Representation of Indigenous health knowledges within health literacy related policy and practice documents across Australia, Canada and New Zealand

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(Bachelor of Health Science)

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Statement of Authorship

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institute of tertiary education. Information derived from the published and unpublished work of others has been acknowledged in the text and a list of references is given.

Signed: Gordon Robert Boot, Darwin, Northern Territory, Australia, 14th June 2016
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Abstract

Australia, Canada and New Zealand are multicultural societies that are considered to have world-class health systems. Extensive efforts are being made by governments and the healthcare sector to improve overall health and quality of life outcomes. The task remains challenging, particularly within the many Indigenous minority populations across all three countries. One of the emerging strategies of the health promotion sectors is to enhance health literacy skills in an attempt to address the ongoing health disparities between Indigenous and non-Indigenous people. It is also being increasingly recognised that cultural beliefs strongly influence the way health and wellbeing are defined, assessed, maintained and promoted.

A review of the literature identified concerns that Indigenous health related knowledges are marginalised or disregarded within health policies and that current research is limited. This research study conducted a critical in-depth investigation of health literacy related policy and practice documents from Australia, Canada and New Zealand. It aimed to explore how, and to what extent, Indigenous health knowledges are recognised within health literacy related policy and practice documents. This research question was answered by conducting an exploratory qualitative content analysis of selected health literacy related policy and practice documents. The documents were purposefully selected from Australia, Canada and New Zealand and selection was confined to the last 10 years, ranging from January 2005 to December 2015. A total of 108 documents were considered relevant to the research question and further analysed with the use of the qualitative research software QSR NVivo10. This in-depth analysis of documents identified 6 main themes and 19 sub-themes.

The study findings suggest that health literacy related policy and practice documents from all three countries increasingly acknowledge that Indigenous concepts and languages should be considered. The findings also support contentions made within the literature that the construction and dissemination of health information continues to be largely confined to the hegemony of Western knowledges, pedagogies and paradigms. As such, it frequently disregards the value of Indigenous knowledges, paradigms and practices. It is further argued that colonial concepts and structures are generally maintained within health literacy related
policy and practice documents. Disregard for, diminution or confinement of Indigenous knowledges, paradigms and practices, may contribute to feelings of disempowerment and isolation amongst Indigenous populations.

Further studies are recommended to investigate current processes of policy development. These might pay particular regard to approaches made to enable Indigenous consultation, participation and self-determination. A detailed analysis of the underpinning power-relationships that inform the construction of knowledge and thereby affect policy outcomes and practices within the health literacy environment would be useful. The exploration of personal perceptions, experiences and expectations from health organisations and Indigenous stakeholders, regarding the status and value of Indigenous knowledges, could be a further, helpful research topic. It appears likely that differences exist between policy documents and everyday practice.
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1 Introduction

Many countries, including Australia, Canada and New Zealand, are considered to have world-class health within which extensive efforts are made by governments and the healthcare sector to improve overall health and quality of life outcomes within populations. This task is beyond doubt extremely challenging, as Australia, Canada and New Zealand are modern multi-cultural societies, and many people have different ethnic, cultural, social and linguistic backgrounds. The majority of people living in these countries are well integrated within the mainstream society, have reasonably good health and enjoy an average life expectancy of 78-82 years of age (Australian Bureau of Statistics, 2014; Statistics Canada, 2015b; Statistics New Zealand, 2015). In addition, all three countries have a similarly rich history of native Indigenous cultures, knowledges and languages. It is important to note and appreciate that there is not a single or one similar Indigenous culture. Indigenous population groups across and within each of the three countries are unique and diverse, and informed by language, the physical environment as in urban, rural, level of remoteness and climate, social relationships and ancestral heritage (Dudgeon, Milroy, & Walker, 2014; Greaves, Houkamau, & Sibley, 2015; Stephens, Porter, Nettleton, & Willis, 2006; Stephenson, 1995).

The Indigenous populations of Australia, Canada and New Zealand have been significantly impacted by the legacy of colonisation through European settlers (Stephens et al., 2006), and are now a minority culture (see Table 1). In contrast to non-Indigenous populations living within these countries, many Indigenous people today experience higher levels of disadvantage in areas such as health, education, employment and political engagement (Baum, 2008; Keleher & MacDougall, 2016). When comparing morbidity and mortality rates between Indigenous and non-Indigenous people across all three countries, Indigenous people are more likely to have higher rates of acute illnesses, infectious and chronic diseases, mental health problems, and on average lower life-expectancy (Dudgeon et al., 2014; Ellison-Loschmann & Pearce, 2006; National Collaborating Centre for Aboriginal Health, 2013; Theodore, McLean & TeMorenga, 2015). Furthermore, some researchers and frontline health services contest that Indigenous knowledges, pedagogies, paradigms and practices lack adequate recognition, acknowledgment and incorporation within health policy and practices (Canadian Nurses Association, 2014; Sherwood, 2013; Sweet, 2014; Vass, Mitchell & Dhurrkay, 2011).
One of the emerging strategies of the health promotion sector to diminish the persisting health disparities between Indigenous and non-Indigenous people, is to develop and enhance the health literacy levels within populations (Batterham, Hawkins, Collins, Buchbinder, & Osborne, 2016; Keleher & MacDougall, 2016; Lambert et al., 2014). Health literacy originates from the field of education and has in recent years evolved to include a wide range of concepts, skills and knowledges. Examples of these include functional literacy, scientific and critical appraisal skills, communication and engagement skills, intercultural competencies and approaches to empowerment (Berkman, Davis & McCormack, 2010; Sørensen et al., 2012). The concept of health literacy endorsed within this thesis emphasises that:

A health literate person is able to participate in the ongoing public and private dialogues about health, medicine, scientific knowledge and cultural beliefs. Health literacy evolves over one’s life and, like most complex human competencies, is impacted by health status as well as demographic, socio-political, psychosocial and cultural factors. (Zarcadoolas, Pleasant & Greer, 2005, p. 196)

This definition was considered appropriate and chosen, as it acknowledges the fact that health literacy skills are being influenced and shaped by social, political and cultural elements. Furthermore, this definition does not confine health literacy to a single set of cultural values, knowledges, paradigms and practices, but instead acknowledges that health and related knowledges are constructed and disseminated within the socio-cultural context in which people live and interact (Germov, 2014; Keleher & MacDougall, 2016). It is critical to recognise the interactive relationship of culture and language within multicultural societies, as the greater context of language, cultural worldviews and beliefs will influence personal and collective behaviours and action (Khalil ur, 2012; Perlovsky, 2011). These attributes will affect how individuals perceive, value and maintain their health, and also inform the approaches considered appropriate to address health related issues.

One of the most common and accepted definitions of health within many Western cultures is provided by the World Health Organisation (WHO) (1948) which defines health as
“a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. A review of the literature however suggests that the constructs of health and wellbeing among Indigenous cultures can vary significantly, as their concepts of health and wellbeing strongly depend on their ontology (worldview and realities), epistemologies (the way that knowledge is constructed) and values. These influences are intrinsic to their culture and language (Dudgeon et al., 2014; Vass et al., 2011; Wilson, 2008).

The aim of this study was to explore the extent and the ways of how Indigenous knowledges are recognised, acknowledged, implemented and promoted within policy and practice related documents from Australia, Canada and New Zealand. Documents were selected when these articulated or implied the concepts of health literacy and informed health services and programs. As no comparable studies were identified that addressed the research question, it was considered appropriate to conduct an exploratory qualitative content analysis of policy and practice documents related to health literacy from Australia, Canada and New Zealand.

The research approach that informs this study sits within a culture centred approach and uses a critical theory lens and will be discussed in detail in Chapter 3, Research Approach. The author wishes to acknowledge that the research findings and discussion put forward within this thesis do not attempt to represent or investigate the views of Indigenous people. It is the author’s intent to critically analyse policy and practice related documents which are predominantly constructed by dominant Western mainstream cultures. The analysis will be from a non-Indigenous perspective with regard to the need, extent and ways through which Indigenous knowledges and languages are acknowledged, valued, incorporated and promoted.
## Table 1

### Population overview

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Canada*</th>
<th>New Zealand</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indigenous population in</td>
<td>3%</td>
<td>4.3%</td>
<td>15.4%</td>
</tr>
<tr>
<td>percent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>spoken</td>
<td></td>
<td></td>
<td>languages</td>
</tr>
<tr>
<td>Life expectancy in years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for non-Indigenous</td>
<td>80 / 84</td>
<td>79 / 83</td>
<td>80 / 84</td>
</tr>
<tr>
<td>population (Male/Female)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life expectancy in years</td>
<td></td>
<td>64 / 73 (1)</td>
<td></td>
</tr>
<tr>
<td>for Indigenous population</td>
<td>69 / 73</td>
<td>73 / 78 (2)</td>
<td>73 / 77</td>
</tr>
<tr>
<td>(Male / Female)</td>
<td></td>
<td>74 / 80 (3)</td>
<td></td>
</tr>
</tbody>
</table>

*Canada distinguishes between Inuit (1), Métis (2) and First Nations people (3)

2 Literature review and Background

2.1 Literature Review

The health promotion sector aims to achieve health equity and equality within populations by implementing healthy public policies, creating supportive environments, strengthening community actions, developing personal skills and reorientating health services. Within these strategies, the conceptualisations of health literacy are being promoted as an invaluable additional asset to achieving these goals. They aim to improve safety and quality in healthcare and empower the individual person, community and society to take control over their health needs (Australian Commission on Safety and Quality in Health Care, 2014b; Centre for Literacy, 2011; Estacio, 2013; Freedman et al., 2009; Johnson, 2014; Kickbusch, 2009; Mitic & Rootman, 2012; Nutbeam, 2008; Sykes, Wills, Rowlands & Popple, 2013). A thorough review of health promotion literature was undertaken in order to determine the current discourse that comprises the inclusion and promotion of Indigenous knowledges within health literacy related policy and practice documents. This would also indicate whether or not the proposed study would provide any significant relevance.

A systematic search within nine academic databases (Academic One, Australian Indigenous Health Info Net, BioMed Central, EBSCOhost, Google Scholar, Informit, ProQuest, ScienceDirect and Trove) provided 37 peer reviewed articles. The combined search terms used were:

“Health literacy” AND Indigenous OR Aboriginal OR “Torres Strait Islander” OR Maori OR "First Nation" OR Metis OR Inuit AND “Health Knowledge” OR “Cultural Knowledge” OR “traditional healing” OR “traditional medicine”

The search was refined by including the following filters where available: keywords, headings and abstract; country of interest (Australia, Canada, and New Zealand); Year of publication (2005 to 2015); scholarly or peer reviewed; journal articles with full-text only.

The headings and abstracts of the first 100 available documents within each database were carefully analysed and if found relevant to answering the research question thoroughly reviewed. Documents were only reviewed when they were either open access or available...
through a Charles Darwin University licence. Clinical studies and other research that did not include Indigenous concerns and populations were systematically excluded, as these were not relevant to this study.

The literature review found that articles explicit to addressing Indigenous health concerns frequently discussed health literacy barriers and challenges, issues and/or approaches that encompassed intercultural competencies within healthcare systems. They also expressed the need for healthcare systems to adequately acknowledge and incorporate Indigenous health knowledges within health promotion practices (Hopkirk & Wilson, 2014; Liaw et al., 2011; Lowell, Kildea, Liddle, Cox & Paterson, 2015; Nielsen, Alice Stuart & Gorman, 2014; Priest, MacKean, Davis, Briggs & Waters, 2012; Rowan et al., 2013; Vass et al., 2011). Researchers argued that the majority of current studies and discussions within the field of health literacy are commonly confined to Western pedagogies and paradigms. As such, they frequently disregard the significance of Indigenous culture, language and knowledges as a strength, health resource and thus a possible determinant for better health (Akena, 2012; Barwin, 2012; Lambert et al., 2014; Priest et al., 2012; Smylie, Williams & Cooper, 2006; Vass et al., 2011). Some scholars additionally contend that Indigenous languages and health knowledges, based on Indigenous ontologies and epistemologies, are frequently disregarded within the mainstream healthcare environment, and that the extent of these knowledges within policies and practices was insufficiently known (Canadian Nurses Association, 2014; Sherwood, 2013; Sweet, 2014; Vass et al., 2011).

The review found no original or comparable studies aimed at identifying the extent to which, or the quality of how, Indigenous health knowledges are acknowledged and promoted within health literacy related policy and practice documents across Australia, Canada or New Zealand. In order to establish the context in which the research question is placed, it is therefore necessary to review the mainstream concepts of health, health promotion practice and health literacy. Furthermore, issues encompassing Indigenous cultural diversity with regard to holistic concepts of health and wellbeing, Indigenous knowledges and language and the history of colonisation will also be explored and discussed.
2.2 Social Model of Health

Our understanding and behaviours that influence health and wellbeing are informed by personal and socio-cultural values, beliefs, adhesions and knowledges, and are affected by proximate and global political decisions. Health and illnesses within the Western world are predominantly viewed and addressed through the biomedical or disease based model (Germov, 2014). However, in recent years the social model of health has gained recognition and prominence due to a wider understanding of the complexity of the underlying social determinants that affect health and wellbeing (Germov, 2014). The germ theory on disease propelled the biomedical model during the late 18th and early 19th Century to become the dominant health paradigm of today’s modern medicine (Baum, 2008; Germov, 2014, p. 11).

The biomedical model upholds the general assumption that the underlying causes of disease and illnesses are produced by pathogens and/or a malfunctioning of the human body which needs to be cured or repaired (Germov, 2014, p. 11). It is further common within the bio-medical paradigm to victim-blame people for their poor health. This is considered a result of making poor health and life-style choices in addition to having very limited or no control over their personal psychological, social and biological circumstances (Germov, 2014; Wade & Halligan, 2004). In addition, health care recipients are believed to have insufficient health knowledge, and are therefore regarded as passive consumers of diagnostics, treatment and care (Germov, 2014; Wade & Halligan, 2004). These generalised and confined views of health by the biomedical field are therefore being contested by some researchers who argue that there are other knowledges and approaches to health which need to be equally valued (Barnett & Kendall, 2011; Vukic, Gregory, Martin-Misener & Etowa, 2011).

In general, the bio-medical approach is evident within most modern healthcare systems, including Australia, Canada and New Zealand, since the main emphasis for care remains fastened on acute medical intervention for individuals through hospitals, general practitioners and other medical professions (Crooks & Andrews, 2009). However, despite the strengths and benefits within this model, it has also been strongly criticised because not all illnesses can be solely determined, prevented or managed by using generalised and universal approaches which have little or no regard for any underlying contextual determinants. These might include elements such as personal, cultural, linguistic, religious and/or spiritual beliefs,
social, political, economic, and environmental influences (Baum, 2008; Crooks & Andrews, 2009; Germov, 2014; Keleher & MacDougall, 2016; Wade & Halligan, 2004). These contextual influences are commonly referenced as the social determinants of health (Baum, 2008; Keleher & MacDougall, 2016) and this term will be referred to throughout this thesis. The WHO (2015, p. 1) defines the Social Determinants of Health as “the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels”.

In 1946, the WHO recognised the limitations of the biomedical model and initiated efforts to deviate away from the conservative biomedical paradigm by defining good health as “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity” (Germov, 2014; WHO, 2015, p. 1). In 1978 the Alma Ata declaration conceptualised the social model of health which became a crucial milestone in consolidating health as a human right. The declaration promoted the principles of primary healthcare with an overall aim to enable universal access to affordable, evidence based and socially acceptable healthcare systems (Gillam & Maeseneer, 2008; Kirk, Tomm-Bonde & Schreiber, 2014). The global stagnation in promoting health equity and social justice resulted in the 1986 Ottawa Charter for Health Promotion and its more recent successors. These urge governments and the healthcare sector to rethink, restructure and broaden the context of health and disease, as it challenges the persisting individualistic and fragmented approaches to health (Baum, 2008; Kirk et al., 2014).

The Ottawa Charter, and with it the ‘New Public Health’ movement, emphasised that health and wellbeing needed to be considered as a positive social and personal resource, and that achieving health required a comprehensive all-encompassing approach which surpasses the traditional health sector (WHO, 1986). The Charter acknowledged further the significance of “peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity” as fundamental prerequisites for good health (WHO, 1986, p. 1). In order to achieve healthy populations, the Ottawa Charter outlined the action areas: building healthy public policy, creating supportive environments, strengthening community actions, developing personal skills and reorienting health services (WHO, 1986). These five action areas have since been recognised as a baseline and augmented, and continue to be of relevance today.
Since the Ottawa Charter, subsequent global health promotion conferences and research have increasingly emphasised the significance and complexity of the impact that the underlying social determinates have on the health and wellbeing of populations and individuals. Addressing and improving the social determinants within populations successfully means implementing the key actions areas as outlined by the Ottawa Charter. The 7th Global conference for Health Promotion in Nairobi in 2009 discussed and acknowledged that health literacy skills were pivotal to empowerment and aimed to enable individuals and communities to take control over their health needs and hence improve health outcomes (WHO, 2016).

National and local health promotion practices across Australia, Canada and New Zealand are largely driven by the prevailing political and public discourse, and subjected to the agendas and priorities of states, territories and federal governments (Raphael, 2015). It is the responsibility of governments to address population health inequalities and inequities by implementing comprehensive public policies, distributing political power equitably and by providing or funding a wider range of social services which are sufficiently resourced (Marmot et al., 2008; Raphael, 2015). The current underlying social ideology emphasised by many Western governments, including Australia, Canada and New Zealand, is informed and driven by liberalism, capitalism, privatisation, deregulation and reduced intervention practices. These frequently appear to disregard or diminish many of the social determinants that are likely to impact on the health and wellbeing within populations (Baum & Fisher, 2014; Raphael, 2015). The dominant notion of many Western orientated countries is that markets are self-regulating systems and differences in socioeconomic status and health within populations are due to the attributes and choices made by the individual person (Baum & Fisher, 2014).

The popularity and acceptance of this ideology upholds and strengthens the traditional biomedical paradigm, as governments, policy-makers and people or organisations holding influential positions of power, appear reluctant to change policies and institutional structures to explicitly address the social determinants (Baum & Fisher, 2014; Germov, 2014; Potvin & Jones, 2011; Raphael, 2015). Instead, public and institutional policies persistently focus on changing those lifestyle and personal behaviours, such as poor diet, lack of exercise or tobacco smoking, that are considered a risk to the health and wellbeing of people (Baum
& Fisher, 2014; Raphael, 2015). The underlying assumption of a moderate link between personal knowledge, attitude and behaviour, which could be addressed by disseminating sufficient information from credible sources, suggests that when people are adequately educated, they will be in a better position to make healthy lifestyle choices and change their risk taking behaviours (Baum, 2008, p. 456). This assumption is reflected within health promotion practice at an individual, and to some extent community and population level. A large proportion of health promotion programs provide public education through targeted community events, social marketing and media campaigns, thus aiming to enhance people’s health literacy (Baum, 2008; Baum & Fisher, 2014; Germov, 2014).

### 2.3 Health Promotion and Health Literacy

Enhancing the level of health literacy within populations and health service providers is increasingly recognised internationally, nationally and locally as an integral component within public health and health promotion practice. It has been largely accepted that improving health literacy skills within both the population and within health services will not only benefit the individual person through empowerment, but also ensure greater quality and safety within healthcare delivery (Australian Commission on Safety and Quality in Health Care, 2014a; Centre for Literacy, 2011; Johnson, 2014).

The origins of health literacy are found within the field of education and have evolved from the process of reviewing functional literacy needs among adult populations, as it was found that functional literacy skills significantly influences health outcomes (Berkman et al., 2010). According to the UNESCO *Education for All Global Monitoring Report*, primary education and functional literacy are crucial elements within health promotion practices, and which considers literacy as “key to enhancing human capabilities” (UNESCO, 2006, p. 17). The report identified wide-ranging benefits including “critical thinking, improved health and family planning, HIV/AIDS prevention, children’s education, poverty reduction and active citizenship” (UNESCO, 2006, p. 17). General functional literacy can be defined as the sufficient level of reading, writing, and calculation skills in order to function in a particular community (Comings, 2011, p. 1), and as skills that are “necessary to cope with the demands of everyday adult life, and to function effectively both socially and in the workplace” (Oxford References, 2015, p. 1).
Developing health literacy skills is commonly approached through conventional primary and adult education based on the principles of functional literacy. Many Western healthcare systems assume that enhancing health outcomes and measuring health literacy skills within populations is simply achieved by developing sufficient functional literacy skills, as in reading, understanding and acting upon information related to health (Nutbeam, 2000, 2009). Individuals and population groups experiencing unfavourable social determinants are, however, likely to be disadvantaged within standardised health literacy education and assessment approaches. The result is that they can be stereotyped as being health illiterate (Germov, 2014; Johnson, 2014; Nutbeam, 2000). It is therefore being argued that standardised approaches will vary in their effectiveness, as health needs to be viewed from a multidimensional perspective and within the specific socio-cultural context (Frisch, Camerini, Diviani & Schulz, 2012; Nutbeam, 2009). This argument is further supported by the fact that, at present, there is no clear and common agreed definition of health literacy. As a result the development and application of a streamlined and integrated approach towards increasing and measuring health literacy skills within populations remains a significant challenge (Sørensen et al., 2012).

A comprehensive study by Sørensen et al. (2012) highlighted, that early definitions and conceptual models of health literacy build on the work of Nutbeam (1998). A review of this study further suggests that the conceptual models of health literacy are primarily focused on individual consumers and confined to communicating Western defined knowledge and skills. The WHO defines health literacy “as the cognitive and social skills which determine the motivation and ability of individuals to gain access to, understand and use information in ways which promote and maintain good health” (WHO, 1998, p. 10). Kickbusch, Wait and Maag (2006, p. 8) refine this definition and conclude that health literacy refers to a person’s “ability to make sound health decisions in the context of everyday life – at home, in the community, at the workplace, in the health care system, the market place and the political arena”.

