necessarily their motive, as humour appears to be a natural part of the way these practitioners behave. Humour provides a sophisticated device with which Deadly Choices practitioners can approach the tension of not telling people what to do, when working to promote their health. However, as the quote above reveals, the basis of the appropriateness of humour depends upon the pre-existing relationships of the practitioners. In other words, credibility comes with being known to the community.

I heard the practitioners attribute the “success” of Deadly Choices to, amongst other things, the pre-existing respect and credibility of the team members, including the consistency of the Deadly Choices “personality” across the online-offline interface. The majority of these practitioners have links with community, including through family connections, which serve to build trust and community engagement in Deadly Choices activities. An example is the Men’s Health Cricket day, where almost 100 health screens were conducted as well as almost 30 sexual health screens. One practitioner provided a recap of this day in their participant diary entry, outlining what he saw to be successes of the day:

Ok, so we're just at the end of our cricket day, we're down to our final. Today went really well. We had a doctor on site, which is probably even better (than last year's cricket day). He did a bit of brief intervention after we did the health screens (see Figure 47) with all the guys and so they could actually talk to a doctor, just about their health screen and just get some information straight from the doc, which was really cool. I think that helps a lot... But we had some good outcomes with the sexual health (screens)... We had 29 screens, which will be P-Tested... they're good ticks off for us as well. I think it was really good, as I said, having the doctor on board here today, all day and he got a couple questions from the guys. But he actually had a bit of a chat as well to the guys after lunch, which was encouraging as well, about what they should be doing around their health and just a bit of information around their description of the health screen as well, which was really helpful.

Having indoor cricket as the day was fun as well because everyone can be involved with cricket, it isn't that hard to be picked up. So we've got all ages here today as well, which was great. We had some younger boys in the 18s and 19s but also some older guys, getting on to 30s, 40s and 50s, which I thought was great. We're creating those role models and getting everyone involved and it's a happy environment. Even though it was a knock out and we're getting a winner, everyone still had a great time. (Participant video diary entry, 2/02/2013)



Figure 47: Cricket players were required to undertake a health screen before playing (photo courtesy IUIH participant diary).

As this practitioner explains, the cricket day was a way to engage a cross-section of men from the community together in a positive environment, where health education could take place alongside having fun together. However, for this day to be a success, the Deadly Choices practitioners had undertaken groundwork with the community beforehand, including encouraging formation of teams. Two practitioners at the Men's Health Cricket Day compiled a participant video diary entry together, which expands upon the above practitioner's reflections to consider the role of the Deadly Choices practitioners and their relationships with the community involved.

- Braden: I suppose too it comes back a lot on the Healthy Lifestyle Team¹³⁶, putting on the event. Anybody can put on an event but whether they get the people there and get the people involved. Getting over 29 Aboriginal and Torres Strait Islander men to do a sexual health screen is unheard of in one day. Full credit to the Healthy Lifestyle Team.
- Sean: So using cricket as a guide or tool to engage everyone to get everyone involved - we used cricket well today?
- Braden: Yeah, we did. And not only, we had 13 teams - could have had more but we competed with the rugby league event (being held today elsewhere), which most fellas would pick rugby league before cricket, so I think we did really well using cricket as a tool to engage men with health. Like I said, our Healthy Lifestyle Team engaged all the fellas well, spoke to them and made them feel comfortable with getting a health screen and sexual health screen. You know, made

¹³⁶ As indicated in Chapter One, Healthy Lifestyle Team is another name for the Deadly Choices team.

them feel comfortable, let them know that everything's confidential and that the local GP we would have here today would contact them all. That reassured the fellas.

Sean: I guess us knowing a lot of the community as well and having our community engagement officers in these areas helping organise these teams, means we already got that link with the participants in the community already and that also shows that it's a safe place to be able to do this stuff.

Braden: If we didn't have that link, I'd say that without the community engagement team and not knowing the players - you know, if we didn't know the players, it would have been a lot harder to get them to have their health screen.

(Joint participant video diary entry, 2/02/2013)

As this participant diary entry suggests, the personal connections of many Deadly Choices practitioners with community form the basis of their work. Likewise, key organisational relationships, such as with the local AMSs or Indigenous organisations, are essential. It was because Deadly Choices practitioners knew “a lot of the community” that so many men attended *and* participated in all activities of the Cricket Day, including sexual health screens for some. This example shows the way sport provides a medium through which engagement can transpire not only between Deadly Choices practitioners and the community but also within the community. In this case, men from all ages and backgrounds were involved, coming together in a positive space facilitated by Deadly Choices.

The physical location of the Deadly Choices team most likely contributes to nurturing these community relationships, with some practitioners based in the community with engagement a key task of their role (discussed in Chapter Four). The placement of officers within host community organisations and AMSs is a strategic team arrangement that provides “ears and eyes on the ground” so that a Deadly Choices ‘face’ and point of connection exists in the community. Relationships involve time to allow for trust and integrity to develop, which is a process these positions facilitate. The value of roles that support relationship must not be discounted for health promotion and is supported by research regarding engaging Indigenous Australians (Hunt, 2013, p. 2).

The relationship and culture-based nature of the Deadly Choices approach to health promotion means that experience with the community is highly regarded amongst the team, perhaps more so than formal health promotion qualifications in some instances,

although formal qualifications are evident in the team. For example, one practitioner described his regard for the Ottawa Charter for Health Promotion.

See, I've lived the life; I understand what the struggles are. But I understand you don't have to have those struggles neither. So when you put that into your work practice, you got a lot of experience. And experience will outweigh those education tools (referring to the Ottawa Charter) every day... I was never... in a job where I just had a guideline, where this is where you need to go. We set our own guidelines really. I hadn't learnt the Ottawa Charter for (the first) 18 months to 2 years I've been in the job... Well I didn't even need to know, I didn't know, but I was doing some of those things in the first place - not all of them. As you said in your paper, we do things differently. (Interview 16/07/2013)

The practitioners' regard – and IUIH's more broadly – for community connections and local knowledge was also evident in the beginnings of Deadly Choices. With a much smaller team compared to today, the Deadly Choices practitioners at the time were tasked to design and establish Deadly Choices without formally having undertaken recognised health promotion training themselves.

Most people (in mainstream settings) have a framework, but we never had that the whole time we put the program together. We wanted to incorporate information such as chronic disease, but that was only when we wanted it in the program. It had nothing to do with health promotion; the program was based on what we learnt from the past. I had no idea around health promotion and population health when we started; health was a new thing for me, and all of us.

12 months later we did some training in health promotion and population health, we could see we were doing it anyway. The training showed us we were working with a holistic approach. We went to the training expecting to learn something but we knew all the answers the facilitators asked and we were telling them. The training didn't strengthen what we were doing, didn't give us good tools or direction. We found out that we do population health; we do this normally. We want to learn what we aren't doing or don't know, we can always be better. We have seen where things are missing in our work, like policy and documenting our work and now we are way better with our internal systems. (Interview, 25/11/2014)

The value placed on cultural knowledge and experience in the community appeared to over-ride official mainstream health promotion approaches, such as the *Ottawa Charter for Health Promotion* (WHO, 1986b). However, by way of adhering to a model of community control, Deadly Choices also practices according to globally recognised principles of health promotion, despite their unfamiliarity with those principles. Arguably, this correspondence reinforces the values of those health promotion

principles, particularly the element of people's control over their own health. Furthermore, it reveals the importance of mainstream health promotion seeking to learn from Indigenous community controlled health promotion practice.

The experience of the practitioners – in community, life, relationships, and from learning from mistakes – is highly valued within IUIH. As the practitioner said above, “experience will outweigh those education tools every day.” When actions identified in the Ottawa Charter have been implemented by Deadly Choices, this has perhaps been because the Ottawa Charter contains strategies that accord with a community controlled agenda, rather than being the intention of deadly Choices practitioners. This is not to say that all practitioners in the team reject the Ottawa Charter. Rather, the team draws on knowledge that suits its purposes, developing new knowledge and skills in the process, all the while being accountable to a community agenda.

Given the embedded nature of Deadly Choices and its practitioners in the community, for many of these workers, their work does not finish when they clock off for the day. These practitioners have a visible profile through their work and as already stated, many are simply part of the community they work in. This positioning translates to some feeling available to community beyond standard work hours.

Yeah, it's like 24/7 is what I've found. Your actions outside work play a big role as well and that's something I've had to learn and something that I've taken on board... you portray yourself outside of work or people ask for advice outside of work. It's definitely something that seems to be around the clock. (Conversational interview, 19/04/2013)

Brendan: For me personally its about closing the gap for everything so we can all be equal and all be one.

Sean: We do this here at work but we go do this at home. I'll go up home and I got cousins smoking at my Aunty's house and stuff and I'll call them aside and do the same thing: "Get out, you can't smoke in here, you know why? Come sit down here, let me talk to you about it."

Brendan: Yeh, aye, let me get my laptop out (laughs).

Sean: I did that end of last year (laughs).

Brendan: I do it with my family all the time. I say if you ever want to talk about smoking, we'll get the laptop around and we'll go through some slides (laughs).

(Interview, 05/03/2013)

Some practitioners refer to the need to be present and visible in the community, to raise the profile of themselves as individuals and as IUIH and Deadly Choices staff. This was emphasised to me in relation to the non-Indigenous practitioners as well, to ensure non-Indigenous practitioners are a familiar face amongst the Indigenous communities Deadly Choices works with. One Indigenous staff member suggested for non-Indigenous staff:

Get to more community organisation days. Like, you got a football carnival this weekend - a massive big touch football carnival. You're gonna have thousands of blackfellas from around... SEQ and perfect opportunity to engage with them. Go there, walk around, introduce yourself, meet people and stuff like that. (Interview, 22/11/2012)

While seeking to introduce one's self as an "outsider" to a community may be daunting for some, perhaps more so for introverted personalities, the point here is for a practitioner to be involved and present in the Indigenous communities with which they intend to work and to nurture those relationships. I have observed staff discuss the importance of the team's actions in community for building and retaining the community's trust:

It started from the early days; it was the little things, following things through, not cancelling at the last minute. And all of this must carry through onto our social media. Similarly, the staff had to be seen eating healthy and being seen in the community upholding what the Deadly Choices brand was about. Everyone understands that you're human but it is about presenting yourself in a good manner in community - you can always be scrutinised. (Interview, 26/11/2012)

Not only do the personal relationships between practitioners and the community enable effective community engagement with Deadly Choices' health promotion, but they also enable a reciprocal form of accountability for the practitioners (as the Murri Cup Carnival example discussed earlier demonstrated). This personal level accountability serves to support the accountability of Deadly Choices and IUIH to the communities they serve.

Likewise, the conversations I observed within IUIH give me the impression that organisationally, Deadly Choices practitioners (and IUIH) expect each other to represent Deadly Choices (and IUIH) positively and as leaders in their community. At a minimum, this expectation applies when they are in uniform. I heard management frequently reiterate their expectation that the team behave as positive role models and be "a good example" in the community – from their choice of meals, to physical activity,

to punctuality. The work ethic of these practitioners is strong and perhaps an important mechanism for these practitioners to uphold their responsibilities is the way they support each other.

Organisational policies also exist to provide support for staff to make deadly choices in order to role model healthy and community-oriented behaviours. For example, twice a week, Deadly Choices practitioners undertake fitness training together for one hour, for which IUIH grants 30 minutes of paid work time. Such a policy provides structure and assistance for practitioners to include regular physical activity into their routine. The experience of this regular training in the workplace enacts a form of accountability (and at times, friendly competition) between practitioners to be consistent in their training, in a fun and inclusive environment. The enjoyment and challenge of training together to be Deadly Choices leaders also impacted me, where I tried to attend these team-training sessions regularly during fieldwork. My field diary entry below talks through one of our sessions:

I had spent the day at the office after the team meeting that morning, conducting interviews and hot-desking in between. I stayed to join the team in their usual 4pm training session. Around 3.30pm, people started to talk about it – getting ready to get changed, what exercises we would do, who would run the session, and so on. Some of the girls asked Shawn if he would run the session, since Ethan and Daniel were away (who often led the sessions). Shawn said he “would love to” run this session for us. By just after 4pm, Danielle, Bianca and I had changed our clothes and made our way downstairs, where the training sessions were held. Dianne and Jolene were already warming up on the stationary bike and skipping ropes.

Shawn efficiently moved the equipment to each station, while we joked around in anticipation. A colleague from the neighbouring NGO on the premises also joined in, as did Steven, who said this session was his first after a long break. In fact, Steven had signed a ‘contract’ with the team on the Deadly Choices whiteboard, committing to participating in both the two weekly training sessions each week. The team had been joking about this during the day but in a good way, holding Steven to account, who seemed slightly apprehensive about his comeback.

After a warm up jog or walk out to the end of the road and back, Shawn allocated us to different stations: burpees, stationary bike, push-ups, dips, sprints, weighted squats, skipping rope, crunches. Shawn timed us and then we moved on to the next station, encouraging us with our technique or pushing us to reach a higher number of repetitions. At one point, Steven disappeared during the workout and after a while, wondering where he was, Danielle and I went upstairs to the office to find him catching his breath. I think he had pushed himself hard for someone coming back after a

2-year break! We three then returned downstairs to continue. There was friendly chatter and laughter throughout the session; it was a fun way to spend social time together and to be healthy - and to be the leaders that Deadly Choices is about, in our own way (Figure 48). (Field diary, 13/05/2013)

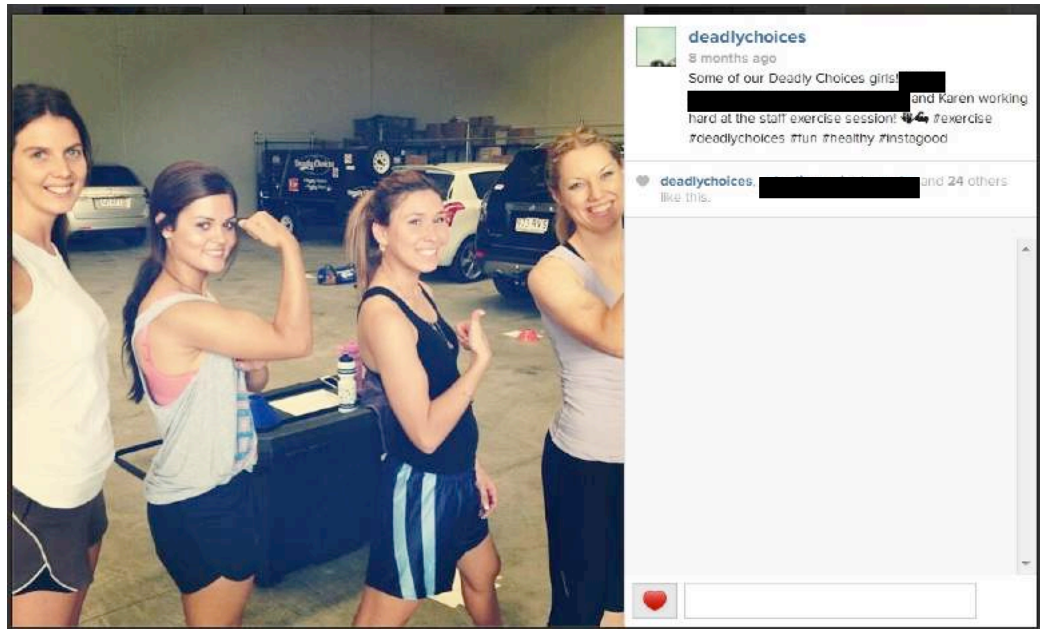


Figure 48: Participating in the Deadly Choices fitness training sessions after work (Deadly Choices, 2013k).

Role modelling does have its challenges for the Deadly Choices practitioners, many of whom carry expectations of themselves to consistently role model the desirable behaviours they espouse. Conceivably, a portion of the pressure on Deadly Choices practitioners to excel in health and fitness comes from having predominantly male, professional and ex-professional athletes in the Deadly Choices team. Take for example one of the practitioners sharing with me their “weakness” of poor eating habits (Field notes, 8/07/2013). Immediately after I had conducted the leadership workshop with the Deadly Choices team (discussed in Chapter Four), Elenor pulled me aside and shared:

The biggest thing for me is role modelling. Like, being a role model, I really struggle with the nutrition side of things.

Elenor disclosed to me her weight and explained,

I don’t drink or have a vice like that but whenever I am down, I eat. I know I am supposed to be out in the community role modelling good behaviour yet I struggle with it.

Elenor appeared somewhat distressed about the dissonance between her eating habits and her desire to be authentic regarding her own behaviours and messages. I asked what would help Elenor in this experience and she replied,

I don't know, hey. Maybe a photograph of myself when I was thinner? Or trying to wear my jeans? – which I tried on again on the weekend and they don't fit me properly now.

I was moved by Elenor's difficulty, sensing the pressure she experienced to be the healthy role model Deadly Choices espoused. Elenor is a relatively fit and strong woman yet clearly being a role model was challenging her, producing feelings of guilt and self-perceptions that she was not meeting the behavioural expectations of a Deadly Choices practitioner.

Elenor is not alone in this tension, as other practitioners similarly have confided to me about their struggles. It appears that healthy nutrition is a common struggle, particularly for women on the team in relation to their bodies. Such a struggle is consistent with research that found a range of harms, including psychological issues, stem from having a body weight one considers to be outside the “normal weight” category, particularly for women (O'Hara, 2014). Yet I also observed that the practitioners lift each other up through this struggle with words of encouragement, sharing their healthy meals in the office, and posting and commenting on social media. The benefit of this team support did not appear to be experienced equally amongst team members though, where practitioners located within a community host organisation (compared to being based in the IUIH office) seemed to more frequently express struggles in maintaining a healthy diet. These practitioners likely experience additional challenges stemming from their higher travel workload, which reduces their access to infrastructure that supports healthy behaviour (for example, a fridge) and exposure to teammate support.

Regardless, this team exhibits an attitude that “we could always be better” and prioritises quality improvement. Over time, I have witnessed team feedback and project management systems improve. As an example, community events now have a documented process that identifies individual practitioners for specific duties at particular times to ensure an efficient set up. Additionally, the team recently commenced trialling themed community days, with the themes selected according to AMS and community requests. Nutrition protocols for community days are also being

developed to ensure local culture is respected (for example, to ensure that the provided lunch does not include the totem of the local community). Merchandise items are strategically distributed across community days and competitions, which represents a change to previous merchandise distribution methods in the earlier years, when every community day a participant received a reward. The team has also developed a structured debriefing process for community events to examine what worked, what didn't work and what could be improved in future. This debrief process is now a standing agenda item at the team's monthly meetings. These are just some examples of the way Deadly Choices endeavours to learn from its practice and continue building and improving its work and systems to deliver Deadly Choices.

Alongside this quality improvement, the team's diverse background appears to have formed a foundation for a peer education approach for their professional development. The way the team works together to learn and achieve appears to be a strength of the team. This was illustrated in Shawn's reflection about the 2012 team retreat, where he expressed that one aspect of the retreat he liked most was learning from other more experienced workers (Field notes, 09/11/2012). In this case, Katie and Russell, two more experienced tobacco workers on the team, designed and delivered smoking cessation training for the Deadly Choices team, based upon tobacco groups and clinics they run in the community.

During the training, Shawn shared with the group in conceivably negative tones that he had observed a pregnant woman "belly up and smoking". I was somewhat surprised to hear this apparently judgemental language, given that mothers (particularly Aboriginal and Torres Strait Islander mothers) living with low income, poor housing and isolated conditions are most likely to be using smoking as a coping mechanism (Australian Government, 2012; D'Este, Passey, & Sanson-Fisher, 2012; Johnston et al., 2011; Wells & Batten, 1990; Wood, France, Hunt, Eades, & Slack-Smith, 2008). My initial interpretation of Shawn's comments was that Shawn was demonstrating a case of "blaming the individual" (Carter et al., 2012a; Saggars & Gray, 2007). The conversation that unfolded, however, revealed the way Deadly Choices members teach and guide each other in their practice and associated attitudes.

Ethan, a fellow male practitioner, responded to Shawn with body language and a tone that appeared to agree or empathise with Shawn's position; I read this to be an affirmation of Shawn's contribution. Ethan then proceeded to claim, "We can't look down on someone smoking. We know and they know they shouldn't". My sense of what Ethan was conveying to Shawn was that the Deadly Choices' health education practice is best when it is not judgemental. Katie then appealed to the whole group to take a moment to consider the wellbeing of the mother herself: "A pregnant woman smoking probably already experiences a great deal of guilt (for smoking), so it's best to avoid making them feel more guilty and instead make them aware of why smokes are bad. Maybe then they are more likely to quit." Katie emphasised that, "Mums are often in a vulnerable state, sometimes with their partner and family smoking around them and possibly not supporting their decision to quit."

I observed how the more experienced workers steered the conversation to shape the understanding of team members, particularly those new to smoking cessation. The tone of this conversation appeared to be one where learners, such as Shawn, were secure enough in their place in the team to voice their reflections. When I later spoke with various team members about their experience of this training, people made references to the mentoring and teaching by their experienced peers as being a supportive experience. Shawn, for example, suggested that this peer training and ongoing support, assisted him to critically reflect on his own attitudes and behaviours regarding community members:

He (Russell) gave examples on what people have said to him and what they think about smoking and I've gotta make sure I try not to put my beliefs and stuff onto them... sometimes I think, 'Oh I've never smoked, this and that,' but I've gotta understand it's a disease, you know, smoking is an addiction and sometimes... I sort of go off that path, and you know, Russell always brings me back and says, 'you gotta remember that it's an addiction, it's a disease, it's very tough to get off the nicotine and it's a drug.' Once he keeps enforcing that, it helps me on my delivery as well. (Interview, 22/01/2013)

Deadly Choices frequently draw on team training approaches where practitioners share their knowledge and experience with each other. By being in relationship with one another and with community, the Deadly Choices practitioners are able to learn together, enabling their own knowledge, attitudes and beliefs to shift. In doing so, the space has been created for the community to co-construct the way the Deadly Choices

practice transpires, with practitioners remaining accountable to one another and their community.

“What’s your Deadly Choice?” Community driven health and the Deadly Choices brand

The key principle in health promotion conducted at the community level is that prevention cannot be imposed on people, but rather, it can be instigated and lead only by them. (IUIH, 2014c, p. 15)

The narratives displayed in and through Deadly Choices are by and of the community. Collaboration between Deadly Choices and the community drives the possibility to co-generate health promotion messages. In doing so, Deadly Choices creates the possibility for community members to shift from being positioned as recipients of health promotion to health promoters. Simply by sharing their chosen ‘deadly choices’, community members co-construct the Deadly Choices brand and inform the practice of Deadly Choices. Distinctly, this is open-ended collaboration, not with an agenda to advise Indigenous people how to change their risk behaviour.

Through the simple question, “What's your deadly choice?” authorship of the health promotion messages – that is, the deadly choices people make and promote – shifts away from health promotion practitioners to the community. Take for example Figure 49 where Deadly Choices welcomes a new follower of Deadly Choices on Twitter with the questions, “so what’s your Deadly Choice?” The follower responded by referring to self-esteem and wellbeing: “...being strong and proud and backing yourself every time”. This response was not constrained by the holy trinity¹³⁷ that frequents mainstream health promotion. Rather, this person chose their deadly choice according to their own understanding of what being healthy means.

¹³⁷ As discussed in Chapter Two, the holy trinity of health promotion refers to substance use (smoking, alcohol), nutrition and physical activity.



Figure 49: Deadly Choices Twitter shout out to their new followers (3 June 2013).

A Deadly Choices practitioner highlighted to me another example of the collaborative construction of Deadly Choices, in a young girl's entry for the Deadly Choices Mental Health Week 2013 Facebook competition. This girl identified ways she promoted her own mental health – exercise, social networks, gratitude, goals, friends and family – by creating a slide show video.¹³⁸ The practitioner interpreted this clip as demonstrating the way humour, social connections and healthy lifestyle are the centrepieces of her approach to promoting mental health. Similarly, the practitioner identified the way these social media competitions stimulate engagement with constructs of health.

First, she says she goes for a run... And she's a bit of a larrikin too. And then she'll put up how long she ran for, how many calories she did. And this one's about depression so she needed to put stuff up around depression... her goal is training for districts and stuff. And then she'll talk to her mum if she's got any problems and then she'll fix them. So this is - I think it's really powerful stuff. Like, you know, before we had this, she wouldn't have understood that depression is a chronic disease... she put some funny photos up of herself um but this is how she pictures her ways of depression: how to combat it. And everyone has got different ways of expressing it. And that's hers. And I think that's awesome and we need to promote it and encourage that creativity as well. And we do, by sharing it and promoting - and telling everyone, 'Hey, this young girl's done this and that and I think it's great.' (Interview, 13/05/2013)

As this example demonstrates, Deadly Choices practitioners manage and facilitate the collaborative process (in this case, through a social media competition). However,

¹³⁸ This video clip was posted 9 May 2013 (URL: <https://www.facebook.com/photo.php?v=10200975295682507&set=o.225245497554520&type=2&theater> -accessed 17 October 2013).

people determine their own deadly choices, which appear to be based on an Indigenous view of health (National Aboriginal Health Strategy Working Party, 1989) that spans across the social determinants of health. For example, other profiled deadly choices include completing a school education (Figure 50), obtaining qualifications to pursue a life goal of running a restaurant (Figure 51), and time with family (Figure 52). Because people *choose* their own deadly choices, the Deadly Choices brand is one that the community shares ownership of and affiliation with. The collaborative process behind Deadly Choices appears to be what makes its brand so powerful, being both representative of and accessible by community. Through this, the Deadly Choices brand represents Indigenous notions of health and identity.

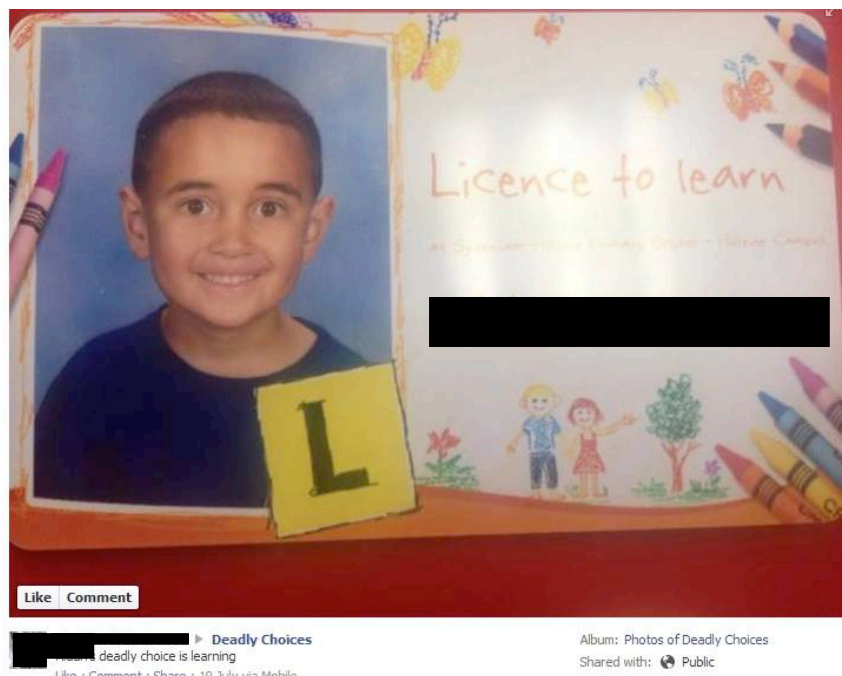


Figure 50: A parent shares their son's deadly choice: To obtain an education (Name withheld for confidentiality purposes, 2013a).

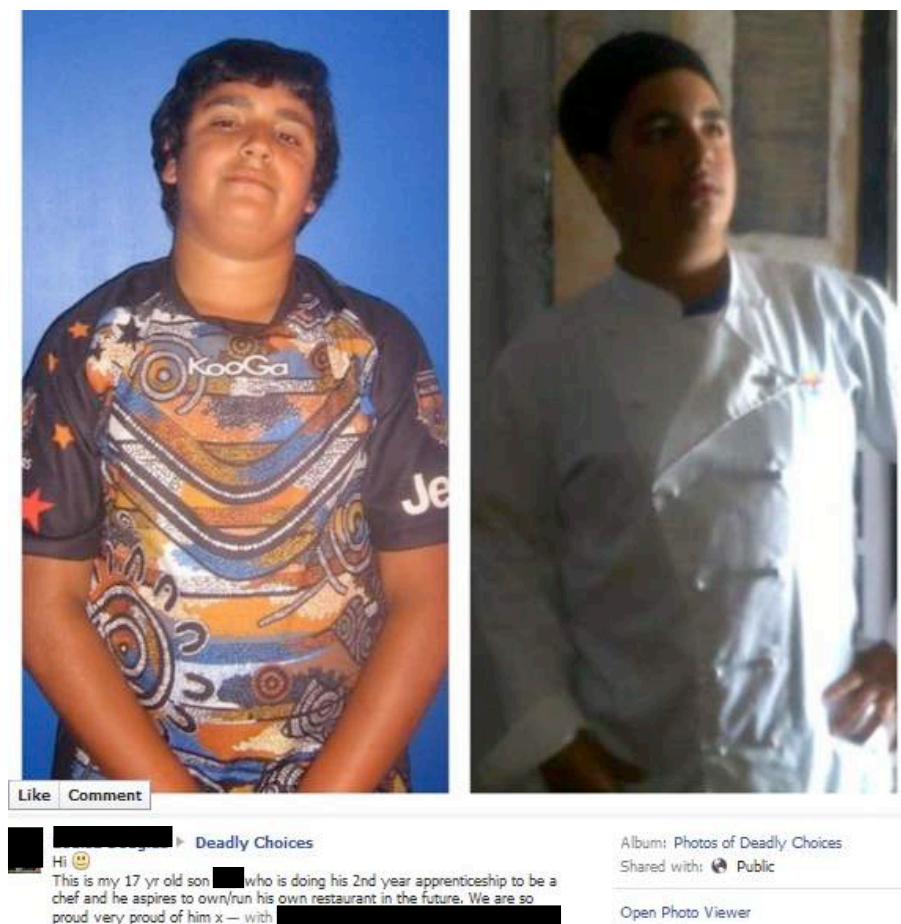


Figure 51: A community member posts about their son's Deadly Choice to complete an apprenticeship (Name withheld for confidentiality purposes, 2013g).

The strength of the Deadly Choices brand is its co-constructive nature; however, there are challenges associated with this. By sharing control with community of the construction of the brand, community members can become “walking billboards” for Deadly Choices. With the rapid acceptance of the Deadly Choices brand in SEQ (and anecdotally more broadly), Deadly Choices has encountered cases where the brand, usually by way of the merchandise, has been associated with behaviours incongruent to the Deadly Choices agenda, such as smoking or unhealthy eating. Through this, a tension is revealed: should or could Deadly Choices attempt to control behaviours and activities associated with Deadly Choices, given that people may choose choices to engage in behaviours misaligned with the Deadly Choices agenda whilst wearing the merchandise?

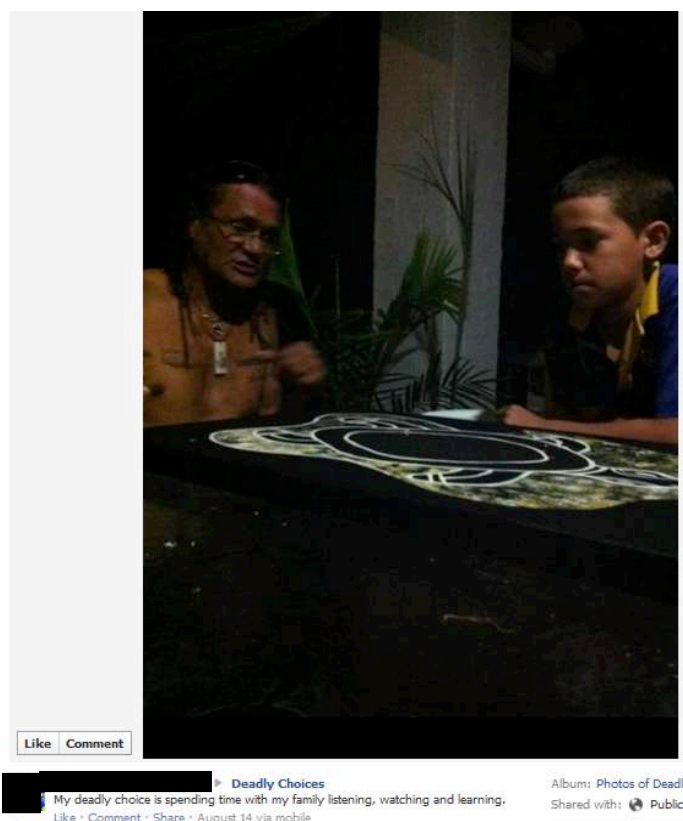


Figure 52: A community member posts that their deadly choice is of "time with my family listening, watching and learning" (Name withheld for confidentiality purposes, 2013d).

Perhaps ironically in light of the Deadly Choices philosophy, “We don’t tell people what to do,” the community control over the brand also has the effect of community maintenance and monitoring of the Deadly Choices brand. For example, community members report cases of public behaviours they witness as disunited with the Deadly Choices agenda. Figure 53 provides an example of this community surveillance, where a community member disclosed to Deadly Choices their observation of an alleged worker associated with Deadly Choices smoking near a vehicle displaying Deadly Choices imagery. This interaction shows us the value Deadly Choices places on relationship, through which they craft healthy norms, rather than enacting judgemental surveillance. The interaction also demonstrates the power of relationship for embedding health promotion where the community takes ownership.

Quite ironically, I just a female driver of your Deadly Choices van parked in Hinkler carpark, Bundaberg, get out of the government van, and light a cigarette. Not a very good advertisement for your cause.

Like · Comment · 27 June at 16:58



Deadly Choices Thanks for your message [redacted] will follow this up as it could be a worker or someone that has received a Deadly Choices shirt through their program.

28 June at 09:29 · Like



[redacted] Yes definitely a worker , she got out of the van to have a cigarette. The van has huge decals all over it about choosing never to smoke.

28 June at 11:57 via mobile · Like

Figure 53: Community member alerts Deadly Choices to merchandise being worn by people undertaking behaviours incongruent with the Deadly Choices message.

A deadly choice is an identity choice: The unspoken curriculum

As stated earlier in the discussion of leadership, Deadly Choices has introduced a narrative of cultural values and identity to health promotion. In doing so, Deadly Choices has created an Indigenised space where people are safe to choose to identify as Indigenous. Effectively, a deadly choice is an identity choice. I observed this frequently as a result of the Deadly Choices Education Program. For instance, Michelle (from the earlier example) expressed excitement in anticipation of learning “about culture” and was supported to explore the possibility of identifying as Indigenous:

While we waited a little longer for possible latecomers, I helped Hunter facilitate conversation, mindful of Deadly Choices’ emphasis upon building and nurturing relationships with and between the students. The students discussed which teacher they didn't like and who had skipped class, as well as asking questions about identifying as Aboriginal. Michelle asserted that she was under the impression her future children “would not be allowed to identify as Aboriginal because the blood would be too diluted”. The flexibility of the session format meant we could inform her of the Commonwealth three-part definition¹³⁹. Hunter then added, “But you can identify if you know you are Aboriginal, even without the papers to prove it. However, some services will require those papers if you wish to access them. But some people can’t get papers”, Hunter explained and indeed, this was the case for Michelle, who said her gran was from the stolen generation and that her family continues their struggle to obtain their papers. (Field notes, 9/07/2013)

¹³⁹ As outlined on the Australian Law Reform Commission website (URL: http://www.alrc.gov.au/publications/36-kinship-and-identity/legal-definitions-aboriginality#_ftn16 - Accessed 10/09/2014).

In the following weeks, Michelle continued her journey regarding her Indigenous identity. After attending a number of sessions, Michelle exclaimed that she was “proud to identify as Aboriginal” and that Deadly Choices taught her about culture through family and values. Michelle’s comments contrasted with her earlier comments where she had expressed a belief that identifying as Indigenous was a negative choice. Important identity work had been taking place through Deadly Choices, as Michelle’s story illustrates, even if it wasn’t captured on the official Deadly Choices educational material.

Another of Michelle’s peers also chose to identify as Indigenous, by association with Deadly Choices. This particular case begins at the awards ceremony staged by Hunter to provide his Deadly Choices students with their reward (a Deadly Choices jersey) for participating in all sessions of the term.

Donavon was invited to the rewards ceremony, although he was not to be awarded a jersey because he started half way through the program. The Deadly Choices rewards were for effort, which in this case was strictly defined by the Deadly Choices policy as attendance at every session. Hunter noted Donavon’s participation and appeared to want to reward Donavon’s efforts but was unable to, given that Donovan began in the Education Program part-way through. However, Donavon was aware of the policy that determined he would not be given a jersey and despite appearing to desire one, was enthusiastic about the awards event and did not complain.

Donavon and I talked as the class walked together to where the rewards ceremony would be held. Donavon reflected upon why he did not attend Deadly Choices until half way through the term, explaining that he suspected the teachers were unaware that he was Indigenous. Indigenous students relied upon their teachers to inform them about Deadly Choices being at their school so that they could then choose to participate or otherwise. Donavon was new to the school and when he arrived, he said, he didn’t want to tell people he was Indigenous because at his last school Indigenous people were not thought of highly. Donavon said people would say, “Agh you’re Black!” and treat you differently. Donavon’s fellow students already involved with Deadly Choices were the ones who eventually informed Donavon of the program. It was only when Donavon chose to participate in Deadly Choices that by effect, he chose to identify as Indigenous at this school. Once he attended the Deadly Choices Education Program (the first time being at the 5th session), Donavon attended each opportunity he had and participated consistently and enthusiastically. (Field notes, 23/07/2013)

Donavon’s story demonstrates that Deadly Choices promotes choices to identify as Indigenous and provides the cultural safety (Eckermann et al., 2010) for people to

choose. In this way, Deadly Choices constructs Indigenous identity as health producing and as a deadly choice. As a visual example, consider Figure 54, in which a Deadly Choices ambassador asserts pride in being Indigenous. In his own words, “Being Aboriginal means everything to me... the connection I have with my people and my country is something money cannot buy.” This image and its narrative display strength, health and pride, which illustrates the way Deadly Choices also functions to provide a counter-narrative to the colonial definitions of mainstream health promotion. Effectively, Deadly Choices provides an alternative way forward in health promotion.



Figure 54: A Deadly Choices ambassador preparing for his world title boxing match, where he would represent the Deadly Choices brand, shares the importance of being Aboriginal (Deadly Choices, 2013e).

Talking to, not down: Depth over body/behaviour-checking

Being a relationship-based practice, dialogue is where the work happens for Deadly Choices. This means that relationship takes priority, even over enforcing a predefined health promotion agenda. Take for example the way Elenor worked with a group of

people known to exhibit behaviours incongruent with the Deadly Choices agenda (drinking in public spaces early in the morning), while wearing their Deadly Choices jerseys. Elenor prioritised taking the time to build relationship with this group of people – that is, to be led by the community interactions in her practice – instead of directly confronting the behaviour.

I'm trying to target the real hard core ones that, man, they've always got a drink in their hands so... Coz they've hit me up about a softball thing so I'm gonna start the softball up next week; meet in the park. I've got a kit now... but then, who was I talking to yesterday? (*Worker's name, from a partner agency*), she was, I guess, saying that, "don't go ahead with it unless you know they're really into it," kind of thing. She knows them. Coz every time I see 'em they're charging up and it's nine o'clock in the morning with a big carton and Deadly Choices shirt on (laughs). So that's sort of... like she (*the community member*) hit me up, she said, "this will help us get off the drink and that". So, you can only try though but it's coming. So hopefully after I finish here, we'll go for just a walk. Might do a bit of boxing or something in the park. And these ones are going through two packets of smokes a day. (Group interview, 21/08/2013)

Elenor's approach was to continue working with this group of people and build relationships – to “go for just a walk” or “a bit of boxing or something in the park”, as opposed to immediately focusing on changing the “poor” behaviours this group of people apparently exhibited. This is not to say Deadly Choices condones these behaviours but rather that the basis of practice for Deadly Choices practitioners is relationship. From relationship, health education can flow.

Consider again Hunter's delivery of the Deadly Choices Education Program as an illustration of Deadly Choices relationship-based practice. Hunter's delivery was much like the practice I had observed with other Deadly Choices practitioners: flexibly based around the format of seven topics¹⁴⁰, over the span of a school term. The following vignette relates to Michelle's story earlier, from the start of the term in the first Deadly Choices session Hunter ran with this class.

Hunter, Danielle and I waited in the classroom for the kids to arrive, while Hunter arranged the computer and data projector with the Deadly Choices slides. Students arrived slowly and we chatted together, some indicating that they had not heard about the program until they heard the loudspeaker call of the expected student names to come. Eventually, Hunter commenced the session. Hunter, Danielle and I each introduced ourselves,

¹⁴⁰ The seven topics are leadership; chronic disease; physical activity; nutrition; harmful substances; smoking cessation; and Medicare and access to primary health care (as discussed in Chapter Five).

sharing where we were from, our cultural heritage and our role in the team. After playing a few ice-breaker games together, Hunter segued into the Deadly Choices slides he had displayed on the screen for the class. As Hunter worked through the slides, he asked questions of the students, including whether they had heard of Deadly Choices (two girls had heard of it before) and Close the Gap (one of these two students had heard of Close the Gap). However, no students were aware of what Close the Gap was. Hunter explained some of Close the Gap's relevance to life expectancy, highlighting the difference between Indigenous and non-Indigenous Australians. Hunter made a call to "fight this together", "to get our health back". (Field notes, 9/07/2012)

This vignette exposes a deeper level of conversation taking place through Deadly Choices, than what first may be apparent. Before Hunter began with the education slides, he yarned and played icebreaker games with the kids to build rapport within the group. Hunter's emphasis upon building relationship is signature to delivery of Deadly Choices. Much of the practitioners' work with community falls outside of the parameters of the official health promotion boundaries, such as those provided through the Deadly Choices education slides. In Hunter's session, as the three Deadly Choices representatives we invested time to establish our positioning in relation to the students, including naming our heritage. This process was indicative of culture's place as an explicit component to Deadly Choices (even if not officially documented on the slides).

This vignette also demonstrates a discrepancy between mainstream agendas, such as Close the Gap, and the lived reality of the people these mainstream agendas affect. In Hunter's class, few, if any, of the students were aware of Close the Gap. However, for Deadly Choices practitioners, Close the Gap is an important part of Deadly Choices' contemporary history. The Close the Gap campaign resulted in the government agenda, Closing the Gap (CTG), to which (among other policies and politics) the SEQ AMSs responded by establishing IUIH. CTG continues to set the policy scene for Deadly Choices practice and reporting, to which Hunter and his colleagues are accountable. Despite CTG's prominent positioning in relation to Deadly Choices, students are unaware of this policy, which perhaps in some ways fails to reflect the lived reality of these students on the ground.

Similarly, while mentoring is not an official objective of Deadly Choices, it is also apparent throughout the work of Deadly Choices practitioners, particularly with

students. Through their presence in mainstream spaces, such as schools, the Deadly Choices practitioners provide positive role models (particularly male) for both Indigenous and non-Indigenous students. Take for example an exchange between Hunter and Evan, a Deadly Choices student, after one of Hunter's education sessions:

At the conclusion of the classroom component, we walked together outside to play some leadership games. Hunter selected three games for us to play: the Human Knot, Crows and Cranes, and the foot-to-foot race. All of the kids appeared to enjoy these games, spending much of the time laughing. Soon, the bell rang and Hunter requested we all return to the library, where we had been for the classroom component. I walked with Jarrod as we walked back and asked if he liked the session today. He had barely said anything for the whole class and I was curious how he was going. Jarrod replied by confirming he did enjoy it, with broad smile on his face as he looked directly at me. Jarrod proceeded to share with me the latest events in his life.

We were soon in the library again, where Hunter requested the students complete their feedback form. While they were doing this, Hunter promised we would play Traditional Indigenous Games next week and another round of Light as a Feather – a game Evan specifically requested. Once the students completed their feedback, Hunter said they were free to go. As they left, Jarrod and Evan remained for a chat. Jarrod stayed briefly to chat before leaving for lunch but Evan stayed much longer.

Evan began asking us questions about consent requirements for getting a tattoo at his age. However, he soon began to discuss his uncle and family more generally. Evan talked and talked and talked, while Hunter and I listened; it was as though Evan needed someone to talk with, particularly an older male as he appeared to gravitate towards Hunter. I had seen in other programs the way boys appeared to be drawn to the male Deadly Choices workers. I suspected that the way Deadly Choices provided these male role model figures was one of the program's most important attributes for these young boys. Although providing male role models was not stated as the program's purpose, it seemed to be an intuitive part of the staff practice of leadership.

It was Evan's first time in Deadly Choices, yet he appeared to immediately connect with Hunter, sharing some very personal details and challenges he faced. Evan conveyed some of his stories regarding why he considered the past year to have been "pretty traumatic". Yet despite this, he appeared to take being a male leader in the family, in his father's absence, quite seriously. Evan easily smiled though when he recounted something he appeared to be proud of or like.

After talking for quite some time, Evan returned to his tattoo intentions. "This would be a family tattoo," Evan told us and showed us the design, explaining which aspects represented the Samoan, Aboriginal and Fijian heritage in his family. Evan said he also had Scottish heritage but "didn't

know what represented that” in the tattoo design. Evan spoke proudly about his heritage. Despite saying a number of times, “Things aren't going so well in the family”, Evan continued to identify with his heritage and family, as though it was important and a source of strength.

It struck me how we had just covered a chronic disease session today and here we were with Evan, talking about his life experiences, identity and troubles – not chronic disease. Hunter listened the entire time to Evan without saying anything; we both did, but Evan appeared to be seeking Hunter's attention in particular. Hunter's presence here today seemed to be important for Evan. I didn't get the impression Evan didn't want me there, though, so I sat and listened. The bell rang a few more times while we were talking and Evan remarked how surprised he was that he was talking for the whole lunch break to us. Hunter said to Evan, "The one thing I would say is to keep positive. Keep that smile on your face. Keep a positive attitude". Evan replied, “Nothing will take this smile off my face - it would take a tragedy.” So much of Evan's life sounded to be full of tragedy and still he smiled. Evan kept talking a little but Hunter announced that Evan had better go to class or we would get him in trouble. Evan soon departed. (Field notes, 23/04/2013)

This vignette reveals that the work of these practitioners does not conclude at the close of the official education session. A distinguishing quality of Hunter's practice – as with that of other Deadly Choices practitioners – is that as a health promotion practitioner, he listens while the “program recipient” talks. This represents a pointed contrast to more common approaches to health promotion that centre the expert voice. Instead, Hunter's practice enabled a two-way channel (also a trademark of mentoring) for health promotion, through which codes of behaviour could be reinforced and guided through practical lessons and fun, while learning about cultural identity and values.

Hunter's program delivery indicates the depth of relationship Deadly Choices practitioners establish, which is also acknowledged by Deadly Choices' partnering health services. At the end of Hunter's program, the students were due for their health checks. Hunter arranged a partnership between the local AMS and the school, which enabled the health checks to be conducted on the school premises in the Deadly Choices mobile medical van. The nurse revealed that many of these health checks identified that a number of the students “needed someone to talk to”.

