**FAMILY AND COMMUNITY HEALTH ASSIGNMENT GUIDELINES**

**Introduction**

The indigenous Australians have been exposed to poorer health outcomes due to various geographical and structural differences that are exhibited in their residences. Most of this population died from preventable conditions due to factors such as inaccessibility to a healthcare facility. The terrain in the rural and remote areas limit the ability to construct more healthcare facilities, and professionals who need to be deployed here may also be limited. For the longest time, the residents had to travel longer distances before accessing medical attention from an authorised facility (Renzaho & Oldroyd, 2014). The impact of such shortcomings is that most of them could not get medical help even when they need acute care. This situation also limits the rate at which the citizens can visit healthcare facilities for checkups that monitor their wellbeing such as cancer screening. The rural communities also face the challenge of poverty which also predisposes them to various chronic diseases such as diabetes. Poverty contributes to disease prevalence among the indigenous Australians in some ways including the failure to educate their children (Altman, 2009). Education is an excellent avenue towards information acquisition as well as a way out of poverty. Therefore, lower standards of healthcare and shorter life expectancies are experienced among the indigenous Australians as compared to the non-indigenous ones. Accessing healthcare between the two groups has also created a gap due to the rising cost of accessing healthcare (Shepherd et al., 2017). Since the quality of healthcare is also determined by the cost incurred, the life expectancy gap is inevitable. Also, Australians who reside in the city can access healthcare facilities at any time while the few who can access the facilities in the remote can only do so in the limited hours of the day. The government and other supportive agencies identified this problem and created the Closing the Gap policy (Kildea et al., 2010). This paper performs an appraisal of the policy to evaluate the changes in the health outcomes that have been realised by the Aboriginal and other indigenous communities after the implementation of the policy.

**Choice of the Policy**

The policy was selected due to its aim at improving the health of indigenous people by closing the gap that is caused by various social and geographical factors. It is based on addressing the factors that make these communities susceptible to adverse health outcomes hence its validity is almost guaranteed. The approach taken by the policy is that of ensuring the equality in human rights which are stipulated in the Aboriginal and Torres Strait Islander Commissioner’s Social Justice Report of 2005 (Altman et al., 2009). The equality in the health plan is guided by realistic targets that aim to be achieved by the community, their representatives, as well as the Australian governments. Seven aims are outlined in the policy, and they include: halving the child mortality rate by 2018, enrolling 95% of indigenous children to early childhood education at the age of four by 2022, to close the school attendance gap by 2018, and to halve the gap of reading and numeracy by 2018. The policy also aimed at halving the gap in Year 12 attainment and employment by 2020 and 2018 respectively. Finally, the gap in life expectancy was expected to have been closed by 2031 (Skinner & Berger, 2003). These aims address the social factors that affect health, and it is expected that its optimum implementation will improve the life expectancy and generate a more productive indigenous community.

**Impacts on the Social Determinants of Health**

The impacts of this policy on the health of the Aboriginal and Torres Strait Islanders will be appraised based on the milestones that have been made in the set-out aims. Each aim has a role in improving the social status of the individuals hence increasing their disease awareness and healthcare centre accessibility. Some progress has been made as far as implementing the policy is concerned since three out of the seven targets have been met. They include halving and closing the gap in child mortality rates, and year 12 attainment, as well as enrolling children into early childhood education once they attain four years. Between 1998 and 2016, a 35% decline in the indigenous child mortality rate has been realised, and mothers are also giving birth to healthy children (Marmot, 2011). This achievement is linked to the health improvements that have been made in maternal health. By 2016, approximately 14700 indigenous children had enrolled for various early childhood education programs, a figure that represented 91% of this population. Since the target was 95% by the year 2020, this represents a fast speed that will see maximum enrollment by the target year. Another positive achievement that has been realised by the policy is some indigenous young people between the ages 20 and 24 have achieved Year 12 qualification. The 2016 figure represents 65.3% which is a tremendous increase from 47.4% of the youth who qualified for the same grade in 2006 (Shepherd et al., 2017).

A policy that improves the social determinants of health is fundamental in solving health disparities since a comprehensive source of literature attributes poor health to socio-economic disadvantages. Some of the indicators that have been used to link poor health outcomes to social issues among the indigenous people include the average household income. According to a national Census that was done in 2001, indigenous Australians spent $364 per week on average, which was further evaluated to represent 62% of the income of the non-Indigenous people (Cooke et al., 2007). Unemployment among the indigenous people was also higher than their non-indigenous counterparts three-fold. Continuing to year 12 among the indigenous students was half as likely as the non-indigenous ones. These factors play an essential role in creating the difference in the well-being of the two communities. Education is essential in both disseminating knowledge as well as creating employment. Students who attain quality education get to learn about various chronic disease regarding their causes, treatment, and prevention. This information helps in demystifying some of the myths associated with some of these diseases back in the remote areas (Marmot, 2011).

