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# Promoting the Health of Aboriginal and Torres Strait Island communities

**Case studies and principles  
of good practice**

**December 1996**

National Health and Medical Research Council

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**NHMRC**

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ISBN 0642272239

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Publication approval number: 2087

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Publications Production Unit (Public Affairs, Parliamentary and Access Branch)  
Commonwealth Department of Health and Family Services

Produced by the Australian Government Publishing Service

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This report was prepared on behalf of the Health Advancement Standing Committee of the National Health and Medical Research Council.

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# Introduction

During 1996 the National Health and Medical Research Council's Health Advancement Standing Committee undertook a review of infrastructure supports for Indigenous health promotion in Australia. A nation-wide consultation was conducted with Aboriginal and Torres Strait Islander health workers, health administrators from both government and community controlled health services. A report was prepared recommending actions to improve Australia's capacity to promote the health of Indigenous Australians.

The review found that the history of colonisation of Aboriginal people and Torres Strait Island people was continually identified as being the single most important factor contributing to the poor health status of Australia's Indigenous people today. Colonisation 208 years ago disrupted traditional Aboriginal lifestyles and continues to affect their health, today.

In most instances, colonisation took away not just the land, the soul, the identity, the language and the spirituality of Australia's Indigenous people, but it also took away the children, broke down family networks and left many people with no alternative than to be embraced by grief, left feeling broken hearted, often welfare dependent and suffering from socioeconomic disadvantage. This resulted in Aboriginal people and Torres Strait Island people finding it difficult to make meaning of the "white" way of doing things.

Many Indigenous children were stolen during the era of the "stolen generation" and adopted by non-Indigenous people. This was done with no thought given to teaching the children about their heritage or their cultural background. These same children from a past era, who are now adults, are left feeling displaced, continually trying to trace close family today, with many who search in vain. In many cases, the effects of alcoholism and drug abuse can be directly attributed to the damage caused by the racist policies and practices of these past oppressive and discriminative eras, where drug and alcohol abuse can be linked to the loss of one's children. These substances are repeatedly used to dull the experience of grief and loss and to numb the lingering pain of losing contact with the land and/or one's family.

Not only are Aboriginal Australians today still denied their heritage, their culture, their language and their spirituality, they are very often not allowed to make decisions that determine their own future. No formal recognition of grief and loss has been established and rarely is there any culturally effective or culturally sensitive counselling recognised or made available. Many non-Indigenous people fail to believe that these occurrences happened and in some cases have even stated that they believe Aboriginal people and Torres Strait Island people fabricated these stories, despite their having been formally documented.

Without acknowledgment from non-Indigenous people that these events did happen and that they do relate the poor health status of Aboriginal people and Torres Strait Island people today, many of Australia's Indigenous people will be unable to move forward.

Another of the consequences of the history of colonisation of Aboriginal people and Torres Strait Island people and their current social, economic, and physical living conditions has been a high rate of disease, with rates of death from both infectious and chronic conditions being much higher among Indigenous Australians than among the rest of the population.

In the course of conducting the review, the Project Coordinator, Ms Sandra Angus, identified many, many projects that were being conducted in and with Aboriginal and Torres Strait Island communities to promote health. It was widely agreed, however, that there is little knowledge about these positive programs outside the individual communities involved. It was decided that, as a component of the review, a book of case studies would be prepared, to highlight the range of positive actions that are occurring and to identify some principles to guide good practice.

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1. National Health and Medical Research Council. *Promoting the health of Indigenous Australians: a review of infrastructure support for Aboriginal and Torres Strait Islander health advancement*. Canberra: National Health and Medical Research Council, 1996.

The case studies that have been included in this document were selected from many possibilities. The following criteria were used to select the cases. The cases, therefore:

1. represent action in different States and Territories;
2. focus on different health issues;
3. have been implemented over sufficient time for outcomes to be achieved; and
4. have been evaluated and achievements identified.

These are by no means the only examples of good practice around Australia. It is hoped that a similar volume can be published annually.

The cases presented in this document are the work of large numbers of people in Aboriginal and Islander communities. Without the vision, commitment and persistence of many people such successful actions would not have been possible. In addition, thanks to Ms Marilyn Wise for her assistance, support and encouragement in preparing *all* the case studies presented in this document.

Ms Sandy Angus  
Project Coordinator  
Review of Infrastructure Support for National Health Advancement

# The Garden Kai Kai Project

## Thursday Island The Torres Strait Islands North Queensland

*Phillip Mills*  
*District Manager*  
*Thursday Island Hospital*

*Poi Pensio*  
*Manager, Public Health Unit*  
*Thursday Island Hospital*

*Billy Sailor*  
*Aboriginal Health Worker*  
*Thursday Island*

### Setting the scene

After visiting Thursday Island, it occurred to me that many people, including some Indigenous people, assume that they know what Thursday Island is like. We may have seen photographs or even known, worked or trained with some of the residents and health workers, many of whom were born in the Torres Strait and have lived there all their lives like their parents and grandparents before them. People might have even read, laughed and cried about the stories specific to the region. Perhaps during fleeting moments, people have even observed the tourists and overheard them talking about their trip to "T. I.". In addition, everybody has heard or seen what the media portrays. Statistics have been collected (some good, some bad-some useful, some not) and almost everybody has imagined what it is like to visit or live on any one of the tropical islands in the Straits.

### The environment and the health sector

Until one has been to Thursday Island, one *does not* know what the region is like. Approximately 3 500 people live on Thursday Island, 90 per cent of whom are Indigenous. Although very beautiful, the isolation in itself could make life difficult if a visitor expects all the conveniences of city life or could prove to be very dull if one is looking for the bright city lights and entertainment and does not know anyone before travelling to the island. In fact, the isolation even makes life difficult for health workers at times, when the only way to access the outer islands is by hitching a ride with the local doctor in a helicopter-albeit, an expensive exercise.

