DIFFERENT VOICES: DECOLONISING INFORMATION IN HEALTH

JENNIFER STRONG  
UNIVERSITY OF NEWCASTLE

ABSTRACT: In his book on modern social work theory Payne (1997, 31) addresses ambiguity of understanding. He sees social work as looking at alternate views of an argument and understanding the complexity of the discourse about a phenomenon. Royal (2002), in Indigenous Worldviews, sees differing origins of basic spiritual belief systems such as those between Eastern - an internalised concept of the ‘divine within’; Western - an externalised concept of God in Heaven, where the world is created by God but is not God; and indigenous - where God is in the world, deserts, forests and seas. This must give rise to ambiguity of understanding because it is not only a difference in language but one of conceptualisation. Moren (1994) in Payne (1997, 2) ‘sees social work as a process of making visible new possibilities of interpretation and action.’ The spirituality of a person ties in with their identity and ways of experiencing the world. This has implications for creation, dissemination and interpretation of health services.

This paper is based on research into the spirituality within families in child and family health. The dominant discourse in an Australian health setting is a Western medical model. The Western approach to information dissemination assumes that people will respond from a western perspective. In a colonised country where first peoples are often rendered invisible this approach has the potential to alienate indigenous clients. Indigenous inclusive research identifies an interface between indigenous and western culture, which provides an exciting opportunity for growth and change in the creation, dissemination and interpretation of information. The paper aims to provide a glimpse of decolonising of information in health.

Background

The World Health Organisation (2008) describes primary health care:

Primary health care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, (author’s italics) through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

Boustany (2006, cited Eckerman et. al. 1992, 124) identifies the public health system as being highly institutionalised, with a history of scientific and institutional racism and a biomedical model focused on curative rather than holistic health. Aboriginal families who originally had a holistic approach to health have suffered transgenerational trauma caused by colonization, which delivered the experience of massacre, the stolen
generations, as well as disempowering attitudes and laws. This has ultimately impacted negatively on the capacity of Aboriginal families to access health services.

Official identification of Aboriginal and Torres Strait Islanders comprises 2.5% of the population of Australians (ABS, 2008). Numbers of people with Aboriginal and Torres Strait Islander ancestry but not identifying as such are unknown. The percentage of people living in Australia who are descendants of other indigenous groups in this geographical region such as Maori and Pacific Islander is 0.9% (ABS, 2008). Those descended from but not choosing to identify is also unknown. So while indigenous people are a minority they are an important minority that presents and will present in the coming years a challenge to health provision within the community.

The disparity between indigenous and non-indigenous measures of health is still very wide. There is a 17 year gap between life expectancy of Aboriginal people and non-aboriginal Australians. Japan has the longest living population in the world. The non-indigenous population in Australia comes second to Japan (ABS, 2008). Indigenous rates in Australia are equivalent to that of a third world country. The Australian Bureau of Statistics (ABS, 2008) has declared that ‘Indigenous people face barriers in accessing health services, in particular primary health care’.

Immigration between the Pacific Islands and New Zealand and from there to Australia is increasing. Samoans generally come to Australia via New Zealand while Tongans and Fijians come directly to Australia. (Rapaport 1999, IMSED 2008) There are currently over 100 000 people identifying as Maoris living in Australia and about 80 000 Islanders. It is necessary for Health Departments in Australia to keep up with the needs of the increasing population. Increased immigration will bring increased psychosocial needs from a growing indigenous group.

The emerging growth of the Pacific Islander Labour Force programs in Australia and New Zealand is an important recognition of our responsibilities as a nation in the Australia Pacific region. This arrival of Islanders coupled with both the overt and hidden aboriginality within Australia will have psychosocial implications and will require more indigenous inclusive and congruent practice and research.

An overview of indigenous social work research demonstrates that there are alternative narratives to be found that involve a grounded, culturally relevant, respectful, person-centred approach. It also addresses the person in relationship with the environment and community. This is in keeping with sound social work practice and a natural progression for practice that is geographically located within Australia, New Zealand and the Pacific (Green & Baldry).
Spirituality and Health

Miriam Rose Ungenmerr-Baumann (1992) describes one of the spiritual gifts inherent in Aboriginal peoples. She calls this gift Dadirri, somewhat similar to that which westerners may call contemplation. Dadirri is described as deep listening and quiet still awareness, listening with the ears and the heart.