Today was the final part of the Deadly Choices program that required Hunter's students to participate. Hunter had arranged that over the span of three days, health checks would be conducted at the high school using the Deadly Choices medical van. I joined Hunter for the final day where I saw the students from the program arrive at various times; those I knew who I

did not see had apparently completed their health checks the first day. Braden drove the medical van in from Deadly Choices headquarters, while the local AMS provided a nurse and doctor, who conducted the health checks inside the health van (see Figure 55). This partnership provided the local AMS a connection to these kids and their families to follow up after the health checks were completed.



Figure 55: The UIIH/Deadly Choices medical van visits the State High School to provide the venue for health checks to take place.

The students arrived individually at their appointment time. Hunter was the familiar face for the kids; he would mark their name off a list when they arrived and introduce them to the two AMS staff. In between the sessions, occasionally there was time waiting for the next student to arrive, which meant Hunter and I could chat with the nurse and/or doctor when they weren't with a student. At one point during the day, the nurse shared her observation that a high number of students coming through for these school-based health checks needed someone to talk to. She said she found that many of the kids came from broken homes, saying these health checks provided opportunity to encourage the students to seek someone out to talk to, whether it is their local AMS or Hunter, or whoever they are comfortable in talking with. I was interested that the medical professionals considered Deadly Choices practitioners an appropriate option to refer to. I recalled the way the students had opened up with Hunter throughout the term and I wondered how Hunter would have the time to maintain these

connections as he continued to roll out Deadly Choices across his portfolio area. However, I knew that Deadly Choices values an ongoing relationship with the schools and students it connects with, seeking ways to remain engaged through the range of activities Deadly Choices offers. (Field notes, 11-17/06/2013)

In addition to clinical acknowledgement of Deadly Choices practitioners' relationships with students, I often heard school staffers, such as a principal, teacher or Indigenous Liaison Officer, comment or declare that the Deadly Choices practitioners met a need of the students to "talk to someone" and for strong role models. Perhaps the presence of these Deadly Choices practitioners as strong, healthy Indigenous people – against a backdrop of a mainstream narrative that asserts Indigenous people are otherwise, and lacking positive Indigenous role models – is an implicit part of what makes them approachable and desirable for the students to connect with. Take for example Brendan's first Deadly Choices session on leadership with a new group of students at a local high school. Here, Sam, the school Indigenous Liaison Officer and the three Deadly Choices practitioners involved in the session, debriefed after the session was finished.

Steven, Brendan, Shawn and I had just spent the past hour or two with a class of boys participating in their first Deadly Choices Education Program module on leadership at a high school. I had observed and participated with the three practitioners in interacting with the boys regarding leadership, both in the classroom and on the field outside through a series of leadership games. While the boys participated, however I considered this group to be quieter compared to other Deadly Choices sessions I had attended. I figured this could in part be because they were in the early stages of establishing as a group; the boys were from different grades and we as the Deadly Choices team were new to most of them too, aside from a few boys who had been a part of Deadly Choices before. However, both Brendan and Shawn made a point of saying to Steven (a new Deadly Choices practitioner) and me that "they'll be talking more in a few weeks". Brendan attempted to strengthen the legitimacy of this claim by stating that in his last Deadly Choices program elsewhere, this was the case, where by week 3 the students "were talking heaps" and by the end of the program they apparently wanted him to come back.

Shawn said he was "a bit disappointed that some of the boys who know me through Deadly Choices didn't talk up more". The three practitioners speculated that the kids could have been quiet because they don't know one another too well. However, Sam, the school's Indigenous Liaison Officer, clarified, "These boys are quiet. I've known them for years and they're always quiet". Sam appeared to be very pleased with the Deadly Choices session. "No offence to women", Sam said, looking at me in a way that

seemed to reiterate she did not mean it personally, “but it’s great to have you fellas come and talk to these boys because that’s what we’re lacking; the boys don’t have that. They don’t have male role models.” As Sam said this, I recalled one of the boys saying in that class that he does not know his father. Perhaps this boy’s experience echoed the “cracks in the community” and “lack of leadership” that I had heard some of these practitioners talk about at times. (Field notes, 17/04/2013)

In the above scenario, the school Indigenous Liaison Officer drew attention to the absence of male role models for these male students. While the school welcomed the Deadly Choices practitioners in relation to a health agenda (that is, to deliver the Deadly Choices Education Program), there appeared to be an unofficial recognition of the greater benefits for the students, beyond health education.

As the above scenario also demonstrates, Deadly Choices relies upon organisational and institutional relationships (with schools, AMSs and so forth) as well as the individual relationships discussed already. Not all agencies are so welcoming or positive to having Deadly Choices operate in their setting and Deadly Choices practitioners do encounter resistance at times. A case in point is the following conversation, regarding a school whose canteen reportedly stocked predominantly unhealthy foods, where Deadly Choices delivered its Education Program. In this scenario Deadly Choices initially endeavoured to provide support to the school to change its canteen menu but when the practitioners encountered resistance, they did not press the matter; it remained the school’s decision to engage with Deadly Choices support.

- Elenor: See the thing is with (*school name*) is we’re in there, promoting healthy lifestyle and nutrition. And you know what their canteen’s like? They’re walking around at nine o’clock with ice-blocks and chips and...
- Jolene: One chips in one hand, and then an ice block in the other.
- Karen: The kids aren’t supported to do what you’re teaching them to do?
- Elenor: Yeah, well even the school is not supporting it.
- Jolene: We tried to change the tuckshop menu a year ago, a year and a half ago or something... Daniel was there as well. And... it apparently didn’t work out... I don’t know if it was just because it’s just their mentality in thinking that, “Look I’ve been here so many years, don’t come in here and tell me what to do”. So it’s like, well, then don’t come crying to me when there’s something you want. You know? It’s like, well, we had the best ideas; we had everything there. We had the best dietician from Queensland Health; she was giving all of her time for that to try and change it and they had a ‘sad’

about it and said, "Look, they come in here and try and tell me what to do. I don't want any part of it", rah, rah rah.

Bianca: Yeah, our work can't work fully unless all things work; like, it kind of negates our work.

Danielle: Yeah.

Elenor: You know how easy it is for the kids to say, "yes"? If you're gonna have a pack of chips in front of you, you're gonna grab it, you know? So, it's terrible what they eat.

Jolene: Kids, kids, if you start 'em young enough, will have anything. If you give 'em the right stuff at the start, they're happy to have it. If that's all they knew, then there'd be no problem. But because all they know is chips and crap, half of them - like, they don't get a feed at home, so when they come to school, anything they get given is like, "Yes!" They get food. And obviously when they give them the bad stuff, then that's all they think of.

Bianca: And they only sell bad stuff, don't they?

Jolene: They don't even sell it; I think they give it to half of them. They just think, "Oh well, I'll give ya something". At least give them some sort of... give them a piece of bread or something like... Anything.

Elenor: And because that's all they've had growing up, its hard to change a teenager, when, "Here, eat your vegies" - "Oh yuck, I'm not eating that". They won't try it.

(Group interview, 21/08/2013)

This conversation demonstrates the practitioners' awareness of the environmental factors that impact upon the students' power to choose healthy food when in their school environment. The conversation also highlights these practitioners' knowledge of the value of the long-term relationship and trust with the school, over short-term health promoting changes such as the tuckshop menu. As a result, these practitioners did not press the matter of developing a healthy tuckshop menu with the school while continuing to deliver the Deadly Choices Education Program.

The practitioners are well aware of the tension of not telling people what to do, while working to help people (young students in this case) change their behaviour. The practitioners understand the broader factors influencing behaviour and that education alone cannot assist the students to eat more healthy food. However, as this chapter has highlighted, Deadly Choices aims to empower Indigenous people and communities, which requires practitioners to adhere to the principle, "we don't tell people what to do". Such an approach requires sensitive negotiation guided by prioritisation of relationship in the health promotion agenda. This approach also requires the respect of

people's choices, which at times may be misaligned with the desired Deadly Choices behaviour but always holds greater value than forcing people to change.

Instead, as members of the community they work with, Deadly Choices practitioners promote the community and celebrate positive transformation. With its locally driven, distributive model of leadership, Deadly Choices acknowledges the agency of the community it works with, evidenced by the co-creation of the Deadly Choices brand and conceptualisation of health. Deadly Choices practitioners have a role in the community as leaders themselves – role models – and so are personally aware of the barriers and enablers to being healthy and empowered. Using a collective approach to health promotion, rather than imposition of a pre-defined health agenda, Deadly Choices practitioners transform health promotion into a dialogue between practitioner and community, where community members in effect become health promoters themselves. As the practitioner stated at the start of this chapter, “It’s all about empowering our people...”

7. “It’s just thinking normal”: Community control and transformative governance

It’s mad, hey, when... our role is chronic disease, nutrition and exercise, and then the tobacco stuff with the smoking group, and we come up with leadership. But it’s just thinking normal, well not normal, but the way we would normally think; instead of looking out looking in, we’re in, looking out. You know what I mean? (Interview, 22/11/2012)

“...We’re in looking out...” could be synonymous with what the decolonisation of health promotion might involve. Deadly Choices operates from a position of Indigenous governance, achieved both through a community controlled health service and community control processes. The processes of community control create a positive, Indigenised space and practice that has generated a broad following, beyond the South East Queensland (SEQ) Indigenous community to include mainstream government and followers alike; a form of “reverse colonisation”, as was explained to me. The result is the centring of Indigenous community “recipients” in Deadly Choices’ health promotion practice.

Informed by Indigenous values, identity and strength, the Deadly Choices practitioners – who are part of the community themselves (see Chapter Six) – have “come up with leadership... (as) normal”. Indigenous community control effectively shifts the colonial focus of health promotion from that of controlling Indigenous people (discussed in Chapter Two) to mutual participation. As the practitioner above states, these practitioners are not so much resisting the colonial processes of health promotion, but rather “just thinking normal”.

Social media has been an important platform to support this transformative governance, where Deadly Choices has built a grassroots following, unmatched by many of its health promotion counterparts. Deadly Choices interblends its online community interactions with its offline interactions, creating a consistent “personality” and community-centred practice across the online-offline interface. Deadly Choices

practitioners respond to this broadened following with positivity and inclusivity, while retaining Indigenous community control over their approach.

Social media – “It’s where they are”

“We’ve got so many likes”: Dialogue and engagement through social media

Deadly Choices consistently focuses on social media for engaging the community and enabling people to profile their deadly choices. A Deadly Choices practitioner explained the inspiration for Deadly Choices’ presence on social media as being because “it’s where they are”:

...because so many of our people are on Facebook, you know, especially South East Queensland... and that’s what our thoughts were. They’re already there on Facebook, we need to get ‘em to our site and then we can get our health promotion away. (Interview, 15/05/2013)

Deadly Choices practitioners demonstrate awareness of the mobile and dispersed nature of the SEQ Indigenous community, and more broadly where diversity across Indigenous populations and patterns of mobility exist (Markham, Bath, Taylor, & Doran, 2013). Social media enables Deadly Choices to connect with people regardless of geographical location or boundaries.

It is important for us to have our Facebook and Twitter. In South East Queensland we got so many blackfellas here and we're all spread out... communication is such a big thing and a lot of these kids have phones - they're always on the Internet, Facebook and Twitter, so this is the best way to communicate with them... I think a lot of the days are gone with fliers and letter drops and stuff like that - they may still work, but you know for the ongoing years this is gonna keep us engaged with them, on an easier platform... really, the only barrier is getting them to our meeting place, which is our page. (Interview, 13/05/2013)

In many ways, statistics support this practitioner’s view. The ABS reports that 63% (131,000) of Indigenous Australian households have an internet connection, an increase from the 40% reported in 2006; while smart/mobile phones are rapidly enhancing internet access (ABS, 2012). Globally, more people have access to a mobile phone than they do to toilets (United Nations, 2013). Internet access is consistently increasing across the globe (The World Bank, 2013). Researchers report that Indigenous people are likely to own a mobile device, with high membership of social media site accounts, particularly in metro areas (McNair Ingenuity Research, 2014). The smartphone has in

fact become the dominant platform for information access and communication across Indigenous communities (Joint Select Committee on Cyber-Safety, 2013). However, not all Indigenous people access the Internet and social media.

Perhaps it is more accurate to say that social media is “where the young people are”. I observed critiques from the Indigenous community, particularly by older people, that they missed out on information from Deadly Choices because they do not access social media consistently, if at all. Some older people still preferred and relied upon access to community information through mail and other hard copy formats such as the “fliers and letter drops” dismissed by the practitioner above. Research has flagged these critiques, identifying that some people and groups are more likely to be excluded by social media, including people living with a disability (Office for National Statistics, 2012) and people from a low socioeconomic background (Baum, Newman, & Biedrzycki, 2012b). What’s more, the effect of exclusion by social media tends to amplify disadvantage (Baum et al., 2012b).

Practitioners appeared to focus on the benefits of social media, rather than increase engagement by older people. This focus is in accordance with Deadly Choices’ emphasis upon young people and in respect of the work by other IUIH programs to engage older people. An advantage of social media for Deadly Choices is its ability to enable connection with community members beyond the offline reach of Deadly Choices. In doing so, Deadly Choices has expanded its program reach to go beyond those involved in its schools programs, community events and other activities, to surpass the SEQ region.

Deadly Choices practitioners appear to acknowledge the importance of the extended reach made available through social media. Each practitioner carries a smartphone with administrator access to the various Deadly Choices accounts, through which they tweet and post throughout the day regarding their practice. Their regular online activity creates a collective of social media posts that exhibits the community work of Deadly Choices in SEQ and beyond. The effect is the online presentation of Deadly Choices as seamlessly navigating the online and offline spaces of practice.

Facebook is arguably the most interactive social media platform for Deadly Choices and the major location of their social media competitions. Facebook statistical information regarding Deadly Choices followers indicates that although the majority of Deadly Choices followers are from Australia, a proportion (approximately 1.5%) is from overseas nations (Figure 56). Although comparatively large hubs of followers align with the locations of IUIH's members and affiliates in SEQ, the locations of their followers go well beyond these, including Melbourne, Sydney and Townsville. Facebook statistics reveal that women are more likely (65%) than men (34%) to engage with Deadly Choices on Facebook, and 25-34 year olds are the largest and most engaged user group for both sexes, followed by 18-24 year old women (15%) and men (13%)¹⁴¹. These statistics suggest that Facebook is a useful tool for engaging women and young people.

Deadly Choices appears to be ensuring that it is available where it believes the community may be online. Its social media following has built on somewhat organic beginnings guided by ongoing interactions between the IUIH management, the SEQ Indigenous community and Deadly Choices. In January 2012, Deadly Choices joined its first social networking sites, Twitter and Facebook. In the following year, Deadly Choices joined Instagram and soon established Deadly TV, platformed on YouTube (accessible through the Deadly Choices website).

¹⁴¹ URL: https://www.facebook.com/deadlychoices?sk=page_insights&section=navPeople (Accessed 27/11/2013).

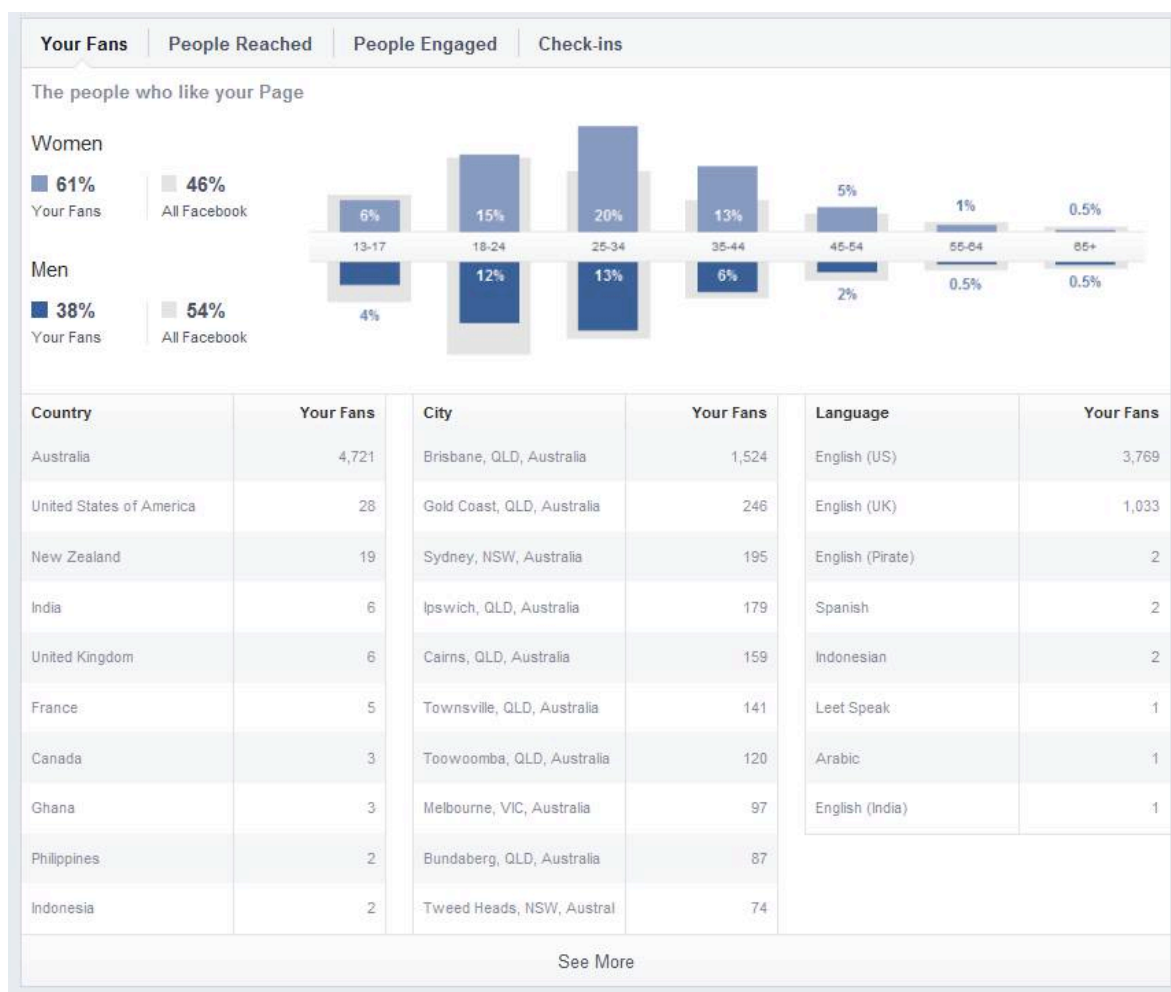


Figure 56: Facebook Insights: People, Your Fans (Deadly Choices, 2013d).

Since its creation, the Deadly Choices social media following has increased exponentially. At the time of writing, Deadly Choices had 2,442 followers on Twitter¹⁴², and 1,871 followers on Instagram¹⁴³. I recall at the December 2012 team meeting that Deadly Choices reported its Facebook page had 700 ‘likes’, with the goal of “1000 likes by Christmas” (Field notes, 3/12/2013). More recently, the Deadly Choices Facebook page had 8,671 ‘likes’¹⁴⁴, a growth of over 12-fold in the span of less than three years. Compare this following to other similar health promotion social media pages. For example, comparable Indigenous Facebook pages include:

- IUIH, which had 8,422 followers¹⁴⁵
- The QAIHC Hero Rewards page, which had 186 followers¹⁴⁶

¹⁴² URL: <https://twitter.com/DeadlyChoices> (Accessed 27/09/2014).

¹⁴³ URL: <http://instagram.com/deadlychoices#> (Accessed 27/09/2014).

¹⁴⁴ URL: <https://www.facebook.com/deadlychoices/likes> (Accessed 27/09/2014).

¹⁴⁵ URL: <https://www.facebook.com/pages/The-Institute-for-Urban-Indigenous-Health/507778255901396?fref=ts> (Accessed 27/09/2014).

- NACCHO Aboriginal Health, which had 3,159 followers¹⁴⁷
- NoSmokes campaign, which had 861 friends^{148,149}
- The National Centre of Indigenous Excellence, which had 8,096 followers.¹⁵⁰

Similar mainstream health promotion pages include:

- Diabetes Queensland, which had 4,290 followers¹⁵¹
- Cancer Council Queensland, which had 12,682 followers¹⁵²
- The National Heart Foundation, which had 25,837 followers.¹⁵³

To put these statistics into context, recognise that Indigenous Australians make up 3% of Australia's population (669,900 people) (ABS, 2014), which makes the Deadly Choices following particularly impressive compared to mainstream sites. Furthermore, unlike IUIH's other social media activity (Hogan, 2013), Deadly Choices does not utilise paid promotions, and yet it still has "so many likes". In comparison, other health promotion initiatives have found they must utilise paid promotions in order to reach their target population, with 900 and 1320 followers in the various study results (Nguyen et al., 2013; Pedrana et al., 2013).

To facilitate their online interactions, Deadly Choices draws on a blend of structured approaches to social media, such as competitions pertaining to themes and significant days of celebration (for example, Diabetes Day, National Nutrition Week and World No Tobacco Day), with more fluid approaches that involve open interaction with the community, such as the community initiated posts (demonstrated in Chapter Five). The social media competitions provide an important mechanism for increasing the number of Deadly Choices followers online (for example, in the past, competition entrants and voters were required to "like" the Deadly Choices page before they could enter). Consider the Facebook competition in March 2014, which required people to submit entries in response to the question, "What's your deadly choice?" (Deadly Choices,

¹⁴⁶ URL: <https://www.facebook.com/pages/Hero-Rewards/115960071773074> (Accessed 27/09/2014).

¹⁴⁷ URL: <https://www.facebook.com/NacchoAboriginalHealth?fref=ts> (Accessed 27/09/2014).

¹⁴⁸ The NoSmokes Facebook page was not a fan page, which meant they accumulate 'friends' instead of 'followers'.

¹⁴⁹ URL: <https://www.facebook.com/NoSmokes.com.au> (Accessed 27/09/2014).

¹⁵⁰ URL: <https://www.facebook.com/theNCIE?fref=ts> (Accessed 27/09/2014).

¹⁵¹ URL: <https://www.facebook.com/DiabetesQueensland?fref=ts> (Accessed 27/09/2014).

¹⁵² URL: <https://www.facebook.com/cancercouncilqueensland?fref=ts> (Accessed 27/09/2014).

¹⁵³ URL: <https://www.facebook.com/NationalHeartFoundation?fref=ts> (Accessed 27/09/2014).

2014h). There were over 35 entrants for this competition including: a father moving away from home to be near his daughter and a part of her life (Name withheld for confidentiality purposes, 2014c); ballet, acrobatics, tap and swimming (Name withheld for confidentiality purposes, 2014a); outrigger canoe marathon racing (Name withheld for confidentiality purposes, 2014e); getting a dog in order to get fit and healthy with her daughter (Name withheld for confidentiality purposes, 2014b); and making a



Figure 57: One of the entries into the Deadly Choices Facebook competition (Name withheld for confidentiality purposes, 2014d).

healthy meal in the image of an Aboriginal flag (Figure 57). As for all Deadly Choices competitions, this one enabled people to showcase their deadly choices in their own words. In doing so, the Deadly Choices brand was re-affirmed as one co-owned by the community and that represents their strength, culture, identity and health.

Such positive interactions position Indigenous people as active agents – as producers as well as recipients of health promotion messages and initiatives. A CRT/postcolonial lens suggests this positioning is in opposition to the mainstream constructions of Indigenous people as passive recipients (Darnell, 2007;

Hall, 1996; Said, 1978). One practitioner explained their negotiated respect of Indigenous agency (Nakata, 2007a) to me:

We're using our people to educate, which I like. It's not just us. It's our community in their own words. (Interview, 13/05/2013)

This quote illustrates that social media provides the means to facilitate and reinforce the notion of leadership discussed in Chapter Six, where “everyone can be a leader”. The open manner of Deadly Choices on social media enables a dialogical approach to health promotion with the community about what their choices are, going beyond the more standard health promotion approach on social media of information dissemination. Instead, Deadly Choices capitalises on social media's potential to sustain two-way dialogue, where people can profile their behaviour and affirm the choices and behaviour

of others. Deadly Choices thus involves health promotion by “our community in their own words”, reinforcing the importance of the Deadly Choices philosophy that *we don’t tell people what to do*.

A welcoming and celebratory space

The intentionally positive and inclusive tone of Deadly Choices is a key ingredient to the operation of relationship and choice, which is visibly manifest on its social media platforms. For example, when people first follow Deadly Choices on Twitter, Deadly Choices welcomes them with a “shout out” (as seen in Figure 49 in Chapter Six). Through this welcoming process, people are included and connected, while encouraged to consider what health – what a deadly choice – means to them. By doing this, Deadly Choices social media has become a place to celebrate people’s choices. For example, a community member posted that their deadly choice was “to give up smokes. Going on 20wks without one.” The Deadly Choices response was affirming: “Giving up smokes WOW & up to 20 weeks without one congratulations, more leaders like yourself is needed” (Figure 58). To be noted here is the inversion of the health promotion meaning, where health promotion is performed as rewarding and promoting leadership, instead of seeking compliance. This means that community members are positioned as leaders for making their own deadly choice, rather than for conforming. This repositioning has the effect of creating a co-produced community where people can participate in the Deadly Choices agenda: “to encourage positive change and decisions within our community and it starts with YOU” (Figure 59).

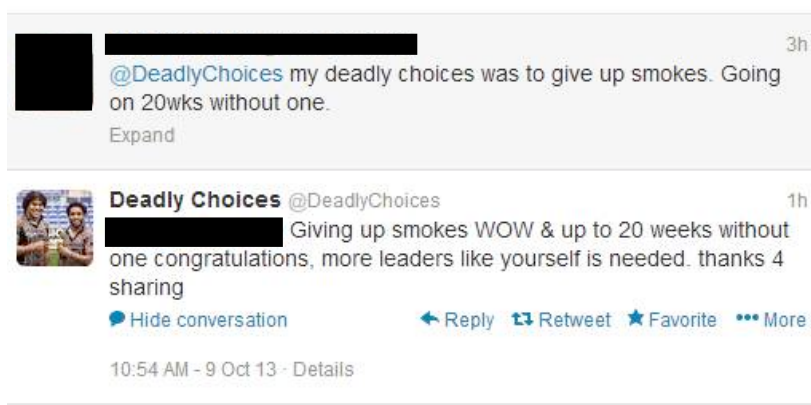


Figure 58: A community member provides an update on Twitter regarding their progress to their Deadly Choice to give up smoking (9 October 2013).



Figure 59: Providing a space to celebrate people and their deadly choices (Deadly Choices, 2013i).

IUIH executives and practitioners who oversee Deadly Choices social media report that no cyber-bullying, trolling or racism has been present. This is notable given racism and fighting exist in online spaces, particularly in relation to Indigenous people (Christie & Verran, 2013; Herborn, 2013; Kolko, Nakamura, & Rodman, 2013). In the case of Deadly Choices, community members appear to engage with and perpetuate the celebratory nature and positive persona of Deadly Choices. The Deadly Choices community effectively adheres to unwritten rules as how to govern itself. One practitioner elaborated on the cultural norms they observed and nurtured in Deadly Choices social media.

One thing I tried really strongly is to not try and be political and anything like that and not talk about politics or anything that's happening negative in the community. It's all about promoting what we we're doing and promoting the community is one big thing.

One issue I've sort of raised is when our young kids do something good or healthy, we sort of say a deadly choice. They might have eaten a healthy meal, or gone for a run - they run home and they tell their aunty, they tell their cousins and brothers and sisters. But now they get into a habit of telling us, getting on our Facebook and posting it up, or on Twitter, and doing it that way. And that's just how communication changed, that's just how it is. We're at that stage where they'll tell their family but they want to tell the wider community and the easiest way is Facebook or Twitter.

And I think that in a way there's sort of a shame aspect of just telling everyone, "Hey, I went for an hour and a half run today, I feel so good". And some people might say, "Oh look at you, big-noter" and stuff like that. But if they're putting on a place like our Facebook or Twitter, we're encouraging that, that's what we want to hear. And they're sort of feeling, "Oh that's good, I'm being congratulated on drinking two litres of water a day". You know, where they may not get that anywhere else.

And I think we need to promote that and encourage that kind of, you know, those healthy and productive choices. With us, we can't be negative in any way. We're there for the community, we're there to promote them and also be an ear or be their forum as well. (Interview, 22/1/2013)

Layers of the Deadly Choices leadership model (as examined in Chapter Six) are revealed in this practitioner's description, where a leader is to stand out – but not too much. As this practitioner indicates, there is a tension in leadership between where one shares and promotes their positive choices with the intention of influencing others, to remaining humble and not being a “big-noter”¹⁵⁴. This is a difficult tension to balance and indeed, the Deadly Choices practitioners themselves spoke of this challenge. However, Deadly Choices has circumvented this tension by creating a space that makes sharing positive choices safe. That is, sharing one's own deadly choice on the Deadly Choices social media is encouraged and normalised.

Practitioners tweet and post about the achievements of people, too. This has the effect of promoting the community, which then provides acknowledgement of the community's good news stories. For example, after one practitioner conducted the physical activity session in the Deadly Choices Education Program, they showcased the artwork of the participating students (see Figure 60). As one practitioner explained, “We want our communities and our families to come together in the good times”.

¹⁵⁴ A “big-noter” is Australian slang for a person who promotes him or herself to appear better than they actually are.

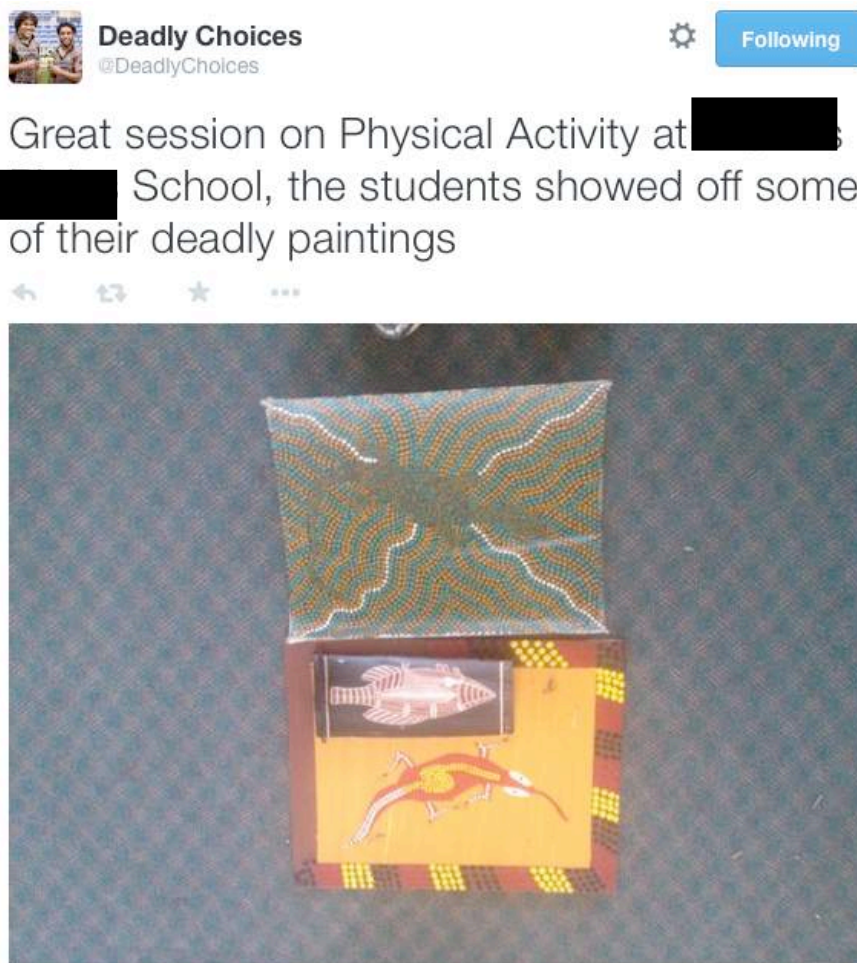


Figure 60: The Deadly Choices team promoted the artwork produced by students who participated in their Deadly Choices program (Deadly Choices, 2013g).

As the practitioner stated above, one of Deadly Choices' main agendas is to promote the community and listen to them. While Deadly Choices is based upon a health promotion agenda, it is an uncommon agenda compared to mainstream health promotion in that while Deadly Choices has a strong basis in promoting particular health issues (diabetes, alcohol use, physical activity, and so forth) it also extends beyond this, through community involvement. In this case, the use of social media enables the community to define health and their deadly choices beyond healthy lifestyle.

Health education and activity promotion

In addition to providing a celebratory platform for the community, the Deadly Choices social media is used as a health education tool. Doing so enables information and education to be quickly disseminated to a large audience. For example, practitioners use photo and video mediums to share a health education message (for example, Figure 61),

text quizzes as an educational strategy for checking people's knowledge (for example, Figure 62) and disseminate encouragement for people to make deadly (healthy) choices. Furthermore, education videos have been created to promote:

- Healthy life choices and not smoking, featuring Indigenous rugby league players and legends from the National Rugby League
- A specific strategy targeting smoking within Indigenous communities, particularly young people and pregnant mothers, featuring prominent local Indigenous community identities.



Figure 61: “Name the three major chemicals in cigarettes” – This is a short video posted on the Deadly Choices Instagram account (Deadly Choices, 2013a).

The Deadly Choices approach to health education on social media involves fun, humour and familiar faces. As an illustration of this, refer to the series of Good Quick Tukka cooking videos produced by Deadly Choices that star ambassadors, staff and some community members. These videos incorporate fun and humour with education to develop practical skills for healthy eating (Figure 63). The following participant diary entry further illustrates the Deadly Choices approach to social media as both an educational and community engagement tool.

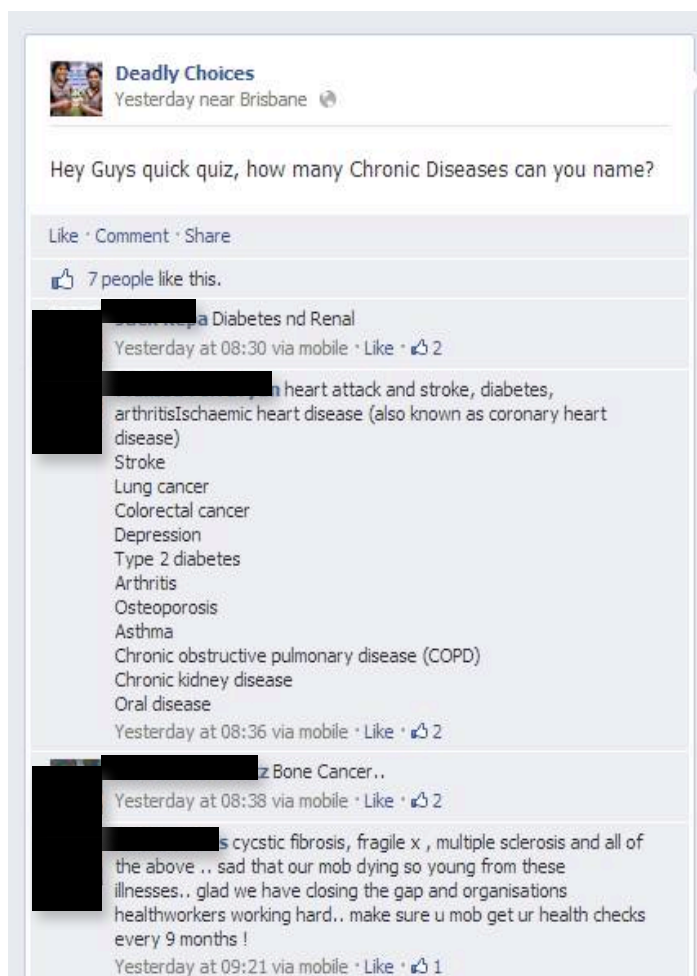


Figure 62: Deadly Choices Facebook quiz regarding chronic disease (2 October 2013).



Figure 63: Deadly Choice cooking video for Good Quick Tukka (Deadly Choices, 2013f).

I will just tell you about our last Deadly Choices competition. So this lady here... Physical activity, wearing their shirts, that's exactly what we want to see (Figure 64). So, I ran a competition around depression and mental health, as we usually are doing competitions around physical activity and nutrition. So I said, "Hey guys, we only had one entry, one day to go..." So I kept it open a bit longer coz I think everyone was a bit scared about what is mental health. And that's actually an outcome in this - for a whole week, I had one entry, OK, with this competition up and I don't think anyone knew how to post something around mental health. They didn't understand that going for a run is good for your mental health, talking to someone is good for your mental health. They didn't understand that so I said,

Here at Deadly Choices HQ we think your mental health is just as important as your physical health. According to Beyond Blue, three million Australians are living with depression and anxiety. Both of these are chronic conditions, which have large impacts on our families and communities. So your mission, if you choose to accept it, is to post up a photo or video showing your Deadly Choice, which keeps...you mentally healthy and strong. Entries with the most likes by 12 noon Friday 11 May will win a Deadly Choices hoodie, just in time for Winter. Likes will only be counted towards your photo if they have liked our page and liked your photo.

So in a way, when I'm putting these competitions up I need an incentive back for us as well. I know we're doing good in health promotion but I need to try and draw people to our page in some way. So if they wanna win this hoodie, they need to go out and tell people, "I need you to like the Deadly Choices page and like my photo and I'm gonna try and win this hoodie". So we're using these competitions well because we need to draw people to get to our page and we're doing that with our Twitter as well. (Participant diary, 13/05/2013)

This diary entry demonstrates the way social media enables Deadly Choices to build on interactions with the community across a range of issues, to tailor the educational message. In this case, not only is the social media competition a tool to promote Deadly Choices to increase its following, it enables a conversation to begin around community expressions of mental health.



Figure 64: One entry into the Deadly Choices mental health competition involved mountain biking and eating healthy (Name withheld for confidentiality purposes, 2013c).

Deadly Choices also utilises social media to promote upcoming community events, using a combination of text, video and photo. Deadly Choices' use of videos on social media appeared to increase during the period of fieldwork, while online fliers remain common for event promotion (for example, Figure 65). A number of practitioners now attribute large or higher than expected attendance at community events to the event promotion on social media. For example one practitioner explained:

...our event at (*local community*), I promoted it pretty strongly on Facebook and before we knew it we had 450 people at our community day and we only really promoted it for about 2 weeks. (Interview, 13/05/2013)

Humour and positivity are consistently present, such as that exemplified in this promotional video for a community event, starring a Deadly Choices ambassador and two practitioners.¹⁵⁵ The video demonstrates that although Deadly Choices may provide serious information, the video stars do not take themselves too seriously, keeping the signature humour of Deadly Choices prominent.

Connecting and partnering

Social media also provides a means to stay connected with and visible to both the Deadly Choices community and a broader audience,

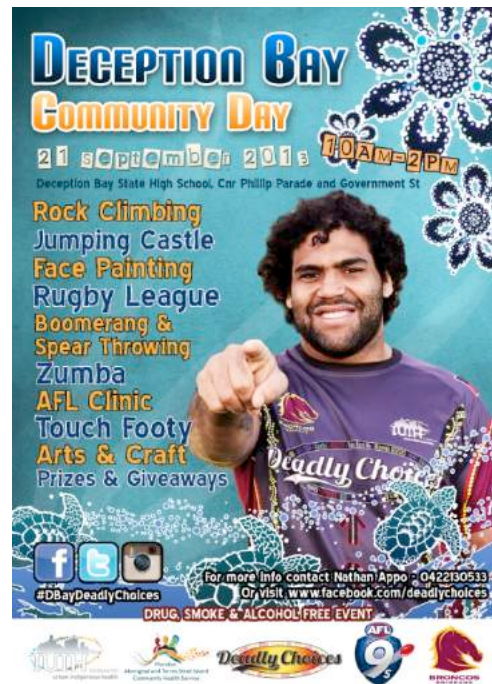


Figure 65: Deception Bay Community Day Flier 2013.

such as politicians and strategic alliances. The two-way nature of social media means that it is a useful way to maintain relationships, with potential for creative interactions online. For example, the students in Hunter's program wrote a thank you letter to Deadly Choices, which Deadly Choices then promoted and acknowledged on Twitter (Figure 66). Ambassadors also remain close to the Deadly Choices community by way of videos and visuals about the way they are living Deadly Choices as a way of life¹⁵⁶. Deadly Choices practitioners share positive community activities in personal ways, including videos of kids participating in fun and healthy activities of Deadly Choices. Examples of this include a chin up competition (Deadly Choices, 2014a) and training the Brisbane Broncos staff and players to use the Deadly Choices icebreakers (Deadly Choices, 2014f) – often with a laugh involved.

¹⁵⁵

URL: <https://www.facebook.com/video.php?v=647749215304144&set=vb.225245497554520&type=2&theater> - Accessed 17/09/2014).

¹⁵⁶ For example, two Deadly Choices ambassadors from the Brisbane Broncos delivered their greetings and updates to Deadly Choices by video message (Deadly Choices, 2014j).

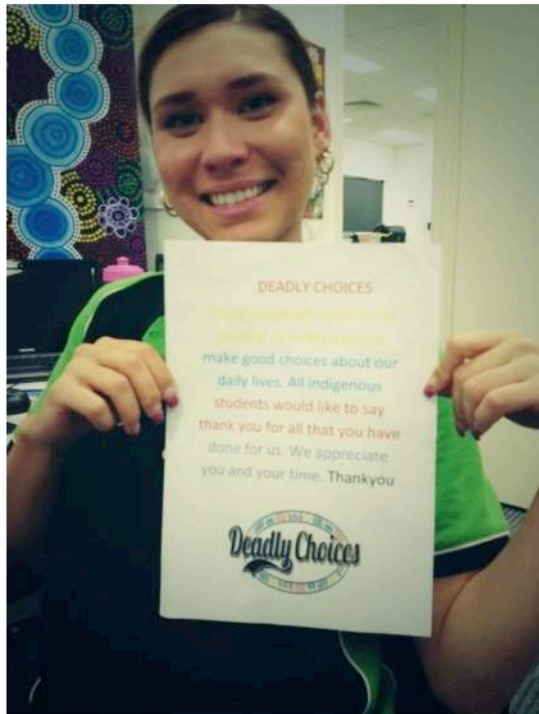
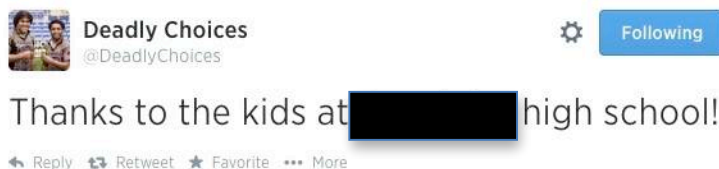


Figure 66: Deadly Choices tweet to thank their students for their thank you message.

Deadly Choices strategically aligns with “good people on social media”. One reason for this alignment appears to be to capitalise on the wider audience to which these people (particularly with celebrity status) can enable access. However, there also appears to be an element of encouragement and affirmation involved, where “good people” are those who practice behaviours agreeable to the Deadly Choices agenda. Deadly Choices would “follow” and “retweet” or “share” the posts and accounts of these individuals as an expression of Deadly Choices’ affirmation, as the following practitioner substantiates.

Yeah, you have a look: OK, so like Wendell Sailor. OK we'll have a look at Wendell Sailor (*showing me on Twitter*). He's got 54,000 followers - he follows us. OK? And he follows 1674 - that's OK but he's selective too. We're very selective as well. We wanna only follow people who are doing positive stuff in the community and who are general role models. And I like to make sure that it's not just people we're following; it's not just stars OK? So Nathan Peats, he just started following us before, he used to play for the Rabbitohs. Um, now these three here - this guy here, he was actually in our competition trying to get people to follow us. He lost but I said hey, we're gonna follow you because you're doing some good stuff in

the community and he was over the moon, he just followed. Because you go through the people we follow, he's in that sort of category now. You know what I mean?

So we've got this young girl too. She drummed up a lot of support for us and got us a lot of followers. She missed out on winning but I said, "Nah I'll follow her as well". You know, just... give her a bit of an incentive and they'll stay on top of that as well. Andrew McCollough, he's a non-Indigenous guy but he's a hooker for the Brisbane Broncos. Now he follows us and he'll throw us a tweet now and then... He's non-Indigenous but he's really passionate about Indigenous - he's got 1000 followers but he's going to be really well-known in future. He doesn't have to do that but why not utilise his networks and you know? He's good mates with Sam Thaiday and he's always retweeting a lot of our stuff and Sam's stuff so, you know, throw him a follow and keep him updated and stay in touch with him. (Interview, 13/05/2013)

As this practitioner explains, “good people” are those who help progress the Deadly Choices agenda, who may have a broad following and/or celebrity status, or influence in their community and family networks. In this way, social media facilitates deliberate alignment between Deadly Choices and people who could progress their agenda with community promotion.

Similarly, the Deadly Choices team participates in broader online interactions, such as Twitter reporting for the Australian Health Promotion Association (AHPA)¹⁵⁷ 2013 Conference using the #AHPA2013 hash tag. This participation contributed to bringing an Indigenous voice to the forefront in the conference (Sweet, 2013). Other conference participants tweeted about the Deadly Choices presentations, providing an indication of the positive reception to Deadly Choices’ work (Figure 67, Figure 68 and Figure 69). This conference participation also shows that Deadly Choices’ approach to social media strategically aligns itself to others who are consistent with its agenda. The effect appears to be promotion, strengthening and creation of partnerships, which are culminating outcomes for social media in the use of health promotion (Neiger, Thackeray, Burton, Giraud-Carrier, & Fagen, 2013).

¹⁵⁷ AHPA is Australia’s peak health promotion body and the only professional association in Australia specifically for people interested or involved in the practice, research and study of health promotion.



Figure 67: Some positive conference participant feedback on the Deadly Choices presentation at AHPA 2013.

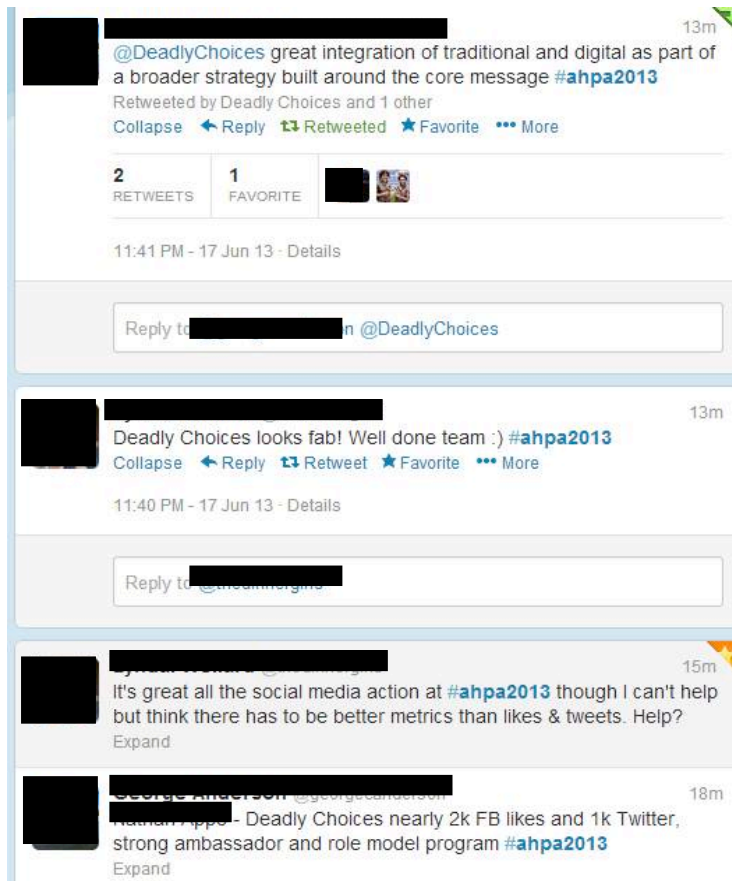


Figure 68: More conference participant tweeting about Deadly Choices at AHPA 2013.



