INDIGENOUS HEALTH

COVER ART BY

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ATHYNA.EDUCATION

LEARNING OUTCOMES

By the end of this lecture students should be able to:

1. Explain the term 'Indigenous people,' in the context of the United Nations' principles of self-identification and a strengths-based perspective.
2. Identify and analyse the unique health risks and determinants of health related to Indigenous populations
3. Compare and analyse the disparity in health status between Indigenous and non-Indigenous Australian population
4. Outline key government initiatives related to Indigenous health in Australia
5. Assess the progress of the targets (benchmarks) of the Closing the Gap strategy
6. Analyse the way in which health professionals and general societal behaviour, biases and attitudes affect access to health care for Indigenous people.

For LOs

This E-Book should be reviewed alongside the lecture videos and the *required reading* materials, including the e-Book, Indigenous Health-Australia available on Moodle and Athyna. This PDF is interactive. Please click on the links to navigate through the E-Book content.

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Tracing the Shadows of History to Understand Present Heath Outcomes

'MALOK, HAK KAN NIK? (WHERE ARE OUR RIGHTS)'
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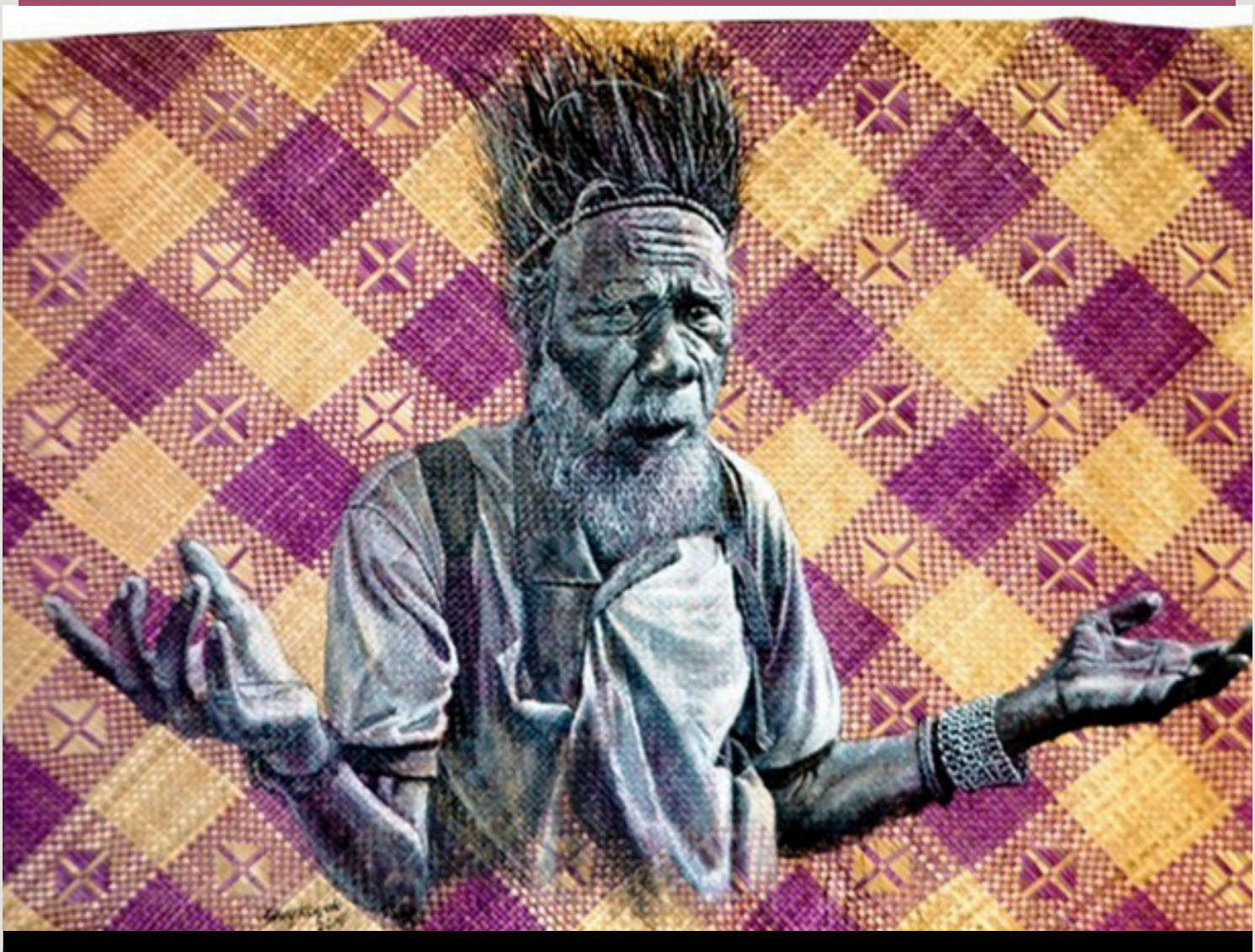

INCLUSIVE LANGUAGE

To know about Monash's policy on inclusive language in the context of Indigenous people, visit: http://www.monash.edu/about/editorialstyle/writing/inclusive-language

Inclusive language in the context of Indigenous peoples refers to the use of words and phrases that respectfully acknowledge their cultures, identities, and contributions without perpetuating stereotypes or biases, including:

1. Using the names and terms that Indigenous communities prefer for themselves, which may vary regionally and even within communities.
2. Recognizing the diversity among Indigenous peoples, and avoiding generalizations that erase distinct cultural identities, unless broadly applicable.
3. Being aware of and sensitive to the cultural nuances and historical contexts that shape Indigenous peoples' experiences and expressions.
4. Choosing language that empowers rather than diminishes them.
5. Using language that acknowledges and respects the sovereignty, rights, and ongoing struggles of Indigenous peoples for recognition and justice.

Inclusive language aims to promote understanding, respect, and equity in conversations about and with Indigenous peoples.

PHOTO BY ADLI WAHID - UNSPLASH

ABOUT INDIGENOUS PEOPLE

Ponciano on Pixabay

The global Indigenous population is estimated to be over 476 million people, spread across 90 countries worldwide. This diverse group represents about 6% of the world's population. Data from 23 countries, covering 83% of the global Indigenous population, reveal that Indigenous peoples make up 9.3% of the population yet represent nearly 19% of those living in extreme poverty(International Labour Organization, 2020).