Similarly, Paarsche-Orlow and Wolf (2007, p. 20) emphasise that health literacy is context specific and therefore define health literacy as “an individual’s possession of requisite skills for making health-related decisions which means that health literacy must always be examined in the context of the specific tasks that need to be accomplished”. This
aspect was supported by Mitic and Rootman (2012), who also acknowledge that health literacy is context specific and which needs to be considered and developed as a resource for daily living across the life-span. The authors define health literacy as “the degree to which people are able to access, understand, evaluate and communicate information to engage with the demands of different health contexts in order to promote and maintain good health across the life-course” (Mitic & Rootman, 2012, p. 17).

More recent research and discussions have recognised that a single expanded educational approach is insufficient and suggested adopting a more holistic approach. Some leading researchers recommend an inclusion of the broader social, cultural, economic and political contexts within the conceptualisations of health literacy (Kickbusch, 2009; Paasche-Orlow & Wolf, 2007; Sørensen et al., 2012). An early and influential conceptualisation of health literacy by Nutbeam (2000) identifies functional, interactive and critical health literacy as a lateral continuum. Functional and interactive health literacy concepts are commonly found within traditional health education programs and campaigns. These are directed towards developing health literate and self-efficacy capabilities within individual people so that they may act independently on knowledge relevant to their personal health needs (Nutbeam, 2000). In contrast, critical health literacy emerges from preceding educational activities and experiences, and reflects advanced cognitive and individual skills which are directed towards social and political action (Chinn, 2011; Nutbeam, 2000).

Elaborating on his own concepts of functional, interactive and critical health literacy, Nutbeam (2008) suggested moving away from the notion that poor levels of functional and interactive health literacy are considered a personal risk factor which need to be managed within the biomedical health paradigm. He instead promoted health literacy as a personal asset, for the reason that people evolve and improve their health literacy skills across the life-span. Promoting health literacy as an asset and expanding current existing health literacy capacities and abilities within individuals is critical towards empowering people in order develop critical health literacy skills (Chinn, 2011). Enhancing critical health literacy skills encourages individuals, communities and populations to exert a higher level of self- and community efficacy. This can enable people to identify and act upon context specific health knowledge and advocate for social and political change. It thereby empowers them to take
greater control over their own health needs with regard to the broader social determinants (Chinn, 2011; Sykes et al., 2013).

Expanding on Nutbeam’s (2000) concept of critical health literacy, Freedman et al. (2009) emphasized that, within a modern and globalised world, it was necessary to broaden the scope and concept of health literacy by including a broad array of factors that are of specific concern to public health. In relation to Nutbeam’s lateral health literacy continuum, Freedman et al. (2009) have identified the three distinguishable dimensions conceptual foundations, critical skills and civic orientation which comprise the core principles of health promotion. The conceptual foundations dimension includes important public health concepts. These include the possessions of sophisticated health knowledge on issues such as primary prevention, population health, the interrelationship of health risk factors, morbidity and mortality, incidence and prevalence, and ecologic perspectives with regard to how particular diseases are transmitted and how this may be mitigated (Freedman et al., 2009, pp. 448-449). The emphasis within the conceptual foundations dimension is to recognise the complex multiple factors that affect health and wellbeing, and to utilise a variety of different knowledges that focus on health promotion and disease prevention instead of treatment at a population level (Freedman et al., 2009).

The critical skills dimension refers to the ability of communities to engage cooperatively in practices that benefit benefits the wider population by obtaining, critically assessing and enacting upon information that is required to make comprehensive and beneficial public health decisions (Freedman et al., 2009). The primary focus of this dimension is the promotion of health and wellbeing across the community through concurrent cross-sectional collaboration efforts and the engagement of a broad range of representatives from politics, health, urban and industrial developers, science, educators and the public (Freedman et al., 2009). A further important characteristic within this dimension is the assessment of the means by which public health problems and solutions are defined, articulated and presented (Freedman et al., 2009). The critical dimension moves towards the principles of empowerment, as it enables citizens to become active and influential participants within community conversations that affect public health outcomes (Freedman et al., 2009).
Civic orientation advances the critical skills dimension and builds on the principles of
the Ottawa Charter, as it embraces the principles of health equity, social justice and civic
engagement. Freedman et al. (2009) conclude that this dimension is crucial for individuals
and population groups to identify, illustrate and respond appropriately on health related
issues that are affected by the distribution of political power and resources within society.
Individuals, organisations and populations that apply civic orientation health literacy
enter the public arena of politicised dialogue and negotiations. These address the social
determinants of health and constructively debate the distribution of power and resources
that underpin those determinants (Freedman et al., 2009).

2.4 Health Literacy and Culture

Culture refers to the accepted and collectively shared understandings, knowledges,
belong systems, values, customs, behaviours and attitudes of a particular population group
within society (Dutta, 2008). One of the current and important discussions within the field of
health literacy accentuates the significance of linguistic and cultural diversity with regard to
how these affect health outcomes. It is important to note that each person’s individual
health literacy capacity, regardless of being a healthcare professional or recipient, is
dependent on his or her form and level of education, linguistic abilities and communication
skills which are influenced by the sociocultural context (Nielsen-Bohlman, Panzer, & Kindig,
2004, p. 32).

Language and cultural differences within multicultural societies may become
determinants of health, as these differences can impose compelling barriers to accessing or
providing primary healthcare services. Such barriers will inevitably diminish health literacy
capabilities and health outcomes (Baum, 2008; Germov, 2014; Lambert et al., 2014; Nielsen-
Bohlman et al., 2004). These current discussions on the issues of language, culture and social
determinants are re-shaping the conceptualisations of health literacy. They shift the
traditional health literacy paradigm away from being entirely consumer focused towards
recognising the broader social and cultural factors that are embedded within healthcare
environments. This development is partially driven by Zarcadoolas, Pleasant and Greer
(2005) who assert that cultural literacy needs to be inherent within health literacy models.
The authors define cultural literacy as having “the ability to recognize and use collective
beliefs, customs, world-view and social identity in order to interpret and act on health information” (Zarcadoolas et al., 2005, p. 197). These abilities become extremely relevant to healthcare systems and services who engage with culturally diverse population groups whose world-views, values, approaches to communication and conceptualisations of health and wellbeing are perhaps significantly different compared to those endorsed by the dominant culture.

The Calgary Charter on Health literacy (2011, p. 4) emphasises that health literacy applies equally to the individual health consumer and the healthcare environment. It concludes further that health literacy needs to encompass an “awareness of and ability to navigate differences between the cultures of the health system and the public, and importantly having an awareness of and ability to minimize the power imbalances between the health system and the public”. Additionally, the Australian Commission on Safety and Quality in Health Care (ACSQHC) (2014a) highlights that frequent power imbalances within the health literacy environment compose a significant barrier to the empowerment of marginalised, culturally and linguistically diverse populations. The health literacy environment refers to “the infrastructure, policies, processes, materials, people and relationships that make up the health system and have an impact on the way in which people access, understand, appraise and apply health-related information and services” (ACSQHC, 2014a, p. 5).

In order to successfully promote health equity and overcome the health literacy gap, policy-makers and healthcare providers need to develop and enhance intercultural competence. This requires leadership and responsibility to implement culturally and linguistically appropriate approaches within the field of health literacy and associated actions (Ferguson & Pawlak, 2011; Ingleby, 2012; Mitic & Rootman, 2012; UNESCO, 2013; Zarcadoolas et al., 2005). Intercultural competence according the UNESCO (2013, p. 24) refers to: the ability of individual people, organisations and institutions to value diversity; being aware of one’s own cultural identity, being conscious of the dynamics inherent in cross-cultural interactions, having the capacity for self-assessment, being able to engage in authentic reciprocal intercultural conversations and relationships that develop shared understanding and meaning through robust and mutual negotiation processes,
institutionalising the importance of cultural literacy and making adaptations to policies and service delivery that reflect cultural understanding.

Incorporating and practicing intercultural competencies requires individuals, and also societies as a collective, within a particular culture to be critically aware of personal or cultural intrinsic strengths and limitations. This requires for example, being aware of one’s personal comfort zone and having sufficient knowledge and skills to manage cultural differences appropriately. According to the UNESCO (2013) this can only be achieved through ongoing personal awareness, self-reflection, and importantly, a willingness and readiness to adjust. Whilst differences in language and culture may significantly influence health communication and the health literacy capacity within health services and between professionals and consumers, it is also critical to recognise that power imbalances are constructed and maintained through cultural dominance. Healthcare is no exception and cultural dominance is commonly exerted through governments, policy-makers, academic institutions and strong public interest groups such as large medical and pharmaceutical institutions (Kaplan-Myrth, 2007). The ways power and authority are exerted will inevitably inform and affect personal health literacy, the health literacy environment and thus health outcomes. This is likely, because according to Connell (2007), (Dutta, 2008), Ingleby (2012) and Kaplan-Myrth (2007) a dominant culture is more inclined to influence the means by which knowledge of health and illness is constructed, validated, articulated and addressed. It is also more likely to be reluctant to accept other cultural ontologies, epistemologies, knowledges, paradigms and practices as equal (Connell, 2007; Dutta, 2008; Ingleby, 2012; Kaplan-Myrth, 2007).

2.5 Health Literacy Assessment

Health literacy, as discussed earlier, is becoming increasingly important concept within the healthcare environment. As such, it is vital to have functional, culturally appropriate and evidence-based approaches to measuring health literacy within diverse populations. However, it appears that many health literacy assessment tools remain focused on measuring the conceptual and functional knowledges and skills of health consumers which are confined to a Western paradigm. A recent study by Altin, Finke, Kautz-Freimuth, and Stock (2014) identified 17 different approaches to measuring health literacy, of which
the majority fail to accommodate the dynamic and interactive nature of the broader health literacy environment. The authors found that the main emphasis in measuring health literacy revolved around the assessment of print literacy, numeracy and, in some cases, communication skills (Altin et al., 2014). Other considerations that have been persistently disregarded within assessment approaches, are the need to equally measure the health literacy and communication skills of health services and professionals, and issues that encompass the reporting on the psychometric properties (reliability, validity) (Altin et al., 2014; Osborne, Batterham, Elsworth, Hawkins, & Buchbinder, 2013).

Assessing the health literacy skills of healthcare services is equally important, as healthcare providers need to be competent, communicate effectively and accommodate the needs of healthcare consumers in order to support them in enhancing their health literacy level (Osborne et al., 2013). The reporting on the psychometric properties is often considered inappropriate, as these disregard contextual, cultural and institutional differences (Altin et al., 2014; Osborne et al., 2013). The application of standardised reliability and validity features within health literacy assessment tools, when applied indiscriminately within multi-cultural societies, can fail to acknowledge and accommodate cultural and language diversity in favour of the culturally dominant group. As a result, marginal and disadvantaged culturally diverse people are frequently stigmatised as having low health literacy skills. Although these aspects are considered important, exploring and discussing these issues in detail is beyond the scope of this thesis.

2.6 Diversity of Indigenous populations

There is significant diversity of Indigenous populations within and between Australia, Canada and New Zealand. It is important to note that, while Indigenous perceptions of identity will vary significantly within and between these countries, the issues of cultural dominance with regard to accepting and promoting different ontologies, epistemologies, paradigms and practices within the health literacy environment, remain similar. The Australian Bureau of Statistics (2012a) and Australian Government (2015) estimate without consensus that prior to European colonisation Australia comprised of approximately 600 different clan groups or 'nations' and 250 different languages. Of these, 150 languages are remaining and many are now extinct or significantly endangered. When referring to
Indigenous people specific to Australia, the terms Aboriginal Australian, Torres Strait Islander people or the name of the specific clan or language group will be used.

Within Canada, it is estimated that there are currently 50 nations or cultural groups and 50 Aboriginal languages (Government of Canada, 2015). Indigenous people from Canada identify either as ethnic First Nations, Inuit or Metis people (Government of Canada, 2014). When referring to Indigenous Canadians, the terms Aboriginal Canadians or the specific cultural group, as in First Nations, Inuit or Metis, or First Nations clan group as in St’at’imc or Kwikwetlem will be used.

The local Indigenous people of New Zealand identify as Maori and it is important to note that their native language te reo Maori has been confirmed as an official and legal language by the New Zealand government ("Māori Language Act 1987," 1987; Statistics New Zealand, 2013a). In addition, seven percent of New Zealand’s population identify as ethnic Indigenous people from the Pacific region (Statistics New Zealand, 2013a). When referring to the Indigenous people of New Zealand, the terms Maori or Pacific Islander people will be used. For further reference, health literacy related policy and practice documents specific to Pacific Islander people were not intentionally sourced, as these were considered to be outside the scope of this study. However, documents from New Zealand that focused on Pacific Islander people and which encompassed sufficient references to Maori people were included.

2.7 Indigenous Health Perspectives

Many Indigenous people across Australia, Canada and New Zealand experience similar health problems. The impact of colonisation, displacement, marginalisation and oppression of Indigenous culture and language has had long-lasting negative effects on Indigenous populations (Armitage, 1995; Dudgeon et al., 2014; Keleher & MacDougall, 2016; Stephens et al., 2006). The majority of persisting health problems are maintained or further exacerbated by unfavourable social determinants. These include lower levels of literacy, education and employment, higher rates of youth and adult incarceration, insufficient housing or overcrowding, food insecurity, ongoing intergenerational trauma, personal or institutionalised racism, negative overrepresentation or stigmatisation within the media,
significantly elevated levels of prolonged stress and insufficient influence or control in policy and decision making processes (Baum, 2008; Dudgeon et al., 2014; Ellison-Loschmann & Pearce, 2006; Keleher & MacDougall, 2016; Stephens et al., 2006). In order, however, to understand the reasons behind the persisting unfavourable social determinants and poorer Indigenous health outcomes within these countries (despite their world class health systems), it is necessary to explore the history of colonisation and Indigenous views on health and wellbeing.

Prior to colonisation, records from early visitors and colonisers suggest that Indigenous people across Australia, Canada and New Zealand purportedly enjoyed much better health than the new arrivals. Infectious and lifestyle diseases were either unknown or minor, and when present they usually occurred within specific regional locations and limited population groups (Campbell, 2002; Durie, 1994; Stephenson, 1995). The main health issues Indigenous people commonly encountered were yaws which was endemic across Australia, malnutrition and physical traumas caused through injury and warfare (Campbell, 2002; Durie, 1994; Stephenson, 1995). Having access to the land, its rich resources and effective traditional medicine systems and sophisticated health knowledges ensured that Indigenous people within all three countries were able to maintain an acceptable standard of good health and well-being (Campbell, 2002; Durie, 1994; Smylie, Kaplan-Myrth, McShane & Métis Nation of Ontario-Ottawa, 2008; Stephenson, 1995). In this regard, it can be argued that Indigenous populations had, and to some extent continue to have, their own health knowledge and thus health literacy capacity. The literature review suggests, however, that this view is rarely shared and acknowledged by mainstream health services and the majority of health literacy definitions and conceptual models remain confined to Western ontologies, epistemologies, paradigms and practices.

The nomadic and semi-nomadic lifestyle of Indigenous people in Australia and Canada (Campbell, 2002; Stephenson, 1995), and the village designs of Maori people in New Zealand (Durie, 1994) prevented the spread of infectious diseases to a high degree. Chronic diseases, such as diabetes and cardio vascular diseases were mostly absent, as the nomadic and semi-nomadic lifestyle provided a well-balanced diet as well as frequent daily physical activities (Durie, 1994; Keen, 2004; Stephenson, 1995). In addition, many mental illnesses, as they are commonly defined, diagnosed and treated today within the Western health
paradigm, were uncommon within Indigenous societies due to a strong sense of cultural identity and established social support networks of family, kin and tribal relationships (Kirmayer, Brass, & Tait, 2000; Purdie et al., 2010).

Indigenous people tended to regard health and wellbeing as a holistic, multidimensional and interconnected concept which cannot be separated from other life aspects or fragmented into distinguishable units as is common practice within a biomedical paradigm (Durie, 1994; Morgan, Slade & Morgan, 1997; Stephenson, 1995). Health and wellbeing is synthesized through physical, psychological, social, ecological, spiritual and cultural aspects and sustained by attending homogeneously to all the relationships within (Campbell, 2002; Durie, 1994; Stephenson, 1995; Vukic et al., 2011; Wilson, 2008). Although Indigenous peoples share some common health beliefs, their health knowledges and healing practices are distinguishable due to the specific social, cultural and environmental context in which they occur (Durie, 1994; Keen, 2004; Priest et al., 2012; Stephenson, 1995). Furthermore, Ingleby (2012) suggests that every person has some form of health literacy which is intrinsic to the personal and cultural beliefs. In this regard it can be argued that Indigenous concepts of holistic health and any associated knowledges and practices qualify as Indigenous specific health literacy competencies.

2.8 Indigenous Knowledges

Indigenous knowledges can be defined as “the local knowledge that is unique to a culture or society, and which is passed from generation to generation, usually by word of mouth and cultural rituals” (UNESCO, 2010, p. 1). In some parts of the world these knowledge systems have existed for millennia and configure the basis of society as they inform everyday life activities, including healthcare (UNESCO, 2010). Among many Indigenous societies, knowledge is driven by the relationships that exist within and between families, communities, clan groups, tribes and the physical, ecological and spiritual environment (Orozco & Poonamallee, 2014; Wilson, 2008).

Observation and importantly the collective discussions and negotiations of observational findings within the social-relationships determine the way knowledge is constructed, disseminated and practiced based on their ontologies, epistemologies and
values (Orozco & Poonamallee, 2014; Wilson, 2008). Many Indigenous people have, however, experienced their knowledge systems and languages being disowned, discredited, dismissed and suppressed by the dominating colonial knowledge systems and languages which, with regard to this study, is predominantly English (Kildea, 2006; Orozco & Poonamallee, 2014; Wilson, 2008). Consequently, the health inequities and inequalities many Indigenous people endure today result from the legacy of colonisation, persisting suppression of Indigenous knowledge systems and languages, and the right for self-determination, which is maintained through culturally biased governance, policies, economics, education and approaches to health issues (Connell, 2014; Henderson, 2012; Vukic et al., 2011).

2.9 Significance of language and communication

The most common and dominant language spoken within Australia, Canada and New Zealand is English. However, communicating health related content effectively is strongly influenced by factors such as language capabilities, level of education, ethnic or cultural background, gender and age (Keleher & MacDougall, 2016). Furthermore, language diversity is evident within all three countries due to the presence of Indigenous languages (see Table 1) and increasing immigration from non-English speaking countries (Australian Bureau of Statistics, 2012b; Statistics Canada, 2015c; Statistics New Zealand, 2013b). All of these aspects influence current levels of health literacy and the development of such skills within populations.

In contrast to Australia where English is used as the dominant main language for official and legal purposes, both Canada and New Zealand are considered bilingual nations with the key difference that Canada recognises the colonial language French, and New Zealand the native language te reo Maori as official legal languages (Australian Bureau of Statistics, 2012b; Human Rights Commission, 2016; Statistics Canada, 2015c). Nonetheless, it is critical to recognise the interactive relationship of culture and language within multicultural societies, as the wider context of language, socio-cultural worldviews and beliefs will affect personal and collective behaviours and action (Khalil ur, 2012; Perlovsky, 2011).
Within an Indigenous context it is therefore essential that health related information is readily accessible, meaningful, communicated sensitively and, when necessary, through languages other than English in order to support the enhancement of health literacy skills (Nagel, Thompson, Robinson, Trauer & Condon, 2009; Vass et al., 2011). According to Vass et al. (2011), this can only be achieved when non-Indigenous health services provide thorough and meaningful health information. The understandings of health information, language and visual grammar differ for different cultural groups and thus perceptions are not uniform. This requires services to move beyond merely translating words and presenting visual aids confined to Western pedagogies and paradigms (Vass et al., 2011).

2.10 History of Colonisation and Assimilation

Indigenous people across Australia, Canada and New Zealand share a similar history with regard to colonisation and the subsequent prevailing health inequities and inequalities (Stephens et al., 2006). During the early settlement by European people in the 17th, 18th and 19th Century, the former British Empire succeeded in seizing these then sovereign nations and imposed their way of life, social order, laws and policies on Indigenous peoples (Armitage, 1995). The colonial powers driving these developments justified their actions based on the underlying ideologies of Imperialism and Social Darwinism. Many people in power from the colonising European countries considered their own race as superior and that Indigenous people needed to be civilised, integrated and in some cases later protected (Armitage, 1995; Connell, 2007; Dutta, 2008; Kelm, 1998). The forced social reforms and assimilation policies that followed resulted in the dispossession, displacement and disenfranchise of Indigenous people and consequently a breakdown or loss of traditional law, language, culture, and social and community functions (Armitage, 1995; Kelm, 1998; Stephens et al., 2006).

Within Australia and Canada many Indigenous people were forcefully driven from their homelands and clustered into missionaries and reserves (Armitage, 1995; Kelm, 1998). In addition, colonial governances within both countries aimed to shape and redefine future Indigenous generations by enforcing assimilation policies that subjected Indigenous children to be removed without consent from their families, kinship and sociocultural networks (Armitage, 1995). Australia’s “Stolen Generations” was a result of these policies, and it has
been estimated that between the late eighteenth century and 1970s Australia’s federal, state and territory governments removed 100,000 Indigenous children forcefully from their families and communities (Armitage, 1995; McNamara, 2013). The assimilation and protection policies within Australia were officially effective in various forms until the 1970s: processes which denied Indigenous Australians essentially any form of human rights and control over their lives (Armitage, 1995). Imperceptible attempts to achieve assimilation and integration continue within Australia with for example: revoking the self-determination act in 1997 (Sherwood, 2013), the Northern Territory Emergency Response in 2007 (Sherwood, 2013; Sweet, 2010; Taylor & Guerin, 2010) and the recent threat of community closures in Western Australia in 2015 (Howitt & McLean, 2015; Weber, 2015) have rekindled old fears of dispossession, displacement and disenfranchisement among many Indigenous Australians (Howitt & McLean, 2015; Taylor & Guerin, 2010).

