Intercultural engagement in Indigenous health care: considering communication and health literacy

Läwurrpa Maypilama, Rosemary Gundjarranbuy and Anne Lowell
Yolŋu : Aboriginal people of North-East Arnhemland

Balanda : everyone else
Interdependence between health literacy, communication and cultural responsiveness

Health Literacy

*Attribute (skills and knowledge) of:*
- Consumers
- Health staff (service providers, managers, policy makers)
- Educators, Interpreters, Media Systems, Organisations

Health Communication

*Process between:*
- Consumers
- Health staff (service providers, managers, policy makers)
- Educators, Interpreters, Media Systems, Organisations

Effective communication enhances health literacy

Level of HL influences effectiveness of communication

Differences between consumer and staff, systems and sources of information and extent to which differences are recognised and accommodated related to:

- Language, communication processes, styles, protocols
- Cultural and conceptual knowledge, attitudes and beliefs
- Power relationships, trust and respect
“We don’t get the full story…

“This is a pen - Balanda only gives the Yolŋu the lid of it and not the whole pen. We need the full information, this has been happening for a long time. Where is the full information?”

“They don’t give the information, they only give us medication and send us home.”
Yolŋu strongly say that they want:

- *dhudi dhäwu* (deep story)
- *dhunupa dhäwu* (straight story)
- *yuwalk dhäwu* (true story)
Sharing the Full and True Stories About Chronic Conditions

- a 3 year project bringing together biomedical and Yolŋu knowledge

- led by the Yalu Marŋgiyhinyaraw, a local community organisation staffed only by Yolŋu

- supported through a developmental evaluation approach in which evaluators were an integral part of the project team

- funded by Department of Health and Ageing’s Local Community Campaigns for Promoting Aboriginal and Torres Strait Islander Health
Core elements of a Yolŋu approach to health education

**Cultural and language experts in control**: community educators planning, developing, implementing and evaluating activities and resources

**Ongoing and sufficient support** and time for community educators to access the knowledge they need from the biomedical domain – from health staff competent in intercultural collaboration
Sharing ‘the deep stories’ (not key messages) to enable genuinely informed decisions:

- detailed explanations including foundational concepts about which there is not shared understanding

... all the way I'd thought breathing was done by the heart not the lungs...then I recognised how we breathe and how blood flows - from the video .... it was like an electric shock.....

The doctors have never explained that before.. I never (heard the story) before in my life until last week when I watched the DVD - now I am 58 - and only now I have heard the straight story about breathing...

(a long term cardiac patient with a high level of conversational English)
- Yolŋu... explaining in Yolŋu language not in English - when it is in Yolŋu language, Yolŋu understand. Not Balanda explaining in English - or telling half - from their thinking (Yolŋu community educator).

Yolŋu educators can:

- recognise and respond to differences in conceptual and cultural knowledge

- conduct education in a time and place that suits community members (e.g. at home in family groups, at ceremonies, in the evening)
• interactive rather than a didactic
• explanatory rather than directive – respecting the strong sense of individual autonomy
• avoiding oversimplification and culturally specific metaphors
• the phrase ‘keep your family smoke free’ was interpreted as advice to give free cigarettes to your family.
• ‘sugar-free’ was interpreted as meaning that the drink contained a lot of (free) sugar rather than no sugar
Recognising health-promoting cultural knowledge and practice as a legitimate element of health literacy:

- engaging local community experts in sharing cultural knowledge and practice related to health
- personal experience of chronic conditions shared through peer education

Oral explanations supported with visual images responsive to local cultural and conceptual knowledge

• realistic not stylised and capturing context- considering differences in pictorial literacy
A Yolŋu approach to resource production

Yolŋu controlling all stages of video production:
planning,
filming,
editing,
distribution.
• collecting a wide range of content (from both Balanda and Yolŋu) related to the topic – not starting with a ‘storyboard’ (a Balanda approach)

• stories were shared from ‘the heart and the mind’ and no scripts were ever used

• as their knowledge deepened the Yolŋu team edited and sequenced the information in a way that would be meaningful to other Yolŋu

_to me it is not long - it's good, interesting... a long story - (Yolŋu) will understand, a short story (they) will not understand... the information goes in and comes out - they are not holding it and understanding with the heart and the mind..._

(community educator)
This story, they (Balanda) haven't told us the story before and yesterday we got the true deep story, about what is happening inside our body and about the parts - what work they do and how they help us... the straight story, before we didn't get this information...