The recognition and enumeration of Indigenous populations are complex due to varying definitions and criteria used by countries, alongside the challenges Indigenous peoples face in self-identification due to historical and ongoing marginalization. These factors contribute to difficulties in obtaining precise figures.

We will now start by examining the definition of Indigenous people.

WHO ARE INDIGENOUS PEOPLE?

Due to the vast diversity among Indigenous peoples, international law and policy lack a universally agreed-upon definition of Indigenous peoples.

The United Nations does not adopt one fixed, legal definition of Indigenous peoples. Instead, it uses a set of commonly accepted characteristics to recognize Indigenous peoples, while avoiding a narrow definition that states could use to exclude certain (United Nations, 2008). This flexible approach respects the diversity of Indigenous nations and supports their rights under international law, including the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations, 2007).

Common characteristics of Indigenous peoples in UN practice

Across UN documents and practice, Indigenous peoples are described using several inter-related characteristics rather than a strict definition (United Nations, 2008). These points can guide us in recognizing Indigenous peoples, but they must never replace the way communities choose to define themselves (United Nations, 2008).

Self-identification as a key principle - In the UN system, self-identification is the core principle for recognizing Indigenous peoples. Communities have the right to decide who they are and who belongs. Indigenous peoples themselves are the main authority on their identity, not governments or institutions. For health professionals, this means taking people's self-identification seriously in clinical care, communication and data collection, as part of culturally safe practice.

Historical continuity with pre-colonial societies - Indigenous peoples trace their presence in a territory back to before invasion, colonization or modern state borders.

Distinct cultures and institutions - They maintain their own languages, spiritual beliefs, social and political institutions, and legal traditions.

their communities, often based on traditional practices and structures.

Non-dominance in relation to the other sectors of society: They are a minority group within broader national societies, where they often have less power, influence, and control over resources and decision-making processes. This aspect underscores their historical and ongoing marginalization and exclusion.

Determination to preserve, develop and transmit to future generations: Indigenous people possess a determination to preserve, develop and transmit to future generations their ancestral territories and identity as peoples in accordance with their own cultural patterns, social institutions and legal system.

Historical and Contemporary Experiences of Marginalization, Dispossession, and Exclusion: Indigenous peoples have often faced historical and ongoing processes of colonization, marginalization, dispossession of their lands, territories, and resources, and exclusion from political and economic power structures.

Group Consciousness: There is often a sense of group consciousness or community solidarity in facing common challenges, preserving shared heritage, and working towards collective well-being.

From deficit to strengths-based perspectives

Thus, how we talk about Indigenous peoples also matters. Historically, they have often been described through a deficit lens - focusing mainly on problems such as disease burdens, “risk factors,” or “gaps” compared with non-Indigenous populations. While these inequities are real and must be addressed, a deficit-only framing can:

- Reinforce stereotypes of Indigenous peoples as “vulnerable” or “broken”.
- Hide the role of colonisation, racism and structural inequity.
- Ignore Indigenous agency, resilience and expertise.

A strengths-based perspective deliberately shifts the focus to Indigenous peoples’ capacities, assets and resources (Fogarty et al., 2018; Kennedy & Lees, 2022). In Indigenous health, this includes:

- Strong kinship and family networks.
- Cultural continuity (language, ceremony, connection to Country).
- Community-controlled governance and health services.
- Elders’ leadership and knowledge.
- Collective resilience and ongoing resistance to colonial harms.

Researchers decribe Indigenous strengths-based approaches as a way of thinking that centres “what is strong” rather than “what is wrong,” while still acknowledging and addressing injustice (Fogarty et al., 2018; Kennedy & Lees, 2022). This strengths-based lens complements the UN’s emphasis on self-identification and collective rights, by focusing on Indigenous peoples as rights-holders and knowledge-holders rather than only as “at risk” populations.

- Fogarty, W., Bulloch, H., McDonnell, S., & Davis, M. (2018). Deficit discourse and Aboriginal and Torres Strait Islander health policy: Summary report. . The Litja Institute. https://www.lowitja.org.au/wp-content/uploads/migrate/deficit-discourse-summary-report.pdf
- Kennedy, A., Sehgal, A., Szabo, J., McGowan, K., Lindstrom, G., Roach, P., Crowshoe, L. L., & Barnabe, C. (2022). Indigenous strengths-based approaches to healthcare and health professions education - Recognising the value of Elders' teachings. Health Educ J, 81(4), 423–438. https://doi.org/10.1177/00178969221088921
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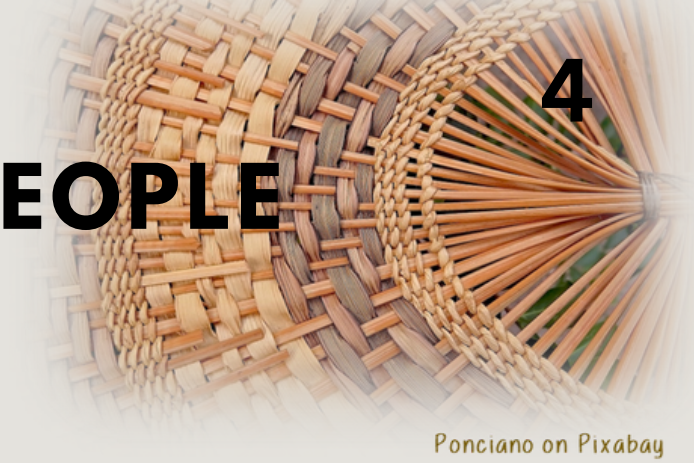
INDIGENOUS PEOPLE OF MALAYSIA



Ponciano on Pixabay

The 2020 Census revealed that the Indigenous Peoples of Malaysia or the orang Asal, and comprising the Orang Asli in Peninsular Malaysia and the Indigenous Peoples of Sabah and Sarawak, constituted approximately 11% of the national population(IWGIA, 2023).

