

# **DREAMING 08 - AUSTRALIAN LIBRARY AND INFORMATION ASSOCIATION BIENNIAL CONFERENCE – IMPROVING THE HEALTH AND WELL-BEING OF ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN – THE ROLE OF THE HEALTH LIBRARIAN**

## **ABSTRACT**

Health professionals such as librarians are in a unique position to assist Aboriginal and Torres Strait Islander women's access to health information and health services. In order to meet the health needs of this client group services must be accessible, flexible and supportive. As argued by Nakata (2006:11), 'any provision of sustainable, relevant and useful services must take into account demographics and the knowledge and information needs and interests of people in different communities. It must provide access to knowledge and information from the quite distinct Western and Indigenous knowledge tradition to meet these needs and interests'. Librarians and their ability to access information and their excellent communication skills may therefore improve the health and well-being of these women as shown in the experiences of one health librarian working within a Queensland Health medical library in Rockhampton.

## **Introduction:**

Australian research has shown that Aboriginal and Torres Strait Islander women want health providers and health information from services and people they can trust and who are respectful towards them. Overcoming cultural barriers requires not only empathy on the part of providers but knowledge of their specific health needs. Community support for these women who are culturally and socially isolated is essential. Access to health information has the potential to improve access to the health care system in general. In Australia it is no longer appropriate to assume that all women seeking health care can be approached/treated the same regardless of their cultural background. Anglo-American services are not culture-free despite their claim to scientific objectivity. Misunderstanding and difficulties in communication between indigenous women and health care providers may result in under utilization of services. Overcoming cultural barriers is a bigger obstacle to health services and information than other variables such as language. For many women there is a reluctance to discuss issues of a personal nature with people in authority.

Current morbidity and mortality data shows that the health of Aboriginal and Torres Strait Islander women is poorer than that of non-indigenous women in Queensland and in Australia overall. The life expectancy for indigenous women is almost 20 years less than non-indigenous women (Bell, 2001). The effects of colonisation, racism, poverty and inequalities in living standards continue to have a damaging effect on women's health. Aboriginal and Torres Strait Islander women face much greater rates of cardiovascular disease, cancer, diabetes and infectious diseases (Bell, 2001). They are subjected to domestic violence and sexual abuse and suffer from substance abuse and mental illness. Access to health services and information is vitally important for women's wellbeing.

### **Access at local community level:**

Aboriginal and Torres Strait Islander community controlled health care is essential if women are going to access health services (Bell, 2001). An integrated and holistic approach is necessary and culturally appropriate for Aboriginal and Torres Strait Islander women who have a different view of health and well-being from non-Aboriginal and Torres Strait Islander women. At the level of clinical services health professionals can provide not only treatment and management of chronic diseases but preventative care such as screening and immunisations as well. Understanding the central role that women play in the family, and the many distresses caused as the result of women leaving their homes and communities in times of a health crisis is essential when designing service/programs.

### **Access to health promotion facilities and access to illness prevention: Cancer**

Aboriginal and Torres Strait Islander women often delay clinical presentation for breast cancer and as a result suffer from a more advanced form of the disease than other women (Shaw, 2002). The provision of health promotion and educational activities on women's specific health issues need to be designed in a culturally appropriate way in order to engage women. BreastScreen Queensland designed a range of promotional activities which succeeded in increasing the screening participation rate for Aboriginal and Torres Strait Islander women from 36% in 1996/1997 to 54% in 1998/1999. Among the strategies they adopted were: community education; screening and follow-up services; workforce development; support services for women and their families and mobile women's health clinics/nurses.

### **Access to screening and medical technology:**

Indigenous women prefer to consult with indigenous female health workers in issues relating to their health care needs. A major objective by Queensland Health in the area of cervical screening has been to work in participation with indigenous health workers to ensure that screening services are culturally effective and safe for Aboriginal and Torres Strait Islander women (Women's Cancer Screening Services, 2000). Other areas to be addressed include chronic disease management especially in the area of diabetes. Research shows that women with diabetes have a significantly higher risk of coronary heart disease than women without diabetes (Wang and Hoy, 2004). More recent research shows that indigenous women in northern Australia have the highest rates of pneumonia in the world (ABC Online, 2008).

### **Access to services that impact on health and well-being:**

Aboriginal and Torres Strait Islander women suffer disadvantages in access to education and employment, both of which impact on their health and well-being. While there has been a slight increase in the number of women entering higher education there is still a long way to go. Labour force participation rates and income level rates are lower for indigenous women than for other women (Commonwealth Office of the Status of Women, 2002). Housing is also a priority area for government with many families living in sub-standard accommodation. According to Indigenous Housing Organisations in Queensland some 40% of permanent dwellings required major repairs or replacement

(*Health Determinants Queensland 2004*). Overcrowding often results in poorer health status, and women experience a range of health issues not specifically related to their gender, e.g. respiratory disease. Private health insurance is also not common among families. Women are also at greater risk of domestic violence and abuse, unwanted pregnancies, and other gynaecological health problems. Their lower incomes also result in poor nutrition and hence ill health, as does their lack of physical activity (Stark and Hope, 2007).