In Canada, early assimilation policies aimed at forcing Indigenous Canadians, under the threat of criminalisation and penalties, to adapt a Western lifestyle, establish Western style settlements and to ensure their children received a Western education (Armitage, 1995). Residential schooling and Western education were considered an effective form of assimilation, as Indigenous Canadian children were forcefully removed from their families and communities, thereby demonising their traditional values, beliefs and customs and claiming that these threatened physical, social and spiritual survival (Armitage, 1995; Kelm, 1998). The Canadian government replaced the ineffective assimilation policies with integration policies in the 1950s which aimed at integrating services specific to Indigenous Canadians into mainstream services which intended to create corresponding citizens (Armitage, 1995). An attempt by the Canadian Government in 1969 to change and repeal the “Indian Act” was unsuccessful due to strong resistance from Indigenous leaders, as it aimed to remove their status of aboriginality (Armitage, 1995). However, Canada’s governments continue to retain their position of integration and assimilation, as demonstrated with the 2014 controversial “First Nations Control of First Nations Education Act” which provides Indigenous Canadian’s with insufficient autonomy over their schooling system and remove reliable, predictable and sustainable funding (Mendelson, 2014).

Maori culture in New Zealand has, in contrast, experienced a different form of assimilation and attempted integration into mainstream society. This can be largely
attributed to the Treaty of Waitangi in 1840 which functions as a cultural protective factor and in contrast, remains absent in Australia and Canada (Armitage, 1995). The original treaty was completed in the languages te reo Maori and English, and includes important aspects of Maori self-governance, ownership of resources such as lands, forests, fisheries and other possessions including language. Significantly, it also recognised Maori inhabitants as full citizens (Ministry for Culture and Heritage, 2014). However, assimilation and integration was pursued through a variety of mechanisms.

Unlike in Australia and Canada, Maori people were not assembled into reservations and children were not removed from their families and communities (Armitage, 1995). In common, however, schools enforced an education that focused entirely on Western culture, worldviews, values, norms and customs, and English became the compulsory language for communication (Armitage, 1995). The colonial government installed a variety of other political bills that aimed at dismantling the culture and political power of Maori by attempting to diminish the significance and power of the Treaty of Waitangi and by absorbing services specific to Maori into mainstream services (Armitage, 1995). Whilst the majority of these attempts have been disputed, rejected or retrospectively revoked, the more recent neoliberal governments in New Zealand have been criticized for maintaining an ongoing status quo with regard to the current distribution of political power (Belgrave, 2014). Further criticism suggests that favouring a capitalistic democracy and Individualism disrupted traditional Maori, as well as Indigenous Australian and Canadian, core values of participation, solidarity, and redistribution (Belgrave, 2014).

Across all three countries, the politics and policies of past and present assimilation and integration attempts, in addition to the current governments’ pursuance of capitalist and individualist democracies, continue to exert cultural dominance. This is reflected in the ongoing unfavourable social determinants, health inequities and health inequalities many Indigenous populations experience, as current social, economic, education and cultural power-imbalance are maintained both consciously and inconspicuously within existing policies and practices which are commonly determined by the cultural group in power (Baum & Fisher, 2014; Connell, 2007). However, the Ottawa Charter and succeeding health promotion charters contest the marginalisation of populations within society. Public health and other experts are advocating for effective political action to address the broader social
determinates of health, including those underpinning policies and power relationships that perpetuate inequality and inequity (Friel, 2010; Marmot & Allen, 2014; Raphael, 2015).

2.11 Summary

The review of the literature suggests that the concepts of health literacy are being increasingly promoted as an invaluable personal asset to increasing control over personal health needs. A strong emphasis is placed within the literature on refining the definition of health literacy, incorporating cultural competencies, developing culturally appropriate tools for measuring health literacy, extending the conceptualisation of health literacy within health promotion practices and expanding these to other fields (ACSQHC, 2014b; Batterham et al., 2016; Kickbusch, 2009; Nutbeam, 2009; Sørensen et al., 2012). Increasing prominence is given to acknowledging cultural diversity and implementing culturally and linguistically competent practices within health promotion and health literacy (Lie, Carter-Pokras, Braun & Coleman, 2012; Paasche-Orlow & Wolf, 2007; Zarcadoolas et al., 2005). These are regarded as not only ethically important but also essential to ensuring culturally safe healthcare delivery (Hopkirk & Wilson, 2014). According to Richardson (2012) cultural safety is defined and achieved by establishing genuine trusting relationships which require a person to recognise and appreciate cultural differences, to be being critically aware of one’s personal and other peoples culture and identity, and sensitive to the values, worldviews and underpinning existing power-relationships.

The review also highlights, however, that current research within the field of health literacy is commonly confined to Western pedagogies and paradigms. As such, it frequently disregards the significance of Indigenous knowledges and culture as strengths, health resources and thus beneficial influences for better health (Akena, 2012; Barwin, 2012; Lambert et al., 2014; Priest et al., 2012; Vass et al., 2011). It appears that Indigenous ontologies and epistemologies are recognised to the extent of a necessary appendage to achieving satisfactory cultural competence rather than an autonomous, equitable and worthy approach alongside others. It is therefore unsurprising that researchers within this field strongly advocate the recognition, conceptualisation and promotion of Indigenous knowledges within health policies and practices, and across other fields.
3 Methods

3.1 Research Question

The study aims to explore how, and to what extent, Indigenous health knowledges are recognised within health literacy related policy and practice documents across Australia, Canada and New Zealand.

3.2 Research Rationale

The review of current health literacy research suggests that the approaches to enhancing health literacy remain mostly confined to western knowledges, paradigms and practices. However, in order for Australia, Canada and New Zealand to embrace cultural diversity and establish supportive health literacy environments for Indigenous people, Indigenous health related ontologies, epistemologies, practices, languages and relationships need to be equally valued. Recognising and accommodating these elements within policy and practice related documents that address Indigenous health is critical. If implemented, it should contribute to decolonising the Indigenous health literacy environment and to ensuring Indigenous people feel culturally safe, empowered and valued by society.

The scope of this thesis is to investigate policy and practice related documents from governments and healthcare organisations from Australia, Canada and New Zealand, that emphasize, promote or imply the development of health literacy skills within their health systems with regard to the research question. A critical investigation of health literacy related policy and practice documents, accessible on the internet, will contribute to understanding the extent of, and the ways in which Indigenous languages, health systems and knowledges are recognised, valued, acknowledged, implemented and promoted. Comparing data from these three countries will in addition highlight any significant similarities and differences, and optimistically the findings within this study will also encourage further research and action. A critical analysis of how Indigenous health policy and practice related documents are developed, debated and implemented by governments, public servants, health services and other stakeholders would have provided additional and valuable insight. However, this more extensive analysis would have exceeded the scope of this honours research degree.
3.3 Research Approach

The aim of this study is to explore and interrogate health literacy related policy and practice documents originating from Australia, Canada and New Zealand. It is argued that the construction and dissemination of health related knowledge and information is predominantly confined to Western pedagogies and paradigms; an approach which is often criticized by some experts for being colonial and imperialistic (Bessis & Camiller, 2003; Connell, 2014; Dutta, 2008). In view of this, it was therefore considered appropriate to use a critical theory lens and a culture-centred concept as the preferred underpinning research approach. Alternative and potentially useful approaches to investigating the health literacy environment are a constructivist and/or participatory approach. However, these approaches explore personal opinions, expertise and attitudes from identified stakeholders relating to policies and practice issues and would not answer the research question. A positivist or post-positivist view to answering the research question was considered unsuitable, as knowledge is commonly constructed from the position that only a single or objective reality exists (Denzin & Lincoln, 2011), and disregard the complex interactive relationships and realities that exist within socio-cultural environment. Within a positivist or post-positivist “Reality” is determined by identifying individual variables through passive observation and experimental study designs (Denzin & Lincoln, 2011).

Critical theory emphasises that the present reality needs to be understood within context of historical events, as these have shaped the current existing social, political, cultural, economic, ethnic and gender values (Denzin & Lincoln, 2011). The ontological concept that informs the critical theory is founded on the principle of power-relationships and power imbalances within society. These may be based on personal, cultural, social, economic, political and religious characteristics and traits (Denzin & Lincoln, 2011). A further important aspect within a critical theory paradigm, and relevant to this research, is that knowledge and truth are subjective and context specific rather than solitary facts and truths constructed from within authoritative and imperialistic structures (Denzin & Lincoln, 2011; Dutta, 2008). The epistemological framework of the critical theory aims to empower marginalised and disadvantaged people and populations, and asserts that the development of critical knowledge is likely to highlight, challenge and change oppressive structures (Denzin & Lincoln, 2011; Dutta, 2008).
The culture-centred approach according to Dutta (2008, pp. 8-10) aligns well with the principles of critical theory, as it highlights and circumscribes the concepts and interactions between structure, culture and agency. The overall aims within the culture-centred approach are to create supportive and nurturing environments for marginalised cultural groups, and to challenge and change persisting culturally dominant ontologies and epistemologies (Dutta, 2008). The aim of inquiry from a critical theory perspective and culture-centred approach, used within this study, is to identify and critically discuss the existing power-structures that may influence the means by which Indigenous knowledges, paradigms and practices are acknowledged and promoted within health literacy related policy and practice documents.

3.4 Authors position as a researcher

Within qualitative studies and the critical theory framework it is crucial to account for personal biases in order to establish sufficient trustworthiness of the conducted research (Denzin & Lincoln, 2011). The author is the sole researcher of this paper and identifies as a non-Indigenous Caucasian person with a culturally diverse background. He has travelled to, and lived within, culturally and linguistically diverse populations. In addition, the author’s close and extended family originate from multiple cultures, have lived or are currently living in countries other than where they were born, and speak up to three different languages on a regular basis. Personal life and family experiences provide the author with an understanding of what comprises cultural dominance and awareness that cultural minority groups may have significantly differing views and approaches to wellbeing.

3.5 Research Methods

Within health research, Sofaer (1999, p. 1101) suggests that qualitative studies are an appropriate and scientific method to conduct an initial exploration of a phenomenon or question where insufficient knowledge is available. This allows the researcher to construct an overview and preliminary understanding of the topic. The literature review has highlighted that no comparable studies of how Indigenous knowledges are recognised, valued, acknowledged, implemented and promoted within health literacy related policy and practice documents appear to have been conducted. An exploratory qualitative approach
was considered the most appropriate approach when pre-existing knowledge regarding the research topic, phenomenon or question under investigation is insufficient or absent (Cho & Lee, 2014). A qualitative content analysis is defined as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (Hsieh & Shannon, 2005, p. 1278).

3.6 Data Selection

Within this study, documents were selected when these influenced, explicitly articulated or implied concepts and approaches of health literacy, and which informed health services and programs in Australia, Canada and New Zealand. Selected documents included strategic plans, policies, frameworks, initiatives, guidelines, policy related reports and discussions. Health literacy related promotion materials for service providers were only selected when these were cited within policy and related documents, and considered useful to answering the research question. The majority of research data was primarily sourced through the broader public internet domain, using popular search engines Google and Yahoo, and websites from governments and identifiable and appropriate primary healthcare organizations. These commonly provide easy and instant access to relevant policy documents and resources and are rarely found within academic databases. A further sampling technique used within qualitative research and which is applicable for this study, is snowballing. Snowballing usually refers to the method of recruiting research participants by using first participants and encouraging them to employ their social networks, which is assumed to lead to a larger cohort (Streeton, Cooke & Campbell, 2004). However, snowballing can also be applied within solely text based research and implies reviewing original or initial document citations and retrieving those that appear relevant (Sayers, 2007).

Data selection was confined to the last 10 years, ranging from 2005 until December 2015. This timeframe was considered appropriate, as the field of health literacy only became increasingly recognised in early 2000, and it was considered that it would take some time for this emerging field to be reflected in documents from governments and the healthcare sector. A systematic screening of the first 200 search results was conducted within the each of the electronic databases Google and Yahoo. The two search engines were chosen due to
their popularity and because it was believed that these would contain and provide the most comprehensive coverage of health literacy related policy documents. Only the first 200 results from each search were screened for relevant documents for inclusion in the analysis. The aim was to contain the volume of documents to a manageable number, and also to ensure documents were not duplicated. Additionally, the search was confined to particular countries of interest, in order to exclude documents that originated from elsewhere.

The generic search term used was Australia, Canada or New Zealand combined with “Health Literacy” AND Policy OR Framework OR Guidelines OR “Action Plan” OR “Position Statement”. An additional search specific to Australia and Canada was also conducted, where the countries were replaced with either a State or Territory, such as Western Australia or Northern Territory, and British Columbia or New Brunswick, and the first 100 search results were reviewed so that locally health literacy relevant documents were not accidently omitted. The search was expanded within Australia, and additional health literacy related documents were sourced within the Department of Health of each State and Territory. Snowballing was applied by reviewing the initially sourced documents and through websites from governments and health related organisations such as the Department or Ministry for Health, Medibank or Cancer Care Nova Scotia. A summary and detailed information on the search strategy can be found in Appendix [1].

Documents were allocated for the initial study sample when these originated from Australia, Canada or New Zealand and were a policy related document: as in strategic plans, policies, frameworks, guideline, actions plans, initiatives, reports, discussion papers, position statement or curricula. Promotion and resource materials were primarily sourced through applying snowballing within the policy related documents and included when these explicitly related to communicating health knowledge and health literacy. Discussion papers, presentations and reports were only included if these were able to provide a direct reference or contribution to governance documents specifically related to health literacy. Journal articles and newsletters were excluded from the study sample.

A total of 194 documents were initially selected during an extensive search and reviewed for relevance to the research question. After excluding all those documents that were duplicates, published prior to 2005 or irrelevant to communicating or accessing health
related knowledges and information, a total of 108 documents were selected for further analysis. Each document was further screened and classified in order to determine their elementary attributes, country of origin, type of document and intended population addressed within, or affected by, the documents (see Graph 1, 2 & 3).

3.7 Data Analysis

Within this study, selected documents were analysed with the assistance of QSR NVivo10 software which supports systematic coding of data and identification of themes and sub-themes. This study applied the inductive qualitative content analysis approach described by Mayring (2000) and Cho and Lee (2014). The selected procedure used a systematic iterative analysis of health literacy related documents included within the study sample. Document references specific to emerging codes, categories or themes are directly drawn from the data (Cho & Lee, 2014; Mayring, 2000). In order to ensure accuracy and trustworthiness within the process, Mayring (2000) suggests the frequent implementation of feedback loops so that the emerging codes, categories or themes are revised and if necessary amended (see Figure 1).
Figure 1. Step model of inductive theme development adapted from (Mayring, 2000)

All selected documents were analysed and coded for themes and sub-themes using the inductive qualitative content analysis approach described earlier (see Figure 1.) with regard to the research question. The initial explorative coding phase analysed the first 40 documents and this process identified six preliminary codes (see Appendix 2). A first review of the introductory codes suggested that additional important codes needed to be included, as the current code-set alone was considered insufficient to answering the research question. A second wave of coding reviewed all 108 documents and codes, themes and subthemes removed, amended or added.

During this process two questions emerged and constructed an additional important theme. Answering these questions was considered crucial in order to understanding the wider context in which the research question has been placed. The first question is with regard to the extent of acknowledging, promoting and enabling Indigenous participation within the decision making processes that affect their health needs. The second emerging question relates to how self-determination, autonomy and sovereignty of Indigenous
populations is being enabled and promoted within health literacy related policy and practice documents. This process also highlighted the need to also investigate the promotion of intercultural competencies within health services and current health literacy assessment tools or approaches within the documents. It was assumed that these aspects all influenced how health literacy levels are currently determined and how health information is disseminated within populations.

A thorough review of the text coded during the second wave of coding also suggested further amendments and refinements of sub-codes. Some codes were considered too broad, unspecific or inconclusive; features which would likely hamper and distort the process of deeper analysis and interpretation. This process resulted in six main themes and 19 subthemes (see Appendix 4) which enabled a sophisticated and meaningful comparison within and across the main themes. Furthermore, in determining the document classification attributes outlined earlier, it enabled a direct comparison within and between the countries investigated with regard to highlighting significant similarities and/or differences within specific themes and sub-themes.

It is important to note that all documents included within the study sample are likely to be represented within multiple themes and sub-themes. In order to explicitly highlight any significant similarities and/or differences within and across the main themes with regard to document classification attributes, it was essential to confine the coding of documents to sub-themes only and apply the filter aggregate coding from child nodes at each main theme. The filter collates all documents from within the embedded sub-themes and eliminates document duplication at the main themes. This application was also applied at an umbrella node in order to collate all documents from the main-themes and ensures that documents are not counted multiple times within the study sample. Applying the filter strategically enabled the study to present basic quantitative information accurately with regard to document classification attributes and in relation to specific themes and sub-themes (see Graph 8 and 9).
3.8 Research trustworthiness and credibility

Ensuring trustworthiness and credibility within qualitative research practice can be challenging, especially when data is collected by a sole researcher and only consists of one single study design. As there are currently no comparable studies for this particular research question, the main objective is therefore to create an initial understanding of the topic. Establishing trustworthiness and credibility within qualitative research can be achieved by applying different strategies simultaneously (Denzin & Lincoln, 2011). Such strategies include accounting for personal biases, ensuring transparency within data collection and coding process, demonstrating clarity in terms of thought processes during data analysis, presenting authentic citations or illustrative references and subsequent interpretations and engaging with other researchers or academics who have sufficient expertise within the field of research (Denzin & Lincoln, 2011; Elo et al., 2014; Goldberg & Allen, 2015; Noble & Smith, 2015). Additionally, Denzin and Lincoln (2011, p. 583) suggest that in terms of a qualitative policy inquiry, trustworthiness and credibility was established by providing sufficient contextual background in which policies have been developed and occur. Similarly, Guba and Lincoln (1994, p. 113) suggest to establish trustworthiness and credibility within critical theory by accounting for historical events, as these create the present reality and inform existing social, political, cultural, economic, ethnic and gender values.

With regard to this study, trustworthiness and credibility were established using multiply methods. Firstly, the honours research thesis provides sufficient transparency on the processes of data collection and coding which is explained in detail in the Appendices 1 – 4 and Chapter 3 Section 6 Data Collection. Secondly, extensive and detailed authentic illustrative quotations are presented within Chapter 4 which incorporates the explicit inclusion criteria for each category coded. Thirdly, an extensive historic contextual review with regard to health promotion and health literacy practices and Indigenous concerns with regard to Indigenous knowledges, colonisation and assimilation was provided and discussed within Chapter 2.

Expert and peer review was provided during the data selection, coding and discussion process. Expert review was conducted by the two thesis supervisors, both of whom have extensive experience within the field of Indigenous health perspectives. Peer review was
provided by other academics with experience in Indigenous health and research practices. Additionally, an Indigenous honours degree student from the School of Psychology and Clinical Sciences, who conducts research within the field of culture and identity, also served as a peer reviewer. All participants assessed and evaluated content and data readability, trustworthiness and credibility and provided feedback to the researcher, in response to which revisions were made.
4 Findings

An in-depth analysis of 108 systematically selected documents (see Appendix 5) was conducted, using the process described above, in order to explore the extent and ways in which Indigenous health knowledges are recognised, acknowledged, implemented and promoted within key health literacy related policy and practice documents. The research findings present themes and sub-themes that have emerged from the explorative qualitative analysis by using and discussing key quotes which were purposefully extracted from investigated documents. In addition, descriptive quantitative information will be provided in order to illustrate the distribution of documents relevant to the themes and sub-themes, intended target populations and country of origin.

The majority of documents originated from Australia (47), followed by Canada (32) and New Zealand (28). A single independent document from the United States of America was also included within this study due to it being frequently referred to with regard to becoming a health literate organisation (see Graph 1). Documents within the study sample were further classified with regard to their intended purpose, as in being a strategic plan, policy, framework, guidelines, initiatives, promotion materials and policy related reports or discussion papers (see Graph 2). Additionally, government and organisational strategic plans, policies, frameworks, approaches or guidelines were further distinguished as high-level governance documents when these explicitly influenced operational processes of health services. Health literacy related documents within this study sample were primarily concerned with Indigenous health, as 39 documents focused exclusively on addressing Indigenous health and a further 29 documents provided substantial references to Indigenous populations. The remaining 40 documents addressed the general population of which four documents provided references to unspecified culturally diverse populations (see Graph 3). The explorative coding process of the study sample identified six main themes which are outlined in Table 2. Embedded within these six themes are 19 sub-themes (see Appendix 3).
Graph 1. Number of document represented by country

Australia (#47)
Canada (#32)
New Zealand (#28)
USA (#1)

Graph 2. Document type and representation by numbers
Table 2

Summary of main themes and number of document inclusion

<table>
<thead>
<tr>
<th>Name</th>
<th>Main Themes</th>
<th>Sources (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A – Promotion of Indigenous cultural health knowledges, paradigms and practices</td>
<td>N = 108</td>
<td># 25</td>
</tr>
<tr>
<td>B – Acknowledging cultural beliefs, practices and norms</td>
<td></td>
<td># 40</td>
</tr>
<tr>
<td>C – Accommodating language diversity</td>
<td></td>
<td># 47</td>
</tr>
<tr>
<td>D – Cultural responsiveness</td>
<td></td>
<td># 75</td>
</tr>
<tr>
<td>E – Participation, self-determination and sovereignty</td>
<td></td>
<td># 99</td>
</tr>
<tr>
<td>F – Approaches to measuring health literacy</td>
<td></td>
<td># 11</td>
</tr>
</tbody>
</table>

4.1 Analysis of main themes and sub-themes

The following section explores similarities and differences between countries and document type related to each of the themes and sub-themes. The specific inclusion criteria will be explained for each theme and key quotes are presented that illustrate the distinctive elements of each of the sub-themes. The first three themes explore information explicitly relevant to the research question. The final three themes provide a deeper level of contextual understanding relevant to the research question.
4.1.1 A) Promotion of Indigenous cultural health knowledges, paradigms and practices

The promotion of Indigenous cultural health knowledges, paradigms and practices emerged as an important theme. The analysis of the study sample identified that some health literacy related policy and practice documents acknowledged the significance of how Indigenous knowledges, paradigms and practices may contribute to providing culturally competent health literacy environments. This study identified a total of 25 documents which specifically recognise, acknowledge and promote a variety of Indigenous knowledges, customs or practices aimed at enhancing health and wellbeing within Indigenous populations (see Table 3). The emerging sub-themes were drawn from document references and represented traditional medicinal, food and childrearing practices, and cultural customs (see Table 3). The majority of documents represented within these sub-themes identified as promotion materials or policy related reports and discussions, and originated predominantly from Canada and New Zealand. In contrast, high level governance documents originated mostly from Australia and to some extent from New Zealand, but were less represented within this theme. Additionally, these documents provided mostly limited or no details to guide health services working within an Indigenous context on what comprises Indigenous knowledge, paradigms and practices and how to communicate or promote these effectively.