It seems that many people have the idea that it is just a matter of getting an aircraft from anywhere in Australia, flying into Thursday Island and getting a taxi to your accommodation or meeting place and then flying out the same day. One does not!

Airplanes leave for Thursday Island from Cairns, are very small and although there are daily flights, it would be almost impossible to fly in and out of Thursday Island on the same day. The first part of the trip takes just over two hours from Cairns and the airplane lands on Horn Island. After landing on Horn Island, the aircraft is met by a bus which transports the passengers from the very small airport to the bay which is about ten minutes drive away, for the second part of their journey to Thursday Island which is by ferry. The ferry trip takes about 25 minutes (on a good day). Mobile telephones can be left at the office as they *do not* function once one leaves Cairns. The walk from the jetty on Thursday Island to the main street, shops and businesses takes about 20 minutes slow walking time and there aren't always taxis waiting at the jetty.

The people of Thursday Island have a different concept of time from that of non-Indigenous people and from that of most people coming from the mainland. Shops and businesses on Thursday Island open and close when they like and sell everything from "antediluvian" goods to hardware and food.

It only takes about ten minutes to drive completely around the island which has one primary school and one high school although many high school students leave the island to attend boarding schools on the mainland.

There are three choices for accommodation including the local pub, a new resort complex and the converted medical centre which has been remodelled to cater for travellers. Not all accommodation offers telephones in each room.

The weather is hot and sticky with a tropical humidity. However, the ocean channels that surround the island, are clear blue, and refreshing breezes float in from across the seawater, which is a welcome relief for everyone. Much activity revolves around the two jetties and the channel area with ferries making crossings to some outer islands, back to Horn Island and for a two hour daily crossing back to Bamaga on the mainland which is situated at the tip of the Cape York Peninsula. Most of the local people have some sort of boat or "tinny" to get around the bay in, as there is more water than land and fishing is not only a form of work but is a favourite pastime.

Everything happens at a different pace. The people are friendly and hospitable and the island's culture is obvious with much of it intact and highly respected.

There are 25 health workers employed in the Torres Strait. All Indigenous health workers are employed by the State government but work for their community. The health workers have a clear sense of identity and most have grown up on the island. They are proud of their work and achievements with much of the work having been documented. The Director of the Torres Strait Health Service is from Thursday Island and is a respected family man. It is impressive to find that many partnerships have been formed with the non-Indigenous residents and local medical and nursing staff. There are no doctors in private practice on Thursday Island. The six non-Indigenous doctors work from the local hospital. In addition, there are two doctors located at Bamaga. There is a hospital soon to be rebuilt and upgraded and many of the nursing and medical staff work alongside skilled Indigenous health workers. Local culture is acknowledged and respected.

## Risks to good health

Like Aboriginal people on the mainland, many Torres Strait Island people have been diagnosed with health problems linked to the increased intake of westernised food and from a reduction in the amount of exercise compared with the exercise that was necessary when they were a traditional hunting and gathering society. There was an increase in the number of people on the island being diagnosed with symptoms of preventable diseases which could cause death, such as diabetes, heart disease, obesity and cancer and with other risk factors arising from eating unhealthy food and complications arising during pregnancy.

There was growing concern in the community about high rates of illness, a noticeable loss of self esteem, continuing low incomes, and the loss of pride and disruption of traditional culture. The elders, who had discontinued or deviated from hunting, gathering and eating traditional food that was plentiful in the past, could see a connection between many of these issues. The community and the health workers decided to take action. They wanted to revert to the old ways and customs of growing and eating the traditional food. However, some of the younger generation were unsure of what traditional food was, whether it could be grown again, or how to cultivate it.

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Working within a community development framework which incorporates a participation philosophy they developed a culturally effective model, which was accepted and adopted by the entire community.

## Barriers to good nutrition

Food is expensive (\$3.80 for 2 litres of milk, 98 cents for one small apple) and choice can be limited. Many people substitute dried milk powder for fresh milk. Processed food or “hot box food” is now a common choice of diet for many and although one of the local eating places did offer healthy choices when it first opened, people did not buy it. When the store began to run at a loss it became essential for the owner’s survival to offer the highly processed and unhealthy food choices in demand.

As mentioned, almost everyone who lives on Thursday Island has some kind of a boat, so their diets are supplemented with fresh seafood. Traditional food such as turtle, dugong and pork is still eaten and is supplemented by rice which has replaced traditional grass seeds. But salad, garden vegetables and fruit are expensive and difficult to keep fresh.

## The program and steps in its development

The Garden Kai Kai Project (Kai Kai being the traditional lingo for tucker or food) was established in July 1994. It addresses the nutrition needs of the community, increases their knowledge and skills, not only in gardening, but also in gathering and distributing the produce. It has also increased employment opportunities on the island. The plan is to maintain an economically viable supply of fresh food in the local community and to maintain their own culture and traditions.

Health workers listened to requests from community elders and young people for assistance in developing a project that would not only assist in improving their nutrition, but that would strengthen the traditional culture, build knowledge and skills, and improve employment.

Culturally sensitive notices of intended meetings were circulated widely throughout the community and in local island and workplace publications. Culturally sensitive venues were secured, with times advertised which fit in with other important local meetings and social gatherings.

The first of many meetings was held and some traditional food was provided as refreshments, to complement the westernised food that people had become accustomed to. It was decided that people wanted to go back to eating the healthy traditional food that was always available in the past. People rallied together, talked about their concerns and came up with an action plan to establish a market garden and claimed that they wanted to explore the possibility of growing plants as hydroponics.

Health workers discussed the issues, the findings and the collective concerns, not only with their clients, family and friends, but with non-Indigenous colleagues and members of the community. Elders and respected people were continually consulted and were kept informed. Health workers and interested members of the community continued to raise the issues at all meetings and discussed their ideas among themselves.