In Sarawak, the Indigenous Peoples are collectively identified as Natives (Dayak and/or Orang Ulu), encompassing various groups such as Iban, Bidayuh, Kenyah, Kayan, Kedayan, Lunbawang, Punan, Bisayah, Kelabit, Berawan, Kejaman, Ukit, Sekapan, Melanau, Penan, and 12 new ethnic groups. They make up around 1.2 million, nearly 50% of Sarawak's population(IWGIA, 2023).

In Sabah, the 39 distinct Indigenous ethnic groups, known as natives or Anak Negeri, constitute about 2.1 million or 62% of Sabah's population of 3.4 million. Major groups include the Dusun, Murut, Paitan, and Bajau(IWGIA, 2023).

Orang Asli, Melaka,Wikipedia

About the Orang Asli

Specifically, the Orang Asli, who are the Indigenous Peoples of Peninsular Malaysia, numbered 206,777 in 2020. 'Orang Asli' is a constructed category. Within Peninsular Malaysia, the 18 subgroups of Orang Asli, categorized as Negrito (Semang), Senoi, and Aboriginal-Malay groups, constitute 0.8% of the population. They are heterogeneous; each group has a distinct language and culture and perceives itself as different(IWGIA, 2023).

The Malaysian Law, specifically the Aboriginal Peoples Act 1954 (Act 134), defines an Orang Asli as, 'Any person whose male parent is or was a member of an aboriginal ethnic group , who speaks an aboriginal language , and habitually follows an aboriginal way of life and aboriginal customs and beliefs, and includes a descendant through males of such persons.'

While the Indigenous people of Sabah and Sarawak have specific constitutional protections for their customs, languages, and institutions, the Orang Asli of Peninsular Malaysia does not enjoy equivalent constitutional protections for their languages, laws, traditions, customs, and institutions. This distinction reflects the varying degrees of constitutional rights and privileges afforded to different indigenous groups within Malaysia (Subramaniam & Nicholas, 2018).

Temuan People, Wikipedia

Characteristics of the Orang Asli include(Nicholas & Baer, 2007; Wong et al., 2014):

- They are largely socially egalitarian
- They demonstrate reverence for all life forms, both living and deceased.
- Their conceptualization and practices related to individual and communal health are linked to environmental, social, cultural, and spiritual factors.
- They adopt a "use and protect" approach toward the environment, taking only as much as they need to avoid depletion or destruction of natural resources.
- The communal repository of knowledge accrued over generations guides the use of natural resources for medicinal, nutritional, shelter, spiritual, and cultural purposes.
- Their practice of traditional forms of social protection and guaranteed sustenance, including care for kin who are ill, incapacitated, disabled, too young, or elderly is founded on social customs of reciprocity, kinship obligation, and cultural sanctions.

The empirical evidence indicates significant health disparities between the Orang Asli communities and the rest of the Malaysian population. The average life expectancy for Orang Asli individuals is 53 years, notably lower than the national average of 73 years (Rusaslina, 2010).

Studies have shown that Orang Asli children are substantially more likely to die before the age of five compared to children from other major ethnic groups in Malaysia (Zainuddin, 2022). The under-5 mortality rate for Orang Asli is more than six times the national peninsular average. However, the true mortality rates in Orang Asli children are not known as many deaths are not reported (some die in the forest). It is possible that the real difference is closer to 10 times (Amar-Singh HSS, 2019).

Factors contributing to these health disparities include high rates of malnutrition, anemia, and

exposure to tropical diseases not typically found in the mainstream population, such as soil-transmitted helminth (STH) infections with very high prevalence rates reported in some studies (Mahmud et al., 2022).

Furthermore, the nutritional status of the Orang Asli, particularly among women and children, is generally low due to factors like poverty. Stunting affects up to 45.8 % of Orang Asli children (Muslim et al., 2021), a significantly higher rate compared to the general population, which stands at 20.7 % (Kok, 2019). The suboptimal health and nutritional status observed among Orang Asli children and adults can be largely attributed to prevalent food and nutrition insecurity, particularly affecting women and children within this demographic. The evolving food systems among the Orang Asli, influenced by the challenges in sustaining traditional dietary practices alongside the growing availability, accessibility, and acceptance of westernized foods, significantly contribute to this insecurity. The consumption of inexpensive, energy-dense, and nutrient-poor food items, driven by limited financial resources, increases the risk of inadequate growth and development among children, while adults may face the consequences of excessive calorie intake, leading to obesity and associated chronic metabolic diseases (Khor & Shariff, 2019). Additionally, about 99.29 percent of the Orang Asli are in the B40 (bottom 40% of the Malaysian household income) group with most in the hardcore poor group (The Star, 2019).

Khor and Shariff (2019) also report that the major prenatal and postnatal determinants of undernutrition among the Orang Asli children include: Short maternal stature, low birth weight, prematurity, low dietary diversity, parasitic infections, and inadequate sanitation and hygiene (Khor & Shariff, 2019).

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THE ORANG ASLI & THEIR OCCUPATIONS

Art by Shaq Koyok

FISHERMEN
Orang Laut, Orang Seletar and Mah Meri

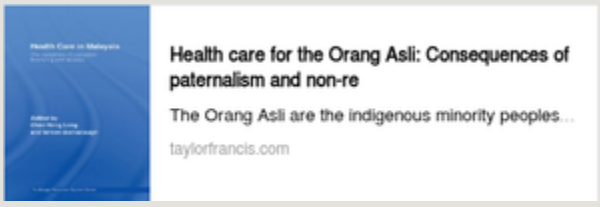
PERMANENT AGRICULTURE
Temuan, Jakun and Semai

SWIDDENING (HILL RICE CULTIVATION) AND SOME HUNTING, FISHING AND FOOD GATHERING
Semai, Temiar, Chewong, Jah Hut, Semelai and Semoq Beri

