Chapter 10
Ways forward in Indigenous health

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Learning objectives

- Develop cultural skills for all staff working with Indigenous peoples.
- Understand the levels of cultural security for Indigenous staff working in organisations.
- Understand the need for cultural training of future health professionals.
- Recognise the diversity of the Indigenous population.
- Develop a practical understanding of cultural security in an Indigenous context.
- Understand the differences between cultural awareness, safety and security and apply this knowledge to a health context.

Introduction

The aim of this chapter is to differentiate between cultural security, safety and awareness, to demonstrate their importance in a health-service context and to give practical strategies for achieving and sustaining culturally secure services.

Cultural security is an essential component of health services for Indigenous people, yet it is largely misunderstood or ignored by health providers (Coffin 2002). What is cultural security? What does it mean to Indigenous people and how can health services and individuals help to create a culturally secure environment? Most of the existing literature considers cultural safety or awareness, but the discussion of security is limited (Williams 1999, Kearns and Dyck 2005). However, for many Indigenous people emotional and physical discomfort will result when cultural security is not an integral part of a health service (Aboriginal Stroke Project Steering Committee 2004, Reading et al 2005). This can lead to inadequate use of health services and, consequently, poorer health outcomes (McCormack et al 2001).

When providing a health service in a community, an awareness of cultural issues is just the start. To really be successful in improving Indigenous health, cultural security must be an essential element of the health care system. All health care providers, including doctors, speech pathologists, social workers, school nurses and dentists, need to provide a culturally secure service (Aboriginal Stroke Project Steering Committee 2004).

Health services may consider that they have a culturally secure service if they have Indigenous staff or an Indigenous liaison officer, or if they provide cultural awareness training for all new staff. In fact, such strategies are the bare minimum and stopping at this stage can create problems. For example, employing only one Indigenous liaison officer who is a female, not from the area and with no cultural connections in the area, means that she will not be able to fulfil all of the responsibilities of her role and will be isolated in the service, with no Indigenous co-workers to team up with. In reality, this health service does not have an Indigenous 'face' and Indigenous people do not have an adequate point of contact. Cultural protocol may stop her dealing with men's issues, yet she will be expected to deal with all clients by the health service.

The large demand for training programs and other support indicate that health services are frustrated with their inability to create solutions to the issues when dealing with Indigenous clients. Fortunately, much can be done to address these issues and move towards a more equitable health service provision for all (VicHealth Koori Health Research and Community Development Unit 2004, Cunningham et al 2005).

Defining terms

Cultural security, or its absence, can take many forms. Many Indigenous people are desensitised to even very blatant racism. After a life of continual stereotyping, further negative or inappropriate treatment by the dominant culture often goes unrecognised, or becomes the norm in an Indigenous person's life. Because racism can become so internalised, many Indigenous people may not have the background or ability to explain to health care providers what they have felt or experienced.

Let's look at the distinction between cultural security, safety and awareness (see Glossary for definitions). These very commonly used terms are often quite inappropriately interchanged. The definitions and their practical applications presented here are the subject of dozens of training sessions delivered to health science students and rural health care providers. Cultural awareness and cultural safety are important foundations for the attainment of cultural security, and the first two levels must be addressed in order to progress to the next level (see Figure 10.1). According to Maslow's theory of self-actualisation (Maslow 1943), we cannot fulfil higher needs unless more basic needs have been met.