They sought information, support and guidance from as many sources as possible, including the Director of Health, medical and nursing staff and the local dietician, whether they were Indigenous or not.

The Health Workers needed to establish to what extent their employer (the Health Services) could support such a venture and whether the existing infrastructure could support the program. Investigations showed that while there would be continuing support with cars available for transport and small amounts of money available for tools and resources (existing people and wages, as well as equipment) and that these could possibly be ongoing, the only other money available would be for the hire of equipment when necessary, and money for the hire of venues. Wages for a full-time project officer and any other essentials were not available.

However, this was not considered to be a barrier to beginning the project. Several people worked on writing a submission and the community successfully applied for three years of funding (non-recurrent) from the Queensland Health Promotion Council, which enabled the project to begin in earnest. Billy Sailor, a young

Torres Strait Islander, has been employed in the full-time project officer's position since the funding began three years ago.

Ideas were brainstormed, tasks were listed, jobs were assigned and a working party was formed. The project was given its name. Goals, targets and outcomes were also brainstormed and listed in order of preference, need and priority.

## **The strategies**

Both female and male workers are involved and the project addresses both men's and women's business. Local statistics were used to demonstrate the need for the project and were readily accepted by the community as they were gathered and introduced back to the community, by the health workers.

Resources were developed including a t-shirt, posters and photos. The t-shirt which recognises the project, is instantly recognisable and worn with pride by the people of both Thursday Island and the outer islands.

Plants were obtained and with advice and assistance from the elders, young people were involved in planting the seedlings and tending them as they grew. Fundamental to the success of the project has been the interaction between young people and the elders.

The Health Service was able to provide resources in the form of staff time, vehicles, computer, administration assistance, transport, venues for meetings, funds for refreshments and support.

## **Outcomes: community involvement, changes in social and physical environments**

The many milestones were documented along the way, with informal get togethers and working bees, which were recorded in photos.

The Garden Kai Kai Project provides fresh traditional food to both Indigenous and non-Indigenous people living on the island. More than that, though, the project brings about new hope for improved health in the future and promotes longevity and the recognition to the elders for their 'old' roles, where storytelling was acknowledged and valued as being an important job in the community and a valuable part of any Indigenous society.

There is pride in achievement and in beautifying the community by young and old, a noticeable keen sense of identity being nurtured among the younger generation through equal involvement in the program, a growing respect shown towards the elders for their wisdom and energy and a new respect for the sharing of knowledge. There is a real sense of purpose felt by all, a boost in everyone's self-esteem, the learning of a trade with ultimately better health outcomes and fresh healthier food choices becoming regularly available at much lower prices.

All of the people who participated in all steps increased their knowledge not only about the growing of traditional food, and submission writing, but about the risk factors involved in not eating a balanced nutritional diet. The media gave the project coverage, t-shirts were then printed and worn with pride and many photos were taken of various milestones along the way.

## **Factors that contributed to the success of the program**

### **The underlying philosophy of the program**

The program was developed out of a need which was identified by the community-it was the community and the health workers who identified the need, not the non-Indigenous administrators. While the program has support and guidance from non-Indigenous administrators, it is the community and the health workers who manage the program.

## **Health worker involvement, community links and partnerships**

The role of the health workers was one of advocacy and liaison across the whole community, guidance in submission writing, and a beginning of the reorientation of health services.

The program relies on a supportive, autonomous partnership between the health workers and non-Indigenous administrators and on each individual's willingness to examine, explore and maybe even change their own attitude to another cultural system or series of beliefs.

Trust and respect between non-Indigenous and Indigenous staff was essential to make the program work. Each individual was able to explore and question decisions that were made about the running of the program. There is a meeting place half way between both cultures recognising and valuing each. All people are learning from each other.

Although the project came about initially because of the growing concern at the increase of sickness and death in the community and at the decreasing lack of available healthy culturally accepted food choices on the island, the community had clear goals and everyone was kept informed. Many members of the community volunteered as part of the many working parties. The Garden Kai Kai Project not only continued long past the early development or planning stages, but through the implementation stages and through to the first evaluation stage.

## **Better health strategies-when duplicating the wheel makes good sense**

Similar programs are being duplicated in the other islands and other areas in the Torres Strait with health workers also involving the community elders. Much of the work is being accomplished by input from voluntary workers or through the Community Development Education Program (CDEP) which is essentially Aboriginal people and Torres Strait Island people working for the dole while at the same time beautifying and improving their own community.

# HEATworks

## Kimberley Aboriginal Medical Service Western Australia

*Marie Cox  
Regional Coordinator  
Aboriginal Health Workers  
Kimberley Aboriginal Medical Service*

*Sue Laird  
National Coordinator  
HEATworks  
Kimberley Aboriginal Medical Service*

### Setting the scene-the location

The Kimberley region extends from Broome to Kununnurra on Australia's west coast. It covers 42 113 000 hectares. It has two seasons, known to locals as wet and dry. In the wet (cyclone) season, rivers often flood and communities become inaccessible by road. During this time temperatures soar to 40 degrees Celsius and above. This vast region, roughly the size of Victoria, is commonly known to the locals as desert, saltwater and freshwater country. Community people often eat the local delicacies when they are in season from the sea, rivers and land. In many remote communities the elders hold the law and culture strong.

Broome is a multicultural town with Japanese, Malay, Thursday Island, Aboriginal, Chinese and Caucasian residents. The unity of these groups is reflected in the spirit of the town during the festive season. Broome is now a tourist destination with people visiting during the months of March through to September. The town has a population of 10 500 people-the number swells during peak tourist season. During these months, food, prices rise and living can be hard for the disadvantaged.

