Topic 2: The Health of Indigenous Australians

Structure of the topic:

This topic has two parts, Part A and Part B. Each part has learning resources for one week of study.

Part A is focused on the requirements of the first assignment. It provides resources for a literature review on the issue of indigenous health in Australia. You will learn about the historical, political, social and economic context of the problem as well as the scope of the problem itself. You will also learn about how chronic disease and ageing affect the quality of life of indigenous people in Australia.

Part B is focused on the requirements of the second assignment. You will learn about the role of the nurse in the aged care assessment team, cultural issues affecting institutionalisation and examples of projects developed to address indigenous health issues.

Learning Outcomes

Upon successful completion of this topic you will be able to:

- present a brief demographic profile of indigenous Australians.
- compare this profile to that of the general Australian population.
- discuss the implications of this profile for indigenous health status.
- Summarise the main causes of death among Australia’s indigenous population.
- Give examples of comparative rates of infectious diseases among indigenous and non-indigenous populations.
- Explain why diabetes and renal disease are major contributions to indigenous ill-health.
- describe three historical reasons for the lowered health status of indigenous Australians.
- give examples of how social, political and economic influences have affected indigenous health status.
• Evaluate four areas of improvement in indigenous health noted by the authors.
• Compare indigenous health in Australian to that of other indigenous populations.
• Briefly describe the role of the ACAT.
• Hypothesise the role of the nurse within the ACAT.
• Describe five rights of clients being assessed by an ACAT.
• Formulate reasons why indigenous clients might have difficulties in accepting hospitalisation or admission to a nursing home.
• Describe factors important in communicating with indigenous clients.
• Analyse myths about indigenous clients that a non-indigenous nurse might have.
• Formulate five strategies useful for a nurse dealing with indigenous clients.
• Describe briefly key issues pertaining to the role of the indigenous health worker.
• Describe the principal features of the empowerment model used in health promotion.
• Apply the model to the issue of improving indigenous health.

Introduction to the topic (Parts A & B)

The word ‘indigenous’ in the Australian context refers to people of Aboriginal or Torres Strait Islander origin. The topic of indigenous health is considered here as a major contemporary health issue because, as was noted in Topic 1, the health status of indigenous Australians is significantly worse than that of non-indigenous Australians. A male indigenous person aged 35 – 44 years is almost six times more likely to die than a non-indigenous person of the same age, and infant mortality rates are three times higher (Duckett 2004). We should also note that indigenous people have a communal concept of health in which the health of the individual is much more dependent on the overall health of the group than is the case for many other Australians. As the National Aboriginal Health Strategy Working Party (2000) stated:
For Aboriginal people, health is “not just the physical well being of the individual, but the social, emotional and cultural well being of the whole community . . . [and] a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self esteem and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity” (cited in Bond 2005).

Through one of the assessment scenarios, you will be able to link the important issue of indigenous health to aged care and nursing.

**Background Skills and Knowledge**

This course assumes that you:

- have completed a Bachelor of Nursing degree from an Australian university or a recognised overseas university.
- hold or are eligible to hold a current practising certificate as a Division 1 or Division 3 nurse in at least one Australian state.
- have a minimum of two-three years of professional experience.
- have successfully completed a research course at an undergraduate level.
- have basic computer skills and reliable internet access.

**Part A: References to be referred to:**


Australian Indigenous HealthInfonet
http://www.healthinfonet.ecu.edu.au/frames.htm

Australian Institute of Health and Welfare (AIHW) 2005, The health and welfare of Australia’s aboriginal and Torres Strait islander peoples.


Part B: References to be referred to:

Bennett, B. and Zubrzycki, J. (2003), Hearing the stories of Australian Aboriginal and Torres Strait Islander social workers: challenging and educating the system, *Australian Social Work*, vol. 56 (1) pp. 61-70.


Commonwealth Government Dept. of Health and Ageing (2005), *How aged care assessment teams (ACATs) can help you.*


Post-graduate medical council of NSW, Cultural diversity in health website (undated):

http://www.diversityinhealth.com/regions/indigaus/


The National Disability Administrators (2004), *Sharing stories: Exploring good practice for disability support services for Aboriginal and/or Torres Strait Islander people living in rural and remote communities.*


Part A:

Topic 2.1: A demographic profile of indigenous Australians

Learning Outcomes

Upon successful completion of this session, you will be able to:

- present a brief demographic profile of indigenous Australians.
- compare this profile to that of the general Australian population.
- discuss the implications of this profile for indigenous health status.

Demographic profile of indigenous Australians

Read the following excerpt from the HealthInfonet (2005) Website.