Some of the patients in the remote areas fail to get medical attention due to the different cultural and spiritual beliefs they hold concerning various condition. However, educating the young people not only prepares a knowledgeable future generation but also ensures that the information spreads within their neighbourhood. The individuals not only find the essence of visiting healthcare facilities once they get ill but also find it necessary to attend the screening and follow-up visits (Cooper, D., 2011). As such, people will not be limited in their capacity to make use of the health information acquired. Employment is a critical social determinant of inequalities in healthcare since various aspects rotate about it. For instance, employment ensures that enough money is generated to limit the gap of quality healthcare access as a result of cost (Reading et al., 2009). Money ensures that quality care is given to the indigenous community just like the one received by the rest of the population. Employment also comes with the funds that are necessary for accessing quality medicines and obtaining decent housing where the spread of communicable diseases is limited. Essential health facts such as proper dieting will also be embraced as a strategy for preventing chronic diseases in the future (Shepherd et al., 2017).

The ‘Closing the Gap' policy is an outstanding example of how underprivileged communities such as the Aboriginal community can be empowered once again. However, while the policy may have strategies for improving the health of the community, the individuals also have a role to play regarding whether or not they decide to be part of the change. For instance, while it may be mandatory for every child to attend schooling beginning from the age of four, the parent decides to ensure that their child is actually at school. The members can also identify and work on their health priorities in different ways that collectively lead to the realisation of the policy's aims. The policy has impacted the Aboriginal community in different other ways that have boosted primary healthcare. The health of women, who are a vulnerable group, has been improved by organisations such as The Northern Territory Well Women’s Programme (West et al., 2010). This group operates mainly on the Aboriginal women regarding their health. It performs cervix screening to women in the Alice Springs remote region, and 61% of the women have turned up for the screening facilities. This rate is comparable to the 62% of women who turn up for screening among the general Australian population. Cancer is among the diseases that are leading in the morality rates of women in their most productive years of life.  For a long time, indigenous women have succumbed to various types of cancer as a result of the lack of information as well as facilities for opportunities for screening. Their counterparts who are mainly based in the urban areas benefit from frequent screening services that are frequently advertised and available in nearby clinics. However, with these changes in rates, there is an equality of some form that is generated hence it is expected that preventable deaths will be avoided. Since cancer is best managed when it is diagnosed in its early stages, such screening programmes will increase the life expectancy even in individuals who test positive (Ginsburg et al., 2017). Mental health has also been catered for through the construction of mental health facilities such as the Geraldton Regional Aboriginal Medical Service. Also, more mothers now attend antenatal care courtesy of programmes such as Aboriginal and Islander Health Service’s Mums and Babies Project which are all under the policy (Ginsburg et al., 2017).

**Colonisation and Racism**

The lower life expectancy and adverse health outcomes realised among the Aboriginal Australian community is in part due to colonisation and racism. Colonialism is an event that introduces people who dictate what their subjects ought to do. As such, the people who are under colonialism have little say about their situation and could be reluctant in changing it even years after the isolated event. Just like colonialism would impart psychological distress and depression on any individual, these effects were also faced by the Aboriginal and Torres Strait Islanders (Gracey & King, 2009). The other effects of colonialism among this population was the poor quality of life and substance abuse. Since they considered the colonialists as the worthy individuals who had their way, they lost value for life and became depressed. Substance abuse then followed as a way of getting over the stressful events of feeling less critical (Shepherd et al., 2017). All these factors subsequently contribute towards the significant ill-health condition of the indigenous population. When an individual is exposed to prolonged periods of stress, also, there are detrimental effects on major body systems such as the endocrine, immune, and cardiovascular systems. When these systems are affected, there is a probability of the individual suffering from a chronic infection which can also stay within the lineage for prolonged periods (Burgess et al., 2005).