### History and infrastructure

The Broome Regional Aboriginal Medical Service was established in 1976. The East Kimberley Aboriginal Medical Service commenced in 1983 followed by Yurra Yungi in Halls Creek. By 1986 it was decided to establish the Kimberley Aboriginal Medical Service's Council as the administrative service for the regional Aboriginal Medical Services (AMS). KAMSC is a community controlled, non-profitable, health organisation with 12 committee members and a staff of 50.

### KAMSC Health Promotion Unit HEATworks

HEATworks (Health Education and Theatre Works) Health Promotion Unit is based in Broome and works under the umbrella of KAMSC. Although there are only two permanent staff members there are 40 people on the books who work as casual employees committed to an array of health projects. The Unit began in 1989. At

that time it was thought that conventional methods of health promotion were not effective and that health promotion needed to be delivered in a primary care setting.

It is believed that visual and oral methods of communication give people a more holistic look at issues that affect their lives. The use of story telling, dance, music, song and theatre links traditional and contemporary methods of communication to pass on important health messages. This philosophy led to the birth of 'No Prejudice' in 1989. The play plants strong roots of awareness about HIV/AIDS, domestic violence, drunkenness and relationships between women and men. The play 'No Prejudice' has delivered 122 performances to 14 500 people. The team has travelled 12 000 km to perform the play and has undertaken six major tours.

During a tour of the Kimberley and Pilbara region in 1990 a documentary around the play was produced by SBS television. The film was called 'Mimi Purika' (big sickness). The following year 'No Prejudice' became known nationally, leading to a further five years of touring interstate to Aboriginal communities, schools and State prisons. The team performed at many national conferences and also delivered several workshops on the use of theatre and drama to communicate health messages. The quality of the play is reflected by its extensive media support. It was performed in the Grand Hall at Parliament House with Mimi Purika screened at the Gay Mardi Gras Film Festival in Sydney.

The Unit then designed and delivered other plays such as 'A change of heart' focusing on diabetes and hypertension, 'The Good Feeling'-a drug and alcohol play, and 'It's a Crab's Life' a self-esteem play for young people. Comic books are also produced with story boards designed by various local groups. In addition to the drama, a range of resources has been developed including a sexual assault book-"I'm the 'Boss of My Own Body'", t-shirts, brochures and posters. The t-shirt which promotes the project, is worn with pride by all of the participants of the theatre group.

By 1995 two KAMSC HEATworks team members, Sue Laird, (National Coordinator), and Marie Cox (Regional Coordinator, Aboriginal Health Worker), decided to approach the committee in regard to using theatre as a counselling tool. This idea was passed and fully endorsed, as the success of previous projects had confirmed that the method of theatre is successful. In addition, after each performance, the Moving Stories team gets together with the group's psychologist for evening debriefing sessions. Here the group discuss the day's events and examine where changes were necessary to improve the 'Moving Stories' technique and how each person was feeling after each performance.

Once approval was gained from KAMSC, HEATworks applied for the necessary funds. The newly developed project is commonly known to locals as 'Moving Stories'. It is theatre in the form of socio/psychodrama, using both the methods of Playback Theatre and Cultural Action.

The history of HEATworks reflects a multifaceted Health Promotion Unit that is creative and innovative. It is an example of the primary health care model using intersectoral links. It is a form of health promotion that is proving to be very successful with Aboriginal people. 'Moving Stories' is believed to be the first time that Aboriginal actors have worked closely with their people with the intention of offering counselling for people with health and life problems. The method of 'Moving Stories' is to allow a person to tell their own story and the actors then mirror it back. It is working well particularly in the areas of alcohol-related problems, family and community conflict, and other social issues.

There is a genuine ownership of all projects through the Kimberley Aboriginal Medical Services and with the employment of Aboriginal actors and there is enthusiastic local support and added potential for national growth. Nevertheless, this project needs to be financially supported with ongoing funding to allow growth, stability and survival.

## Evaluation

As this is the first time that theatre has been used in this way to promote the health of Aboriginal people, HEATworks staff felt that it was only appropriate to focus on process evaluation. This was done at various stages throughout the project. Community feedback, actors' responses, project shortfalls and successes were closely examined and documented.

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*Promoting the Health of Aboriginal and Torres Strait Island communities*

## Resources and partnerships

Funding is always a problem. A lot of the daily work on a project such as this is searching, writing proposals and waiting, hopefully, for the arrival of funds. Over time, the Unit has not received funding from the Western Australian Health Department's Office of Aboriginal Health. The Unit is the only non-funded AMS Health Promotion Unit in Western Australia. This is of great concern to the KAMSC Committee as other units are able to get on with the job, not having to carry the concern of trying to stay afloat.

During the lifespan of HEATworks the team has seen many changes in funding sources. Being 2 500 kms from Perth means that the Unit is very isolated and finds it difficult to keep up with the city politics that influence funding decisions. Although the team have seen funding sources come and go they still manage to struggle on.

HEATworks survives, financially, from project to project. This makes it hard to develop a long-term vision for HEATworks.

In spite of the struggle, the staff work exceptionally well together. There is no racist division with a working relationship of trust and respect for one other. There is strong organisational support from the management of the KAMSC. Those employed are the best person for the job as KAMSC focuses on quality work and equal opportunity for all. People employed are members of unions such as Actors Equity and are paid accordingly. Award wages and travel allowances can make grants costly, as touring can take up to two months or more. Such remote tours provide an effective service to all people living within the region-it is important that the real costs of reaching people in remote areas are met.

At times the team travels for 300 km or more each day and often sets up and performs at the end of it. This is arduous and dedicated work. The average Kimberley tour travels 3 000 km or more by road in two four-wheel drive vehicles and a trailer loaded with props, food, water and swags. At times staff's preschool children travel with them as time away from family can be extensive. Many tours are a challenge as the team is often confronted with small bush tracks, corrugated dusty roads, seasonal cyclones, torrential rains and flooding rivers.

## Factors that contribute to the success of the program

The Unit is mobile and travels to the people on invitation. Programs are provided within the community with the team and actors often staying the night. Community Aboriginal Health Workers are very supportive and work alongside Marie Cox to design the tours and deliver the health programs. Tours respect community commitments such as funerals and law, and the team will not enter if the time is inappropriate.

Theatre projects are sensitive to Aboriginal views of health, including the spiritual, physical, and mental well-being of the person, and acknowledging Aboriginal cultural influences. The script dialect is simple and local, using uncomplicated medical words with a public language. This breaks down the division between health services and the people. The method of theatre also targets people who have been disadvantaged and who have not had the opportunity to learn to read or write. These groups can be included to learn about ways to improve their health.

The plays travel to very remote communities and always perform to the whole community with an average of 80 per cent of the people attending, from grannies and old men down to the little ones.

There is Aboriginal ownership and control through the AMS, with meaningful Aboriginal involvement. Wherever possible, Aboriginal people are employed as stage managers, actors, child minders, musicians, cooks and drivers. Emphasis is on enabling community members to participate in health discussion and solve their own problems-they have their own answers. Here, people gain control over determining their own health.

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*NOTE: This case study was written by KAMSC with committee approval. It is imperative that a delegated KAMSC member; or another person approved by KAMS, presents this paper; as this follows the practice and philosophy of a community controlled organisation.*

# Koori Heart Health Screening Program

## Greater Murray Area Health Service New South Wales

*Gail May  
Aboriginal Health Educator  
Greater Murray Area Health Service  
NS W Health*

### Setting the scene

Albury is situated in the Murray River region on the border of New South Wales and Victoria. It is a regional city, about three hours' drive on the freeway from Melbourne and approximately eight hours' drive from Sydney.

### The environment, the population and health services

Very scenic, the town is a popular tourist destination and is the gateway to the southern snowfields and several wineries. Although the business centre is relatively small, the shops and businesses open and close at regular hours and sell most items one needs. Small aircraft fly from most major cities daily and there are many choices for accommodation. Trout fishing, skiing in the adjoining snowfields, sight-seeing and wine tasting are popular activities.

Approximately 5 500 Aboriginal people live in the region, in 22 communities varying in size from 6 to 1 500. There are 31 hospitals in the region, and two community controlled health care services-the Cummeragunja Housing and Development Aboriginal Corporation which offers a primary health care service with three staff members, and the Riverina Medical and Dental Aboriginal Corporation which employs one drug and alcohol worker and two dental assistants.

The government health services employ three Aboriginal Hospital Liaison Officers, an Aboriginal Social Health Educator (HIV/AIDS), and eight Aboriginal Health Education Officers.

### Factors that determine the health of Aboriginal people and Torres Strait Island people

Diseases of the circulatory system are the leading cause of death for both males and females with Aboriginal people experiencing over twice the non-Aboriginal rates (National Aboriginal Health Strategy). Although age-standardised death rates from cardiovascular disease declined by 19 per cent among Aboriginal males between 1985 and 1992, the risk of heart disease is great in Aboriginal communities. Rates of hospitalisation for circulatory diseases are much higher for Indigenous people than for their non-Indigenous counterparts. High rates of smoking, high levels of blood pressure, poor nutrition, overweight, and low levels of physical activity are physical risk factors that contribute to the high rates of disease and premature death.

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However, beyond the individual, physical risk factors, it is important to understand that Aboriginal health is linked to a variety of structural, environmental, political, economic, social and biological factors. It means more than the physical well-being of the individual, and refers to the social, emotional, spiritual and cultural well-being of the whole community. In view of this, action to promote health must strive to achieve the state where every individual can achieve their full potential as human beings and thus bring about the total well-being of the community.<sup>2</sup>

## The program and its development

In recognition of the need for acknowledgement of the effects of colonisation on the health of Aboriginal people today, the South West Centre for Public Health's cultural awareness program has been approved at NSW Cabinet level. This program includes three major strategies to:

1. Sensitise health services staff, including ambulance staff, to Aboriginal people's cultural needs. Each district has been requested to agree to a schedule of staff sessions based on the cultural awareness display and the accompanying cassette tape. The program explores the dreaming, the pre-history, the invasion and the subsequent destruction of an Indigenous people. It examines "Mabo" and the way ahead in partnership with all Australians;
2. Identify ways to encourage Aboriginal people to use existing community-controlled or mainstream health services; and
3. Promote the service and skills of the Aboriginal Health Education Officers to both Aboriginal communities and mainstream health service staff.

These are ongoing strategies and are in the process of development.

In addition to their work on the cultural awareness program, Aboriginal health workers have worked with the Greater Murray Area Health Services to develop clear goals to improve the health status of their people. They have worked together with community members to plan, develop, implement and evaluate programs and to obtain resources to address the issue.

The Koori Heart Health Screening Program was established out of a need to lower the incidence of heart disease. There were growing concerns in the community about a range of risk factors for heart disease including obesity, smoking, diet, exercise and alcohol and drugs.

The Aboriginal Health Education Officers working in the then, South West Region of NSW Health, initiated the project. This was done with the support of Koori communities and organisations, and of non-Indigenous Community Health staff. In 1991 Gail May became the Project Coordinator of the "Koori Heart Health Screening Project". In all, a team of five Aboriginal Health Education Officers from the South West Region worked with a smaller group of non-Indigenous Community Health staff during the first years of the project.

The issue of heart disease was selected by looking at the regional and state targets and by using local statistics from the Greater Murray Region. There had also been requests from the local community. The aim was improve awareness of the factors associated with heart disease and to reduce the risk of heart disease. The goals were determined by the Aboriginal health team in a collective decision-making strategy with community input. The program addressed both men's and women's business.