The overall proportion of indigenous Australians is about 2.3% of the general population. According to HealthInfonet (2005), there were around 483,990 indigenous people living in Australia in 2004 (around 432,560 Aboriginal people, 30,740 Torres Strait Islanders, and 20,690 people of both Aboriginal and Torres Strait Islander descent). Indigenous people comprise around 2.4% of the total Australian population. Most indigenous people live in New South Wales (NSW), followed by Queensland (Qld), Western Australia (WA), and the Northern Territory (NT). The NT has the highest percentage of indigenous people among its population and Victoria (Vic) the lowest. Most Torres Strait Islander people live in Queensland, with NSW the only other state with a large number of Torres Strait Islanders.

The indigenous population is much younger overall than the non-indigenous population. According to the 2001 Australian census, about 40 out of 100 indigenous people were aged less than 15 years, compared with 20 out of 100 non-indigenous people. About 3 out of 100 indigenous people were aged 65 years or over, compared with 10 out of 100 non-indigenous people.
Births

According to HealthInfonet (2005), in 2003, there were 11,740 births registered in Australia where one or both parents were indigenous (five out of every one hundred births). Overall, indigenous women had more children and had them at younger ages than did non-indigenous women.

Based on the pattern of births in recent years, indigenous women would have, on average, around 2.15 births in their lifetime, compared with less than 1.8 births for non-Indigenous women. More than 52 out of 100 indigenous women are 24 years or younger when they have their babies, compared with less than 18 out of 100 non-indigenous women. More than 21 in 100 Indigenous mothers are teenagers, compared with less than four in 100 non-Indigenous mothers.

On average, babies born to Indigenous women in recent years have weighed around 200 grams less than those born to non-indigenous women. Babies born to indigenous women are more than twice as likely to be of low birthweight (less than 2,500 grams) than are those born to non-indigenous women. (Low birthweight can increase the risk of health problems.)

Deaths

According to HealthInfonet (2005), indigenous people are much more likely to die before they are old than people in the rest of the Australian population. Estimates from the Australian Bureau of Statistics (ABS) indicate that at birth an indigenous male born in the period 1996-2001 could be expected to live to 59 years, which is around 17 years less than a male in the total population at that time (who had a life expectancy of 76.5 years). In the same period, an Indigenous female could be expected to live to 65 years, which is around 17 years less than a woman in the total population (82 years).

In 2003, there were 2,079 people who died and were identified as indigenous. Many indigenous deaths are incorrectly identified as non-indigenous — the actual number of Indigenous deaths is likely to be around 3,600.

Death rates relate the numbers of deaths to the total numbers of people. After taking account of the facts that the indigenous population is much
younger overall than the non-indigenous population and that many indigenous deaths are not identified as such, the death rates for indigenous males and females are likely to be around four times higher than those of their non-Indigenous counterparts.

Indigenous babies are more likely to die in their first year than non-indigenous babies. In 2001-2003, the infant mortality rate for indigenous babies was highest in WA (16 babies died out of 1,000 births) and the NT (16 babies died out of 1,000 births) and lowest in NSW (9 babies died out of 1,000 births). (The rate for the total Australian population is around 5 deaths per 1,000 births.

Source: HealthInfonet 2005


Activity 2A

Demographic profile and health status

Read:

Re-read the notes in topic 2.1 related to the demographic profile of indigenous Australians.

Develop answers to the following questions:

1. What are two significant demographic factors that distinguish the indigenous population from the general population of Australia?

2. Outline how your chosen factors impact on indigenous health status?

Feedback is available at the end of Part C of the online course materials.
Topic 2.2: The health status of indigenous Australians

Learning Outcomes

Upon successful completion of this session, you will be able to:

• Discuss the main causes of death among Australia’s indigenous population.
• Give examples of comparative rates of infectious diseases among indigenous and non-indigenous populations.
• Explain why diabetes and renal disease are major contributions to indigenous ill-health.

Life expectancy of indigenous Australians

Read the following excerpt from the Healthinfonet (2005) Website.

The current life expectancy of indigenous males is 56 years and that of females is 63 as compared to the non-indigenous figures of 77 and 82 years respectively. To gain a more detailed knowledge of indigenous health status three aspects of health status will be examined: principal causes of death, births and pregnancy and rates of common infectious diseases.

As mentioned at the beginning of this topic, indigenous Australians have a significantly lower health status than non-indigenous Australians. You will now have the opportunity to read and analyse some of the key indicators on indigenous health and compare them to those of non-indigenous Australians.