Table 3

<table>
<thead>
<tr>
<th>Number of documents promoting aspects of Indigenous cultural health knowledges, paradigms and practices within sub-themes</th>
<th># 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.) Acknowledgment and promotion of Indigenous paradigms</td>
<td># 9</td>
</tr>
<tr>
<td>2.) Indigenous healing and medicinal practices</td>
<td># 10</td>
</tr>
<tr>
<td>3.) Indigenous food practices</td>
<td># 8</td>
</tr>
<tr>
<td>4.) Indigenous traditional and contemporary cultural practices</td>
<td># 7</td>
</tr>
<tr>
<td>5.) Indigenous birthing and child rearing practices</td>
<td># 2</td>
</tr>
</tbody>
</table>

4.1.1.1 1.) Acknowledgment and promotion of Indigenous paradigms

The promotion of Indigenous paradigms with an aim to address the concerns that affect the health and well-being of Indigenous populations was identified within only few health literacy related documents. Document references explicitly acknowledged and
promoted Indigenous paradigms based on the principles of self-determination, autonomy and sovereignty (see Table 4). In contrast, document references that acknowledged and supported the inclusion of bi-cultural approaches to health that are confined to a Western pedagogies or paradigms have been coded to the sub-theme *Bi-Cultural approaches confined to Western knowledge* (see Table 20).

The study identified nine documents that advocate the integrating of Indigenous pedagogies and paradigms within Indigenous health literacy environments. The quotations collated within Table 4 illustrate the similarities across all three countries in recognising that Indigenous health concerns can only be successfully addressed when Indigenous ontologies, epistemologies and paradigms are adequately respected, acknowledged and incorporated across the healthcare sector. The majority of documents that acknowledge and promote the incorporation of Indigenous paradigms are policy related reports, discussion papers and presentations that affect health literacy outcomes. High-level governance documents that advocate, endorse or mandate an incorporation of Indigenous paradigms within the field of health literacy were limited and originated from Australia and New Zealand. High-level health governance documents from Canada provide no references with regard to promoting Indigenous pedagogies or paradigms within approaches to enhancing health literacy in the study sample. Instead, gradual efforts to achieving high-level governance recognition were illustrated within a single research report aimed at developing policy guidelines for palliative care programs within First Nations communities (see Table 4).

**Table 4**

**Acknowledgement and Promotion of Indigenous paradigms**

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong> Framework</td>
<td>“Key to addressing health literacy within Aboriginal and Torres Strait Islander communities is ensuring that strategies to address literacy and health literacy build on Indigenous understandings and perspectives, including language and worldview”. (Australian Commission on Safety and Quality in health care, Health Literacy: Taking action to improve safety and quality, p. 25).</td>
</tr>
<tr>
<td>Country</td>
<td>Example</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>“Overarching Policy Guidelines for Palliative Care Programs with First Nations Communities. 1) The policy endorses a unique philosophy, definition, and, community-based process for providing palliative care in First Nations communities that is distinct from a westernized, medicalized or urban model of palliative care. The policy is: Based on Indigenous understandings of health, illness, birth, and death which differ across communities and linguistic groups”. (Kelly &amp; Prince, 2015, A Framework to guide policy and program development for palliative care in First Nations communities, p. 3)</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>“Māori community development models offer another route to wellbeing. These approaches use Māori strengths and assets to develop their own initiatives tailored to meet their own health needs. This includes support to develop programmes and interventions that incorporate Māori models of health and wellbeing, rongoā (traditional healing) and innovation. Services should also be organised around the needs of Māori consumers and their whānau rather than the needs of providers”. (Ministry of Health, 2014, The Guide to He Korowai Oranga Maori health strategy, p. 10)</td>
</tr>
</tbody>
</table>

**4.1.1.2 2.) Indigenous healing and medicine practices**

Inclusion and promotion of Indigenous healing and medicinal approaches and practices were explicitly referenced within high-level governance documents, as in strategic plans and frameworks, and originated from Australia and New Zealand. In contrast, Canada emphasises the utilisation of Indigenous healing and medicinal practices within promotional materials and resources, and in policy related reports, discussion papers and presentations only. This study sample revealed no recent evidence of their recognition at higher levels of health governance in Canada. Nonetheless, all document references represented within this sub-theme emphasised the importance of such practices and recognised their need to be considered as an integral part of an Indigenous holistic worldview to health and wellbeing (see Table 5). The examples highlight similar specific functional references with some also providing details on different Indigenous healing and medicinal practices (see Table 5).
<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
</table>
| **Australia**                      | “Ngangkari traditional healers have been practising for thousands of years, and are respected by Aboriginal communities throughout Australia as traditional doctors. Ngangkaris play a vital role in shaping the lives of Aboriginal people and influencing and managing a person’s spiritual and physical wellbeing. This skill has been passed down to them through their ancestors and in by practising traditional health healing. Where Aboriginal people request the support of a Ngangkari SA Health staff must respect the wishes of a patient and facilitate access to a Ngangkari”.  
(Health South Australia, 2010, Aboriginal Health Care Plan 2010 – 2016, p. 20)                                                                                                                                                                                                                       |
| **Canada**                        | “An example of a community-based approach utilizing cultural and spiritual methods as healing practices can be found in Alkalki Lake, British Columbia. Dances, ceremonies, and spiritual practices, such as pow-wows, sweetgrass ceremonies, sweat lodges, and drumming circles were used by traditional healers to try and treat the substance-abuse issues of some of its members”.  
(Centre for Suicide Prevention, 2013, Suicide Prevention Resource Toolkit, Community and Spirituality, para 4)                                                                                                                                                                                                                                           |
| **New Zealand**                   | “Several of the GPs and nurses acknowledged the preference Māori often express for natural herbal remedies or traditional Māori medicines (rongoā). Several provider staff noted the role that such traditional therapies may play in their patients’ wellbeing and were able to negotiate taking Western medicines alongside rongoā”.  
(Jones et al., 2015, He Māramatanga Huangō: Asthma health literacy for Māori children in New Zealand, p. 50)                                                                                                                                                                                                                                           |
|                                   | OR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                   | “Includes support to develop programmes and interventions that incorporate Māori models of health and wellbeing, rongoā (traditional healing) and innovation”.  
4.1.1.3 Indigenous knowledge related to food practices

Indigenous knowledges encompassing food practices such as traditional food processing, hunting and gathering practices was identified as an emerging sub-theme within some health literacy related documents (see Table 6). Similarly across all three countries, high level governance documents provided marginal or no apparent references towards acknowledging Indigenous knowledge related food practices. The majority of documents identified within the study sample that recognise the importance of Indigenous food practices originated from Canada, and are predominantly represented within health literacy related promotion materials and resources. Documents from Australia rarely recognised or acknowledged the value traditional Indigenous food knowledges and practices may have for some Indigenous people with regard to their health and wellbeing. Nonetheless, some documents from Australia and Canada identify that traditional food practices are intrinsic to the holistic concept of health for some Indigenous people, and that when sufficiently practiced are likely to provide food security and physical, spiritual and environmental health and wellbeing.

No explicit references with regard to valuing or promoting traditional Maori food practices were identified within health literacy related documents from New Zealand. The only reference to Maori food practices found in the context health services being culturally competent, was a single document suggesting that denying Maori people traditional foods may create a culturally unsafe environment for some (see Table 6).

Table 6
Indigenous food practices

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
</table>
| Australia Guidelines              | “Traditional foods still require some physical effort to obtain (fishing, hunting, gathering fruit) but assisted by outboard motors, cars, guns and thus not as active – however these activities are often considered to also contribute significantly to spiritual, physical, mental and social wellbeing as well as providing food”.
(Colles, Maypilama & Brimblecombe, 2014, Food and Health Communication Across Cultures: Considerations for Health Professionals Working with Remote Aboriginal Communities, |
“Through a partnership with the Canadian Diabetes Association and Dietitians of Canada, a tool kit was developed to assist with disseminating the products, including adapted resources for use with Inuit populations in the North and First Nations communities.

This tool kit included the development of picture-based nutrition fact sheets that incorporate traditional “country” foods and cooking practices”.

(Canadian Public Health Association, 2006, Health literacy interventions, p. 4)

“Commercialization of Country Food Project One of the Coalition’s objectives is to help ensure that Nunavummiut who are most vulnerable to food insecurity are able to access country food”.


“Barriers to Palliative Care services identified
Not being permitted to bring traditional food to comfort the dying person”.

(Kidd et al., 2014, Kia Mau te Kahu Whakamauru: Health Literacy in Palliative Care. p. 85)

4.1.1.4 4.) Indigenous traditional and contemporary cultural practices

Few documents across Australia, Canada and New Zealand recognise the significance of incorporating Indigenous cultural practices to ensure a more responsive health literacy environment. Some of the examples presented in Table 8 suggest that Indigenous cultural practices are integral to Indigenous holistic concepts of health and wellbeing. The majority of these documents are promotional materials and resources or policy related reports and discussions. The study findings suggest that cultural practices and affiliated relationships are commonly recognised and promoted within Australia and New Zealand in association with palliative care. This can be interpreted as an attempt to develop culturally competent end-of-life care aimed at enhancing mental and spiritual wellbeing (see Table 8). In contrast, documents from Canada promote the utilisation of cultural practices more broadly in order
to develop culturally safe environments for interaction and to establish new or maintain existing important relationships (see Table 8). The findings and comparison suggest a general lack of understanding, clarification and definition of what comprises Indigenous cultural practices, and furthermore indicates an absence of understanding and acknowledgement of Indigenous cultural diversity within high-level health governance.

Table 7

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia Framework</td>
<td>“Aboriginal people are to be supported to ‘return to country’ to die if requested” and “Kinship groups are to be permitted to remain with a person during inpatient care and management and recognition of post-death practices are to be permitted”.</td>
</tr>
<tr>
<td></td>
<td>(South Australia Health, A framework for comprehensive primary health care services for Aboriginal people, p. 28)</td>
</tr>
<tr>
<td>Canada Promotion Materials</td>
<td>“A more formal approach involves a traditional talking circle where a sacred object (such as a feather or rock) is passed from grandmother to grandmother. The one holding the object speaks without interruption by others, creating a respectful and safe environment for all. Teachings are based on the four domains of the traditional Medicine Wheel and the alignment with aspects of human behaviour: mental, emotional, physical and spiritual”.</td>
</tr>
<tr>
<td></td>
<td>(Canadian Public Health Association, Examples of health literacy in practice, p. 20)</td>
</tr>
<tr>
<td>New Zealand Discussion Paper</td>
<td>“Whānau participating in the Waikato project described the last days and hours spent with a dying whānau member or friend as a spiritual experience, and emphasised the critical role of tikanga (cultural practices). They specifically discussed the importance of waiata (song) and karakia (prayer) in managing pain and facilitating the dying person’s spiritual journey through making connections between the spiritual and material worlds. These cultural practices were an expression of Māori beliefs and values and often involved strengthening interpersonal relationships (including spiritually) between the person dying and whānau members, and among whānau members”.</td>
</tr>
<tr>
<td></td>
<td>(Ministry of Health, 2014, Palliative Care and Māori from a Health Literacy Perspective, p. 50)</td>
</tr>
</tbody>
</table>
4.1.1.5 5.) Indigenous birthing and child rearing practices

Traditional Indigenous child rearing and birthing practices appear to be rarely advocated as beneficial. The study identified only two documents originating from Australia and Canada that explicitly endorse or promote Indigenous approaches to birthing and childrearing practices. None of the documents represent high-level governance. However, both documents advocate similarly for the implementation of culturally appropriate approaches that encompass Indigenous knowledges, including concepts of holistic health (see Table 8).

The document from Australian in particular details the potential benefits of traditional Indigenous child rearing and birthing practices. Suggested benefits include: the development of Indigenous family and social networks and a contribution to developing a healthy and strong Indigenous cultural identity across the life-span. These aspects could to some extent be considered as Indigenous specific health literacy competencies.

Table 8

<table>
<thead>
<tr>
<th>Indigenous birthing and child rearing practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of origin and document type</td>
</tr>
<tr>
<td>Illustrative Quote</td>
</tr>
</tbody>
</table>

**Australia**

Discussion Paper

“Birthing on country” is defined as, “...maternity services designed and delivered for Indigenous women that encompass some or all of the following elements: are community based and governed; allow for incorporation of traditional practice; involve a connection with land and country; incorporate a holistic definition of health; value Indigenous and non-Indigenous ways of knowing and learning; risk assessment and service delivery; are culturally competent; and developed by, or with, Indigenous people.

The term BOC should be understood “as a metaphor for the best start in life for Aboriginal and Torres Strait Islander babies and their families, an appropriate transition to motherhood and parenting for women, and an integrated, holistic and culturally appropriate model of care for all”.

(Thoms, Mohamed & Grant, 2015, Draft National Framework for Health Services for Aboriginal and Torres Strait Islander Children and Families, p. 13)
Canada Report

“Life skills such as choosing healthy foods and budgeting limited incomes are central to food security in Nunavut. The Qaujigiartiit Health Research Centre and Arviat Wellness Centre have been teaching these skills to Nunavummiut through their Inunnguiniq Parenting Program. The purpose of the Inunnguiniq Parenting Program is to support families in revitalizing the role of Inunnguiniq (Inuit perspectives on parenting childrearing); to rebuild the role of extended family and community in childrearing, and to support healing”.


4.1.2 B) Acknowledging cultural beliefs, practices or norms

Acknowledging cultural beliefs, practices or norms was identified within the study sample as a distinctive separate theme. This was because document references coded within the following sub-themes presented a passive approach to promoting Indigenous knowledges, paradigms and practices. Instead of fulsome support, document references modestly acknowledged, respected and valued Indigenous diversity (see Table 9).

In summary, this theme was evident across all three countries, and also well represented within high-level governance documents. Strategic plans, policies and frameworks that originate from Australia and New Zealand especially acknowledge and demonstrate a substantial recognition of Indigenous culture diversity. Their acknowledgment and promotion of Indigenous holistic health concepts, particularly within health literacy related documents, is clear (see Table 9), and occurs at all levels of health governance (see Table 10).

Table 9

<table>
<thead>
<tr>
<th>Number of documents acknowledging cultural beliefs, practices or norms</th>
<th># 40</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) Recognition of Indigenous holistic health</td>
<td># 34</td>
</tr>
<tr>
<td>7) Indigenous social networks and support systems considered a health resource</td>
<td># 14</td>
</tr>
<tr>
<td>8) Indigenous culture and languages considered a health asset</td>
<td># 10</td>
</tr>
<tr>
<td>9) Recognition of cultural protocols</td>
<td># 5</td>
</tr>
</tbody>
</table>
4.1.2.1 6.) Recognition of Indigenous holistic health

The study identified that health literacy related policy and practice documents across all levels of health governance from Australia, Canada and New Zealand substantially acknowledged the importance of incorporating and promoting holistic concepts of health and wellbeing within an Indigenous health literacy environment. A number of documents references suggest that governments and health governance from all three countries are increasingly recognising the significance of holistic concepts to health and wellbeing. They also acknowledge that these may be beneficial to enhancing Indigenous health outcomes. In some instances, there appears to be a gradually acceptance that Indigenous holistic concepts surpass the boundaries of the traditional social model of health. Quotes from Australia, Canada and New Zealand highlighted this by recognising the interconnectedness of physical, social, cultural, emotional and environmental factors, including language and spiritual connections or relationships (see Table 10).

Table 10

<table>
<thead>
<tr>
<th>Recognition of Indigenous holistic health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of origin and document type</td>
</tr>
<tr>
<td>Australia Framework</td>
</tr>
<tr>
<td>Canada Report</td>
</tr>
</tbody>
</table>
“Māori perceive health in a holistic way where good health is dependent on a balance of factors affecting wellbeing. Wairua (the spiritual), hinengaro (mental), tinana (physical), te reo rangatira (language) and whānau (family) elements interact to produce actual wellbeing. The wellbeing of te ao tūroa (environment) contributes also. This approach requires that Māori health be understood in the context of the social, economic and cultural position of Māori”.

(Ministry of Health, Rauemi Atawhai A guide to developing health education resources in New Zealand, p. 28)

4.1.2.2 7.) Indigenous social network and support systems considered as a health resource

Social and family wellbeing is a fundamental aspect of Indigenous health which is becoming increasingly recognised and promoted within more recent health literacy related documents. Documents at all levels of health governance from Australia, Canada and New Zealand promote the inclusion of Indigenous family and social networks. The majority of documents from all three countries refer to Indigenous family and social networks within the context of holistic health concepts. They rarely, however, identify and cite the significance of how these relationships and social networks influence the wellbeing of Indigenous families, communities or populations.

There are some documents that do acknowledge, in more detail, the beneficial outcomes of including Indigenous family and social networks within personal healthcare. Examples in Table 11 illustrate that Indigenous populations across all three countries shared and discussed health related information frequently within social networks. Documents have also recognised that the sharing of knowledge collectively may be of relevance to some people who are not in care at the time when these discussions take place. This informal sharing of information may lead to beneficial health outcomes in the future (see Table 11). Some documents also recognised that an inclusion of family and social networks within healthcare can strengthen relationships. Nurturing these relationships can potentially remove or bridge cultural and communication barriers. As such, they can be crucial to establishment of culturally safe environments and in the effective communication of health information (see Table 11).
Table 11

Indigenous social network and support systems considered as a health resource

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong></td>
<td>“Family and community connectedness are some of the most important factors enabling individuals to recover from the damaging affects of adversity. Family and community connectedness are acknowledged strengths of Aboriginal communities”. (New South Wales Health, Aboriginal Mental Health and Well Being Policy 2006-2010, p. 5)</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>“The role of the doula is to build on the more traditional role of Aunty; a lay woman recruited from the community who bridges language and cultural barriers and provides the woman, her partner and family with continuous emotional support, physical comfort and assistance in obtaining information before, during, and just after childbirth”. (Ministry of Health British Columbia, Health Authorities’ Aboriginal health programs Annual Report 2011 – 2012, p. 14).</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>“Involving whānau in support for self-management increases the likelihood that healthy behaviour will be adopted. Since family and whānau members are likely to have similar risk factors to the person with the chronic condition, involving family/whānau is a sound preventative approach”. (Health Improvement and Innovation Resource Centre, Improving responsiveness to Maori with chronic conditions, p. 8)</td>
</tr>
</tbody>
</table>

4.1.2.3 8.) Indigenous culture and language considered a health asset

Few documents were found within the study samples that explicitly highlight the beneficial health aspects of Indigenous culture and language, rather than referring to them as health constraints or risk factors. It is important to note that documents have also been coded under this sub-theme whenever they referred to utilising an Indigenous strength-based approach rather than proclaiming Indigenous culture or languages as a health asset. Statements acknowledging the importance of Indigenous people having a strong and healthy cultural identity were identified within some high-level governance documents. These are
illustrated by two exceptional examples from Australia and Canada in Table 12. Both quotes demonstrate the importance that cultural literacy has with regard to health and wellbeing.

The document originating from Australia highlights that social and cultural factors need to be recognised and accommodated at a local level, and that health services are therefore required to obtain adequate cultural literacy skills. The document from Canada acknowledges the importance that native languages for Indigenous people are considered an integral part in the development of a healthy cultural identity. Use of local languages will also enable Indigenous people to communicate traditional knowledges, including health information, more effectively. In contrast, documents from New Zealand predominantly refer to utilising Maori strength based approaches which are commonly associated with incorporating Maori holistic concepts of health within health literacy related policy and practice documents.

Table 12

**Indigenous culture and language considered a health asset**

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
</table>
| **Australia** Strategic Plan       | “Services at the local level should recognise the protective factors of culture, and the strong connection between culture and positive wellbeing, to help improve Aboriginal and Torres Strait Islander people’s access to timely and culturally appropriate mental health care”.  
(Australian Government Department of Health, 2015, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, p. 21) |
| **Canada** Strategic Framework     | “The Northwest Territories attaches a strong value to self-identity, traditional culture and language, as being important and integral to lifelong learning. It is reasonable and obvious in the minds of the elders that language is very much a part of who Aboriginal people are as people and can only enrich the learning environment as an important asset”.  
| **New Zealand** Strategic Plan     | “The aim of this plan is to give a strategic implementation framework to improve Māori health gains in the Wairarapa. This will be realised through effective strategies and actions that support positive health outcomes for whānau Māori at a local...” |
4.1.2.4 9.) Recognition of cultural protocols

The study identified a clear distinction within references encompassing the recognition and/or promotion of Indigenous cultural protocols. Document references that provide a marginal or descriptive recognition were coded within this sub-theme, whereas references that endorse and promote Indigenous cultural protocols have been coded accordingly within the sub-theme *Indigenous traditional and contemporary cultural practices* (see Table 7). Five documents originating exclusively from Australia and New Zealand have been identified that plainly recognise or accept the existence of Indigenous cultural protocols. Some of these documents are high level governance documents and the quotes from both countries similarly illustrate the importance of integrating cultural competencies and cultural literacy skills within health services (see Table 13). In contrast, documents from Canada are not represented within this sub-theme. It was identified that these proactively promote cultural practices within health literacy related promotion materials and resources, or advocate for the inclusion of such practices within reports and discussion papers (see Table 7).

**Table 13**

Recognition of cultural protocols

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
</table>
| **Australia** Framework           | “A woman from an Aboriginal or Torres Strait Islander community may need to speak with a female healthcare provider if she wants to talk about women’s business”.
(Australian Commission on Safety and Quality in health care, 2014, Health Literacy: Taking action to improve safety and quality, p. 52) |
The premises were blessed by our kaumatua before it re-opened. (Cultural literacy is an important contributor to health literacy).”

(New Zealand Guidelines Group, 2011, Health Literacy and Medication Safety, p. 30)

4.1.3 C) Accommodating language diversity

The literature review highlighted the significance of how language and other aspects of communication influence personal health literacy. Although both Australia and Canada have substantial Indigenous languages represented within their countries (see Table 1), statistics are inconsistent with regard to how many Indigenous people are actually fluent in these. The majority of Indigenous people across all three countries use English as their first language. The study identified twelve documents which recognised and addressed general communication issues, and which promoted strategies such as using plain English and teach back techniques. Some Indigenous people may, however, use English only as a second or third language. It was, therefore, considered vital to investigate the ways in which Indigenous languages are recognised in an Indigenous healthcare environment where these languages are considered strong or substantially evident.

The analysis of the study sample identified three distinctive sub-themes regarding the extent and methods of accommodating language diversity within literacy related policy and practice documents (see Table 14). Document references that explicitly cited the inclusion, promotion or utilisation of Indigenous languages and/or interpreter and translation services, formulated the sub-themes Promotion of Indigenous languages (see Table 15) and Promotion of interpreter or translation services (see Table 16). Some documents provided inexplicit references of the need to consider or address language diversity without providing specific solutions and these references defined the sub-theme Marginal or descriptive recognition of language diversity (see Table 17).

In summary, 47 documents within the study sample were identified as recognising and addressing the issue of language diversity (see Graph 7). Health literacy related documents across Australia, Canada and New Zealand recognise Indigenous language diversity at all levels of health governance. In particular high-level governance documents
from Australia acknowledge the need to address the issue of language barriers within health communication. Some documents from Australia and New Zealand are also found to promote both local Indigenous languages and the utilisation of interpreter services in order to achieve the highest possible level of health communication. Despite Canada having a significantly linguistically diverse population (see Table 1) only a relatively small number of documents address issues encompassing language diversity. Nonetheless, a total of 61 documents originating evenly from all countries did not provide any references and guidelines towards addressing issues that encompass language diversity within an Indigenous health literacy environment.

Table 14

<table>
<thead>
<tr>
<th>Number of documents and sub-themes addressing language diversity</th>
<th># 47</th>
</tr>
</thead>
<tbody>
<tr>
<td>10) Promotion of Indigenous languages</td>
<td># 20</td>
</tr>
<tr>
<td>11) Promotion of interpreter or translation services</td>
<td># 22</td>
</tr>
<tr>
<td>12) Marginal or descriptive recognition of language diversity</td>
<td># 8</td>
</tr>
</tbody>
</table>

Graph 4. Number of documents accommodating language diversity by sub-themes

4.1.3.1 10.) Promotion of Indigenous languages

The use of Indigenous languages is gradually being recognised as a critical feature to improving cross-cultural communication, enhancing health literacy skills and/or providing culturally appropriate and holistic healthcare. The majority of documents that recognise the importance of Indigenous languages originate from New Zealand and promote the
incorporation of te reo Maori at all levels of health governance. The quote from New Zealand below is a good example of how te reo Maori and Maori artistic skills are promoted within high-level governance documents that aim to enhance health literacy skills with the Maori population. A limited number of more recent high-level health governance documents from Australia and Canada similarly recognise the beneficial influence promoting Indigenous languages may have on wellbeing and health literacy skills (see Table 15). The promotion of Indigenous languages within recent high-level health governance documents from Australia and Canada may indicate a gradual paradigm shift with regard to how governments and primary healthcare services perceive and respond to Indigenous language needs.

Table 15

Promotion of Indigenous languages

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia Strategic Plan</td>
<td>“Support initiatives that promote Aboriginal and Torres Strait Islander wellbeing through connections to languages and culture, and that help to keep Aboriginal and Torres Strait Islander languages and culture strong”. (Australian Government Department of Health, 2015, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, p. 22)</td>
</tr>
</tbody>
</table>
| New Zealand Policy & Practice     | “Brief Strategies for Improving Health Literacy/Universal Health Literacy Precautions

Action Point 1: Improve communication

Learn about and acknowledge cultural differences and be respectful. Develop resources with and for the intended audience e.g. Te reo/English resources, and use Māori design features”.

(New Zealand Nurses Organisation, 2011, Health Literacy Policy and Practice for Nurses – A Call for Action, p. 2)
Promoting the utilisation of interpreter or translation services within Indigenous healthcare environments was identified as a critical tool towards providing culturally competent services. This was evident within documents from all three countries and across all levels of health governance. The majority of document references within this sub-theme originate from Australia (see Graph 8). Interpreter or translations services were particularly emphasized within health literacy related strategic plans, frameworks, policies and initiative approaches. Document references within this study sample suggest that all three countries are similarly concerned with minimizing communication barriers and achieving high-level quality care. Quotes within Table 16 illustrate the concise language of how healthcare professionals are urged to use qualified interpreter or translation services when required and available (see Table 16).

Table 16

Promotion of interpreter or translator services

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia Framework</td>
<td>“Ensuring high quality communication between service providers and Aboriginal people. This includes use of interpreters wherever possible”. (South Australia Health, 2011, A framework for comprehensive primary health care services for Aboriginal people, p. 34)</td>
</tr>
<tr>
<td>Canada Position Statement</td>
<td>“Strategies to remove or minimize the barriers created by a lack of health literacy should be developed and shared with physicians and other health care providers. Further, programs which facilitate access to services including interpretation and translation of key health information should be supported”. (Canadian Medical Association, n.d., Ensuring Equitable Access to Care: Strategies for Governments, Health System Planners, and the Medical Profession, p. 6.)</td>
</tr>
<tr>
<td>New Zealand Policy &amp; Practice</td>
<td>“Speak clearly and listen carefully – use an appropriately trained interpreter where necessary, ask open ended questions”. (New Zealand Nurses Organisation, 2011, Health Literacy Policy and Practice for Nurses – A Call for Action, p. 2)</td>
</tr>
</tbody>
</table>
4.1.3.3 12.) Marginal or descriptive accommodation of language diversity

Some documents within the study sample acknowledge problems which exist regarding Indigenous language diversity and general communication. They do not specify any action, nor do they offer directions to address potential issues. The eight sources cited within this sub-theme originate from Australia, Canada, New Zealand and the USA, and are not represented in the previously explored sub-themes 10 and 11. Table 17 illustrates some common quotes from across all levels of health governance. There were marked similarities between all sources coded within this sub-theme. The majority of documents are generally concerned with communication challenges; recognising their impact on how health information is communicated and received by consumers. Despite this recognition, documents within this sub-theme provide health services with little guidance. There is no indication of successful strategies or supporting resources that address potentially emerging language challenges. There is, however, some advice on being sensitive to the target audience and context with regard to communicating health messages (see Table 17). The quotes from Australia, Canada or the USA illustrated in Table 17 are examples of how some health literacy related policy and practice documents lack specific guidance with regard to preventing ineffective and potentially culturally inappropriate methods of communication.

Table 17
Marginal or descriptive accommodation of language diversity

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia Strategic Plan &amp; Report</td>
<td>“Significant cultural and linguistic diversity across the Far North Queensland region impacts on levels of health literacy in communities, access to health services and ability to complete complex treatments. This results in service demands for a culturally competent service and workforce, and targeted health services”. (Queensland Health, 2012, Cairns and Hinterland Hospital and Health Service Plan 2012–2026, p. 14) OR “When tailoring programs, it needs to be noted that language and literacy are very distinct concepts. If an individual does not speak English well, this does not imply that they have low health literacy. They could in fact have very high health literacy. This is...”</td>
</tr>
</tbody>
</table>
an important point to note when considering the context of the audience a health literacy intervention is targeting”.
(Medibank Australia, 2011, Health literacy Implications for Australia: Final Report, p. 22)

**Canada**

*Action Plan*

“Make health and education sensitive and responsive to language, culture and health literacy”.
(Canadian Public Health Association, 2008, Priorities for action: Outcomes from the National Symposium on Health Literacy, p. 1)

**New Zealand**

*Guidelines*

“The characteristics of consumers, including health literacy, ethnicity, locality, health status, medical condition that may impact on consumers’ ability to communicate, age, carer and family/whānau, protocols, representatives, language, past experience of involvement and employment status”.
(Health Quality and Safety Commission, 2015, Engaging with consumers: A guide for district health boards, p. 28)

**USA**

*Discussion Paper*

“Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact: Secures language assistance for speakers of languages other than English”.
(Brach et al., 2012, Ten attributes of a health literate organization, p. 2)

### 4.1.3.4 Additional Analysis

A further comparison of how language diversity is being addressed within and across the countries investigated is presented in Graph 8. The graph highlights the distribution of the total number of sources within Theme C (#47) across all countries investigated. The analysis found that Australia strongly emphasises the use of interpreter and translator services. Similarly, Canada endorses the use of interpreter services rather than native Indigenous languages when engaging within First Nations People, Inuit or Metis. The reason that health literacy related documents from these two countries rarely incorporate or promote Indigenous languages may be because the majority of Indigenous people speak English as a first language. Governments and health service providers may be unwilling, incapable or constrained by funding and resources to sufficiently accommodate the many existing Indigenous languages. In contrast, New Zealand identifies as a bilingual nation where the Maori language is accepted as an equally legal language. It is therefore
unsurprising that health literacy related documents are increasingly accentuating the inclusion and promotion of te reo Maori.

Graph 5. Number of documents accommodating language diversity by sub-theme and country

4.1.4 D) Cultural responsiveness of healthcare providers

This theme summarises references regarding issues encompassing cultural competence and cultural safety within a cross-cultural healthcare environment. References were coded in accordance to the emerging sub-themes, described in Table 18, when these addressed topics and/or issues that concern the capacity of health services with regard to intercultural competencies and/or establishing culturally safe environments. The study found that the importance of health services being culturally competent within Indigenous healthcare environments is overall well acknowledged within documents originating from all three countries. It is also well recognised across all levels of health governance.

Table 18

<table>
<thead>
<tr>
<th>Number of documents and sub-themes encompassing cultural responsiveness</th>
<th>#</th>
</tr>
</thead>
<tbody>
<tr>
<td>13) Acknowledging and promoting intercultural competencies</td>
<td>74</td>
</tr>
<tr>
<td>14) Bi-Cultural approaches confined to Western knowledge</td>
<td>16</td>
</tr>
<tr>
<td>15) Recognition, Inclusion and promotion of Aboriginal Health Practitioners</td>
<td>28</td>
</tr>
</tbody>
</table>
4.1.4.1 13.) Acknowledging and promoting intercultural competencies

The importance of providing culturally competent care is increasingly recognised within the health literacy related documents from Australia, Canada and New Zealand and across all levels of health governance. Documents across all three countries and at all levels of health governance provided references to all or some of the following approaches: (1) acknowledging cultural and linguistic diversity within the workforce and populations; (2) provision of training in cultural competencies and safety to health services and professionals; (3) disseminating health related information in a culturally sensitive manner; and (4) developing a competent and empowered Indigenous health workforce. Examples within Table 19 illustrate that all three countries recognise the importance of developing and strengthening the intercultural competencies within healthcare services. Some of the documents also identify the interrelationship between cultural literacy, culturally safe environments and health literacy skills within culturally diverse environments. This is illustrated, in particular, by two quotes originating from Canada and New Zealand (see Table 19).

**Table 19**

**Acknowledging and promotion of intercultural competencies**

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Framework &amp; Framework</td>
<td>“Including introductory training on health literacy to all new staff at orientation, as part of cultural diversity training”. (Australian Commission on safety and quality in health care, 2014, Health Literacy: Taking action to improve safety and quality, p. 36)</td>
</tr>
<tr>
<td>OR</td>
<td>“Employing more Aboriginal people in the health workforce – and supporting them to develop their skills and leadership potential – is an important way of incorporating Aboriginal cultural perspectives into our health services. At the same time, we need to develop a non-Aboriginal workforce that understands and respects these perspectives and reflects this in their day-to-day involvement with Aboriginal clients and colleagues”. (Western Australia Health, 2012, WA Health Aboriginal Cultural Learning Framework, Introduction from the Director General,</td>
</tr>
</tbody>
</table>
4.1.4.2 14.) **Bi-Cultural approaches confined to western knowledge**

The study identified a modest number of health literacy related documents that proposed using bi-cultural approaches within Indigenous healthcare environments where Indigenous ontologies and epistemologies are respected, valued or marginally represented. The underpinning paradigm with regard to health and wellbeing is, however, either vague or 

<table>
<thead>
<tr>
<th><strong>Canada</strong></th>
<th><strong>New Zealand</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Position Statement &amp; Strategic Plan</strong></td>
<td><strong>Framework &amp; Action Plan</strong></td>
</tr>
</tbody>
</table>
| “The culturally competent physician embraces indigenous knowledge and the significance of forbearance in indigenous culture; this shows a true understanding of how historical legacies affect indigenous people”. | “To practise effectively in Aotearoa New Zealand, a physiotherapist therefore needs, in addition to meeting cultural competence, to understand the relevance and be able to demonstrate contemporary application of Te Tiriti o Waitangi / the Treaty of Waitangi’s three principles of partnership, participation and protection and incorporate the four cornerstones of Māori health, which are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health)”.

(Royal College of Physicians and Surgeons of Canada, 2013, Indigenous health values and principles statement, p. 4) | (Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, 2015, Physiotherapy practice thresholds in Australia and Aotearoa New Zealand, p. 10) |
| OR | OR |
| “Provide a leadership perspective and advocacy related to health literacy, including self-advocacy, and health literacy as a two-way conversation which improves the cultural competency and safety of the health systems for First Nations”. | “Strengthen the practice of health literacy in the health workforce through cultural competency education (Pacific Analysis Framework Training, Ministry of Pacific Island Affairs)”.

potentially confined to western dominated pedagogies. Documents that explicitly incorporated and promoted Indigenous paradigms based on the principles of self-determination, autonomy and sovereignty were excluded from this sub-theme and are either found within the themes associated with the *Promotion of Indigenous cultural health knowledges, paradigms and practices* (see Table 3), or within the sub-theme *Acknowledgment and promotion of Indigenous self-determination, autonomy and sovereignty* (see Table 26).

The study found vague, or western confined, bi-cultural approaches within health literacy related documents from all three countries and across all levels of health governance. Examples within Table 20 illustrate the similarities across all three countries with regard to the imprecise definitions or concepts that determine bi-cultural approaches. References within high-level health governance documents from Australia cited the importance of supporting Indigenous models or approaches to care, or implementing evidence-based cultural programs. However, both references imprecisely specify the paradigm or approach that will provide ultimate authority on which elements of Indigenous models are to be supported, or determine what is considered evidence (see Table 20).

Other examples from Canada and New Zealand illustrate similar imprecise pedagogies and paradigms regarding the construction and dissemination of health knowledges and information within the field of health literacy (see Table 20). The quote from New Zealand for instance suggests that, although Maori models of health need to be integrated within all levels of the healthcare sector, the subsequent recommendations fail to reinforce this position. The document only acknowledged that services need to meet the health needs and aspirations of Maori children without explicitly outlining how Maori needs may be determined and accommodated. The examples highlighted below illustrate the discrepancies and issues within this sub-theme. They also indicate that bi-cultural approaches within the field of health literacy appear to be predominantly confined to western pedagogies, paradigms, and practices.
<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
</table>
| **Australia**                      | “Engage with Aboriginal people, Aboriginal Controlled Community Health Organisations, and Aboriginal Medical Services to support and sustain Aboriginal models and approaches to care

- Support integration of mainstream health programs and specialist programs
- Address health issues from a holistic perspective, taking into account the importance of social, emotional, cultural and spiritual health”.

(Western Australia Health, 2012, WA Primary Health Care Strategy, p. 16)

OR

“Community owned and controlled programs are to be supported by AMHSs as a vital building block upon which culturally informed evidence-based programs can be implemented”.

(New South Wales Health, 2007, Aboriginal mental health and well being policy 2006-2010, p. 21) |

| **Canada**                         | “The Seven Sisters Heart Health Project is a demonstration project created by BC Women’s Hospital and Health Centre to address both the complexities and context of Aboriginal women’s lives in order to prevent heart disease. The project partnered with Pacific Association of First Nations Women and focused on Aboriginal women who are community and health care leaders. This project incorporates traditional Aboriginal practices into standard medical practices to improve heart health”.


OR

“To inform the direction of all health literacy initiatives, it is essential to use, on an ongoing basis, the most accurate and up-to-date information available. However, research on how to augment health literacy is still evolving and there are few established “best” practices. Therefore, promising practices and ideas that emerge from community experience and/or cultural knowledge should be included in the mix of strategies to be used”.

(Mitic & Rootman, 2012, An inter-sectoral approach for improving...
“The health system needs to recognise and promote the importance of health literacy and chronic disease management competencies for all health professionals and other health-care workers involved in asthma management. Health professional bodies and academic training institutions need to ensure adequate provision of training in these areas and provide monitoring in the attainment of these skills. The health system must also promote the integration of cultural competency, cross-cultural communication and holistic Māori models of health into all levels of the health sector to ensure the health workforce are equipped to engage in meaningful collaborative partnerships with Māori patients.

Recommendations

- Influence medical, nursing and pharmacy schools and other health training programmes to teach health literacy and chronic care management to students.
- Establish and monitor competencies for all health professionals in health literacy education and chronic disease management.
- Set an expectation within health policies and strategies that all health services will deliver high-quality care that focuses on meeting the health needs and aspirations of Māori children with asthma”.

(Jones et al., 2015, He Māramatanga Huangō: Asthma health literacy for Māori children p. 77)

4.1.4.3 15.) Recognition, inclusion and promotion of an Indigenous Health Workforce

The study found that Aboriginal Health Practitioners (AHPs) are increasingly recognised within health literacy related documents as an integral component to delivering culturally competent care within Indigenous communities. A modest number of high-level governance documents from Australia and New Zealand acknowledged that AHPs are critical to bridging potential culture, language and communication barriers. They also recognise the contribution of AHPs towards preserving and protecting Indigenous cultural values which, in turn, support the development of health literacy and cultural literacy skills within their work and community environment (see Table 21). In contrast, high level governance documents from Canada provided no references with regard to explicitly recognising, including or
promoting AHPs within the study sample. Policy related reports did, however, discuss the importance and the need to include and promote AHPs within policies and programs, in order to enhance cultural competencies within Indigenous healthcare (see Table 21).

**Table 21**

**Recognition, inclusion and promotion of an Indigenous Health Workforce**

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong></td>
<td>“Improve workforce capability through the continued implementation of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework, including supporting the take-up of health careers and support for people working in the health and healing professions”. (Australian Government Department of Health, 2015, National Aboriginal and Torres Strait Islander Health Plan 2013-2023, p. 25)</td>
</tr>
<tr>
<td>Strategic Plan &amp; Policy</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>“The Aboriginal mental health workers are valued for their specialist expertise and cultural competency. It is recognised that their role is a challenging one. There is a “complexity of ties within the community, professional boundaries and kinships””. (New South Wales Health, 2007, Aboriginal Mental Health and Well Being Policy 2006-2010, p. 27)</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>“Collaborates with cultural, traditional, and spiritual helpers/healers to ensure they are included in the Circle of Care”. (Kelly &amp; Prince, 2015, A Framework to Guide Policy and Program Development for Palliative Care in First Nations Communities, p. 5)</td>
</tr>
<tr>
<td>Report &amp; Report</td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>“Lastly, the Aboriginal Health team at IHA is currently developing an Aboriginal Human Resource plan that will look at enhancing a culturally competent workforce and a representative Aboriginal workforce. They are also reviewing the complaint process to ensure that Aboriginal people feel safe to bring forward complaints about health care services”. (Ministry of Health British Columbia, 2012, Health Authorities’ Aboriginal health programs Annual Report 2011 – 2012, p. 15)</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>“Investment in building the capacity and capability of the Māori health workforce is vital to fostering effective Māori leadership”.</td>
</tr>
<tr>
<td>Strategic Plan</td>
<td></td>
</tr>
</tbody>
</table>
4.1.5 E) Participation, Self-Determination and Sovereignty

The study found a significant number of documents across all three countries, and at all levels of health governance, that acknowledged the importance of individual and community participation with regard to enhancing health literacy skills and health outcomes. To understand the broader context that influences whether or not Indigenous health related ontologies, epistemologies and practices are adequately acknowledged, incorporated and promoted within the study sample, it was considered important to investigate the extent of Indigenous participation, self-determination and sovereignty. A distinction was identified between references that promote health consumer participation, and those that advocate for empowerment, self-determination and sovereignty. This distinction created the sub-themes Consumer and Community participation and collaboration and Consumer and community self-determination, empowerment and sovereignty (see Table 22). An additional differentiation was also identified within documents with regard to approaches specific to Indigenous populations and those addressing health consumers in general. These document references created two additional sections within each sub-theme (see Table 22). The emerging sub-themes are discussed below in detail.