There are deep springs within each one of us. Within this deep spring, which is the very spirit, is a sound. The sound of Deep calling to Deep. The time for rebirth is now. If our culture is alive and strong and respected it will grow. It will not die. I believe the spirit of Dadirri that we offer will blossom and grow, not just within ourselves but in our whole nation. (Ungenmerr-Baumann 1992)

The health of indigenous clients is grounded in its spirituality. Panzironi (2006) argues that the ‘spiritual dimension of reality’ is a ‘core element in indigenous worldviews’. This view is repeated in the works of Ermine, Royal, Settee, Henry et. al., Kahakalau, Orley and others. Indigenous worldviews incorporate a holistic paradigm, which includes the spiritual, intellectual, physical and emotional (Durie 1999, Orley 2007, Taurima & Cash 2000). The connection with land, family and community is also an important aspect of both spirituality and health; the two concepts being intertwined. There is a negative impact on wellbeing when these connections are broken.

In indigenous communities spiritual and cultural beliefs and practices that have been handed down through the family and community also affect health and health management. Spirituality is deemed to be an inherent attribute within Aboriginal and Torres Strait Islander and other indigenous communities and impacts greatly on the way people experience and cope with life. This is despite the complex and diverse cultural aspects of the many indigenous nations. The grief and loss accompanying the trauma of cultural genocide must be healed as part of a spiritual process.

There are some people who do not identify as indigenous, but who are descendants of aboriginal families. They also experience the river of spirituality flowing beneath their lives, hearts and minds. Many of these people are still strong in the Aboriginal spirit. However they have lost the words and the knowledge that goes with it and they also experience a loss of identity and the grief that goes with that. These people also need the spiritual healing that comes with spiritual identity, knowledge and understanding.

Colonisation

In his book ‘Collapse: How Societies Choose to Fail or Survive’, Diamond (2005) discusses the sustainability of societies and the way they cling to cultural practices that ultimately feature in their destruction. He discusses the longest surviving people in the world, the Australian Aborigines, who have survived in one of the oldest and
most hostile environments in the world. He wonders at the people that almost wiped them out in the space of a few hundred years, without learning from their successful longevity. He does however have hope for Australians because he sees us as being capable of and open to change. ‘Australians are beginning to think radically about the central question: which of our traditional core values can we retain, and which ones instead no longer serve us well in today’s world’ (Diamond 2005, 379). Colonising processes belong to a past that is no longer appropriate for today’s population. They are rooted in imperialist, hierarchical and Eurocentric conditions where the colonised are seen as ‘other’ where ‘other’ is dehumanised, deidentified, suppressed, oppressed and devalued.

Colonisation is based on ethnocentric assumptions where those without power are devalued and discriminated against. It is a hierarchical paradigm and covers all beings who may be considered inferior at any moment in time by those who can place themselves in a more powerful position. Indigenous people in colonised countries suffer from this as do women, people with disabilities, children, animals, plants, even the land we walk on. All are subject to discrimination and a colonising approach. In a colonial paradigm the correlation between knowledge and power (Freire, 1970) supports the devaluation of people whose knowledge is not valued by those in power. Any knowledge differing from that of the powerful elite is devalued in order to maintain that power. Even though many countries no longer have the colonising country in a current ruling position the social, legal and medical structures from the colonising country still maintain power both implicitly and explicitly. Independence does not bring emancipation.

Payne (1997, 244) states that ‘powerful groups in society maintain discrimination in society as a way of preserving their power…. One of the ways this is done is by the use of language and social assumptions to support conventions which are discriminatory.’ Race, social strata, gender, religion, age, disability, mental health; all are affected by a colonial paradigm. Spiritual knowledge owned by a colonised racial minority, healing knowledge owned by a gender, for example, midwives in the middle-ages were demonised and burned at the stake as witches when male doctors felt their power was being usurped by these women. The French and English ruling classes in England imposed their power in the English courts of law by using the French language to communicate and name articles of law. The use and denial of language has long been a way the powerful prevent the colonised access to power either by using a language known only to those in power, or denying the use of a community’s original language to assist in destroying their culture. For example, people speaking the Aboriginal Australian languages, the Maori language, the American first people’s language, have all had prohibitions put on the usage of their language. This limit’s access to knowledge and therefore power.
Decolonisation

Decolonisation, once viewed as the formal process of handing over the instruments of government, is now recognised as a long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power. (Tuhiiwai Smith 1999, 199)

As part of the decolonising process it is necessary to develop a critical awareness, as expounded by Freire (1970) and promoted by such indigenous researchers as Edwards & Taylor, Green & Baldry, Royal, Settee, and Smith. It is necessary to deconstruct our beliefs, values and prejudices. A move beyond cultural knowledge to decolonisation is important for an inclusive practice that assists in maintaining the healthy evolution of the region’s spiritual and cultural identity.

Non-indigenous social workers may have internalised discriminating beliefs and values without being aware, working from the assumption that their practice is value free. The colonial underbelly is so entrenched and ingrained as to be invisible. Even indigenous people can experience the shame and sense of alienation that comes from an unidentified incongruous belief system. It is necessary to critically examine our beliefs, values and prejudices before we can begin to address societal needs and provide a culturally safe service. There is a need to cease to accept the storylines that interpret people as being ‘other’. It is necessary to create a different narrative, which means revisiting history and asking ourselves if the assumptions and beliefs around Aboriginality are fact or convenient fiction.