Figure 69: Positive reception for a Deadly Choices presentation at AHPA 2013.

“We’ve brought culture to social media”: The blurring of online and offline spaces

In the words of a Deadly Choices practitioner, Deadly Choices “brought culture to social media.” In the online space, the Indigenous cultural values and identity espoused by the Deadly Choices practitioners in their offline practice are present. A collective approach to health is visible where the broader community, including those beyond the SEQ Indigenous population, is included. Indigenous ways of life and identity are celebrated, including Indigenous governance and accountability (as well as the accountability of Deadly Choices practitioners). The effect of such accountability is the requirement that the staff and practice of Deadly Choices remain congruent with the Deadly Choices brand, online and offline. Given relationships are of foundational status (discussed in Chapter Six), the consistency of Deadly Choices behaviour is paramount to maintain a consistent “personality”.

It’s very easy to have two different personas: you know, your one out in the community, and one on your social media, sort of personality. But I think both personalities are very similar within when we do our Deadly Choices talks and our events. It’s all very positive, it’s encouraging, it’s promoting leadership, and how we can look after our family and our culture. And I think we can take that into a social media site - we can’t have two different angles. It has to be consistent. (Interview 13/05/2014)

Essentially, Deadly Choices promotes and affirms Indigenous cultural values through its social media spaces. This requires Deadly Choices to “practice what it preaches”, fostering a sense of reciprocity and trust, “because once you give that word on social media you’ve gotta stick by it”; the “consistent personality” online and offline is to remain positive and affirming. This also translates to mean that Deadly Choices is selective in who they follow on social media, beyond the “good people”.

Shawn: I have to be very wary of who we follow... coz that’s what you do on Twitter, you say, “Oh, I wonder who they’re following”. So I go onto their following and go “Oh yeah, I’ll follow these people”... And you’ve got to be very – if they’re saying some very outlandish kinda stuff, we’ve gotta... pull back and say, “Hey, is that the kind of people we want to be following and promoting?”

Karen: So by following them as Deadly Choices, you’re promoting them?

Shawn: Yep. Yep... See, you’re sort of vouching for them, you know.

Karen: It’s not just you hearing what they got to say?

Shawn: No. No, in an indirect kind of way. It's all that culture - its adapting Twitter's culture but bringing it back to our culture as well and sort of trying to find a medium and a way we can connect with both sides.

(Interview, 13/05/2013)

However, the online and offline worlds are not separate. A blended reality exists for Deadly Choices. Take for example my exchange with Donavon, a student in Hunter's program. In this exchange, Donavon was directed to Deadly Choices on Facebook where a continued relationship outside of the schools program would be available.

As we walked to the sports fields, I walked with the boys. Donavon conveyed that he wanted to get a Deadly Choices T-shirt and should get one if he gets a health check, which he indicated he planned to do. I added, "Deadly Choices also have those pretty cool hoodies you can win too. If you hop onto their Facebook page, there's often a lot of competitions where you can win a hoodie and other prizes". I was aware that as I did this, I was promoting the Deadly Facebook page, just as the team's social media coordinator had requested all team members to do. Donavon assured us that he would 'like' the page. (Field notes, 09/07/2013)

Connecting and communicating via social media seemed to weave into the daily lives of most young people I met through Deadly Choices, including the Deadly Choices staff themselves. I personally experienced the centrality of social media in this team's practice during one of my feedback sessions, which I delivered as part of one of my workshops with the team. In this case, a practitioner tweeted about my presentation while I was presenting (Figure 70) and subsequently tweeted about the workshop at its completion, commenting that it was "awesome" and asking their followers what they think "makes a good leader" (Figure 71).

This tweeting activity is interesting in a number of ways. Firstly, it reflects my shifting positioning in relation to these practitioners as research participants, as a result of social media. While research participants were tweeting *about* me, I became the object and the practitioners became the subjects with voice. In this way, Twitter provides a platform to share power between researcher and participants. These tweets are affirming and positive of both the community and me, but are also reaffirming of the agency of these practitioners as research participants, as revealed through a lens of the cultural interface (Nakata, 2007b). In this case, tweets created a form of capital the team used to continue a dialogue with community regarding leadership.

Deadly Choices @DeadlyChoices 2 Jul
@solomon_kazza running and presenting her research on leadership within our team. pic.twitter.com/VKwIHrRG1E
[Hide photo](#) [Reply](#) [Retweet](#) [Favorite](#) [More](#)



5:55 PM - 2 Jul 13 · Details

[Flag media](#)

Reply to @DeadlyChoices

Karen McPhail-Bell @solomon_kazza 2 Jul
@DeadlyChoices @solomon_kazza Good one! Thanks for the pic - what a great morning with a great team!
[Expand](#)

Figure 70: Deadly Choices tweet mid-workshop (3 July 2013).



Figure 71: The Deadly Choices tweet at the conclusion of my workshop.

One effect of this power distribution was that I had less control over some aspects of the research process. In this particular case, by way of participants tweeting about this research in association with me, the team created clear public links between us. This meant that the identity of research participants and IUIH were potentially revealed in relation to my research.¹⁵⁸ The tweet was indicative of the problematic nature of confidentiality in this research, where the strong brand recognition as a research finding, could inhibit my efforts to de-identify those involved in the research. However, this tweeting behaviour also provided a form of feedback for me from participants about their experience of the research. As the practitioner revealed earlier, tweeting and retweeting someone's tweet can be a way to indicate to someone you like them or their post enough to broadcast it to your own Twitter audience. The fact that the original tweet was also retweeted by another practitioner suggests some level of engagement with or support for the tweet's message amongst the practitioners.

The online spaces are indeed melded with the offline practice of these practitioners. An illustration of this is my experience with the Deadly Choices team at a lunch they held to celebrate National Nutrition Week. About one week ahead of the usual monthly team meeting, Danielle emailed the team (including me) to inform us that our meeting would be during National Nutrition Week, for which the theme was "Cook-Eat-Enjoy". Danielle explained that:

...we will be marking this week by celebrating the social and emotional connectedness that food can bring. Following the team meeting on Monday 14th October, we will be having a lunch where all staff are invited to bring in a (relatively) healthy home cooked meal to share with everyone. We will gather together to share food, swap recipes, and connect around the lunch table. Please bring a food that tells a story of who you are. For example, your grandmother's favourite scone recipe, a traditional food from your culture, or something you just really love to eat! Head Office will also be celebrating National Nutrition Week with the same activity on Thursday the 17th of October. Please let me know what you will be bringing on Monday so we don't have any double-ups! (Email, 09/10/2013)

I responded with a suggestion that I bring a Layer Salad (a salad mum and I often prepared for special family occasions). Danielle was "super excited" about my eagerness to participate and revealed that Ethan would bring Numus ("a traditional

¹⁵⁸ At that time, IUIH was yet to approve its identification in this research, which was pending until IUIH was able to view the final seminar version of this thesis in February 2015.

TSI¹⁵⁹ dish that sounds amazing”); Devlan, damper; Shawn, coconut chicken curry; Hunter, his family’s noodle dish, and; Steven, a tuna bean salad – “So lots of variety and yummy food happening.”

When the day came (Field notes, 13/12/2013), I brought my Layer Salad to the Deadly Choices office and placed it in the fridge before the team meeting was to commence. As we sauntered around the entrance to the meeting room, Ethan jokingly announced that a number of staff had not brought their dish as promised, so there would be a few people who could watch us but not eat the food. During the team meeting, Ethan instructed that at the close of the meeting, he would allocate 30 minutes for unprepared team members to purchase a meal to contribute. When that time came, I noticed a few staff members typing into their iPhones, discussing where they could go to purchase healthy food within the timeframe.

The 30 minutes passed and soon, staff regathered in the office with their meals. We each arranged our dishes on the meeting room table, ready for people to serve themselves on the paper plates. Staff began to fill their plates, moving around the table to collect samples of the various foods. As we did this, a few staff members worked together to make a short video of the meals we brought and immediately posted this on Instagram¹⁶⁰, as well as creating a photo album on Facebook for the event¹⁶¹. Some of the team used their iPhones to take photos of us with our meals and posted those pictures online (for example, Figure 72). We ate, we shared the story behind our chosen meals, we enjoyed the food and simply talked. The narrative that we shared and created together about our food brought meaning to the experience. A few extra people in the office from other teams in the building joined, including the car washer who was working down stairs, sharing in the food and conversation. The lunch was an intimate affair between those present and appeared to be a nourishing space for team relations. Yet, this was also a public affair, due to the posts on the various Deadly Choices social media.

¹⁵⁹ TSI is an acronym for Torres Strait Islander.

¹⁶⁰ URL: <http://instagram.com/p/fbkvJ2wS97/> (Accessed 13/12/2013).

¹⁶¹ URL: <https://www.facebook.com/media/set/?set=a.543068252438908.1073741835.225245497554520&type=3> (Accessed 13/12/2013).



Figure 72: A team lunch for National Nutrition Week; we each brought a dish in (Deadly Choices, 2013j).

This simple act of sharing a lunch together became an avenue for the merging of the obscure online and offline dimensions of space, allowing people from alternative physical spaces to “participate” with us. In effect, any Deadly Choices social media follower could virtually be part of our experience and in doing so the Deadly Choices practitioners and brand remained available to its community even while the team was on a lunch break. Furthermore, these online exchanges promoted the health message behind National Nutrition Week, which because of its online placement, continued to exist once the day had passed. As an ethnographer, I had entered and experienced the multi-site, multi-sensory nature of the interface of today’s offline and online worlds.

Decolonisation and reverse colonisation: A non-Indigenous audience

I entered this research relationship with an agenda of decolonisation of health promotion practice (McPhail-Bell, 2012). It is from this researcher positioning (discussed in Chapter Three) that I argue this research carries important lessons for the decolonisation of mainstream health promotion practice. Yet, it must also be said that I did not observe Deadly Choices practitioners refer to their practice as decolonising. In fact, one IUIH staff member declared to me that health promotion is a concept and as such, cannot be decolonised. Rather, they explained, people’s minds must be

decolonised. Such a statement is one of an empowered person, reflecting their agency, rather than a coloniser's voice – which in this particular case was my voice.

The statement provided me with a different understanding of the positive and celebratory space of Deadly Choices and its agenda of promoting and affirming Indigenous people and communities. I was reminded of Fanon's claim that: "The oppressed will always believe the worst about themselves" (Fanon, 1963) and of the power of the mainstream public health discourse positioning Indigenous people as an oppressed, sick and disadvantaged population. In contrast, Deadly Choices provides an alternative positioning of Indigenous people; and perhaps Deadly Choices' *deadly* positioning of Indigenous Australians is also a labour towards decolonising people's minds (Smith, 2012).

The statement also highlighted my understanding of decolonisation as from the position of coloniser. Decolonisation may mean something entirely different from an Indigenous perspective. As a non-Indigenous researcher and practitioner, I have laboured to "step back" in my efforts towards decolonising my practice and that of health promotion, to create space for alternative voices amidst the hegemonic norm of my positioning and health promotion. However, as the findings of this research reveal, decolonisation from an Indigenous positioning could well be about "stepping forward". As one worker declared to me, "Deadly Choices is *colonising* health promotion". Consider again the practitioner's reflection that opened this chapter regarding the Deadly Choices approach to health promotion, where Indigenous governance and agency is also seen to be "normal":

It's mad, hey, when... our role is chronic disease, nutrition and exercise, and then the tobacco stuff with the smoking group, and we come up with leadership. But it's just thinking normal, well not normal, but the way we would normally think; instead of looking out looking in, we're in looking out. You know what I mean? (Interview, 22/11/2012)

There is reason for the claim that Deadly Choices is colonising health promotion, for although Deadly Choices exists to serve the SEQ Indigenous communities, its audience goes well beyond this. The Deadly Choices audience is also non-Indigenous, both in the general Australian community and mainstream health system. That is, the Deadly Choices approach to health promotion is beginning to populate mainstream spaces,

which represents an important change in power relations in a (debatably) postcolonial environment (Spivak, 1995).

Take for example the Deadly Choices TVCs. These TVCs, produced by Wayne Blair¹⁶², were placed on the Brisbane Broncos website¹⁶³ as well as the big screen in the stadium of home games (IUIH, 2013d). Both of these mainstream locations mean that a predominantly non-Indigenous audience viewed the Deadly Choices message when they were screened. Furthermore, the Australian Government funded IUIH for placement of Deadly Choices TVCs on SEQ commercial television for four months, commencing October 2013 for the purpose of a wider non-Indigenous audience. This government investment suggests that the Australian Government considered the TVCs relevant and beneficial for its own health promotion agenda. This exchange represents a remarkable reversal of roles within mainstream health promotion in relation to Indigenous people, where control of health promotion products has historically been with the non-Indigenous stakeholders.

Similarly, non-Indigenous people aspire to own and wear the Deadly Choices merchandise and to be associated with Deadly Choices. The National Nutrition Week Facebook competition provides an example of this, where the winner was a non-Indigenous woman.

What a draw card – starring in the next Deadly Choice Good Quick Tukka cooking show. I have witnessed how people enjoy spotting themselves or people they know in Deadly Choices materials, so I imagined this starring role as a prize for the Nutrition Week Facebook competition would stimulate interest – both in attempts to win and also in viewing, once the show was produced.

Before the winner was announced to the team, the coordinating practitioner informed me that the winner was non-Indigenous and said to me, “It will be interesting to see how people respond to having a non-Indigenous person (starring in the cooking show).”

At the team meeting when the winner was announced, the reporting practitioner noted the winner’s non-Indigenous status with care. The practitioners listened and responded sensitively to how that may be

¹⁶² Wayne Blair is an Indigenous Australian writer, actor and award-winning director. He directed the film “Sapphires” and the ABC’s “Redfern Now”.

¹⁶³ At the time of writing, when visiting the Brisbane Broncos website (<http://www.broncos.com.au>) any video a viewer wished to view was preceded by a Deadly Choices commercial before the selected video started (1/10/2014).

perceived in the Indigenous community they served. However, they did not position the winner's non-Indigenous status as a negative factor. In fact, the discussion transpired to frame having a non-Indigenous winner as being a positive outcome for the Deadly Choices agenda. One practitioner commented it would be a constructive way to show that "Deadly Choices has the wider community's support", with which a number of practitioners appeared to be in agreement, nodding. (Field Diary, 18/11/2013)

The GQT show starring this winner has subsequently been produced and is available on Deadly TV.¹⁶⁴ The show is yet another Deadly Choices product that demonstrates inclusivity and the strength of Indigenous governance, with its "wider community support". This inclusive approach is akin to the virtual Deadly Choices community where "everyone can be a leader" and "having a go" is valued. Deadly Choices continues to welcome non-Indigenous people to attend community days and enter social media competitions. Arguably, the inclusion of non-Indigenous Australians presents a wider display of identity in Deadly Choices.

Deadly Choices (and IUIH) "talk up" to its mainstream audience in other ways. As for any government-funded agency, Deadly Choices makes use of standard communication with its funding bodies through products such as annual reports. Deadly Choices practitioners appear to be conscious of a broader audience, including government, politicians and other non-Indigenous supporters, when displaying their work. For example, Deadly Choices use social media to leverage wider support and promotion of the Deadly Choices brand.

...Ethan is really... helping in pulling, in pushing the social media side of things coz it gets our messages out to government as well and I think that's important as well. It's a great reporting tool and you know, it's just really good for... be(ing) able to show politicians what we're doing as well. And I think that's important and having, like I said, you know Scott Prince and those kinds of people, Greg Inglis, retweeting a lot of our stuff, its going out to such a larger demographic of people. You know, it's aimed at Indigenous people but we want the wider community to try and take on this culture around health. You know, it's a good thing to make healthy and deadly choices. And we have non-Indigenous people do that, you know and I think in a way... our persona, our character, is when someone follows us, the first thing I do is say "thank you for your support."

I guarantee we have a lot of non-Indigenous people that follow us but they're very passionate around closing the gap and you've gotta utilise those people as well, you've gotta promote them as well. It's not just Indigenous people...

¹⁶⁴ URL: <https://www.youtube.com/watch?v=-hRI5Zij7s0> (Accessed 1/09/2014).

we're aiming our stuff at Indigenous people but this stuff is show-casing what we're doing in the community as well and we're drumming up a lot of support. (Interview, 13/05/2013)

Deadly Choices speaks to mainstream audiences through additional print media (for example, Figure 73) and research, promoting the success and lessons of Deadly Choices. IUIH delivers outputs that are of value in a mainstream system and prioritises “building the evidence base in urban Aboriginal and Torres Strait Islander health” (IUIH, 2013d). Deadly Choices has been evaluated, with publications in peer-reviewed journals (Malseed, 2014; Malseed et al., 2014a; Malseed et al., 2014b). Similarly, tobacco initiatives within Deadly Choices are evaluated and inform program design in an ongoing way.

Deadly Choices is doing more than providing an alternative voice in these mainstream spaces; it is a part of a revolutionary process of the colonisation of health promotion by Indigenous practitioners. The non-Indigenous response to Deadly Choices suggests a shift is possible through which broader mainstream health promotion will not continue to view Indigenous community controlled health promotion – such as Deadly Choices – as appropriate only for Indigenous people. Rather, the transformative agenda of Deadly Choices highlights the possibilities for mainstream and Indigenous community controlled stakeholders to together transcend the colonial use of health promotion as an apparatus of control.



Figure 73: Article in The Australian regarding the success of Deadly Choices and IUIH (McKenna, 2013).

Deadly Choices: A community controlled agenda

As stated previously, I first looked to Deadly Choices for lessons in the decolonisation of health promotion practice. However, the practitioners and IUIH more broadly speak of the Deadly Choices agenda as one of community control. “Deadly Choices works because it is a part of something bigger”: it is a part of the broader model of the community controlled health sector. Deadly Choices does not operate in isolation but rather in synergy with other initiatives and services, embedded in the principles of community control, within and beyond IUIH. Deadly Choices works with and alongside all of IUIH’s activities, including the operation and support of primary health care clinics operated by IUIH member organisations (IUIH, 2013d) as a part of IUIH’s Model of Care (IUIH, 2013a;2013b). Other important initiatives such as Work It Out (a chronic disease self management program), mobile services, improving access to mainstream health services, a research program, student placements and traineeships, developing new allied health services for AMSs, and working with vulnerable families are also in place – and this is not a complete list. The key here is that all of this activity functions together, based upon a community controlled agenda.

In a conversation at IUIH, it was explained to me that community control is the higher order concept behind Deadly Choices and all of IUIH’s work, and that community control encapsulates decolonisation. Accordingly, IUIH measures success in terms of control. IUIH does also measure other indicators of success. For example it contributes to building the scientific evidence base for its own purposes and for creating a common ground with mainstream stakeholders, such as politicians, through “outcomes”. These “outcomes” are one resource for IUIH to innovatively and deliberately engage with politics, “talking up” and “talking to” stakeholders at the interface of power brokers and politicians. In this way, IUIH is involved with the politics of thriving and surviving at local, state and federal levels, for which it leverages and displays its political support (for example, Figure 74).

Despite this involvement with political stakeholders and politics, as raised earlier, Deadly Choices does not advocate for a political movement. Rather, it operates from a position of Indigenous governance, which because of its historical and political history in the context of Indigenous health (discussed in Chapter Two) incurs a political positioning for Deadly Choices. Yet, the importance of the community control agenda is

reflected in the way IUIH and its members value and measure control. Control is directly related to empowerment, given empowerment is a process by which people gain control over the factors and decisions that shape their lives (Laverack, 2006). IUIH staff explained to me that these measures of control could not be quantified in the way external stakeholders understand: “It’s a feeling. It’s how you feel when you go into an AMS; you feel warm, you sense an Aboriginal identity.”



Acting PM supports the 2013 NACCHO “deadly choices” NRL national challenge



Figure 74: A NACCHO communiqué promotes the support of the acting Prime Minister of Australia (NACCHO, 2013a).

8. “We don’t tell people what to do”

Control over Indigenous peoples’ health is this study’s fundamental issue, where the core concern is whose control is being increased by health promotion. This thesis argues that the health promotion endeavour of increasing people’s control over their health is fraught with tensions in practice. Whether conscious of doing so or otherwise, health promotion practitioners must negotiate the overarching tension of working with people to improve their health, while “enabling” people through empowering processes to control their own health (Laverack, 2007). The implication of this primary tension is that health promotion has more in common with colonisation than is widely recognised, where health promotion itself is a colonising endeavour over people’s bodies (Hughes, 1997). The ethical dilemmas of this tension are amplified in an Indigenous Australian context, in light of the health system’s role in ongoing colonial, controlling processes (discussed in Chapter Two). Consequently, Indigenous-led health promotion, such as Deadly Choices, provides important lessons not only for Indigenous health promotion practice but also for mainstream health promotion more broadly.

Little theoretical or ethical guidance exists for health promotion practitioners in traversing health promotion’s primary tension. This is a significant deficiency, which this thesis has sought to address. To achieve this, this study aimed to contribute to the decolonisation of health promotion practice by inquiring into the daily practice of a cross-section of Indigenous and non-Indigenous health promotion practitioners, in an urban Indigenous setting. The overarching research question was “*How do health promotion practitioners in an urban Indigenous setting make sense of and navigate the tensions inherent to health promotion in daily practice?*” I was guided by a number of sub-questions in terms of research process and data focus, to answer this question:

- What does contemporary daily health promotion practice look like in an Indigenous community controlled urban setting? Is there a difference between Indigenous managed and mainstream managed health promotion practice?
- How do health promotion practitioners approach the inclusion of community concerns and issues in their daily practice?

- How do urban health promotion practitioners negotiate the tensions of practice, including the challenge of behavioural versus structural accounts of health?
- How are urban health promotion practitioners incorporating Indigenous worldviews into their practice?
- What are the barriers and enablers experienced by urban-based health promotion practitioners to meet the needs of, and to work with the strengths of community?

Informed by a conceptual bricolage that draws upon postcolonialism, critical race theory and cultural interface theory (see Chapter Three), this chapter discusses the findings in relation to how Deadly Choices practitioners navigate health promotion's primary tension. The research questions above guide this discussion. To support the translation of this study's findings to a broader health promotion agenda, I conclude the chapter with four proposed principles to enable the decolonisation of health promotion.

“We do things differently”: Engaging with the tensions of health promotion practice

Distributive leadership as a model for change

The Deadly Choices practitioners traverse health promotion's primary tension with creative strategies from which broader health promotion practitioners can learn. Firstly, as Chapter Six indicated, the Deadly Choices model of leadership is a model for *change*. I emphasise *change* because this includes but goes beyond health promotion's typical behavioural change focus, to incorporate broader community change. As a model for change, Deadly Choices develops and “distributes” leadership amongst community members throughout their community, who are then responsible to lead by role modelling and profiling their deadly choices. As Chapter Six described, using leadership, Deadly Choices reposes Indigenous people as having agency, influence and “effect on other people”. The viewpoint of Indigenous people as leaders is theoretically discerning, for it effectively transforms the public health deficit discourse beyond a postcolonial reprieve to lift health promotion out of the colonised/coloniser binary.

The consequence of the repositioning of all Indigenous people as having the capacity to be leaders is a major point of difference for Deadly Choices compared to other health

promotion approaches. In a mainstream health context, leadership generally focuses on authoritative positioning and attaining a level of competency (Wright et al., 2000). For example, a Victorian nursing study defined leadership by way of a series of inter-related themes: “leading by example, communication, ability to think outside the management square, knowing your staff and stepping up in times of crisis” (Linton & Farrell, 2009, pp. 66-69). More locally, the Queensland Health core competencies for health promotion identify leadership as a core competency but again, based upon a position with some level of responsibility (Queensland Health, n.d.-a). At the international level, the Galway Consensus solidified the significance of leadership in health promotion by identifying leadership as a core domain of health promotion competency, defining leadership as “providing strategic direction and opportunities for participation in developing healthy public policy, mobilizing and managing resources for health promotion, and building capacity” (Barry et al., 2009, p. 9). Leadership is by design associated with a position of power over others in formalised structures. Indeed, in an article regarding health promotion leadership in Australia, the key informants for “leadership” were government-employed health promotion directors with responsibility for advancing effective health promotion approaches (Herriot & Desmarchelier, 2004). Mainstream health promotion generally conceptualises leadership according to a position of authority and power in a type of hierarchy, to lead a team or initiative to delivery.

In contrast, Deadly Choices conceptualises leadership as meaning “everyone can be a leader”. People do not need to hold a particular position or command a team, to be a leader. Parallels exist between the Deadly Choices model of leadership and Indigenous leadership more generally. Indigenous leadership has been defined as a collective process, differing to mainstream understandings of leadership mentioned above (Dodson, 2009). Many Indigenous leaders exercise their leadership according to different values and criteria compared to the wider Australian society, with leadership being shared and not necessarily equal (Dodson, 2009). Numerous new forms of Indigenous leadership arise with the blending of a range of other contexts (Maddison, 2009), just as is the case for Deadly Choices.

Indigenous models of health promotion have also recognised the importance of Indigenous leadership, arguing that this leadership must reflect a combination of skills

and a range of influences, as well as support to build that leadership (Durie, 2004). Recently, in its *Health promotion capacity building* project, the Lowitja Institute recommended that the body of professional practice in Indigenous health promotion be built and supported under Indigenous leadership (Wise et al., 2012a). Deadly Choices is a demonstration of Indigenous-led health promotion, being led and constructed by Indigenous practitioners and community. Research has found that health promotion is only successful in an Indigenous context when it is “initiated, designed and carried out under Aboriginal and/or Torres Strait Islander authority and leadership – governance” (Durie, 1999; Wise et al., 2012a, p. 48). The lack of success of conventional health promotion approaches to developing health improvements within Indigenous communities correlates this finding, which typically focus upon deficit in Indigenous communities (as discussed in Chapter Two) and the destructive myth that no Indigenous leadership exists (Reconciliation Australia, 2010).

The question, “What’s your deadly choice?” is a powerful driver of Deadly Choices’ leadership model, for its ability to open dialogue and collaborate with Indigenous people and communities to co-author health messages by making and sharing their deadly choices. Deadly Choices labels these healthy choices as a demonstration of leadership and in doing so, positions Indigenous people as having agency: they *have* leadership and *are* deadly. The presence and profiling of Indigenous people, including Deadly Choices practitioners, who are making deadly choices is significant in terms of a decolonising agenda. Simply by being leaders, an alternative “healthy story” is created about Indigenous people and communities, thereby presenting a contrasting and negotiated strategy for empowerment to that in public health, which is based upon Indigenous illness and death. In this context, the Deadly Choices model of leadership provides a clear contrast to the public health deficit discourse (discussed in Chapter Two).

The use of Deadly Choices ambassadors and role models throughout the community is a key strategy for embedding community voices in its implementation of the healthy lifestyle agenda. Deadly Choices establishes the presence of Indigenous practitioners in traditionally White spaces, such as schools and health services. Indigenous people are portrayed in a positive way and as having choice (for example, the Deadly Choices posters discussed in Chapter Five), where profiling and sharing one’s own deadly

choice for the wider community to see “shows leadership”. By doing so, Deadly Choices creates a new narrative in health promotion practice, where Indigenous agency is the health message. Through this process, Deadly Choices reclaims the healthy lifestyle agenda as incorporating Indigenous leadership.

The portrayal of Indigenous agency is in part a resistance to Australia’s colonial, essentialised narrative of Indigenous Australians as “Stone Age people” who are inferior to White middle class Australians (Wadham, 2004) and without leadership (Reconciliation Australia, 2010). This mainstream narrative is congruent with the deficit approach typical of government that justifies outside intervention to bring Indigenous Australians up to par. In contrast, Deadly Choices not only provides a counter-narrative to mainstream deficit discourse, it chronicles an alternative reality and history of Indigenous strength and vitality. In part, this is achieved by positioning Indigenous identity and culture as cool, as positive, as *deadly*.

While role modelling is a central plank to the Deadly Choices leadership, it is not a straightforward undertaking. By sharing control over Deadly Choices with the community, they have the choice to display behaviour that is incongruent with the brand. Chapter Six described instances of this where NRL players who are Deadly Choices Ambassadors were involved with controversies. Likewise, community members have been publicly identified by their Deadly Choices jersey while participating in undesirable acts in terms of the Deadly Choices agenda, such as public alcohol consumption or tobacco use. However, as the previous chapters also demonstrated, the possibility that the brand may be involved in disagreeable behaviours is a result of the wide community following and engagement with Deadly Choices. Community engagement is key for success in Indigenous health promotion (Wise et al., 2012a), suggesting that the choice of Deadly Choices practitioners to prioritise relationship over enforcing healthy behaviours is in the spirit of a community agenda for health improvement. In this way, through role modelling, Deadly Choices supports change to take place through community action, rather than reliance upon practitioner-driven health plans.

Role modelling and community interactions have demonstrated Indigenous community definitions of health as being leadership, culture, pride, community connections, and

healthy lifestyle choices. Such definitions enable Deadly Choices to position leadership as a foundation for healthy lifestyle: “for you to change your nutrition, or for a young person to say ‘I don’t wanna smoke no more. Where can I get help?’ or ‘I drink too much’” (see Chapter Six). Leadership thus functions as a resource to work according to a behavioural change focus as funded, while reflecting community agendas across a range of social determinants; for example (as presented in Chapter Six): to “look after your family”, to “get help”, to be “proud and back... yourself”, to complete an apprenticeship, and so on.

The Deadly Choices model of leadership thus provides a creative alternative to the either/or prospect of resisting or implementing particular agendas. Deadly Choices achieves this by including healthy lifestyle as a form of leadership, as well as Indigenous values and transformation. Behavioural change approaches are infused in the practice of Deadly Choices where its practitioners elevate such messages in their communication. For example, countless deadly choices shared by Deadly Choices practitioners online were their healthy lunches or gym/training session. Yet, these messages serve a higher purpose, where the Deadly Choices model of leadership transcends the boundaries of behavioural change theories, through involvement of and accountability to the community with which Deadly Choices works. That is, Indigenous values and concepts of health enable Deadly Choices to incorporate a healthy lifestyle agenda, while avoiding equating health with bodies of “normal weight”, or the presence or absence of particular behaviours.

Yet, while these practitioners work to *not* control the community’s and people’s behaviours, they seek to wield control over their own behaviour in accordance with a healthy lifestyle agenda – and often struggle to do so. This is where the prodigious rhetoric of Deadly Choices arises; its practitioners are rooted in the community and resolved to practice health promotion collectively, yet pursue to role model the healthy behaviours promoted by a mainstream discourse. This tension may be the effect of individualism, the great tyranny of health promotion (Becker, 1986; Shiell & Hawe, 1996), interplaying with the efforts of Deadly Choices practitioners to “stand out but not too much”. Practitioners frequently acknowledge experiencing the expectations placed upon them as a “24/7” requirement that is “the biggest thing” and “never easy” to meet.

Because practitioners “do this here at work but we go do this at home”, establishing professional boundaries in support of self-care is difficult.

Perhaps this tension is not one that can be removed or resolved, given practitioners are community members themselves who personify the Deadly Choices brand. However, practitioners appear enabled and supported in their efforts to role model by the inclusive, positive and transparent environment of Deadly Choices. The Deadly Choices team help each other to “always be better” and “present... yourself in a good manner in community”. The practitioners talk of themselves as learning and growing, together aiming for excellence, rather than perfection. Likewise, importantly, IUIH aims to provide a supportive environment for practitioners to be role models, which includes family-friendly policies and allocation of work time to exercise together as a team.

Competing agendas

The tension of brand representation through role modelling reveals a deeper, potential conflict between the Deadly Choices philosophy of, “people don’t want to be told what to do”, and the agenda of advancing health-promoting behaviours. On the one hand, community control and choice are central to the Deadly Choices brand and approach, where it is not for Deadly Choices practitioners to judge people’s behaviour as healthy or otherwise. On the other hand, Deadly Choices practitioners translate and implement an “outsider’s” (government/funding body) agenda that is overtly focused upon healthy lifestyle. Furthermore, alongside the competing macro level agendas are the micro level ones that accompany the personal relationships of practitioners with their community networks, employer, colleagues and so forth. As a result, Deadly Choices practitioners traverse a blurry interface of community, organisational and funding body agendas.

Accountability to these various agendas brings challenges in demonstrating success at the various community, urban and regional levels. For example, in the current environment of Closing the Gap (CTG) policy, national level statistics provide important evidence regarding progress against policy targets, for example, the regular Closing the Gap Prime Ministerial reports (Australian Government, 2015). Yet, this national level discourse and its associated statistics do not represent regional variations (Altman, 2009). While national level monitoring is important, the regional successes, such as those of IUIH and Deadly Choices, may be absorbed in the general message of

Australia's lack of progress against CTG targets. As an example, it is illuminating to consider statistics regarding Body Mass Index (BMI). At the national level, the proportion of Indigenous adults living in non-remote areas with a BMI score in the overweight or obese range increased by 9% from 1995 to 2004–05 (Australian Government, 2012). In comparison, clients of the IUIH-established clinic Moreton Aboriginal and Torres Strait Islander Community Health Service (MATSICHS) demonstrated a reduction in their BMI scores of over 35% (IUIH, 2014b).

At the same time, Deadly Choices must remain accountable to the community with which it works, according to its principle, “we don’t tell people what to do”. This is not straightforward and as Chapter Six demonstrated, the Deadly Choices practitioners experienced moments when they were unsuccessful in their efforts. For example, at the Murri Cup Carnival when Deadly Choices imposed restrictions upon the food and beverage choices of attendees, the community backlash was strong and voiced promptly, including via social media. This situation imparts a number of lessons. Firstly, the backlash indicates that the community was involved in Deadly Choices and that particular event. Secondly, social media provided an important platform for the community voice, which is consistent with research showing its use for activism and self-writing of identity (Carlson, 2013; Petray, 2013). Thirdly, the emphasis that Deadly Choices places upon relationship meant that these practitioners listened to community feedback and acted to learn and adopt strategies to avoid making the same error again in future. The relationship between Deadly Choices practitioners and the community, combined with the community involvement, meant that the practitioners were held accountable and responsive. Perhaps most fundamentally, this incident shows the importance of “we don’t tell people what to do”, in terms of ensuring that people have choice.

Inclusive and incentivised choice

The value Deadly Choices place upon not forcing change is a contrast to the usual colonial exertions by health promotion regarding compliance and control. While Deadly Choices practitioners do employ health education strategies and endorse the healthy “moral” talk of health promotion, Indigenous community control governs their processes of health promotion, where relationship and choice take priority. Therefore, the Deadly Choices practitioners support people to “learn by doing”, rather than telling;

encourage people to “have a go” rather than aim for perfection; and build relationship and positive dialogue about healthy choices – rather than telling people how they should live.

Deadly Choices practitioners work to this agenda by creating a supportive environment for people to be leaders. People are taught boundaries for self-discipline, rewarded for demonstration of leadership, taught to help each other, and celebrated for their choices. To support development of these leadership qualities, Deadly Choices rewards “good behaviour”, while withholding rewards when that behaviour is not displayed. For example, Indigenous people are encouraged – incentivised – to have a health check, in order to receive the Deadly Choices merchandise. Contrast this to some mainstream approaches, such as the proposed compulsory health checks of the Northern Territory Emergency Response (discussed in Chapter Two) or the anti-smoking poster in Figure 19 (see Chapter Five) that positions mothers who smoke as an undesirable, irresponsible Other. In comparison, Deadly Choices stimulates a conversation about health, and affirms and incentivises healthy choices, in order to encourage, rather than compel healthy behaviour.

By having the authority to reward particular behaviours, the Deadly Choices practitioners are endowed with a degree of power that can negate the equal, two-way relationship for which they aim. This can also position practitioners awkwardly in their endeavour to support people who do not adhere to the behaviours Deadly Choices promotes. For example, in Chapter Six, Hunter could not provide Donavon with a Deadly Choices jersey at his program awards ceremony because Donavon did not attend all seven Deadly Choices classes, despite having a legitimate reason for not attending. Even though the boundaries of the Deadly Choices rewards are transparent and known by the community (which serves to confirm the value of the rewards), this conundrum is still one that points to the deeper ethical tensions of health promotion.

The tension of rewarding “good behaviour” is a recognised dilemma of health promotion (Kelly & Charlton, 1995; Seedhouse, 2004). Health promotion is based upon the ideal of an active citizen and health equity (WHO, 1986b), which begs the interrogation of what a “good society” is (Carter et al., 2012a) and whether one must be healthy to be a “good citizen”. Such questions point to the preconceptions and

misconceptions that underpin health promotion, and the predicament of ensuring people behave healthily while respecting their right to choice. In the case of Deadly Choices, while the community is encouraged to be healthy, the community co-defines what being healthy means. By encouraging people to “have a go” and make deadly choices, being healthy does not equate to making a perfect choice, but rather a better choice. This may mean that a practitioner celebrates a person’s choice to continue an unhealthy behaviour, if that choice is part of their positive transformation – for example, when a person chooses to reduce the number of cigarettes smoked per day, rather than quitting entirely.

The Deadly Choices narrative of choice, rather than compliance, is important for ensuring genuine choice for people in making their deadly choices and enables the broader and creative concepts of health to be documented. For example, the merchandise, the Deadly Choices Education Program and positive framing of Indigenous identity have worked together to legitimise and normalise healthy behaviours, such as undergoing a health check. The power of choice is evident in the way that Deadly Choices has created a space within the health system – known for its racist and controlling approach with Indigenous people and communities (discussed in Chapter Two) – where the Indigenous community wants to be present and involved. In other words, by rewarding engagement and aiming to empower, Deadly Choices has enabled the co-creation of a new narrative in Indigenous health promotion.

The inclusive and distributive nature of Deadly Choices leadership – that *everyone can be a leader* – creates an all-encompassing “target group”. Deadly Choices works with the whole community, in order to establish leaders “distributed” throughout the community. Such an approach juxtaposes with health promotion’s tendency to target individuals or groups participating in risky lifestyles or behaviours (for example, tobacco smokers, obese people and so forth). Instead, Deadly Choices targets the whole community, including those involved in risky behaviours and those who are not, because “everyone can be a leader” and has a “responsibility to look after your family”. This means that individuals who do not display risky behaviours are also potential participants of health promotion (as shown in the example of a practitioner engaging a non-smoker, in Chapter Six).

That Deadly Choices endeavour to include all people in the community, while still focus on particular groups such as young people, is indicative of a broader tension in health promotion to be inclusive of all people at all times. In health promotion's efforts to be effective and "value-adding" by targeting particular groups, the health of some groups may improve at the cost of widening health inequalities (Baum, 2007a; Thompson & Kumar, 2011). Health promotion with a diverse community will be always likely to face this tension and this research demonstrates that there is no one clear strategy to negotiate it. Some people may be included while others feel excluded. For example, Deadly Choices' predominant use of NRL to engage the community continues to be critiqued in some parts of the community, for its masculine emphasis and apparent exclusion of and silence regarding females.

Academic literature acknowledges the limitations of sport for engagement and health benefits, highlighting that children and young people can be excluded on the basis of structural factors including gender, sexuality, race, ethnicity, social class or disability (Godwell, 2000; Macdonald et al., 2012; Ware & Meredith, 2013). However, while sport is not a "panacea for health, education and behavioural issues" (Nelson, 2009, p. 101), researchers do claim sport settings provide opportunity for health promotion due to their associated engagement and community ownership (Thorpe et al., 2014). While there are benefits to gain from participating in organised sport, these benefits are not automatic and require a comprehensive approach to the activities, aims, and purposes of the sports (Geidne, Quennerstedt, & Eriksson, 2013; Ware & Meredith, 2013).

This means that while Deadly Choices works to close the gap, it also risks widening the gap and thus further disadvantaging particular groups, such as Indigenous women or older people. The response to this tension by Deadly Choices and IUIH is important to note. Practitioners have acknowledged this tension in conversations and responded to feedback that there was "a demographic of people who we've missed through the cracks". Diversification in Deadly Choices' imagery in relation to sports and gender is evident as a result. While Deadly Choices admits it is "not perfect", the *inclusive* identity of Deadly Choices enabled it to transform its practice.

Indigeneity as health promoting

Deadly Choices demonstrates a possible approach to the negotiation of the “strong logic to behavioural change strategies” that heavily influences health promotion and the politicians involved, where the preference is to tell people not to behave in unhealthy ways and instead behave in healthy ways (Baum & Fisher, 2014, p. 218). Through the shift away from the problematic health promotion imperative of compliance, Deadly Choices creates space to celebrate and recognise Indigenous agency, cultural values and identity. This is illustrated by Deadly Choices’ showcasing of Indigenous leadership in the profiling of Deadly Choices ambassadors and promotion of people’s deadly choices, such as on social media.

Deadly Choices’ positive framing of Indigeneity is remarkable for a health program when considering the public health backdrop, renowned for positioning Indigenous Australians as sick and dying, lacking in agency to improve their own health (Bond, 2005; 2007). Public health continues to play a role in constructing Indigenous identity (Bond, 2007; Bond & Brough, 2007), as it also does regarding other marginalised groups (Lupton, 1995). In fact, mainstream policing and controlling of Indigenous identity goes beyond public health, particularly regarding urban Indigenous identity, which continues to be contested and constructed according to mainstream perspectives.

Contradictions abound. For example, public health employs Indigenous identity as a marker of illness and biological inferiority, thereby excusing its continued failure (as demonstrated by the high Indigenous morbidity and mortality rates) as being caused by Indigenous people (Bond, 2007). Mainstream endeavours to control Indigenous identity are also evident in discourses where Indigenous people are expected to conform and work hard to overcome disadvantage, while the authenticity of their Indigenous identity is questioned when they do (Bond, 2007). Skin colour has been and continues to be the criterion of Aboriginality in mainstream spaces (Carlson, 2011; Tatz, 1980). Time and again Indigenous people talk of being asked, “What body part is Aboriginal?” or “What percentage of Aboriginal blood?” (Behrendt, 1994; Bolt, 2010; Bond, 2007; Fredericks, 2004). Rather than seeing Indigenous culture as dynamic and Indigenous identity comprising multiple narratives (Bolt, 2010), a mainstream discourse continues, based on past notions of authenticity and surveillance (Bond, 2007; Casey, 2012; Lumby, 2010).

There is a deeper meaning of the Deadly Choices slogan “urban is the new black”. This slogan has been used in America for work in relation to teaching critical race awareness of the subtle and systematic social processes that maintain and reproduce racial inequality (Bell, 2014, p. 31). In South East Queensland (SEQ), the slogan strategically connects and affirms the “normality” of urban-dwelling and Indigenous Australians. As stated in Chapter One, large numbers of Indigenous Australians live in urban areas, including in SEQ (IUIH, 2013d). Despite this, a powerful mainstream narrative continues to contest and police urban Indigenous identity. The myth that “real” Indigenous people only live in rural and remote areas is magnified by the belief that urban-based Indigenous people are lost to their (Indigenous) culture and completely integrated into non-Indigenous way of life (Behrendt, 1994). Urban-dwelling Indigenous people are seen as not “traditional” or “authentic” enough for mainstream imaginations (Fredericks, 2004). In contrast, the failure of non-Indigenous Australia to acknowledge the plurality of Indigenous identity narratives (Bond, 2007) is directly addressed by Deadly Choices.

The sensational media attention towards the plight of Indigenous Australians presents an additional layer of complexity and injustice. This is clearly a matter of power and control. The way an issue is framed in the media influences political agendas and public perceptions, and reflects elite agendas (McCallum, 2012). What’s more, negative media in relation to Indigenous Australians perpetuates racist stereotypes among the wider population, which impacts on the health of Indigenous Australians (Stoneham, 2014). As an example, consider Andrew Bolt’s contestation of Indigenous identity in the media, where he argued that to claim an Indigenous identity an individual must be identifiable by racial differences and practice traditional culture (Bolt, 2009). Subsequently, the Australian High Court found Andrew Bolt to have been dishonest, misleading and careless in his representation of a group of Indigenous people and in contravention of the Racial Discrimination Act (Federal Court of Australia, 2011). This did not appear to stop him from continuing his public taunt of an even greater number of Indigenous Australians, by questioning the authenticity of their Indigenous identity (Bond, 2014). It is little wonder a teenage boy such as Donavon, the student in Deadly Choices in Chapter Six, was wary about identifying as Indigenous at his school.

Perpetuating public health's problematic construction of Indigenous identity is bountiful evidence that describes the nature and extent of the wide gap between Indigenous and non-Indigenous Australians. This evidence enables significant advocacy efforts, such as the Close the Gap campaign, which has resulted in important progress towards equality (as discussed in Chapter Two). However, this evidence also depicts a weak and dying Indigenous population, echoing the colonial narrative of Indigenous health (see Chapter Two). Take for example Figure 75, highlighting that an Indigenous man is 10 times

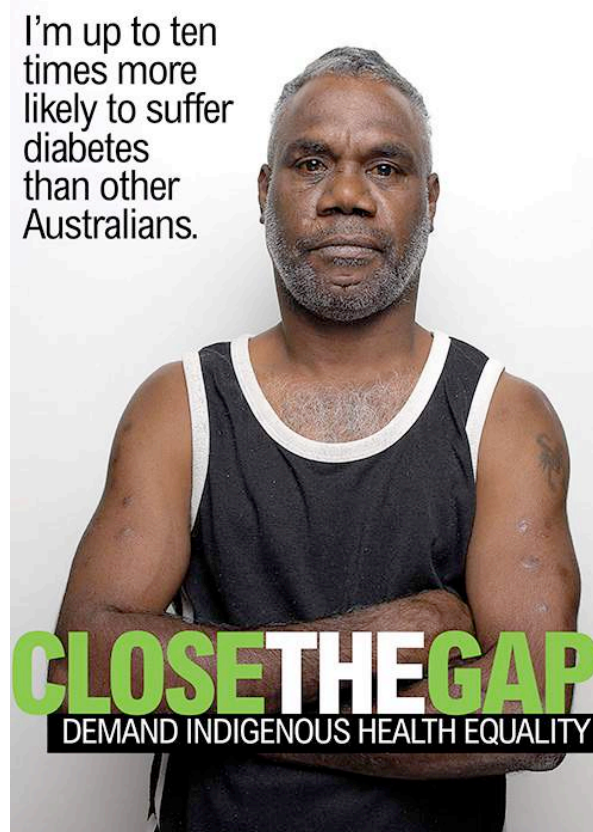


Figure 75: Close the Gap campaign image (thephysicalworld.net, 2010).

more likely to have diabetes, with a call to “close the gap”. The narrative imposed on this man’s image does not appear to be his own, but rather one of a mainstream voice and thus, no matter how noble, reflects a colonial agenda. As Figure 75 demonstrates, the evidence aligns Indigenous bodies with a statistical narrative, rather than the conditions that have produced the inequality. In doing so, a moral imperative is provided for the mainstream health system to act *on* Indigenous Australians’ health – an approach at odds with the health promotion rhetoric of increasing people’s control over their own health (WHO, 1986b).

By contrast, Deadly Choices regards urban Indigenous identity as health-producing and Indigenous people as health promoters. For example, contrast Figure 75 to that of Figure 54 in Chapter Six, where the Deadly Choices Ambassador declares, in his own words,

Being Aboriginal means everything to me... the connection I have with my people and my country is something money cannot buy.