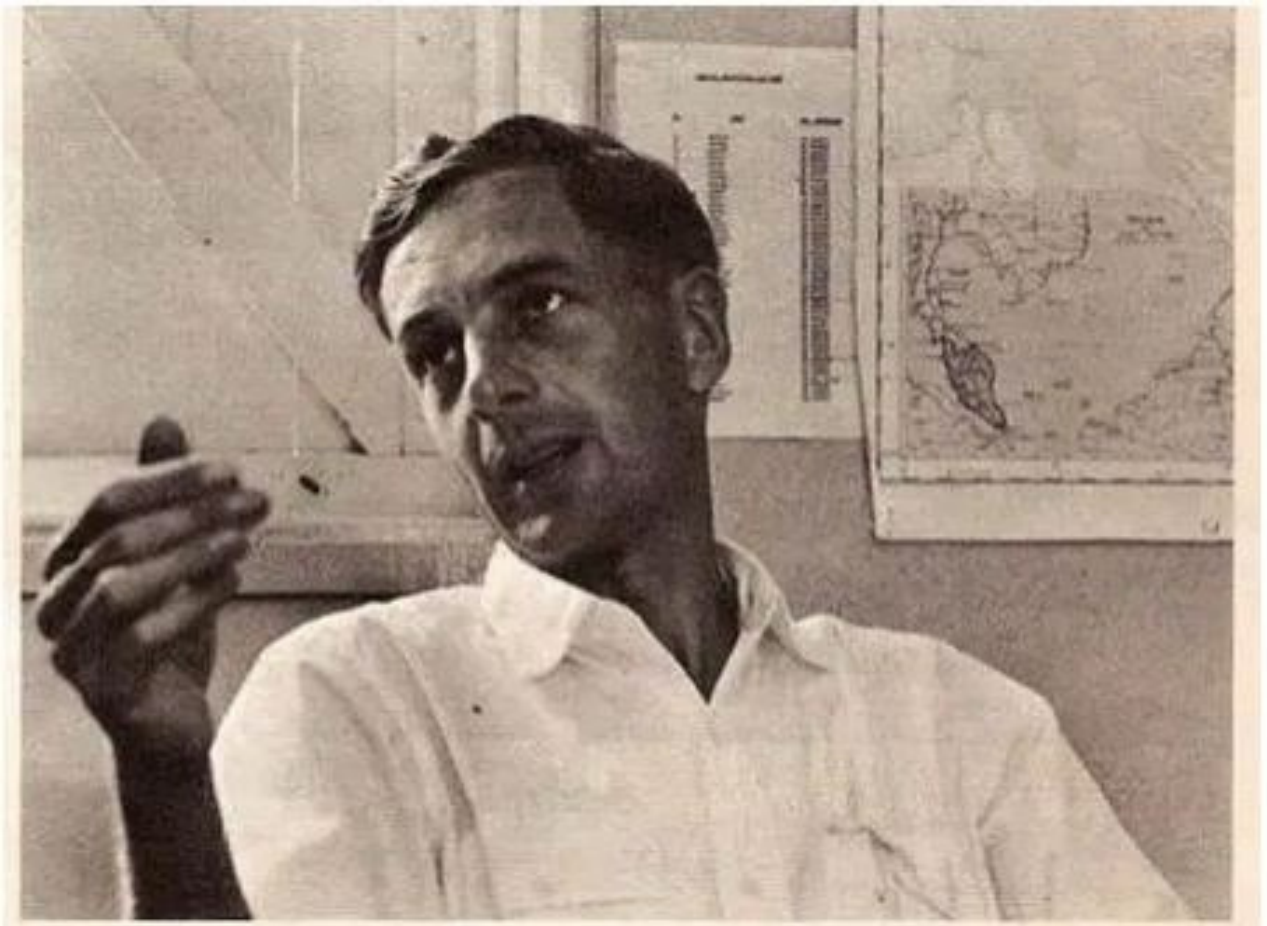
FOOD GATHERING
Jahai and Batek

For more info on Orang Asli health, see

Nicholas C, Baer A. Health care for the Orang Asli. Consequences of paternalism and non-recognition. In: Chee HL, Barraclough S, editors. Health Care in Malaysia The dynamics of provision, financing and access2007. p. 119-36.



DR. MALCOM BOLTON

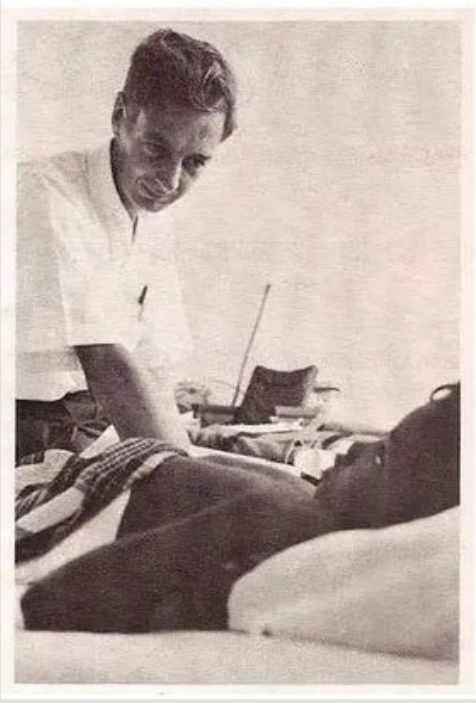


DR. BOLTON in his office at Gombak hospital.

Dr. J. Malcolm Bolton, a British medical doctor, played a pivotal role in establishing and advancing a comprehensive medical service tailored for the indigenous minorities of Malaya (Peninsular Malaysia), overseeing its development from its inception in 1955 during the "Emergency" period until 1972.

His efforts included the creation of a "Flying Doctor Service" to provide direct biomedical practices and treatments to Orang Asli in remote areas.

Bolton was known for his dedication to public health, and was celebrated for his determination, intelligence, and commitment to serving Indigenous communities (The Independent, 2006).



Features of Dr. Malcom Bolton's Approach to Orang Asli Health (Bedford, 2009; Oorjitham, 2015; The Independent, 2006)

- Engage in a culturally respectful relationship with the Orang Asli.
- Recruitment policy of preferment for Orang Asli men and women as medical orderlies, nurses and midwives who made up half the staff at Hospital Gombak.
- Orang Asli health volunteers did outreach, health education, administration of antimalarials with community members.
- Recognizing the confidence of the people in bomohs[1], they were trained in hygiene and first aid.
- Instituted a "Flying Doctor Service" and personally visited all the posts every month.
- Family and accompanying relatives of Orang Asli patients could stay at the hospital.
- Educational and other activities were organized for children of Orang Aslipatients.
- Screening of family members of patients admitted to the hospital and providing health education on malaria and tuberculosis, maternal and child healthcare, family planning and personal hygiene.