(Yolŋu community educator).
We believe that is a true story – it touched us ..... because when we saw the video we can recognize what is happening to ourselves..

When we watch the video we learn and believe the story ..... that story went into our blood
At the same age Yolŋu and Balanda should die - we need an ongoing program

Yolŋu to Yolŋu really helping each other so that young people don't die - so that Yolŋu die at 95 or 100. At the same age Yolŋu and Balanda should die. Not Balanda living longer and Yolŋu dying (early). So closing the gap together like this - so Yolŋu will reach the same level as Balanda and walk together...

(Gundjarranbuy, Project Coordinator)
Our people are dying – this project is ending... the community desperately wants more education.... more and more until we understand... so we get sick at the right time, so we get dead at the right time, like that..

(Yolŋu Project Coordinator)
Working with interpreters

- Provision of interpreters is fundamental to the protection of the health rights of Aboriginal people who do not speak English as their primary language.

- This is recognised in legislation and policy – but not always reflected in the culture and practice of health services.
• approximately 70% of Aboriginal people in the NT speak an Aboriginal language at home

• more than half of hospital separations will involve Aboriginal people who do not speak English as a first language

• approximately of Aboriginal people admitted to Royal Darwin Hospital, who do not primarily speak English, have an interpreter booking made. Only 5.2% have the booking completed.
There is a growing focus on the health literacy of organisations, systems and staff and the health literacy environment.

A ‘health literate’ health professional presents information in ways that improve understanding and ability of people to act on the information. This requires competence in intercultural engagement and communication in interactions with consumers from diverse backgrounds.

An organization must also be culturally responsive to be health literate, i.e. to provide services that are responsive to the cultural and linguistic needs of consumers.
Indigenous knowledges and practices are also a legitimate component of health literacy – but rarely recognised.

Health literacy is dynamic not static.
- depends on the cultural, conceptual and linguistic demands of the context.
Considering health literacy in the context of language and culture

**Scenario 1:**

An Aboriginal client and a health professional from the same cultural and language group discussing diabetes management (health-promoting information e.g. traditional foods, medicines, exercise through hunting and gathering, ceremony e.t.c and health-damaging factors e.g. sources of stress and disempowerment).

Both the client and health professional will have a relatively high level of health literacy in this context due to their shared language, cultural background and health-related knowledge relevant to their specific cultural, social, economic and environmental context.

**Scenario 2:**

An Aboriginal client (who speaks a language other than English at home) and a non-Aboriginal health professional discussing diabetes management (medication, diet, exercise, cause and consequences). An interpreter has not been used in this interaction.

Both the client and health professional will have a relatively low level of health literacy in this context due to the absence of shared language and cultural knowledge. The client may not be familiar with the Western medical concepts and language related to the body and illness and the health professional may not be familiar with the client’s understanding of the body, causation, socio-cultural and economic influences on health and health management. System health literacy is also low as standards for service provision with clients from culturally and linguistically diverse backgrounds have not been met.
Effective communication is crucial to ensuring health care is:

- equitable
- safe
- ethical
- of high quality
When health staff and their clients do not share the same cultural and language background:

- there is a high risk of miscommunication
- this is often unrecognised – by all participants
- ineffective communication is common even with those fluent in conversational English
What is needed?

Recognition of the right of Indigenous consumers to access health care in their own languages through culturally responsive processes.

*Ongoing and sufficient* support to ensure equity of access to meaningful information needed to make informed decisions.

*Shifting control* of communication policy and processes to the experts - those who share the cultural and language background of the clients:

