‘There is nothing that identifies me to that place’: Indigenous Women’s Perceptions of Health Spaces and Places

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There is a growing body of literature within social and cultural geography which explores notions of place, space, culture, race and identity.[1] The more recent works suggest that places are experienced and understood in multiple ways and are politically embedded.[2] Memmott and Long—who have undertaken place-based research with Australian Indigenous people—present the position that ‘place is made and takes on meaning through an interaction process involving mutual accommodation between people and the environment’.[3] They argue that places and their cultural meanings are generated through one or a combination of three types of people–environment interactions. These include a place that is created by altering the physical characteristics of a piece of environment and might encompass a feature or features which are natural or made; a place that is totally created via behaviour that is carried out within a specific area and therefore that specific behaviour becomes connected to that specific place; and a place that is created by people moving or being moved from one environment to another and establishing a new place where boundaries are created and activities carried out.

All these ideas of places are challenged and confirmed by what Indigenous women have said about their particular use of and relationship with space within several health services in Rockhampton, Central Queensland. As my title suggests Indigenous women do not see themselves as ‘neutral’ or non-racialised citizens who enter and ‘use’ a supposedly neutral

health service. Instead, Aboriginal women demonstrate they are active recognisers of places that would seek to identify them. That is, they as Aboriginal women didn't just 'make' place, the places and spaces 'made' them. The health services were identified as sites within which spatial relations could begin to grow with recognition of themselves as Aboriginal women in place or instead create a sense of marginality in the failure of the spaces to identify them.

The women's voices within this essay are drawn from interviews undertaken with twenty Aboriginal women in Rockhampton who participated in a research project exploring 'how the relationship between health services and Aboriginal women can be more empowering from the viewpoints of Aboriginal women'.[4] The assumption underpinning this study was that empowering and reempowering practices can lead to improved health outcomes.[5] The focus of the study arose from discussions with Aboriginal women in the Rockhampton community as to what they wanted me, another Aboriginal woman, to investigate as part of a formal research project.[6] Throughout the interviews women shared some of their lived realities including some of their thoughts on identity, the body, employment in the health sector, service delivery and their notions of health service spaces and places.

Sommerville, also writing on Indigenous place, states that it is both a 'specific local place and a metaphysical imaginary' and 'has been noted as an organising principle in Aboriginal ontologies and epistemologies by both Indigenous and non-Indigenous Australian scholars'.[7] Moreton-Robinson articulates how Indigenous peoples' sense of place, home and belonging is configured differently to that of migrants.[8] She asserts that 'there is no other homeland that provides a point of origin, or place for multiple identities. Instead our rendering of place, home and country through our ontological relation to country is the basis for our ownership.'[9] While colonisation has dispossessed and displaced Indigenous peoples and may have altered Indigenous connection, access and control within and of place, it does not alter the reality of Indigenous place and Indigenous ownership of place. This is even in the case of large metropolitan cities such as Perth, Melbourne and Sydney.[10]

Sommerville contends that there are 'complex political realities of Indigenous/non-Indigenous relationships in place'.[11] Some places offer multiple and contested stories of experiences and experiences that may contain deeply held beliefs and emotions; people may even display affection, nostalgia, dislike or other emotions in relation to place.[12] Furthermore, as emotions and behaviours develop, they may also then be 'maintained by groups of people having collective experiences at those parts of the environment and reinforced through feedback from ongoing experiences at such places'.[13] Through this process it is possible that places can enact the politics of inclusion and allow for multiple identities and marginalised groups or enact 'a place-based politics which is reactionary, exclusionary and blatantly supportive of dominant regimes'.[14] Along with these understandings of place is a body of work which relates to the everyday practices of belonging within or to place. De Certeau constructs the notion of belonging as a sentiment which develops over time through the everyday activities.[15] Simple, everyday activities are part of the process of appropriation and territorialisation and, following de Certeau, non-Indigenous peoples' attachment and belonging to places based on the dispossession of Aboriginal people and on their everyday practices of the past two hundred years. Such attachments, however, do not erase Indigenous ownership.

In discussing place, space will also be considered since place and space are so 'deeply implicated in one another it is difficult to consider one without the other'.[16] Mills explains that 'space is a question of relations: perceptions of and actual relations between the individual, the group, institutions and architecture, with forces being perceived as restricting or enabling movement or access'.[17] Gregory and Urry add to this by explaining that 'spacial structure is now seen not merely as an arena in which social life unfolds, but rather as a medium through which social relations are produced and reproduced'.[18] What can be understood is that spaces act as almost social texts, which convey messages of belonging and exclusion and produce and reproduce power relations within society.[19] They are, as suggested by Foucault, sites of social struggle and contested realms of identity.[20] In this way, places are in mutually constitutive relationships with spaces.[21]

There is no doubt that there are complex interrelations between who women are — women's identities — and the environments or spaces and places in which women live.[22] The aspects of women's identities such as class, race, ethnicity, culture and sexual orientation must add to the complexity of the interrelationships between women and space and place.[23] Women therefore don't just physically use spaces and places; they interpret, represent, and produce and reproduce space within places. It is therefore probable that non-Indigenous women and Indigenous women will interpret the same place as different spaces and that these may be in conflict with each other.[24] Indigenous women's understandings of place and space within health services operate within this complex context.[25] Indigenous women I interviewed refer to a particular site, building or a feature as a place. They see space as the interactions and activities within a defined area and understand that they convey texts of society, including inclusion, exclusion, domination, control and power. They additionally see purposefully defined areas within a larger place as spaces based on what the function of that defined area is. That is, a site could be a place, and an allocated area within the place could be called a space. Areas where a program may do outreach work or create an area within their space for an activity might also be called spaces and all the things that are within that space are important to acceptance of that space. For example, the Community Health and Public Service building and the Mammography Unit are places. The Accident and Emergency section at a hospital is a space within the place called the Hospital.

Entering health places

Generally health services or health programs that are specifically established for Indigenous people are operated by governments or by Indigenous community-controlled non-government organisations. Indigenous women referred to both forms of service during their interviews. While the women referred to the different forms of services they additionally made references to the spaces and places within those services. The women provided clear understandings of how they access these services and the powerful way that their idea

of place impacts on their interactions with those services.

One of the older Indigenous women interviewed gave a very clear example of place and a space within a government operated health service. She explained that when the Queensland government developed their new Community and Public Health complex and opened it in 1998, they placed the Indigenous Health Program 'in the back room'. She made reference to a past era in Australia when the 'blacks were in the back'.[26] The era she refers to is when Indigenous people were expected to stand at the back in shops and wait to be served or sit in the back of the cinema. In this situation the woman explained that when Indigenous people entered the building they had to ask a non-Indigenous person at the large reception desk at the front of the building where to go to get to the Indigenous Health Program and if they could go there.

As the entry was large and with a highly public waiting area, other people could view who was going in and out through this entry. In addition, in the foyer, on the wall facing the door hangs a print of what is considered one of the masterpieces of Australian art: Frederick McCubbin's triptych titled *The Pioneer* (1904). This work depicts the pioneering spirit of the white settler in the bush. In addition to this print there are two other prints by the same artist on the two adjoining walls of the foyer. Both of these paintings—*The Lost Child* and *Lost*—represent young white children on their own, facing away from the painter's gaze, lost in the bush. The image of the lost child is presented in a range of Australian imagery and writings;[27] Torney suggests that being a lost child in colonial times was no more common than drowning or death by fire and that the idea of lost children in the bush hides a greater anxiety.[28] Pierce asserts that it is about Anglo-Australian adult anxieties of what they perceived as a hostile and indifferent environment and their feelings of alienation within the Australian bush.[29]

The prints, then, are not simply three prints within an empty space. They assert an emphasis on European settler history and the claiming and clearing of Aboriginal land and erasure of Aboriginal sovereignty. They act as markers, centring white power within the building and making Indigenous women visiting 'non-locals' or 'strangers,' allocated the use

of the 'back room' along with Indigenous men and children. Within this foyer, colonial power is inscribed and conveyed to Indigenous women without a word even being said. It is an extremely political space which reflects expressions of cultural memory, belonging, identity and citizenship.[30]

The Indigenous Health Program was established within the new premises to be part of the full selection of programs offered under the unitary banner of primary and public health, yet it became a site which manifested a form of social exclusion. By having to ask a non-Indigenous person to enter the area named Indigenous health, non-Indigenous people were placed in a position of domination and Indigenous people in a position of subordination. Non-Indigenous people were positioned as the owners of the place in much the same way as they control who has citizenship and who has the right to grant citizenship. Indigenous re-engagement with the site has then been mediated via a form of surveillance and cultural guardianship at the main entry and exit of the building. There is an irony here in that while Queensland Health was trying to bring everyone together within the one building (place), the symbolic representation and configuration of the front reception desk, the paintings and the Indigenous Health Program 'out the back' (spaces) were underwritten by the on-going colonial stories of the settlers who made the nation and the negation of the sovereign rights of the Indigenous population.

In this way, Indigenous peoples and Indigenous sovereignty are suppressed and white Australians are able to exercise racialised power and their possessiveness of place.[31] Furthermore, the possessiveness and whiteness exercised is productive in that it constitutes both the white and the Indigenous subject within the place and space. Moreton-Robinson contends that possessiveness is 'predicated on the taking of other peoples' lands and resources for the benefit of Empire'.[32] This exercising of possessiveness commenced with Britain taking possession of Australia and hasn't stopped. In exercising white possessiveness within health environments a range of other behaviours and emotions are demonstrated. For example, it might result in Indigenous resistance via reluctance to access or participate in the services and for the place to be clearly identified as a white place or space. A

number of the women interviewed clearly stated that as a result of the move into the new building they ceased to go to the Indigenous Health Program and that they were aware that there was a large reduction in the number accessing the Indigenous Health Program.

This was not about transport to the new premises as transport is available to clients though the program. The 'drop off' could be attributed to a form of resistance to the epistemological position of the Department about how Indigenous people should access their health service through the new building, to the exercising of white possession and to the reproduction and affirmation of Indigenous dispossession.[33] A decision was made at a later date by the Rockhampton Health Service District that the old Indigenous Health Program premises in Phillip Street would be renovated and that the program would move back where it became 'business as usual'. Indigenous people did need to go to the new premises in Bolsover Street for some of the other community and public health programs. The program still operates from the Phillip Street address today and while the buildings there are accessed by Indigenous people they are still owned by Queensland Health. From this perspective, Indigenous sovereignty is still denied. The McCubbin paintings, while now faded from sunlight, still hang in the building foyer facing the entry.

One of the women discussed the new Community and Public Health building along with the other new buildings being built in the hospital grounds and in the region. She stated: 'It's no good putting up big buildings, I'd rather go to Amy's tin shed.' The tin shed was the site of the Bidgerdii Aboriginal and Torres Strait Islander Community Health Service's premises prior to September 2000. At that time the service operated from a renovated tin shed attached to the rear of a legal business opposite the new Community and Public Health building. 'Amy' refers to Amy Lester who was the chief executive officer of Bidgerdii, a community-controlled, not-for-profit Aboriginal and Torres Strait Islander health service. It is operated by an Indigenous board of directors, an Indigenous chief executive officer and where possible it employs qualified Indigenous staff.

It became very apparent during the interviews that the Indigenous women felt comfortable accessing the 'tin shed'/ Bidgerdii and they articulated that their needs as Indigenous women were not only discussed but considered and included. It was obvious that there was a sense of belonging to Bidgerdii and that there were connections to the people and place where Bidgerdii delivered its health services. In that one woman naming it 'Amy's tin shed', she also demonstrates an act of protest against white domination over what kind of health services Indigenous peoples 'should have'.[34] In members of the Indigenous community finding what was a storage shed and gaining planning, landlord and funding approval to renovate it to develop and deliver a health service demonstrates incredible drive to shape and plan a site of belonging and attachment by and for Indigenous people. Furthermore, it demonstrates their capacity to develop a place to root identity and to ensure regulation of their environments within the development delivery and accessing of health services.[35] Dixon and Durrheim explain that people are 'agents who are able to appropriate physical contexts in order to create, here, a space of attachment and rootedness, a space of being'.[36]

What was clearly demonstrated in the interviews was the degree to which spaces and places can be recognised as culturally specific and gender-specific and as non-Indigenous. That is, places and spaces can be seen as broader community places and spaces and as women's places and spaces, but not inclusive of Indigenous women. They can also be seen as Indigenous places and spaces or non-Indigenous places and spaces. Soja cautioned against seeing and treating places as depoliticised arenas in which people live and act.[37] Women's services are predominately operated in Australia by non-Indigenous women and—unless they are aware of the complexity of the interrelationships between women and the spaces and places they occupy[38]—then they may be ignorant of the way their services and the spaces and places their services occupy can be privileging to themselves and disadvantage other women. Women interpret, represent, and produce and reproduce space within places and in this way women's spaces and places can be additional sites of social struggle and contested realms of identity even while proclaiming to be

'women friendly'.[39]

Women's places and spaces may continue to constrain and oppress and disempower Indigenous women, rather than improving health and wellbeing or empowering Indigenous women. In discussing her sense of place and space, one of the women was quite particular about her overall needs and her woman's health needs. She was uncomfortable about accessing the Rockhampton Women's Health Centre due to the feelings within the place and the spaces within the centre. Her feelings of discomfort were around not having a connection with the place as a place for Indigenous women. Other women also expressed discomfort with the Women's Health Centre. For example, one woman commented that it was 'culturally uncomfortable'. Several Indigenous women highlighted that the Women's Health Centre was obviously a place for women, but for 'white women'. The natural order of the place is as a location for white women and as a site of belonging and attachment for white women.[40] This is evident in the voice of one Aboriginal woman who explains that:

> it's not an Indigenous woman's space, the design of the space. It is a totally white designed space. There is nothing that identifies me to that place. I just won't go there as a client because I don't feel they cater for me as a black woman.

This woman did not get a sense of belonging, nor does she have any sense of identification or connection with the place as an Aboriginal woman. She came back to the point later when she was discussing notions of place. In reference to the Women's Health Centre, she said that:

> there was no Aboriginality around the place, I didn't see black people, I didn't see black workers, I didn't see any posters either ... that kind of says its not a place for me, maybe that's an assumption but all of the things ... that's how I gauge whether it wants me to be part of its centre or if I'm just going to be sitting on the fringes as I have done all my life.

This particular woman's expression of whether she feels included or not as part of the core is evident. The identity, meaning and power are constructed and bound within the Women's Centre space and place in a way that does not create this for her. She and other women saw the centre as a racialised place to which they had no sense of belonging or attachment. There are clearly practices and structures operating which enact forms of social inclusion and exclusion despite the claims that the centre is for women in Rockhampton. The services being offered from the centre are also given full legitimacy as women-centred services, thus re-centring white ways of offering women's services, white ways of womanhood and white ways of knowing. Since there was (and still is) no specific Indigenous women's service in Rockhampton, the issue of resources attached to the Women's Health Centre and other women's services was raised several times during the interviews. It was very clearly stated that it is non-Indigenous women who are granted monies to provide services for women. The centre derives its income from both the Queensland and the Australian governments, further adding to the legitimisation of white women's ways of knowing and of being. The boundaries of womanhood are clearly defined in terms of non-Indigenous women to the exclusion of Indigenous women and resonate powerfully with the research work undertaken in the area of feminism by Aileen Moreton-Robinson.[41]

What can be ascertained is that the nature of a place, what happens there, who is present and how they work, and how the place and spaces look, feel and are interpreted and experienced impacts on whether Indigenous women physically access that place. The women interviewed who knew of the Women's Health Centre did not feel comfortable accessing it. They did not identify it as being a place that was for Indigenous women and did not use its services. Non-Indigenous women are positioned as the owners within the centre. Moreton-Robinson provides a powerful analysis of how white race privilege manifests itself through the subject position of the middle-class white woman and the dominance of ideological assumptions of womanhood. Her work offers a context as to why Indigenous women might find themselves being marginalised in such feminist identified environments

and what happens when Indigenous women attempt to highlight and address this dominance.[42] Furthermore, non-Indigenous women can only do this within the centre and on the site of the centre because of the dispossession of the Darumbal people. The Rockhampton Women's Health Centre was aware that access by Indigenous women was an issue.[43] The only way this can be changed is if Indigenous women are involved in the designing, developing, production and operation of women's spaces and places and if our critiques and challenges are not marginalised by statements of 'goodwill' and 'benevolence' which mask the power differentials.[44] The next section will begin to address how such changes can be made to bring about more inclusive health places and spaces.

Including Indigenous women

I am not suggesting that there aren't any health services in Rockhampton that recognise and value indigeniety other than the Indigenous specific health service. There are several that do and they are seen as attempting to recognise Indigenous women and to value aspects of indigeniety. This kind of effort fosters greater inclusion. If there is nothing within a place that reflects Indigenous women then it can be viewed that Indigenous women are not valued and not wanted. If the place in total creates this feeling then as the women explained they will not access those services or they do so with anxiety, ill comfort or trauma.[45] The way a place is designed and the placement of furniture and the paintings, however, also need to be more than symbolic to bring about any longer term changes. Otherwise they do little more than deflect white possession and ways of knowing briefly, all the while recentring non-Indigenous power over Indigenous people.

The Indigenous women interviewed talked about a range of healthspaces and places within the geographic locality and implied that at times they felt less able, not able or too intimidated to enter those spaces and places. It was made very clear by many that if they feel that that space is not for them, they will not go there. At times, it may take a lot of courage to enter a space or place which you know has not included you in any shape or form and yet it tells you through one leaflet that it wants to provide a service for you or that it has

some program money for 'you' or 'your community' or 'your organisation' which you might be able to use. Sometimes these may operate as forms of seduction to 'get Indigenous people in' but really this offering or gift masks the truth of Indigenous poverty and dispossession and non-Indigenous privilege.[46] I know how it feels to enter a building with the feeling that I am only there in a sense to see what 'they are willing to hand out' to Indigenous people and Indigenous organisations. I and other Indigenous people hate being in the position of receivers within this benevolence process but sometimes we are left with little choice in order to bring about change or to receive services. In this way Indigenous people are often asked to concede to or fit within the dominant culture's ways of 'doing health care'. Writing about the education system in Canada, James Sakej Youngblood Henderson explains that because of the poverty and welfare consequences of not accepting education, Indigenous peoples are forced to validate the colonialists' mythology about themselves.[47] Moreover, he states: 'We are being forced to affirm alien values and to sacrifice Aboriginal worldviews and values for norms outside traditional cultural aims.' Parallels can be drawn with Indigenous peoples and health services and health systems in Australia. Having to accept the way health services are delivered or where they are delivered means Indigenous people could be affirming the dominant culture's values about their way of knowing health and their way of providing health services. As Henderson asserts, the 'penalties are high for refusing to conform to Eurocentric thought'.[48] If we don't accept health services as they are delivered then we can find ourselves in a position of extreme illness and possibly death. It is not the case, and should not be assumed, that Indigenous people are happy with health services simply because Indigenous people are using them and that we are included within those health spaces and places.

In looking at what makes Indigenous women feel good about space and place, some had concrete suggestions. One woman said: 'I like a bright happy place ... I like to see Indigenous paintings on the walls.' Indigenous-identified spaces including government agencies that are specific to Indigenous people generally have a range of Indigenous

artworks and/or posters on the walls that portray Indigenous imagery. Another woman stated in reference to places, 'make it a place that Murri women want to use it and be comfortable to use it, lay out of the place, Murri staff, not that you're the only one, liaise with Murri organisations'.[49] Another women suggested that there needed to be leaflets around, easily accessible information and posters on health issues. However, it is not as simple as laying down brochures and leaflets and putting up any old posters. As Kirk et al. found through their research with Indigenous women in the area of breast cancer, the women 'in all of the study sites (across Queensland) felt that the generic mainstream materials were not always appropriate, did not catch the attention of Indigenous women, or were not seen as relevant to them'.[51] The health education materials were criticised for not using plain English, which is imperative for people who speak English as a second or third language or people who have a limited education in Western systems. The women who were part of their study wanted to be involved with the development of educational programs.

Kirk et al. also asserted that a 'cost-effective method of developing appropriate materials would be to develop a basic format to which communities could provide input. Local education materials, such as artwork and banners, are one way of disseminating health education messages.' Care needs to be taken that the messages are not too simplistic when the information is disseminated. Just because people may have difficulty with English or with health terminology does not mean that people cannot understand issues if placed in an appropriate context. This allows for the appropriation of the new medical and health knowledge in ways that give Indigenous women more control and the ability to become masters of one more aspect of their lives. It is Indigenous women who need to be involved in the processes of working out the best way to convey messages and the contexts.