Table 22

<table>
<thead>
<tr>
<th>Number of documents and sub-themes promoting participation, self-determination and sovereignty</th>
<th># 99</th>
</tr>
</thead>
<tbody>
<tr>
<td>16) Consumer and community participation and collaboration</td>
<td># 93</td>
</tr>
<tr>
<td>a. General or standardised approaches to participation and collaboration</td>
<td># 91</td>
</tr>
<tr>
<td>b. Collaboration and participation approaches specific to Indigenous populations</td>
<td># 57</td>
</tr>
</tbody>
</table>
17) Consumer and community self-determination, empowerment and sovereignty

a. Health consumer autonomy, empowerment and self-determination

b. Acknowledgment and promotion of Indigenous self-determination, autonomy and sovereignty

4.1.5.1 16.) Consumer and Community participation and collaboration

Health literacy related policy documents are increasingly recognising that health consumer engagement and participation are integral to providing high quality and safe healthcare. The study identified that the majority of health literacy related documents from all three countries and across all levels of health governance readily acknowledged, endorsed and promoted the inclusion of health consumers within the care they receive. The section General or standardised approaches to participation and collaboration emerged within this sub-theme, as document references cited the need for health services to broadly improve, or continue, their commitment to engaging with health consumers and their communities. Examples within Table 23 illustrate the similarities across all three countries and indicate a cohesive and conceptual understanding by governments and the health services sector of existing issues and challenges. In addition, example references found in high-level governance documents depict the concise language directed at health services. Health services are advised to be considerate of health consumer needs, and to incorporate and promote health consumer engagement and active participation, ensuring high quality of communication in health and care (see Table 23).

Approaches specifically aimed at engaging and collaborating with Indigenous communities, organisations and consumers were also modestly identified at all levels of health governance and similar across Australia, Canada and New Zealand. The section Collaboration and participation approaches specific to Indigenous populations (see Table 24) emerged from document references within this sub-theme that cited the importance to engage and involve Indigenous communities, organisations and health consumers as active partners within the care and services they receive. High-level governance documents, in particular from Australia and New Zealand, encourage health services to engage in mutual collaborative partnerships with Indigenous communities, services and consumers. The
intention is to ensure that services are culturally competent to enhance health literacy levels and improve health outcomes. Examples within Table 24 highlight the similarities across all three countries with regard to the importance of engaging effectively with Indigenous health consumers.

The quotes from Canada within the *Health Authorities’ Aboriginal health programs Annual Report 2011 – 2012* (by the Ministry of Health, British Columbia), and from New Zealand within *The Guide to He Korowai Oranga Maori Health Strategy* (by the Ministry of Health, New Zealand) are good examples of concise language and direction regarding what comprises effective partnership with Indigenous peoples. They also detailed how this is to be approached (see Table 24). An additional aspect identified within some documents (presented as an example within the quote from Australian within the guidelines *Food and health communication across cultures: considerations for health professionals working with remote aboriginal communities*) is that the construction and dissemination of health knowledge and associated meanings need to be negotiated within reciprocal relationships (see Table 24).

**Table 23**

**Generalised approach to participation and collaboration**

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia</td>
<td>“Consumer participation is critical in developing appropriate and responsive health literacy initiatives, health information development and assessment. Consumers are often inundated with information which can be of poor quality and unresponsive to their needs. It is imperative therefore to ask consumers what they need. Consumer participation must be embedded into the design and implementation of any health literacy initiative at the outset and at its conclusion”. (Victoria Health, 2012, Health literacy initiatives, p. 3)</td>
</tr>
<tr>
<td>OR</td>
<td>“Partnerships with consumers are essential for both individual health and health care and for the development of better healthcare systems. Improving health literacy ensures that consumers can fully participate in these partnerships, and that the health system and healthcare organisations are oriented to support such partnerships”.</td>
</tr>
</tbody>
</table>

*Victoria Health, 2012, Health literacy initiatives, p. 3*
(Australian Commission on Safety and Quality in health care, 2014, Health Literacy: Taking action to improve safety and quality, p. 5)

OR

“Clients have a right to be involved in decision-making about their health and wellbeing”.


“Include members of patient communities, including new readers, in organizational assessments and health literacy improvement efforts. For example, involve members of the target population—including persons with limited health literacy—in planning, developing, implementing, disseminating and evaluating health and safety information”.

(Mitic & Rootman, 2012, An inter-sectoral approach for improving health literacy for Canadians, p. 39)

OR

“The best form of health education is always a purposeful conversation between the Patient and the Health Professional. Print and multimedia resources are tools to support this education. When used effectively, print/multimedia resources can assist health care professionals to maximize limited teaching time and enable patients to better manage their health. The provision of educational information is considered to be a fundamental prerequisite of consumer participation in health care”

“Individuals and whānau have access to health care services that are user friendly, accessible and easy to navigate. Success looks like: All individuals and whānau accessing services are active partners in the management of their health and wellbeing. Individuals and whānau feel welcome when accessing services, and are able to find their way easily in the service environment. Individuals and whānau are involved in the planning, design and delivery of health information and services”

(District Health Board Bay of Plenty, n.d., Position Statement: A framework for health literacy: a health system response, Individuals and Whanau, Success looks like, para 2)

OR

“Individuals and whānau are partners in actively managing their own health and wellbeing; and they take opportunities to provide feedback on health services they use and contribute to quality improvement programmes”.

Ministry of Health, 2015, A framework for health literacy, p. 2)

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia &amp; Guidelines</td>
<td>“The knowledge and skills of health practitioners are only of value to Aboriginal people if they connect with their concerns and priorities, and are conceptually meaningful and accessible. For Aboriginal people to freely choose to engage in educational activities, they need to have access to meaningful information and see, feel and understand a reason to learn more and become...”</td>
</tr>
<tr>
<td></td>
<td>(Queensland Health, 2010, Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010 – 2033, p.12)</td>
</tr>
</tbody>
</table>

Table 24

Indigenous focused approach to collaboration and participation

<table>
<thead>
<tr>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Involves diverse audiences, including those with limited health literacy, in development and rigorous user testing”</td>
</tr>
<tr>
<td>(Brach et al., 2012, Ten attributes of a health literate organization, p. 2)</td>
</tr>
</tbody>
</table>
involved. This will be facilitated when health information and new knowledge is constructed in collaborative ways which are relevant and acceptable to Aboriginal people, their families and communities. Changes in the health status of Aboriginal people in part depend on this”.

(Colles, Maypilama & Brimblecombe, 2014, Food and health communication across cultures: considerations for health professionals working with remote aboriginal communities, p. 11)

<table>
<thead>
<tr>
<th>Canada</th>
<th>Discussion Paper &amp; Report</th>
</tr>
</thead>
</table>
| “Aboriginal people are heavily committed to improving health outcomes for themselves and must be provided opportunity to contribute actively and appropriately according to their political, service delivery and community structures, assets and resources across Canada. These many strengths provide significant opportunities for partnerships with Aboriginal people that can help to increase health literacy levels and contribute to improving health outcomes for the indigenous people of Canada”.

(Mitic & Rootman, 2012, An Inter-sectoral approach for improving health literacy for Canadians, p. 16) OR

“Consultation with Aboriginal partners on strategic planning and initiatives serves to ensure the appropriateness of health authority policies and actions. For instance, Aboriginal interests and perspectives are included in planning and decision making for the Diabetes Initiative through Aboriginal representation at all levels of planning and the implementation of diabetes care”.


<table>
<thead>
<tr>
<th>New Zealand</th>
<th>Guidelines &amp; Framework</th>
</tr>
</thead>
</table>
| “Partnership involves working together with iwi, hapū, whānau and Māori communities to develop strategies for Māori health gain and appropriate health and disability services. Participation requires Māori to be involved at all levels of the health and disability sector, including in decision-making, planning, development and delivery of health and disability services”.


“Ko te Tuatahi – Article One – Kawanatanga Goal for Health Promotion – Achieve Māori participation in all aspects of health promotion”.

(Health Promotion Forum of New Zealand, 2012, Ngā Kaiakatanga Hauora mō Aotearoa: Health Promotion Competencies for Aotearoa New Zealand, p. 6)
4.1.5.2 17.) Consumer and Community Self-Determination, Empowerment and Sovereignty

The literature review highlighted that the core principles and concepts of health promotion and critical health literacy are concerned with empowering health consumers and communities. In addition, the review of health literacy literature, specific to Indigenous populations, highlighted that it was critical for Indigenous people to be enabled to exert autonomy and sovereignty within the decision making processes that affected their health and wellbeing. It was therefore considered pivotal to investigate the extent of and the practice whereby Indigenous self-determination and empowerment is conceded within health literacy related policy and practice documents.

An analysis of document references within this sub-theme identified an additional differentiation, and resulted in two distinctive sections. The first section describes general approaches to health consumer autonomy, empowerment and self-determination. These approaches were acknowledged and promoted within a modest number of document references from all three countries and across all levels of health governance (see Table 25). It was found that high-level health governance documents from all three countries similarly encouraged or mandated health services to specifically incorporate a patient centred care approach and to develop health literacy skills of health consumers.

Some document references additionally stated that this approach will enable health consumers to become active partners, as these are encouraged and expected to take control and responsibilities over their own health needs (see Table 25). Some examples indicate, however, that the underpinning concepts of a patient centred care approach and empowerment with regard to health literacy skills may perhaps be confined to ideologies found within neo-liberalism and the bio-medical model. This possibility emerges because a number of document references (see Table 25) firmly confined the concept of empowerment to health consumers taking personal responsibilities and control over concerns that affect their personal health. This definition disregards the broader social determinants which health services need to encourage and support.

In contrast, section b (Acknowledgment and promotion of Indigenous self-determination, autonomy and sovereignty) emerged as a separate section within this sub-
theme. A limited number of documents acknowledged and promoted the view that Indigenous people have the right to exert self-determination, autonomy and sovereignty as culturally diverse populations, rather than just as “ordinary” health consumers within healthcare systems. References specific to this section were found within documents from all three countries, with few being high level health governance documents. The majority of documents that acknowledged and promoted Indigenous self-determination, autonomy and sovereignty comprised of reports, discussion papers, promotional materials and resources.

These findings suggest that the absence of acknowledgement of Indigenous self-determination, autonomy and sovereignty within high-level governance documents is likely to have further ramifications within Indigenous health promotion practice and approaches to enhancing health literacy. Nonetheless, examples within Table 26 reflect the current tensions, discussions and advocacy which occur similarly across all three countries. These document references contend that Indigenous self-determination, empowerment and sovereignty must be evident within the levels of control Indigenous people have over their health needs at a personal, community, and political level. This includes determining the modes of health service delivery and also the ways through which health related knowledges are constructed, disseminated and communicated within research and health education approaches (see Table 26).

Table 25

<table>
<thead>
<tr>
<th>Health consumer autonomy, empowerment and self-determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Country of origin and document type</td>
</tr>
<tr>
<td><strong>Australia</strong></td>
</tr>
<tr>
<td><strong>Policy &amp; Framework</strong></td>
</tr>
</tbody>
</table>

Gordon Robert Boot (BHSC) – June 2016
health literacy has the potential to reduce preventable hospital admissions, decrease costs and improve health care outcomes”.

“Health literate health professionals and systems are those that allow and encourage patients to feel welcome and empowered to ask questions, that deliver information in ways that people can use, and that proactively take the steps to prevent ill health and provide treatment to all people in need”.
(Coleman et al., 2008, The Calgary Charter on Health Literacy: Rationale and Core Principles for the Development of Health Literacy Curricula, p. 4)

OR

“Health literacy concerns must be addressed at all stages of the strategy. These include but are not limited to plain language review and consumer involvement in all stages of the development, production and testing of information materials. It has also been suggested that the best approach to enhancing the mental health literacy of Canadians may involve building their capacity for critical thinking and personal and collective empowerment”.

“Individuals and whānau are supported to obtain, process and understand health information from everyone they have contact with in the health system, and are empowered to make informed decisions”.
(Ministry of Health, 2015, A framework for health literacy, p. 2)

OR

“Use education and empowerment strategies to promote and optimise the client’s health and well-being”.
(Physiotherapy Board of Australia and Physiotherapy Board of New Zealand, 2015, Physiotherapy practice thresholds in Australia and Aotearoa New Zealand, p. 27)

Table 26

Promotion of Indigenous self-determination, autonomy and sovereignty

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
“Partnership Agreements are one way of ensuring self-determination for Aboriginal people – they enable Aboriginal people to determine what is relevant to them and to participate in determining how services will be provided”.

Australia Policy & Promotion Materials


OR

“In essence, nutritionists working with remote communities need to support and empower Aboriginal people to evaluate their own projects and determine what they want to know”.

(Colles et al., 2014, Food and Health Communication Across Cultures: Considerations for Health Professionals Working with Remote Aboriginal Communities, p. 140)

“For First Nations people, empowerment is identified mainly with addressing effects of historical and intergenerational trauma, and other aspects of colonization, and thereby enhancing self-care and self-determination”.

(Canadian Alliance on Mental Illness and Mental Health, 2008, p. 25)

OR

“Autonomy; cultural beliefs represent a freedom of choice; this is a sacred right that must be respected. By celebrating a person’s culture, the collaborator shows respect and preserves a patient’s dignity while recognizing their unique circumstances.

Self-determination; responsible and informed decisions by patients and providers promote autonomy and independence. It recognizes ownership, control, access and possession (OCAP) applied to research. OCAP is a powerful indigenous political response — by the Steering Committee of the First Nations Regional Longitudinal Health Survey — to colonial approaches to management of information”.

(Royal College of Physicians and Surgeons of Canada, 2013, Indigenous health values and principles statement, p. 7)
“Tino rangatiratanga (self-determination). This principle was expressed through recognition of the rangatiratanga of Māori collectives such as iwi (tribe), hapū (subtribe) and whānau, the rights of Māori as indigenous people and Treaty partners, Māori leadership and control of the research, and the generation of Māori knowledge that may contribute to increased self-determination”.

Ministry of Health, 2014, Palliative Care and Māori from a Health Literacy Perspective, p. 9

OR

“Many factors such as healing; self-determination; and reclamation of identity, language, and cultures play a major role in the complex issue of Aboriginal literacy. Models of literacy that have been successful and meaningful in these communities have, therefore, been ones where literacy has been identified as a means to “expanding opportunities, improving prospects, and preserving, perpetuating, and maintaining indigenous languages”

(Adult and Community Education Aotearoa, 2014, Pasifika Success as Pasifika: Pasifika Conceptualisations of Literacy for Success as Pasifika in Aotearoa New Zealand, p. 45)

4.1.5.3 Additional Analysis

An additional comparison of the extent of Indigenous participation, self-determination and sovereignty within each country is represented in Graph 9. The graph displays the distribution of the total number of sources within Category E (#99) across all countries investigated, and how each country recognises, acknowledges and promotes Indigenous participation, self-determination and sovereignty. The graph suggests a similar trend within health literacy related documents originating from Australia and Canada. Both countries have emphasised the importance of collaboration and participation when aiming to enhance health literacy levels within populations. However, Indigenous collaboration and participation efforts are modestly recognised and promoted, whereas efforts aimed at Indigenous self-determination, autonomy and sovereignty are supported less frequently (see Graph 9).

In contrast, health literacy related documents from New Zealand seem to value, emphasise and promote Maori participation and collaboration. These efforts are also
evident within health literacy related documents that address the general population more broadly. In common with Australia and Canada, health literacy related documents from New Zealand also appeared to be imprecise with regard to Maori self-determination, autonomy and sovereignty. These concepts were cited less frequently or inexplicitly supported and promoted within the study sample (see Graph 9).

![Graph 6. Document representation of Indigenous participation and self-determination by country within the study sample](#)

### 4.1.6 F) Health Literacy Assessment

Low levels of health literacy among health consumers and within populations have frequently been cited within the literature as a concern that required effective action. A critical investigation of the common methodologies used to assess population health literacy levels would exceed the scope of this paper. It was, nevertheless, considered important to briefly review any references within this study sample made with regard to the research question.

All documents references citing health literacy assessment approaches aimed at the general population were coded to the sub-theme 18. The majority of documents within this sub-theme originate from Canada and represent all levels of health governance. In contrast document references from Australia and New Zealand citing approaches to assessing health literacy skills were less evident. The health literacy assessment tools that were cited across
all three countries were either identical or similar, and predominantly confined to English language and to Western knowledge (see Table 28).

Documents citing health literacy assessment approaches specific to Indigenous needs were coded in sub-theme 19 (see Table 29). The study identified three documents, (two from Australia and one from New Zealand) that included or promoted health literacy assessment criteria specific to Indigenous culture (see 29 Table). These few findings indicate that current health literacy assessment tools remain strongly confined to Western pedagogies, practices and English language. This could potentially disadvantage Indigenous populations and also represent them negatively by stereotyping or stigmatising them as possessing generally low health literacy skills.

Table 27

<table>
<thead>
<tr>
<th>Number of documents and sub-themes citing approaches to measuring health literacy</th>
<th># 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>18) Generalised approaches to measuring health literacy</td>
<td># 10</td>
</tr>
<tr>
<td>19) Indigenous specific health literacy assessment approaches</td>
<td># 3</td>
</tr>
</tbody>
</table>

Table 28

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quotations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Commonly used tools for measuring individual health literacy</td>
</tr>
<tr>
<td></td>
<td>The most commonly used tools for measuring individual health literacy are the Test of Functional Health Literacy in Adults (TOFHLA), the Rapid Estimate of Adult Literacy in Medicine (REALM) and the Newest Vital Sign (NVS).</td>
</tr>
<tr>
<td>Australia Framework &amp; Report</td>
<td>TOFHLA measures reading fluency. It consists of a reading comprehension section (a 50-item test using the modified Cloze procedure) to measure prose literacy, and a numeracy section with 17 items that assess an individual’s capacity to read and understand actual hospital documents and labelled prescription vials.</td>
</tr>
<tr>
<td></td>
<td>REALM is a 66-item word recognition and pronunciation test that measures the domain of vocabulary.</td>
</tr>
<tr>
<td></td>
<td>Although these two tests measure different capacities, they are</td>
</tr>
</tbody>
</table>
highly correlated with each other and with general vocabulary tests.

NVS is a short practical questionnaire that requires the interpretation of health information from a nutritional label”.


OR

As such, there are a wide variety of screening tools have been developed to assist clinicians to measure an individual’s health literacy level – each with their own psychometric properties, advantages and limitations. Examples of the most common of these tools found in the literature are: Rapid Estimate of Adult Literacy in Medicine (REALM), Test of Functional Health Literacy in Adults (TOFHLA), Set of Brief Screening Questions (SBSQ), Medical Achievement Reading Test (MART), Newest Vital Sign (NVS)

These tools are not designed to be comprehensive tests of an individual’s health literacy – rather they serve as screening tools to be used by clinicians to determine whether an individual possesses functional health literacy. They are generally quick to administer and consist of having the patient interpret health information of the type found on food packaging or medication labels”.

(Medibank Australia, 2011, Health literacy Implications for Australia: Final Report, p. 18)

“Of the three most widely used health literacy assessment tools, two were developed for use by researchers in clinical settings: the Rapid Estimate of Adult Literacy in Medicine (REALM, Davis et al., 1993, cited in Columbia University); and the Test of Functional Health Literacy in Adults (TOFHLA, Parker et al., 1995, cited in Columbia University). REALM is a medical-word recognition and pronunciation test comprising 66 medical terms, which takes less than two minutes to administer. TOFHLA measures the numeracy and reading comprehension level of patients, using health care materials, such as patient education information, prescription bottle labels, registration forms, and instructions for diagnostic tests. TOFHLA takes longer to administer, although a short version can be completed in approximately 12 minutes”.

(Canadian Public Health Association, 2008, Priorities for action: Outcomes from the National Symposium on Health Literacy, p. 5)

“The ALL survey examined the following skills:

• prose literacy – the knowledge and skills needed to understand
and use information from texts such as editorials, news stories, poems and fiction

- document literacy – the knowledge and skills required to locate and use information contained in various formats such as tables, forms, graphs and diagrams

- numeracy – the knowledge and skills required to effectively manage the mathematical demands of diverse situations

- problem solving – the ability to solve problems by clarifying the nature of the problem and developing and applying appropriate solution strategies”.

(Ministry of Health, 2010, Korero Marama Health Literacy and Maori Results from the 2006 Adult Literacy and Life Skills Survey p. 16)

### Table 29

Indigenous specific health literacy assessment approaches

<table>
<thead>
<tr>
<th>Country of origin and document type</th>
<th>Illustrative Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Zealand Initiative</strong></td>
<td>“The NHC Whānau Ora Assessment Tool This tool has been developed to get a snapshot of the needs of whānau who access Whānau Ora programmes and initiatives. AND Te Awa – A Whānau Self-Assessment Tool Te Awa captures the whānau experience. The primary value is that it is completely uninfluenced by the practitioner so that it clearly indicates what and where the thinking is at the moment, providing a common language. This shared knowledge and understanding creates the catalyst for change.</td>
</tr>
</tbody>
</table>
Te Awa initiates relationships by asking whānau what is important to them, and giving them an opportunity to self-identify areas of priority. It creates buy-in to the change required for individuals and their whānau”.

(National Hauora Coalition, n.d., Māori Health Innovation Programme, p. 3)

4.2 Summary of main themes

An analysis of 108 health literacy related documents suggests that the main emphasises within the field of health literacy are placed on health consumer participation and self-determination (Graph 7, Theme E). The number of documents citing the importance of health services developing and improving intercultural competencies was also well recognised and represented within the study sample (Graph 7, Theme D). It was also found within the study sample that the themes Participation, Self-Determination and Sovereignty (E) and Cultural responsiveness of healthcare providers (D) were similarly relevant across all three countries (see Graph 9). In contrast, documents within the study sample providing references on high and low level recognition and promotion of Indigenous health knowledges, paradigms and practices (Themes A and B), and accommodating language diversity (Theme C) were less common across all three countries (see Graph 9). It is important to note that the discussion paper on health literacy from the USA is only represented within the Themes Accommodating language diversity and Participation, self-determination and sovereignty (E) and was therefore excluded from Graph 5 and 9 for convenience purposes.