The Deadly Choices image in Figure 54 does not reproduce the constraining and deficit-oriented view of Indigenous identity. Rather, it portrays that Indigeneity equates to value and an empowered voice. While drawing on statistics and data around health outcomes to target and seek funding for their programs, Deadly Choices views urban identity as a strength. By doing so, Deadly Choice raises the visibility of positive Indigenous urban identity. This strategic and empowered strategy provides a response to mainstream imagination of Indigeneity as rural- and remote-based (Fredericks, 2004) and as deficient and requiring expert knowledge and solutions (Moreton-Robinson, 2007). In the case of the Deadly Choices merchandise, by making urban Indigenous identity *cool*, it performs the postcolonial manoeuvre of contrasting and contesting the mainstream construction of urban Indigenous identity as something to “fix” (Loomba, Kaul, Bunzl, Burton, & Esty, 2005; Said, 1978). Even Deadly Choices’ use of ‘deadly’ speaks powerfully to the tendency of health promotion to frame Indigenous identity as deficit – as deadly, as a risk factor and producer of illness (discussed in Chapter Two), as illuminated through a postcolonial lens (Hall, 1996; Young, 2001). Instead, in using “deadly”, Deadly Choices positions Indigenous people as positive and strong.

Deadly Choices thus plays an important role in repositioning identity within health promotion, providing a counter-narrative of pride and health in urban Indigenous values and identity, and a safe space to choose to identify and be proud of doing so. Deadly Choices’ unwritten identity work is an example of this. While Deadly Choices practitioners (and IUIH) understand that cultural identity is fundamental to Indigenous health and wellbeing (Bond, 2007; Bond & Brough, 2007; King et al., 2009; McLennan & Khavarpour, 2004; Watson, 2006), it is not a recognised funding outcome for Deadly Choices. Keep in mind that the United Nations has advocated that its member states, including Australia, adopt appropriate indicators of Indigenous identity¹⁶⁵ and apply these in performance measurement and monitoring processes (Permanent Forum on Indigenous Issues, 2006).

Understandably given the apparent lack of interest from the Australian Government, the identity work of Deadly Choices is not apparent in its reports (IUIH, 2014c). Yet in my observations of Deadly Choices, identity work is ever-present and central to Indigenous

¹⁶⁵ As well as indicators of Indigenous lands, ways of living, and indigenous rights to, and perspectives on, development and well-being (Permanent Forum on Indigenous Issues, 2006).

notions of health – and continues despite the funding constraints. In this way, Deadly Choices emphasises a particular Indigeneity and set of outcomes for funding bodies and politicians, compared to that when working with the community. From this we can understand that identity work is a key part of health promotion and performed in relation to the range of knowledge systems and agendas.

Knowledge enables the production of discourse and subsequently the construction of identity (Bolt, 2010; Bond, 2007, p. 17; Nakata, 2007b; Said, 1978). Deadly Choices practitioners produce and utilise a range of knowledges, including Western, local and Indigenous, in its practice and communications. For example, Deadly Choices practitioners draw on the knowledge systems preferred by their funding body, including health education, which is clear in their annual reports (for example, IUIH, 2014c). The practitioners also draw on other knowledges suitable to the contexts in which they work, including Indigenous perspectives produced by staff and community in the dialogical cycles of Deadly Choices practice. In this way, different knowledges do not remain static, but rather assumptions are moulded and modified. This has the effect of expanding existing health promotion knowledge, rather than simply adding another perspective. This expansion of knowledge has the effect of shaping Deadly Choices health promotion to be useful to the Indigenous people and communities involved (Nakata, 2007a, p. 197).

As Chapter Six described, the knowledge and process of Deadly Choices health promotion remain Indigenous community controlled, with a greater emphasis upon community connections of their practitioners, above “those education tools (such as the Ottawa Charter) every day”. Non-Indigenous and Indigenous practitioners work together, while Indigenous people and communities control the agenda. Ongoing daily exchanges continue to build a collective, expanded health promotion practice, unrestrained by a binary of Indigenous/non-Indigenous knowledge (Nakata, 2007b). In doing so, Deadly Choices has formed a space that is recognisably Indigenous, where Indigenous people and communities are the experts and Indigenous values are healthy.

Deadly Choices can thus position health according to Indigenous perspectives, as a means to live life to the fullest and achieve one’s full potential (National Aboriginal Health Strategy Working Party, 1989). Take for example Uncle Gordon’s story in

Chapter Five, talking about Indigenous health meaning “more than just physical well-being. It’s emotional wellbeing; everything connected to your family”. Deadly Choices provides and nurtures examples of health that are broader than the individualistic approach, so rampant in mainstream health promotion. Through its holistic and flexible approach, Deadly Choices can negotiate health promotion’s challenge of moving beyond the individualistic focus by sharing power with Indigenous people and communities to determine what should be defined as health.

Of the community

Deadly Choices work with the community as health promoters and the practitioners are community members themselves. The lack of need for outside “experts” and their intervention is reflected in the Deadly Choices recruitment strategy and its approach of embedding health promotion in the community. As described in Chapter Seven, the Deadly Choices practitioners identified their health promotion responsibilities as including being “there for the community... to promote them... be an ear or be their forum”. Furthermore, the community is literally embedded into the Deadly Choices health promotion through the recruitment of community members into the Deadly Choices team. This is not to disregard the value of qualified and experienced health promotion practitioners. Rather, this highlights that, as the Ottawa Charter states, health promotion is to draw on existing human resources in the community “to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters” (WHO, 1986b, p. 3). In the case of Deadly Choices, community expertise is fundamental to Deadly Choices’ success.

The way the Deadly Choices practitioners relate with the community is also noteworthy. As the findings illustrated, the Deadly Choices practitioners spend a large part of their practice listening to participants and community members. Practitioner listening is important in terms of empowerment, for genuine community participation and the naming of one’s experience to take place (Labonte, 1994). Through a process of engagement and listening, Deadly Choices facilitates open-ended collaboration with the community towards a joint understanding and construction of health and Deadly Choices.

Indigenous humour is also an enabler for the practitioners to navigate the moral agenda of health promotion directives, with respect to people's choice. Humour positions the practitioners as non-authoritative, and lubricates the execution of the philosophy, "we don't tell people what to do". Using humour, Deadly Choices practitioners can engage in tobacco or nutrition education, for example, but "do things differently". Likewise, because of relationships within and between the community and practitioners, Deadly Choices could become in some way an "in joke" between Indigenous people and non-Indigenous allies, evidenced through the Indigenous humour in the official and unofficial components of Deadly Choices, from everyday conversation, to the television commercials (TVCs).

The role of Indigenous humour in Deadly Choices is profound. Indigenous people claim strengths, words, choices, role models and approaches on their own terms. In doing so, the mainstream becomes the Other, while resisting the mainstream positioning of Indigenous people as victims requiring mainstream practitioners to rescue them. The TVC with Steve Renouf, discussed in Chapter Five, is one example of this humour, where it may be difficult for an "outsider" to understand the fullness of why this is funny. Yet, for much of the Indigenous community in SEQ (and beyond), they know the stars in this TVC; they know the relationship between the people in the plot and their relationship to them. In this way, Deadly Choices uses humour as a social commentary about something Indigenous people have in common, perhaps unsaid, and can laugh at together (Nakata, 2007b).

Humour is entrenched in relationship, which is a point of departure for Deadly Choices in comparison to mainstream health promotion approaches. Relationship is an enabler for Deadly Choices' work, which practitioners nurture with a range of stakeholders beyond the community it serves. By no means is relationship a panacea to overcoming all tensions of health promotion practice, though, for it carries its own set of specific tensions. For example, consider the approach of practitioners described in Chapter Six, not to push a change in the school tuckshop menu when the school representatives resisted. Instead, the Deadly Choices practitioners prioritised maintaining their individual and organisational relationships with that school. As this example illustrates, relationship can in some ways present a barrier to health promotion activities. However,

when working according to principles of community control and choice, relationship carries more importance than short-term health gains.

The influence of accountabilities upon Deadly Choices relationships is also evident in their relationship with government and politics. Deadly Choices maintains an intentionally non-political persona¹⁶⁶, while navigating the local to national politics. Such a persona may appear to be at odds with global health promotion discourses, which emphasise advocacy as a key strategy and acknowledge that health, and therefore health promotion, is political (Carlisle, 2000; Raphael, 2011a;2011b;2013;2014). Still, Deadly Choices is by its nature political, because of the politico-historical positioning of Indigenous Australians (discussed in Chapter Two). Arguably, given this positioning, it is Deadly Choices' positive and non-political persona that enables Deadly Choices to effect changes in relation to mainstream positioning of Indigenous identity, health and regard for Indigenous knowledge.

The IUIH explanation of Deadly Choices as executing reverse colonisation (discussed in Chapter Seven) illustrates this dynamic. Deadly Choices has gained a non-Indigenous following from community-level through to government-level, which is a remarkable shift of power relations in the historical context of the state and federal health system working to control Indigenous Australians. In this way, Deadly Choices demonstrates a wider display of Indigenous identity by involving non-Indigenous people. That is, Deadly Choices constructs Indigenous identity as being inclusive. Therefore, anyone – Indigenous or non-Indigenous – can be a leader by making a deadly choice. This inclusive identity is a deliberate approach to widen the base of “allies” for the Deadly Choices agenda. Furthermore, Indigenous people are controlling health promotion products that are traditionally controlled by mainstream actors, while those mainstream actors are investing to access those products. Take the Deadly Choices TVCs as an example, which were designed by Indigenous people in an Indigenous organisation (IUIH), on their own terms. The Australian Government then funded IUIH for the placement of their Deadly Choices TVCs in a mainstream context for broader population health. Deadly Choices does more than provide an alternative, Indigenous

¹⁶⁶ While Deadly Choices may work to maintain a non-political persona, IUIH is more overtly involved in politics and advocacy.

voice in mainstream spaces; it is a part of a revolutionary process that, in their own words, is Indigenous-led colonisation of health promotion.

To consider the power of this positioning requires a non-Indigenous actor, such as me, to realise that my mainstream perception of decolonisation is just that: from the position of a non-Indigenous actor. Thus, while I have laboured to learn of my privilege and develop strategies to relinquish my power and control in research and practice, the Deadly Choices practitioners are doing the opposite: they are proceeding to colonise the non-Indigenous spaces in the mainstream health system and discourse. As the practitioner stated in Chapter Seven they are “just thinking normal”. In other words, “normal” practice for Deadly Choices practitioners is to populate mainstream spaces. The theoretical ramifications of this are perhaps that for Indigenous health promotion practitioners, decolonising practice involves “stepping forward”, while for non-Indigenous practitioners, such as me, it requires “stepping back”. Perhaps the decolonisation of health promotion is more than just *including* citizens in health promotion but “defining and updating our vision of health promotion” (Carter, 2014, p. 24). Perhaps decolonising health promotion is, as health promotion’s foundations claim to be (WHO, 1986b), all about control in the spirit of self-determination; which, as the findings of this study suggest, translate to Indigenous community control, relationship, choice and empowerment.

Theory and health promotion as colonisation

The bricolage (Kincheloe & McLaren, 2005) comprising the three theoretical tools (discussed in Chapter Three) was an important framework to enable this study’s attention to privilege and power, both in the research project itself and in health promotion more broadly. The use of theory in this manner, combined with standpoint, assisted me as researcher and practitioner to reconsider the terrain that influences health promotion, and in particular, me. This was critical for this work’s decolonising aims for a number of reasons. Firstly, as Chapters One and Two established, the majority of Indigenous Australians have experienced mainstream health promotion as a controlling and disempowering enterprise, throughout history and in contemporary practice, rather than the empowering venture it imagines itself to be. Secondly, health promotion’s existing theoretical state of affairs has proven inadequate to redress this duplicity, where moral claims permit the whitewashing of its own ethical deficiencies. The result has

been continuing intervention in Indigenous people's lives, which has at best maintained status quo, or heightened inequality and stigmatisation (Baum, 2007a; Bond, 2005;2007; Thompson & Kumar, 2011). Thirdly, because of this, health promotion researchers and practitioners alike – myself included – must examine these theoretical and ethical deficiencies to establish a new way forward that can redress health promotion's general failure in engaging with Indigenous people for health equity.

It is useful to reconsider the metaphor of colonisation for health promotion here. Colonisation entails invasion and establishment of settler colonies who obtain privileges and rule over Indigenous peoples. The colonisers genuinely believe in their cause as progressing civilisation, even if it is at the expense of others, particularly the displaced Indigenous people. Some colonisers may express concern with the inequity of the situation for the colonised and implement their colonial-defined solutions. For example, in Australia “good White women” tried to progress the mission of domesticity by imposing their Eurocentric ideals on to Aboriginal women (Bishop, 2008). These solutions are all founded on the belief that the colonised are dependant, incapable, uncivilised, dirty, and so on (e.g., Huggins, 1998). Thus, the colonisers' perceived superiority, alongside the apparent inferiority of the Indigenous people and behaviours, justifies the continuation of intervention on the colonised (e.g., Donovan, 2002; Thomas, 2004).

Like colonisation, health promotion necessitates the ruling by practitioners and authorities over new territory, in this case, over people's bodies. This domination is to be in accordance with a healthism that is similar to the racism that informs the colonisation of nations (Hughes, 1997). Health promotion authorities thus create a *power over* relationship with the “recipients”, who are effectively colonised by health promotion interventions that aim to change their unhealthy behaviours. Like colonisation, health promotion progresses a moral agenda to create a “good society” (WHO, 1978;1981;1986b). To do so requires expert intervention, where those who comply are “good citizens” while those who do not are deemed irrational and irresponsible (Brown, Shoveller, Chabot, & LaMontagne, 2013; Carter, 2014). While some health promotion professionals debate the ethical cogency of this practice (e.g., Braunack-Mayer & Louise, 2008; Carter, 2014; Carter et al., 2012a; Carter et al., 2011; DeMaria, 2013; Tengland, 2012; Wardrope, 2015; Yeo, 1993), generally health

promotion is celebrated and practised with little attention to its ethical and theoretical deficiencies.

While not the intention of health promotion, marginalised groups are known to resist health promotion intervention in order to retain and regain empowerment in their lives (Bond et al., 2012; Hughes, 1997). Health promotion may believe that its messages and promotion of particular behaviours will make society “better”. However, individuals and communities who participate in the discouraged risky behaviours may instead experience health promotion as a negative imposition and labelling (for example, lazy, irrational, deviant), devoid of attention to their life circumstances (e.g., Hughes, 1997; Lupton, 2013b;2014b). Accordingly, such individuals and communities may gain a greater sense of empowerment in resisting health promotion by continuing the discouraged behaviours, to contest such labels and retain a sense of choice, rather than complying. In this case, people’s bodies become the site of resistance to colonisation by health promotion (e.g., Bond et al., 2012; Rofes, 2002; Thompson & Kumar, 2011).

Thus, the role of peoples’ choice must take precedence in any decolonising endeavour, be it decolonisation of nations, health promotion or (as Chapter Seven identified) people’s minds. Given mainstream health promotion’s repeated intervention on Indigenous people’s lives, decolonising health promotion requires that Indigenous concerns and worldviews are centred (Chilisa, 2012; Smith, 2012). As *Deadly Choices* has demonstrated, “we don’t tell people what to do” can be particularly powerful for guiding this approach and respectfully engaging communities. More profoundly, the principle can guide the navigation of health promotion’s primary tension, as represented by the metaphor of colonisation.

As a non-Indigenous researcher and practitioner, I relied upon the bricolage of theoretical tools to assist me in the decolonising endeavour regarding health promotion and my own practice. The composition of the bricolage guided my critique of the Euro-Western paradigm of dominance in health promotion and my standpoint. As Chapter Three established, decolonisation also requires the suspension of foregone conclusions generated through this anti-colonial critique. For this, the bricolage included the cultural interface to extend the critique beyond a structural binary, to support the integration of knowledge and agency at the interface of Indigenous analysis, resistance, practice,

knowledge revitalisation and futures (Nakata et al., 2012, p. 135). The composition of the bricolage thus enabled this study's attention to health promotion's theoretical and ethical deficiencies, while also elaborating on Indigenous knowledge, agency and practice in health promotion. Without such a lens, it is possible that understandings gained about the "unofficial" work of Deadly Choices (perhaps the most important) would have been discounted, with attention instead towards the subset of techniques for behaviour change, for which health promotion is renowned.

This particular bricolage may assist other health promotion practitioners to decolonise their health promotion practice, and as a guide to expose hidden privileges and power structures. However, the composition of this bricolage is not presented as a model or meta-theory to indiscriminately apply to health promotion. Rather, its critically reflexive nature is encouraged for all health promotion endeavours, with particular attention to the power relations and privileges that form health promotion practice.

“We’re in, looking out”: Decolonising health promotion practice

This study has established that health promotion has been used as both a colonial apparatus of control over Indigenous people and a form of colonisation over people's bodies. The study has also found that Deadly Choices practitioners demonstrate an alternative approach, where health promotion practitioners aim to not “tell people what to do”. Instead, Deadly Choices practitioners use innovative, diverse, relationship-based approaches to health promotion that can redress health promotion's colonial control by shifting power toward Indigenous communities. For this, empowerment, community control and choice are central to the practitioners' dialogical approach, drawing on Indigenous notions of health, healthy behaviours and Indigenous identity.

Deadly Choices practitioners present fundamental lessons for the decolonisation of health promotion. Yet, the Deadly Choices practitioners do not appear to refer to their work as decolonising; nor are the parameters they work within entirely decolonising. For these practitioners, their work is “the way we would normally think... we’re in, looking out”. By contrast, as a non-Indigenous practitioner and researcher, I was positioned as “out looking in” and viewed the work of Deadly Choices according to a

decolonising agenda for health promotion. Precariously, my choice (and the availability of that choice) to represent *Deadly Choices* according to a decolonising agenda risks negating the decolonial agenda for which I argue.

Decolonisation is not a simple requirement that those of us in the hegemonic centre include those at the margins, for these categories of marginality assume (and perhaps require) that those in the margins be more disadvantaged than others (Hurley, 2007). These categories also necessitate the positional superiority of the centre regarding the Other in the margins (Hurley, 2007, p. 181; Said, 1978) – a positionality so vigorously executed by White privilege (Fredericks, 2009;2014; Kowal, 2011; Moreton-Robinson, 2006; Nielsen, 2008). White privilege can empower well-meaning health promotion practitioners, me included, to speak *for* the disadvantaged Other in our labours to improve health. The effect can be that instead of improving poor health outcomes, our masquerade of defending the weak protects the power of White privilege. This reason alone is sufficient to make the decolonisation of health promotion our core business.

As health promotion professionals we must challenge not only health inequities but also the White privilege that creates and legitimises them. To do so brings us into contentious territory that may involve representations of others – as this thesis is positioned to do. While it is beyond the scope of this thesis to cover the complex terrain of speaking for others, I recognise that there are many factors that influence the meaning and effect of what is said in those representations (Alcoff, 1991). Being a White health promotion practitioner thus requires the personal endeavour of examining and disrupting our own thoughts and challenging the discourses of our profession; it also remains an awkward tension for me. Yet just as White privilege is systematically denied and protected, we can systematically draw attention to and disrupt that privilege. Failing to do so leaves us failing as health promotion professionals.

Decolonisation requires a process of reconstituting the fabric of the setting that creates and imagines these positions and categories of marginality and White privilege. Decolonisation thus translates for me as the destabilisation of my position as White, non-Indigenous, coloniser, researcher and mainstream practitioner; as well as the destabilisation of my understanding of *Deadly Choices* as decolonising practice. My claims that *Deadly Choices* represents a decolonising agenda stand only in relation to

my position. I conclude from this that for a non-Indigenous practitioner and researcher, the decolonial project requires the grappling with and embrace of the tension of positioning. Such a conclusion is similar to this study's call for health promotion to acknowledge and engage with its primary tension of imposing a health improvement agenda while working to support people's control over their own health. In this way, decolonisation of health promotion practice requires a radical reworking of practitioner relationships with Indigenous people and communities (Sherwood & Edwards, 2006).

What constitutes decolonising health promotion practice – and whether health promotion can be decolonised – remains contested and requires further dialogue and debate. To progress this dialogue, this study proposes four interrelated principles for decolonising health promotion, informed by the practice of Deadly Choices practitioners. Figure 76 provides a representation of these four principles, which are: community control, choice, empowerment and relationship. This thesis does not suggest that the model in Figure 76 is a conclusive model of Deadly Choices' practice but rather that it is a representation of my interpretation of the practice of Deadly Choices practitioners. Nor does this thesis argue that these principles are to replace existing health promotion charters and frameworks. Instead, the principles complement the health promotion endeavour of increasing people's control over their health.

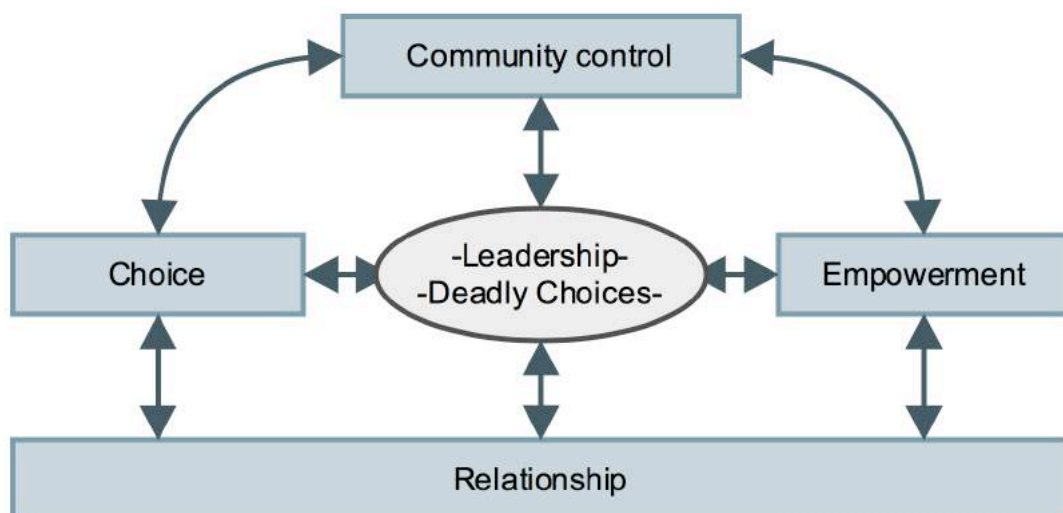


Figure 76: Four principles to enable decolonising health promotion practice and their associated processes and outcomes.

The location of the concepts displayed in Figure 76 are such that they reflect my understanding of the way Deadly Choices practitioners conceptualise their practice. For example, relationship is located as beneath the three remaining principles not because it is lowest in a hierarchical ranking but because relationship is foundational and necessary in all work undertaken by Deadly Choices. Similarly, community control is consigned to the apex of Figure 76, reflecting practitioner explanation to me that community control is “the higher order concept” of their practice. Control, choice and empowerment work together: choice requires control in order to exercise one’s agency; empowerment requires choices in order to provide pathways for people to participate in and control their life. All three principles require relationship in order to occur and are all intertwined with the achievement of the other.

The processes and outcomes from these principles are leadership and Deadly Choices, which are accordingly displayed in the centre of the model in Figure 76. Through the enactment of the four principles, Deadly Choices has been co-created with community, and continues to thrive with a broadening community following. Likewise, when the four principles are practised, community members make their own deadly choices – healthy choices according to Indigenous concepts of health – thereby implementing a health promotion agenda on the community’s terms. The act of doing so is also an act of leadership, as conceptualised by Deadly Choices. As the findings demonstrated, leadership is a process and an outcome based upon connectedness, relationship, responsibility and role modelling. The act of role modelling one’s deadly choice exemplifies leadership in relation to those with whom one is connected, and so embodies empowerment, community control and choice. The following section discusses the four principles proposed for decolonising health promotion practice in more detail. The intention of such discussion is not to provide a template for health promotion practice, projects, policy and so on, but rather to introduce the possibilities in their application.

“It was our way”: Community control as a measure of success

Health promotion by its nature is concerned about people’s control over their health (WHO, 1978;1986b). Indigenous people talk about control over their own affairs as the “difference between success and failure of Aboriginal health care programs” (Foley, 1991, p. 4). For Indigenous Australians, health means self-determination through

community control (Foley, 1991; NACCHO, 1993). Given health promotion has yet to clarify how to ethically grapple with its primary colonising tension, the logic of Indigenous community control presents useful instruction for mainstream health promotion to explore in practice.

The Deadly Choices philosophy “we don’t tell people what to do” speaks directly to this tension and to the issue of power and control. By labouring to *not* tell people what to do, Deadly Choices practitioners navigate the moral grounds of health promotion. As Chapters Five to Seven explicated, the Deadly Choices agenda is the community itself. That is, Indigenous community control is the “higher order concept” for Deadly Choices health promotion practice, and recognised as having the power to resist and transform ongoing paternalistic policies that seek to control Indigenous Australians (Maddison, 2008). It follows then that this thesis has identified control as being a measure of decolonising health promotion practice.

Indigenous community control has been the guiding principle for Deadly Choices since its beginnings, resulting in considerable success in community engagement. This is an important point to make, particularly in light of Deadly Choices being first established in response to an Australian Government funding agenda (see Chapter One). One could argue that Deadly Choices is no different to any other mainstream health promotion program, given the nature of its beginning and use of health promotion techniques including health education, posters, shirts, champions, social media and so on (as discussed in Chapter Five). Indeed, the individualistic approach of these techniques has been widely critiqued (e.g. Alvaro et al., 2010; Baum, 2011a; Baum, 2011c; Baum & Fisher, 2014; Hughes, 1997; Katz, 2002). However, there are important points of difference for Deadly Choices, including that these techniques are used within an approach of community control in the health promotion practice.

Governance and leadership are important aspects of community control, including processes to establish community controlled health organisations, by and for the community (as discussed in Chapter Two). In this case, the successes of Deadly Choices speak to the importance of Indigenous leadership and governance in health promotion, and the CCHS more broadly (Best, 2005; Foley, 1999; Gillor, 2012). For example, through a partnership of SEQ Indigenous community controlled health services, Deadly

Choices was able to overcome the distrust in their local Indigenous communities of the health system and the medical science agenda as an imposition and mechanism of colonial control (Fanon, 1965). While Indigenous community controlled health organisations are critical for improving Indigenous health (e.g. Panaretto et al., 2014), the lessons gained from this study are applicable to health promotion practice, regardless of where a practitioner is based.

In the context of Indigenous health promotion, this means that both Indigenous and non-Indigenous practitioners can be important contributors, but control and leadership remain with the Indigenous community. For example, a health promotion practitioner could prioritise listening to and creating space for Indigenous community voices in designing and implementing a health promotion project. To genuinely do so requires a practitioner to relinquish control over their health promotion practice, to enable two-way sharing (Carnes, 2011a; Geia, 2012; O'Donnell & Kelly, 2011). It also requires that a practitioner is critically self-reflexive, with attention to the White noise that can cloud one's ability to hear (Carnes, 2011a;2011b). Listening to community and providing space for community control over health promotion processes may require the practitioner to work on cultivating their skills in listening and acceptance, observing actions and feelings, of reflecting and learning (West, Stewart, Foster, & Usher, 2012). In choosing to listen, a practitioner can take the opportunity to learn about themselves as well as the community, to move beyond the rigid position of health promotion "expert" and work with the community involved as equals. Deadly Choices provides us with an example of this in the way they facilitated ongoing dialogue with the Indigenous community involved regarding health and healthy behaviours.

This is not to say that community control removes the tensions of practice inherent to Australia's neoliberal reality of preference for behaviour change interventions (Baum & Fisher, 2014; Baum et al., 2013). This tension was indeed evident in Deadly Choices practice. Community control in health promotion highlights the inadequacies of the top-down/bottom-up binary to reflect the complexities of community control in health promotion. Deadly Choices reinforces that community control in health promotion practice requires an occupation of the paradoxical space in between and complementary to bottom-up and top-down realities (Laverack & Labonte, 2000; Warr et al., 2012). Furthermore, Deadly Choices demonstrates that community control and participation

create the space for emancipatory potential in health promotion. Indigenous community control is a necessary ingredient for Deadly Choices' success; without it, Deadly Choices is unlikely to succeed or be able to roll out elsewhere.

Community control in governance and practice of health promotion may also be a way forward for mainstream health promotion to address its vulnerability as a sector. Queensland recently experienced an “historic dismantling of public health and preventative health services” (Sweet, 2012) where the government introduced censorship in government-funded nongovernment (NGO) contracts that precluded those NGOs from any advocacy for state or federal legislative change, or associations with organisations that do (Daube, 2012). Understandably, health promotion practitioners have reported feeling marginalised within the broader health system (Sunderland et al., 2015) but perhaps this is a sign to engage the community and raise the profile of health promotion's benefits, as Deadly Choices has undertaken. Community control enables citizens to “have a stake in the future and contribution of health promotion” and to “see themselves as co-authors in its creation” (Carter, 2014, p. 24). If embedded in primary health care services, as Deadly Choices is, the services involved may also increase their awareness of the value of health promotion for their work and the community. Community control may thus be an important step to legitimise and recognise health promotion as a profession.

An agenda of choice

Central to the operation of community control in Deadly Choices is choice. Choice is fundamental to the way control manifests in health promotion, being about action – the act of choosing between two or more possibilities – and based upon a right or ability to choose (Oxford Dictionary, 2014a). It follows that in order to choose, Indigenous people have agency and ability (Bainbridge, 2011). Just as its own name implies, the Deadly Choices philosophy, “we don't tell people what to do” translates into the community defining and electing their own deadly choices. This is a powerful paradox to mainstream health promotion, which is renowned for imposing advice and health messages, and for positioning unhealthy and non-compliant people as irrational and irresponsible. Moreover, this positioning of Deadly Choices also challenges the health system's moral imperative to control and intervene in the lives of Indigenous Australians.

Persuading citizens to take responsibility for their health and wellbeing is a focus of most Western governments, largely driven by neoliberalism's ambition for cost-containment, reducing the state and freeing the market (Macdonald, Wright, & Abbott, 2010). Through surveillance¹⁶⁷, individuals are persuaded to conform and therefore be transformed and improved according to state-determined appropriate behaviours (Hughes, 1997). For example, the "Go for 2 and 5" and "Measure Up" campaigns were found to recycle dominant (and contested) discourses and methods to promote population health, without addressing the major concerns and needs of the population expected to action the selected healthy "choices" (O'Hara, Taylor, & Barnes, 2015; Sebar & Lee, n.d.). Another illustration of health promotion's agenda of conformity to state-determined behaviours is the LiveLighter¹⁶⁸ anti-obesity campaign, which exposes viewers to images of fat and unhealthy flesh, imploring them to prevent being obese or overweight. While intending to promote health, these campaigns carry a harmful side, where fear and anxiety about physical decay and death are projected onto groups and individuals already socially marginalised and stigmatised (Lupton, 2014b; O'Hara et al., 2015). Through this "pedagogy of disgust", the social disadvantage that contributes to poor health is overlooked, while positioning these groups and individuals as inferior (Lupton, 2014b, p. 1). This demonstrates that in a neoliberal context, choice implies personal responsibility – the freedom to choose one's class, to spend one's money as anybody else (poor or rich), and to care for one's self. The neoliberal rhetoric intervenes at the point of the individual, laden with the judgement of those who do not comply. To focus on the individual transgressor absolves the state of responsibility and instead frames social problems as belonging to the individuals themselves (Hughes, 1997).

In contrast, *Deadly Choices* teaches us that choice in the context of decolonising health promotion practice translates to acknowledgement of strength and agency within the community with which a practitioner works. Choice also equates to the practitioner recognising the structural drivers including ongoing colonial processes that continue to shape the choices available to people. For example, a practitioner might look to design a health promotion project that seeks to uncover and work with the meanings attached to health and wellbeing by the Indigenous community with which they work. Rather than

¹⁶⁷ Such as research on individual, group and population health.

¹⁶⁸ View the related website here: <https://livelighter.com.au> (Accessed 1/11/2014).

focus on risk factors or behaviours, such a project could seek to strengthen community agency. The project may then be able to resist the deficit paradigm that plagues Indigenous health, while ensuring that the community retains the choice to decide what constitutes health and healthy behaviour. Such a project might then promote those healthy choices as choices that people *may* or *may not* choose to enact. In other words, such a project could respect the act of making one's own choice as fundamental to health promotion practice that is empowering and cognisant of the historical and contemporary experiences of colonisation (see Chapter Two).

We can see this approach exemplified by Deadly Choices, where choice is based upon Indigenous agency: agency of the community and in the model of community controlled governance. Deadly Choices is more than advice and messaging provided by trained experts. Deadly Choices is about everyday people sharing their choices, celebrated in a positive space. As a result of people *choosing* their healthy behaviour, a multiplicity of behaviours are defined “in their own words” as deadly choices that range across the social determinants of health, including identity. From this we learn that choice as a principle for health promotion could enable health promotion to be practiced in a more empowering way.

“It’s a feeling”: Empowerment as a health promotion goal

Deadly Choices provides us with an opportunity to learn what an empowerment agenda translates into “on the ground”, an area, to date, critically under-researched (Berry et al., 2014). While empowerment may be a means towards health promotion’s “proper end of health improvement” (Braunack-Mayer & Louise, 2008; Carter et al., 2012a, pp. 9-10), without empowerment, the “proper end” will not be achieved. This point is underscored by the long history of government intervention and attempts to improve Indigenous health, with minimal improvement to show for it. Deadly Choices affirms the role of a health promotion practitioner as one that supports the groups and communities in which people participate to gain power, and that enables individuals to increase their control over the decisions that influence their lives and participation (Laverack, 2007). Thus, to be empowering, health promotion must support people to gain power to be active participants in addressing the issues they identify (Snijder, Shakeshaft, Wagemakers, Stephens, & Calabria, 2015).

The processes of empowerment are dynamic and so a health promotion practitioner wishing to work in an empowering manner for decolonising health promotion practice could do so in a number of ways. Empowerment in health promotion is a problematic endeavour that requires of a practitioner ethical reflexivity (Rissel, 1994; Spencer, 2015). To begin a project, a practitioner could embed empowerment as their aim for process and outcome and ensure they approach this with critical self-reflexivity. From this basis, a practitioner might then collaborate with the community with which they wish to work to jointly identify issues and strengths with which the project could begin. A practitioner may need to facilitate ways to bring the community together to do this if the community is not yet organised. Empowerment also tends to carry a transformation agenda (Berry et al., 2014) and as part of this, a practitioner might seek to identify the resources and support required of the communities. For example, this might be in the form of designing and delivering a project that the community asks for. Deadly Choices provides an example of this, with its schools health education program incorporating cultural values and identity, and being based upon leadership. I witnessed many families and schools request this program, quite often more than Deadly Choices had the capacity to deliver. The program contributed to an increase in the number of Indigenous health checks in SEQ, but also empowered its students to be role models in health (Malseed, 2014). Likewise, Deadly Choices used social media in a manner that profiled the voice of Indigenous people and communities, which is key for empowerment for health and community development (Bond & Brady, 2015). There are many possibilities for a practitioner seeking to design an empowering project, all which are to take place in conjunction with the other three principles for decolonising health promotion.

As Deadly Choices teaches us, empowerment for health takes place through freedom and power: to make collective decisions, to share, to learn, to experience, to choose. The way these indicators are measured is not necessarily quantifiable but rather a “feeling”; as discussed in Chapter Seven, “It’s how you feel when you go into an AMS; you feel warm, you sense an Aboriginal identity.” This statement intimates the links between self-determination and empowerment, and the impact that empowerment has on Indigenous health (Dudgeon et al., 2014a). The Deadly Choices practitioners, and IUIH, explicitly state empowerment as the aim of their practice; they also demonstrate a deeper understanding of empowerment as a physical experience for Indigenous people.

In this way, the practice of Deadly Choices converges with global health promotion discourse. However, this study shows that the principle of empowerment requires that “we do things differently” in an Indigenous context, while adhering to health promotion’s philosophical foundations of empowerment and control. Deadly Choices presents us with an example of how this might be achieved.

Relationship as an enabler

All three of the principles discussed so far – community control, choice and empowerment – require relationship to be in place. Through the various strategies to build relationship, Deadly Choices practitioners maintain organisational and community relationships, resulting in outstanding levels of community engagement. As the Deadly Choices practitioners have emphasised, this engagement results because of their relationship with community.

Deadly Choices practitioners and IUIH understand the value of relationship and invest in it, explicitly seeking ways to build trust and reciprocity, and to connect and create new norms collectively. The practitioners seek to create reasons for people to want to be in relationship with Deadly Choices. That is, relationship is not a once-off experience. Likewise, the Deadly Choices team is structured so that practitioners are located in an IUIH office as well as those of partner AMSs and Indigenous organisations throughout SEQ. The advantage of locating Deadly Choices staff positions in host organisations for the purpose of relationship, and thus practice, is so well understood by IUIH that it continued to invest in the co-located positions when the Australian Government withdrew its support at short notice in 2014.

Given the paramount importance of relationship both for Deadly Choices and for health promotion generally, mainstream health promotion could benefit by identifying community relationship as an objective for practice towards health improvement. The Australian Government’s own research recognises that “long-term relationships of trust, respect and honesty as well as accessible, ongoing communication and information” are required for successful engagement with Indigenous Australians (Hunt, 2013, p. 2). Funding requirements could be tied to these principles and processes shown to “work” in an Indigenous context, and accommodate relationship as an outcome. This could

include making funding requirements less prescriptive and more flexible to the growth and priorities of the communities involved in the health promotion initiative.

More broadly, decolonising health promotion practice involves a profound reworking of practitioner relationships with Indigenous people. As discussed in Chapter Seven and earlier in this chapter, decolonising health promotion requires mainstream practitioners to “step back” in order to learn from and work with Indigenous-led health promotion. To do this, a health promotion practitioner could prioritise establishing and nurturing a relationship with the community with which they wish to work. To build relationship requires time and prioritisation of building trust, recognition and values (NHMRC, 2003b) – ideally long before the potential project is to commence. A practitioner could attend community events and learn about the community priorities, for example, to identify ways they can support those priorities. As stated earlier, it is inappropriate to provide a template for how this principle and the other three can be applied. However, a practitioner could seek strategies known to initiate, facilitate and support relationships, such as yarning, collaboration and partnership, time, mentoring, participatory action research processes, and so on (Bessarab & Ng’andu, 2010; Fredericks et al., 2011b; Redman-MacLaren et al., 2012; Sherwood, 2013b). The application of the three previous principles for decolonising health promotion practice could also provide opportunity to build relationships.

“Now that’s a deadly choice”: Moving forward

The four principles outlined guide both process and outcome for health promotion. Should health promotion not attend to these principles, it risks continuing to perpetuate unacceptable health inequities experienced by Indigenous Australian. Our core business as health promotion practitioners must be to support groups and communities to participate as co-authors of health promotion. Practitioners must relinquish control over the process of health promotion, which as this chapter has discussed, holds a number of tensions.

The overarching tension examined by this thesis is health promotion’s ethical conundrum of respecting peoples’ autonomy while attempting to make people behave in

a way they have not chosen (McPhail-Bell et al., 2015; Wardrope, 2015). The four principles presented above could therefore be considered components of autonomy. Autonomy has been identified as key dimension of Indigenous health promotion in New Zealand (Durie, 2004). Respect for people's autonomy is broadly considered a "best practice" focus in critical health promotion (Gregg & O'Hara, 2007a;2007b; O'Hara, Taylor, & Barnes, 2015). In practical terms, autonomy ensures people can consent to processes of change proposed by health promotion, with the option not to make those changes (O'Hara et al., 2015). However, while respecting autonomy is an aspirational goal of health promotion practitioners, autonomy cannot exist without power relations, social cohesion and social control (Tonkinson, 2007). This means that despite attention to autonomy, the power structures behind inequalities may in fact remain untransformed and lack of choice perpetuated.

In Australia, autonomy in the context of Indigenous health promotion is entangled with ongoing colonial agendas. Processes of control over Indigenous people's lives, land and culture are indistinguishable from the paternalism in health promotion interventions (Arabena, 2006; McPhail-Bell et al., 2015) (as discussed in Chapter Two). *Deadly Choices* is explicitly about the *choice* of Indigenous people and communities and is instructive for those seeking to engage in the decolonisation of health promotion practice. Including choice in health promotion means respect for people's autonomy is possible. Nonetheless, "autonomy" is a mainstream discourse in health promotion that has not yet meaningfully connected with the historical movement of self-determination in Australia, or processes of colonisation.

Autonomy and self-determination are related. Self-determination is a critical concept that straddles the four principles of decolonising health promotion practice. Self-determination is talked about as being community control, as enabling choices, as centring the empowerment of Indigenous people, as being about community relationship (Australian Human Rights Commission, n.d.; Best, 2005; Gillor, 2012). Self-determination relates to the lived experiences of Indigenous people and their right to be Indigenous people in the past, present and future (Fredericks, 2003). Self-determination locates power with sovereign Indigenous Australians and in doing so, provides a way to not only resist but also deconstruct processes of colonisation by providing alternative frameworks (Rigney, 2001). A decolonising framework, which

centralises self-determination, can restore Indigenous sovereignty, reclaim knowledge, language and culture, and transform relationship between Indigenous and non-Indigenous peoples (Walker, Fredericks, Mills, & Anderson, 2013).

The way Deadly Choices embed choice, community control, empowerment and relationship in their practice provides an example of how these four principles can be used to decolonise health promotion. These principles can inform health promotion practice. Health promotion is challenging terrain to travel and its tensions not easily resolved. However, by adhering to the philosophy, “we don’t tell people what to do”, the Deadly Choices practitioners have exemplified creative strategies from which we can learn. The Deadly Choices philosophy is a compelling one for the project of decolonising health promotion. Using the four principles discussed here, health promotion may be able to achieve its aim of increasing people’s control over their own health. Deadly Choices shows that Indigenous-led health promotion can bridge the disjuncture between rhetoric and practice of empowerment in Australian health promotion practice.

9. Conclusion: “We learn from each other”

This study set out to contribute to the decolonisation of health promotion practice. The study’s design achieved this aim by centralising recognition of Indigenous knowledge, skills and experience in health promotion. The research arose as a response to health promotion’s general failure to improve the health of Indigenous Australians – an aberration for a profession that regards itself to be based upon empowerment and social justice in health for all people. Upon interrogation of the literature, a gulf became apparent in terms of critical reflection regarding health promotion practice in an Indigenous Australia context, particularly within an urban setting. Even more limited was health promotion research that values Indigenous knowledge, practice and perspectives. This lamentable silence is not only harmful for the groups with which health promotion works, it leaves health promotion practitioners without ethical and theoretical guidance to navigate the tensions of practice.

“We learn from each other” is a practice philosophy I observed amongst Deadly Choices practitioners and represents a possible path forward for us, as health promotion practitioners, in our efforts to redress our profession’s shortcomings. The philosophy implies that we are to listen and share in relationship with those our practice impacts, to become informed of alternative “truths”, to remain humble in our expertise. This philosophy also grants that those we work with have agency, knowledge and wisdom from which health promotion practitioners can learn. Just as this philosophy necessitates, this study sought to learn from and with Indigenous-led health promotion practice. This chapter provides a concluding commentary on the study’s findings.

“They see you leading by example, being accountable”: Summary of argument

The thesis has highlighted the gap between the rhetoric of empowerment in health promotion, and its practice with Indigenous Australians. It explored the primary tension of imposing a health improvement agenda on populations while also supporting community empowerment and control over their own health. I argued that health

promotion's general failure with Indigenous Australians is a result of its colonial underpinnings and associated lack of theoretical and ethical guidance in navigating this critical tension.

This thesis traced the foundations of health promotion in Australia. These foundations exposed the practice of health promotion as an apparatus of mainstream control and condemnation of Indigenous Australians. The epistemological discrepancies of Indigenous health promotion are such that while health promotion claims the aim of empowering Indigenous Australians to improve their health, more often than not, health inequalities have remained, if not widened. Moreover, the evidence of these health inequalities have provided moral justification for ongoing mainstream intervention in relation to Indigenous risk, disease and deficit, and continued the positioning of Indigenous people as a cultured and weak Other. This critically unreflexive practice is contradictory to the hope brought by health promotion in its call to enable people to increase control over their own health. This is not to say that health promotion is to be rejected or abandoned with Indigenous Australians; in fact, quite the opposite. This thesis has affirmed the principles espoused in global health promotion discourse and called for their practice to be decolonised.

Decolonising practice centres marginalised knowledges through a reflective process in relation to knowledge systems and ways of knowing, being and doing (Martin, 2003; Sherwood, 2010; Smith, 2012). Therefore, the process of decolonising health promotion requires unpacking health promotion's colonial basis while creating space for alternative knowledges. To contribute to this pursuit, it was necessary for this study to examine power structures of this study and in health promotion, including those that I, as researcher and practitioner, carry and reproduce. I developed a bricolage to meet this objective, which involved three theoretical tools: postcolonialism, critical race theory and cultural interface, and was informed by my research standpoint and a decolonising approach. Together these tools worked to broaden the understanding of Indigenous health promotion through the centring of Indigenous and participant voices and practices in this study. As a result, this study has been able to learn from Indigenous-led health promotion practice in an urban setting, in a reciprocal and strengths-based manner.

The practice of Deadly Choices reveals innovative, diverse, relationship-based approaches to health promotion, which effectively shift power from health promotion practitioner to Indigenous peoples and communities. Through a dialogical approach with Indigenous peoples and communities, Indigenous notions of health and healthy behaviours have been embedded into the Deadly Choices practice, with Indigeneity asserted as health promoting. Community choice and control remain central to Deadly Choices practice, with community control embedded both in the health promotion practice and governance of Deadly Choices and IUIH.

Cognizant with community control, Deadly Choices has co-created with the community a positive, celebratory and proud space, where “everyone can be a leader”. In doing so, Deadly Choices provides a site of resistance to the colonial use of health promotion, including its deficit-oriented inscriptions upon Indigenous Australians. The Deadly Choices model of distributive leadership also enables Deadly Choices practitioners to navigate the tensions of practice. By promoting transformative change, the leadership model converts the healthy lifestyle agenda to incorporate Indigenous notions of health. By doing so, Deadly Choices has expanded health promotion knowledge and practice to be more useful for Indigenous people and communities involved.

While Deadly Choices does not position itself as decolonising, its practice provides important lessons for decolonising health promotion. This includes Deadly Choices’ “reverse colonisation” of mainstream health promotion, whereby a shift of power relations is evident. Instead of mainstream actors controlling the process and products of Indigenous health promotion, Deadly Choices draws upon community controlled processes to develop products and processes sought not only by Indigenous people and communities, but also mainstream government and non-Indigenous people and communities. This broad engagement reveals that, as has been identified since its genesis with the Ottawa Charter for Health Promotion, health promotion is all about people’s control over their own health. It follows that the Deadly Choices principle, “we don’t tell people what to do”, embodies a decolonising message for health promotion practice.

Contribution

The significance of this study's findings is twofold. Firstly, the findings provide lessons to support improved practice in Indigenous health promotion. Secondly, these findings have implications for mainstream health promotion and the decolonisation of its practice. These findings are important in terms of how health promotion ethically works with any group, particularly marginalised or excluded groups.