Indigenous mortality rates:


<table>
<thead>
<tr>
<th>Causes of death</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>SMR</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>680</td>
<td>3.2</td>
</tr>
<tr>
<td>Injuries</td>
<td>512</td>
<td>2.9</td>
</tr>
</tbody>
</table>
Cancer | 347 | 1.6 | 289 | 1.6
Respiratory | 206 | 4.4 | 154 | 3.9
Endocrine | 181 | 7.9 | 236 | 11.7
Digestive | 110 | 4.8 | 89 | 4.8
Mental disorders | 77 | 4.1 | 26 | 1.9
Infectious | 68 | 5.2 | 48 | 5.3
Nervous system | 59 | 2.4 | 48 | 2.1
Genitourinary | 56 | 6.2 | 94 | 8.7
Other | 222 | - | 161 | -
All causes | 2,518 | 3.1 | 1,867 | 3.0

Sources: ABS, AIHW, 2003

Infectious disease rates

- Tuberculosis – the rate of newly diagnosed cases for Indigenous people was 10 times the rate for Australian-born non-Indigenous people;
- Haemophilus influenzae type B – the notification rate for Indigenous people was 10 times that for the total Australian population;
- Meningococcal infection – the notification rate for Indigenous people was more than six times the rate of the total Australian population;
- Salmonellosis – the notification rate for Indigenous people was more than eight times the all-Australian rate;
- syphilis and gonorrhoea – notification rates for Indigenous people were between 40 and 70 times higher than those for the total Australian population;

Source: Healthinfonet 2005
Specific health conditions

Two specific health conditions are mentioned in the assessment scenario concerning indigenous health i.e. diabetes and renal disease. Some further information about these related conditions is presented here.

**Diabetes**

According to HealthInfonet (2005), diabetes is a major health problem among Indigenous people, but it is difficult to know just how many Indigenous people have the disease. The best evidence suggests that diabetes is between two and four times more common among Indigenous people than among non-Indigenous people. Indigenous people are likely to be diagnosed with diabetes at a much lower age than non-Indigenous people. Deaths from diabetes are much more common for Indigenous people than for non-Indigenous people. In recent years in Qld, WA and the NT, diabetes accounted for 11 times as many deaths as expected for Indigenous males and 18 times as many deaths as expected for Indigenous females (based on total Australian male and female rates, but, as with other estimated death rates, the actual difference is likely to be up to 30% greater).

In the 2001 National Health Survey, five out of every one hundred Indigenous people reported that they had diabetes as a ‘long-term health condition’. Indigenous people living in remote areas were more likely to report having diabetes than Indigenous people in other areas. (It should be noted that for every person who reports in surveys that they have diabetes it is likely that there is another person who doesn't know they have the disease.)

**Renal disease**

According to HealthInfonet (2005), renal disease, which affects the kidneys, has only recently been fully recognised as a serious public health threat to indigenous people. End-stage renal disease (ESRD) occurs when the kidneys are no longer able to function. Rates of ESRD are much higher for indigenous people than they are for non-indigenous people across most of the country, and particularly in remote areas where they are up to 30 times higher. Death rates from chronic kidney disease for people living in Qld, WA, SA and the NT in 1999-2001 were eight times higher for Indigenous people than for non-
Dialysis (the usual treatment for ESRD – where the work of the kidneys is done artificially) accounted for more than one-third of all hospital admissions among indigenous people in 2002-03 (many of these involved repeat admissions for the same people, some on an almost daily basis). Indigenous people were seven-and-a-half times more likely to be hospitalised for dialysis than non-indigenous people. In recent years, almost half of all indigenous ESRD patients have come from regions without dialysis or transplant facilities, and around one in six from regions with only satellite dialysis facilities.

Activity 2B
Indigenous health status

Read:

Re-read the notes on topic 2.3 related to the health status of indigenous Australians.

Develop answers to the following questions:

1. What are the five leading causes of death among indigenous Australians?
2. How do these compare to the five leading causes of death among the general Australian population?
3. What factors in the section on births and pregnancy are likely to have a significant impact on health status?
4. What are three infectious disease rates which are significantly higher that those of the general population?
5. What do you think are three likely causes for these higher rates?
6. What are two reasons for the high incidence of
diabetes and renal disease?

Feedback is available at the end of Part C of the online course materials.
Health Sciences

Topic 2.3: Historical, social, political and social factors affecting indigenous health status

Learning Outcomes

Upon successful completion of this session, you will be able to:

- describe three historical reasons for the lowered health status of indigenous Australians.
- give two examples of how social influences have affected indigenous health status.
- give two examples of how political influences have affected indigenous health status.
- give four examples of how economic influences have affected indigenous status.

Historical origins of indigenous ill-health


Before the arrival of Europeans, the Aboriginal peoples of Australia were a strong and healthy race of hunters and gatherers whose active lifestyle promoted good health. Little evidence has been found of widespread illness or disease in Aboriginal people, making it unlikely that they suffered from obesity, hypertension, diabetes, renal failure, coronary heart disease, cancer, arthritis or other diseases endemic in Aboriginal people today.