The physical layout of the place and the use of spaces needs to be discussed, planned and then implemented. The politics of places and spaces need to tabled as part of the planning process along with 'whose memory is being commemorated or ignored'.[52] This includes what goes inside as well as the physical structure of buildings. For example, one

Indigenous woman in the study made the suggestion that health personnel 'should have smaller chairs and clients should have bigger chairs', making them equal. At the present time 'most health professionals have large comfortable chairs and us clients have little seats'. She indicated this was a symbol of power before any conversation even happened about health and that it 'clearly defines who has more power than me when I enter that space'. Clinical practitioners needed to look at the layouts of their clinical rooms, the positioning of furniture, equipment and information and question themselves around the power dynamics within that designated space. They need to ask, what power dynamics are at play? Are they interfering in their communication with Indigenous women? And with Indigenous people? What could make them more accessible based on the emotions enacted from the space or place?

Four women were all very clear and articulate in their desire to see Indigenous people within the services they use, even in mainstream services. One stated she'd like:

> to see Aboriginal faces around, to know its a service that employs Aboriginal people around, to see Aboriginal people around in the waiting room accessing the service ... women's things that are displayed like pamphlets ... they are taking consideration of women's issues, sometimes it's easier to pick up something than ask.

She expressed her wish to be 'amongst other Murri people' when she accesses services. She did not wish to be segregated but to be among people of which some were also other Indigenous people. Most of the time Indigenous people find themselves in a clinic waiting room full of non-Indigenous people when visiting a mainstream health service. This again raises the issue of where Indigenous women locate themselves according to their comfort levels in being with other Indigenous women, Indigenous people or among non-Indigenous people accessing services. The additional concern is whom do Indigenous women feel most comfortable with in disclosing private information and health problems. In regards to women-specific services, the same woman

suggested that services need to be:

> looking at where Murri women gather, not coming in with a big fan fare, making links first and then coming in to work with Murri people ... working across daughters, mothers, grandmothers ... [There is a] need for women specific program still, lot of women don't want to talk about.

Government programs and organisations could incorporate a process of decision-making, planning and implementation that involved Indigenous women in the production of materials for Indigenous women. Indigenous women could utilise their own words, meanings and symbols for the services or agencies and what was available to them. This would increase visibility and meaning for Indigenous women and also recognise that Indigenous women's needs are also considered important by those agencies or services too. Indigenous women could be involved in designing the space and adding what Indigenous women see as a form of identification to place. This, of course, would need to be followed up with what happens inside the place and the spaces that operate within that place.

Conclusion

Places and space are neither innocent nor neutral. As is demonstrated in this essay they can work to marginalise, oppress or include and engage. They are instruments of the political: they are embedded with power and unwritten laws informing women whether they belong or they don't. What has been revealed through the interviews with Indigenous women are the times that Indigenous women feel included and the times when they feel excluded and that they don't belong. What can be established is that if thought, time and energy is placed into consideration of how health spaces and places are developed then they can be a successful part of the equation in servicing the health needs of Indigenous women. This requires a commitment from governments and management and staff of health services, organisations, agencies and departments to see their services more comprehensively than

they presently do. It is more than just having the service, it is also how the service is delivered and from what point the service is delivered. Ensuring Indigenous women are comfortably going to walk through the door or telephone is one step on the pathway of servicing Indigenous women. Ensuring that the environment is Indigenous friendly is a major step and yet this is the step which can be easily overlooked. In looking at what is Indigenous friendly the questions that need to be asked are: What does the health service mean by Indigenous friendly? How far will it extend? Is it Indigenous friendly according to the dominant culture's perceptions or according to local Indigenous women?

Services should also be looking out for ways that do not constrain but rather improve and empower Indigenous women. They need to be Indigenous women friendly rather than being sites where the dominant culture controls all within that environment and reinscribes the colonial stereotypes. Planners, designers and managers of health spaces and health places need to give consideration to how Indigenous women access spaces and places. Weisman explains that, 'design is a reflection of prevailing social, political and economic values and is often symbolic of the place that each individual holds in society'.[53] If Indigenous women are not part of the design process they are reflected within the social, political and economic values by their absence. It is very clear the role that memory, representations, symbols and images have in showcasing who is of value and who is not. As we have understood from the Indigenous women who participated in this research, the buildings may end up looking beautiful, have all the latest equipment and room for staff and clients but are in fact highly unsuitable and unwelcoming for certain groups, including Indigenous women. This ultimately impacts on and maintains the poor health status of Indigenous women in Australia and hinders improvements to their health and wellbeing.

Notes

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