The Aboriginal health workers invited all members of the Aboriginal community in, what is now, the Greater Murray Area Health Service to attend a venue where the health workers checked people's height, weight and diet, checked blood pressure and cholesterol, carried out drug and alcohol assessments and made referrals to the doctor. People were given their results on the spot which they liked, and they were also given advice about nutrition, exercise and ways that they might reduce their risk of heart disease.

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2. *Queensland Aboriginal and Torres Strait Islander health policy 1994. Brisbane: Queensland Health, 1994.*

Aboriginal handouts were prepared for people to take if they wanted. These included posters, explanations of the screening and of actions that people could take to reduce their risk of heart disease. All written material was culturally relevant and there was no charge for the workshops. National data and local public health and community data were used by the health workers to back up the educational information. These were readily accepted by all participants.

The timing of the screening sessions was important — ensuring that they did not clash with paydays and/or shopping days or weekends. While there was no discrimination on the basis of race, “Koori friendly” venues which were usually accessed by the community were used. These included local Koori community halls, Indigenous people’s homes and Aboriginal organisations’ buildings, rather than unfamiliar venues.

Members of the Aboriginal community were introduced to non-Indigenous staff of the local health services, helping to develop a more trusting relationship between the two groups.

Management supported the program with staff time, vehicles, computer, administration assistance, transport, venues for meetings, cost of morning teas and support.

## **Outcomes**

It was evaluated regularly by making note of the participation, designing an evaluation form and by collating verbal responses.

In all, 90-100 Aboriginal people have been screened annually since the program began in 1991. This is approximately one third of the Aboriginal population living in the Murrumbidgee District. The ages of the participants varied between 18 and 80 years. Both males and females have participated in the program.

Verbal feedback from the participants has been very positive, with people finding the venues acceptable, the screening service offered by the Aboriginal health workers very helpful, and the information that they have received (written and verbal) has been found to be useful.

## **Factors that contributed to the success of the program**

Aboriginal Health Workers, the community health workers and the Aboriginal community have built up a rapport and thus trust and respect each other. The program is still operating with all resources and recurrent funding from the local Regional Health Service and is currently reaching younger people in the community.

## **For the future**

Programs which address the same issues could be further developed in other communities provided that the Aboriginal health workers and the community are involved in all stages of the project and providing the material which is developed, is allowed to be presented in a culturally effective, culturally sensitive way and owned by each particular community. The benefits would be increased information and knowledge about heart disease.

Support networks between other non-Indigenous organisations such as the National Heart Foundation could grow. Partnerships with organisations such as local food shop owners through intersectoral collaboration would be valuable.

## **Health worker involvement, community links and partnerships**

The role of the Aboriginal health workers was information sharing, advocacy and liaison across the whole community. They facilitated the development of the program by consulting with the community, by ensuring that the program was offered in culturally sensitive venues, using culturally sensitive materials. They assisted people to attend the program and provided ongoing advice and support for people wanting to adopt changes to reduce their risk of heart disease.

The health workers also provided a strong bridge between the Aboriginal people and the mainstream health services, helping to build a more trusting, respectful relationship so that Aboriginal people can have access to the health care services they need.

A regional focus was important. Members of the Koori community in the region move about frequently, and having an identifiable Koori team working on the project meant that people knew the team members and about the project no matter where in the region they were living. The community was more accepting of the project when there were more Koori workers in a regional team. With the division of the region into smaller districts and now, an Area Health Service Network, the Koori team was split up and the program was not maintained equally in each district. However, Aboriginal Health Education Officers and communities in other districts want to resume the program.

# Ngua Gundi-The Mother/Child Project

## Woorabinda Queensland

*Rhonda Dorman*  
*Aboriginal Health Worker*  
*Aboriginal Health Team*  
*Central Regional Health Authority*  
*Queensland Health*

*Shirley Perkins*  
*Clinical Nurse Consultant*  
*Central Regional Health Authority*  
*Queensland Health*

### Setting the scene

Rockhampton, on Queensland's Capricorn Coast is a region that encompasses vast geographical and climatic differences. From the wide open plains of the cattle country to the north and to the west, which includes pockets of sugar cane fields around the coast, to the seaside resorts along the east coast, the locals have a sense of pride about what the city has to offer.

Inland from Rockhampton there remains one of Queensland's first Aboriginal mission settlements, Woorabinda. Its history is steeped in colonial shame and many non-Indigenous people know nothing about Woorabinda, its residents or its development.

More than 5 100 Aboriginal people and Torres Strait Island people lived in the region in 1991. Teenagers make up 25 per cent of the Aboriginal and Torres Strait Islander population in Central Queensland. The rate of pregnancies occurring in this group is higher than the rate for the Aboriginal population of Queensland, and much higher than for the total Queensland population.

Aboriginal health teams, in partnership with non-Indigenous medical and nursing staff employed by Queensland Health in both Woorabinda and in the surrounding Rockhampton area, provide primary, secondary and tertiary health care services and education. The area the health teams must cover is vast and the needs of the various Aboriginal communities are diverse.

### The program

Ngua Gundi or The Mother/Child Project began in 1993 as an initiative of the Central Regional Health Authority of Queensland. Dr Beres Joyner carried out a review of the charts of women attending the Antenatal Clinic at Woorabinda and found that there was a noticeably low attendance of pregnant mothers. Shirley Perkins, a non-Indigenous clinical nurse consultant, and Rhonda Dorman, an Aboriginal/Islander Health

Worker then worked in partnership with the Aboriginal health workers to develop a needs assessment to investigate the reasons for the poor attendance at the antenatal clinics and to begin to reorient the health services so that the young women, in particular, would receive the health care services they needed during their pregnancies and following the birth of their babies.