[1] shaman and traditional medicine practitioner

Bedford, K. J. A. (2009). Gombak hospital, the Orang Asli hospital. Indonesia and the Malay World, 37(107), 23-44. https://doi.org/10.1080/13639810902743032

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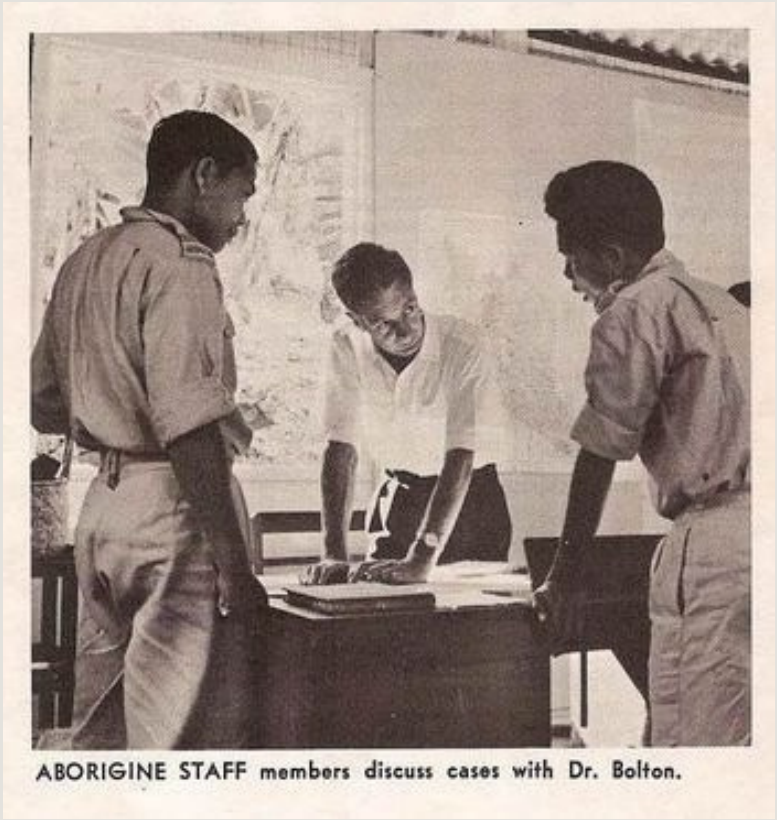
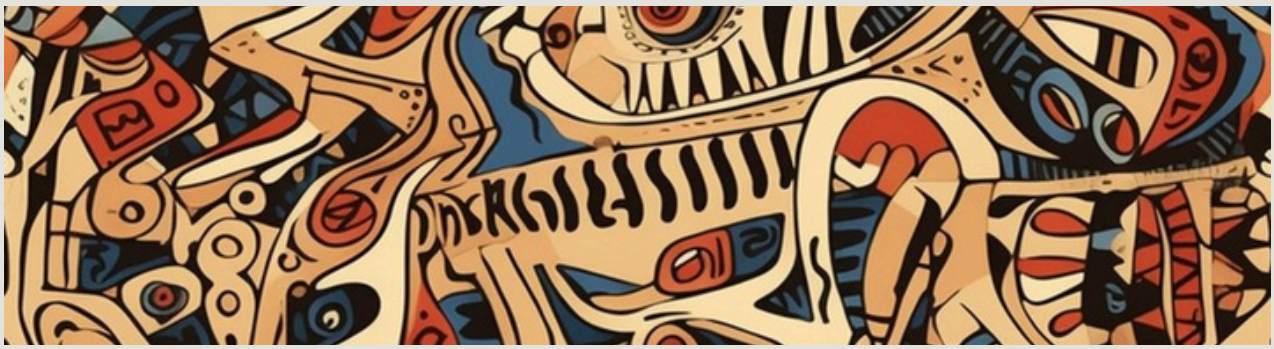


ABORIGINE STAFF members discuss cases with Dr. Bolton.

Quoting Bolton (1973), Bedford (2009) writes,

For Bolton it was imperative that the Orang Asli, be encouraged to lead as normal and active life as possible while they are at the hospital. Most cook their own food for which they are provided with rations . . .The patients are free to fish, hunt, gather jungle produce, or just wander.



DETERMINANTS OF INDIGENOUS HEALTH

Indigenous peoples worldwide experience many of the same health conditions as other populations (Gracey & King, 2009). However, the pattern of disease for Indigenous peoples is strongly shaped by colonization, racism, land dispossession and political and economic marginalization (King et al., 2009; Reading & Wien, 2013). Large comparative analyses show that, across multiple regions and income settings, Indigenous and tribal peoples have higher burdens of chronic and infectious diseases, poorer self-reported health, and lower life expectancy than neighbouring non-Indigenous populations (Anderson et al., 2016). These distinctive patterns reflect historical legacies of land seizure, cultural assimilation and governance change, including policies such as residential or boarding schools that disrupted families, languages and community structures and contributed to collective, intergenerational trauma (Brave Heart et al., 2011; Crosby, 2004; Kirmayer et al., 2000). These inequities are best interpreted using a determinants framework that distinguishes **structural, social and cultural determinants of health**, rather than focusing on individual-level risk factors singularly (Loppie & Wien, 2022; Reading & Wien, 2013).

Structural determinants

Structural determinants refer to the broad political, legal and economic systems that distribute power and resources. For Indigenous peoples, this includes histories and ongoing realities of colonisation, forced assimilation and disruption of Indigenous law and governance (Gracey & King, 2009; King et al., 2009). Colonial processes such as expropriation of land, imposed systems of government and missionary or state-run schooling undermined Indigenous institutions and displaced Indigenous authority over health, education and social systems (Gracey & King, 2009; Kirmayer et al., 2000). Anti-Indigenous racism within laws, policies and key institutions, such as education, employment, housing, justice and health systems, acts as a continuing structural determinant by limiting access to opportunities and reinforcing inequities (Anderson et al., 2016; Reading & Wien, 2013). These structures also shape access to decision-making about land, environment and development, influencing whose interests are prioritised when resources are allocated or extractive projects are approved (Durie, 2004; Wilson, 2008).