To inform the translation of these findings to practice, this study presented a model for decolonising health promotion practice, represented in Figure 76 (Chapter Eight). This model was also a response to calls for development of decolonising processes for health (Dudgeon, Milroy, & Walker, 2014b; Fredericks et al., 2011a; Sherwood & Edwards, 2006; Sweet, Dudgeon, McCallum, & Ricketson, 2014). The model entails four principles: relationship, which enables the remaining three principles; empowerment, choice and control. Relationship at multiple levels is an enabler across the range of Deadly Choices practice, products and activities, and works to support practitioners to include community issues and concerns in their daily practice. Community control is positioned as the higher order principle, to reflect the way practitioners involved in the research conceptualised it. Community control also aligns with the health promotion discourse that promotes people's control over their own health. Likewise, empowerment is a principle that corresponds with global health promotion discourse. However, unlike many mainstream health promotion initiatives Deadly Choices' (and IUIH's) explicit aim is the empowerment of Indigenous people and communities. Finally, the principle of choice contends the continued colonial efforts to control Indigenous Australians and instead generates scope for health promotion to collaborate with and acknowledge Indigenous agency.

This research also contributed towards the practice of Deadly Choices by supporting the team's development of its framework of practice. This contribution was requested by IUIH during the research design phase and subsequently included as a research objective in the spirit of ethical research practice (NHMRC, 2003b). To deliver upon this objective, regular informal and formal feedback through a dialogical process was integrated into the fieldwork, accompanied by a series of thematic feedback papers (as discussed in Chapter Four). The result was a process described by the team as

constructive, and a practice framework of which they are proud. The reciprocal nature of this study is echoed in the statement of one practitioner at this study's conclusion, when they thanked me on behalf of the team: "The work that you've here is evident in everything we do today".

Implications

Health promotion is complex and at times, problematic. It aims to be inclusive and collaborative, yet applies knowledge generated through epidemiological methods and professionalisation (Laverack & Labonte, 2000; Warr et al., 2012). Health promotion is, as explored in Chapters Two and Eight, a form of colonisation itself, whereby expert-driven health improvement remedies are thrust onto people's bodies, in the name of empowerment. In its efforts to bridge these at times conflicting agendas, health promotion will likely continue to exclude and disempower people, as has been the case for Indigenous Australians. As practitioners, we must contend with this challenge and engage with our profession's at times disempowering and marginalising impacts on people and communities (Durey & Thompson, 2012; Lupton, 2014b). One way to accomplish this is to "learn from each other", as the Deadly Choices practitioners do, particularly with and from groups that health promotion has failed. This study has progressed this undertaking by learning from Indigenous-led health promotion.

I contend that Indigenous-led health promotion presents a way to shift Australian health promotion practice beyond the rhetoric of empowerment. Like most health promotion practitioners, Deadly Choices practitioners grapple with the various tensions of their practice, sometimes more successfully than others. The Deadly Choices practitioners teach us that with relationship and accountability to those impacted by their practice, support is created for practitioners to deliver on their agenda in an empowering and inclusive way. This reaffirms that learning with and from the community to which we are directing our health promotion efforts must be a priority, in order to develop locally tailored and appropriate practice.

As a relatively new discipline, health promotion is moving towards maturation. Yet, this process will remain incomplete until the influence of White privilege and exclusion of

non-Western knowledges and peoples is challenged and redressed. Mainstream health promotion illustrates this in its general oversight of a wealth of wisdom and knowledge in the Indigenous Community Controlled Health Service (CCHS) sector. Keep in mind that the CCHS sector established itself as a result of the strength, resilience and advocacy of Indigenous Australians (Bell et al., 2000; Foley, 2010; Fredericks et al., 2014), soon becoming a global exemplary model for primary health care (Fredericks & Legge, 2011; Gillor, 2012), while health promotion was establishing itself as “focused on the needs in industrialized countries” (WHO, 1986b, p. 1). Despite the expertise of the CCHS sector and other Indigenous-led health promotion, mainstream health promotion in Australia continues to demonstrate a general disregard for non-Western knowledges.

To “learn from each other” requires engaging with and centring non-Western knowledges and practices. To unsettle the knowledge structures of hegemonic norms is directly relevant to the health promotions agenda, given the privileged knowledge of “hard science” carries with it a capacity to further entrench social ideologies and reinforce prejudice (Brough, 2001, p. 69). Knowledge has been used to position middle class as normative to the deficit practice of the lower class (Nakata, 2007b). The act of Othering by middle-class researchers and practitioners performs a powerful function of retaining a social distance between the Other and the researcher/practitioner, leaving the middle-class positioning intact (Moreton-Robinson, 2000). The result is one that prohibits health promotion from successfully improving health.

While quantitative and epidemiological research has an important place in health promotion, so too do qualitative approaches that build understanding regarding social action, community engagement and partnership building. This study provides an example of an approach to learn from and with Indigenous-led health promotion, using a flexible, strengths-based methodology. The approach used also demonstrates that working with Indigenous Australians can lead to research and practice that benefits those involved. In today’s neoliberal context, health promotion has much to gain by heeding the lessons of decolonising health promotion – and much to lose if it does not and cannot demonstrate its worth beyond rhetoric.

Evidence alone is insufficient to translate a health agenda of holistic health into action. Attention to power and ideology is also required (Baum & Fisher, 2014). Decolonising health promotion requires we seek equity for Indigenous people while accepting difference, choice and self-determination (Altman, 2009). This endeavour is not simply to include an alternative perspective, but rather, to question and expand the underpinning knowledge, theory and assumptions of health promotion. Health promotion must embrace the opportunity to learn from alternative perspectives, skills and knowledge, including those from Indigenous people and communities. In doing so, health promotion has the opportunity to redress its largely failed endeavour with Indigenous Australians.

Decolonising health promotion practice therefore involves a radical reworking of practitioner relationships with Indigenous people. As the Deadly Choices practitioners have demonstrated, promoting an agenda of choice and community control is directly related to the empowerment a community may experience or otherwise. Without empowerment, sustained health improvement is unlikely (Braunack-Mayer & Louise, 2008; Carter et al., 2012a). Therefore, decolonising practice is an ethical matter for health promotion practitioners, requiring our engagement with concepts of privilege and power, which we perform according to our professional and personal locations. Our privilege and power is always in relation to others. Therefore, we must have respect and reciprocal relationship between practitioners and the communities and their representative structures that will be impacted by our health promotion practice, including Indigenous people and communities.

Limitations and future research

This research identifies lessons and principles, rather than “neat” recommendations, for broader health promotion. This study provided a rich account of one particular group of health promotion practitioners, based within an Indigenous community controlled company. Deadly Choices is one specific example of Indigenous-led health promotion and therefore not necessarily representative of Indigenous-led health promotion more broadly. Future research could build on this study’s findings by examining Indigenous health promotion in other locations, both within and beyond the CCHS sector, including

government and mainstream organisations where Indigenous-led health promotion may be occurring.

This study has affirmed that the tensions of health promotion practice are not only present in Indigenous health promotion but amplified. The lack of frameworks and guidance for health promotion practitioners in navigating these tensions was also revealed. For example, currently Australia's health promotion professional body has only a draft Code of Ethics based upon an American ethics framework, without adaptation to the Australian postcolonial context (AHPA, 2009). Future research could therefore contribute to the maturation of the health promotion profession by contributing to the development of a Code of Ethics for health promotion in Australia, and one that includes acknowledgement of the ongoing roles of colonisation and principles of decolonising practice.

This study explored the daily practice of a group of health promotion practitioners. It did not evaluate the campaigns, projects and programs these practitioners implemented and therefore did not provide findings in relation to such objectives. Alongside this PhD study, IUIH obtained funding to conduct an evaluation of Deadly Choices' Education Program and community events. It is beyond the scope of this study to comment on these studies; however I note some of the findings, which found that Deadly Choices (Malseed, 2014; Malseed & Nelson, 2014; Malseed et al., 2014a; Malseed et al., 2014b; Malseed, Nelson, Ware, Lacey, & Lander, 2014c):

- Significantly increased knowledge, attitudes and self-efficacy
- Improved a number of health behaviours
- Empowered participants to be positive role models in reshaping health, lifestyle and physical activity choices
- Improved leadership skills, confidence and pride in cultural identity among participants
- Facilitated a large number of health checks (MBS item 715)¹⁶⁹

¹⁶⁹ The MBS item 715 refers to the Medicare Health Assessment for Aboriginal and Torres Strait Islander people, which can be claimed by medical practitioners. The aim of the MBS item 715 is to help ensure that Aboriginal and Torres Strait Islander people receive primary health care according to their needs, by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause morbidity and early mortality (Department of Health, 2014).

- Increased awareness regarding the availability of services at local Indigenous health services.

As has been explicitly stated throughout this thesis, this research was an *interpretation* of stories and practice where I observed and participated. Although my ethnographic research may be based on fieldwork with Indigenous people, it is by no means an Indigenous account of that culture (McCarthy & Martin-McDonald, 2007). As emphasised in Chapter Three, my experience, assumptions and worldviews influence this research and drove me to ask a particular question about a particular topic, using specific theoretical frameworks. The composition of the bricolage framework I developed was useful for positioning this study as a practice-oriented one to address these questions. However, the constraint of drawing on different theoretical tools means that each is not explored or applied in a depth that accounts for the broad body of work associated with each. Likewise, critical race theory and postcolonialism are somewhat theoretically in conflict with the cultural interface. I have endeavoured to address this potential incongruence through the design of the bricolage and their application.

Research aims revisited

The aim of this research was to contribute to the decolonisation of health promotion practice. The research achieved this by inquiring into the daily practice of a cross-section of Indigenous and non-Indigenous health promotion practitioners, in an urban setting. The overarching research question was “*How do health promotion practitioners in an urban Indigenous setting make sense of and navigate the tensions inherent to health promotion in daily practice?*”

This thesis has described the tensions of health promotion practice, informed by the literature and findings of this study. Through participant observation and its components, I observed and interpreted the daily practice of health promotion practitioners as they navigated health promotion’s overarching tension from within in an Indigenous community controlled health organisation. The observations regarding how these practitioners remain accountable to the community with which they work, and to those who provide funds and other key stakeholders, clarified how community concerns

and issues are incorporated into their daily practice. The leadership model, underpinned by principles of decolonisation (discussed in Chapter Six), guides the practitioners to navigate the various tensions of their practice, including those between behavioural and structural accounts of health by incorporating and expanding the healthy lifestyle agenda. Indigenous worldviews, knowledges and practice are incorporated into the work of Deadly Choices through community control at multiple levels, complemented by a team composition comprising primarily Indigenous people who are part of the communities with which Deadly Choices work.

Barriers faced by these practitioners, beyond the tensions already identified, include the constraints of funding requirements. The short term and unpredictable nature of funding has impacted upon Deadly Choices' ability to retain staff positions that facilitate the relationship so fundamental to their success. In some ways, relationship can be a barrier to implementing a health improvement agenda, yet its power as an enabler far outweighs this. Relationship with the remaining three principles of decolonising health promotion presented in this thesis (empowerment, choice and community control) supported practitioners to navigate the tensions of their practice.

Reflection: "Everyone can be a leader"

I began this PhD wary of undertaking research in Indigenous health. I was finding my way through my own tension: the paradox of being a non-Indigenous researcher with Indigenous people and communities, where my positioning leaves me as part of the "problem" I seek to address (Carnes, 2011b). I was well aware that research has perpetrated harm and failed to bring benefit to the Indigenous communities involved (Moreton-Robinson, 2000; Rigney, 1999a; Sherwood, 2010; Sherwood & Edwards, 2006; Smith, 2005;2012). I came to the PhD wary that even the idea of a PhD is a Western concept, with its value for Indigenous communities questioned by some of my Indigenous friends and colleagues. Was I simply going to repeat those past mistakes and perpetuate my own White privilege by obtaining a qualification based upon the investment of Indigenous people and communities?

I almost allowed my awareness of my potential to be part of the problem, to stop me from pursuing the PhD. Yet I knew from what I had read that decolonisation is better served by relationships between Indigenous people and communities, and with the colonial institutions (such as research and health promotion) in order to transform the underlying, taken-for-granted structures and process (Smith, 2005). I also understood that White guilt is not constructive on its own. I was privileged to be guided by the wisdom of Indigenous and non-Indigenous practitioners and researchers, who themselves grapple with and are aware of this tension. The opportunity to participate in the Indigenous Research Methodology Masterclass Module (Yurriala) was one such forum of guidance. I knew deep down, that to not pursue this research agenda would reinforce the status quo.

I chose to acknowledge the collective responsibility of non-Indigenous Australians to develop a revitalised national self (Maddison, 2011) – ever aware of my privilege in having that choice to make. I sought to design the PhD study in such a way that it worked with Indigenous people, “not around... and over...” them, to examine issues that Indigenous Australians wanted examined, with a methodology of integrity and respect (as encouraged by my supervisor BF; see Chapter One). I developed my standpoint by exploring my own assumptions and beliefs, in order to be open to other ways of knowing, being and doing (Sherwood & Edwards, 2006). I embraced the opportunity (and requirement) “to develop a capacity to bracket long held Western research paradigms and assumptions in order to become knowledgeable about and immersed within an Indigenous paradigm” (Bartlett, Iwasaki, Gottlieb, Hall, & Mannell, 2007, p. 2378).

No matter what I learnt or did, my White privilege could not be absolved. I came to the realisation that a more constructive approach would be to examine and identify ways to use my White privilege for Indigenous agendas. To do so requires relationship with Indigenous people and communities. In the case of my PhD, it required time to build relationship before the research commenced with potential participants and the possible host organisation. My supervisory team, two of whom are Indigenous, played a central role in this process, helping me to develop my critical self-awareness while applying a caring lens over my thoughts, attitudes and behaviours. In this way, relationality as methodology became a reality for me (Martin, 2008).

The act of my representation of participants fundamentally positions me as one who *does* speak for the participants. I admit to my desire for a simple position based upon my claim that I not speak for Indigenous people – those involved in the study or beyond – or for the non-Indigenous participants involved. In some regards, I cannot speak for the participants, only for myself. However, it is not entirely possible to be so removed from others that I can avoid affecting them (Alcoff, 1991). Thus, while I do “speak for” the participants in this thesis, I have sought to “speak to” in dialogue with those involved to be accountable and responsible for what I say (Alcoff, 1991; Spivak, 1995). I have endeavoured to represent the Deadly Choices story respectfully and with clear acknowledgement of my own biases implicit in my researcher standpoint. I elected to weave my personal story into my academic work, recognising that narratives enable a deep understanding of what it means to be located at the cultural interface (Young, 2001). Being a non-Indigenous researcher seeking to learn from Indigenous peoples is a point of contention and a matter with which all researchers must contend; this is, as Linda Smith says, “tricky ground” (Smith, 2005, p. 114). With these contentions in mind, I present this work as both “how and what I know” (Nielsen, 2008, p. 56).

The decolonisation of my own practice and mind is an ongoing process. Decolonisation requires thinking, reflection over time, asking of difficult questions and understanding these cannot be resolved immediately (Nakata et al., 2012, p. 135). The ethics of referring to this PhD as “my own” is also problematic, given it is based upon Indigenous knowledge and practice that is not “mine”. While IUIH and research participants agreed to this arrangement from the start, it continues to trouble me. Even in designing the bricolage for this study, I was disturbed by my potential to appropriate Indigenous knowledge for my own purposes, while I was learning from Indigenous researchers and Indigenous methodologies. I see myself falling back into old habits, learned and reinforced through my privileged White positioning and public health training. I can easily invoke binaries and oversimplify my social justice intentions. I know I am one who at times falls into the “too hurried movement from colonial critique to the instatement of alternative Indigenous knowledge positions” (Nakata et al., 2012, p. 128). It is clear that given the invisible nature of Whiteness to White people (Pease, 2010; Zufferey, 2012), to be responsible for my own White privilege is a continuing process.

Understanding the impact of my profession's goal of a "better" society also requires persistent, deep reflection. The lofty statements of our health promotion charters and our courageous forerunners who helped "birth" health promotion continue to inspire perseverance amidst the neoliberal encroachment into the fabric of Australian society. Yet the silence regarding health promotion's ethical and theoretical deficiencies amidst its failure with Indigenous Australians amplifies the importance, for me, of decolonising our practice. In contrast, the Deadly Choices practitioners taught me "everyone can be a leader". This means that non-Indigenous health promotion practitioners can be leaders and support a decolonising agenda, through everyday choices and role modelling the change advocated by Indigenous people and communities. When I doubt myself or remain unsure about the "right" way forward, I know that I can lead by doing, in relationship with others.

As this research shows, there is alignment between relationship as methodology and relationship in practice. In this study, I was an "outsider", yet IUIH and the Deadly Choices team enabled my involvement in such a way that I became part of its collective during fieldwork. Likewise, the Deadly Choices team (both participants and non-participants) were part of this study through planning, data collection, my regular feedback, as well as group and individual conversations. My relationship with this team meant that the practitioners influenced me and I influenced them, creating a space of two-way learning.

The team of practitioners responded positively to the iterative process of this study and in fact appeared to value being affirmed and validated in their work. IUIH managers have commented they have observed positive shifts in the way the practitioners articulate their practice, as well as increasing team capacity for pursuing additional research projects, implying my presence and involvement was a contributing factor. Likewise, I have grown and had the opportunity to learn through the knowledge and practice shared with me. These practitioners encouraged me in my work and I have gained confidence that research by a non-Indigenous researcher can be a positive and empowering experience for participants from within an Indigenous space.

The positivity, generosity and inclusivity of the practitioners involved in this study cannot be overstated. I consider these relationships to be personal and spanning beyond this PhD research. When we held our farewell lunch to celebrate this research journey and the milestones we had achieved together, the Deadly Choices team gifted me with one piece of every Deadly Choices merchandise, as well as magazines (Figure 77), expressing *their* thanks for the work I had done with them, even though it was *me* who should be thanking them. Knowing the value placed upon the Deadly Choices merchandise (as Chapters Five to Seven described), I was lost for words upon receipt of these gifts. Members of the Deadly Choices team also attended my PhD Final Seminar in support of the milestone and wanted to share on Twitter that it had eventuated (Figure 78).



Figure 77: The Deadly Choices team gifted me with one of every piece of their merchandise and some magazines at our farewell party, held to celebrate the research journey.

I remain influenced by the Deadly Choices practitioners in how I view the world and possibilities for the future. I believe a decolonising way forward is attainable for health promotion; that health promotion institutions and professionals can rise to new heights in their endeavour to increase people's control over their health. I may be an optimist,

but these are matters of power and control that we can influence. For Australia to realise this possibility, non-Indigenous people must engage with Indigenous people, practices and knowledge, on Indigenous terms. This study has shown that it is possible to achieve this together.



Figure 78: Some of the Deadly Choices team members attended my PhD Final Seminar and wanted a photo together afterwards to post on Twitter.

References

- Abbott, P., Davison, J., Moore, L., & Rubinstein, R. (2010). Barriers and enhancers to dietary behaviour change for Aboriginal people attending a diabetes cooking course. *Health Promotion Journal of Australia*, 21(1), 33-38.
- ABC News. (2007). Health body welcomes non-compulsory child health checks. Retrieved from <http://www.abc.net.au/news/2007-06-28/health-body-welcomes-non-compulsory-child-health/84068>
- Aboriginal and Torres Strait Islander Commission. (1994). *A National Aboriginal Health Strategy: An evaluation 1994*. Canberra: Australian Government
Retrieved from <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-NAHSeval>.
- Aboriginal and Torres Strait Islander Social Justice Commissioner. (2014). Social justice and native title report 2014. Sydney.
- Aboriginal Health and Medical Research Council of New South Wales. (2009). 10 out of 10 deadly health stories: Nutrition and physical activity. Successful programs from NSW Aboriginal community controlled health services. Sydney: Aboriginal Health and Medical Research Council of New South Wales.
- Adam, P. (2009). The second annual John Saunders lecture. Australia – whose land? : Baptist Union of NSW Social Issues Committee.
- Adams, K., Dixon, T., & Guthrie, J. (2004). Evaluation of the Gippsland Regional Indigenous Hearing Health Program - January to October 2002. *Health Promotion Journal of Australia*, 15(3), 205-210.
- Australian Health Promotion Association. (2009). Core competencies for health promotion practitioners. Maroochydore: AHPA.
- Australian Health Promotion Association, International Union for Health Promotion and Education, Cooperative Research Centre for Aboriginal Health & Queensland Aboriginal and Islander Health Council. (2009). Success stories: Environmental, social, emotional and spiritual health of Aboriginal and Torres Strait Islanders. Report of the Indigenous Health Workshop. Brisbane: AHPA, IUHPE, CRCAH, & QAIHC.
- AHS Tri-Project Glossary Working Group, & Population and Public Health. (2001). Towards an understanding of health equity: Annotated glossary Alberta.
- Ajzen, I., & Fishbein, M. (1980). *Understanding attitudes and predicting social behavior*. Englewood Cliffs, NJ: Prentice-Hall.
- Akom, A. (2011). Black emancipatory action research: Integrating a theory of structural racialisation into ethnographic and participatory action research methods. *Ethnography and Education*, 6(1), 113-131. doi: 10.1080/17457823.2011.553083
- Alames, CEBES, CUT Brasil, Medicos Del Mundo, CTA, World Social Forum, . . . People's Health Movement. (2011). Debate and action about the social determinants of health: The position of the civil society movements Rio de Janeiro.
- Alcoff, L. (1991). The problem of speaking for others. *Cultural Critique*(20), 5-32.

- Alford, K. (2014). Investing in Aboriginal community controlled health makes economic sense. Canberra: National Aboriginal and Islander Health Organisation.
- Allegrante, J., Barry, M., Airhihenbuwa, C., Auld, M. E., Collins, J., Lamarre, M.-C., . . . Galway Consensus Conference. (2009). Domains of core competency, standards, and quality assurance for building global capacity in health promotion: The Galway Consensus Conference Statement. *Health Education & Behavior*, 36(3), 476-482. doi: 10.1177/1090198109333950
- Allen, C. (1998). Health promotion, fitness and bodies in a postcolonial context: The case of Trinidad. *Critical Public Health*, 8(1), 73-92. doi: 10.1080/09581599808409213
- Allen, C. (1999). *Power, identity and eurocentricism in health promotion: The case of Trinidad and Tobago*. (Doctor of Philosophy), University of Warwick, Warwick.
- Allison, S., Bauermeister, J. A., Bull, S., Lightfoot, M., Mustanski, B., Shegog, R., & Levine, D. (2012). The intersection of youth, technology, and new media with sexual health: Moving the research agenda forward. *Journal of Adolescent Health*, 51(3), 207-212. doi: <http://dx.doi.org/10.1016/j.jadohealth.2012.06.012>
- Altman, J. (2009). Beyond closing the gap: Valuing diversity in Indigenous Australia. Paper presented at the conference Values and Public Policy: Fairness, Diversity and Social Change, Centre for Public Policy, University of Melbourne, 26–27 February 2009. Canberra: Centre for Aboriginal Economic Policy Research.
- Altman, J., & Hunter, B. (2003). Evaluating Indigenous socioeconomic outcomes in the reconciliation decade, 1991-2001. *Economic papers (Economic Society of Australia)*, 22(4), 1-15.
- Altman, J., & Johns, M. (2008). Indigenous welfare reform in the Northern Territory and Cape York: A comparative analysis. Canberra: Centre for Aboriginal Economic Policy research.
- Alvaro, C., Jackson, L. A., Kirk, S., McHugh, T. L., Hughes, J., Chricop, A., & Lyons, R. F. (2010). Moving governmental policies beyond a focus on individual lifestyle: Some insights from complexity and critical theories. *Health Promotion International*, 15(3), Open Access.
- Anaya, J. (2010). Report by the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous people. The situation of Indigenous peoples in Australia. In H. R. Council (Ed.), *Fifteenth session agenda item* (pp. 1-66). Geneva: United Nations.
- Anderson, I. (1997). I, the 'hybrid' aborigine: Film and representation. *Australian Aboriginal Studies*, 1, 4-14.
- Anderson, I. (2007a). Health policy for a crisis or a crisis in policy? In J. Altman & M. Hinkson (Eds.), *Coercive reconciliation: Stabilise, normalise, exit Aboriginal Australia* (pp. 133-140). North Carlton: Arenda Publications Association.
- Anderson, I. (2007b). Policy processes. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of indigenous health*. Crows Nest: Menzies School of Health Research.
- Anderson, I. (2009). Mapping the cultural interface. *Postcolonial studies*, 12(2), 261-267. doi: 10.1080/13688790902905833
- Anderson, I., Baum, F., & Bentley, M. (2007). Conclusion. In I. Anderson, F. Baum & M. Bentley (Eds.), *Beyond band-aids: Exploring the underlying social determinants of Aboriginal health. Papers from the Social Determinants of*

- Aboriginal Health Workshop, Adelaide, July 2004*. Darwin: Cooperative Research Centre for Aboriginal Health.
- Angus, S. (1997). Promoting the health of Aboriginal and Torres Strait Island communities: Case studies and principles of good practice 2006. Canberra: National Health and Medical Research Council.
- Angus, S., & Wise, M. (1997). Promoting the health of Indigenous Australians: A review of infrastructure support for Aboriginal and Torres Strait Islander health advancement 2006. Canberra: National Health and Medical Research Council.
- Anonymous. (1978, Saturday 12 August). ABC will show film despite objections, *The Canberra Times*. Retrieved from [http://trove.nla.gov.au/ndp/del/article/110902306?searchTerm=They Used To Call It Sandy Blight&searchLimits=l-decade=197](http://trove.nla.gov.au/ndp/del/article/110902306?searchTerm=They%20Used%20To%20Call%20It%20Sandy%20Blight&searchLimits=l-decade=197)
- Anonymous. (1994, September 9). Joint advisory body to manage Aboriginal health, *The Koori Mail*, p. 3. Retrieved from <http://www.aiatsis.gov.au/koorimail/issues/pdf/075.pdf>
- Anonymous. (n.d.). Conceptual model of distributed leadership. Retrieved 4 May, 2015
- ANPHA. (2012). *Australian National Preventive Health Agency strategic plan 2011-2015*. Canberra: Commonwealth of Australia Retrieved from [http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/26A8DC3218FDABA0CA2578F100059B4F/\\$File/ANPHA-Strategic_Plan.pdf](http://www.anpha.gov.au/internet/anpha/publishing.nsf/Content/26A8DC3218FDABA0CA2578F100059B4F/$File/ANPHA-Strategic_Plan.pdf).
- ANTaR. (2007). Success stories in Indigenous health: A showcase of successful Aboriginal and Torres Strait Islander health projects. Sydney: Australians for Native Title and Reconciliation.
- ANTaR. (2010). A better way: Success stories in Aboriginal community control in the Northern Territory. Sydney.
- Antonovsky, A. (1996). The salutogenic model as a theory to guide health promotion. *Health Promotion International*, 11(1), 11-18. doi: 10.1093/heapro/11.1.11
- APONT. (2011). Response to Stronger Futures. Darwin: Aboriginal Peak Organisations of the Northern Territory.
- Arabena, K. (2006). Preachers, policies and power: The reproductive health of adolescent Aboriginal and Torres Strait Islander peoples in Australia. *Health Promotion Journal of Australia*, 17(2), 85-90.
- Arabena, K., & Mikhailovich, K. (2005). Evaluating an Indigenous sexual health peer education project. *Health Promotion Journal of Australia*, 16(3), 189-193.
- Arabena, K., Rowley, K., & MacLean, S. (2014). Building evidence about effective health promotion in Aboriginal and Torres Strait Islander communities. *Australian Journal of Primary Health*, 20(4), 317-318.
- Ardler, C., Booker, J., McLeod, I., & Mark, A. (2004). The Koori Tobacco Cessation Project. *Health Promotion Journal of Australia*, 15(3), 200-204.
- Ashcroft, B., Griffiths, G., & Tiffin, H. (2004). *The empire writes back: Theory and practice in post-colonial literatures* (2nd ed.). London: Routledge.
- Ashcroft, B., Griffiths, G., & Tiffin, H. (2007). *Post colonial studies: The key concepts* (2nd ed.). Milton Park: Routledge.
- Atkinson, J., Boudville, A., Stanford, E., Lange, F., & Anjou, M. (2014). Australian Football League clinics promoting health, hygiene and trachoma elimination: The Northern Territory experience. *Journal of Primary Health*, 20, 334-338.
- Atkinson, P., & Hammersley, M. (2005). Ethnography and participant observation. In N. Denzin & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research*. California: SAGE Publications Inc.

- Augoustinos, M., Lecouteur, A., & Soyland, J. (2002). Self-sufficient arguments in political rhetoric: Constructing reconciliation and apologizing to the Stolen Generations. *Discourse & Society*, 13(1), 105-142. doi: 10.1177/0957926502013001005
- Australian Anthropological Society. (2011). AAS code of ethics.
- Australian Bureau of Statistics. (2012). 2076.0 - Census of population and housing: Characteristics of Aboriginal and Torres Strait Islander Australians, 2011. Canberra.
- Australian Bureau of Statistics. (2013a). 3302.0.55.003 - Life Tables for Aboriginal and Torres Strait Islander Australians, 2010-2012. Canberra.
- Australian Bureau of Statistics. (2013b). 4727.0.55.001 - *Australian Aboriginal and Torres Strait Islander health survey: First results, Australia, 2012-13*. Canberra: Australian Bureau of Statistics Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/84BBCF1F0DA6424ECA257C2F001456B3?opendocument>.
- Australian Bureau of Statistics. (2014). 3238.0 - *Estimates and projections, Aboriginal and Torres Strait Islander Australians, 2001 to 2026*. Canberra: Australian Bureau of Statistics Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/Products/AB6A2434805DA512CA257CC900143887?opendocument>.
- Australian Government. (2001). World Health Organization Act 1947. In A. Government (Ed.), *Act No. 93 of 1947 as amended*. Canberra ComLaw.
- Australian Government. (2008). *Close the gap - Statement of intent*. Canberra: Australian Government.
- Australian Government. (2012). Aboriginal and Torres Strait Islander health performance framework: 2012 report. Canberra: Department of Health and Ageing.
- Australian Government. (2013). *National Aboriginal and Torres Strait Islander health plan 2013-2023*. Canberra Commonwealth of Australia.
- Australian Government. (2015). Closing the gap Prime Minister's report 2015. Canberra.
- Australian Health Ministers Advisory Council. (2008). *Aboriginal and Torres Strait Islander health performance framework report 2008*. Canberra: AHMAC.
- Australian Human Rights Commission. (n.d.). Right to self determination. Retrieved 5 December, 2015, from <https://www.humanrights.gov.au/right-self-determination>
- Australian Institute for Aboriginal and Torres Strait Islander Studies. (2011). Guidelines for ethical research in Australian Indigenous studies. Canberra: AIATSIS.
- Australian Institute for Health and Welfare. (2007). *National indicators for monitoring diabetes: Report of the Diabetes Indicators Review Subcommittee of the National Diabetes Data Working Group*. (CVD 38). Canberra: Australian Institute for Health and Welfare Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=6442455061>.
- Australian Institute for Health and Welfare. (2008). *Aboriginal and Torres Strait Islander health performance framework 2008 report. Detailed analyses*. (IHW22). Canberra: Australian Institute of Health and Welfare.
- Australian Institute for Health and Welfare. (2011a). Comparing life expectancy of indigenous people in Australia, New Zealand, Canada and the United States: Conceptual, methodological and data issues. Canberra: Australian Institute of Health and Welfare.

- Australian Institute for Health and Welfare. (2011b). *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples, Oct 2010*. (4704.0). Canberra: Australian Institute of Health and Welfare Retrieved from <http://www.abs.gov.au/AUSSTATS/abs@.nsf/lookup/4704.0Chapter755Oct+2010>.
- Australian Institute for Health and Welfare. (2011c). *The health and welfare of Australia's Aboriginal and Torres Strait Islander people an overview 2011*. (IHW 42). Canberra: AIHW Retrieved from <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737418955>.
- Australian Institute for Health and Welfare. (2011d). Life expectancy and mortality of Aboriginal and Torres Strait Islander people. Canberra: Australian Institute of Health and Welfare.
- Australian Institute for Health and Welfare. (2012). Healthy lifestyle programs for physical activity and nutrition (Vol. 12). Canberra: Closing the Gap Clearinghouse, Australian Institute of Health and Welfare.
- Australian Medical Association. (2011). 2010-11 AMA Indigenous health report card - "Best practice in primary health care for Aboriginal peoples and Torres Strait Islanders". Barton: Australian Medical Association.
- Australian Institute for Health and Welfare. (2013). *Aboriginal and Torres Strait Islander health performance framework: 2012 report - Queensland*. (Cat. no. IHW 85). Canberra: Australian Institute of Health and Welfare.
- Australian Institute for Health and Welfare. (2014). Australia's health 2014. Canberra: Australian Institute of Health and Welfare.
- Awofeso, N., Brooklyn, K., & Williams, N. K. V. (2010). Letter - Closing the 'targets' gaps: Review of 2008-2030 National Indigenous Health Equality Targets. *Health Promotion Journal of Australia*, 21(1), 75.
- Ayoob, M. (2002). Inequality and theorizing in international relations: The case for subaltern realism. *International Studies Review*, 4(3), 27-48.
- Babbie, E. (2004). *The practice of social research* (10th ed.). Southbank: Thomson Wadsworth.
- Bailie, R. (2007). Housing. In B. Carson, T. Dunbar, R. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health*. Crows Nest: Menzies School of Health Research.
- Bainbridge, R. (2011). Becoming empowered: A grounded theory study of Aboriginal women's agency. *Australasian Psychiatry*, 19, S26-S29. doi: 10.3109/10398562.2011.583040
- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84(2), 191-215. doi: 10.1037/0033-295X.84.2.191
- Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior*, 31(2), 143-164. doi: 10.1177/1090198104263660
- Bannerman, M. (2004). No rape charges but NRL fines Bulldogs, 7.30 report. Retrieved from <http://www.abc.net.au/7.30/content/2004/s1097323.htm>
- Bardus, M. (2011). The Web 2.0 and social media technologies for pervasive health communication: Are they effective? *Studies in Communication Sciences*, 11(1), 119-136.
- Barry, M., Allegrante, J., Lamarre, M.-C., Auld, M. E., & Taub, A. (2009). The Galway Consensus Conference: International collaboration on the development of core competencies for health promotion and health education. *Global Health Promotion*, 16(2), 5.

- Bartlett, J. G., Iwasaki, Y., Gottlieb, B., Hall, D., & Mannell, R. (2007). Framework for Aboriginal-guided decolonizing research involving Me' tis and First Nations persons with diabetes. *Social Science & Medicine*, 65, 2371-2382.
- Barton, A. (2010). 'Going White: Claiming an identity of White privilege'. Paper presented at the Symposium: Future Stories/Intimate Histories, Adelaide, South Australia.
http://asianaustrianstudies.org/static/files/assets/be7fbb20/ACRAWSAConferenceBooklet_2010.pdf
- Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research*, 45(2), 143-154. doi: 10.1080/0013188032000133548
- Baum, F. (2005). Who cares about health for all in the 21st century? *Journal of Epidemiology and Community Health*, 59, 14-715.
- Baum, F. (2007a). Cracking the nut of health equity: Top down and bottom up pressure for action on the social determinants of health. *Promotion and Education*, XIV(2), 90-95.
- Baum, F. (2007b). Health for All Now! Reviving the spirit of Alma Ata in the Twenty-first century: An Introduction to the Alma Ata Declaration *Social Medicine*, 2(1), 34-41
- Baum, F. (2008). The new public health evolves. In F. Baum (Ed.), *The new public health* (3rd ed., pp. 31-67). South Melbourne: Oxford University Press.
- Baum, F. (2011a, 12 April 2011). *Avoiding lifestyle drift in Australian health policy and practice*. Paper presented at the Australian Health Promotion Association national conference: Health promotion and the determinants of health, Cairns
- Baum, F. (2011b). Fran Baum on the background of the Rio conference. Retrieved from <http://blogs.bmj.com/bmj/2011/10/20/fran-baum-on-the-background-to-the-who-rio-conference/>
- Baum, F. (2011c). From Norm to Eric: Avoiding lifestyle drift in Australian health policy. *Australian and New Zealand Journal of Public Health*, 35(5), 404-406. doi: 10.1111/j.1753-6405.2011.00756.x
- Baum, F., & Fisher, M. (2010). Health equity and sustainability: Extending the work of the Commission on the Social Determinants of Health. *Critical Public Health*, 20(3), 311-322. doi: 10.1080/09581596.2010.503266
- Baum, F., & Fisher, M. (2014). Why behavioural health promotion endures despite its failure to reduce health inequities. *Sociology of Health & Illness*, 36(2), 213-225. doi: 10.1111/1467-9566.12112
- Baum, F., Fisher, M., & Lawless, A. (2012a). Health equity in Australia. In D. Raphael (Ed.), *Tackling health inequalities: Lessons from international experiences*. Toronto: Canadian Scholars Press Incorporated
- Baum, F., Laris, P., Fisher, M., Newman, L., & MacDougall, C. (2013). "Never mind the logic, give me the numbers": Former Australian health ministers' perspectives on the social determinants of health. *Social Science & Medicine*, 87(0), 138-146. doi: <http://dx.doi.org/10.1016/j.socscimed.2013.03.033>
- Baum, F., MacDougall, C., & Smith, D. (2006). Participatory action research. *Journal of Epidemiology and Community Health*, 60(10), 854-857. doi: 10.1136/jech.2004.028662
- Baum, F., Newman, L., & Biedrzycki, K. (2012b). Vicious cycles: Digital technologies and determinants of health in Australia. *Health Promotion International*. doi: 10.1093/heapro/das062

- Baum, F., Newman, L., Biedrzycki, K., & Patterson, J. (2010). Can a regional government's social inclusion initiative contribute to the quest for health equity? *Health Promotion International*, 25(4), 474-482.
- Baum, F., & Sanders, D. (1995). Can health promotion and primary health care achieve Health for All without a return to their more radical agenda? . *Health Promotion International*, 10(2), 149-160.
- Baunach, E., Lines, D., Pedwel, B., Lange, F., Cooney, R., & Taylor, H. (2012). The development of culturally safe and relevant health promotion resources for effective trachoma elimination in remote aboriginal communities [online]. *Aboriginal and Islander Health Worker Journal*, 36(2), 9-11, 16, 19.
- Becker, M. (1986). The tyranny of health promotion. *Public Health Reviews*, 14(2), 15-23.
- Becker, M. (Ed.). (1974). *The health belief model and personal health behavior*.
- Begg, S., Khor, S.-L., Bright, M., Stanley, L., & Harper, C. (2008). *Burden of disease and injury, life expectancy and health adjusted life expectancy in Queensland Health Service Districts, 2003*. (6). Brisbane: Queensland Health Retrieved from http://www.health.qld.gov.au/ph/documents/pdu/c6_districts_final.pdf.
- Behar, R. (1999). Ethnography: Cherishing our second-fiddle genre. *Journal of Contemporary Ethnography*, 28(5), 472-484.
- Behrendt, L. (1994). Aboriginal urban identity: Preserving the spirit, protecting the traditional in non-traditional settings. *Australian Feminist Law Journal*, 4, 55-62.
- Behrendt, L. (2013, 19 June). Aboriginal humour: 'The flip side of tragedy is comedy', *The Guardian*. Retrieved from <http://www.theguardian.com/commentisfree/2013/jun/19/aboriginal-comedy-humour>
- Behrendt, L. (n.d.). The urban landscape. Sydney: University of Technology.
- Bell, J. M. (2014). The importance of a race-critical perspective in the classroom. In K. Haltinner (Ed.), *Teaching race and anti-racism in contemporary America: Adding context to colorblindness* (pp. 25-34). New York: Springer.
- Bell, K., Couzos, S., Daniels, J., Hunter, P., Mayers, N., & Murray, R. (2000). Aboriginal community controlled health services. In General Practice Branch (Ed.), *General Practice Australia: 2000* (pp. 74-103). Canberra: Department of Health and Ageing, Australian Government.
- Beneito-Montagut, R. (2011). Ethnography goes online: Towards a user-centred methodology to research interpersonal communication on the internet. *Qualitative Research*, 11(6), 716-735. doi: 10.1177/1468794111413368
- Bergh, A., & Nilsson, T. (2010). Do liberalization and globalization increase income inequality? *European Journal of Political Economy*, 26 488-505.
- Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches* (4th ed.). Oxford: AltaMira Press.
- Berry, N. S., Murphy, J., & Coser, L. (2014). Empowerment in the field of health promotion: Recognizing challenges in working toward equity. *Global Health Promotion*. doi: 10.1177/1757975914528725
- Bessarab, D., & Ng'andu, B. (2010). Yarning about yarning as a legitimate method in Indigenous research. *International Journal of Critical Indigenous Studies*, 3(1), 37-50.
- Best, O. (2005). *Community control theory and practice: A case study of the Brisbane Aboriginal and Islander Community Health Service*. Master's dissertation. Griffith University. Brisbane.

- Beurden, E. v., & Kia, A. (2011). Wicked problems and health promotion: Reflections on learning. *Health Promotion Journal of Australia*, 22(2), 83-84.
- Bhabha, H. K. (1983). The other question. *Screen*, 24(8), 18-36.
- Bhabha, H. K. (1994). *The location of culture*. London: Routledge.
- Binns, C., Howat, P., & Jancey, J. (2014). Health promotion success in Australia and a note of warning. *Health Promotion Journal of Australia*, 25, 157-159.
- Bishop, C. (2008). "She has the native interests too much at heart": Annie Lock's experiences as a single, white, female missionary to Aborigines, 1903-1937. In A. Barry, J. Cruickshank, A. Brown-May & P. Grimshaw (Eds.), *Evangelists of empire?: Missionaries in colonial history*. Melbourne: University of Melbourne eScholarship Research Centre.
- Blue Moon. (2007). Australian Better Health Initiative: Diet, exercise and weight. Developmental communications research report. Canberra: Prepared for the Australian Government Department of Health and Ageing.
- Boffa, J. (1993). *The National Aboriginal Health Strategy (NAHS) & the National Rural Health Strategy (NRHS) in dialogue*. Paper presented at the 2nd National Rural Health Conference, Armidale.
- Bolt, A. (2009, 21 August). White fellas in the black. *Herald Sun*.
- Bolt, R. (2010). *Urban Aboriginal identity construction in Australia: An Aboriginal perspective utilising multi-method qualitative analysis*. (Doctor of Philosophy), University of Sydney, Sydney. Retrieved from http://ses.library.usyd.edu.au/bitstream/2123/6626/3/RJBOLT_2009thesis.pdf
- Bond, C. (2002). Beyond the dotted drawings - The Aboriginal Health Worker and health promotion practice. *Aboriginal and Islander Health Worker Journal*, 26(6), 16-18.
- Bond, C. (2005). A culture of ill-health: Public health or Aboriginality? *Medical Journal of Australia*, 183(1), 39-41.
- Bond, C. (2007). *"When you're black, they look at you harder" - Narrating Aboriginality within public health*. (Doctor of Philosophy), University of Queensland, Brisbane.
- Bond, C. (2009). Starting at strengths... an Indigenous early years intervention. (Dr Ross Ingram Memorial Essay Competition). *Medical Journal of Australia*, 191(3).
- Bond, C. (2014). Andrew Bolt not a racist but... Retrieved from <http://www.abc.net.au/news/2014-03-25/andrew-bolt-isnt-a-racist-but/5344286/?site=indigenous>
- Bond, C., & Brady, K. (2015). Locating Indigenous Australia within community development practice – Clients, consumers or change makers? *Quarterly Journal for Social Justice, Sustainability, Community Development and Human Rights*, 43.
- Bond, C., & Brough, M. (2007). The meaning of culture within public health practice: Implications for the study of Aboriginal and Torres Strait Islander health. In I. Anderson, F. Baum & M. Bentley (Eds.), *Beyond band-aids: Exploring the underlying social determinants of Aboriginal health. Papers from the Social Determinants of Aboriginal Health Workshop, Adelaide, July 2004* (pp. 229-238). Darwin: Cooperative Research Centre for Aboriginal Health.
- Bond, C., Brough, M., & Cox, L. (2014). Blood in our hearts or blood on our hands? The viscosity, vitality and validity of Aboriginal 'blood talk'. *International Journal of Critical Indigenous Studies Volume 7, Number 2, 2014*, 7(2), 2-14.

- Bond, C., Brough, M., Spurling, G., & Hayman, N. (2012). 'It had to be my choice' Indigenous smoking cessation and negotiations of risk, resistance and resilience. *Health, Risk & Society*, 14(6), 565-581. doi: 10.1080/13698575.2012.701274
- Booth, J., & Nelson, A. (2013). Sharing stories: Using narratives to illustrate the role of critical reflection in practice with First Australians. *Occupational Therapy International*, 20(3), 114-123. doi: 10.1002/oti.1343
- Boudville, A., Anjou, M., & Taylor, H. (2013). Eye health promotion to improve awareness and prevent vision loss among Indigenous Australians. *Health Promotion Journal of Australia*, 24(1), 76-77.
- Bourdieu, P. (1990). *The logic of practice*: Polity Press.
- Brady, M., & MacKenzie-Taylor, M. (2002). Testing an Indigenous health resource: The participatory development process with 'The Grog Book'. *Health Promotion Journal of Australia*, 13(3), 247-249.
- Braun, K. L., Browne, C. V., Ka'opua, L. S., Kim, B. J., & Mokuau, N. (2013). Research on Indigenous elders: From positivistic to decolonizing methodologies. *The Gerontologist*. doi: 10.1093/geront/gnt067
- Braunack-Mayer, A., & Louise, J. (2008). The ethics of community empowerment: Tensions in health promotion theory and practice. *Promotion & Education*, 15(3), 5-8.
- Braveman, P., Egerter, S., & Williams, D. R. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, 32, 381-398.
- Briggs, V. L., Lindorff, K. J., & Ivers, R. G. (2003). Aboriginal and Torres Strait Islander Australians and tobacco. *Tobacco control*, 12(suppl 2), ii5-ii8. doi: 10.1136/tc.12.suppl_2.ii5
- Broucke, S. V. d. (2012). Theory-informed health promotion: Seeing the bigger picture by looking at the details. *Health Promotion International*, 27(2), 143-147. doi: 10.1093/heapro/das018
- Brough, M. (1999). A lost cause?: Representations of Aboriginal and Torres Strait Islander health in Australian newspapers. *Australian Journal of Communication*, 26(2), 89-98.
- Brough, M. (2001). Healthy imaginations: A social history of the epidemiology of Aboriginal and Torres Strait Islander health. *Medical Anthropology*, 20, 65-90.
- Brough, M. (2007). Media release: National emergency response to protect children in the NT. In H. Families, Community Services and Indigenous Affairs, (Ed.). Canberra: Australian Government.
- Brough, M., Bond, C., & Hunt, J. (2004). Strong in the city: Towards a strength-based approach in Indigenous health promotion. *Health Promotion Journal of Australia*, 15(3), 215-220.
- Brough, M., Bond, C., Hunt, J., Jenkins, D., Shannon, C., & Schubert, L. (2006). Social capital meets identity: Aboriginality in an urban setting. *Journal of Sociology*, 42(4), 396-411.
- Brough, M., Henderson, G., Foster, R., & Douglas, H. (2007). *Social capital and Aboriginal and Torres Strait Islander health - Problems and possibilities*. Paper presented at the Social Determinants of Aboriginal Health Workshop, Adelaide.
- Brown, R. (2009). Matthew Johns: What happened and what people are saying about it. Retrieved from <http://www.crikey.com.au/2009/05/14/matthew-johns-what-happened-and-what-people-are-saying-about-it-2/>
- Brown, S., Shoveller, J., Chabot, C., & LaMontagne, A. D. (2013). Risk, resistance and the neoliberal agenda: Young people, health and well-being in the UK, Canada

- and Australia. *Health, Risk & Society*, 15(4), 333-346. doi: 10.1080/13698575.2013.796346
- Browne, J., D'Amico, E., Thorpe, S., & Mitchell, C. (2014). Feltman: evaluating the acceptability of a diabetes education tool for Aboriginal health workers. *Australian Journal of Primary Health*, 20, 319-322.
- Buckett, K., Williams, C., & Wildgoose, D. (2011). *Health in all policies: South Australia's country case study on action on the social determinants of health*. Paper presented at the WHO - World Conference on Social Determinants of Health, Rio de Janeiro, Brazil. <http://bit.ly/oK1yji>
- Burkett, I. (2007). Between the devil and the deep blue sea: The fates of community practice under neo-liberalism. *New community quarterly*, Autumn, 3-10.
- Burrows, R., Nettleton, S., & Bunton, R. (1995). Sociology and health promotion: Health, risk and consumption under late modernism. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 1-9). New York: Routledge.
- Calma, T. (2006). Achieving Aboriginal and Torres Strait Islander health equality within a generation - A human rights approach *Social Justice Report 2005*. Sydney.
- Calman, K. (2009). Beyond the 'nanny state': Stewardship and public health. *Public Health*, 123(1), e6-e10. doi: 10.1016/j.puhe.2008.10.025
- Campbell, D., Pyett, P., & McCarthy, L. (2007). Community development interventions to improve Aboriginal health: Building an evidence base. *Health Sociology Review*, 16(3-4), 304-314.
- Campbell, M., Finlay, S., Lucas, K., Neal, N., & Williams, R. (2014). Kick the habit: A social marketing campaign by Aboriginal communities in NSW. *Australian Journal of Primary Health*, 20, 327-333.
- Cardano, M. (2009). Ethnography and reflexivity: Notes on the construction of objectivity in ethnographic research. *NetPaper: Dipartimento di Scienze Sociali*, 1.
- Carey, M. (2008). *Whitefellas and Wadjulas: Anti-colonial constructions of the non-Aboriginal self*. (Doctor of Philosophy), Murdoch University, Melbourne. Retrieved from <http://researchrepository.murdoch.edu.au/id/eprint/1757>
- Carey, M., & Prince, M. (2014). Designing an Australian Indigenous studies curriculum for the twenty-first century: Nakata's 'cultural interface', standpoints and working beyond binaries. *Higher Education Research & Development*, 1-14. doi: 10.1080/07294360.2014.956691
- Carlisle, S. (2000). Health promotion, advocacy and health inequalities: A conceptual framework. *Health Promotion International*, 15(4), 369-376.
- Carlson, B. (2011). *The politics of identity: Who counts as Aboriginal today?*, University of New South Wales, Sydney.
- Carlson, B. (2013). The 'new frontier': Emergent Indigenous identities and social media. In M. Harris, M. Nakata & B. Carlson (Eds.), *The Politics of Identity: Emerging Indigeneity* (pp. 147-168). Sydney: University of Technology Sydney E-Press.
- Carnes, R. (2011a). Changing listening frequency to minimise white noise and hear Indigenous voices. *Journal of Australian Indigenous Issues*, 14(2-3), 170-184.
- Carnes, R. (2011b). *Signposts that helped a white activist find her way as a critical ally*. Paper presented at the Directions and Intersections, Surfers Paradise, QLD.