### **Access to State and Federal government health resources:**

A report entitled, *Achievements in Aboriginal and Torres Strait Islander Health* (2003) emphasised the need for additional funding in order to deliver health care to Aborigines or Aboriginal people (Australian Department of Health and Ageing, 2003). As argued by Henry et al. (2004:517) 'Overall funding of Aboriginal healthcare is not commensurate with extra need' They argue that existing funding is based on a 'body part' model such as diabetes and heart disease rather than a holistic approach favoured by the people themselves. Debate continues, however, in the area of accountability and evaluation of community owned services. Many existing programs in operation especially in remote areas of Australia, are reliant on State and Commonwealth funding which is not recurrent. This funding model inhibits planning by local communities and authorities. More recently, government intervention has been more dramatic and contentious as applied in the Australian Government's intervention into Northern Territory communities. In response to the growing awareness of child sex abuse, medical personnel have been sent into communities to assess the situation, welfare payments have been quarantined and new alcohol bans imposed in an attempt to address the problem.

### **Geographical barriers to access:**

Aboriginal and Torres Strait Islander women are often located in remote regions with limited access to services. Lack of transport and poor roads contribute to the problem of access. Fear of leaving their homes/communities to attend large centres for medical treatment is a significant barrier for women who are in need of treatment. In Queensland half of the Aboriginal communities with a population of 50 plus were located more than 50 km from a hospital (*Health Determinants Queensland 2004*). Unfortunately, the delay in diagnosis and treatment of medical conditions often results in poorer health outcomes. In remote areas the cost of healthy food is inflated due to higher transport costs and it is this additional expense that accounts for the low consumption of fruit and vegetables by people in remote communities (*Health Determinants Queensland 2004*).

### **Language and communication barriers:**

Many indigenous women have a different language and communication style. The use of medical jargon and the biomedical model used by health professionals act as barriers to effective communication for women. Women use non-verbal gestures, silence and indirect eye contact as part of the communication process. Misunderstandings and difficulties in communication between women and health care providers may result in underutilization of services. For many women there is a reluctance to discuss issues of a

personal nature with people in authority. For effective communication to occur a relationship of trust and respect needs to be established between parties.

### **Cultural barriers:**

To understand indigenous culture and women's place within it requires one to respect the importance of women's role within their family and community structure. Aboriginal and Torres Strait Islander women have a holistic view to health and well-being which includes the social, emotional, spiritual and cultural well-being of the whole community (Shannon, 1994). They are the major carers in their families and communities and as do their male counterparts have a deep sense of belonging to their land (Pink and Allbon, 2008). As argued by Walker and Shepherd (2008:2), 'Aboriginal families are pivotal to the wellbeing of indigenous communities and their culture and survival'. Women still suffer as the result of the unjustifiable taking of their children in the past.

### **Prejudice:**

Racism causes ill health. As a result of colonisation women (and men) experience feelings of powerlessness and low self-esteem. Stereotypical views of indigenous people in Australia exist because of lack of understanding of their values and culture. As a result of colonisation institutional racism is said to exist in the Australian health care system as the result of historical racist beliefs and values (Henry et al., 2004). While Aboriginal and Torres Strait Islander community controlled health services were seen as a model of care best suited to the needs of both Aboriginal and Torres Strait Islander men and women (National Aboriginal and Torres Strait Islander Health Council, 2003), government intervention of late in northern Australia has been more externally controlled. Some 73 indigenous communities are now under government control. Despite the intervention being seen as racist, many indigenous women have acknowledged the improvement in their communities. As claimed by Mildred Inkamala: 'Kids now have more food to eat and new clothes and it's helped stop the drinkers from pressuring others for money, known here as humbugging' (Insight, 18 March 2008). In the past, health services have been seen by Aboriginal and Torres Strait Islander women as unfriendly and insensitive to their needs. This situation has arisen because the workforce has historically been made up of health professionals who were not trained in the specific cultural issues relevant to Aboriginal and Torres Strait Islander women. In the case study to be now discussed we present the experiences of library staff in Rockhampton who have moved from their initial role as direct service providers to information literary trainers.