Social determinants

The above-mentioned structural forces flow into the social and material conditions of daily life. Indigenous communities in many countries have higher rates of poverty and insecure employment, more overcrowded and substandard housing, and less secure access to nutritious food, safe water, sanitation and transport (Gracey & King, 2009; Loppie & Wien, 2022). As a result, people are more exposed to behaviours and environments that increase risk for cardiovascular disease, type 2 diabetes, chronic respiratory and kidney disease, and some cancers such as unhealthy diet, tobacco use, physical inactivity,

harmful alcohol use and environmental hazards (Anderson et al., 2016; King et al., 2009). These same social determinants contribute to higher rates of psychological distress, substance use, suicide and self-harm, as mental health is affected by intergenerational trauma, discrimination and reduced control over life circumstances (Gee et al., 2014; Reading & Wien, 2013). cross many settings, these inequities are compounded by under-resourced or geographically inaccessible services, limited culturally safe primary care, and fragmented referral pathways, all of which reduce timely access to prevention and treatment (Gracey & King, 2009; Tukuitonga, 2009).

Health-care systems themselves function as a determinant of Indigenous health. Barriers such as distance, cost, lack of transport, and scarcity of Indigenous or culturally responsive providers make it harder for Indigenous peoples to use services when needed (Gracey & King, 2009). Historical and ongoing experiences of racism and discrimination in health settings contribute to mistrust and avoidance of services, even when they are formally available (Paradies, 2016). In addition, when mainstream services do not respect Indigenous knowledge, healing practices and community priorities, they can inadvertently reproduce colonial dynamics and further alienate patients (Kirmayer et al., 2000).

Cultural determinants

From a strengths-based perspective, cultural determinants of health are central to understanding both vulnerability and resilience for Indigenous peoples. Cultural determinants include kinship and community relationships, cultural identity, language, spiritual beliefs, and Indigenous governance and self-determination (Reading & Wien, 2013; Verbunt et al., 2021). Indigenous conceptions of health are typically holistic, integrating physical, mental, emotional, spiritual and relational dimensions, and linking individual wellbeing to the health of family, community and environment (Durie, 2004; King et al., 2009). This perspective underscores the importance of cultural continuity—the ability of Indigenous communities to sustain languages, traditions and systems of self-governance—for promoting health and wellbeing (Hallett et al., 2007; Reading & Wien, 2013). Evidence from Aboriginal and Torres Strait Islander contexts indicates that strong family and community connections, active participation in cultural practices, and access to Indigenous-led, community-controlled services are associated with better health and wellbeing outcomes (Gee et al., 2014; Verbunt et al., 2021).

A distinctive cultural determinant is the relationship to land and waters: ongoing connections with ancestral territories, as living entities and sources of identity, law, knowledge and responsibility, are closely linked to social and emotional wellbeing, mental health and a sense of purpose (Anderson et al., 2016; Verbunt et al., 2021). Indigenous philosophies typically frame land not as a commodity to be owned and exploited, but as part of a network of reciprocal relationships that entail obligations of care and stewardship (Durie, 2004; Wilson, 2008). Environmental degradation, resource extraction and climate change therefore affect Indigenous health not only through ecological pathways, but also by disrupting cultural practices, spiritual relationships and intergenerational responsibilities (Durie, 2004; Wilson, 2008). When Indigenous peoples can exercise meaningful control over land, resources and services, and when cultural continuity and self-determination are supported rather than undermined, these cultural determinants can buffer some of the harms produced by structural and social disadvantage (Anderson et al., 2016; Loppie & Wien, 2022).

Together, these structural, social and cultural determinants demonstrate that the health of Indigenous peoples cannot be separated from broader struggles over land, governance, language and rights. Effective responses require approaches that respect Indigenous knowledge and law, address historical and contemporary injustices, and involve coordinated action across sectors such as education, housing, environmental protection and recognition of Indigenous self-determination (Paradies, 2016; Tukuitonga, 2009). The key is to recognise that “unique” Indigenous health risks arise from the specific ways in which

colonization, dispossession and racism configure structural and social determinants, and from whether Indigenous cultural determinants—especially relationships to land, culture, community and self-determination—are constrained or enabled.

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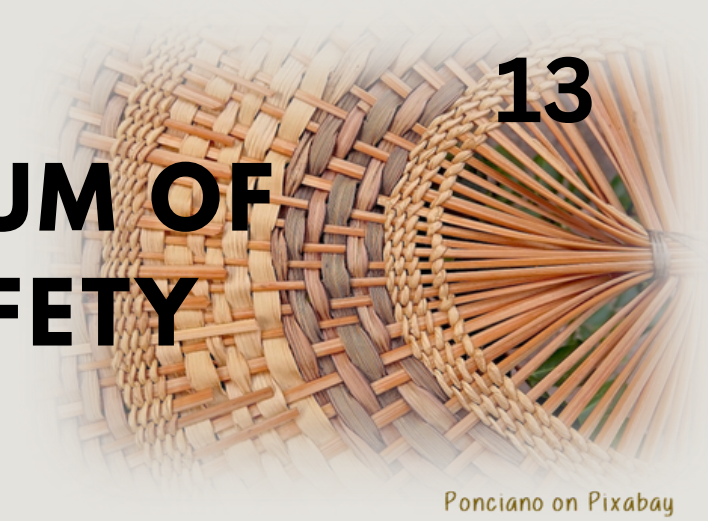
THE CONTINUUM OF CULTURAL SAFETY



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Cultural safety is a way of thinking about health care that comes directly from Indigenous peoples' struggles against racism, colonisation and unsafe services (Papps & Ramsden, 1996; Williams, 1999). It asks a different question from "How culturally competent is this clinician?" and instead asks, "Does this person or community feel safe in this health service, safe in their identity, their culture and their rights?" (Papps & Ramsden, 1996; Williams, 1999). For Indigenous peoples, this means care that does not reproduce colonial power relations, does not deny or minimise experiences of racism, and actively supports self-determination, connection to land, family and culture (Dell et al., 2016; Williams, 1999).