- Carson, B., Dunbar, T., Chenhall, R. D., & Bailie, R. (2007). Introduction. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health*. Crows Nest: Menzies School of Health Research.
- Carspecken, P. F. (1996). *Critical ethnography in educational research: A theoretical and practical guide*. New York: Routledge.
- Carter, S. M. (2014). Health promotion: An ethical analysis. *Health Promotion Journal of Australia*, 25(1), 19-24. doi: <http://dx.doi.org/10.1071/HE13074>
- Carter, S. M., Cribb, A., & Allegrante, J. P. (2012a). How to think about health promotion ethics. *Public Health Reviews*, 34(1).
- Carter, S. M., Klinner, C., Kerridge, I., Rychetnik, L., Li, V., & Fry, D. (2012b). The ethical commitments of health promotion practitioners: An empirical study from New South Wales, Australia. *Public Health Ethics*, 5(2), 128-139. doi: 10.1093/phe/phs014
- Carter, S. M., Rychetnik, L., Lloyd, B., Kerridge, I. H., Baur, L., Bauman, A., . . . Zask, A. (2011). Evidence, ethics, and values: A framework for health promotion. *American Journal of Public Health*, 101(3), 465-472. doi: 10.2105/ajph.2010.195545
- Casey, M. (2012). Racial legitimations: Colonisation, notions of authenticity and Aboriginal Australian performance. *Australian Critical Race and Whiteness Studies Association e-journal*, 8.
- Catford, J. (2004). Health promotion's record card: How principled are we 20 years on? *Health Promotion International*, 19(1), 1-4.
- Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: SAGE Publications.
- Chartrand, P. (2009). Reconciling Indigenous peoples' sovereignty and state sovereignty *AIATSIS Research Discussion Paper*. Canberra.
- Chilisa, B. (2012). *Indigenous research methodologies*. London: SAGE Publications Ltd.
- Chino, M., & DeBruyn, L. (2006). Building true capacity: Indigenous models for Indigenous communities. *American Journal of Public Health*, 96(3), 9-12.
- Christie, M., & Verran, H. (2013). Digital lives in postcolonial Aboriginal Australia. *Journal of Material Culture*, 18(3), 299-317. doi: 10.1177/1359183513492081
- Chu, C., Breucker, G., Harris, N., Stitzel, A., Gan, X., Gu, X., & Dwyer, S. (2000). Health-promoting workplaces—International settings development. *Health Promotion International*, 15(2), 155-167. doi: 10.1093/heapro/15.2.155
- Clapham, K., O'Dea, K., & Chenhall, R. D. (2007). Interventions and sustainable programs. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health*. Crows Nest: Menzies School of Health Research.
- Clark, E. (2014, 14 November). G20: Hundreds march against Aboriginal deaths in custody ahead of summit, *ABC News*. Retrieved from <http://www.abc.net.au/news/2014-11-14/g20-deaths-in-custody-march-in-brisbane/5892038>
- Clelland, N., Gould, T., & Parker, E. (2007). Searching for evidence: What works in Indigenous mental health promotion? *Health Promotion Journal of Australia*, 18(3), 208-216.
- Clinch, D. (2010). Sporting opportunities for Aboriginal men in Melbourne's Western Suburbs. *Aboriginal and Islander Health Worker Journal*, 34(4), 8-9.

- Close the Gap Steering Committee. (2010). Close the Gap making it happen: Planning for Aboriginal and Torres Strait Islander health equality within a generation: workshop report. Canberra: Close the Gap Steering Committee.
- Clough, A. R., Robertson, J. A., & MacLaren, D. J. (2009). The gap in tobacco use between remote Australian communities and the Australian population can be closed. *Tobacco control*, 18(4), 335.
- Colles, S., Maypilama, E., & Brimblecombe, J. (2014). Food, food choice and nutrition promotion in a remote Australian Aboriginal community. *Australian Journal of Primary Health*, 20, 365-372.
- Council of Australian Governments. (2009a). *National Indigenous reform agreement (Closing the gap)*. Canberra: COAG Retrieved from http://www.coag.gov.au/coag_meeting_outcomes/2009-07-02/docs/NIRA_closing_the_gap.pdf.
- Council of Australian Governments. (2009b). *National partnership agreement on closing the gap in Indigenous health outcomes*. Canberra: COAG Retrieved from http://www.coag.gov.au/intergov_agreements/federal_financial_relations/docs/national_partnership/NP_closing_the_Gap_indigenous_health_outcomes.pdf.
- Council of Australian Governments. (2011a). *Heads of Agreement – National Health Reform*. Canberra: Council of Australian Governments Retrieved from http://www.coag.gov.au/coag_meeting_outcomes/2011-02-13/docs/communique_attachmentA-heads_of_agreement-national_health_reform_signatures.pdf.
- Council of Australian Governments. (2011b). *National health reform agreement*. Canberra: Australian Government Retrieved from [http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/0C457FB93670D84ECA2578DF00167297/\\$File/National_Health_Reform_Agreement.pdf](http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/0C457FB93670D84ECA2578DF00167297/$File/National_Health_Reform_Agreement.pdf).
- Tobacco Plain Packaging Act. 2011 (2012).
- Commission on Social Determinants of Health. (2007). Social determinants of Indigenous health: The international experience and its policy implications. Adelaide: Commission on Social Determinants of Health, Cooperative Research Centre for Aboriginal Health, Flinders University
- Australian Government, Canadian National Collaborating Centre for Aboriginal Health, Government of South Australia.
- Commission on Social Determinants of Health. (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health. Geneva: World Health Organization.
- Community Affairs References Committee. (2013). Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report "Closing the gap within a generation". Canberra
- Conigrave, K., Freeman, B., Carroll, T., Simpson, L., Lee, K. K., Wade, V., . . . Freeburn, B. (2012). The alcohol awareness project: Community education and brief intervention in an urban Aboriginal setting. *Health Promotion Journal of Australia*, 23(3), 219-225.
- Cook, K. E. (2005). Using critical ethnography to explore issues in health promotion. *Qualitative Health Research*, 15(1), 129-138. doi: 10.1177/1049732304267751
- Cooke, M., Mitrou, F., Lawrence, D., Guimond, E., & Beavon, D. (2007). Indigenous well-being in four countries: An application of the UNDP'S Human

- Development Index to Indigenous Peoples in Australia, Canada, New Zealand, and the United States. *BMC International Health and Human Rights*, 7(9), Open Access.
- Cooper, D. (2011). Closing the gap in cultural understanding: Social determinants of health in Indigenous policy in Australia Darwin: Aboriginal Medical Services Alliance Northern Territory.
- Corti, L. (1993). Using diaries in social research. *Social Research Update*, 2.
- Council for Aboriginal Reconciliation. (1999). Draft document for reconciliation: A draft for discussion by the Australian people. Canberra.
- Couzos, S. (2004). Practical measures that improve human rights - towards health equity for Aboriginal children. *Health Promotion Journal of Australia*, 15(3), 186-193.
- Cowlishaw, G. (2007). Introduction: Ethnography and the interpretation of 'Cronulla'. *The Australian Journal of Anthropology*, 18(3), 295-299.
- Cox, A., Dudgeon, P., Holland, C., Kelly, K., Scrine, C., & Walker, R. (2014). Using participatory action research to prevent suicide in Aboriginal and Torres Strait Islander communities. *Australian Journal of Primary Health*, 20, 345-349.
- Cox, E. (2014). Forrest report ignores what works and why in Indigenous policy. Retrieved from <http://theconversation.com/forrest-report-ignores-what-works-and-why-in-indigenous-policy-30080>
- Cross-Townsend, M. (2011). Indigenous education and Indigenous studies in the Australian academy: Assimilation, critical pedagogy, dominant culture learners, and Indigenous knowledges. In G. S. Dei (Ed.), *Indigenous philosophies and critical education*. New York: Peter Lang.
- Crossley, M. L. (2001). 'Resistance' and health promotion. *Health Education Journal*, 60(3), 197-204. doi: 10.1177/001789690106000302
- Crouch, A., & Fagan, P. (2014). Are insights from Indigenous health shaping a paradigm shift in health promotion praxis in Australia? *Australian Journal of Primary Health*.
- Cueto, M. (2004). The origins of primary health care and selective primary health care. *American Journal of Public Health*, 94(11), 1864-1874.
- Cunneen, C. (2008). Reflections on criminal justice policy since the Royal Commission into Aboriginal Deaths in Custody *University of New South Wales Faculty of Law Research Series*. Sydney
- Cunningham, J., & Baeza, J. I. (2005). An 'experiment' in Indigenous social policy: The rise and fall of Australia's Aboriginal and Torres Strait Islander Commission (ATSIC). *Policy & Politics*, 33(3), 461-473. doi: 10.1332/0305573054325684
- Czymoniewicz-Klippel, M. T., Brijnath, B., & Crockett, B. (2010). Ethics and the promotion of inclusiveness within qualitative research: Case examples from Asia and the Pacific. *Qualitative Inquiry*, 16(3), 332-341.
- D'Este, C. A., Passey, M. E., & Sanson-Fisher, R. W. (2012). Knowledge, attitudes and other factors associated with assessment of tobacco smoking among pregnant Aboriginal women by health care providers: A cross-sectional survey. *BMC Public Health*, 12, 165.
- D'Cruz, H., Gillingham, P., & Melendez, S. (2007). Reflexivity, its meanings and relevance for social work: A critical review of the literature. *British Journal of Social Work*, 37(1), 73-90. doi: 10.1093/bjsw/bcl001
- Darnell, S. C. (2007). Playing with race: Right to play and the production of whiteness in 'development through sport'. *Sport in Society*, 10(4), 560-579. doi: 10.1080/17430430701388756

- Daube, M. (2012). Censoring public health in Queensland - A dangerous precedent? *The Conversation*.
- Davey, N., & Goudie, S. (2009). Hope Vale digital storytelling project using the camera: Telling stories our way. *3C Media: Journal of Community, Citizen's and Third Sector Media and Communication*(5), 28-48.
- Davison, C., & Smith, G. D. (1995). The baby and the bath water: Examining socio-cultural and free-market critiques of health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 91-99). New York: Routledge.
- Dawson, A., Richards, R., Collins, C., Reeder, A., & Gray, A. (2013). Edible gardens in early childhood education settings in Aotearoa, New Zealand. *Health Promotion Journal of Australia*, 24(3), 214-218.
- Department of Community Services and Health (DCSH) & World Health Organization (WHO) Regional Office for Europe. (1988, 5-9 April). *Report on the Adelaide Conference: Healthy public policy*. Paper presented at the 2nd International Conference on Health Promotion, Adelaide, South Australia.
- de Laine, M. (1997). *Ethnography: Theory and applications in health research*. Sydney: MacLennan & Petty Pty Ltd.
- Deadly Choices. (2013a). Can you name the 3 major chemicals in a Cigarette? Deadly Choices Instagram page: Institute for Urban Indigenous Health.
- Deadly Choices (Producer). (2013b, 27 October). Deadly Choices - Healthy Lifestyle Commercial #2 (Sam Thaiday & Scott Prince). Retrieved from https://www.youtube.com/watch?v=o0iRutKj0Ok&index=17&list=UUGy10jyTMOF26Ef_AQA2y_A
- Deadly Choices. (2013c). Dr Chelsea Bond, University of Queensland is one of our Deadly Choices Ambassadors. Her Deadly Choice is the value of education and how this has opened doors for her career. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013d). Facebook insights: People, your fans. Deadly Choices Instagram page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013e). Good luck to our #deadlychoices ambassador Damien Super Hooper when he boxes for a world title next Saturday night in Brisbane. Damien is a proud aboriginal man who wears his heart on his sleeve. Please repost and Share with your friends and show your support. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013f). Good Quick Tukka; Bush beef stir fry Bowen Hills: Institute for Urban Indigenous Health.
- Deadly Choices. (2013g). Great session on Physical Activity at Browns Plains School, the students showed off some of their deadly paintings Deadly Choices Twitter page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013h). Hey guys COMPETITION time!!! Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013i). Hey guys when you make a Healthy Choice, the Right Choice the Deadly Choice we want to hear about it. It's time to encourage positive change and decisions within our community and it starts with YOU. Stay Deadly. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013j). National Nutrition Week team lunch. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013k). Some of our Deadly Choices girls! Claire, @writteninthesky @zoeannagoanna and Karen working hard at the staff exercise session!

- #exercise #deadlychoices #fun #healthy #instagood. Deadly Choices Instagram page: Institute for Urban Indigenous Health.
- Deadly Choices. (2013l). Tracy Thompson one our Deadly Choices Ambassadors. Tracy's deadly choice is to not drink or smoke and exercise at least 30mins each day. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014a). Chin up comp at Metricon Stadium with the @GoldCoastSUNS gym, the kids are having a great time. Really good to see what a professional athlete does everyday. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014b). Deadly Choices - About. Retrieved 16/09/2014, 2014, from <http://www.deadlychoices.com.au/about/>
- Deadly Choices. (2014c). Deadly Choices Ambassador Larissa Chambers will be on Channel 9 tonight around 6.40 as she talks about her trip to America and dreams of competing at the commonwealth games & Olympics. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014d). Deadly Choices home page. Retrieved 19/09/2014, from <http://www.deadlychoices.com.au>
- Deadly Choices. (2014e). Good luck 2 our Deadly Choices @brisbanebroncos 2night as they take on the Dragons in our last home game #bronxnation. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014f). Ice breaker games with the @brisbanebroncos staff & players. @jharalyowyeh5 @jordankahu. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014g). No title. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014h). Not long now until our competition closes you mob, make sure you check it out. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014i). Our prizes are all sorted and ready for this weekends Goodna Community day. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Deadly Choices. (2014j). Shout our from the boys thanks @jharalyowyeh5 @scottprince7 from the @brisbanebroncos #deadlychoices please share this post... Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Demaio, A., Drysdale, M., & de Courten, M. (2012). Appropriate health promotion for Australian Aboriginal and Torres Strait Islander communities: Crucial for closing the gap. *Global Health Promotion*, 19(2), 58-62. doi: 10.1177/1757975912441230
- DeMaria, A. N. (2013). The nanny state and “coercive paternalism”. *Journal of the American College of Cardiology*, 61(20), 2108-2109.
- Department of Health. (2011). Review of current arrangements for the collection, recording, transfer and reporting of national trachoma data. Canberra.
- Department of Health. (2014). *Medicare health assessment for Aboriginal and Torres Strait Islander people (MBS ITEM 715)*. Canberra: Australian Government
Retrieved from http://www.health.gov.au/internet/main/publishing.nsf/Content/mbsprimarycare_ATSI_MBSitem715.
- Department of Health, W. A. (2005). *A best practice model for health promotion programs in Aboriginal communities*. Perth: Department of Health, Western Australia.

- DICWCWA. (2014). Ward campaign for justice 2008-2010. Retrieved 12 December, 2014, from <http://www.deathsincustody.org.au/ward-campaign-justice-2008-2010>
- Dillon, M., & Westbury, N. (2007). *Beyond humbug: Transforming government engagement with Indigenous Australia* Westlakes: Seaview Press.
- Dodson, M. (2009). Indigenous governance toolkit. Canberra: Reconciliation Australia.
- DoHA. (2011). *Australian National Preventive Health Agency: Agency resources and planned performance*. Canberra: Australian Government.
- Dominguez Figaredo, D. (2012). Hybrid scenarios, transmedia storytelling, expanded ethnography. *Revista de Antropologia Social*, 21, 197-215. doi: http://dx.doi.org/10.5209/rev_RASO.2012.v21.40056
- Doneman, P. (2009). 'A few kisses' led to Broncos sex scandal, *The Sunday Mail (Qld)*. Retrieved from <http://www.couriermail.com.au/news/kisses-led-to-broncos-scandal/story-e6freon6-1225712933031>
- Donovan, V. (2002). *The reality of a dark history: From contact and conflict to cultural recognition*. Brisbane: Queensland Government.
- Dooris, M. (2006). Health promoting settings: Future directions. *IUHPE - Promotion & Education*, 13(1), 4-6.
- Doran, F., & O'Brien, A. (2007). A brief report of attitudes towards physical activity during pregnancy. *Health Promotion Journal of Australia*, 18(2), 155-158.
- Douglas, R. (2015, 15 January). Senate report shows why Australia needs to talk about inequality. *The Conversation*.
- Driscoll, C., & Gregg, M. (2010). My profile: The ethics of virtual ethnography. *Emotion, Space and Society*, 3(1), 15-20. doi: <http://dx.doi.org/10.1016/j.emospa.2010.01.012>
- Dudgeon, P., Cox, A., Walker, R., Scrine, C., Kelly, K., Blurton, D., . . . Taylor, N. (2014a). Voices of the peoples: The National Empowerment Project national summary report 2014. Crawley: School of Indigenous Studies, University of Western Australia.
- Dudgeon, P., Milroy, H., & Walker, R. (2014b). Working together: Aboriginal and Torres Strait Islander mental health and wellbeing principles and practice (2nd ed.). Barton.
- Dudgeon, P., & Walker, R. (2015). Decolonising Australian psychology: Discourses, strategies, and practice. *Journal of Social and Political Psychology*, 3(1), 276-297.
- Dudgeon, P., Wright, M., Paradies, Y., Garvey, D., & Walker, I. (2014c). Aboriginal social, cultural and historical contexts. In P. Dudgeon, H. Milroy & R. Walker (Eds.), *Working together: Aboriginal and Torres Strait Islander Mental health and wellbeing principles and practice* (2nd ed., pp. 3-24). Barton: Commonwealth of Australia.
- Dunbar, T., & Scrimgeour, M. (2007). Education. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health* (pp. 135-152). Crows Nest: Allen & Unwin.
- Duncan, P., & Cribb, A. (1996). Helping people change—An ethical approach? *Health Education Research*, 11(3), 339-348. doi: 10.1093/her/11.3.339
- Durey, A. (2010). Reducing racism in Aboriginal health care in Australia: Where does cultural education fit? *Australian and New Zealand Journal of Public Health*, 34(S1), S87-S92.
- Durey, A., & Thompson, S. (2012). Reducing the health disparities of Indigenous Australians: Time to change focus. *BMC Health Services Research*, 12(1), 151.

- Durie, M. (1999, 2-5 December 1999). *Te Pae Mahutonga: A model for Māori health promotion*. Paper presented at the Health Promotion Forum of New Zealand Newsletter 49, New Zealand.
- Durie, M. (2004). An Indigenous model of health promotion. *Health Promotion Journal of Australia*, 15(3), 181-185.
- Dussart, F. (2009). Diet, diabetes and relatedness in a central Australian Aboriginal settlement: Some qualitative recommendations to facilitate the creation of culturally sensitive health promotion initiatives. *Health Promotion Journal of Australia*, 20(3), 202-207.
- Eades, S. J., Taylor, B., Bailey, S., Williamson, A. B., Craig, J. C., & Redman, S. (2010). The health of urban Aboriginal people: Insufficient data to close the gap. *Medical Journal of Australia*, 193(9), 521-524.
- Eakin, J., Robertson, A., Poland, B., Coburn, D., & Edwards, R. (1996). Towards a critical social science perspective on health promotion research. *Health Promotion International*, 11(2), 157-165.
- Eckermann, A.-K., Dowd, T., Chong, E., Nixon, L., Gray, R., & Johnson, S. (2010). *Binan Goonj: Bridging cultures in Aboriginal health* (3rd ed.). Chatswood: Elsevier Australia.
- Edmunds, M. (2010). The Northern Territory intervention and human rights - An anthropological perspective. In T. W. Institute (Ed.), *Perspectives*. Sydney: The Whitlam Institute.
- Eriksson, M., & Lindstrom, B. (2008a). Promoting mental health - Evidence of the Salutogenic Framework for a positive health development. *European Psychiatry*, 23(Supplement 2), S83-S83. doi: 10.1016/j.eurpsy.2008.01.675
- Eriksson, M., & Lindstrom, B. (2008b). A salutogenic interpretation of the Ottawa Charter. *Health Promotion International*, 23(2), 190-199. doi: 10.1093/heapro/dan014
- Evans, B. W. (2012). Northern Territory Emergency Response: Criticism, support and redesign. *Australian Journal of Rural Health*, 20(3), 103-107. doi: 10.1111/j.1440-1584.2012.01265.x
- Evans, L., Hall, M., Jones, C. M., & Neiman, A. (2007). Did the Ottawa Charter play a role in the push to assess the effectiveness of health promotion? *Promotion & Education*, 14(Supplement 2), 28-30.
- Fanon, F. (1963). *The wretched of the earth*. New York: Grove Press.
- Fanon, F. (1965). *A dying colonialism*. New York: Grove Press.
- Fanon, F. (1967). *Black skin, white masks*. New York: Grove Press.
- Eatock v Bolt [2011] FCA 1103 (28 September 2011) (2011).
- Ferdinand, A., Paradies, Y., Perry, R., & Kelaher, M. (2014). Aboriginal health promotion through addressing employment discrimination. *Australian Journal of Primary Health*, 20, 384-388.
- House debates: Parliamentary Joint Committee on Human Rights; Report*, 44th Parliament (2014).
- Ferguson, S. (2009). Code of silence, *Four Corners*. Retrieved from <http://www.abc.net.au/4corners/content/2009/s2565007.htm>
- Fetterman, D. M. (2010). *Ethnography: Step-by-step* (3rd ed.). Thousand Oaks: SAGE Publications.
- Fletcher, F. (2012). Healthy Lifestyle Program report. Bowen Hills: Institute for Urban Indigenous Health.
- Fletcher, S. (2007). Communities working for health and wellbeing: Success stories from the Aboriginal community controlled health sector in Victoria. Melbourne.

- Floss, F. (2011). Draft report on sport and leadership camp. Brisbane: Institute for Urban Indigenous Health.
- Foley, D. (2002). Critical ethnography: The reflexive turn. *International Journal of Qualitative Studies in Education*, 15(4), 469-490. doi: 10.1080/09518390210145534
- Foley, G. (1982). Aboriginal community controlled health services: A short history. *Aboriginal Health Project Information Bulletin*, 2, 13-15.
- Foley, G. (1991). Redfern Aboriginal Medical Service: 20 years on. *Aboriginal and Islander Health Worker Journal*, 15(4), 4-8.
- Foley, G. (1999). *Whiteness and Blackness in the Koori struggle for self-determination*. Paper presented at the Winter School on Advocacy and Social Action Trades Hall, Melbourne. http://www.kooriweb.org/foley/essays/essay_9.html
- Foley, G. (2010). A short history of the Australian Indigenous resistance 1950-1990. Canberra.
- Foley, G. (n.d.-a). Timeline of significant moments in the Indigenous struggle in South East Australia. *The Koori History Website*. Retrieved 29 April 2015, from <http://www.kooriweb.org/foley/timeline/histimeline.html>
- Foley, G. (n.d.-b). Timeline of significant moments in the Indigenous struggle in South East Queensland. Retrieved 10 December, 2014, from <http://www.kooriweb.org/foley/timeline/histimeline.html>
- Foley, G., & Muldoon, E. (2014). Pynning for Indigenous rights in the Australian curriculum *The Conversation*. Melbourne: The Conversation Media Group.
- Ford, C. L., & Airhihenbuwa, C. O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health*, 100(S1), S30-S35.
- Ford, P., Clifford, A., Gussy, K., & Gartner, C. (2013). A systematic review of peer-support programs for smoking cessation in disadvantaged groups. *International Journal of Environmental Research and Public Health*, 10(11), 5507-5522. doi: 10.3390/ijerph10115507
- Fredericks, B. (2003). *Us speaking about women's health: Aboriginal women's perceptions and experiences of health, well-being, identity, body and health services*. (Doctor of Philosophy), Central Queensland University, Rockhampton.
- Fredericks, B. (2004). Urban identity: The identity of urban Indigenous Australians. *Eureka Street*, 14(10), 30-31A.
- Fredericks, B. (2007). Utilising our warrior ways in higher education. *The Julie Mango: International Online Journal of Creative Expressions. Special Edition of Education and Transformative Pedagogy, Summer*.
- Fredericks, B. (2008). Which way that empowerment? Aboriginal women's narratives of empowerment. *Alternative*, 4(2), 6-19.
- Fredericks, B. (2009). The epistemology that maintains white race privilege, power and control of Indigenous studies and Indigenous peoples' participation in universities. *Australian Critical Race and Whiteness Studies Association e-journal*, 5(1).
- Fredericks, B. (2010). Reempowering ourselves: Australian Aboriginal women *Signs: Journal of women in culture and society*, 35(3), 546-550.
- Fredericks, B. (2013). 'We don't leave our identities at the city limits': Aboriginal and Torres Strait Islander people living in urban localities. *Australian Aboriginal Studies*(1), 4-16.
- Fredericks, B. (2014). The epistemology that maintains white race privilege, power and control of indigenous studies and indigenous peoples' participation in

- universities. *Critical Race and Whiteness Studies, 10th Anniversary Special Issue*, 10(2).
- Fredericks, B., Adams, K., & Edwards, R. (2011a). Aboriginal community control and decolonizing health policy: A yarn from Australia. In H. Lofgren, E. De Leeuw & M. Leahy (Eds.), *Democratizing health: Consumer groups in the policy process*. Cheltenham: Edward Elgar Publishing Limited.
- Fredericks, B., Adams, K., Finlay, S., Fletcher, G., Andy, S., Briggs, L., . . . Hall, R. (2011b). Engaging the practice of Indigenous yarning in Action Research. *ALAR Journal*, 17(2), 7-19.
- Fredericks, B., & Anderson, M. (2013). *Aboriginal and Torres Strait Islander cookbooks: Promoting Indigenous foodways or reinforcing Western traditions?* Paper presented at the Peer Reviewed Proceedings of the 4th Annual Conference, Popular Culture Association of Australia and New Zealand (PopCAANZ), Brisbane, Australia.
- Fredericks, B., Lee, V., Adams, M., & Mahoney, R. (2012). Aboriginal and Torres Strait Islander health. In M. L. Fleming & E. Parker (Eds.), *Introduction to Public Health, 2nd Edition Print Book* Sydney: Elsevier Australia.
- Fredericks, B., & Legge, D. (2011). Revitalizing health for all: International Indigenous representative group. Learning from the experience of comprehensive primary health care in Aboriginal Australia - A commentary on three projects. Melbourne: Lowitja Institute.
- Fredericks, B., Maynor, P., White, N., English, F., & Ehrich, L. (2014). Living with the legacy of conquest and culture: Social justice leadership in education and the Indigenous peoples of Australia and America. In I. Bogotch & C. M. Shields (Eds.), *International Handbook of Educational Leadership and Social (In)Justice* (pp. 751-780). New York: Springer Science+Business Media Dordrecht.
- Fredericks, B., Row Row, A., & Weazel, J. (2005). Promoting healthy weight in the Central Highlands *Aboriginal and Islander Health Worker Journal*, 29(5), 30-31.
- Freeman, T., Jolley, G., Baum, F., Lawless, A., Javanparast, S., & Labonté, R. (2013). Community assessment workshops: A group method for gathering client experiences of health services. *Health & Social Care in the Community*, n/a-n/a. doi: 10.1111/hsc.12060
- Friel, S. (2011). So we now have another international declaration on the social determinants of health. What difference will it make (or not)? Retrieved from <http://blogs.crikey.com.au/croakey/2011/11/02/so-we-now-have-another-international-declaration-on-the-social-determinants-of-health-what-difference-will-it-make-or-not/>
- Gajjar, D., Zwi, A., Hill, P., & Shannon, C. (2014). A case study in the use of evidence in a changing political context: An Aboriginal and Torres Strait Islander health service re-examines practice models, governance and financing. *Australian Health Review*, 38(4), 383-386.
- Gallaher, G., Ziersch, A., Baum, F., Bentley, M., Palmer, C., Edmondson, W., & Winslow, L. (2009). In our own backyard: Urban health inequities and Aboriginal experiences of neighbourhood life, social capital and racism. Adelaide.
- Gandhi, L. (1998). *Postcolonial theory: A critical introduction*. Sydney: Allen & Unwin.

- Gardner, B. (2011). Comprehensive community initiatives: Promising directions for "wicked" problems? Toronto: Wellesley Institute.
- Garnett, S. T., Sithole, B., Whitehead, P. J., Burgess, C. P., Johnston, F. H., & Lea, T. (2008). Healthy country, health people: Policy implications of links between Indigenous human health and environmental condition in Tropical Australia. *The Australian Journal of Public Administration*, 68(1), 53-66.
- Geertz, C. (1973). *The interpretation of cultures: Selected essays by Clifford Geertz*. New York: Basic Books.
- Geertz, C. (1988). *Works and lives: The anthropologist as author*. Stanford Stanford University Press.
- Geia, L. (2012). *First steps, making footprints: Intergenerational Palm Island families' Indigenous stories (narratives) of childrearing practice strengths*. PhD thesis, . (PhD thesis), James Cook University, Cairnes.
- Geidne, S., Quennerstedt, M., & Eriksson, C. (2013). The youth sports club as a health-promoting setting: An integrative review of research. *Scandinavian Journal of Public Health*, 41(3), 269-283.
- Gilchrist, D., Woods, B., Binns, C., Gracey, M., Scott, J., & Smith, H. (2004). Breastfeeding and health promotion: The experience of Aboriginal and non-Aboriginal mothers. *Health Promotion Journal of Australia*, 15(3), 226-230.
- Gillor, G. (2011). The Program Effectiveness Review as a case study of the relationship between the Aboriginal Community-controlled Health Services movement and the State, 1980-1982. *Journal of Australian Indigenous Issues*, 14(2-3), 151-169.
- Gillor, G. I. (2012). *Taking Control. A case study of the National Aboriginal and Islander Health Organisation (NAIHO)*. (Doctor of Philosophy), University of Western Sydney, Sydney.
- Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Company.
- Godwell, D. (2000). Playing the game: Is sport as good for race relations as we'd like to think? *Australian Aboriginal Studies*, 1/2, 12-19.
- Goldie, C. (2014). Submission to the Senate Select Committee on Health. Canberra.
- Golds, M., King, R., Meiklejohn, B., Campion, S., & Wise, M. (1997). Healthy Aboriginal communities. *Australian and New Zealand Journal of Public Health*, 21(4), 386-390. doi: 10.1111/j.1467-842X.1997.tb01719.x
- Goleman, D. (2000). Leadership that gets results. *Harvard Business Review*, March-April, 78-90.
- González, M. a. C. (2000). The four seasons of ethnography: A creation-centered ontology for ethnography. *International Journal of Intercultural Relations*, 24(5), 623-650. doi: [http://dx.doi.org/10.1016/S0147-1767\(00\)00020-1](http://dx.doi.org/10.1016/S0147-1767(00)00020-1)
- González y González, E. M., & Lincoln, Y. S. (2006). Decolonizing qualitative research: Non-traditional reporting forms in the academy. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*, 7(4). doi: URN: urn:nbn:de:0114-fqs060418
- Gooda, M. (2014a). Engage with us, says Commissioner Gooda. Sydney: Australian Human Rights Commission.
- Gooda, M. (2014b). 'Work with us not for us', Commissioner tells Parliament. Sydney: Australian Human Rights Commission.
- Goodson, P. (2010). *Theory in health promotion research and practice: Thinking outside the box*. Sudbury: Jones and Bartlett.
- Gorman, D., & Toombs, M. (2009). Matching research methodology with Australian Indigenous culture. *Aboriginal and Islander Health Worker Journal*, 33(3), 4-7.

- Gould, G. S., McEwen, A., Watters, T., Clough, A. R., & van der Zwan, R. (2012). Should anti-tobacco media messages be culturally targeted for Indigenous populations? A systematic review and narrative synthesis. *Tobacco control*. doi: 10.1136/tobaccocontrol-2012-050436
- Graham, L., Brown-Jeffy, S., Aronson, R., & Stephens, C. (2011). Critical race theory as theoretical framework and analysis tool for population health research. *Critical Public Health*, 21(1), 81-93. doi: 10.1080/09581596.2010.493173
- Gray, N. (2007). Human rights. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health*. Crows Nest: Menzies School of Health Research.
- Gregg, J., & O'Hara, L. (2007a). The Red Lotus Health Promotion Model: a new model for holistic, ecological, salutogenic health promotion practice. *Health Promotion Journal of Australia*, 18(1), 12-19.
- Gregg, J., & O'Hara, L. (2007b). Values and principles evident in current health promotion practice. *Health Promotion Journal of Australia*, 18(1), 7-11.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 191-215). Thousand Oaks: Sage Publications.
- Gunstone, A. (2006). The Howard government's approach to the policy of Indigenous self-determination. *MAI Review*, 1(Peer Commentary 2), 1-3.
- Gunstone, A. (2012). *Reconciliation and 'The Great Australian Silence'*. Paper presented at the Australian Political Studies Association (APSA) Conference, Hobart.
http://www.auspsa.org.au/sites/default/files/reconciliation_and_the_great_australian_silence_andrew_gunstone.pdf
- Gussow, Z., & Tracey, G. (1971). The use of archival materials in the analysis and interpretation of field data: A case study in the institutionalization of the myth of leprosy as "Leper". *American Anthropologist*, 73, 695-709.
- Guthrie, J., & Walter, M. (2013). The positioning of Indigenous Australians as health care recipients. In B. Cathy, U. Stanley, S. U. Jane DixonA2 - Cathy Banwell & D. Jane (Eds.), *When culture impacts health* (pp. 239-249). San Diego: Academic Press.
- Hall, S. (1996). The west and the rest. In S. Hall, D. Held, D. Hubert & K. Thompson (Eds.), *Modernity: An introduction to modern societies* (pp. 185-227). Massachusetts: Open University Press.
- Hammersley, M. (2008). *Questioning qualitative inquiry: Critical essays*: SAGE Ltd.
- Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). New York: Taylor and Francis.
- Hanrahan, M. (1998). *Enhancing critical analysis in research through reflective writing*. Paper presented at the Annual Conference of the Australian Association for Research in Education, Adelaide.
http://www.fed.qut.edu.au/staff/mste/mhanraha/pub_html/paper1.htm
- Hardcastle, M.-A., Usher, K., & Holmes, C. (2006). Carspecken's five-stage critical qualitative research method: An application to nursing research. *Qualitative Health Research*, 16(1), 151-161. doi: 10.1177/1049732305283998
- Harding, S. (2002). Rethinking standpoint epistemology: What is "strong objectivity"? (pp. 352-384).

- Harris, M. (2013). Emergent Indigenous identities: Rejecting the need for purity. In M. Harris, M. Nakata & B. Carlson (Eds.), *The politics of identity: Emerging Indigeneity* (pp. 10-25). Sydney: UTSePress.
- Harris, N., & McPhail-Bell, K. (2007). Evolving directions in health promotion workforce development. *Pacific Health Dialog*, 14(2), 63-65.
- Hart, V. (2003). Teaching black and teaching back. *Social Alternatives*, 22(3), 12-16.
- Hearn, S. (2004). Closing speech: IUHPE Health2004 Conference, Melbourne Australia. *Aboriginal and Islander Health Worker Journal*, 28(3), 27-28.
- Hearn, S., Nancarrow, H., Rose, M., Massi, L., Wise, M., Conigrave, K., . . . Bauman, A. (2011). Evaluating NSW SmokeCheck: A culturally specific smoking cessation training program for health professionals working in Aboriginal health. *Health Promotion Journal of Australia*, 22(3), 189-195.
- Henderson, A. (2015, 5 May). Majority of grants from Indigenous Advancement Strategy first round given to non-Aboriginal groups, *ABC News*. Retrieved from <http://www.abc.net.au/news/2015-05-05/majority-of-indigenous-grants-go-to-non-aboriginal-organisations/6444534>
- Herborn, D. (2013). Racial vilification and social media. *Indigenous Law Bulletin*, 8(4), 16-19.
- Herriot, M., & Desmarchelier, M. (2004). Health promotion leadership in Australia - 2004 and beyond. *Health Promotion Journal of Australia*, 15(1), 11-16.
- Hine, C. (2000). *Virtual ethnography*. London, England: SAGE Publications Ltd.
- Hodgson, D., & Bennett, P. (2014). Case study - Hero rewards...The choice is yours: Building on program success. In G. Elliott, S. Rundle-Thiele & D. Waller (Eds.), *Marketing* (3rd ed., pp. 37- 39). Milton: John Wiley and Sons Australia.
- Hogan, K. (2013). Paid promotions & the UIIH Facebook page: September-October 2013. Bowen Hills: Institute for Urban Indigenous Health.
- Holland, C. (2014). Close the gap: Progress and priorities 2014. Melbourne: Oxfam Australia.
- Holt, L. (2009). Aboriginal humour: A conversational corroboree. In F. De Groen (Ed.), *Serious frolic: Essays on Australian humour*. St Lucia: University of Queensland Press.
- House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs. (2013). Sport – More than just a game. Contribution of sport to Indigenous wellbeing and mentoring. Canberra
- Houston, S. (2006). Equity, by what measure? *Health Promotion Journal of Australia*, 17(3), 206-210.
- Howes, C. (2009, September 9). Home ownership vision in Mapoon, *The Koori Mail*, pp. 1, 13. Retrieved from <http://www.aiatsis.gov.au/koorimail/issues/pdf/459.pdf>
- Huggins, J. (1998). *Sister girl: The writings of Aboriginal activist and historian*. St Lucia: University of Queensland Press.
- Hughes, E. (1997). Health promotion and 'non-compliance' - An analysis of resistance to regulatory technologies. *Health Sociology Review*, 7(1), 18-27.
- Human Rights and Equal Opportunity Commission. (1997). Bringing them home: National inquiry into the separation of Aboriginal and Torres Strait Islander children from their families. Canberra: HREOC.
- Human Rights and Equal Opportunity Commission. (2005). Social justice report 2005. Canberra: HREOC.
- Human Rights and Equal Opportunity Commission. (2007). Social justice report 2007. Canberra: HREOC.

- Hunt, J. (2013). Engaging with Indigenous Australia— Exploring the conditions for effective relationships with Aboriginal and Torres Strait Islander communities. Canberra: Closing the Gap Clearinghouse.
- Hunt, J., Marshall, A., & Jenkins, D. (2008). Exploring the meaning of, the barriers to and potential strategies for promoting physical activity among urban Indigenous Australians. *Health Promotion Journal of Australia*, 19(2), 102-108.
- Hunter, B. H. (2010). Pathways for Indigenous school leavers to undertake training or gain employment *Closing the Gap Clearinghouse*: Australian Institute of Health and Welfare and Australian Institute of Family Studies.
- Hurley, M. (2007). Who's on whose margins? In M. Pitts & A. Smith (Eds.), *Researching the margins: Strategies for ethical and rigorous research with marginalised communities* (pp. 160-187). New York: Palgrave Macmillan.
- Hyers, L. L., Swim, J. K., & Mallet, R. K. (2006). The personal is political: Using daily diaries to examine everyday prejudice-related experiences. In S. N. Hesse-Biber & P. Leavy (Eds.), *Emergent methods in social research* (pp. 313-335). Thousand Oaks: SAGE Publication.
- Hylton, K. (2005). 'Race', sport and leisure: Lessons from critical race theory. *Leisure Studies*, 24(1), 81-98. doi: 10.1080/02614360412331313494
- Hyndman, B., Libstug, A., Giesbrecht, N., Hershfield, L., & Rootman, I. (1993). The use of social science theory to develop health promotion programs: Illustrated with examples from heart health and low birthweight prevention programs. Ontario: Centre for Health Promotion, University of Toronto.
- Ibrahim, Y. (2012). The politics of watching: Visuality and the new media economy. *International Journal of E-Politics (IJEP)*, 3(1), 1-11. doi: 10.4018/jep.2012010101
- Institute for Urban Indigenous Health (Producer). (2010a, 16 May 2014). Deadly Choices Facebook page. Retrieved from <https://www.facebook.com/deadlychoices>
- Institute for Urban Indigenous Health. (2010b). Deadly Choices: Quick guide. Bowen Hills: Institute for Urban Indigenous Health.
- Institute for Urban Indigenous Health. (2011a). Healthy Lifestyle Team progress report July 1 2010 - July 1 2011. Bowen Hills.
- Institute for Urban Indigenous Health. (2011b). Institute for Urban Indigenous Health: Corporate profile. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2011c). Institute for Urban Indigenous Health: Strategic plan 2011-2014. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2012). Submission report: Inquiry into the contribution of sport to Indigenous wellbeing and mentoring. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2013a). DRAFT: IUIH model of care service manual. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2013b). *Facilitating implementation in Indigenous health care*, Brisbane: IUIH.
- Institute for Urban Indigenous Health. (2013c). Healthy Lifestyle Team annual report July 1 2012 - June 30 2013. Darra: IUIH.
- Institute for Urban Indigenous Health. (2013d). Institute for Urban Indigenous Health annual report 2012/2013. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2013e). Student orientation package. Bowen Hills: IUIH.