## **Case study – Rockhampton**

The Rockhampton Health Sciences Library is situated within the Rockhampton Hospital campus and was, up to the end of 2007, an integral part of a Rural Health Training Unit (RHTU). The catchment area for this unit included Central and Central Western Queensland plus the coastal and inland communities from Rockhampton City to just north of Brisbane. In this region there are the two Aboriginal communities of Cherbourg and Woorabinda. The library now has a southern cut off in the Fraser Coast area and no longer services the southern community of Cherbourg. Woorabinda is 170 kilometres to the west of Rockhampton.

### **Health worker education**

As early as 1993, the RHTU was offering Primary Health Care Worker training to Aboriginal and Torres Strait Islander men and women. These further educational courses included the Associate or Advanced Diploma or Certificate IV in Primary Health Care, Certificate III in Community Services, Alcohol and Other Drugs and Certificate III in Indigenous Health Care. Dozens of Aboriginal and Torres Strait Islander men and women have completed these courses. However, some 75 per cent of students were female and their interest was mainly in the area of child and family care, whereas the male students saw alcohol and others drugs and sexual health being more culturally appropriate for their study. Due to the loss of Registered Training Organization status and problems with recurrent funding, the last course commenced at the unit in 2003. From 2004-2007, the emphasis was placed on facilitating workshops for the existing health workers. The majority of these workshops were based around nutrition of women and children during their life stages such as pregnancy as well as basic clinical practices. In the past few months an Aboriginal and Torres Strait Islander Workforce Training Unit has been established in Community Health which hopefully goes some way to meet the need for more Indigenous case studies from the field (Stephenson, 2004:37).

### **Overcoming cultural differences**

Overcoming cultural barriers was discussed earlier in the paper. Queensland Health makes “Cultural Awareness Training” mandatory for all new staff members and retrospectively for existing staff. The Aboriginal and Torres Strait Islander Cultural Awareness Program aims to foster culturally appropriate behaviour at work through an understanding of Aboriginal and Torres Strait Islander people’s history and culture. Originally the training took 3 or more days but this has now been condensed to 1 day and is also offered online through the [COOL - Cultural Orientation Online \(Aboriginal & Torres Strait Islander Communities\)](#) site. Queensland Health also has an internet site designed to assist in the dissemination of information for Aboriginal and Torres Strait Islander people: <http://www.health.qld.gov.au/atsihealth/default.asp>

For a short time, the RHTU offered South Sea Islander Cultural Awareness training. In a small coastal community near Rockhampton and also to the north and south are the descendants of the South Seas peoples who were coerced or forcefully brought over to Queensland as labour in the 19<sup>th</sup> and early 20<sup>th</sup> Century. In the Rockhampton district

there are many families who can claim their ancestral heritage from a combination of the local Aboriginal, Torres Strait and South Seas peoples.

### **Collection development**

In the middle to late 90's the library built a collection of culturally appropriate training materials plus writings relevant to Aboriginal and Torres Strait islander health, culture, society and history. This collection was heavily used by Queensland Health staff. Rockhampton Hospital is the major treatment centre for Woorabinda and the library seeks out resources pertaining to Aboriginal health issues with an emphasis on diabetes, renal disease, eye disease and neonatal care. The library also provides information to non Queensland Health organisation outside our core clientele.

### **Library services to Health Workers and students**

The information sessions given by the library to the health worker students were at first informal and were conducted in the classroom usually over a cup of coffee and something to eat. These sessions were more of a 'meet and greet' and offered the basics such as the location of the library and the services offered. Many of the students came from a background of unfavourable educational experiences and were entering education as mature aged students in their 30's and beyond. The majority of whom were women. Being a mature aged student with little formal education is daunting enough without having the challenges that these students were facing, being isolated from their families and communities and having, in the early years at least, white teachers. Many had little experience with computers and even less with librarians and libraries.

The two Rockhampton Hospital librarians at this time had no experience of dealing with Aboriginal and Torres Strait Islander peoples. The Cultural Awareness training had helped but we were apprehensive. A change of tactics when conducting the reference enquiry interview was the first challenge. We found the limited eye contact was essential as was waiting longer before prompting with a further question. This became easier as our working relationships with the students progressed. As a woman, I noted that the male students were reluctant to ask me for information, especially about "women's business" health matters and would either go to my male colleague or get one of their fellow female students to ask for them. There were frequent instances of the teachers having to ask on behalf of the students as the request was seen as embarrassing. This was an issue which caused some problems for the students but acted as a catalyst for their determination to learn how to find the information themselves. The questions that we were asked about the mechanics of the finding process were of a general nature. The specific request was kept private.

This corresponds with what was presented earlier with the women preferring to consult a female health worker in their own community. Personally, I know of male health workers who have gravitated towards men's health issues for their professional development. However within a few sessions, the initial shyness between the students and library staff faded. The usual library orientation sessions of clinical database searching techniques were adapted to show them where to access information that was readily attainable and which could be used by their communities, as frequently these health workers were the sole practitioner. It was vital that the health workers knew where to go, whom to call and be able to put a face to the name.