The study also found that only a modest number of health literacy related documents, specific to addressing Indigenous health concerns, acknowledged and promoted Indigenous health knowledges, paradigms and practices (see Graph 8, Theme A). The recognition of language diversity and associated challenges was found to be generally limited within health literacy related documents aimed at addressing Indigenous health (Graph 8). Current approaches or discussions with regard to health literacy assessment tools were identified within 11 documents, representing all levels of health governance, and the majority of documents originated from Canada (see Graph 9 and Table 28 & 29).
Graph 7. Theme emphasis within study sample

Graph 8. Document target population across the main themes within the study sample
Graph 9. Number of documents represented by country and themes
5 Discussion

The importance of considering Indigenous cultures and languages is increasingly recognised and acknowledged within health literacy related policy and practice documents. However, health literacy related documents appear to remain predominantly confined to communicating Western knowledges, as the explicit inclusion and/or promotion of Indigenous specific knowledges, paradigms and practices remains sporadic or absent. This section will critically discuss the study findings with reference to the literature using a critical theory perspective and culture-centred approach.

5.1 Acknowledging and promotion of Indigenous cultural beliefs, health knowledges, paradigms and practices

The findings of this study suggest that, at a governance level, health knowledges and the methods of how these should be communicated are predominantly determined and confined by Western pedagogies, paradigms and practices. The majority of documents that promote the inclusion of Indigenous knowledges based on Indigenous ontologies, epistemologies and values, as highlighted within Chapter 4. A, were policy related reports, discussions and promotion materials. Some of these documents provided detailed descriptions of specific traditional healing, food or culture practices. In contrast, high-level governance documents provided little guidance to health services and professionals in terms of what defines Indigenous knowledges and how to effectively incorporate and promote these within an Indigenous environment. Those high-level governance documents that acknowledged and promoted Indigenous health knowledges were more likely to provide marginally descriptive or generalised references. These references provided simplified statements which commonly suggested that health literacy approaches needed to build on Indigenous understandings and perspectives. They did not provide comprehensive detail or further guidance on what comprises Indigenous health knowledges.

It was expected that overarching health literacy related policy and practice documents aimed at addressing the health of entire populations might not include and promote Indigenous distinguishable health knowledges and practices. These are more likely to be relevant to Indigenous people and context specific. However, the study found that the promotion of Indigenous health related ontologies, epistemologies, paradigms and practices
were also generally limited or absent within high-level governance, and to some extent other documents, that specifically referred to Indigenous health (see Graph 8). A further investigation identified that this tendency was consistent across Australia, Canada and New Zealand (see Graph 9). These findings confirm repeated claims of scholars such as Hopkirk and Wilson (2014), Love and Tilley (2014), Priest et al. (2012), Vass et al. (2011), Smylie et al. (2008) and Stephens et al. (2006) that the recognition and promotion of Indigenous health knowledges, paradigms and practices are generally limited within governance and policy related documents.

A significant, and widely acknowledged, aspect of Indigenous culture is that health and wellbeing is perceived as an interactive holistic concept. The concept of holistic health is relevant to many Indigenous populations regardless of where they live. It encompasses physical, psychological, social, ecological, spiritual and cultural aspects. These aspects are considered interrelated and require equivalent attention and care to sustain health and wellbeing (Dudgeon et al., 2014; Stephens et al., 2006; Vukic et al., 2011). Approximately one-third of all health literacy related documents across all levels of health governance acknowledged that many Indigenous people consider health and wellbeing as an interactive holistic concept. They recognise that healthcare providers needed to be aware of, respect and respond to this perception (see Table 10). The acknowledgement and integration of holistic health concepts was particularly evident within documents from New Zealand. Many of these documents associated an incorporation and promotion of holistic health concepts with establishing culturally safe environments for Maori people. Establishing culturally safe healthcare environments is according to Richardson (2012) significant and essential to decolonising the healthcare environment. This concept is discussed later in conjunction with issues encompassing intercultural competencies.

The increasing recognition and promotion of Indigenous holistic health concepts can be regarded as a positive and necessary step forward. It prompts healthcare providers to reflect on existing paradigms and approaches to delivering healthcare and methods to improve health literacy within Indigenous populations. Incorporating Indigenous holistic views of health and wellbeing equally to other models of care within service delivery is essential to addressing the extensive and complex health problems many Indigenous people face. It requires services to critically consider Indigenous specific social determinants
(Dudgeon et al., 2014; Keleher & MacDougall, 2016). Despite an increased acceptance that many Indigenous people across the three countries identify with holistic concepts of health and wellbeing, the inherent meanings of these concepts seem to be less well clarified within health literacy related documents. It can, therefore, be argued that Indigenous concepts of holistic health and the associated knowledges and practices are rarely recognised and acknowledged as being Indigenous specific health literacy skills.

Supporting evidence for this statement can be found in the review of Chapter 4 Theme A. This relates to health literacy related policy and practice documents that address Indigenous health but only sparsely acknowledged or promoted Indigenous cultural knowledges, paradigms and practices. It was further identified that although the majority of documents acknowledge Indigenous social networks and support systems as integral components within Indigenous concepts of holistic health, they were rarely recognised as an asset towards enhancing health and wellbeing (see Table 11). Even fewer documents within this sample noted that Indigenous culture, language and identity may function as a personal and community health asset (see Table 12). The spiritual and emotional connection some Indigenous people have with their homelands or country, and how this relationship may affect emotional, physical wellbeing, was only marginally recognised (see Table 5). Additionally, very few health literacy related documents from Australia and Canada recognised the significance of Indigenous knowledges of traditional foods and associated hunting and gathering practices. This is despite them being considered as intrinsic elements within holistic health by some Indigenous people (see Table 6). Health literacy related documents, addressing Indigenous health, continue to focus predominantly on the promotion of healthier nutrition choices and physical exercise based on Western knowledge and practice.

A limited clarification and comprehension of Indigenous holistic health concepts within an Indigenous health literacy environment is likely to increases the risk of health services implementing the concepts of cultural literacy poorly (Zarcadoolas et al., 2005). Healthcare providers that have inadequate cultural literacy skills are more at risk of providing services which may be considered culturally inappropriate or unsafe. This will inevitably influence and potentially diminish the progress of enhancing health literacy skills of both service providers and Indigenous people.
It is therefore vital for governments, policy-makers and service providers to adapt to individual Indigenous socio-cultural health literacy environments. This requires them to recognise and to value the interactive aspects that inform Indigenous knowledges, including holistic health concepts. Social network-systems and connection to country play a pivotal role within the lives and identity of many Indigenous people. The encompassing relationships are considered a vital source to giving meaning to life and they thus have a profound influence on individual and community resilience, health and wellbeing (Dudgeon et al., 2014; Priest et al., 2012; Vukic et al., 2011). Many Indigenous people consider that cultural practices are particularly important, for these maintain cultural identity and extended relationships. These are significant commitments towards which many feel obligated, responsible and accountable (Dudgeon et al., 2014; Wilson, 2008).

Although establishing partnerships is considered important within the Western health literacy paradigm (as suggested within Chapter 4 Theme E) acknowledging, promoting and developing Indigenous relationships and their associated cultural responsibilities, accountabilities, norms and practices (as highlighted in Table 7 and Table 13), remain marginal within health literacy related documents. For many Indigenous people, social relationships have a huge influence on how they determine, assess and disseminate important health knowledge and information (Wilson, 2008). There may, however, be some conflict between the involvement of extended social relationships in the processes of how health information is communicated within some Indigenous cultures, and the common Western concepts of health and communication (Colles, Maypilama & Brimblecombe, 2014; Dudgeon et al., 2014; Hopkirk & Wilson, 2014; Priest et al., 2012; Smylie et al., 2008).

For instance, in some contexts Indigenous Australians will distinguish between men’s and women’s business and specific health knowledges and information are likely to be confined to one particular gender only (Colles et al., 2014; Lowell et al., 2015). Inuit elders in Canada who receive a high level of respect are frequently the preferred the first point of contact for health information within many Inuit communities. This is because the elders are held to have extensive wisdom and knowledge (Smylie et al., 2008). Within many Indigenous communities, cultural responsibilities such as funerals, ceremony and other socio-cultural events have significant importance, they consider a priority which may interfere with medical appointments, procedures or treatment plans (Dockery, 2010; Dudgeon et al.,
The strong connection some Indigenous Australians have to their country, is cited by Dudgeon et al. (2014, p. 105), who point to Australian studies by Burgess et al. (2009), Dockery (2010) and Rowley et al. (2008). These studies identified a plausible strong linkage between Indigenous people who maintain and exert a strong physical, cultural and spiritual connection with their land and a lower prevalence of chronic diseases such as diabetes, hypertension and obesity, and therefrom relating lower mortality and hospitalisation rates.

The examples above highlight the significant role culture and the relationships within groups can have on influencing health literacy. Cultural insensitivity amongst non-Indigenous healthcare providers may cause them to view these knowledges and practices sceptically. In some cases this can result in the stigmatisation of Indigenous people for disregarding Western knowledge and being non-compliant (Lambert et al., 2014; McBain-Rigg & Veitch, 2011; Taylor & Guerin, 2010). It can be argued that Indigenous holistic health concepts are perfunctorily acknowledged and rarely promoted within health literacy related documents that address Indigenous health.

These findings also indicate an inability or unwillingness to fully embrace diversity. They suggest that other knowledges and practices associated with Indigenous ontologies, epistemologies and values are potentially disregarded, confined or diminished. Such disregard may disempower and disenfranchise some Indigenous people and thereby hamper their engagement within the health literacy environment. Governments, policy-makers and health services need, therefore, to be critically aware of cultural differences. They need to be aware and understand that, for some Indigenous people, holistic concepts of health and wellbeing are inseparably entwined within their personal cultural identity, language and social and physical environment (Colles et al., 2014; Dudgeon et al., 2014; Gooda & Dudgeon, 2014; Vukic et al., 2011).

5.2 Accommodating language diversity

The verbal and illustrative languages used to determine, construct, negotiate, maintain or resist health meanings, are strongly embedded within the contextual and socio-cultural environment in which they take place (Dutta, 2008). When issues in communication and language diversity are poorly considered and accommodated, the provision of quality and safe healthcare may be jeopardised (Lowell et al., 2012; Taylor & Guerin, 2010).
Examples would include the insufficient use of interpreter services or the presentation of health literacy resources predominantly in English without confirming their effectiveness and contextual appropriateness (Colles et al., 2014; Lowell et al., 2012; Taylor & Guerin, 2010; Vass et al., 2011). Such differences in culture and language may present complex and overwhelming challenges or barriers for both healthcare providers and Indigenous people (Colles et al., 2014; Lowell et al., 2012; Taylor & Guerin, 2010; Vass et al., 2011).

Communicating health information effectively within culturally and linguistic diverse populations requires health governance and policy-makers to identify and acknowledge encompassing communication and language issues. Only then can they provide health services with guidance and support towards developing cultural literacy and cross-cultural communication skills (Lowell et al., 2012; Vass et al., 2011; Zarcadoolas et al., 2005). This study therefore explored the extent of published strategies and guidance offered to health services in respect of accommodating the needs of Indigenous populations. The investigation focused explicitly on the issue of language diversity. It is, however, acknowledged that general communication difficulties frequently exist within health literacy environments even when people communicate in the same language. It was, therefore, recognised that the influence of cultural, as well as language, differences on communication, needed to be considered.

The study found a moderate number of document references from all three countries and within all levels of health-governance (Chapter 4, Theme C) that acknowledged the significance of differences in language as a determinant of health. A further analysis of the study sample (see Theme C) identified that many documents relevant to Indigenous health provided limited or no recognition, leadership and guidance towards accommodating Indigenous language differences (see Graph 4 and Graph 8, Theme C). Those documents that recognise the importance of accommodating language differences within Indigenous health literacy environments slightly favoured the use of interpreter and translation services over the inclusion and promotion of Indigenous native languages (see Graph 4). This emphasis was particularly evident within documents from Australia, and to some extent Canada (see Graph 8).
High level health governance documents from Australia and Canada similarly encouraged or mandated health services to engage and utilise trained interpreter services to ensure professional and culturally appropriate communication of health related information (see Table 16). Additionally, the use of simple or plain English language, teach back techniques and an avoidance of medical terminologies and jargon were strategies frequently recommended within the literature and also evident within the study sample (Australian Commission on safety and quality in health care, 2014b; Ministry of Health, 2014b; Mitic & Rootman, 2012; Smylie et al., 2006). The gradual recognition and promotion of these strategies within health literacy related documents is essential to communicating health information effectively within culturally and linguistically diverse populations. Identifying the extent and quality of how communication strategies are effectively implemented and practiced by health services was, however, not within the scope of this thesis.

The literature suggests that health services working within Indigenous healthcare environments may disregard the importance of using interpreter services or other communication strategies. Such disregard can significantly impede effective cross-cultural communication. Some studies from Australia and Canada suggest that, despite trained interpreter services being readily accessible and available at no expense to health services, they seem to be frequently underused by health professionals (Dowbor et al., 2015; Lowell et al., 2012; Phillips, 2010). Additionally, the use of simple and plain English language may be limited in its effect. Differences of Indigenous and non-Indigenous language based worldviews and meanings with regard to health knowledges may be misunderstood and misinterpreted. When not recognised and addressed appropriately, these issues can create frustrating experiences for healthcare professionals and consumers alike, with a potential for unfavourable outcomes in both health and relationships (Lowell et al., 2012; Smylie et al., 2006; Vass et al., 2011).

A further point of concern is the genuine risk or perception of reinstating or maintaining colonial-type oppressive structures within Indigenous healthcare environments. This perception can be revived when health services disregard or diminish the significance of local Indigenous languages, especially where these are strong and readily spoken (Akena, 2012; Smylie et al., 2006). Language is inherent to a person’s cultural identity and provides a vital tool for expressing and shaping world-views, values and beliefs which again determine
personal and collective behaviours (Dudgeon et al., 2014; Khalil ur, 2012; Perlovsky, 2011; Vass et al., 2011). It can be argued that by confining the communication and teaching of health related information and knowledge to solely English, Indigenous languages and their associated intellectual knowledges are virtually disrespected, discredited, distorted or devalued (Akena, 2012; Pitama, Ahuriri-Driscoll, Huria, Lacey & Robertson, 2011; Smylie et al., 2006).

Ignoring Indigenous languages can, in some cases, have a disempowering effect on affected people and potentially diminish their engagement within the health literacy environment. These issues were also identified by Lowell et al. (2012) who in an Australian study highlighted the risks of limited communication and education in regard to the effectiveness of health communication and outcomes in chronic diseases between Yolngu people and non-Indigenous health services. It is, therefore, crucial that high-level health governance documents provide adequate guidance and support towards identifying and implementing appropriate communication strategies, including language aspects where applicable, within services that work in an Indigenous health literacy environment.

In contrast to Australia and Canada, a modest number of high level health governance documents from New Zealand acknowledged and strongly emphasised the integration and promotion of te reo Maori (see Graph 8). As indicated earlier in this study, New Zealand is a bilingual nation and the 1987 Maori Language Act affirms te reo Maori being a legal and official language. A good example of how high-level health governance documents from New Zealand currently confirm and endorse bilingualism is found within the Equity of Health Care for Māori 2014 Framework. The framework provides a strong focus on enhancing health literacy levels and also encourages health professionals to promote and personally acquire sufficient skills in te reo Maori (Ministry of Health, 2014a).

Although some critics might argue that the Maori language and knowledges are commonly considered as non-relevant or insignificant by many members of the dominant culture (Huia, 2014), the study findings support suggestions made by Pitama et al. (2011) that progressive efforts are being made to decolonise the healthcare environment by promoting te reo Maori. According to Pitama et al. (2011) the New Zealand Government, and Maori and non-Maori health professionals are gradually augmenting the use of te reo
Maori within primary healthcare. Te reo Maori is increasingly recognised and valued as an important component to providing culturally competent healthcare to Maori. The endorsement and promotion of te reo Maori within New Zealand health literacy related policy documents can be commended as a positive way forward.

Promoting the integration of local Indigenous languages within Indigenous health literacy environments, where this is relevant to the context, across Australia and Canada may be considered feasible and needs to be driven and supported by governments and policymakers. The promotion and integration of Indigenous languages can be achieved by providing health services with sufficient guidance and support within health literacy related policy and practice documents. This support would apply especially to documents that advise Indigenous people on how to develop health related information and resources, where relevant, in the most prominent local Indigenous language and in the preferred mode of dissemination (Smylie et al., 2008; Vass et al., 2011). This is not just a matter of showing cultural respect. More importantly a demonstration of honest efforts made by the dominant culture towards decolonisation, reconciliation, acknowledging diversity and the genuine intent of developing supportive environments for Indigenous people.

5.3 Cultural responsiveness

The development of supportive, accommodating, holistic and culturally safe healthcare environments, as outline by the Ottawa Charter, is increasingly recognised as critical to enhancing health literacy skills and overall health within populations (Baum, 2008; Durey & Thompson, 2012; Mitic & Rootman, 2012; Nutbeam, 2000; WHO, 1986). However, increasing health literacy skills within culturally and linguistically diverse populations can only be achieved when governments, policy-makers and service providers demonstrate a high-level of cultural literacy and cultural competencies (Durey & Thompson, 2012; Zarcadoolas et al., 2005). In this regard the findings within this study suggest that concepts of cultural competence and cultural safety are becoming increasingly acknowledged and promoted across all three countries and within all levels of health-governance (see Chapter 4, D13).
Within the study sample a number of common strategies to promote cultural competencies were identified. Significant amongst these were: acknowledging culturally diverse worldviews and holistic concepts of health within the organisation or institution, providing cultural awareness training and education to staff, and a strengthening of the Indigenous health workforce (IHW) (see Table 19). It is also critical, however, to ensure that strategies promoting cultural competencies within health literacy related policy documents are effectively implemented, realised and practiced at an operational level. This is where it is essential to create genuinely supportive environments. The literature also frequently refers to a requirement to acknowledge existing power imbalances and enable genuine Indigenous consultation, participation and self-determination within decision making processes (Dudgeon et al., 2014; Lie et al., 2012; Lowell et al., 2015; Taylor & Guerin, 2010).

Recent studies from Australia, Canada and New Zealand highlighted that health governance and services across all three countries were similarly struggling to negotiate and accomplish effective intercultural competencies within Indigenous healthcare environments. Studies by Durey and Thompson (2012), Lambert et al. (2014), Lowell et al. (2015), Lowell et al. (2012), Sheridan et al. (2011) and Vass et al. (2011) cited similarly the perpetuating cultural challenges, communication barriers, poor relationships and culturally associated misconceptions. The issues cited within these studies are consistent with the findings presented within this study. They represent a coherent indication that health governance and policy-makers need to increase their support to improve and ensure the development of health and cultural literacy capacities within health services.

An important strategy to ensure culturally competent practice within Indigenous healthcare environments is the establishment of Aboriginal Controlled Health Services (ACHS) and a well-represented and supported Indigenous health workforce (IHW) (Dudgeon et al., 2014; Ellison-Loschmann & Pearce, 2006; Liaw et al., 2011; McConnel, Demos, & Carson, 2011; Taylor & Guerin, 2010). ACHS and a competent and well supported IHW are essential to establish cultural safety which, according to Richardson (2012), is about safeguarding cultural identity, negotiating reciprocal meaning and recognising the moment of trust. The concept of cultural safety within the health literacy environment is fundamental in extending support to people from culturally and linguistic diverse backgrounds to enhance their health literacy skills. It is, therefore, argued that the IHW has an indispensable role in
successfully bridging the cultural and communication differences between Indigenous and non-Indigenous people.

The study findings, however, suggest that recognising and appreciating the vital role a competent IHW has in delivering cultural safety and health literacy outcomes was inconsistent and limited across all three countries within health literacy related policy and practice documents relevant to Indigenous health. Despite that, a total of 68 documents within the study sample addressed Indigenous health (see Graph 3), only 28 of those documents endorse, promote or mandate the inclusion of Aboriginal Health Practitioners (see Table 21). Additional discrepancies and tensions are highlighted when comparing the literature with high-level health governance documents from Australia and New Zealand. It is commendable that both countries in particular endorse and promote the development of an IHW within high-level health governance (see Table 21). Yet researchers within this field frequently contend that the IHW is insufficiently represented, resourced, staffed, and lacks adequate culturally appropriate and professional support at an operational level (McConnel et al., 2011; Nuku, 2013; Roche et al., 2013; Taylor & Thompson, 2011).

The study also found that the IHW in Canada is poorly recognised and represented within high-level health governance documents. No references that explicitly acknowledged and promoted the development of the IHW were evident at this level (see Table 21). The study did, however, identify some policy related reports from Canada which discussed the significance and need to promote and develop a competent IHW in order to enhance health communication and cultural competencies. These discussions are encouraged and supported by current research, as a Canadian study by Najafizada, Bourgeault, Labonte, Packer, and Torres (2015) contends that Aboriginal Health Practitioners or Community Health Workers can positively impact on health inequities and inequalities within marginalised and disadvantaged communities: It further argues that there was an urgent need to develop and integrate a competent IHW within health, social and public services.

An additional strategy identified within this study which aims to provide cultural competencies within Indigenous healthcare, is the promotion of bi-cultural approaches. Despite identifying a modest number of efforts within policy and practice documents related to health literacy across all three countries and at all levels of health governance (see Table
limited evidence was found within this study sample of a genuine incorporation and promotion of Indigenous knowledges, epistemologies, pedagogies paradigms and practices. The majority of identified high-level governance documents from all three countries that promoted bi-cultural approaches, were considered imprecise and vague. There is little or no guidance with regard to the underpinning authority and little detail about what elements or aspects of Indigenous models or concepts are to be supported, and how evidence was to be constructed and determined.