Holmes and Saleebey (in Payne 1993, 268) argue that ‘only a collaborative approach will remove the power aspects of the traditional medical model.’ From the empowerment perspective espoused by Gutierrez et. al. (1995) there is a focus on strengths, rather than problems, where the clients have control over their own lives. Universal health practices will also play an important role in determining whether health clients feel able to access the services. Health is traditionally hierarchical and it is necessary to consider how the language and the way services are delivered might be changed to redistribute power. To be truly emancipatory, critical practice must have an element of social change where it is deemed that there is racist or discriminatory practice occurring. The more subtle practices invisible to white eyes due to a sense of being ‘normal’ need to be identified through a better understanding of indigenous worldviews.

In the more succinct words of Edwards & Taylor (2008, 32),

Decolonisation requires an unpacking of history and preconceptions, and recognition that our professions, health policy and services, are founded upon and privilege Western cultures and world
views. In a practical sense it might include examining the language of division - the ‘us and them’
dialogues, critiquing policy for potentially disempowering practices, refocusing on capacity rather
than popular deficits and blame approaches to indigenous people.

Child Health and Identity

The research this paper is based on looks at the spiritual strengths of families where there is a child with
developmental disabilities or delay. These problems include autistic spectrum disorders, global developmental
delay and pervasive developmental delay. Early childhood health problems of this type can be a result of
genetics, physical trauma, psychological trauma, social trauma, drug and alcohol issues and mental health
problems of the parents.

The transgenerational trauma experienced by indigenous communities will have an impact on the
developmental health of the children. Children with Aboriginal ancestry who do not identify as such have similar
health issues to those who do identify, for example, otitus media, as well as developmental disabilities and
delay. Aboriginal children are ten times more likely to get otitus media than non-aboriginal children. While it is
associated with poverty and lack of sanitary living conditions, other indigenous populations, the Baffin Bay Inuit,
have been found to have had no reported incidence of otitis media until contact with Europeans in the 1960s
(Matthews et al 1992). American First Nation People where children have been adopted into better living
standards still have higher levels of otitis media than other populations. These health problems can have
significant impact on children's health, communication skills and therefore behaviour. Awareness of the
possibility of indigenous identity is important in the early identification of potential health concerns.

An illustration of the need for a mindful approach to clinical practice can be seen in the following example
experienced by the author:

A woman brought her 6-year-old son to see a counsellor for anger management. She had other children and had
been accessing the service for depression, which had seemed intransigent. She did not identify as aboriginal,
however the worker felt that she may have been. The worker sat contemplating the child and his mother,
thinking about the issue of Aboriginality, feeling the boy’s anger, which reminded her of several other Aboriginal
children she had seen, with anger issues, and feeling unable to raise this, as the mother had denied aboriginality
earlier. The boy put his hand on her knee, looked into her eyes and said ‘Hey, ... Hey,... I’m Aboriginal’.
Immediate relief followed allowing the worker to ask the mother if this was so. The boy’s mother disclosed that
her Aboriginal grandmother had been taken into a girl’s home as part of the stolen generation at age 4 and she
felt that she had no right to identify as they had lost their culture and language. Her son, even at age 6, had shown a deep interest in the Aboriginal art he had seen at school and had developed a passion for all things Aboriginal. The worker offered the idea that in fact they are both Aboriginal and have the right to call themselves that. Since the acknowledgment of their identity there has been a positive shift in both mother and son’s wellbeing.

Durie (1999) discusses the negative effects of deculturation on health. He identifies positive links between acculturation and health and sees cultural identity as critical to health and wellbeing. Indigenous researchers in Australia, New Zealand, Hawaii and Canada have identified connections with customs, the land and community, and cultural and spiritual identity as being important prerequisites for good health, wellbeing and resiliency (Boustany 2000, Durie 1999, Ermine 2000, Kahakalau 2004, Orley 2008, Royal 2002, Settee 2007).

**Conclusion: Is There Room for Different Voices?**

When a particular narrative is used as a backdrop for interacting with families in the health system it automatically, in Frank’s words, ‘neglects, avoids or rejects other narratives’ (2004, 132). Who controls the information dissemination and who benefits from it? What are the historical structures and systems within health that perpetuate it?

This leaves us with more questions than answers but in seeking to respond to these questions it is hoped that we can develop an alternate way of disseminating health information and health services. The need is for a service that addresses the requirements of the health client and makes way to accept and acknowledge those clients who until now have felt unable to access the services on offer. What steps will we take towards an ongoing sustainable health service that provides a fair and equitable service to all people?

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