It is possible that, in 1770, when Cook charted the east coast of Australia, Aboriginal people were healthier than the average person in Britain or other parts of Europe. Further, Aboriginal people had a strong oral pharmacopoeia which was passed down from generation to generation. The early European colonists, without a means of replenishing their medical supplies, were taught by Aboriginals to use "medicinal plants growing in the new country".

After at least 50 000 years of a strong and intact culture, the Aboriginal population was decimated by diseases introduced by Europeans, and those remaining were displaced from their lands and forced to change...
their lifestyle. Now, more than 200 years on, and despite attempts to improve Aboriginal health, the health of Aboriginal people is markedly worse than that of other Australians and of the indigenous peoples of New Zealand and the United States.

Since the arrival of Europeans there has been very little formal recognition of the profound spiritual links of Aboriginal peoples to their land. The common law principle of *Terra Nullius* -- a territory belonging to no one -- was applied unilaterally. The British "took possession" of the land because they considered it to be unoccupied. Moreover, unlike the experience of Maori in Aotearoa (New Zealand) or the indigenous peoples in both the United States and Canada, there has never been a formal treaty between the Aboriginal people and the newcomers to Australia. It has been argued that the absence of a treaty with Aboriginal peoples is causally associated with their poor health and social disadvantage. Disempowerment has been accepted as a causative factor by the Royal Australasian College of Physicians in its Darwin Declaration (1997): . . . that the health of Aboriginal and Torres Strait Islander Australians is disastrously poor compared with other Australians, and that the fundamental cause is disempowerment, due to various factors including continued dispossession from land, cultural dislocation, poverty, poor education and unemployment.

To Aboriginal people, ill-health is more than physical illness; it is a manifestation of other factors, including spiritual and emotional alienation from land, family and culture. Aboriginal people have a spiritual link with the land which provides a sense of identity, and which lies at the centre of their spiritual beliefs. Land is the crux of Aboriginal health and well-being.

**Source:** Jackson and Ward, 1999.

**Social, political and economic health determinants**

According to Anderson (2004) there are a number of social determinants which have contributed negatively to indigenous health status. These also tend to have economic and political implications. Among these are:

- Dispossession
- Marginalisation
- Remoteness from health services
• Discrimination
• Education level (e.g. 18% completed yrs. 10-12 compared with 32% non-indigenous).
• Unemployment (approx. 3 times as high as the non-indigenous rate)
• Income (average significantly lower than for non-indigenous)
• Indigenous households are larger (3.5 individuals compared to 2.6)
• Lower home ownership rate (32% compared to 69%).

As well as the points given by Jackson & Ward (1999) and by Anderson (2004) above, historical, social, political and economic factors impacting on indigenous health can be illustrated in personal stories told by Aboriginal or Torres Strait Islander people themselves. One such story is given here – the story of Mavis Golds.

Activity 2C
Case Study: Understanding historical, social, political and economic factors impacting on indigenous health

Task: Access the following website

Students are required to access the following website article entitled Aboriginal health – a personal perspective by following the promotes provided below. This can be found in the following website:

http://www.medicineau.net.au/clinical/abhealth/abhealt1338.html

You should now have access to Mavis Golds’ story.

Read:
• Re-read the points made by Jackson & Ward (1999) and by Anderson (2004) in topic 2.3.
• You are also required to read the case study by Mavis
Golds entitled Aboriginal Health – a personal perspective.

Develop answers to the following questions:

Based on the points made by Anderson (2004) in topic 2.3 and by Mavis Golds in her Case Study, you are required to answer the following questions:

1. Describe three historical reasons for the lowered health status of indigenous Australians

2. Provide two examples of how social influences have affected indigenous health status.

3. Provide two examples of how political influences have affected indigenous health status.

4. Provide two examples of how economic influences have affected indigenous status.

Feedback is available at the end of Part C of the online course materials.

Activity 2D

Responses to indigenous health statistics

Read:

Access the following article from the folio of readings for Topic 2.

Ring, I. and Brown, N. (2002), Indigenous health: chronically inadequate responses to damning statistics, Medical Journal of Australia, vol. 177 (11), pp. 629-631. This can be accessed at the following website:


Develop answers to the following questions:
1. What are four areas of improvement in indigenous health noted by the authors?

2. How does Australian indigenous health status compare to indigenous populations in New Zealand and North America?

3. What do the authors see as the main political obstacle to improved indigenous health?

4. What principal recommendation for improvement is made by the authors?

Feedback is available at the end of Part C of the online course materials.

Additional reading:

Part B:

Topic 2.4: The aged care assessment team (ACAT)

Learning Outcomes

Upon successful completion of this topic, you will be able to:

- Briefly describe the role of the ACAT.
- Hypothesise the role of the nurse within the ACAT.
- Describe five rights of clients being assessed by an ACAT.