The findings within this study therefore suggest that the construction of health related knowledges, and the methods of disseminating health information are confined to Western knowledge, pedagogies, paradigms and practices. Additionally, it appears that Indigenous knowledges and practices are considered appendages, secondary or untenable assertions by current governments, institutes and organisations in power. Supporting evidence for this conclusion can be drawn from the findings that the incorporation and promotion of Indigenous health knowledges, paradigms and practices, as discussed in 5.1, are inconsistent and limited within many high-level health governance documents that address Indigenous health.

These findings are also consistent with the literature, where it is argued that, by confining knowledges, pedagogies and approaches to Western hegemonies, the existing colonial concepts and structures are maintained (Akena, 2012; Connell, 2014; Kaplan-Myrth, 2007). Furthermore, the limited representation of Indigenous knowledges within health literacy related policy and practice documents supports the argument that persisting social and health inequities are, at least in part, a result of poorly designed public health policies. Contributory factors include a lack of Indigenous consultation and insufficient government commitments ("Aboriginals face discriminatory funding rules," 2014; Friel, 2014; Germov, 2014; Keleher & MacDougall, 2016; Lloyd & Wise, 2010; Marmot et al., 2008; Woodall, Warwick-Booth & Cross, 2012). These findings in conjunction with the literature indicate persisting tensions and challenges with regard to Indigenous participation, empowerment and self-determination. These will be discussed in detail in the following section.
5.4 Participation, self-determination and sovereignty

Genuine relationships and partnerships based on mutual respect are fundamental to enable health consumer participation, self-determination and empowerment. In order to enhance health literacy skills and health equity within Indigenous populations, it is vital to enable Indigenous people to be empowered by increasing their representation and influence within the decision making processes that affect their lives (Keleher & MacDougall, 2016). Indigenous people also need to be genuinely enabled and supported to exert their right to participation, self-determination and self-governance (Howitt, 2012): principles which is enshrined within the United Nations Declaration on the Rights of Indigenous people 2008 (United Nations, 2008). This study therefore investigated the level of recognition and the approaches aimed at enabling participation, self-determination and sovereignty. The aim was to determine the underpinning context in which Indigenous knowledges and language are placed, presented, acknowledged and promoted.

The study findings identified an existing cohesive endorsement across Australia, Canada and New Zealand that requires or mandates health services to engage and include consumers within the decision making processes that affect their health (see Chapter 4 E). A significant majority of health literacy related policy and practice documents, regardless of location published and intended target populations, encouraged, promoted or mandated that healthcare providers engage and collaborate with the communities and the people they serve (see Chapter 4, Section 4.2.5.1). These findings suggest that governments across all three countries are increasingly acknowledging the importance of improving community participation, collaboration and communication practices between health services and consumers. There is an evident intention to enhance the quality of the healthcare system and care, health literacy skills and hence health outcomes within the population.

The recognition and promotion of active participation and reciprocal relationship building also indicates that health governance and services are increasingly enabling healthcare recipients to become pro-active partners and empowered to participate and take control over their own health. This finding suggests a gradual easing of the dominating and conservative bio-medical towards health consumer engagement and empowerment. This shift in approach has persistently been called for by many experts (Baum, 2008; Dutta, 2008; Kickbusch, 2009; Mitic & Rootman, 2012; Nutbeam, 2008; Osborne et al., 2013). However,
the concepts and approaches that inform, determine and support health consumer and community empowerment need to be viewed critically. This involves consideration of underpinning conditions, existing power-relations and potentially conflicting interests between governments, health services and consumers groups.

From a critical perspective, the findings within this study suggest that health literacy related policy and practice documents strongly emphasised forms of empowerment which predominantly accommodates the interests and needs of the biomedical model and neo-liberal governments. Similarly across all three countries, high-level health governance documents commonly promoted a Patient Centred Care approach (see Table 25), which associates empowerment and health literacy with enabling consumers to take control over their health. This assumes that consumers will thereby make fully informed decisions, reduce their health risk behaviours and feel entitled to ask questions. These findings support contentions frequently made by some researchers that the concepts of empowerment within a bio-medical and neo-liberal ideology is commonly confined to individualism, self-care, and personal responsibility and accountability with an underlying intent aimed to contain the social responsibilities of government (Dutta, 2015; Germov, 2014; Keleher & MacDougall, 2016; Woodall et al., 2012).

Most Western countries that are either dominated or influenced by the neo-liberalistic ideology of empowerment and emphasised individualism are primarily concerned with economic growth rather than social equity (Germov, 2014; Keleher & MacDougall, 2016; McGregor, 2001). It is therefore unsurprising that many neo-liberal governments pursue the concept of individualised empowerment, as suggested within Table 25, in an attempt to diminish their responsibility and accountability towards having to address the broader social determinants and complex social issues. This approach may conversely exacerbate social marginalisation, disadvantage and deprivation of social welfare support, funding and resources (Germov, 2014; Woodall et al., 2012). In this context the development of culturally safe and supportive environments appears less of a priority. Furthermore, the health literacy concepts aimed at developing interactive and critical health literacy skills (Nutbeam, 2000) and public health literacy skills (Freedman et al., 2009) within disadvantaged population groups that are unwilling to assimilate into current dominant systems, will become significantly challenging and perhaps unattainable. Under these
circumstances many Indigenous people and their knowledge systems, will most likely remain marginalised.

Genuine empowerment within culturally diverse populations requires a multi-lateral and inter-sectoral government, community and organisational approach which cannot be confined to a standardised neoliberal ideology and/or bio-medical principles (Wallerstein, 2006). According to Hennink, Kiiti, Pillinger and Jayakaran (2012) and Wallerstein (2006) empowerment needs to be considered both a theoretical framework and action orientated approach which is dynamic and complex as it interacts within intricate environments. Depending on the socio-cultural context, the terminology, conceptualisation and meaning of empowerment can vary. The broad concept of empowerment is concerned with the removal of formal or informal barriers within existing political, social, economic, cultural and personal environments. These are constraints which prevent individual people, communities and populations from exerting self-determination and maintaining autonomy and control over their own life and destiny (Hennink et al., 2012; Wallerstein, 2006). With regard to the health literacy environment, and from an academic and community development point of view, the process of empowerment aims to increase social justice and health equity. This can be achieved by transforming and shifting the existing power relations in an attempt to ensure that power and resources are evenly distributed between governments, health services and consumers (Kickbusch, 2009; Wallerstein, 2006).

In order for Indigenous people to become genuinely empowered, they need to be able to negotiate and determine what comprises a culturally safe environment, and which provides sufficient physical and psychological space. According to Akena (2012) and Huia (2014) this space must be free from the domination of non-Indigenous ontologies epistemologies, paradigms and practices. Public health policies and programs have frequently been criticised for being too standardised. They have been accused of disregarding marginal and disadvantaged population groups and favouring those that accept or conform to the ontologies, epistemologies, pedagogies, paradigms and practices exerted by the dominant culture (Akena, 2012; Czyzewski & University of Toronto, 2011; Durey & Thompson, 2012; Dutta, 2008; Germov, 2014). This argument discursively supports the study findings with regard to empowerment being confined to the bio-medical model and
neoliberal ideologies, as Indigenous languages, knowledges, paradigms and practices within health literacy related documents are marginally represented or absent.

Supporting evidence can be found when reviewing Graph 8 and 9 with reference to the Themes A, B and C, and Graph 6 which clearly highlights the limited formal endorsement and promotion of Indigenous self-determination, autonomy and sovereignty. In this regard it can be argued that despite the many health literacy related policy and practice documents that proclaim and intend to address the broader social determinants of health, little will be achieved for marginalised cultural groups while health governance documents maintain colonial structures and neo-liberalistic concepts of individualism and self-responsibility (Woodall et al., 2012).

Nonetheless, the study was able to identify very few but exceptional examples within some health literacy related policy and practice documents from all three countries which demonstrated a decolonising and culture centred approach. Those documents acknowledged, endorsed and promoted Indigenous autonomy and self-determination (see Table 26). Such efforts need to be supported and augmented. This progress is crucial, as it provides the foundation for honest relationships, negotiation and reconciliation. In the process it offers the prospect of genuine culturally safe and supportive environments in which Indigenous knowledges, epistemologies and values are highly regarded and contribute to enhancing health literacy skills within Indigenous populations.

5.5 Approaches to measuring health literacy

The final discussion within this thesis encompasses issues within current approaches to measuring health literacy. Assessing health literacy levels within populations, especially within the health service sector, is important for governing health bodies. The knowledge collated aims to improve service delivery, participation, public health education and policy development (Batterham et al., 2016). However, Durey and Thompson (2012) assert that approaches to measuring health literacy within culturally diverse populations need to be culturally competent in order to be effective and provide accurate and trustworthy results. A study by Altin et al. (2014) highlighted that common health literacy assessment tools are predominantly confined to the languages commonly used by the dominant cultural groups,
functional skills as in reading, writing and basic mathematics and with few measuring basic communication skills.

The findings within this study support the statement made by (Altin et al., 2014), as that the most common health literacy assessment tools cited or promoted across Australia, Canada and New Zealand are confined to measuring Western knowledge (see Table 28). Furthermore, issues encompassing cultural and language challenges when assessing health literacy skills within culturally and linguistically diverse populations were rarely recognised within policy and practice documents. Only three documents, two from Australia and one from New Zealand, cited the need to include or promote criteria specific to Indigenous cultures (see Table 29). A significant point of concern is that the current health literacy assessment tools promoted within health literacy related policy and practice documents frequently disregard the competencies and abilities of services providers. The majority of assessment tools cited within the study sample are designed to measure the knowledge and skills of health consumers (see Table 28). This issue has also been identified by (Batterham et al., 2016), who propose that healthcare providers need to be equally assessed in order to ensure health services have sufficient awareness and appropriate communication and other strategies to accommodate the needs of cultural and linguistically diverse population groups.

The limited recognition within health literacy assessment tools that culture and language differences may negatively affect health literacy measurement outcomes and strengthens the argument that the health literacy environment is generally dominated by Western knowledge, pedagogies, paradigms and practices. Confining health literacy assessments to Western pedagogies and practise will most likely contribute to maintaining the colonial structures of knowledge construction and dissemination (Akena, 2012; Dutta, 2008). Assessment benchmarks will continue to be tailored in favour of the culturally dominant population. In this regard, Indigenous populations are potentially deprived of having their own socio-cultural health knowledges equitably valued, acknowledged and assessed. Such disadvantages will continue to hamper efforts to develop genuine, culturally safe and supportive environments.
6 Conclusion

The study presented within this thesis provided an extensive analysis of the extent and ways in which Indigenous health knowledges are valued, acknowledged, incorporated and promoted within health literacy related policy and practice documents across Australia, Canada and New Zealand. The findings suggest that the incorporation and promotion of Indigenous knowledges, paradigms and practices, including holistic concepts of health, are mostly limited or absent within high-level health governance documents. There is evidence of improving efforts to incorporate Indigenous holistic concepts and, to some extent, bi-cultural approaches within health literacy related policy and practice documents. These appear, however, to be less well understood, fragmented or largely confined to the hegemonies of Western knowledges, pedagogies and practices.

Many Indigenous people from all three countries embrace similar sophisticated health knowledge systems, including holistic health concepts, which are intrinsic to their cultural identity, language and community. To effectively promote and improve health literacy within Indigenous populations, it is clearly important for health services to become culturally competent and develop culturally safe and supportive environments. Efforts to improve cultural competencies within health services were particularly evident within documents from New Zealand. These demonstrated a strong commitment and emphasis towards Maori participation, self-determination and the establishment of culturally safe healthcare environments. It is, however, of some concern that health services and programs working within an Indigenous health literacy environment are provided with little or no guidance and support from governments and policy-makers. There is largely an absence of such support in relation to enhancing cultural literacy and the effective negotiation and incorporation of Indigenous knowledges within health literacy approaches.

Empowerment is considered a pivotal element to enhancing health literacy skills, yet this was also only modestly acknowledged and emphasised within this study. Health literacy related policy and practice documents from the three countries similarly promoted a patient centred care approach. The aim is evidently to empower populations to take control over their health and improve health literacy skills. It is argued, however, that such an approach risks marginalising Indigenous people, as empowerment within a bio-medical and neo-liberal
ideology is largely confined to individualism, self-care, and personal responsibility within the dominant population. The underpinning intent of this approach seems to be the containment of the social and financial responsibilities of government. The current discrepancies between the concepts and approaches of empowerment, self-determination and sovereignty, regarding the construction and dissemination of health knowledges and information, are consistent with tensions highlighted in the literature between health governance, policy-makers, researchers and other interest groups. The collective aim is to enhance health literacy skills and improve health equity within Indigenous populations. To achieve this, it is vital that governments, policy-makers and services acknowledge the significance and relevance of Indigenous knowledge systems. These will include health related knowledges and practices, as well as holistic concepts of health within the Indigenous health literacy environment.
7 Recommendations for future research

The short time frame available to accomplish an honours research degree inevitably limited the scope of this study. An investigation of personal opinions, perceptions and experience of the significance of Indigenous knowledges and language within the health literacy environment would warrant further study. The study findings suggest that it is important to investigate these personal perceptions and experiences from a wide range of stakeholders. These must include government representatives, policy-makers and Indigenous stakeholders and pay attention to the status and value Indigenous knowledges may have within current policy discussions. Such research can potentially highlight the underpinning power-relationships that affect the construction of knowledge and current policy outcomes. It may then be possible to identify positive steps to overcome the perpetual tensions and discrepancies between the intentions and expectations of policy documents and their outcomes.

Further studies are recommended to investigate current processes of policy development. These might pay particular regard to approaches made to enable Indigenous consultation, participation and self-determination. A detailed analysis of the underpinning power-relationships that inform the construction of knowledge and thereby affect policy outcomes and practices within the health literacy environment, would be useful.

Future studies may also consider investigating the extent of existing grass-root attempts to incorporate and promote Indigenous languages, knowledges, pedagogies, paradigms and practices within health literacy promotion materials, resources and approaches. These may differ from policy aims and have different outcomes. Such grass-root approaches may be confined to particular communities or regions and may not be accessible through the internet. It is hoped that these and other studies may collectively contribute towards developing an integrated, culturally appropriate national framework for health literacy in Australia. This would provide effective guidelines on how health literacy skills are to be addressed and enhanced within a culturally and linguistically diverse population and healthcare system.
8 References


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9 Appendices

9.1 Appendix 1: Data Collection and search strategy for study sample

9.1.1 Australia

Google: 11,600 hits – reviewed the first 200 search results.

Yahoo: 7590 hits – reviewed the first 200 search results.

**Department of Health States & Territory**

Terms searched: *"Health Literacy" AND Framework OR Guidelines OR Policy OR "Action Plan" OR "Position Statement" OR Resources*

Australian Capital Territory – Search results: 28

New South Wales – Search results: 43

Northern Territory Government – Search results: 6,909

Simplified to *Health Literacy AND Framework (PDF and Word-Doc only)*

Search results: 136

Queensland – Search results: 48

South Australia – Search results: 0

Broadened to “health literacy” AND Framework – Search results: 36

Tasmania - Search results: 41

Victoria – Search Results: 175

Western Australia – Search results: 0

Broadened to just health literacy – Search results: 9

9.1.2 Canada

Google: 6,900 hits – reviewed the first 200 search results.

Yahoo: 8,220 hits – reviewed the first 200 search results.
Additional search conducted replacing the term Canada with Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Nova Scotia, Ontario, Prince Edward Island, Quebec, Saskatchewan, Northwest Territories, Nunavut, and Yukon. Review of the first 100 search results for each conducted search, totalling 1300.

**Health Canada - Department of Health**

Terms searched:

Exact word or phrase: *Health Literacy*

Any of these words: *Framework, Guidelines, Policy, Action Plan, Position Statement, Resources*

Search Results: 14

**9.1.3 New Zealand**


Google: 2,950 Hits – Reviewed the first 200 search results

Yahoo: 2,010 hits – reviewed the first 150 search results

**Ministry of Health**

Terms searched: *“Health Literacy” AND Framework OR Guidelines OR Policy OR “action plan” OR “position statement” OR Resources*

Search Results: 17

**9.1.4 Summary of search results**

**Table 30**

<table>
<thead>
<tr>
<th></th>
<th>Total Search Results</th>
<th>Crude Document Inclusion</th>
<th>Final Study sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australia</strong></td>
<td>916</td>
<td>86</td>
<td>47</td>
</tr>
<tr>
<td><strong>Canada</strong></td>
<td>1714</td>
<td>65</td>
<td>31</td>
</tr>
<tr>
<td><strong>New Zealand</strong></td>
<td>367</td>
<td>43</td>
<td>29</td>
</tr>
<tr>
<td><strong>International</strong></td>
<td>/</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2997</td>
<td>194</td>
<td>108</td>
</tr>
</tbody>
</table>
9.2 Appendix 2: Initial codes identified and labelled during the first coding phase

Table 31

<table>
<thead>
<tr>
<th>Initial emerging codes</th>
<th>Inclusion criteria</th>
<th>Number of sources (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of Indigenous culture or language diversity</td>
<td>Statements made with regard to acknowledging the cultural and language diversity of Indigenous people</td>
<td># 24</td>
</tr>
<tr>
<td>Promotion of Indigenous health knowledges</td>
<td>Evidence of the inclusion and promotion of Indigenous health practices, such as traditional medicines or cultural health practices</td>
<td># 2</td>
</tr>
<tr>
<td>Accommodating Indigenous language needs</td>
<td>Evidence of using cultural appropriate forms of communication, as translations or cross cultural communication skills</td>
<td># 13</td>
</tr>
<tr>
<td>Cultural challenges</td>
<td>Evidence of acknowledging cross-cultural challenges, such as language diversity or differing cultural views of health and wellbeing</td>
<td># 14</td>
</tr>
</tbody>
</table>
### 9.3 Appendix 3: Concluding list of identified themes and sub-themes

#### Table 32

Concluding list of identified themes and sub-themes

<table>
<thead>
<tr>
<th>Name</th>
<th>Sources (#)</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main themes and sub-themes</strong></td>
<td><strong>N = 108</strong></td>
<td><strong>1088</strong></td>
</tr>
<tr>
<td><strong>A - Promotion of Indigenous cultural health knowledges, paradigms and practices</strong></td>
<td>25</td>
<td>81</td>
</tr>
<tr>
<td>1) Acknowledging and promoting Indigenous health paradigms</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>2) Indigenous healing and medicine practices</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>3) Indigenous food practices</td>
<td>8</td>
<td>19</td>
</tr>
<tr>
<td>4) Indigenous traditional and contemporary cultural practices</td>
<td>7</td>
<td>13</td>
</tr>
<tr>
<td>5) Indigenous birthing and child rearing practices</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>B - Acknowledging cultural beliefs, practices and norms</strong></td>
<td>40</td>
<td>106</td>
</tr>
<tr>
<td>6) Recognition of Indigenous holistic health</td>
<td>34</td>
<td>65</td>
</tr>
<tr>
<td>7) Indigenous social network and support systems as a health resource</td>
<td>14</td>
<td>21</td>
</tr>
<tr>
<td>8) Culture considered a health asset</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>9) Recognition of cultural protocols</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>C - Accommodating language diversity</strong></td>
<td>46</td>
<td>78</td>
</tr>
<tr>
<td>10) Promoting Indigenous languages</td>
<td>19</td>
<td>40</td>
</tr>
<tr>
<td>11) Promoting interpreter or translator services</td>
<td>22</td>
<td>28</td>
</tr>
<tr>
<td>12) Marginal or descriptive recognition of language diversity</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td><strong>D - Cultural responsiveness of healthcare providers</strong></td>
<td>75</td>
<td>375</td>
</tr>
<tr>
<td>13) Acknowledging and promoting intercultural competencies</td>
<td>74</td>
<td>292</td>
</tr>
<tr>
<td>14) Bi-cultural approaches imprecise or confined to Western knowledge</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>15) Recognition, inclusion or promotion of an Indigenous Health Workforce</td>
<td>28</td>
<td>51</td>
</tr>
<tr>
<td><strong>E - Participation, Self-Determination and Sovereignty</strong></td>
<td>99</td>
<td>424</td>
</tr>
<tr>
<td>16) Consumer &amp; Community Participation and Collaboration</td>
<td>93</td>
<td>296</td>
</tr>
<tr>
<td>a. <em>Universal collaboration and participation</em></td>
<td>91</td>
<td>190</td>
</tr>
<tr>
<td>b. <em>Indigenous specific collaboration &amp; participation</em></td>
<td>56</td>
<td>106</td>
</tr>
<tr>
<td>17) Consumer &amp; Community Sovereignty, Self-determination &amp; Empowerment</td>
<td>59</td>
<td>128</td>
</tr>
<tr>
<td>a. <em>Health Consumer Empowerment</em></td>
<td>41</td>
<td>64</td>
</tr>
<tr>
<td>b. <em>Consent and promotion of Indigenous self-determination, autonomy and sovereignty</em></td>
<td>23</td>
<td>50</td>
</tr>
<tr>
<td>F - Health Literacy Assessment</td>
<td>11</td>
<td>23</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>18) Approach to measuring health literacy</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>19) Recognition or approach to Indigenous specific health literacy measurement</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
9.4 Appendix 4: Reference list of all the documents included within the study sample


http://www.cpha.ca/uploads/portals/healthliteracy/pr...pdf


http://www.cancercare.ns.ca/site-cc/media/cancercare/Guidelines%20for%20Dev%20of%20Edn%20Material%20FINAL%20(2).pdf


https://suicideinfo.ca/LinkClick.aspx?fileticket=MVIyGo2V4YY%3D&tabid=563