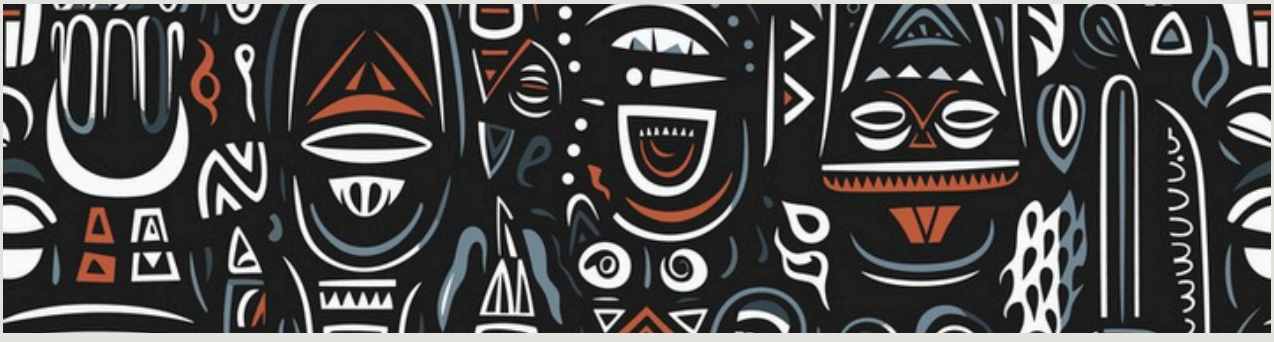
I like to think about cultural safety as a continuum that starts with unsafe care and moves towards culturally safe and equitable relationships and systems.

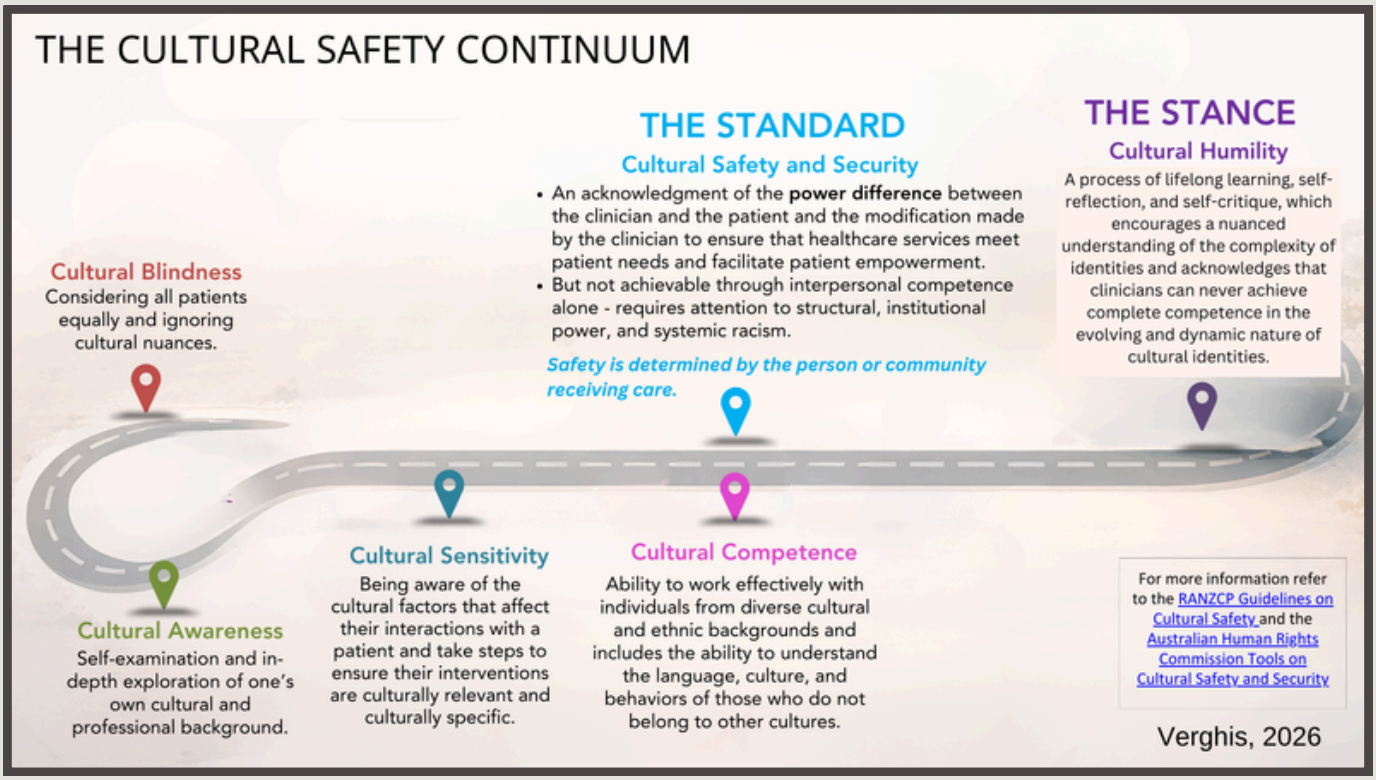
Cultural Blindness

At the most unsafe end lies cultural blindness, which refers to treating everyone "the same" and disregarding the salience of culture (Lujan, 2009). In practice, this often involves uncritically applying the norms and expectations of the dominant cultural group to all patients, including Indigenous peoples, and attributing poorer outcomes to deficits within those patients or communities when those norms do not align with their lives or realities (Lujan, 2009). In the context of Indigenous health, cultural blindness is evident when Western biomedical assumptions about illness, time, family and decision-making are taken as universal, obscuring how such assumptions reproduce marginalization and maintain existing power imbalances.

Cultural Awareness

Moving away from blindness begins with cultural awareness. Cultural awareness is the deliberate self-examination of one's own cultural and professional background, and recognition of one's own biases, prejudices and assumptions (Campinha-Bacote, 2002). For clinicians working with Indigenous peoples, this means acknowledging that there is no such thing as a culturally "neutral" stance; each practitioner enters the clinical encounter with their own history, worldview and location within existing power structures, and these inevitably shape how care is provided.





Cultural Sensitivity

Cultural sensitivity builds on this awareness by focusing on the specific ways culture shapes each interaction. It can be understood as the willingness and interpersonal skill required to engage respectfully with people from different backgrounds, including asking rather than assuming about values, practices and communication needs (Finnish Institute for Health and Welfare, 2013). A culturally sensitive clinician pays attention to how language, non-verbal communication, family roles, history with health services and experiences of racism influence the consultation and intentionally adapts their communication and interventions so they are meaningful and respectful for that person or community.