Introduction

The assessment scenario involving indigenous health refers to the nurse as a member of an ACAT (Aged care assessment team). If you work in the aged care sector, this will be a concept familiar to you. However if you work in a different sector of nursing the following information will assist you with your assignment.

Purpose and scope of the ACAT program

According to the Australian Government Dept. of Health and Ageing (2005), ACATS help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance.

ACATs provide information on suitable care options and can help arrange access or referral to appropriate residential or community care.

The Australian Government provides funds to the State and Territory Governments, specifically to operate and manage the ACATs.
ACATs are made up of doctors, nurses, social workers and other health professionals who can provide a thorough assessment of your care needs and offer advice on suitable and available care options.

If care at home is agreed as being the most appropriate type of care, ACATs will refer you to local community services. If residential care is agreed as the best care option, ACATs can approve high or low level care and help arrange a place for you in a suitable facility.

Members of the ACAT will ask a series of question in order to find the best care option for your particular situation.

These questions are designed to work out how much and what sorts of help you need with daily and personal activities. With your approval, ACATs may also contact your local doctor to gain more information on your medical history to help with the assessment process.

Many people are assessed as needing community care services, such as Home and Community Care (HACC), to help them to stay in their own home for as long as possible.

ACATs may also approve a Community Aged Care Package (CACP) or an Extended Aged Care at Home (EACH) Package, which are packages of coordinated care services provided in your own home.

This option may be more appropriate if you have more complex care needs and you prefer to remain at home. If you need residential aged care, the ACAT can approve either high level (nursing home) care or low level (hostel) care.

Some aged care homes will provide high level care only, while some will provide low level care only.

Others may meet a wider range of care needs.

The ACAT can also help arrange respite care. The idea of respite care is to give you and the person who cares for you a break. It can either be:
care in a day-centre, support in your home for a few hours a week or the ACAT can approve a short stay in a residential aged care home. ACATs cover all of Australia and are based in hospitals or in the local community.

Client rights:

Clients of the ACAT program have the following rights:

• the right to be treated with dignity and respect.
• the right to information about the assessment process
• the right to be told what is happening and why.
• the right to express your own views and ideas.
• the right to have someone with you during the assessment if you wish, for example, a carer, close friend or relative.
• The right to an interpreter if required, which the ACAT can arrange.
• The right to an independent advocate if required, to help you with advice, or to act on your behalf.

Source: Commonwealth Government Dept. of Health and Ageing (2005), How aged care assessment teams (ACATs) can help you.


Activity 2E

Aged care assessment

Read:

Read the information on Aged Care Assessment Teams in topic 2.4 above.
Develop answers to the following questions:

1. What are three important factors in a person’s home situation which must be considered before recommendation is made for a move to an institution?

2. What are three additional factors which would have to be considered if the person was from an indigenous background?

Feedback is available at the end of Part C of the online course materials.

**Topic 2.5: The nurse’s role in improving indigenous health**

**Learning Outcomes**

Upon successful completion of this topic, you will be able to:

- Formulate two reasons why indigenous clients might have difficulties in accepting hospitalisation or admission to a nursing home.

- Describe five factors important in communicating with indigenous clients.

- Describe three myths about indigenous clients that a non-indigenous nurse might have.

- Describe five strategies useful for a nurse dealing with indigenous clients.

**Culture and health care**

According to the post-graduate medical council of NSW (Cultural diversity in health website), the following factors need to be taken into consideration by health professionals working with indigenous individuals, families and groups:
General

- Given the pre-invasion colonisation diversity of Aboriginal cultures and the complex results of invasion, there is a huge diversity among Aboriginal people. There continue to be over 100 indigenous languages in Australia at this time.
- There are a range of reasons why people may or may not wish to claim their Aboriginal heritage. Be careful of making assumptions, especially with Aboriginal children and in any public setting.

Language / Communication

- Indigenous Australians in NSW are generally English speakers or bilingual.

- Communication:
  - Should be simple, clear and concise
  - Is generally reserved with strangers, although some patients may become vocal if they feel defensive.
  - Attitude to eye contact is variable. Follow the lead shown by the patient on this issue.
  - Building trust with the client is important and may take time.
  - Ask patients how they wish to be addressed.
  - Indigenous Australians may be reluctant to disagree openly. This means that disagreement may be articulated in the form of non-compliance.
  - Silence is valued as an element of communication. It does not necessarily indicate unresponsiveness. Health professionals should allow silence within the consultation in order for their patients to consider the implications of the conversation.
  - Community elders generally have a high status and may be a rich resource for information. Ask Aboriginal health workers to identify appropriate individuals, but be careful of assuming that they speak for the community.
  - Literacy may be poor, especially for older people.
Customs

- Extended family structure. Each child may have a range of adults who are responsible for caring for them.
- The role of gender varies according to the community.
- Death and dying conventions - in NSW it is generally acceptable to say the name of someone who is deceased, but check with elders for community specific customs

Approach to the health system

Indigenous people will often present for medical care when their illness has significantly progressed or when they have multiple complaints. This may be because:

- There is a reluctance to violate community responsibilities (e.g. leave children or elderly relatives unattended).
- Historically, hospitals and the health system have been the site of significant racism against indigenous peoples.
- Indigenous Australians generally have a high tolerance to pain.