- Institute for Urban Indigenous Health. (2014a). Deadly Choices campaign. Retrieved 16 September, 2014, from http://www.iuih.org.au/Services/Preventative_Health-deadlychoicesbrnoscampaign
- Institute for Urban Indigenous Health. (2014b). Health access outcomes. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2014c). Healthy Lifestyle Team annual report: Prepared August 2014 for the reporting period July 1 2013 - 30 June 2014. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2014d). Institute for Urban Indigenous Health annual report 2013/2014. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2014e). IUIH corporate structure. Retrieved 22 April, 2014, from http://iuih.org.au/About/Corporate_Structure
- Institute for Urban Indigenous Health. (2014f). IUIH Deadly Choices education program procedures - Draft. Bowen Hills: IUIH.
- Institute for Urban Indigenous Health. (2014g). Media. Retrieved 22 April, 2014, from <http://www.iuih.org.au/resources/>
- Institute for Urban Indigenous Health. (2014h). Preventative health. Retrieved 17 September, 2014, from http://www.iuih.org.au/Services/Preventative_Health
- Institute for Urban Indigenous Health. (2015). Moreton Aboriginal and Torres Strait Islander Community Health Service brochure. Bowen Hills: IUIH.
- Ivanitz, M. (1999). Achieving improved health outcomes for urban Aboriginal people: Biomedical and ethnomedical models of health. Brisbane: Aboriginal Politics and Public Sector Management, Centre for Australian Public Sector Management.
- Ivers, R., Castro, A., Parfitt, D., Bailie, R., Richmond, R., & D'Abbs, P. (2005). Television and delivery of health promotion programs to remote Aboriginal communities. *Health Promotion Journal of Australia*, 16(2), 155-158.
- Jackson-Pulver, L. R., & Fitzpatrick, S. A. (2004). Sitting 'round the table of rights-based reconciliation: A health perspective. *Health Promotion Journal of Australia*, 15(3), 193-199.
- Jamal, S. (2005). Critical ethnography: An effective way to conduct anti-racism research. In G. J. Sefa Dei & G. S. Johal (Eds.), *Critical issues in anti-racist research methodologies* (pp. 225-239). New York: Peter Lang.
- Janz, N. K., & Becker, M. H. (1984). The health belief model: A decade later. *Health Education and Behavior*, 11(1), 1-47. doi: 10.1177/109019818401100101
- Jayasinghe, S. (2011). Conceptualising population health: From mechanistic thinking to complexity science. *Emerging Themes in Epidemiology*, 8(2), Open Access.
- Jochelson, K. (2006). Nanny or steward? The role of government in public health. *Public Health*, 120(12), 1149-1155. doi: 10.1016/j.puhe.2006.10.009
- Johnson, J., & Bytheway, B. (2001). An evaluation of the use of diaries in a study of medication in later life. *International Journal of Social Research Methodology*, 4(3), 183-204. doi: 10.1080/13645570010029467
- Johnson, J. C., Avenarius, C., & Weatherford, J. (2006). The active participant-observer: Applying social role analysis to participant observation. *Field Methods*, 18(2), 111-134. doi: 10.1177/1525822x05285928
- Johnston, V., & Thomas, D. P. (2010). What works in Indigenous tobacco control? The perceptions of remote Indigenous community members and health staff. *Health Promotion Journal of Australia*, 21(1), 45-50.
- Johnston, V., Thomas, D. P., McDonnell, J., & Andrews, R. M. (2011). Maternal smoking and smoking in the household during pregnancy and postpartum:

- Findings from an Indigenous cohort in the Northern Territory. *Medical Journal of Australia*, 194(10), 556-559.
- Johnston, V., Westphal, D., Earnshzaw, C., & Thomas, D. (2012). Starting to smoke: A qualitative study of the experiences of Australian Indigenous youth. *BMC Public Health*, 12(1), 963.
- Joint Select Committee on Cyber-Safety. (2013). Inquiry into issues surrounding cyber-safety for Indigenous Australians. Canberra: Parliament of Australia.
- Jolley, G., Freeman, T., Baum, F., Hurley, C., Lawless, A., Bentley, M., . . . Sanders, D. (2014). Health policy in South Australia 2003–10: Primary health care workforce perceptions of the impact of policy change on health promotion. *Health Promotion Journal of Australia*, 25(2), 116-124.
- Jones, J., Buzzacott, T., Briscoe, G., Murray, R., & Murray, R. (2008). Beyond Sandy Blight: Five Aboriginal experiences as staff on the National Trachoma and Eye Health Program. Canberra: Australian Institute of Aboriginal and Torres Strait Islander Studies.
- Jones, J., Smith, L., & Briscoe, G. (2006). They used to call it Sandy Blight: Aboriginal health and censorship in Australia. *Aboriginal Australian Studies*, 2, 62-67.
- Jones, S., Hadgraft, R., Harvey, M., Lefoe, G., & Ryland, K. (2014). Evidence-based benchmarking framework for a distributed leadership approach to capacity building in learning and teaching. Sydney: Office for Learning and Teaching, Department of Education.
- Jordan, D. E. (1986). Aboriginal identity: The management of a minority group by the mainstream society. *The Canadian Journal of Native Studies*, 9(2), 271-311.
- Juhila, K. (2009). From care to fellowship and back: Interpretative repertoires used by the social welfare workers when describing their relationship with homeless women. *British Journal of Social Work*, 39(1), 128-143. doi: 10.1093/bjsw/bcm092
- Juneau, C.-E., Jones, C. M., McQueen, D. V., & Potvin, L. (2011). Evidence-based health promotion: An emerging field. *Global Health Promotion*, 18(1), 79-89.
- Katz, A. (2002). AIDS, individual behaviour and the unexplained remaining variation. *African Journal of AIDS Research*, 1(2), 125-142. doi: 10.2989/16085906.2002.9626552
- Kelly, M. P., & Charlton, B. (1995). The modern and the postmodern in health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 78-90). London: Routledge.
- Kendall, G. E., & Wickham, G. (1999a). Can I apply this stuff to Shakespeare and shopping? In G. E. Kendall & G. Wickham (Eds.), *Using Foucault's methods*. London, UK: SAGE Publications Ltd.
- Kendall, G. E., & Wickham, G. (1999b). Is Foucault a party animal? In G. E. Kendall & G. Wickham (Eds.), *Using Foucault's methods*. London, UK: SAGE Publications Ltd.
- Kickbusch, I. (1987). Issues in health promotion: Dr Ilona Kickbusch. *Health Promotion International*, 1(4), 437-442. doi: 10.1093/heapro/1.4.437
- Kickbusch, I. (1994). Foreword. In A. Wass (Ed.), *Promoting health: The primary health care approach* (2nd ed., pp. vii). Sydney: Harcourt Saunders.
- Kickbusch, I. (2007). The move towards a new public health. *Promotion and Education*, 14(2 supplement), 9. doi: 10.1177/10253823070140020301x

- Kickbusch, I., & Payne, L. (2003). Twenty-first century health promotion: The public health revolution meets the wellness revolution. *Health Promotion International*, 18(4), 275-278. doi: 10.1093/heapro/dag418
- Kincheloe, J. L., & McLaren, P. (2005). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 303-342). Thousand Oaks: Sage Publications.
- King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet*, 374, 76-85.
- Kiran, A., & Knights, J. (2010). Traditional Indigenous games promoting physical activity and cultural connectedness in primary schools - Cluster randomised control trial. *Health Promotion Journal of Australia*, 21(2), 149-151.
- Kogoy, P. (2009). Group sex 'ingrained' in rugby league culture, *The Australian*. Retrieved from <http://www.theaustralian.com.au/news/nation/group-sex-ingrained-in-rugby-league/story-e6frg6nf-1225710738164>
- Kolko, B., Nakamura, L., & Rodman, G. (2013). *Race in cyberspace*. Retrieved from <http://QUT.ebib.com.au/patron/FullRecord.aspx?p=1144395>
- Kowal, E. (2011). The stigma of white privilege: Australian anti-racists and Indigenous improvement. *Cultural studies*, 25(3), 313-333.
- Kowal, E., & Paradies, Y. (2005). Ambivalent helpers and unhealthy choices: Public health practitioners' narratives of Indigenous ill-health. *Social Science & Medicine*, 60(6), 1347-1357. doi: 10.1016/j.socscimed.2004.07.009
- Krech, R. (2011). Social determinants of health: Practical solutions to deal with a well-recognized issue, Editorial, *Bulletin of the World Health Organization*, pp. 703-703. Retrieved from <http://gateway.library.qut.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=afh&AN=67030734&site=ehost-live>
- Kreuter, M. W., Lukwago, S. N., Bucholtz, D. C., Clark, E. M., & Sanders-Thompson, V. (2003). Achieving cultural appropriateness in health promotion programs: Targeted and tailored approaches. *Health Education & Behavior*, 30(2), 133-146. doi: 10.1177/1090198102251021
- Krieger, N. (2000). Epidemiology, racism and health: The case of low birth weight. *Epidemiology*, 11(3), 237-.
- Krieger, N., Williams, D., & Zierler, S. (1999). "Whiting out" white privilege will not advance the study of how racism harms health. *American Journal of Public Health*, 89(5), 782.
- Krueger, R. A., & Casey, M. A. (2009). *Focus groups: A practical guide for applied research* (4th ed.). California: SAGE Publications.
- Kunoth-Monks, R. (2014). *"I am not the problem" - Response to audience member question on Q&A*. SBS. Sydney. Retrieved from <https://www.youtube.com/watch?v=vCYhO6yRWgU>
- Labonte, R. (1993). *Health promotion and empowerment: Practice frameworks*. Ontario: Centre for Health Promotion, University of Toronto and ParticipACTION.
- Labonte, R. (1994). Health promotion and empowerment: Reflections on professional practice. *Health Education Quarterly*, 21(2), 253-268.
- Labonte, R. (1997). The population health/health promotion debate in Canada: The politics of explanation, economics and action. *Critical Public Health*, 7(1-2), 7-27. doi: 10.1080/09581599708409075
- Labonte, R. (2005a). The future of health promotion. *Health Promotion Journal of Australia*, 16(3), 172-176.

- Labonte, R. (2005b). Towards a critical population health research. *Critical Public Health*, 15(1), 1-3
- Labonte, R., & Laverack, G. (2001). Capacity building in health promotion, Part 2: Whose use? And with what measurement? *Critical Public Health*, 11(2), 129-138. doi: 10.1080/09581590110039847
- Labonte, R., Sanders, D., Baum, F., Schaay, N., Packer, C., Laplante, D., . . . Pooyak, S. (2008). Implementation, effectiveness and political context of comprehensive primary health care: Preliminary findings of a global literature review. *Australian Journal of Primary Health*, 14(3), 58-67.
- Ladson-Billings, G. (1998). Just what is critical race theory and what's it doing in a nice field like education? *Qualitative Studies in Education*, 11(1), 7-24.
- Lalonde, M. (1974). A new perspective on the health of Canadians : A working document.
- Lampert, J. (2003). The alabaster academy: Being a non-Indigenous academic in Indigenous Studies. *Social Alternatives*, 22(3), 23-26.
- Lapegna, P. (2009). Ethnographers of the world... United? Current debates on the ethnographic study of "globalization". *Journal of World-Systems Research*, XV(1), 3-24.
- Larson, A., Gillies, M., Howard, P. J., & Coffin, J. (2007). It's enough to make you sick: The impact of racism on the health of Aboriginal Australians. *Australian and New Zealand Journal of Public Health*, 31(4), 322-329.
- Lau, A., Gabarron, E., Fernandez-Luque, L., & Armayones, M. (2012). Social media in health - What are the safety concerns for health consumers? *Health Information Management Journal*, 41(2), 30-35.
- Laverack, G. (2006). Improving health outcomes through community empowerment: A review of the literature. *Journal of Health and Population Nutrition*, 24(1), 113-120.
- Laverack, G. (2007). *Health promotion practice: Building empowered communities*. New York: McGraw-Hill Education, Open University Press.
- Laverack, G., & Labonte, R. (2000). A planning framework for community empowerment goals within health promotion. *Health Policy And Planning*, 15(3), 255-262. doi: 10.1093/heapol/15.3.255
- Lea, T. (2008). *Bureaucrats and bleeding hearts: Indigenous health in Northern Australia*. Sydney: University of New South Wales Press.
- Lederman, R. (2005). Challenging audiences: Critical ethnography in/for Oceania. *Anthropological forum*, 15(3), 319-328. doi: 10.1080/00664670500281396
- Lee, K., Jagtenberg, M., Ellis, C., & Conigrave, K. (2013). Pressing need for more evidence to guide efforts to address substance use among young Indigenous Australians. *Health Promotion Journal of Australia*, 24(2), 87-97.
- Legge, D. (2003). The evaluation of health development: The next methodological frontier. *Australian and New Zealand Journal of Public Health*, 23(2), 117-118.
- Lenette, C., Cox, L., & Brough, M. (2013). Digital storytelling as a social work tool: Learning from ethnographic research with women from refugee backgrounds. *British Journal of Social Work*. doi: 10.1093/bjsw/bct184
- Liamputtong, P. (2009). *Qualitative research methods* (3rd ed.). Sydney: Oxford University Press.
- Liberman, J. (2013). Plainly constitutional: The upholding of plain tobacco packaging by the High Court of Australia. *American Journal of Law and Medicine*, 39(2/3), 361-381.

- Liddle, C. (2014). It's the "Recognise" thing that REALLY gets me. from <http://blackfeministranter.blogspot.com.au/2014/08/its-recognise-thing-that-really-gets-me.html>
- Lindström, B., & Eriksson, M. (2006). Contextualizing salutogenesis and Antonovsky in public health development. *Health Promotion International*, 21(3), 238-244. doi: 10.1093/heapro/dal016
- Linton, J., & Farrell, M. J. (2009). Nurses' perceptions of leadership in an adult intensive care unit: A phenomenology study. *Intensive and Critical Care Nursing*, 25(2), 64-71. doi: 10.1016/j.iccn.2008.11.003
- Llewellyn-Jones, L. (2001). Sharing power: Principles for community participation in health promotion. *Australian Journal of Primary Health*, 7(1), 97-100.
- Loomba, A., Kaul, S., Bunzl, M., Burton, A., & Esty, J. (2005). Beyond what? An introduction. In A. Loomba, S. Kaul, M. Bunzl, A. Burton & J. Esty (Eds.), *Postcolonial studies and beyond* (pp. 62-79). Durham and London: Duke University Press.
- Loos, N. (1982). *Invasion and resistance: Aboriginal-European relations on the North Queensland frontier, 1861-1897*. Canberra: Australian National University Press.
- Lumby, B. (2010). Cyber-indigeneity: Urban Indigenous identity on Facebook. *Australian Journal of Indigenous Education*, The, 39(Supplementary), 68-75.
- Lundy, T. (2010). A paradigm to guide health promotion into the 21 st century: The integral idea whose time has come. *Global Health Promotion*, 17(3), 44-53. doi: 10.1177/1757975910375169
- Lupton, D. (1995). *The imperative of health: Public health and the regulated body*. Thousand Oaks: Sage Publications.
- Lupton, D. (2012). M-health and health promotion: The digital cyborg and surveillance society. *Social Theory & Health*, 10, 229-244. doi: 10.1057/sth.2012.6
- Lupton, D. (2013a). Introducing digital sociology. Sydney: University of Sydney.
- Lupton, D. (2013b). Revolting bodies: The pedagogy of disgust in public health campaigns. Sydney.
- Lupton, D. (2014a). Health promotion in the digital era: A critical commentary. *Health Promotion International*. doi: 10.1093/heapro/dau091
- Lupton, D. (2014b). The pedagogy of disgust: The ethical, moral and political implications of using disgust in public health campaigns. *Critical Public Health*, 1-14. doi: 10.1080/09581596.2014.885115
- Lynch, J. W., Kaplan, G. A., & Salonen, J. T. (1997). Why do poor people behave poorly? Variation in adult health behaviours and psychosocial characteristics by stages of the socioeconomic lifecourse. *Social Science and Medicine*, 44(6), 809-819.
- Lyneham, M., & Chan, A. (2013). Deaths in custody in Australia to 30 June 2011: Twenty years of monitoring by the National Deaths in Custody Program since the Royal Commission into Aboriginal Deaths in Custody *AIC Reports. Monitoring Reports 20*. Canberra: Australian Institute of Criminology.
- Macdonald, D., Pang, B., Knez, K., Nelson, A., & McCuaig, L. (2012). The will for inclusion: Bothering the inclusion/exclusion discourses of sport. In S. Dagkas & K. Armour (Eds.), *Inclusion and exclusion through sport* (pp. 9-23). New York: Routledge.
- Macdonald, D., Wright, J., & Abbott, R. (2010). Anxieties and aspirations: The making of active, informed citizens. In J. Wright & J. D. Macdonald (Eds.), *Young*

- people, physical activity and the everyday* (pp. 121-135). London and New York: Routledge.
- Macdonald, H. (2012). [Indigenous participation - Ottawa Charter Conference 1986].
- MacLaren, D. (2006). *Culturally appropriate health care in Kwaio, Solomon Islands: An action research approach*. (Doctor of philosophy), Griffith University, Brisbane.
- Madden, R. (2010). *Being ethnographic: A guide to theory and practice of ethnography*. London: SAGE Publications Ltd.
- Maddison, S. (2008). Indigenous autonomy matters: What's wrong with the Australian government's 'intervention' in Aboriginal communities. *Australian Journal of Human Rights*, 14(1), 41-61.
- Maddison, S. (2009). *Black politics: Inside the complexity of Aboriginal political culture*: Allen & Unwin.
- Maddison, S. (2011). *Beyond white guilt : The real challenge for black-white relations in Australia*. Crows Nest, N.S.W.: Allen & Unwin.
- Madison, S. (2005). Critical ethnography as street performance: Reflections of home, race, murder, and justice. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 537-546). London: SAGE Publications.
- Madison, S. (2011). *Critical ethnography: Method, ethics, and performance*. Los Angeles: SAGE.
- Madsen, W., & Bell, T. (2012). Using health promotion competencies for curriculum development in higher education. *Global Health Promotion*, 19(1), 43-49. doi: 10.1177/1757975911428818
- Mahler, H. (1981). The meaning of 'health for all by the year 2000'. *World Health Forum*, 2(1), 5-22.
- Malseed, C. (2014). Evaluation of a health education initiative for urban Aboriginal and Torres Strait Islander people. Bowen Hills: Institute for Urban Indigenous Health, University of Queensland, and The Lowitja Institute.
- Malseed, C., & Nelson, A. (2014). DRAFT: The impact of Deadly Choices™ health promotion community events on the health of urban Aboriginal and Torres Strait Islander people: Evaluation of Deadly Choices community events.
- Malseed, C., Nelson, A., & Ware, R. (2014a). Evaluation of a school-based health education program for urban Indigenous young people in Australia. *Health*, 6, 587-597.
- Malseed, C., Nelson, A., Ware, R., Lacey, I., & Lander, K. (2014b). Deadly Choices™ community health events: A health promotion initiative for urban Aboriginal and Torres Strait Islander people. *Australian Journal of Primary Health, In production*.
- Malseed, C., Nelson, A., Ware, R., Lacey, I., & Lander, K. (2014c). *Poster: Evaluation of the Deadly Choices school based health education program for urban Indigenous young people* Paper presented at the Equity @ the Centre: Action on social determinants of health, Alice Springs Convention Centre. Poster retrieved from
- Marck, K., Glover, M., Kira, A., McCool, J., Scragg, R., Bullen, C., & Nosa, V. (2014). Protecting children from taking up smoking: Parents' views on what would help. *Health Promotion Journal of Australia*, 25(1), 59-64.
- Mark, A., McLeod, I., Booker, J., & Ardler, C. (2005). Aboriginal Health Worker smoking: A barrier to lower community smoking rates? *Aboriginal and Islander Health Worker Journal*, 29(5), 22-26.

- Markham, F., Bath, J., Taylor, J., & Doran, B. (2013). New directions in Indigenous service population estimation. Canberra: Centre for Aboriginal Economic Policy Research.
- Marmot, M. (2011). Social determinants and the health of Indigenous Australians. [Provenance: Commissioned; not externally peer reviewed.]. *Medical Journal of Australia*, 194(10), 512-513.
- Martin, K. (2003). Ways of knowing, being and doing: A theoretical framework and methods for Indigenous re-search and Indigenist research. *Journal of Australian Studies*, 27(76), 203-214.
- Martin, K. (2008). *Please knock before you enter - Aboriginal regulation of Outsiders and the implications for researchers*. Teneriffe: Post Pressed.
- Massachusetts Society. (1974). Barefoot doctors. *New England Journal of Medicine*, 291(20), 1090-1091. doi: doi:10.1056/NEJM197411142912020
- Max, K. (2005). Anti-colonial research: Working as an ally with Aboriginal peoples. In G. J. Sefa Dei & G. S. Johal (Eds.), *Critical issues in anti-racist research methodologies* (pp. 79-94). New York: Peter Lang.
- May, T., & Perry, B. (2011). *Social research and reflexivity: Content, consequence and context*. London: SAGE Publications Ltd.
- McCallum, K. (2012). Framing Indigenous health, 1988-1995. In K. McCallum, M. Meadows, L. Waller, M. D. Breen & H. Reid (Eds.), *The media and Indigenous policy: How news media reporting and mediatized practice impact on Indigenous policy* (pp. 37-42). Canberra: University of Canberra.
- McCalman, J., Tsey, K., Bainbridge, R., Rowley, K., Percival, N., O'Donoghue, L., . . . Judd, J. (2014). The characteristics, implementation and effects of Aboriginal and Torres Strait Islander health promotion tools: A systematic literature search. *BMC Public Health*, 14. doi: 10.1186/1471-2458-14-712
- McCarthy, A., & Martin-McDonald, K. (2007). 'A politics of what': The enactment of peritoneal dialysis in Indigenous Australians. *Sociology of Health & Illness*, 29(1), 82-99. doi: 10.1111/j.1467-9566.2007.00520.x
- McDonald, E., Bailie, R., Grace, J., & Brewster, D. (2010). An ecological approach to health promotion in remote Australian Aboriginal communities. *Health Promotion International*, 25(1), 42-53.
- McEwan, A., Crouch, A., Robertson, H., & Fagan, P. (2013). The Torres Indigenous Hip Hop Project: Evaluating the use of performing arts as a medium for sexual health promotion. *Health Promotion Journal of Australia*, 24(2), 132-136.
- McGloin, C. (2009). Considering the work of Martin Nakata's "cultural interface": A reflection on theory and practice by a non-Indigenous academic. *The Australian Journal of Indigenous Education*, 38(Supplement), 36-41.
- McGregor, R. (1997). *Imagined destinies: Aboriginal Australians and the doomed race theory, 1880-1939*. Carlton South: Melbourne University Press.
- McIntosh, P. (1990). White privilege: Unpacking the invisible knapsack. *Independent School*, 49(2), 5, 31.
- McKenna, M. (2013, 26 May). Health overhaul closes the gap, *The Australian*.
- McLennan, V., & Khavarpour, F. (2004). Culturally appropriate health promotion: Its meaning and application in Aboriginal communities. *Health Promotion Journal of Australia*, 15(3), 237-239.
- McNair Ingenuity Research. (2014). Survey amongst Aboriginal and Torres Strait Islanders in Australia. Crows Nest: McNair Ingenuity Research.

- McPhail-Bell, K. (2012). Confirmation document - Practitioner experiences in an urban Indigenous context: Exploring tensions of health promotion practice. Brisbane: Queensland University of Technology.
- McPhail-Bell, K. (2014a). *Deadly Choices or deadly choices? An ethnography of health promotion practice with Indigenous Australians*. Paper presented at the IUIH/Lowitja Symposium - Innovations in urban Aboriginal and Torres Strait Islander health: Closing the gap, University of Queensland, St Lucia. <http://eprints.qut.edu.au/72990/>
- McPhail-Bell, K. (2014b). Deadly Choices: Better ways of doing health promotion. Retrieved from <http://blogs.crikey.com.au/croakey/2014/09/14/deadly-choices-better-ways-of-doing-health-promotion/>
- McPhail-Bell, K. (2014c). *We have a lot to learn yet: A postcolonial lens in health promotion*. Paper presented at the AIATSIS National Indigenous Studies Conference - Breaking Barriers in Indigenous Research and Thinking: 50 Years On, National Convention Centre, Canberra. <http://eprints.qut.edu.au/69595/>
- McPhail-Bell, K., & Appo, N. (2015). *Deadly Choices social media: Empowering our people to create change*. Paper presented at the Conference: Population Health Congress – One vision, many voices, Hobart, Australia. https://www.researchgate.net/publication/281749433_Deadly_Choices_social_media_Empowering_our_people_to_create_change
- McPhail-Bell, K., Bond, C., Brough, M., & Fredericks, B. (2015). “We don’t tell people what to do”: Ethical practice and Indigenous health promotion. *Health Promotion Journal of Australia*, 26(3), 195-199. doi: 10.1071/HE15048
- McPhail-Bell, K., Bond, C., & Redman-MacLaren, M. (2013a). Skins for smokes and the use of cultural content and imagery. *Queensland Health Promotion Quarterly*, 8.
- McPhail-Bell, K., Fredericks, B., & Brough, M. (2013b). Beyond the accolades: A postcolonial critique of the foundations of the Ottawa Charter. *Global Health Promotion*, 20(2), 22-29. doi: 10.1177/1757975913490427
- McQueen, D. (1989). Thoughts on the ideological origins of health promotion. *Health Promotion International*, 4(4), 339-342. doi: 10.1093/heapro/4.4.339
- McQueen, D. (2000). Perspectives on health promotion: Theory, evidence, practice and the emergence of complexity. *Health Promotion International*, 15(2), 95-97. doi: 10.1093/heapro/15.2.95
- McQueen, D. (2001). Strengthening the evidence base for health promotion. *Health Promotion International*, 16(3), 261-268.
- McQueen, D. (2007). Evidence and theory: Continuing debates on evidence and effectiveness. In D. V. McQueen & C. M. Jones (Eds.), *Global perspectives on health promotion effectiveness* (pp. 281-303): Springer New York.
- McQueen, D., & Kickbusch, I. (2007). Introduction - Health promotion: The origins of the third public health revolution leading to a new public health. In D. McQueen & I. Kickbush (Eds.), *Health and modernity: The role of theory in health promotion* (pp. 1-5). New York: Springer.
- Mendes, R., Plaza, V., & Wallerstein, N. (2014). Sustainability and power in health promotion: community-based participatory research in a reproductive health policy case study in New Mexico. *Global Health Promotion*, 0(0), 1-14.
- Mikhailovich, K., Morrison, P., & Arabena, K. (2007). Evaluating Australian Indigenous community health promotion initiatives: A selective review. *Rural and remote health*, 7, 746 (Online).

- Miller, D., & Slater, D. (2000). *The Internet: An ethnographic approach*. New York: Berg Publishers.
- Minniecon, D., Franks, N., & Heffernan, M. (2007). Indigenous research: Three researchers reflect on their experiences at the interface. *The Australian Journal of Indigenous Education*, 36(Supplementary), 23-31.
- Mitchell, E., Steeves, R., & Hauck Perez, K. (2014). Exploring Creole women's health using ethnography and Photovoice in Bluefields, Nicaragua. *Global Health Promotion*. doi: 10.1177/1757975914547545
- Mitchell, J. (2007). History. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health* (pp. 41-64). Crows Nest: Menzies School of Health Research.
- Mittelmark, M. B., & Bull, T. (2013). The salutogenic model of health in health promotion research. *Global Health Promotion*, 20(2), 30-38. doi: 10.1177/1757975913486684
- Moffitt, P., & Vollman, A. R. (2004). Photovoice: Picturing the health of Aboriginal women in a remote northern community. *Canadian Journal of Nursing Research*, 36(4), 189-201.
- Monk, J. M., Rowley, K. G., & Anderson, I. P. (2009). Setting and meeting priorities in Indigenous health research in Australia and its application in the Cooperative Research Centre for Aboriginal Health. *Health Research Policy and Systems*, 7(25).
- Monrouxe, L. V. (2009). Solicited audio diaries in longitudinal narrative research: a view from inside. *Qualitative Research*, 9(1), 81-103. doi: 10.1177/1468794108098032
- Mooney, G., & Ataguba, J. E. (2009). The global financial meltdown and the need for a political economy of health promotion. *Health Promotion Journal of Australia*, 10(1), 3-4.
- Mooney-Somers, J., Erick, W., Scott, R., Akee, A., Kaldor, J., & Maher, L. (2009). Enhancing Aboriginal and Torres Strait Islander young people's resilience to blood-borne and sexually transmitted infections: Findings from a community-based participatory research project *Health Promotion Journal of Australia*, 20(3), 195-201.
- Moreno, M. A., Fost, N. C., & Christakis, D. A. (2013a). Special article: Research ethics in the MySpace era. *Pediatrics*, 121-157. doi: 10.1542/peds.2007-3015
- Moreno, M. A., Grant, A., Kacvinsky, L., Moreno, P., & Fleming, M. (2013b). Older adolescents' views regarding participation in Facebook research. *Journal of Adolescent Health*, 51(5), 439-444.
- Moreton-Robinson, A. (2000). *Talkin' up the white woman: Indigenous women and white feminism*. St Lucia: University of Queensland Press.
- Moreton-Robinson, A. (2003a). I still call Australia home: Indigenous belonging and place in a white postcolonising society. In S. Ahmed (Ed.), *Uprootings/regroundings: Questions of home and migration* (pp. 23-40): Berg Publishing.
- Moreton-Robinson, A. (2003b). Researching whiteness: Some reflections from an Indigenous Woman's standpoint. *Hecate*, 29(2), 72-85.
- Moreton-Robinson, A. (2006). Whiteness matters. *Australian Feminist Studies*, 21(50), 245-256.
- Moreton-Robinson, A. (2007). Epistemic violence: The hidden injuries of whiteness in Australian post-colonising borderlands. In S. Petrilli (Ed.), *White matters: Il bianco in questione* (pp. 299-312). Rome: Meltemi editore.

- Moreton-Robinson, A. (2011). The white man's burden. *Australian Feminist Studies*, 26(70), 413-431. doi: 10.1080/08164649.2011.621175
- Moreton-Robinson, A. (2013). Towards an Australian Indigenous women's standpoint theory. *Australian Feminist Studies*, 28(78), 331-347. doi: 10.1080/08164649.2013.876664
- Moreton-Robinson, A., & Walter, M. (2010). Indigenous methodologies in social research. In M. Walter (Ed.), *Social research methods*. Melbourne: Oxford University Press.
- Morton, S., & Procter, J. (2009). Colonial discourse, postcolonial theory. In The English Association (Ed.), *The Year's Work in Critical and Cultural Theory* (Vol. 17, pp. 164-181).
- Mostert, C. (2010). Reconciliation and the church. *Pacifica (Brunswick East, Vic)*, 23(2), 192-211.
- Mundel, E., & Chapman, G. E. (2010). A decolonizing approach to health promotion in Canada: The case of the Urban Aboriginal Community Kitchen Garden Project. *Health Promotion International*, 25(2), 166-173. doi: 10.1093/heapro/daq016
- Mungabareena Aboriginal Corporation & Women's Health Goulburn North East. (2008). Using a health promotion framework with an 'Aboriginal lens': Making Two Worlds Work - Building the capacity of the health and community sector to work effectively and respectfully with our Aboriginal community. Wodonga and Wangaratta: MAC & WHGNE.
- Murphy, L., Kordyl, P., & Thorne, M. (2004). Appreciative inquiry: A method for measuring the impact of a project on the well-being of an Indigenous community. *Health Promotion Journal of Australia*, 13(3), 211-214.
- Murray, M., Bonnell, E., Thorpe, S., Browne, J., Barbour, L., MacDonald, C., & Palermo, C. (2014). Sharing the tracks to good tucker: Identifying the benefits and challenges of implementing community food programs for Aboriginal communities in Victoria. *Australian Journal of Primary Health*, 20, 373-378.
- Murri Rugby League. (2014). Press release: QAIHC Arthur Beetson Murri Rugby League Carnival 2014. Retrieved 13 May, 2015, from <http://www.murrirugbyleague.com>
- Nadin, S., & Cassell, C. (2006). The use of a research diary as a tool for reflexive practice: Some reflections from management research. *Qualitative Research in Accounting & Management*, 3(3), 208-217.
- Nakata, M. (2002). Indigenous knowledge and the cultural interface: Underlying issues at the intersection of knowledge and information systems. *IFLA Journal*, 28(5-6), 281-291. doi: 10.1177/034003520202800513
- Nakata, M. (2004). Ongoing conversations about Aboriginal and Torres Strait Islander research agendas and directions *The Australian Journal of Indigenous Education*, 33, 1-6.
- Nakata, M. (2006). Australian Indigenous studies: A question of discipline. *The Australian Journal of Anthropology*, 17(3), 265-275.
- Nakata, M. (2007a). The cultural interface. *The Australian Journal of Indigenous Education*, 36(Supplement), 7-14.
- Nakata, M. (2007b). *Disciplining the savages: Savaging the disciplines*. Canberra: Aboriginal Studies Press.
- Nakata, M. (2007c). An Indigenous standpoint theory. In M. Nakata (Ed.), *Disciplining the savages: Savaging the disciplines* (pp. 213-217). Canberra: Aboriginal Studies Press.
- Nakata, M. (2013). Foreword. *Australian Aboriginal Studies*, 2, 2-7.

- Nakata, M., Day, A., Howells, K., Wanganeen, R., McCausland, R., Santolo, J. D., . . . Havini, T. (2008). Beneath the surface of anger: Understanding the context of Indigenous men's anger. In A. Day, M. Nakata & K. Howells (Eds.), *Anger and Indigenous men* (pp. 103-131). Leichardt: The Federation Press.
- Nakata, M., Nakata, V., Keech, S., & Bolt, R. (2012). Decolonial goals and pedagogies for Indigenous studies. *Decolonization, 1*(1).
- Nakhla, A., Middleton, M., McDonald, A., Guy, R., & Ward, J. (2014). Bloodborne viral and sexually transmitted infections in Aboriginal and Torres Strait Islander people: Surveillance and Evaluation Report 2012. Sydney.
- Name withheld for confidentiality purposes. (2013a). Aidan's deadly choice is learning. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013b). Deadly Choices now = Deadly Buraay's for the Future (-0-) ~ (-0-) ~ (-0-) Could not just choose one as so many of our choices now will affect our kids in the future. We walk, Swim, Bike ride, jump on the Trampoline to even playing tennis with the cat. PLUS ALOT MORE. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013c). Loving my new jersey :-))) perfect for MTB!! Riding my bike, eating well is how I keep healthy :-)). Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013d). My deadly choice is spending time with my family listening, watching and learning. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013e). My kids and all of my nieces, nephews great nieces and nephews. This is a few but I would go Insane if they were not in my life. They all make me laugh each and everyday. LAUGHING IS THE BEST MEDICINE. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013f). My Wiradjuri Princess's doing Her Hip Hop Dancing and more. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2013g). This is my 17 yr old son Karl who is doing his 2nd year apprenticeship to be a chef and he aspires to own/run his own restaurant in the future. We are so proud very proud of him x. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2014a). ballet, acrobatics, tap and swimming. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2014b). getting a dog to get fit and healthy with my daughter. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2014c). My deadly choice was moving away from bundaberg so I could be in my daughters life!! Being a single dad is hard but here I am 8 years later still going strong!! Love her with every beat xo. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2014d). My Deadly Choices is choosing healthier food options. Making these choices along with regular exercise will help our community maintain happier, healthier and longer lives! Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Name withheld for confidentiality purposes. (2014e). Outrigger canoe racing is a deadly way to get fit and healthy. This sine with my team winning gold in a marathon

- race. We also won 2 gold medals at the national titles. We are all 10 and 11 year olds. Deadly Choices Facebook page: Institute for Urban Indigenous Health.
- Nash, F. (2014a). *Another step towards Indigenous health equality*. Young, NSW: The Nationals Retrieved from <http://www.fionanash.com.au/Media/MediaReleases/tabid/84/articleType/ArticleView/articleId/1249/categoryId/7/Another-Step-Towards-Indigenous-Health-Equality.aspx>.
- Nash, F. (2014b). *National Indigenous Health Plan to focus on outcomes*. Young, NSW: The Nationals Retrieved from <http://www.fionanash.com.au/Media/MediaReleases/tabid/84/articleType/ArticleView/articleId/1241/categoryId/7/National-Indigenous-Health-Plan-to-Focus-on-Outcomes.aspx>.
- National Aboriginal Community Controlled Organisation. (1993). *Policy statement: Manifesto on Aboriginal well-being 1993*. National Aboriginal Community Controlled Health Organisation. Canberra. Retrieved from [http://www.naccho.org.au/Files/Documents/Policy Statement Manifesto on Aboriginal Well-being 1993.pdf](http://www.naccho.org.au/Files/Documents/Policy%20Statement%20Manifesto%20on%20Aboriginal%20Well-being%201993.pdf)
- National Aboriginal Community Controlled Organisation. (2013a). Acting PM supports the 2013 NACCHO “deadly choices” NRL national challenge. Canberra: NACCHO.
- National Aboriginal Community Controlled Organisation. (2013b). NACCHO healthy futures 10 point plan 2013-2030: Aboriginal health in Aboriginal hands. Canberra: NACCHO.
- National Aboriginal Community Controlled Organisation. (2014a). Joint Statement: Groups call for Government to reject Forrest Review Healthy Welfare Card; pursue decent welfare reform. Canberra: NACCHO.
- National Aboriginal Community Controlled Organisation. (2014b). NACCHO History. Retrieved 10 December, 2014, from <http://www.naccho.org.au/about-us/naccho-history/> - naiho
- National Aboriginal Community Controlled Organisation. (2014c). NACCHO media release: Current policies will not overcome Indigenous disadvantage. Canberra: NACCHO.
- National Aboriginal Community Controlled Organisation. (2014d). NACCHO submission: Senate Select Committee on Health. Canberra: NACCHO.
- National Aboriginal Community Controlled Organisation, & Oxfam. (2007). Close the gap: Solutions to the Indigenous health crisis facing Australia. Carlton: NACCHO.
- National Aboriginal Health Strategy Working Party. (1989). National Aboriginal health strategy. Canberra: Commonwealth of Australia.
- National Aboriginal and Islander Health Organisation. (n.d.). The NAIHO experience: Evolving to the NAIHO congress: NAIHO.
- National Health and Medical Research Council. (2003a). *The NHMRC Road Map: A Strategic Framework for Improving Aboriginal and Torres Strait Islander Health Through Research October 2002*. Canberra: Commonwealth of Australia.
- National Health and Medical Research Council. (2003b). *Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research*. Canberra: Australian Government Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/file/health_ethics/human/conduct/guidelines/e52.pdf.

- National Health and Medical Research Council. (2006). *Keeping research on track: A guide for Aboriginal and Torres Strait Islander peoples about health research ethics*. Canberra: Australian Government Retrieved from http://www.nhmrc.gov.au/_files_nhmrc/file/publications/synopses/e65.pdf.
- National Health and Medical Research Council. (2007). *Australian Code for the Responsible Conduct of Research*. Canberra: National Health and Medical Research Council.
- National Preventative Health Taskforce. (2009). Australia: The healthiest country by 2020. Canberra.
- National Rugby League. (2013). Media release: NRL help Close the Gap. Brisbane: NRL.
- Navarro, V. (2008). Neoliberalism and its consequences: The world health situation since Alma Ata. *Global Social Policy*, 8(2), 152-155. doi: 10.1177/14680181080080020203
- Navarro, V. (2009). What we mean by social determinants of health. *International Journal of Health Services*, 39(3), 423-441. doi: 10.2190/HS.39.3.a
- Navarro, V., & Shi, L. (2001). The political context of social inequalities and health. *Social Science and Medicine*, 52, 481-491.
- Neiger, B. L., Thackeray, R., Burton, S. H., Giraud-Carrier, C. G., & Fagen, M. C. (2013). Evaluating social media's capacity to develop engaged audiences in health promotion settings: Use of Twitter metrics as a case study. *Health Promotion Practice*, 14(2), 157-162. doi: 10.1177/1524839912469378
- Nelson, A. (2009). Sport, physical activity and urban Indigenous young people. *Australian Aboriginal Studies*, 2, 101-111.
- Nelson, A. (2010). *"I do stay healthy": The place and meaning of physical activity and health in the lives of urban Indigenous young people*. (Doctor of Philosophy), University of Queensland, Brisbane.
- Nelson, A. (2011). 'You don't have to be black skinned to be black': Indigenous young people's bodily practices. *Sport, Education and Society*, 17(1), 57-75. doi: 10.1080/13573322.2011.607912
- Nelson, A., & Hall, C. (2013). *Building the evidence for service and workforce reform – A case study* Bowen Hills.
- Nettleton, S. (1997). Surveillance, health promotion, and the formation of a risk identity. In M. Sidell, L. Jones, J. Katz & A. Peberdy (Eds.), *Debates and dilemmas in promoting health*. London: Open University Press.
- Nettleton, S., & Bunton, R. (1995). Sociological critiques of health promotion. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 41-58). London & New York: Routledge.
- Newman, L., Baum, F., & Harris, E. (2006). Federal, State and Territory government responses to health inequities and the social determinants of health in Australia. *Health Promotion Journal of Australia*, 17(3), 217-225.
- Nguyen, P., Gold, J., Pedrana, A., Chang, S., Howard, S., Ilic, O., . . . Stooze, M. (2013). Sexual health promotion on social networking sites: A process evaluation of the FaceSpace project. *Journal of Adolescent Health*, 53(1), 98-104. doi: <http://dx.doi.org/10.1016/j.jadohealth.2013.02.007>
- Nicholls, R. (2009). Research and Indigenous participation: Critical reflexive methods. *International Journal of Social Research Methodology*, 12(2), 117-126. doi: 10.1080/13645570902727698

- Nielsen, J. (2008). *An Intractable Problem: The endurance of whiteness in the mainstream workplace*. (Doctor of Philosophy), Southern Cross University, Lismor.
- Northern Territory Emergency Review Board. (2008). Report of the NTER Review Board. Canberra.
- NSWHealth. (2004). Principles for better practice in Aboriginal health promotion: The Sydney consensus statement NSW Health 2002. Sydney: NSW Department of Health.
- Nutbeam, D. (2008). What would the Ottawa Charter look like if it were written today? *Critical Public Health*, 18(4), 435-441.
- Nutbeam, D., & Harris, E. (2004). *Theory in a nutshell: A guide to health promotion theory*. Sydney: McGraw-Hill.
- O'Byrne, D. (1998). The power of partnership in health promotion. *Promotion & Education*, 5(3-4), 7-8. doi: 10.1177/102538239800500304
- O'Donnell, K., & Kelly, J. (2011). Using Ganma knowledge sharing as a decolonising approach to conference planning and facilitation. *ALAR: Action Learning and Action Research Journal*, 17(2), 137-156.
- O'Hara, L. (2014). *The extent to which weight-related public health initiatives reflect the values and principles of health promotion – A critical discourse analysis*. (Doctor of Philosophy), University of Sunshine Coast, Sippy Downs.
- O'Hara, L., Taylor, J., & Barnes, M. (2015). We are all ballooning: Multimedia critical discourse analysis of 'Measure Up' and 'Swap It, Don't Stop It' social marketing campaigns. *M/C Journal*, 18(3).
- O'Reilly, K. (2009). *Key concepts in ethnography*: SAGE Ltd.
- O'Donoghue, L., Percival, N., Laycock, A., McCalman, J., Tsey, K., Armit, C., & Bailie, R. (2014). Evaluating Aboriginal and Torres Strait Islander health promotion activities using audit and feedback. *Australian Journal of Primary Health*.
- O'Hara, L., Taylor, J., & Barnes, M. (2015). The extent to which the public health 'war on obesity' reflects the ethical values and principles of critical health promotion: A multimedia critical discourse analysis. *Health Promotion Journal of Australia*. doi: <http://dx.doi.org/10.1071/HE15046>
- Office for National Statistics. (2012). Disability tables 1A and 1B. *Statistical bulletin: Internet Access Quarterly Update, 2012 Q2*.
- Office of Economic Development. (2013). Health at a glance 2013: OECD indicators. Geneva: OECD Publishing.
- Okely, J. (1992). Anthropology and autobiography: Participatory experience and embodied knowledge. In J. Okely & H. Callaway (Eds.), *Anthropology and autobiography* (pp. 1-27). London: Routledge.
- Owen, J. R., & Westoby, P. (2011). The structure of dialogic practice within developmental work. *Community Development*, 43(3), 306-319. doi: 10.1080/15575330.2011.632093
- Oxfam Australia. (2014). Close the Gap highlights. Retrieved 13 December, 2014, from <https://www.oxfam.org.au/explore/indigenous-australia/close-the-gap/close-the-gap-highlights/>
- Oxford Dictionary. (2014a). Choice *Oxford English dictionary*. Oxford: Oxford University Press.
- Oxford Dictionary. (2014b). Empowerment *Oxford English dictionary*. Oxford: Oxford University Press.

- Panaretto, K. S., Wenitong, M., Button, S., & Ring, I. T. (2014). Aboriginal community controlled health services: Leading the way in primary care. *Medical Journal of Australia*, 200(1), 649-652. doi: 10.5694/mja13.00005
- Paradies, Y., & Cunningham, J. (2009). Experiences of racism among urban Indigenous Australians: Findings from the DRUID study. *Ethnic and Racial Studies*, 32(3), 548-573.
- Paradies, Y., & Modra, C. (2008). *Policy brief: Racism undermines health*. Cooperative Research Centre for Aboriginal Health. Melbourne.
- Parish, R. (1995). Health promotion: Rhetoric and reality. In R. Bunton, S. Nettleton & R. Burrows (Eds.), *The sociology of health promotion: Critical analyses of consumption, lifestyle and risk* (pp. 13-23). London: Routledge.
- Park, K., & Calamaro, C. (2013). A systematic review of social networking sites: Innovative platforms for health research targeting adolescents and young adults. *Journal of Nursing Scholarship*, 45(3), 256-264.
- Parker, E., Meiklejohn, B., Patterson, C., Edwards, K., Preece, C., Shuter, P., & Gould, P. (2006). Our games our health: A cultural asset for promoting health in Indigenous communities. *Health Promotion Journal of Australia*, 17(2), 103-108.
- Parker, M. (2007). Ethnography/ethics. *Social Science & Medicine*, 65(11), 2248-2259. doi: <http://dx.doi.org/10.1016/j.socscimed.2007.08.003>
- Parliamentary Joint Committee on Human Rights. (2013). Examination of legislation in accordance with the Human Rights (Parliamentary Scrutiny) Act 2011: Stronger Futures in the Northern Territory Act 2012 and related legislation. Canberra.
- Parliamentary Joint Committee on Human Rights. (2014a). Commonwealth Indigenous Advancement Strategy tendering processes. Canberra: Parliament of Australia
- Parliamentary Joint Committee on Human Rights. (2014b). Review of Stronger Futures in the Northern Territory Act 2012 and related legislation. Canberra: Parliament of Australia
- Parsons, M. (2010). Defining disease, segregating race: Sir Raphael Cilento, Aboriginal health and leprosy management in twentieth century Queensland. *Aboriginal History*, 34, 85.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). California: Sage Publications Ltd.
- Pazzano, C. (2012). Factbox: The 'Stronger Futures' legislation. Retrieved 12 December, 2014, from <http://www.sbs.com.au/news/article/2012/06/20/factbox-stronger-futures-legislation>
- Pease, B. (2010). *Undoing privilege: Unearned advantage in a divided world*. New York: Zed Books.
- Pedrana, A., Hellard, M., Gold, J., Ata, N., Chang, S., Howard, S., . . . Stooove, M. (2013). Queer as F**k: Reaching and engaging gay men in sexual health promotion through social networking sites. *Journal of Medical Internet Research*, 15(2), e25. doi: 10.2196/jmir.2334
- People's Health Movement. (2000). People's health charter. Savar, Bangladesh: People's Health Movement.
- People's Health Movement. (2011, 18th October). *Protecting the Right to Health through action on the Social Determinants of Health: A Declaration by Public Interest Civil Society Organisations and Social Movements*. Paper presented at the World Conference on Social Determinants of Health, Rio de Janeiro, Brazil
- Report of the meeting on Indigenous peoples and indicators of well-being, para 33 C.F.R. (2006).

- Petray, T. L. (2013). Self-writing a movement and contesting indigeneity: Being an Aboriginal activist on social media. *Global Media Journal: Australian Edition*, 7(1), 1-20.
- Phillips, G. (2007). Healing and public policy. In J. Altman & M. Hinkson (Eds.), *Coercive reconciliation: Stabilise, normalise, exit Aboriginal Australia* (pp. 141-150). North Carlton: Arena Publishing Association.
- Pholi, K., Black, D., & Richards, C. (2009). Is 'Close the Gap' a useful approach to improving the health and wellbeing of Indigenous Australians? *Australian Review of Public Affairs*, 9(2), 1-13.
- Picken, F. (2009). Ethnography. In M. Walter (Ed.), *Social research methods* Melbourne: Oxford University Press.
- Pink, S. (2012). Visual ethnography and the Internet: Visuality, virtuality and the spatial turn. In S. Pink (Ed.), *Advances in visual methodology* (pp. 113-130). London: SAGE.
- Pohlhaus, G. (2002). Knowing communities: An investigation of Harding's standpoint epistemology. *Social Epistemology*, 16(3), 283-293. doi: 10.1080/0269172022000025633
- Poland, B., Lehoux, P., Holmes, D., & Andrews, G. (2005). How place matters: Unpacking technology and power in health and social care. *Health & Social Care in the Community*, 13(2), 170-180.
- Porter, C. (2006). Ottawa to Bangkok: Changing health promotion discourse. *Health Promotion International*, 22(1), 72-79.
- Potvin, L., & Balbo, L. (2007). From a theory group to a theory book. In D. McQueen & I. Kickbush (Eds.), *Health and modernity: The role of theory in health promotion* (pp. 6-11). New York: Springer.
- Potvin, L., Juneau, C.-É., Jones, C. M., & McQueen, D. V. (2011). How is evidence used for planning, implementation and evaluation of health promotion? A global collection of case studies. *Global Health Promotion*, 18(1), 7-8, 92-94, 136-138.
- Power, J., Grealy, C., & Rintoul, D. (2009). Tobacco interventions for Indigenous Australians: A review of current evidence. *Health Promotion Journal of Australia*, 20(3), 186-194.
- Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, 47(9), 1102-1114. doi: 10.1037/0003-066X.47.9.1102
- Productivity Commission. (2014). Overcoming Indigenous disadvantage key indicators 2014: Fact sheet #1. Canberra.
- Project 10%. (2010). Reducing incarceration rates in Queensland: Towards a new future - A submission to Queensland Government. Brisbane.
- Pullen-Smith, B., Carter-Edwards, L., & Leathers, K. (2008). Community health ambassadors: A model for engaging community leaders to promote better health in North Carolina. *Journal of Public Health Management and Practice*, 14(6 (November Supplement)), S73-S81.
- Purdie, N., & Buckley, S. (2010). School attendance and retention of Indigenous Australian students *Closing the Gap Clearinghouse* Australian Institute of Health and Welfare and Australian Institute of Family Studies.
- Pyett, P., Waples-Crowe, P., & van der Sterren, A. (2008). Challenging our own practices in Indigenous health promotion and research. *Health Promotion Journal of Australia*, 19(3), 179-183.