Cultural Competence

Cultural competence involves recognising and respecting people from all cultural backgrounds, and actively fostering an environment free from discrimination. It also involves designing and delivering services so that they are available, accessible and responsive to the differing needs of culturally diverse groups (Finnish Institute for Health and Welfare, 2013). In Indigenous health, this might involve learning about local Indigenous histories, health beliefs, kinship systems, common health conditions and how to work with interpreters or family decision-making. However, competence has limitations when it is treated as an endpoint, something a clinician can "achieve" and then stop thinking about. A checklist approach to competence risks turning Indigenous cultures into static bodies of knowledge to be mastered, instead of living, dynamic systems, and it does not, by itself, address power, racism or colonisation (Papps & Ramsden, 1996).

Cultural Humility

Beyond this, cultural humility is the foundation for moving beyond these limitations. Cultural humility is an ongoing, lifelong process of self-reflection and self-critique, in which clinicians continually examine how their own identities, privileges and blind spots shape their practice and their relationships with Indigenous patients (Lekas et al., 2020). It assumes that no clinician can ever be fully "competent" in another person's culture and that patients and communities are the experts on their own lives

(Lekas et al., 2020). Cultural humility also requires openness to being challenged, listening deeply, and being willing to change one's practice and assumptions in response to what Indigenous peoples identify as safe or unsafe (Lekas et al., 2020).

Cultural Safety

From this foundation, cultural safety is best understood as the outcome experienced by Indigenous patients and communities when care is provided in ways that recognise and redress power imbalances, racism and colonial histories (Papps & Ramsden, 1996; Williams, 1999). A culturally safe environment is one that is spiritually, socially, emotionally and physically safe; where there is no assault, challenge or denial of who a person is, where they come from, or what they need to be well (Williams, 1999). In culturally safe practice, the person or community receiving care, not the clinician, decides whether care feels safe and respectful (Papps & Ramsden, 1996). For Indigenous health, this means health professionals must:

- acknowledge the power difference between clinician and patient,
- recognise the impacts of colonisation and racism on health and healthcare, and
- adapt communication, decision-making and service structures so that care supports Indigenous self-determination, connection to Country, family and culture (Dell et al., 2016; Papps & Ramsden, 1996; Williams, 1999).

Thus, in this framework, cultural safety is not simply the next step after competence; it is what becomes possible when clinicians and services are grounded in cultural humility and willing to share power. Cultural blindness, awareness, sensitivity and competence each describe a different way of noticing (or not noticing), interpreting and responding to culture in clinical practice. Cultural humility is the stance that keeps clinicians learning and accountable. Cultural safety is the standard of care Indigenous peoples are entitled to, care that feels safe, respects identity and rights, and actively works against the reproduction of colonial and racist harms in health systems.

You can find the First Nations Cultural Safety Framework by Australian Evaluation Society here.

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CULTURAL SAFETY CONTINUUM

- **Cultural blindness** – Treating everyone “the same” and disregarding the significance of culture, which often means applying dominant norms to all patients and blaming Indigenous and other minoritised groups when those norms do not fit their lives or realities (Lujan, 2009).
- **Cultural awareness** – Recognising that everyone has a culture and deliberately examining one’s own cultural and professional background, including biases, prejudices and assumptions about others (Campinha-Bacote, 2002, as cited in Carter & Wheeler, 2019).
- **Cultural sensitivity** – Noticing how culture shapes specific clinical encounters and demonstrating the willingness and interpersonal skill to engage respectfully with people from different backgrounds, for example by asking rather than assuming about values, practices and communication needs (Finnish Institute for Health and Welfare, 2023).
- **Cultural competence** – Designing and delivering services that recognise and respect people from all cultural backgrounds, actively foster an environment free from discrimination, and are available, accessible and responsive to the differing needs of diverse groups, while acknowledging that “competence” should not be treated as a fixed endpoint (Finnish Institute for Health and Welfare, 2023; Lujan, 2009; Papps & Ramsden, 1996).
- **Cultural humility** – A lifelong process of self-reflection, self-critique and openness to being taught by patients and communities, in which clinicians continually examine how their own identities, privileges and blind spots shape practice, and accept that they can never be fully “competent” in another person’s culture (Khan, 2021; Lekas et al., 2020).
- **Cultural safety** – Care that Indigenous and other patients experience as spiritually, socially, emotionally and physically safe, where there is no assault, challenge or denial of identity, and where power imbalances, racism and colonial histories are actively recognised and addressed; crucially, the person or community receiving care determines whether it is culturally safe (Dell et al., 2016; Papps & Ramsden, 1996; Williams, 1999).

Cultural humility is the stance and cultural security is the standard.

MUST KNOW

MUST KNOW

- Determinants of Indigenous health
- Indigenous health – Australia – historical factors and current empirical evidence on epidemiology of Indigenous health in Australia
- Concepts in the continuum of cultural safety
- What is the Closing the Gap report and progress, particularly on targets noted within the MUA eBook.

An Important Resource

NATIONAL GUIDE TO A PREVENTIVE HEALTH ASSESSMENT FOR ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

Early detection, preventing disease and promoting health

The National Guide is a practical resource intended for all health professionals delivering primary healthcare to Aboriginal and/or Torres Strait Islander people.

Its purpose is to provide GPs and other health professionals with an accessible, user-friendly guide to best practice preventive healthcare for Aboriginal and Torres Strait Islander patients.

Visit the NACCHO-RACGP Resource hub to access resources including health check recommendations and good practice tables to support effective and culturally safe healthcare that is valued by Aboriginal and Torres Strait Islander people.

RACGP
Royal Australian College of General Practitioners

NACCHO
National Aboriginal Community Controlled Health Organisation
Aboriginal health in Aboriginal hands
www.naccho.org.au

INDIGENOUS HEALTH

COVER ART BY

SHAQ KOYOK

DR. SHARUNA VERGHIS

THEME II:POPULATION, SOCIETY HEALTH AND ILLNESS
Med1100/1200 Semester 1

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