To illustrate these levels, consider the management of an eight-year-old Indigenous boy by a speech pathologist.
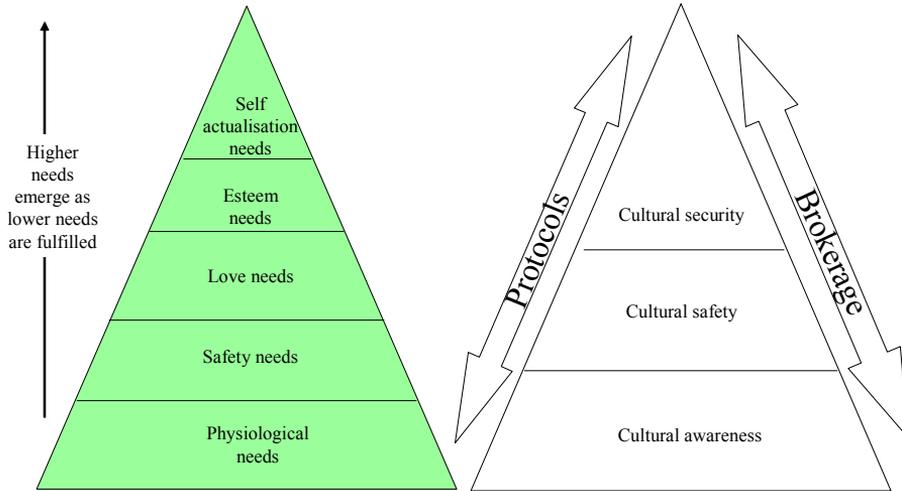
Source: adapted from Maslow (1943) by J Coffin

Figure 10.1   Comparison of cultural security and self-actualisation hierarchies

Awareness

> I know that most Aboriginal people have very extended families.

Although the speech pathologist demonstrates a basic understanding of a relevant cultural issue, it does not lead into action. There is no common or accepted practice, and any subsequent actions will depend upon the individual and their knowledge of Indigenous culture and cultural security.

Safety

> I am going to make sure that I tell Johnny's mum, aunty and nanna about his appointment because sometimes he is not with his mum.

Cultural safety involves health providers working with individuals, organisations and, sometimes, the community. More often, it consists of small actions and gestures, usually not standardised as policy and procedure.

Security

> I am going to write a note to Johnny's family and ask the Aboriginal and Torres Strait Islander Health Worker to deliver and explain it. I will check with the Aboriginal and Torres Strait Islander Health Worker to see if any issues were raised when explaining the procedure to the family and if transport is sorted out. I will ask to see if Sylvia (the Aboriginal and Torres Strait Islander Health Worker) can be in attendance at the appointment as well.

Cultural security links understandings and actions directly. Policies and procedures create processes that are automatically applied from the time that Indigenous people first seek health care.

Another practical application of the three levels can be seen in the organisation of waiting rooms. Awareness could simply mean recognising that sometimes, depending on the protocols, Indigenous men and women do not wish to be grouped together in the same room. Safety would mean that two exits are provided and two different rooms are used for such purposes. In a culturally secure service, male and female doctors and appropriate staff would also use two rooms for the treatment of clients. Without the establishment of some awareness in a health context, it is hard to appreciate what safety and security in a cultural sense would look like. This does not mean that it is necessary to know all about men's business, but if a practitioner is treating an Indigenous man, it is necessary to know who to ask for urgent information about appropriate care.

Cultural security is the hardest to achieve; but, if the foundations are good, security can be provided and will be easy to maintain. Security can be strengthened by community engagement in service provision decisions such as appointment of staff, training, job descriptions, and protocols. It means that there is a definitive compulsory action when an Indigenous person is transferred from one hospital to the next, or when someone dies in hospital. Cultural security means that there is a definite point of contact and that actions are well established. It should not matter if the health service is manned by temporary staff. No matter who is in the health service, they will know that these are the procedures to follow.

Achieving and sustaining cultural security

One of the biggest issues in Indigenous health is stereotyping and media depiction, which is often negative. This means that everyone comes to the table with preconceived ideas, even if they have never actually met an Aboriginal or Torres Strait Islander (Williams 1999). For example, at a health service it may be common practice for men to only see a male doctor. A new staff member may think that this is peculiar, but with cultural awareness he or she will understand why this practice exists and will be in a better position to ensure that these culturally safe practices continue.

In addition to improving the foundations of awareness and safety, two more elements must be developed to achieve and sustain cultural security: brokerage and protocols. If there are links between these elements and the process of achieving cultural security, it is much more likely that appropriate and sustainable security will be achieved.