Approach to medication.

- Lack of compliance is a significant concern.
- There is a significant orientation to symptoms. This may mean that patients stop taking medication as soon as symptoms cease.
- It is important to explain the importance of completing medication. Provide clear, specific and simple instructions both verbally and in written form.
- Medication may be shared within the community.

Symptoms and hospitalisation

- Orientation to symptoms may have a significant impact on preventative medicine.
- High incidence of
  - Diabetes
  - Cardiovascular disease
  - Kidney disease
• Indigenous people may be reluctant to stay in hospital, particularly older people who may remember a hospital as a site associated with the Stolen Generations. Other treatment options should be explored before hospital is considered. If hospitalisation is required, indigenous patients may wish to receive as many visitors as possible.

• Keeping appointments may be a problem

Traditional health practices

• There may be a belief in some traditional communities that disease is caused by bad spirits or 'bone pointing'.

• Some communities may use bush medicine concurrently with biomedical health practices.

Mental health

• Due to the impacts of colonisation there is a high rate of mental health issues in the indigenous community. Particularly
  o Transgenerational trauma related to the Stolen Generations
  o Bipolar disorder
  o Depression
  o The sequelae of substance abuse.

• Mental illness is generally not stigmatised in the community

Gender/Women's health

• Attitudes to gender vary greatly between indigenous communities.

Source: Post-graduate medical council of NSW, Cultural diversity in health website:

http://www.diversityinhealth.com/regions/indigaus/
Activity 2F

Nursing indigenous people

Read:

Read the information on strategies for nursing indigenous people in topic 2.5 above.

Develop answers to the following questions:

1. Describe five factors important in communicating with indigenous clients
2. Formulate two reasons why indigenous clients might have difficulties in accepting hospitalisation or admission to a nursing home.

Feedback is available at the end of Part C of the online course materials.

The role of the nurse

Wilson (2003, p. 238), writing from a New Zealand Maori perspective believes that the high-level socio-economic and political issues associated with improving health status among local indigenous populations may be beyond the changes that many nurses feel they can make. However, she believes there are strategies that nurses working with indigenous groups can adopt and implement in their practice, and that they are strategies that could be considered as good practice in any setting - indigenous or non-indigenous.

- Analyse the position of power you as a nurse possess in your practice and recognise the potential misuse of this power.
- Analyse the myths and misconception you may hold about indigenous people and groups - failure to do so may mean these inform your practice.
• Avoid adopting a universal approach to nursing care and begin by greeting each indigenous person as an individual in a genuine and welcoming manner.

• Respect and acknowledge the person's worldview. This conveys to them a willingness to include important aspects of their beliefs and practices into the assessment and intervention processes of their health experience.

• Utilise a language that can be understood and check out that you are being understood. Language can be a powerful barrier that influences future access and use of health services.

• Provide time for the person to respond and ask questions. An atmosphere of 'no time' results in misinformation and a lack of understanding about the health experience.

• Facilitate access to advocates for indigenous consumers of health services. The provision of support, and someone who can assist in understanding what is happening and who may speak on behalf of the person may make a difference to the outcome of your interaction.

• Advocate for the health service to work with local indigenous people to develop a user-friendly service. This facilitates access and use of the health service and conveys a message that the service respects the local indigenous people.

• When working with indigenous people, consider using the principles of partnership, participation and protection. That is, work in partnership with indigenous people; enable their participation in all facets of the assessment process and planning of interventions; and act in ways that protect their beliefs and practices while in a health service. This will engender a sense of trust and credibility.

Read the information on strategies for nursing indigenous people in topic 2.5 above.

Develop answers to the following questions:

1. Name three myths about indigenous clients that a non-indigenous nurse might believe.
2. Name two of Wilson’s proposed strategies which are also reflected in the list of rights for clients being assessed by an ACAT (See topic 2.4 above).
3. When considering the assessment scenario about indigenous health and aged care how would you apply the principles of partnership outlined by Wilson (2003) in her final strategy?

Feedback is available at the end of Part C of the online course materials.
**Topic 2.6: The role of the indigenous health worker**

**Learning Outcomes**

Upon successful completion of this session, you will be able to:

- Describe briefly the role of the indigenous health worker.
- Discuss two dilemmas faced by the indigenous health worker.

**The use of self in practice**

According to researchers Bennett and Zubrzycki (2003), indigenous social workers embrace the self as a key element of their practice. Their personal experiences create a powerful link with the Indigenous and non-Indigenous people that they work with. This is supported by Lynn et al’s research which identified that; 'considered and deliberate use was made by the workers of their own experience and problems and their way of dealing with them' (p. 35).

Read the following excerpt from Bennett and Zubrzycki (2003).

One of the most important aspects of the use of self occurs during the introduction process. The participants spoke of the need, when working with other Indigenous people, to introduce not only their professional role, but also their cultural identity. This involves identifying birthplace and kinship ties, which remain a lifelong reference point. Due to the kinship system, workers often find themselves related to their clients and this needs to be established at the moment of introduction. This is both a professional and cultural responsibility and requires the establishment of culturally respectful communication and the need to clarify issues such as confidentiality especially in small communities (Lynn et al. 1998).

The introduction process can also involve sharing personal stories and experiences. The participants spoke about using self-disclosure, carefully recognising that it is often necessary to share their stories in order to enhance working relationships and establish credibility.

People would always ask where are you from, where have you been and how did you get here? Often elder Aboriginal people will ask me what experiences have you got in this situation? Have you been
Health Sciences

depressed or anxious? How long have you been in this community? What is your story? So I think I don't really want to commit to this, but I have to' (Bindi) Acknowledging the influence of the kinship system also means engaging with the family as opposed to being individually focused. For example, it is important to get family permission to talk to and work with others as they may have a more appropriate intervention strategy than the worker and also have established more trust with the individual.

So when you work with Aboriginal people you've got to expect that you're working with the family and not working with an individual, and you've got to respect that often the answers are within that family' (Jess and Sue).

Although Bennett and Zubrzycki (2003) were researching the practice of indigenous social workers in their study, the same concept of use of self can be applied to any form of indigenous health work.

Activity 2H

Issues faced by indigenous health workers

Read:

Read the following article which can be accessed in the folio of readings for Topic 2.


n10020_fm.pdf

Develop answers to the following questions:

1. What were four activities carried out by Bond in her capacity as a newly graduated Aboriginal health worker?

2. What caused her to re-think her role?
3. What does she believe is most conducive for achieving better outcomes among indigenous people?

Feedback is available at the end of Part C of the online course materials.

Additional Readings:

**Improving vascular health:**

**Preventing coronary heart disease rates:**

**Eradicating trachoma:**
King, M. & Baxter, S. (2003), Cooperative inquiry: The development of a visual impairment prevention program initiative for two Aboriginal communities in South Australia


**Topic 2.7: The empowerment model of health promotion**

**Learning Outcomes**

Upon successful completion of this session, you will be able to:

- Describe the principal features of the empowerment model used in health promotion
- Apply the model to the issue of improving indigenous health

**Process of empowerment**

One model of health promotion which may be useful to consider in the context of improving indigenous health is the ‘empowerment model’. This involves negotiating your objectives with the client or the family or the group. In this model you don’t assume you know all the answers or possible outcomes in advance.

Read the following excerpt from Talbot and Verrinder, 2005, p.95.

According to Talbot and Verrinder (2005, p. 99), the process of empowerment is central to community development work (Ife 2002, p. 53) and is aimed at increasing the power of those who are disadvantaged… People and groups can be disempowered because of the way existing structures in society maintain their powerless situation, such as being unemployed, or by virtue of their personal characteristics, such as their gender, sexual orientation or personal values.

In health-promotion activities across the continuum of approaches, the Primary Health Care philosophy directs us to focus on the most disadvantaged groups in terms of their equitable access to health care. A fundamental way to achieve sustained change is to strengthen community involvement in decision-making so there are more community-based structures in place. Empowerment may be a by-product of other community-based activities. For instance, policy that is already in place at various levels of administration including national, state and local government, and within organisations, can be a very useful tool of empowerment. In addition, individuals and groups
who become active in influencing policy formulation or change gain a number of very useful skills along the way.

**Working towards empowerment**

Ife (2002, p.208) describes the role of the community development worker seeking empowerment of a vulnerable group as one of providing people with the resources, opportunities, vocabulary, knowledge and skills to increase their capacity to determine their own future, and to participate in and affect the life of their community. Ife (2002) offers four perspectives on empowerment:

- Various groups in society are competing for power (politicians, unionists, lobby groups, professions, media, etc). Empowerment is a process of helping disadvantaged groups to compete more effectively with other interests.

- Elite groups have more than their share of power and exercise disproportionate influence over decision-making. They control the institutions, media, education, political parties, public policy, the bureaucracy, parliament, professions, etc. Empowerment is learning the ability to compete for political power, to seek alliances with elites, or to limit their power, such as service clubs, school networks, the Australian Medical Association and other professional associations.

- Structural inequality and oppression are major forms of power (white, wealthy, men). Empowerment is achieved through challenging structural disadvantage through social change.

- Power is expressed through the use of language (discourse) which is used as a mechanism of control. Empowerment is achieved through validating other voices than those currently dominating the discourse.

**Source:** Talbot and Verrinder, 2005
Activity 2I

The empowerment model of health promotion

Source:


Case Study:

Read the following case study entitled “There can be too many problems” and answer the questions below.

There can be too many problems in an Aboriginal community to know where to start. Unemployment, poverty, boredom, alcohol all go towards the destruction of the community. Child health problems, diabetes, poor nutrition, and lack of medical services.

That is how the situation seemed to a community health nurse until she was invited to work with the community.

In 1987, the Aboriginal Council formally invited some health care workers into the community. The team was expanded to include two Aboriginal enrolled nurses. These nurses set up a women’s group which ‘lurched from week to week’. The idea was to start with advice and education on nutrition but the women were more interested in learning how to make quilts and curtains, and upholster chairs. The program started with what the women wanted which meant that the women did some beautiful needlework and their children were warm at night. This approach gave them plenty of time for talking and learning how to be more assertive. It was a catalyst for:
The women learning to speak for themselves and others, resulting in four of them gaining places on the council
• Making plans for a childcare centre
• Starting to use the library

As the group progressed the workers noticed that the women were not eating regularly or well. The community health nurse offered to cook lunch next week, which they all enjoyed. Many of the women wanted to know how to make it, so cooking and sharing food became a regular feature of the group. The spin-offs were:

• One 10 year old boy started skipping school to get a free meal every Tuesday. However, the women told him in no uncertain terms to get back to school, so that he could be educated to get a better job later on
• ‘I stopped drinking so I could come today’ was how one women with an alcohol problem explained her presence to the group
• using the recipe leaflets they were given, the women began cooking more nutritious meals
• a number of people have applied for houses and received them
• several people have completed TAFE courses
• a young woman, planning for the future of her child, had made the decision to move out to the wider community

Develop answers to the following questions:

1. Describe three ways in which this group of indigenous women became more empowered through the program?
2. Using the information on evaluation from Topic 1 Part B, how could you evaluate this program?

Feedback is available at the end of Part C of the online course materials.
Frequently Asked Questions

There will be a series of questions posted on the Bulletin Board of Online Classroom during the study of this topic. You will find it useful to post questions here, and gain responses from your peers and the course coordinator.

Feedback for Activities 2A-2I

Any questions or clarification can be addressed to your online tutor and/or course coordinator.

Summary and Outcome Checklist

Tick the box for each statement with which you agree:

- I am able to present a brief demographic profile of indigenous Australians.
- I am able to compare this profile to that of the general Australian population.
- I am able to discuss the implications of this profile for indigenous health status.
- I am able to summarise the main causes of death among Australia’s indigenous population.
- I am able to give examples of comparative rates of infectious diseases among indigenous and non-indigenous populations.
- I am able to explain why diabetes and renal disease are major contributions to indigenous ill-health.
- I am able to describe three historical reasons for the lowered health status of indigenous Australians.
- I am able to give examples of how social, political and economic influences have affected indigenous health status.
- I am able to evaluate four areas of improvement in indigenous health noted by the authors.
I am able to compare indigenous health in Australian to that of other indigenous populations.

I am able to briefly describe the role of the ACAT.

I am able to hypothesise the role of the nurse within the ACAT.

I am able to describe five rights of clients being assessed by an ACAT.

I am able to formulate reasons why indigenous clients might have difficulties in accepting hospitalisation or admission to a nursing home.

I am able to describe factors important in communicating with indigenous clients.

I am able to analyse myths about indigenous clients that a non-indigenous nurse might have.

I am able to formulate five strategies useful for a nurse dealing with indigenous clients.

I am able to describe briefly key issues pertaining to the role of the indigenous health worker.

I am able to describe the principal features of the empowerment model used in health promotion.

I am able to apply the model to the issue of improving indigenous health.

Assessment
Part A of this topic focuses on the requirements of the first assignment which is due on Friday of week 7, by 5pm Australian Eastern Standard Time.

Part B of this topic focuses on the requirements of the second assignment which is due on Friday of week 12, by 5pm Australian Eastern Standard Time.

Evaluation
Evaluation responses will be requested upon completion of Assignment 2. Check with your coordinator for details.