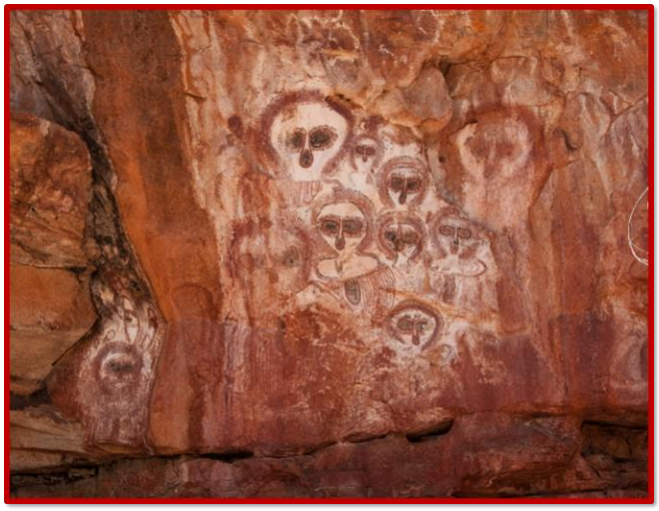
Engaging Aboriginal and Torres Strait Islander Communities

AVHEC
Australasian Viral Hepatitis Elimination Conference 2017

CENTRE FOR CHRONIC DISEASE PREVENTION

JAMES COOK UNIVERSITY AUSTRALIA

Disclosure of interest: nil



Gurriny Yealamucka Health Service [Yarrabah]

Wuchopperen Health Service

Torres Strait Primary Healthcare

Apunipima Cape York Health Council

2

Yirrganydji and Yidinji people
The elders and ancestors

3

Engagement:

"As for health, context is the key. A nation's afflictions are written in its history."

William Farrow, 1924

4

Engagement: various settings

Urban
Regional
Rural
Remote

→ Each community has a unique history

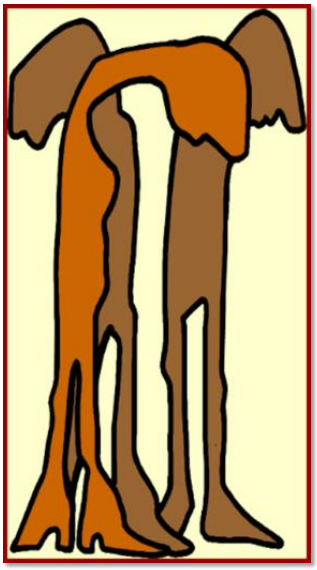
5

An approach for rural and remote communities……..

- Do the homework: makeup of the community, languages, culture, history, geography, weather, infrastructure, leadership, etc.
- Visit and listen
- Show respect
- Be mindful of language
- Provide service
- Build local healthcare capacity
- Take time
- Check progress
- Provide community feedback
- Follow-up

In the light of what we know……..

What we know……..



- History plays a huge part in the health disparity; it shapes people's world view
- Remoteness is one of many factors
- The overall burden of illness is high……and cannot be siloed-off
- Opportunity is in short supply [education, employment, housing, self-determination, etc]
- Many communities are sick of being researched [especially when it's someone else's research agenda & when the research just describes health problems rather than fixes them]
- Translation of research findings to effective healthcare practice has been less than a resounding success
- Things will always be complex. A pharmaceutical approach doesn't work.
- Institutional discrimination is still alive and kicking

Institutional discrimination

- Structured into political and social institutions; embedded in policy and practice
- Often unthinking rather than malicious
- Difficult to recognise and counter
- Reflects the cultural assumptions of the dominant group
- Generates patient mistrust and refusal
- Leads to exclusion from access to services
- Reinforces disadvantage

Human Rights and Equal Opportunity Commission
http://www.hreoc.gov.au

Where to start……

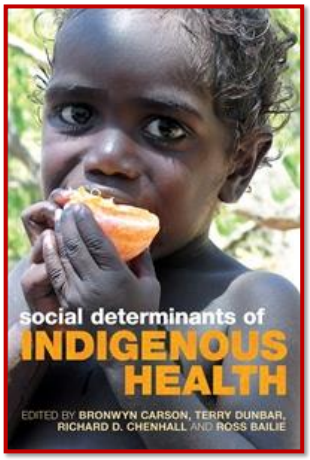
- Community health service: manager, **health workers**, nurses, doctors, allied health
- Community Council
- Health Council or Action Team
- Community Justice Group
- Women's group
- Wellbeing centre
- **The 'Nannas'**
- Sports teams
- Arts Centre
- Schools
- Local religious leaders
- Parole and probation officer[s]
- Community events

The overall health burden – HBV & HCV are but a part

- Cultural priorities
- Degree of self-determination
- Housing and crowding
- Education
- Employment
- Substance use
- Incarceration
- Institutional structures
- Distance
- Climate

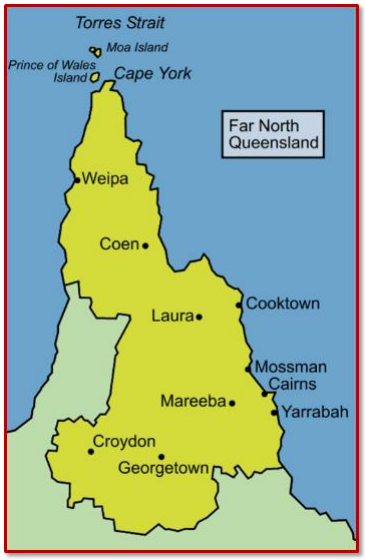
The 'coming-to-town' burden is formidable

A different mix in every household and every community



Primary healthcare has radically changed in the last 30 years

- **Multidisciplinary** approach
- **Better services**: SEWB and mental health services, better trained health workers, maternal and child health services, diabetes educators, nutritionists, exercise physiologists, podiatrists, etc
- **Better systems**: especially communications [mobile phones], eHealth records and recall systems
- **Information**: evidence-based guidelines, CARPA, PubMed, UpToDate, Google Scholar, etc
- **Diagnostics:** POC testing, rapid DNA/RNA detection, onsite ultrasound imaging, **in-community Fibroscan**
- **Effective interventions:** antenatal care, safe births, vaccines [childhood, **HBV**, HPV, influenza, etc], statins, ACEi, aspirin, azithromycin [STI and trachoma], **HBV/HCV treatment**, HAART…….many more



Health Silos

"Miscommunication is pervasive."

Daunting challenges of a 'whitefella' health system

- Informed consent…..for whom?
- Plenty of 'tricky' forms
- Incomprehensible 'explanations'
- Individual priorities, family experiences and harmful labels
- Perceived 'shame jobs'
- Self-removal is common

INDIGENOUS HEALTH

Sharing the true stories: improving communication between Aboriginal patients and healthcare workers

Alan Cass, Anne Lowell, Michael Christie, Paul L Snelling, Melinda Flack, Betty Marrnganyin and Isaac Brown

DOCTOR–PATIENT COMMUNICATION, by creating good interpersonal relationships, allowing the exchange of information and facilitating treatment-related decisions, is fundamental to optimal medical care.[1] Effective communication correlates with improved outcomes, including physiological criteria such as levels of blood pressure and blood sugar.[2] Conversely, professional, language and cultural barriers can impede communication.[3,4]

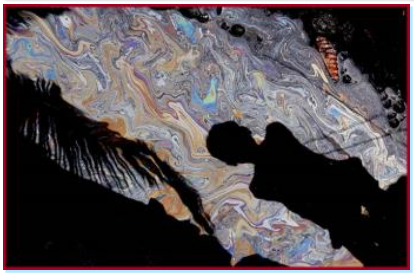
ABSTRACT

Objectives: To identify factors limiting the effectiveness of communication between Aboriginal patients with end-stage renal disease and healthcare workers, and to identify strategies for improving communication.

Design: Qualitative study, gathering data through (a) videotaped interactions between patients and staff, and (b) in-depth interviews with all participants, in their first language, about their perceptions of the interaction, their interpretation of the video record and their broader experience with intercultural communication.

Setting: A satellite dialysis unit in suburban Darwin, Northern Territory. The interactions occurred between March and July 2001.

Participants: Aboriginal patients from the Yolngu language group of north-east



13

"The key to providing effective healthcare in community….

is relationship."

- Respect for cultural tradition
- Real engagement*
- Suspension of preconceptions and judgements
- Flexibility
- Recognition of people's autonomy
- Continuity of care

***"The world is run by the people who show up"**

Sometimes attributed to **Woody Allen**

Take Home Message

Viral hepatitis eradication programs in these communities:

- Can and should be run **from** within the communities
- Can and should be run **by** the communities

Thank you for your time