Brokerage is a mechanism by which awareness of successful and safe practice can be deepened. It involves two-way communication, where both parties are equally informed and equally important in the discussion. Communication and respect are of the utmost importance (Sinnott and Wittman 2001, VicHealth Koori Health Research and Community Development Unit 2004): values and ideas are not pushed, but considerations from both sides are regarded equally. Good brokerage is a key ingredient in cultural

security and it must be developed with the Indigenous community. It is the way to build faith and trust. One of the largest components of brokerage is listening and yarning.

Health services need to recognise that Aboriginal and Torres Strait Islander Health Workers and Elders in the community are the health system's greatest resource. Even if there are no clearly identified Elders in the catchment area, there is always someone of respect with whom health care providers should consult if they want to create an equitable and appropriate program or service.

Protocols are strategies that can take a culturally safe practice and make it a culturally secure one (VicHealth Koori Health Research and Community Development Unit 2004, Westwood 2005). Protocols formalise the need, in an Indigenous context, for health care delivery and programs to be done in consultation with the Elders and key stakeholders within the particular community (or context). The right people will generally support many of the processes by advising on the correct guidelines for community engagement. For example, in one community, after talking with an Aboriginal and Torres Strait Islander Health Worker, a group of midwives discovered that the older Indigenous women were the ones to speak to in relation to young pregnant women. Subsequently, whenever issues arise with young mothers, there is an established point of contact with the older women first — thus an assurance is created for cultural security. Community leaders are made aware of the situation and are involved. Community participation can then make progress beyond mere 'involvement.' Communities become partners in an equitable, culturally secure provision of service. This is the pathway to cultural security.

Measuring cultural security

All health care providers must know what cultural awareness, safety and security is, and have a practical understanding of how is it maintained through appropriate brokerage and protocol (VicHealth Koori Health Research and Community Development Unit 2004). The first step to achieving cultural security is defining and standardising the language to reduce confusion. Then, people can plot themselves or their health service along a continuum as a basis to either move forward or maintain the same level of cultural security, if it is deemed to have been achieved. This basis is a starting point for everyone involved, including community and health service staff and other health professionals.

If we were to draw a scale (Figure 10.2) and ask health care providers and health services to honestly plot themselves and their services along it, few would consider themselves to be at the end point of sustainable cultural security. However, using the scale to think about their place and where they want to be can be an important first step to change.

Awareness   *Brokerage*   Safety   *Protocol*   Security   *Sustainability*

Source: Coffin

Figure 10.2   Cultural security scale

The concept and attainment of cultural security is extremely important and must be understood in every workplace where staff come into contact with Indigenous people. Cultural awareness alone does not lead to better health care (Westwood 2005). Indigenous people need to be clearer in defining what is expected of the health care provided for them and be united in voicing support for actions to bring about the creation of a more equitable health care system. Indigenous people are sometimes employed in health areas, but may not be heard (Westwood 2005). Health services need to listen to the Indigenous community and the community needs to be clear about what it wants.

Case study 10.1   Cultural security

On several occasions at a rural hospital, an elderly Indigenous man with chest pains presented, accompanied by his family members. This occurred mainly in the quiet hours of the early morning, on week nights. The daughter of the man carried a small child and several other children were running around the accident and emergency waiting area. The man in question went in to see the nurse for the third night in a row. However, the nurse on duty was different from the night before and the man had to explain his story over again.

This was frustrating to him as English was his second language. The issues were discovered to be of a very personal nature and the nurse checked him out thoroughly, and admitted him immediately. Half an hour later when the ward clerk went to check on the man's status he had left the building. The man never returned again.

Discussion

The man in the case study was a very well-respected Elder. His treatment was not only inappropriate but also repeated three times. The admission process was the final straw. The man's daughter came in to the hospital the following day, appalled at how her father had been treated. She was at no time asked questions regarding his health, language preferences or history, yet she had presented with him three times when he had chest pains.

The saddest thing is that the hospital staff were following what they thought was the right course of action. Interpretive services, Aboriginal liaison officers and Indigenous nursing staff would have been able to support the man's journey through the hospital — even his own family members were there to be included. There was no security for Indigenous people in the hospital. His treatment was gender-inappropriate, yet male doctors were working on the night of the man's admission. Even the admitting procedures were culturally unsound as the man did not understand the seriousness of his symptoms, the health issues related to his symptoms or why he was being admitted to the hospital.

To ensure cultural security, the most useful questions could have been asked at the appropriate times, including which health practitioner the man would have preferred to see and talk to. Staff could have spoken to the daughter in private and asked her some of the questions that the man was finding difficult to answer.

Cultural security is a set of prescribed actions and reactions to someone of another culture. It is not a hard road to take, but it requires a really good map. When it works correctly, the journey is enjoyed by all.

Case study 10.2   Leaving the bright lights

This case study describes the experiences of students who chose to attend a week-long cultural immersion program within an Indigenous remote community. They were told that the week did not only include working within the health care system; students were required to take part in all the activities organised by the local community (Palmer 1997, Teubner and Prideaux 1997). At the briefing session, it was pointed out that the week was to be a cultural learning experience, not a holiday, and certain protocols of respect, dress code and recognition of the role of a visitor were explained.

Throughout the program, students were challenged both culturally and clinically with a series of impromptu emergency scenarios that highlighted the difficulties of dealing with the needs of clients in a remote area. The program also highlighted the need to develop skills other than clinical skills, in order to be able to treat a patient in a remote setting. The responses of the students ranged from positive to negative, with the latter feeling unexpectedly inadequate in dealing with medical emergencies in the bush.

Students visited a bush clinic where the community nurse who had practised for 30 years cared for approximately 80 residents. She pointed out that 70 people in the community suffered from diabetes at varying levels. She challenged the students about how to improvise in the bush without medicines or other supplies, an unreliable telephone, no flying doctor and with the nearest hospital 120 km away (if the road is open). This demonstrated in a practical way the knowledge and innovation required to work in remote Australia.

Back at the campfire, students heard stories which allowed time for them to ask questions or reflect on the day's learnings. Students' comments included:

'To be able to experience the history of the Indigenous culture has given me an understanding and awareness of the health issues that may be present in Indigenous people.'

'This was a fun, educational and effective camp. I learnt heaps, enjoyed myself and met new people and it has encouraged me to work in Indigenous health in rural or remote places.'

Discussion

Developing an understanding of cultural security in medical and nursing students can be viewed as an aspect of social responsibility (Jamrozik 1995, Palmer 1997). Providing opportunities for medical and nursing students to experience first hand the health conditions, and the lack of resources and access to health care experienced by Indigenous people living in rural and remote Australia, is of critical importance (Garvey and Hazell 1997, Palmer 1997).

Students experienced a different cultural setting and teaching methods that provided them with a rare opportunity to step briefly into an Indigenous worldview (Jamrozik 1995, AMC 1998).

> ### Case study 10.3 Community checklist and researcher protocols
>
> You have accepted an offer of a clinical placement in a rural area, where you have been invited to gain research skills working on a research project. It is a large case–control study to implement an intervention relating to smoking, targeting Indigenous adults from a number of communities across the region.
>
> You meet Carmel, who is also a junior researcher and the sole Indigenous investigator in the research group, at your first team meeting. During the meeting, the project proposal, study design and project personnel are discussed. Carmel's ideas include extensive consultation in each of the respective community research sites and that the group should take a capacity building approach to the research by training community people to help implement the intervention. This would improve the acceptability and cultural security of the research in the communities. You notice that the chief investigators listen respectfully, but don't take Carmel's ideas on board because they seem to be 'too hard' and would take 'too long' to implement. You are still new to research, but you feel unsettled as you think what Carmel says makes sense. What can you do?

Discussion

If researchers ever wonder why there is such resistance to the concept of research amongst Indigenous people, they needn't look back very far. Communities have watched as processions of researchers from a range of fields have bowled in, measured heads, checked teeth and recorded language and customs, only to take that knowledge and leave, never to return and never to give back (Humphery 2000). Over generations, suspicion of researchers has developed, resulting in communities often feeling they have been 'researched to death' (Atkinson et al 2002).

This is a shame, because there is much the modern researcher has in common with Indigenous communities. Mainstream health research is driven by problem resolution through the scientific process; Aboriginal and Torres Strait Islander communities also want to solve the urgent, persistent health crises. However, rather than having methodological rigor, track record and research outcomes as the focus, as one senior Indigenous health professional has put it:

> Aboriginal people are more focused on the process than on the outcome.
> (Humphery 2000)

There is a good chance of bridging the gap between competing priorities if solid, trusting, equal and sustainable partnerships with Indigenous stakeholders are built up from the conception of a research project through to the dissemination stages (NHMRC and CHF 2002, Couzos et al 2005). Quality research that engages stakeholders and communities

can help improve the health problems faced by Aboriginal and Torres Strait Islander people, particularly if it is of practical use in addressing priority needs and offering a methodology that fills a gap (eg assessing interventions and their transferability) (VicHealth Koori Health Research and Community Development Unit 2000, Sanson-Fisher et al 2006, Thomas and Anderson 2006). In other words, a good process will lead to good outcomes:

> Community-based research can be of a high scientific standard without compromising the values and principles of those being researched. (Couzos et al 2005)

Early career researchers can be in a difficult position if they sense that something is not right with a project. In Case study 10.3, you do have a responsibility to confer with a co-worker like Carmel and speak up to the other investigators. In return, they should be compelled to take Carmel's suggestions on board and to act on her (and any other junior colleagues') concerns.

A practical step towards avoiding potentially damaging scenarios like the one described in Case study 10.3 is to follow a set of research protocols. If this is done, as in any good systems management process, the maintenance of cultural security in a research project will not depend on any one individual reacting each time an issue arises.

Protocols for Aboriginal and Torres Strait Islander health research can be drawn from existing documents (eg Aboriginal Stroke Project Steering Committee 2004), or a research team may wish to develop their own guidelines. Either option should always be set up under the direction of the researchers' local Indigenous communities, stakeholders and colleagues. This will ensure that the research is done in a culturally secure way from beginning to end. There are a number of excellent examples to guide researchers in how to go about compiling Indigenous health research protocols (Eades and Read 1999).

Another means of ensuring cultural security in research is to support local Indigenous people to create, through a consultation process, their own local community health research checklist. Similar to protocols for researchers, a checklist is a practical tool, but it is owned by local communities and community organisations, and facilitates their making of informed decisions about participating in research when they are approached by researchers.

Whilst it should be flexible and deal with projects on a case-by-case basis, a good research checklist can identify what overall standards the community should expect from research. It should also describe what ethically, culturally and methodologically sound research with genuine objectives looks like (Eades and Read 1999, VicHealth Koori Health Research and Community Development Unit 2000).

For example, the Kimberley Land Council (KLC) Executive set out a number of questions when they were approached by a researcher who was asking the KLC to support a project on local Indigenous community development issues. These questions provide a simple, but wise and all-encompassing framework that is still relevant for communities investigating the appropriateness of individual primary health care research

projects. As a final safeguard, protocols developed by researchers may be based on the community checklist.

A health research checklist (modified from Kinnane 2006)

1. What will the research bring to the people/community?

2. What will we as researchers take away from the community?

3. Will we train and employ the community's people to do the research?

4. How will the community know if what we are talking about will help them?

5. What committee will steer the researchers?

6. Who is the report of the research findings for?

7. Who will look at it or use it?

Case study 10.4 Research involving Indigenous Australians

The project involved the training of health staff to undertake a new diagnostic procedure, and introduce it to the health services at several Indigenous communities. The overall aim of the project was to establish acceptance and utilisation of the procedure by clients, and achieve appropriate follow-up and subsequent good health care outcomes for those clients.

Evaluation was an integral part of the project, to assess whether the aims of the project had been met. However, the evaluation was instigated as a research project, without any community involvement or consultation with the Indigenous communities or their representative bodies. This lack of consultation had a negative impact on the project as a whole, and reduced the uptake and utilisation of training opportunities. Once the communities, health services employees and other respective organisations were consulted, the barriers to successful training and subsequent implementation of the new procedure were overcome.