The evidence based searching techniques were offered further into their course and only after consultation with the teachers as to the content.

The RHTU teachers instilled a love of learning and the benefits of doing research. The first cohorts of students became our best ambassadors and as the years progressed, our new health worker students were seeking us out before more formal library instruction. Our role as librarians was effectively changed from being direct service providers to taking on more responsibility as information literacy trainers.

As the first Rural Liaison Librarian, I had the privilege of travelling many times with two of the RHTU's Aboriginal Health Worker trainers. Being in a car for hours at a time allowed us as women to have frank and wide ranging discussions about our lives and beliefs and these talks increased my very limited knowledge of their culture. Although we no longer work together we have remained firm friends and I can state that these times remain one of my top life experiences.

The librarian's role also broadened to include general literacy instruction as some of the student cohorts had low literacy levels. We were able to source appropriate background material for questions on grammar and spelling, building a trusting relationship between librarians, teachers and students. Librarians should not underestimate the trust that is developed between clients and themselves in our multicultural workplaces and society. The Rockhampton Hospital library staff have been asked to proof read assignments and job applications written by clinical staff who have English as a second language. As librarians we see this as something that we "just do", but it is doing the extra work for our clients that helps bridge cultural divides. Normally, for a medical library, this proof reading would not be seen as core business.

### **Outreach services**

Since 1995, the Rockhampton Hospital Library has also had an outreach component where the Rural Librarian travels throughout the large catchment area conducting workshops for Queensland Health staff in accessing and using electronic databases. As part of this brief, every hospital and health facility in each district is visited at least once a year (12 weeks a year on the road). It is interesting to note that a recent article by Wendi Arant-Kaspar (2008) states that taking library instruction to the classroom can help reduce anxiety and resistance as it is at the convenience of the teacher and for the comfort of the class.

On checking the records, the numbers of staff who have attended training and who identified as Health Workers is unfortunately low (20). It is tempting to speculate that this is because they were comfortable with the skills they had learned during their education with RHTU. When I travelled with the Health Workers to the communities, I had better access to the few local community staff who were obviously more comfortable in my being accompanied by an Aboriginal woman. I relied on my colleagues to open doors for me and in subsequent visits, found the organization of training was easier. Training was and is conducted in both the communities of Cherbourg and Woorabinda with a special emphasis on subject matter and sites relevant to Aboriginal and Torres Strait Islander Health. However, the majority of staff who attend training on the visits to the communities are of European heritage and this reflects the staffing ratio. As more Queensland Health staff now have open internet access, the

library is focusing on accessing material outside of the traditional Medline and CINAHL databases, such as showing the collection of articles available through the Medical Journal of Australia web site or the information and links in the Australian Indigenous Health InfoNet.

### **Current Awareness Service**

In January 2007, the library commenced its Indigenous Health Current Awareness Service. There are 378 known recipients, plus one librarian who forwards the service to her entire district . To gauge the effectiveness of this service a short answer survey was conducted via SurveyMonkey and distributed to all known recipients. While the results are not statistically significant due to the poor response rate (N=81), the usefulness of the service was highlighted. Respondents were asked to rate the current awareness service and some 60% noted that it was 'above average' in meeting their clinical/work needs. In response to another question on whether the service had improved the delivery of services to Aboriginal and Torres Strait Islander peoples, 76% of respondents agreed that it had.

The Health Sciences Library will continue to develop the Indigenous Health Current Awareness Service and it will be offered to non-Queensland Health facilities in the Central Queensland region in 2008 due to demand from this sector.

As a result of outreach database searching workshops there has been an increase in the number of sessions being requested by the Woorabinda community. Unfortunately, time and budget constraints have limited this expansion. Despite these constraints and recent restructuring in the Central Queensland Health Service District it is most likely that a stronger emphasis will be placed on education and the Health Sciences Library will continue to play a significant role in the future.

The Health Sciences Library in Rockhampton is committed to continuing and expanding its services of connecting Aboriginal and Torres Strait Islander health workers with culturally and clinically relevant information. It is fortunate that our physical location permits face to face contact with the largest numbers of Aboriginal and Torres Strait Islander communities and that these communities also have access to electronic resources which the library can use as an additional means of communication.

As this paper has shown health professionals such as librarians are therefore in a unique position to assist Aboriginal and Torres Strait Islander women's access to health information and health services. This paper has provided some background to indigenous women's current health status drawing from Australian research. A limitation of the paper is its lack of overseas research from other indigenous cultures.

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