The feeling of denial affected even the manner in which the Aboriginal and Torres Strait Islanders sought medical services. When they visited the healthcare facilities, they felt unwelcome and uncomfortable due to the prejudgment they received regarding their wellbeing. Most of the times they would even receive inadequate care by being presumed to have a minor infection even when they are seriously ill. On most occasions, most of them were perceived to have been intoxicated since they engaged in excessive substance abuse (Baum, 2007). Various pointers can be viewed as the contributors of racism to the situation among the Aboriginal and Torres Strait Islander people. They include the inequalities in the distribution of resources that lead to health promotion since the best centres were left for the colonialists and racists. The population was also disengaged from activities that promote health such as taking medications, adequate sleep, as well as physical activity. They were also injured physically as a result of the assault that was facilitated by racism (Azzopardi et al., 2018).

**Conclusion**

Even with the implementation of a policy that seeks to close the gap in health outcomes between the indigenous and non-indigenous Australians, some of the effects of colonialism and racism may come into play when medical attention is sought. Adjustments should be made in the implementation process to encompass the setbacks that may meet during this process. For instance, it is likely that Aboriginal people may present to the hospital during the later stages of an infection. Healthcare professionals should learn how to handle such individuals without having to give a negative prejudgment about their situation. Training the professionals on cultural competence is also vital in limiting the impact of racism on health outcomes. The failure to address some of these factors that contribute to health outcomes could have been the reason for the slowed rate of achieving the aims of the policy according to set deadlines.

**Bibliography**

Altman, J.C., 2009. *Beyond closing the gap: Valuing diversity in Indigenous Australia* (Vol. 54). Canberra: Centre for Aboriginal Economic Policy Research.

Altman, J.C., Biddle, N. and Hunter, B.H., 2009. Prospects for ‘closing the gap in socioeconomic outcomes for Indigenous Australians?. *Australian Economic History Review*, *49*(3), pp.225-251.

Azzopardi, P.S., Sawyer, S.M., Carlin, J.B., Degenhardt, L., Brown, N., Brown, A.D. and Patton, G.C., 2018. Health and wellbeing of Indigenous adolescents in Australia: a systematic synthesis of population data. *The Lancet*, *391*(10122), pp.766-782.

Baum, F., 2007. Cracking the nut of health equity: top down and bottom up pressure for action on the social determinants of health. *Promotion & Education*, *14*(2), pp.90-95.

Burgess, C.P., Johnston, F.H., Bowman, D.M. and Whitehead, P.J., 2005. Healthy country: healthy people? Exploring the health benefits of Indigenous natural resource management. *Australian and New Zealand Journal of Public Health*, *29*(2), pp.117-122.

Cooke, M., Mitrou, F., Lawrence, D., Guimond, E. and 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*(1), p.9.

Cooper, D., 2011. Closing the gap in cultural understanding: social determinants of health in Indigenous policy in Australia. *Darwin, NT: Aboriginal Medical Services Alliance Northern Territory. Tanja has lived and worked in rural/remote settings for the past*, *15*.

Ginsburg, O., Bray, F., Coleman, M.P., Vanderpuye, V., Eniu, A., Kotha, S.R., Sarker, M., Huong, T.T., Allemani, C., Dvaladze, A. and Gralow, J., 2017. The global burden of women’s cancers: a grand challenge in global health. *The Lancet*, *389*(10071), pp.847-860.

Gracey, M. and King, M., 2009. Indigenous health part 1: determinants and disease patterns. *The Lancet*, *374*(9683), pp.65-75.

Kildea, S., Kruske, S., Barclay, L. and Tracy, S., 2010. ‘Closing the Gap’: how maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women. *Rural and Remote Health*, *10*(3).

Marmot, M., 2011. Social determinants and the health of Indigenous Australians. *Med J Aust*, *194*(10), pp.512-3.

Reading, C.L. and Wien, F., 2009. *Health inequalities and the social determinants of Aboriginal peoples' health*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Renzaho, A.M. and Oldroyd, J.C., 2014. Closing the gap in maternal and child health: a qualitative study examining the health needs of migrant mothers in Dandenong, Victoria, Australia. *Maternal and child health journal*, *18*(6), pp.1391-1402.

Shepherd, C.C., Li, J., Cooper, M.N., Hopkins, K.D. and Farrant, B.M., 2017. The impact of racial discrimination on the health of Indigenous Australian children aged 5–10 years: analysis of national longitudinal data. *International journal for equity in health*, *16*(1), p.116.

Skinner, H.C.W. and Berger, A.R. eds., 2003. *Geology and health: closing the gap*. Oxford University Press.

West, R., Usher, K. and Foster, K., 2010. Increased numbers of Australian Indigenous nurses would make a significant contribution to ‘closing the gap in Indigenous health: What is getting in the way?. *Contemporary Nurse*, *36*(1-2), pp.121-130.