Discussion

Some Indigenous people involved viewed this research project with frustration; however, this perception shifted through the input and engagement of a research team that included two Indigenous academics that came on board at a time when the project had reached a stalemate. Their role was critically important in shifting and changing the focus and process of the project, making it a culturally secure and beneficial strategy. This was done through the engagement of Indigenous participants in the evaluation of outcomes, and led to acceptance by the communities involved. There was, however, a lack of acknowledgment of the Indigenous participants' involvement in the project and their role in facilitating the required change in documents related to the project. This is unacceptable.

Importantly, the Aboriginal and Torres Strait Islander Health Workers who received training were also involved in the research consultations, planning and evaluation processes. They felt safe and empowered to undertake research training, so that they could make the evaluation activities meaningful to themselves, their culture and associated values and beliefs, and the communities.

Key points

- Health services need to listen to the Indigenous community and the community needs to be clear about what it wants.

- Indigenous people need to be clearer in defining what is expected of the health care provided for them and be united in voicing support for actions to bring about the creation of a more equitable health care system.

- It is important to understand the differences between cultural awareness, safety and security and apply this knowledge practically in a health context. A practical understanding would be this description:

    In a culturally secure environment, the individual feels 'culturally safe', the health professional is 'culturally competent' and the service provided is 'culturally appropriate'. The health services organisation that meets the benchmarks for cultural safety and cultural appropriateness is 'culturally secure'.

- Central to cultural security is brokerage – a two way communication where both parties are equally informed, equally respected and equally important in the discussion.

- Cultural security processes include brokerage, protocols and resource allocation to embed cultural security in organisations and health systems in a sustainable manner.

- Specific cultural training is important to equip professionals with a recognition of their own culture and cultural safety requirements as well as to equip themselves with appropriate cultural skills to interact competently and appropriately with Indigenous colleagues, staff and consumers.

- It is important not to stereotype people and to treat each patient/client as an individual person.

Recommended readings and resources

- AITSIS (Australian Institute of Aboriginal and Torres Strait Islander Studies) (2000). *Guidelines for Ethical Research in Indigenous Studies*. http://www.aiatsis.gov.au/__data/assets/pdf_file/2290/ethics_guidelines.pdf

This is an essential document for people wishing to undertake research involving Indigenous peoples. It concerns them sharing an understanding of the aims and methods of the research, and sharing the results.

- Humphery K (2000). *Indigenous Health and 'Western Research'*, Discussion Paper 2, VicHealth Koorie Health Research and Community Development Unit. http://www.onemda.unimelb.edu.au/docs/DP2_KimHumpheryFINAL.pdf

This paper documents and discusses the conduct and process of Australian Indigenous health research and its reform over the past two decades. It outlines what both Indigenous and non-Indigenous writers have argued in their endeavour to raise questions about the methods, process, priorities, ethics, use and usage of the now large and ever-increasing body of work inquiring into Aboriginal and Torres Strait Islander health issues.

- Smith JD (2007). *Australia's Rural and Remote Health, A Social Justice Perspective*, 2nd edition, Tertiary Press, Melbourne, 18–37.

This publication provides real insight into the rural, remote and Indigenous health landscape, using story-telling techniques, historical accounts and real-life experience.

- Williams R (1999). Cultural safety — what does it mean for our work practice? *Australian and New Zealand Journal of Public Health* 23(2):213–214.

An article which discusses the issues of cultural safety in our work practice.

Learning activities

1. What impact does history have on the health and wellbeing of Aboriginal and Torres Strait Islander people?

2. How would an understanding of Aboriginal and Torres Strait Islander culture and protocols help you to deliver culturally secure health care?

3. How would an understanding of Aboriginal and Torres Strait Islander culture and protocols help you to undertake culturally secure research?

4. Reflect on the availability of resources in a remote Indigenous health service and how you, as a health professional, would work in this environment.

5. Describe how working as a health professional in an Indigenous community may challenge your beliefs and values.