- Queensland Aboriginal and Islander Health Council. (2010). A blueprint for Aboriginal and Islander health reform in Queensland. Draft for discussion. Brisbane: QAIHC.
- Queensland Aboriginal and Islander Health Council. (2011). Good Quick Tukka facilitator manual. Brisbane: QAIHC.
- Queensland Aboriginal and Islander Health Council. (n.d.). *Case study – Institute for Urban Indigenous Health (IUIH)*. Brisbane: QAIHC.
- Queensland Government. (2000). Queensland Aboriginal and Torres Strait Islander Justice Agreement. Brisbane.
- Queensland Health. (2005). *Queensland chronic disease strategy 2005-2015*. Brisbane: Retrieved from <http://www.tdsa.org.au/wp-content/uploads/2011/06/Chronic-Disease-Strategy-Qld-Health-2008.pdf>.
- Queensland Health. (2008). *What to eat: Staying healthy for you and your family*. Cairns: Tropical Public Health Services
- Queensland Health. (2010). *Making Tracks: Toward closing the gap in health outcomes for Indigenous Queenslanders by 2033. Policy and accountability framework*. Brisbane: Queensland Government Retrieved from http://www.health.qld.gov.au/atsihealth/documents/makingtracks/making_tracks_pol.pdf
- Queensland Health. (n.d.-a). *Queensland Health, Health practitioner core competency descriptor: Health promotion officer*. Brisbane: Queensland Government.
- Queensland Health. (n.d.-b). *Queensland Health, Health practitioner core competency descriptor: Public health officer*. Brisbane: Queensland Government.
- Racine, L., & Petrucka, P. (2011). Enhancing decolonization and knowledge transfer in nursing research with non-western populations: Examining the congruence between primary healthcare and postcolonial feminist approaches. *Nursing Inquiry*, 18(1), 12-20. doi: 10.1111/j.1440-1800.2010.00504.x
- Royal Australian College of Ophthalmologists. (1980). The national trachoma and eye health program. Sydney: RACO.
- Raeburn, J. (2007). Ottawa Charter: Reflections from down under. *Promotion & Education*, 14(2 suppl), 10. doi: 10.1177/10253823070140020401x
- Raeburn, J., & Peters, L. (1987). The first international conference on health promotion: A new zealand perspective. *Health Review*, 6(4), 24-27.
- Raphael, D. (2006). The social determinants of health: What are the three key roles for health promotion? *Health Promotion Journal of Australia*, 17(3), 167-170.
- Raphael, D. (2008). *Escaping from the Phantom Zone: Social Determinants of Health, Public Health Units, and Public Policy in Canada*. York University. Toronto.
- Raphael, D. (2011a). The political economy of health promotion: Part 1, national commitments to provision of the prerequisites of health. *Health Promotion International*. doi: 10.1093/heapro/dar084
- Raphael, D. (2011b). The political economy of health promotion: Part 2, national provision of the prerequisites of health. *Health Promotion International*. doi: 10.1093/heapro/dar058
- Raphael, D. (2013). Challenges to promoting health in the modern welfare state: The case of the Nordic nations. *Scandinavian Journal of Public Health*, 0, 1-11. doi: 10.1177/1403494813506522
- Raphael, D. (2014). Beyond policy analysis: The raw politics behind opposition to healthy public policy. *Health Promotion International*. doi: 10.1093/heapro/dau044

- Raphael, D. (Ed.). (2012). *Tackling health inequalities: Lessons from international experiences*. Toronto: Canadian Scholars Press Incorporated
- Reconciliation Australia. (2010). Mythbusters. Retrieved 9/12/2013, from <http://www.reconciliation.org.au/home/get-involved/learning-tools/mythbusters>
- Redman-MacLaren, M., MacLaren, D. J., Harrington, H., Asugeni, R., Timothy-Harrington, R., Kekeubata, E., & Speare, R. (2012). Mutual research capacity strengthening: A qualitative study of two-way partnerships in public health research. *International Journal for Equity in Health*, 11(79). doi: 10.1186/1475-9276-11-79
- Reilly, R., Cincotta, M., Doyle, J., Firebrace, B., Cargo, M., van den Tol, G., . . . Rowley, K. (2011). A pilot study of Aboriginal health promotion from an ecological perspective. *BMC Public Health*, 11(1), 749.
- Rural Health Training Unit. (1997). An introduction to recent Aboriginal and Torres Strait Islander history in Queensland. Brisbane: RHTU.
- Richmond, K., & Germov, J. (2009). A sociology of health promotion. In J. Germov (Ed.), *Second opinion: An introduction to health sociology* (4th ed., pp. 476-498). South Melbourne: Oxford University Press.
- Ridde, V., Guichard, A., & Houéto, D. (2007). Social inequalities in health from Ottawa to Vancouver: Action for fair equality of opportunity. *Global Health Promotion*(17579759), 12-16, 44-17.
- Riggs, D. (2004). Benevolence and the management of stake: On being 'good white people'. *Philament*(4).
- Rigney, L.-I. (1999a). *A first perspective of Indigenous Australian participation in science: Framing Indigenous research towards Indigenous Australian intellectual sovereignty*. Paper presented at the Chamcool Conference, Alberta, Canada.
- Rigney, L.-I. (1999b). Internationalization of an Indigenous anticolonial cultural critique of research methodologies: A guide to Indigenist research methodology and its principles. *Wicazo sa review*, 14(2), 109-121.
- Rigney, L.-I. (2001). *A first perspective of Indigenous Australian participation in science: Framing Indigenous research towards Indigenous Australian intellectual sovereignty*. Paper presented at the Chamcool Conference, Alberta, Canada.
- Rigney, L.-I. (2006). Indigenous Australian views on knowledge production and Indigenist research. In J. Kunnie & N. Goduka (Eds.), *Indigenous peoples' wisdom and power: Affirming our knowledge* (pp. 32-48). Burlington: Ashgate Publishing Ltd.
- Rissel, C. (1994). Empowerment: The holy grail of health promotion? *Health Promotion International*, 9(1), 39-47. doi: 10.1093/heapro/9.1.39
- Ritchie, J. (2005). The Bangkok Charter: Impressions at its birth. *Health Promotion Journal of Australia*, 16(3), 167-168.
- Rofes, E. (2002). Desires as defiance: Gay male sexual subjectivities and resistance to sexual health promotion. *Health Education Journal*, 61(2), 125-137. doi: 10.1177/001789690206100204
- Rose, M., & Pulver, L. R. J. (2004). Aboriginal health workers: Professional qualifications to match their health promotion roles. *Health Promotion Journal of Australia*, 15(3), 240-244.
- Rosenstock, A., Mukandi, B., Zwi, A., & Hill, P. (2013). Closing the Gaps: Competing estimates of Indigenous Australian life expectancy in the scientific literature.

- Australian and New Zealand Journal of Public Health*, 37(4), 356-364. doi: 10.1111/1753-6405.12084
- Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health Education & Behavior*, 15(2), 175-183. doi: 10.1177/109019818801500203
- Ross, I. J. (2006). Aboriginal Land Rights: A Continuing Social Justice Issue. *Australian eJournal of Theology*, 8.
- Rowley, C. D. (1978). *A matter of justice*. Canberra Australian National University Press.
- Royal Commission into Aboriginal Deaths in Custody. (1992). *Aboriginal deaths in custody: Overview of the response by governments to the Royal Commission*. Canberra: Australian Government Publishing Service.
- Rudd, K. (2008). Apology to Australia's Indigenous peoples. Canberra: Australian Parliament.
- Rychetnik, L., & Frommer, M. (2002). A schema for evaluating evidence on public health interventions. Version 4. Melbourne: University of Sydney.
- Rychetnik, L., & Wise, M. (2004). Advocating evidence-based health promotion: Reflections and a way forward. *Health Promotion International*, 19(2), 247-257.
- Ryde, J. (2009). *Being white in the helping professions: Developing effective intercultural awareness*. London: Jessica Kingsley Publishers.
- Sade-Beck, L. (2004). Internet ethnography: Online and offline. *International Journal of Qualitative Methods*, 3(2).
- Sadgrove, D. (2012). Creating a sustainable health promotion workforce: Discussion paper - Part 1, project deliverable 1. Canberra.
- Saggers, S., & Gray, D. (2007). Defining what we mean. In B. Carson, T. Dunbar, R. D. Chenhall & R. Bailie (Eds.), *Social determinants of Indigenous health*. Crows Nest: Menzies School of Health Research.
- Said, E. W. (1978). *Orientalism*. New York: Vintage Books Edition.
- Said, E. W. (1993). *Culture and imperialism*. London: Vintage.
- Sanders, D. (2006). A global perspective on health promotion and the social determinants of health. *Health Promotion Journal of Australia*, 17(3), 165-167.
- SBS. (2009, 11 August). Inglis scandal causes storm for Melbourne, *SBS News*. Retrieved from <http://www.sbs.com.au/news/article/2009/08/11/inglis-scandal-causes-storm-melbourne>
- Schoen, D., Balchin, D., & Thompson, S. (2010). Health promotion resources for Aboriginal people: Lessons learned from consultation and evaluation of diabetes foot care resources. *Health Promotion Journal of Australia*, 21(1), 64-69.
- Scrimgeour, M., & Scrimgeour, D. (2008). Health care access for Aboriginal and Torres Strait Islander people living in urban areas, and related research issues: A review of the literature. In J. Yule (Ed.). Darwin: Cooperative Research Centre for Aboriginal Health.
- Sebar, B., & Lee, J. (n.d.). How do we 'Measure Up'? A critical analysis of knowledge translation in a health social marketing campaign (pp. 211-214).
- Seedhouse, D. (2004). *Health promotion: Philosophy, prejudice and practice*. West Sussex: John Wiley and Sons, Ltd.
- Sefa Dei, G. J. (2005). Critical issues in anti-racist research methodologies: An introduction. In G. J. Sefa Dei & G. S. Johal (Eds.), *Critical issues in anti-racist research methodologies* (pp. 1-27). New York: Peter Lang.

- Sefa Dei, G. J. (2008). Indigenous knowledge studies and the next generation: Pedagogical possibilities for anti-colonial education. *The Australian Journal of Indigenous Education*, 37(Supplementary), 5-13.
- Seiple, R. A. (2004). *Ambassadors of hope: How Christians can respond to the world's toughest problems*. Downers Grove: InterVarsity Press.
- Sheehan, M., Ridge, D., & Marshall, B. (2002). 'This was a great project!': Reflections on a 'successful' mental health promotion project in a remote Indigenous school. *Health Promotion Journal of Australia*, 13(3), 201-204.
- Sherwood, J. (2010). *Do no harm: Decolonising Aboriginal health research*. (Doctor of Philosophy), University of New South Wales, Sydney.
- Sherwood, J. (2013a). Colonisation - It's bad for your health: The context of Aboriginal health. *Contemporary Nurse : a Journal for the Australian Nursing Profession*, 46(1), 28-40.
- Sherwood, J., and Sacha Kendall. (2013b). Reframing spaces by building relationships: Community collaborative participatory action research with Aboriginal mothers in prison. *Contemporary Nurse*, 46(1), 83-94.
- Sherwood, J., & Edwards, T. (2006). Decolonisation: A critical step for improving Aboriginal health. *Contemporary Nurse*, 22(2), 178.
- Shiell, A., & Hawe, P. (1996). Health promotion community development and the tyranny of individualism. *Health Economics*, 5(3), 241-247.
- Shilton, T., Howat, P., James, R., & Lower, T. (2001). Health promotion workforce development and health promotion workforce competency in Australia. *Health Promotion Journal of Australia*, 12(2), 117-123.
- Shilton, T., O'Hara, L., Sparks, M., White, I., Redman, J., & Ritchie, J. (2010). Twenty years of your national health promotion association. *Health Promotion Journal of Australia*, 21(2), 83-85.
- Silva, A. N. d., de Mendonça, M. H. M., & Vettore, M. V. (2008). A salutogenic approach to oral health promotion. *Cadernos de Saúde Pública*, 24, s521-s530.
- Smith, J., & Bollen, C. (2009). A focus on health promotion and prevention through the development of the National Men's Health Policy [online]. *Health Promotion Journal of Australia*, 20(2), 97-100.
- Smith, L. T. (2005). On tricky ground: Researching the native in the age of uncertainty. In N. Denzin & Y. S. Lincoln (Eds.), *The Sage Handbook of Qualitative Research* (3rd ed., pp. 85-107). Thousand Oakes: Sage Publications.
- Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). London: Zed Books.
- Smith, N. (2010). Incorporating local knowledge(s) in health promotion. *Critical Public Health*, 20(2), 211-222. doi: 10.1080/09581590902906187
- Snijder, M., Shakeshaft, A., Wagemakers, A., Stephens, A., & Calabria, B. (2015). A systematic review of studies evaluating Australian Indigenous community development projects: The extent of community participation, their methodological quality and their outcomes. *BMC Public Health*, 15(1), 1-16. doi: 10.1186/s12889-015-2514-7
- Solar, O., & Irwin, A. (2006). Social determinants, political contexts and civil society action: A historical perspective on the Commission on Social Determinants of Health. *Health Promotion Journal of Australia*, 17(3), 180-185.
- Solorzano, D. G., & Yosso, T. J. (2001). Critical race and LatCrit theory and method: Counter-storytelling. *International Journal of Qualitative Studies in Education*, 14(4), 471-495. doi: 10.1080/09518390110063365

- Solórzano, D. G., & Yosso, T. J. (2002). Critical race methodology: Counter-storytelling as an analytical framework for education research. *Qualitative Inquiry*, 8(1), 23-44. doi: 10.1177/107780040200800103
- Spencer, G. (2015). 'Troubling' moments in health promotion: Unpacking the ethics of empowerment. *Health Promotion Journal of Australia*. doi: <http://dx.doi.org/10.1071/HE15049>
- Spillane, J. (2005). Distributed leadership. *The Education Forum*, 69(Winter), 143-150.
- Spillane, J. P., Halverson, R., & Diamond, J. (2004). Towards a theory of leadership practice: A distributed perspective. *Journal of Curriculum Studies*, 36(1), 3-34. doi: 10.1080/0022027032000106726
- Spivak, G. C. (1995). Can the Subaltern Speak? In B. Ashcroft, G. Griffiths & H. Tiffin (Eds.), *The post-colonial studies reader* (pp. 24-). London: Routledge.
- Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart and Winston.
- Spradley, J. P. (1980). *Participant observation*. New York: Holt, Rinehart and Winston.
- Stacey, K., Keller, N., Gibson, B., Johnson, R., Jury, L., Kelly, D., . . . Short, T. (2007). Promoting mental health and well-being in Aboriginal contexts: Successful elements of suicide prevention work. *Health Promotion Journal of Australia*, 18(3), 247-254.
- Steering Committee for the Review of Government Service Provision. (2014). *Overcoming Indigenous disadvantage: Key indicators 2014*. Canberra.
- Stephens, C. (2010). Privilege and status in an unequal society: Shifting the focus of health promotion research to include the maintenance of advantage. *Journal of Health Psychology*, 20(10), 1-8. doi: 10.1177/1359105310371554
- Stevenson, H. M., & Burke, M. (1991). Bureaucratic logic in new social movement clothing: The limits of health promotion research. *Health Promotion International*, 6(4), 281-289.
- Stewart, J., & Walsh, A. (2011). Collaborating to make Aboriginal and Torres Strait Islander young people's sexual and reproductive health "everybody's business". *Aboriginal and Islander Health Worker Journal*, 35(4), 14-15.
- Stoneham, M. (2014). The portrayal of Indigenous health in selected Australian media. *The International Indigenous Policy Journal*, 5(1).
- Stringer, R. (2012). Impractical reconciliation. *Australian Feminist Studies*, 27(71), 19-36. doi: 10.1080/08164649.2012.648257
- Sullivan, P. (2011). The policy goal of normalisation, the National Indigenous Reform Agreement and Indigenous National Partnership Agreements *Desert Knowledge CRC Working Paper Number 76*. Alice Springs.
- Sunderland, N., Harris, P., Johnstone, K., Del Fabbro, L., & Kendall, E. (2015). Exploring health promotion practitioners' experiences of moral distress in Canada and Australia. *Global Health Promotion*, 22(1), 32-45. doi: 10.1177/1757975914532505
- Sweet, M. (2012). Overview of Qld Health changes, including the "historic" dismantling of public and preventative health services. Retrieved from <http://blogs.crikey.com.au/croakey/2012/09/11/overview-of-qld-health-changes-including-the-historic-dismantling-of-public-and-preventative-health-services/>
- Sweet, M. (2013). Indigenous tweeps out in force at health promotion conference. Retrieved from <http://blogs.crikey.com.au/croakey/2013/06/16/indigenous-tweeps-out-in-force-at-health-promotion-conference/>
- Sweet, M. (2014). Closed for business... *Croakey - the Crikey health blog*. Retrieved 30 June, from <http://blogs.crikey.com.au/croakey/2014/06/30/closed-for-business/>

- Sweet, M. A., Dudgeon, P., McCallum, K., & Ricketson, M. D. (2014). Decolonising practices: Can journalism learn from health care to improve Indigenous health outcomes? *Medical Journal of Australia*, 200(11), 626-627.
- Syme, S. L. (1998). Social and economic disparities in health: Thoughts about intervention. *The Milbank Quarterly*, 76(3), 493-505.
- Syme, S. L. (2004). Social determinants of health: The community as an empowered partner. *Preventing Chronic Disease*, 1(1), 1-5.
- Tannahill, A. (1985). What is health promotion? *Health Education Journal*, 44(4), 167-168.
- Tatz, C. (1980). Aboriginality as civilisation. *The Australian Quarterly*, 52(3), 352-362.
- Tengan, T. P. K. (2005). Unsettling ethnography: Tales of an Oiwi in the anthropological slot. *Anthropological forum*, 15(3), 247-256.
- Tengland, P.-A. (2012). Behavior change or empowerment: On the ethics of health-promotion strategies. *Public Health Ethics*, 5(2), 140-153. doi: 10.1093/phe/phs022
- The Senate. (2014). Select Committee on Health: First interim report. Canberra: Parliament of Australia.
- The World Bank. (2013). *Internet users (per 100 people)*. Retrieved from: <http://data.worldbank.org/indicator/IT.NET.USER.P2>
- thephysicalworld.net. (2010). Close the gap: mm.
- Thomas, D. (2004). *Reading doctors' writing: Race, politics and power in indigenous health research, 1870-1969*. Acton: Australian Institute of Aboriginal and Torres Strait Islander Studies, Aboriginal Studies Press.
- Thomas, D. (2012). Changes in smoking intensity among Aboriginal and Torres Strait Islander people, 1994–2008. *Medical Journal of Australia*, 197(9), 503-506. doi: 10.5694/mja12.10558
- Thomas, D., Bainbridge, R., & Tsey, K. (2014). Changing discourses in Aboriginal and Torres Strait Islander health research, 1914–2014. *Medical Journal of Australia*, 201(1 Supplement), S15-S18.
- Thomas, D., Briggs, V., Anderson, I., & Cunningham, J. (2008). The social determinants of being an Indigenous non-smoker. *Australian and New Zealand Journal of Public Health*, 32(2), 110-116.
- Thomas, J. (1993). *Doing critical ethnography* (Vol. 26). London: Sage Publications.
- Thomas, Y., Gray, M., & McGinty, S. (2011). Occupational therapy at the 'cultural interface': Lessons from research with Aboriginal and Torres Strait Islander Australians. *Australian Occupational Therapy Journal*, 58(1), 11-16. doi: 10.1111/j.1440-1630.2010.00917.x
- Thompson, L., & Kumar, A. (2011). Responses to health promotion campaigns: Resistance, denial and othering. *Critical Public Health*, 21(1), 105-117. doi: 10.1080/09581591003797129
- Thompson, S. (2009). Aboriginal perspectives on physical activity in remote communities: Meanings and ways forward DRAFT. Casuarina: Menzies School of Health Research.
- Thorne, S. (2000). Data analysis in qualitative research. *Evidence Based Nursing*, 3(3), 68-70. doi: 10.1136/ebn.3.3.68
- Thorpe, A., Anders, W., & Rowley, K. (2014). The community network: An Aboriginal community football club bringing people together. *Australian Journal of Primary Health*, 20, 356-364.
- Toll, C. A., & Crumpler, T. P. (2004). Everything is dangerous: Pastoral power and university researchers conducting interviews. In B. Baker & K. Heyning (Eds.),

- Dangerous coagulations? The uses of Foucault in the study of education.* New York: Peter Lang Publishing.
- Tonkinson, R. (2007). Aboriginal 'difference' and 'autonomy' then and now: Four decades of change in a Western Desert society. *Anthropological forum*, 17(1), 41-60. doi: 10.1080/00664670601168476
- Trigger, D. S. (1992). *Whitefella comin' - Aboriginal responses to colonialism in northern Australia*. Melbourne: Cambridge University Press.
- Tsey, K. (2010). Making social science matter? Case studies from community development and empowerment education research in rural Ghana and Aboriginal Australia. *Asian Social Science*, 6(1), 3-12.
- Tsey, K., & Every, A. (2000). Evaluating Aboriginal empowerment programs: the case of Family WellBeing. *Australian and New Zealand Journal of Public Health*, 24(5), 509-514.
- Tsey, K., Whiteside, M., Deemal, A., & Gibson, T. (2003). Social determinants of health, the 'control factor' and the Family Wellbeing Empowerment Program. *Australian Psychiatry*, 11(Supplement), S34-S39.
- Tsey, K., Whiteside, M., Haswell-Elkins, M., Bainbridge, R., Cadet-James, Y., & Wilson, A. (2009). Empowerment and Indigenous Australian health: A synthesis of findings from Family Wellbeing formative research. *Health and Social Care in the Community*, 1-11.
- Tsey, K., Wilson, A., Haswell-Elkins, M., Whiteside, M., McCalman, J., Cadet-James, Y., & Wenitong, M. (2007). Empowerment-based research methods: A 10-year approach to enhancing Indigenous social and emotional wellbeing. *Australian Psychiatry*, 15(Supplement), S34-S38.
- Tunçalp, D., & Lê, P. L. (2014). (Re)Locating boundaries: A systematic review of online ethnography. *Journal of Organizational Ethnography*, 3(1), 59-79. doi: <http://dx.doi.org/10.1108/JOE-11-2012-0048>
- United Nations. (2013). Deputy UN chief calls for urgent action to tackle global sanitation crisis. Retrieved from <http://www.un.org/apps/news/story.asp?NewsID=44452&Cr=sanitation&Cr1=>
- Vaartjes, V., & Goff, S. (2008). Living inquiry: Embodiment of action learning. *Action Learning and Action Research Journal*, 14(2), 50-72.
- Venediktov, D. (1998). Primary health care: Alma Ata and after. *World Health Forum*, 19(1), 79-86.
- Vickery, J., Faulkhead, S., Adams, K., & Clarke, A. (2007). Indigenous insights into oral history, social determinants and decolonisation. In I. Anderson, F. Baum & M. Bentley (Eds.), *Beyond band-aids: Exploring the underlying social determinants of Aboriginal health. Papers from the Social Determinants of Aboriginal Health Workshop, Adelaide, July 2004. I.* . Darwin: Cooperative Research Centre for Aboriginal Health.
- Viola, A. (2006). Evaluation of the outreach school garden project: Building the capacity of two indigenous remote school communities to integrate nutrition into the core school curriculum. *Health Promotion Journal of Australia*, 17(3), 233-239.
- Virtual Genetics Education Centre. (n.d.). NHS Stop Smoking campaign to encourage pregnant women to quit smoking. Image taken from Smokefree campaign website. In E. c. h. y. baby (Ed.): University of Leicester.
- Vos, T., Barker, B., Begg, S., Stanley, L., & Lopez, A. D. (2009). Burden of disease and injury in Aboriginal and Torres Strait Islander Peoples: The Indigenous health

- gap. *International Journal of Epidemiology*, 38, 470-477. doi: 10.1093/ije/dyn240
- Vos, T., Barker, B., Stanley, L., & Lopez, A. (2007). The burden of disease and injury in Aboriginal and Torres Strait Islander Peoples - Summary report. Brisbane: School of Population Health.
- Vos, T., Carter, R., Barendregt, J., Mihalopoulos, C., Veerman, L., Magnus, A., . . . Wallace, A. (2010). Assessing cost-effectiveness in prevention (ACE-Prevention): Final report. Brisbane and Melbourne.
- Wadham, B. (2004). Differentiating whiteness: White Australia, white masculinities and Aboriginal reconciliation. In A. Moreton-Robinson (Ed.), *Whitening race: Essays in social and cultural criticism*. Canberra: Aboriginal Studies Press.
- Wahab, A. (2005). Questioning authority and the politics of representation in social science research. In G. J. Sefa Dei & G. S. Johal (Eds.), *Critical issues in anti-racist research methodologies* (pp. 29-51). New York: Peter Lang.
- Walker, M., Fredericks, B., & Anderson, D. J. (2012). Understanding Indigenous Australian women's social and emotional wellbeing and wellness through yarning: The Indigenous Women's Wellness Program. *Indigenous Knowledges Development Conference, Nga Pae o te Maramatanga*, 270-276.
- Walker, M., Fredericks, B., Mills, K., & Anderson, D. (2013). Perspectives on a decolonizing approach to research about Indigenous women's health: The Indigenous Women's Wellness Study. *AlterNative: An International Journal of Indigenous Peoples*, 9(3), 204-216.
- Wallerstein, N. (2006). What is the evidence on effectiveness of empowerment to improve health? Copenhagen: Health Evidence Network.
- Walter, M. (2005). Using the 'Power of the Data' within Indigenous Research Practice. *Australian Aboriginal Studies*, 2, 27-34.
- Wang, C., & Burris, M. A. (1997). Photovoice: Concept, methodology, and use for participatory needs assessment. *Health Education & Behavior*, 24(3), 369-387. doi: 10.1177/109019819702400309
- Wang, C. C., & Redwood-Jones, Y. A. (2001). Photovoice ethics: Perspectives from Flint Photovoice. *Health Education & Behavior*, 28(5), 560-572. doi: 10.1177/109019810102800504
- Wang, T. (2013). *Talking to strangers: Chinese youth and social media*. (Doctor of Philosophy in Sociology), University of California, San Diego. Retrieved from http://triciawang.com/storage/Dissertation_Trícia_Wang_021014.pdf
- Ward, J. (2014). So far, so good: Maintenance of prevention is required to stem HIV incidence in Aboriginal and Torres Strait Islander communities in Australia. *AIDS education and prevention*, 26(3), 267-279.
- Wardrope, A. (2015). Relational autonomy and the ethics of health promotion. *Public Health Ethics*, 8(1), 50-62. doi: 10.1093/phe/phu025
- Ware, V.-A., & Meredith, V. (2013). *Supporting healthy communities through sports and recreation programs*. Canberra and Melbourne: Australian Institute of Health and Welfare and Australian Institute of Family Studies.
- Warr, D. J., Mann, R., & Kelaher, M. (2012). 'A lot of the things we do ... people wouldn't recognise as health promotion': Addressing health inequalities in settings of neighbourhood disadvantage. *Critical Public Health*, 23(1), 95-109. doi: 10.1080/09581596.2012.739681
- Waterford, J. (1982). The Aboriginal medical services - A uniquely Australian phenomenon. *Aboriginal Health Project Information Bulletin*, 2, 16-21.

- Watson, M. R. (2006). A journey of Indigenous identity. *Medical Journal of Australia*, 185(3), 150-151.
- Watson, S. (n.d.). History of AICHS. Brisbane: Aboriginal and Islander Community Health Service.
- Waziyatawin, & Yellow Bird, M. (2005). Beginning decolonization. In W. A. Wilson & M. Yellow Bird (Eds.), *For Indigenous eyes only: A decolonization handbook* (pp. 1-7). New Mexico: School of American Research.
- Wee, A. (2008). Leadership perspectives, and the Asian & Western leader. Retrieved 10 April, 2013, from https://www.dlsweb.rmit.edu.au/bus/public/LTIF_viet/org_beh/org_beh.html
- Wells, J., & Batten, L. (1990). Women smoking and coping: An analysis of women's experience of stress. *Health Education Journal*, 49(2), 57-60. doi: 10.1177/001789699004900204
- Wenzel, E. (1997). A comment on settings in health promotion. *Internet Journal of Health Promotion*.
- Werner, D. (2005). [Bangkok Charter - Action Needed!].
- West, R., Stewart, L., Foster, K., & Usher, K. (2012). Through a critical lens: Indigenist research and the Dadirri method. *Qualitative Health Research*. doi: 10.1177/1049732312457596
- Whitby, G. B. (n.d.). Distributive leadership as an emerging concept. Wollongong: The Australian Centre for Educational Leadership, University of Wollongong.
- Whitelaw, S., Baxendale, A., Bryce, C., MacHardy, L., Young, I., & Witney, E. (2001). 'Settings' based health promotion: A review. *Health Promotion International*, 16(4), 339-353. doi: 10.1093/heapro/16.4.339
- Whiteside, M., Tsey, K., Crouch, A., & Fagan, P. (2012). Youth and Relationship Networks (YARNS): Mobilising communities for sexual health. *Health Promotion Journal of Australia*, 23(3), 226-230.
- Wild, R., & Anderson, P. (2007). Ampe Akelyernemane Meke Mekarle: "Little Children are Sacred". Report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse. Darwin.
- Wilkin, A., & Liamputtong, P. (2010). The photovoice method: Researching the experiences of Aboriginal health workers through photographs. *Australian Journal of Primary Health*, 16(3), 231-239.
- Wilkinson, R., & Marmot, M. (2003). *The Solid Facts* (2nd ed.). Denmark: International Centre for Health and Society.
- Willis, E., Pearce, M., McCarthy, C., Jenkin, T., & Ryan, F. (2006). Utility stress as a social determinant of health: Exploring the links in a remote Aboriginal community. *Health Promotion Journal of Australia*, 17(3), 255-259.
- Wilson, A. (2011). *Addressing uncomfortable issues: The role of White health professionals in Aboriginal health*. (Doctor of Philosophy), Flinders University, Adelaide. Retrieved from <http://apo.org.au/research/addressing-uncomfortable-issues-role-white-health-professionals-aboriginal-health>
- Wilson, S. (2001). What is an Indigenous research methodology? *Canadian Journal of Native Education*, 25(2), 175-179.
- Wilson, S. (2009). *Research is ceremony: Indigenous research methods*. Nova Scotia: Fernwood Publishing.
- Wise, M., Angus, S., Harris, E., & Parker, S. (2012a). Scoping study of health promotion tools for Aboriginal and Torres Strait Islander people: A report prepared for the Lowitja Institute. Sydney: Centre for Health Equity Training Research and Evaluation, University of New South Wales.

- Wise, M., Massi, L., Rose, M., Nancarrow, H., Conigrave, K., Bauman, A., & Hearn, S. (2012b). Developing and implementing a state-wide Aboriginal health promotion program: The process and factors influencing successful delivery. *Health Promotion Journal of Australia*, 23(1), 25-29.
- Wise, M., & Nutbeam, D. (2007). Enabling health systems transformation: What progress has been made in re-orienting health services? *Promotion and Education*, 23-30.
- Wise, M., & Signal, L. (2000). Health promotion development in Australia and New Zealand. *Health Promotion International*, 15(3), 237-248. doi: 10.1093/heapro/15.3.237
- Wittel, A. (2000). Ethnography on the move: From field to net to internet. *Forum: Qualitative Social Research*, 1(1).
- Wolf, E. (2010). *Europe and the people without history*. Berkley: University of California Press.
- Wolff, J. (2011). How should governments respond to the social determinants of health? *Preventive Medicine*, 53(4-5), 253-255. doi: 10.1016/j.ypmed.2011.07.008
- Wood, L., France, K., Hunt, K., Eades, S., & Slack-Smith, L. (2008). Indigenous women and smoking during pregnancy: Knowledge, cultural contexts and barriers to cessation. *Social Science & Medicine*, 66(11), 2378-2389. doi: <http://dx.doi.org/10.1016/j.socscimed.2008.01.024>
- World Bank. (1993). World development report 1993 : Investing in health. Washington: World Bank.
- World Health Assembly. (1998). Resolution WHA 51.12 on health promotion. Agenda item 20. 16 May 1998. Geneva.
- World Health Organization. (1946). Constitution of the World Health Organization. Geneva: WHO.
- World Health Organization. (1978). Declaration of Alma-Ata *The International Conference on Primary Health Care*. Alma-Ata: WHO.
- World Health Organization. (1981). Global strategy for health for all by the year 2000 *Health for all*. Geneva: WHO.
- World Health Organization. (1986a). An international conference on health promotion: The move towards a new public health - List of participants: WHO, Health and Welfare Canada, and Canadian Public Health Association.
- World Health Organization. (1986b). Ottawa charter for health promotion. Ottawa: World Health Organization,.
- World Health Organization. (1988). *Adelaide Recommendations on Healthy Public Policy (WHO/HPR/HEP/95.2)*. Paper presented at the Second International Conference on Health Promotion, Adelaide, South Australia.
- World Health Organization. (1991). Sundsvall statement on supportive environments for health *Third International Conference on Health Promotion*. Sundsvall, Sweden: WHO.
- World Health Organization. (1997). Jakarta declaration on leading health promotion into the 21st century *Fourth International Conference on Health Promotion: New Players for a New Era - Leading Health Promotion into the 21st Century*. Jakarta: WHO.
- World Health Organization. (1998). Health promotion glossary. Geneva: WHO.
- World Health Organization. (2011). Rio political declaration on social determinants of health. Rio de Janeiro: WHO.
- World Health Organization. (2013). The Helsinki statement on health in all policies *The 8th Global Conference on Health Promotion*. Helsinki: WHO.

- World Health Organization. (2014). The Commission on Social Determinants of Health - What, why and how? Geneva: WHO.
- World Health Organization, & Government of South Australia. (2010). Adelaide statement on health in all policies: Moving towards a shared governance for health and well-being. In WHO & Government of South Australia (Eds.). Adelaide: WHO and Government of South Australia.
- World Health Organization & UNICEF. (1978). Primary health care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 Geneva.
- World Health Organization & UNICEF. (1978). International Conference on Primary Health Care: List of participants *International Conference on Primary Health Care*. Alma Ata, URSS: WHO.
- World Health Organization Secretariat. (2005). Global health promotion scaling up for 2015 - A brief review of major impacts and developments over the past 20 years and challenges for 2015. Background Document for the 6th Global Conference on Health Promotion in Bangkok, Thailand *Unedited Working Paper, 14-07-2005*. Bangkok.
- Wright, K., Rowitz, L., Merkle, A., Reid, W. M., Robinson, G., Herzog, B., . . . Baker, E. (2000). Competency development in public health leadership. *American Journal of Public Health, 90*(8), 1202-1207.
- Yaman, F., & Higgins, D. (2011). *What works to overcome Indigenous disadvantage: Key learnings and gaps in the evidence*. Canberra and Melbourne: Australian Institute of Health and Welfare; Australian Institute of Family Studies.
- Yanow, D., Ybema, S., & van Hulst, M. (2012). Practicing organizational ethnography. In G. Symon & C. Cassell (Eds.), *Qualitative organizational research: Core methods and current challenges*. London: Sage.
- Yeo, M. (1993). Toward an ethic of empowerment for health promotion. *Health Promotion International, 8*(3), 225-235. doi: 10.1093/heapro/8.3.225
- Young, J. A. B., & McGrath, R. A. (2011). Exploring discourses of equity, social justice and social determinants in Australian health care policy and planning documents. *Australian Journal of Primary Health, 17*(4), 369-377. doi: <http://dx.doi.org/10.1071/PY11038>
- Young, R. (1995). *Colonial desire: Hybridity in theory, culture and race*. London: Routledge.
- Young, R. (2001). *Postcolonialism: An historical Introduction*. Carlton: Wiley-Blackwell Publishing.
- Yunkaporta, T., & McGinty, S. (2009). Reclaiming Aboriginal knowledge at the cultural interface. *Australian Educational Researcher (Australian Association for Research in Education), 36*(2), 55-72.
- Zhang, D., & Unschuld, P. U. (2008). China's barefoot doctor: Past, present, and future. *The Lancet, 372*(9653), 1865-1868.
- Zufferey, C. (2012). 'Not knowing that I do not know and not wanting to know': Reflections of a white Australian social worker. *International Social Work*. doi: 10.1177/0020872812436624

**Appendix A: “Beyond the accolades” – paper published in Global
Health Promotion**

Due to copyright restrictions, the published version of this journal article cannot be made available here. Please view the published version online at:

<http://dx.doi.org/10.1177/1757975913490427>

Appendix B: Participant information form



Queensland University of Technology
Brisbane Australia

Health promotion practice with Indigenous people in urban areas Information for participants

Introduction

This research looks at the delivery of health promotion to Indigenous people in urban areas. The research aims to contribute to the decolonisation of health promotion practice. It does this by learning about how Indigenous and non-Indigenous health promotion practitioners go about their work with Indigenous people and communities. The project will take approximately 3 years from 2011 over the duration of Karen's PhD candidature (finishing end of 2014). This form is a summary of what is involved in the research project. Please read it carefully and ask questions about anything you wish to know more about.

What do I need to do?

If you want to be involved then you need to:

- Sign the consent form giving consent to participate in the project
- Participate in group and individual discussions with Karen about your experience of health promotion practice. Karen may record these discussions, with your permission.
- Keep a personal diary about your work using photos, video, audio and/or text. You may use your iPhones to collect this information.

What will I be asked?

Karen will talk with you about your work in health promotion with Indigenous people in urban areas. This will include talking about the challenges, what helps you, and how you manage the tensions such as different knowledge systems (e.g. Western, Indigenous) and demands (e.g. from funding body, employer, community, etc).

Why do we need this study?

The research will contribute to improving health promotion practice in urban areas, particularly with marginalised groups. It will be one of the few studies to document actual health promotion practice with Indigenous people in urban areas, that acknowledges an Indigenous perspective.

How will the information be used to help me and others?

We cannot guarantee that you will receive any personal benefits from this study. However, the de-identified findings will be shared with Institute for Urban Indigenous Health (IUIH) to contribute to IUIH's development of its health promotion framework for Deadly Choices. This will have indirect benefit to the Aboriginal Medical Services supported by IUIH, and the communities they serve. It will also contribute to improving health promotion practice more generally, particularly with marginalised groups.

Who is conducting this study?

The study is being conducted as part of Karen McPhail-Bell's PhD (doctorate) at QUT. Karen is supervised by Dr Mark Brough, Professor Bronwyn Fredericks and Dr Chelsea Bond.



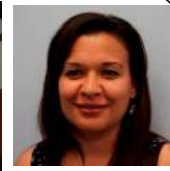
Karen
McPhail-
Bell



Mark
Brough



Bronwyn
Fredericks



Chelsea Bond

How will the information I give be used?

The information collected from you and others will be used to write up Karen's PhD thesis. A copy of this thesis will be provided to IUIH and to an academic panel for assessment. Summary results will be shared with IUIH throughout the research. Other research participants will also be provided with a summary of findings. Where information from this research in relation to IUIH may be published, IUIH will have authority to dis-/approve doing so, with opportunity for co-authorship of papers and presentations where appropriate and possible.

All information will be de-identified to protect your privacy, meaning your name or any identifying information will not be used in published reports, unless you and IUIH consent for this.

Is this research project approved?

This study has been approved by the *QUT Human Research Ethics Committee*. Written support has also been obtained from *Adrian Carson*, CEO of IUIH.

This research is being carried out according to QUT ethical requirements and National Health and Medical Research Council (NHMRC) guidelines for research with Aboriginal and Torres Strait Islander peoples, which protects the interests of people who agree to participate in research studies.

What if I want to complain?

If you have any questions, concerns or complaints about this project, then you may contact:

- The research team (contact details below).
- The QUT Research Ethics Unit on 07 3138 5123 or ethicscontact@qut.edu.au. The QUT Research Ethics Unit is not connected with the research project and can facilitate a resolution to my concern in an impartial manner.

Do I have to take part in the study?

If you don't wish to participate in this study you don't have to. Your decision whether or not to take part will not affect your relationship with the researchers, QUT or IUIH. Also, you can withdraw at any time from the research after giving consent.

How can I find out more?

If you have any questions about this project, please contact any of the team:

Lead investigator

Karen McPhail-Bell, PhD candidate, QUT (07 3138 4881 / 0421 061 403 or karenmcphailbell@gmail.com)

Supervisors

Dr Mark Brough, Principal Supervisor, QUT (07 3138 4664 or m.brough@qut.edu.au)

Professor Bronwyn Fredericks, Associate Supervisor, CQUniversity Australia (07 49 232 045 or b.fredericks@cqu.edu.au)

Dr Chelsea Bond, Associate Supervisor, Inala Indigenous Health Service, Queensland Health (07 3275 5388 or Chelsea_Bond@health.qld.gov.au)

Appendix C: Participant consent form



Health promotion with Indigenous people in urban areas **CONSENT FORM**

INDIVIDUAL PARTICIPANT: Institute for Urban Indigenous Health

Principal Researcher: Karen McPhail-Bell

Supervisors: Dr Mark Brough, Professor Bronwyn Fredericks, Dr Chelsea Bond

Research Organisation: Queensland University of Technology (QUT)

I _____
have consented to participate in the above research project on the following basis:

- ☐ **Observation** – I am happy for Karen to participate in and observe my health promotion practice.
- ☐ **Interviews** – I am happy for Karen to conduct interviews with me during the research, at a mutually agreed place and time.
- ☐ **Participant diary** – I am happy to keep a diary about the health promotion work I do using all or some of text, audio, photo or video methods.

1. I have received the Participant Information Form and have had the opportunity to ask questions. I understand the purpose of the research and my involvement in it.
2. I can stop participating in the project at any time, for any reason without consequence, and any information I have provided prior to this will not be used.
3. Any information I provide during the course of this research will remain confidential. Where the results of the research are published, my involvement and my personal results will not be identified.
4. I understand that interviews and group discussions may be audio-taped and/or videotaped, and that the tapes will be securely stored and then destroyed at the completion of the project.
5. All the information I provide is completely confidential. Any information relating to this project will be stored in locked filing cabinets and in password protected documents.
6. Emerging results of the project will be made available to me throughout the research process and final results at the conclusion of the research. I will not necessarily receive any individual feedback.
7. I understand that if I have any complaints or questions concerning this research project I can contact the principal researcher, research team or the QUT Research Ethics Unit on 07 3138 5123 or ethicscontact@qut.edu.au. The QUT Research Ethics Unit is not connected with the research project and can facilitate a resolution to my concern in an impartial manner.

Name: _____

Signature _____ Date _____

Witnessed by _____ Date _____

Appendix D: Participant diary template

Participant name:	Participant position:
Position/portfolio:	

How to use this diary

- Simply use the reflective framework to help you record your experiences of practicing health promotion.
- You might also like to use this framework to help you with your audio/photo/video diary entries using your iPhone.
- You can attach or link to your audio/photo/video diary entries in this text diary if you wish.
- Please complete a separate template for each diary entry.
- You can use this diary either electronically or in hard copy, or both – whatever is most convenient for you.
- Remember, the participant diary method makes you a ‘collaborator’ or ‘data collector’, rather than only a participant. This is because you become the researcher-observer of your own experience being recorded – and can decide what data is included in the research.
- You can contact me for help in completing this diary and/or ask questions on k.mcphail-bell@student.qut.edu.au or 3138 4881/0421 061 403.

Diary entry – Date:

What happened today?

What worked?

What didn't work?

Recommendations

Reflections and/or things to remember next time

Thank you!

Appendix E: IUIH consent form – Deadly Choices Education Program

PRIVATE AND CONFIDENTIAL



CONSENT FORM

I give permission for _____ (Child's full name) to be involved in the 'Deadly Choices' program

- ☐ **Permission for photo** (*group shots may be taken in program setting and these images may be used for social media including Facebook and Twitter, as well as Resources*).
- ☐ **Permission for health check** (*a form is attached if you wish to complete; this form will be private and confidential information provided to the local medical service for nurses and doctors to access only*)
- ☐ **Permission for program evaluation** (*all programs are evaluated to support ongoing continual program improvement and funding to better Indigenous health outcomes*)

Please do not tick the box/s if you do not wish your child to be involved in any of the above activities.

Child's date of birth: ____/____/____

Parent/Guardian Name: _____

Guardian's phone number: _____

Signed: _____ Date: __/__/____



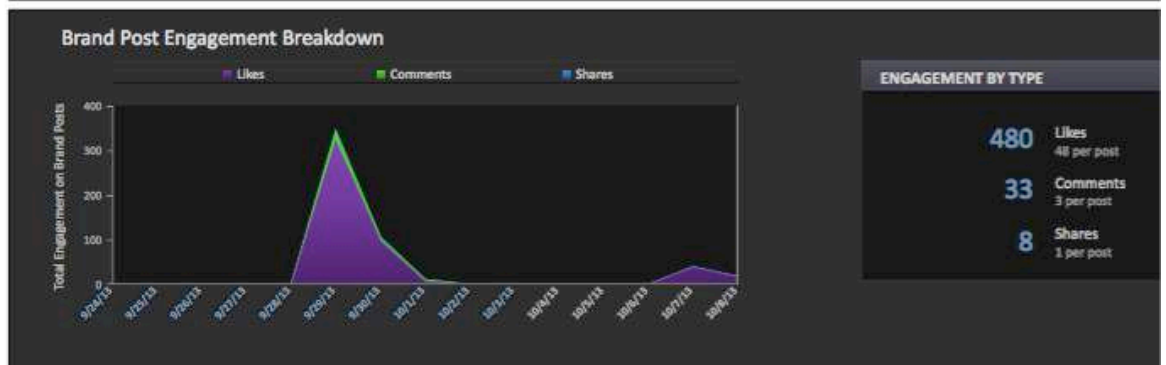
Appendix F: Samples of SimplyMeasured reports

[SimplyMeasured](#)

[Log In](#) [Export to PowerPoint](#) [Download to Excel](#)

This is Your Free Facebook Fan Page Report. [Get More With a Free Trial.](#)

- Free Facebook Fan Page Report
- Facebook Fan Page for Deadly Choices
- 09/24/2013 - 10/08/2013 - Daily
- Unthemed



Twitter Follower Report



Followers

You | Audience (Avg)
1,239 | **948**

On average, your audience has 1.3x as many followers as users they are following.



Tweets (Lifetime)

You | Audience (Avg)
2,558 | **2,977**

On average, your audience tweets 0.8 times per day.

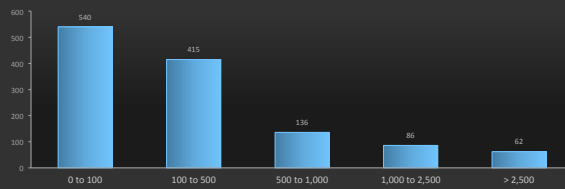


Klout Score

You | Audience (Avg)
49.9 | **29.0**

26% of your total followers are above the Worldwide Klout Score of 40.

Audience Follower Distribution



AUDIENCE SUMMARY

1,239
Followers

1,239
Followers in this Report

On average, your audience is followed by 948 people and follows 756 people.

44% of your audience has between 0 and 100 followers.

Your audience is included in other Twitter users' lists on average of 14 times. The top 1% has been listed an average of 422 times.