## Current health status linked to history

It is only when one begins to understand and value traditional Aboriginal lifestyles and understand the devastation which underpins the grief, loss and pain inflicted by the assimilation, segregation and protection policies, that it is possible to begin to understand the way in which one might begin to address the health needs of Aboriginal people and Torres Strait Island people today. Before colonisation each Indigenous Australian had meaningful work and every job had its own importance in Aboriginal society. Today by comparison, Aboriginal people and Torres Strait Island people die, on average, many years younger than their non-Indigenous counterparts, are under-represented in the 'white' employment market and are over-represented in the corrective system.

In addition, contrary to the belief of many non-Indigenous people, one's Aboriginality is not just skin-based. It is living, believing and belonging to a complex system where kinship is the strength of the race. Aboriginal people and Torres Strait Island people have a pride in their communities which for some, extends to national membership.

## The effects of history on the health of mothers and babies

Over the period 1987-1991, the perinatal death rate for Aboriginal and Torres Strait Islander babies born to women in Central Queensland was 26.7 per 1 000 births, compared to 14.1 per 1 000 births to all women in the region. Young women made up the largest group of females in the Rockhampton Aboriginal and Torres Strait Islander community and it had been found that they were more disadvantaged than other age groups.<sup>3</sup> Over two thirds of births to Aboriginal and Torres Strait Islander mothers in 1992 were to women who were less than 20 years old. They were less likely to have thorough antenatal care and more likely to be hospitalised for complications of pregnancy, birth and the puerperium.<sup>3</sup> The babies were more likely to die and there was a high proportion of low birthweight babies.

The Aboriginal health workers working in the region, together with the Project Coordinator, discussed with women in the region their reasons for not attending the antenatal clinics during their pregnancies. They found that the isolation of Woorabinda and lack of large hospital facilities can make pregnancy difficult for some. Besides the everyday complications that can arise during any pregnancy, many Aboriginal women feared contact with the health services for several reasons.

When they had attended the antenatal clinic, many women were requested by medical/nursing staff to attend hospital in Rockhampton prior to the birth of their child. It was the fear that Rockhampton, rather than Woorabinda, would be entered as the child's birthplace on the birth certificate that was often a reason that women did not want to go to Rockhampton for health care services. One's birthright or landright is extinguished if born in another area other than one's tribal land. In addition, with most Aboriginal people remembering instances in the past when babies were removed from the natural parents solely because of ethnocentric paternalistic practices, Indigenous women can be wary or mistrusting of non-Indigenous health personnel.

The women also felt isolated when giving birth so far from their families; they were concerned about their other children, and the fact that the care they were receiving was not always healthy. They also felt alienated in the city and hospital environments and often absconded as a result.

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3. *Epidemiology and Health Information Branch, Queensland Health. Central Region information brief: Aboriginal and Torres Strait Islander Health Policy Workshop. Queensland Government Publishing Service, 1994.*

## The challenge

It was important that the program address the issue of why Indigenous mothers presented in the very late stages of pregnancy at the antenatal clinic and why they sometimes presented at the hospital when the baby was due, without having any prior clinic attendance.

It became obvious that health care needed to be delivered in ways that recognised the diverse needs of different community groups, and in ways that are culturally sensitive and culturally effective. Having recognised these needs the challenge for the Project was to design a program that would provide a support network for young Aboriginal mothers during pregnancy, and at the same time offer information/education about pregnancy, birthing, baby care, child health, parenting skills, and other information when requested.

## The risk factors

The early discussions with women in the community found that the young women did not understand that they were at risk of delivering pre-term babies, of stillbirth of their babies, complications at birth or of having a low weight baby. The health service staff found that they had not understood the reasons that the young women were not attending the antenatal clinic, and that they had not been offering sufficient support for young women during their pregnancies. Following the discussions, the Aboriginal Health Team and other services were then able to work collaboratively to reorient the health care services that would be provided to women during pregnancy.

## The program

The Project Team, working in collaboration with the women in the community developed the program. The Service aims to:

- provide quality medical and general health care for pregnant mothers and their babies;
- provide information on care and preparation for pregnancy and birth in a self-help learning environment;
- provide home assessment of the health of the pregnant mother by a midwife and accompany the mother to visit a doctor when necessary;
- assess the health of the mother and baby in the six weeks following birth;
- facilitate easier access for mothers requiring immunisation for their newborn babies;
- monitor the health, growth and development of the children, and offer information, support and referral to other health care providers as necessary;
- assist young parents in the development of their parenting skills in a self-help learning environment;
- enable the development of skills and knowledge in women offering to assist birthing mothers.

As a result of the program, antenatal services, based on a Midwifery model of care, are now offered in a clinic established in a more culturally appropriate setting. Home visiting is now carried out by the Midwife and the Aboriginal Health Worker, and education sessions are held regularly.

A pregnancy workbook and support networks of women (older women and young women) were developed to encourage the women to attend the antenatal clinic early in and regularly throughout their pregnancies. Through the network, as well, the program offers education/information and referrals when necessary. The women receive information about pregnancy, antenatal and postnatal care, immunisation, breast feeding, and baby care. In addition, through the program women have access to information and assistance in areas including contraception and family planning, sexually transmitted diseases (STDs), HIV/AIDS, domestic violence, drunkenness, sex outside marriage and broken relationships, sexual and other forms of assault, family conflict, and a range of mental health issues.

The program, like most Indigenous initiatives, does not discriminate against non-Indigenous women. Everyone is welcome regardless of race or circumstance.

## Outcomes

The Program has now been accessed by 300-400 women who have received continuity of care in a relaxed, non-threatening, friendly and culturally sensitive environment. A further 100-200 women have accessed the mother's group for informal talks on health, community awareness and other issues.

The program was evaluated approximately 18 months after it began. There was a high level of satisfaction among the women who had used the service. They reported an improved level of confidence in communicating with health professionals and hospital staff. This confidence has shown itself in the way women are using a wider range of health care services. They also stated that their knowledge of the birth process, care in pregnancy, contraception and immunisation had improved greatly.

Women are now seeking antenatal care earlier in their pregnancies and are attending more frequently than records of previous years show. This carries on into the postnatal period with mothers returning for pap smears and contraceptive advice, and accessing child health and immunisation with greater frequency.

There has been a significant increase in the number of women attending antenatal classes. They are indicating their choices more frequently and are surprising hospital staff with their understanding of medical terminology. The rate of caesarean section in women attending the program is 10 per cent while the rate for Aboriginal and Islander women at Rockhampton Base Hospital is 18 per cent. This is an indication that women are accessing antenatal care earlier and not turning up close to birth with little history of health care, thus subjecting themselves to more intervention.

The reduction in pre-term, still births and low birthweight babies is still not confirmed. There is not, yet, sufficient data from a control group outside the service to be able to make a valid comparison. More research is needed before it will be possible to substantiate this claim. Nonetheless, anecdotally, it appears that there have been reductions among the women of this community.

The records show a declining rate of admissions of Aboriginal children in the 0-5 year age group with severe health problems. The paediatrician and Department of Family Services have attributed this to the program. While there has been no real examination of the behaviour changes among mothers, there has been a substantial increase in calls to the service pertaining to the health of children, indicating that when a service is available, mothers will access it early.

The service endeavours to build trusting relationships with parents who have historically avoided government services. The service seeks out, actively, those parents who appear to be at risk. This time-consuming process in seeking to service these elusive parents who regularly refuse help is commonly rewarded by their using the service later on, indicating that they find the service non-threatening and that they are prepared to turn to it when they are in need.

The constantly increasing demand for the service is rewarding for staff and there is now a need for another worker to be employed.

The health of Indigenous people in this country needs to be addressed in a more holistic way. This project demonstrates why it is of great importance to understand why Aboriginal women fear attendance at clinics and hospitals which often have more non-Indigenous staff than Indigenous staff, or at worst, no Indigenous staff at all. One begins to witness a beginning of the reorientation of health services with programs of this nature.

This type of program gives everyone who uses it and those who link in as resource people a far wider understanding of the historical context of past policies and addresses issues that Aboriginal people are still dealing with today, and at the same time all who participate in the program (including non-Indigenous people) increase their knowledge about the risk factors associated with not accessing antenatal classes.

The program has also shown that there is a lack of accurate information pertaining to Aboriginal and Islander births. Often hospital staff assume women are not Aboriginal and do not ask. In other cases, although the women may be Caucasian, the father may be Aboriginal, but the baby is not recorded as being Aboriginal. The Ngua-Gundi-Mother-Child Project has been attempting to rectify this so that records are more accurate, but to date, has met with resistance from hospital staff.

## **Factors that influenced success**

### **Partnership between the Aboriginal and Torres Strait Island community and the health care services**

Clearly, the advancement of Aboriginal and Torres Strait Island health depends upon not only the recognition of our history and the impact that colonisation has had on the community nationally, but on the development and acceptance of more holistic, coherent, culturally effective and cohesive health care services, through which we might plan, implement and evaluate effective primary health care services that offer planned health promotion programs. There is a need to build strong, healthy partnerships between all the services and organisations that have a role in delivery of health care services and in promoting health, as it is impossible to separate issues when our health has to do with the total environment — social and physical.

For the birthing program, the community had clear goals and the Aboriginal health workers were involved in the planning, the implementation and the evaluation of the project at all stages. The project addressed a number of growing concerns in the community about the lack of culturally effective support services that were available.

The program addresses women's business although their male partners are encouraged to support their women and are given information when it is requested. For example, statistics gathered from the local community were presented and accepted, although these statistics were not gathered by Aboriginal people. Essentially female workers are involved and the project targets all women with teenagers being very keen participants.

### **Resources**

The program is well supported by management and resources that were available were: staff time, vehicles, computer, administration assistance, transport, venues for meetings, cost of refreshments and support.

The wages of a full-time midwife and a half-time Aboriginal health worker are funded by the Birthing Services Program, Queensland Health.

### **Better health strategies-when duplicating the wheel makes good sense**

Programs which address the same issues are being established in other areas of Australia. By encouraging community members to take action and by involving Aboriginal health workers, medical and nursing staff and younger members of the community, and with each group having equal input, much is gained. There is increased information and knowledge, lower incidence of birth difficulties and birth defects, sharing and support networks have grown and partnerships have been created.

The project provides new hope for improved health in the future and promotes healthy pregnancy and lifestyles. There is respect towards both Indigenous and non-Indigenous health workers for their assistance, dedication and energy and a noticeable boost in self-esteem of the participants who ultimately enjoy better health outcomes.

### **Health worker involvement, community links and partnerships**

The roles of the health workers are that of support and educators, advocacy and liaison across the whole community. Advice given by the health workers has led to the involvement of other health workers who plan to

establish similar services. The health workers have encouraged them to keep better statistics and to evaluate the program more regularly and more thoroughly.

A strong partnership has formed between non-Indigenous and Indigenous people and has continued in all stages of the program. All workers trust and respect each other's input and support each other.

The authors of this case study received Australia Day Awards in 1997 for their services to the community through this program.

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# The Aboriginal Sexual Health Program

## Greater Murray Area Health Service New South Wales

*Sue Minniecon*  
*Aboriginal Sexual Health Educator*  
*Greater Murray Area Health Service*  
*NS W Health*

### Meeting national standards by decreasing risk factors

The risk of contacting HIV/AIDS is a threat to any community but when Aboriginal people already have the worst health status of any group of Australians, the introduction of HIV/AIDS into the community is extremely threatening. Developing partnerships with non-Indigenous health workers is one strategy to counteract the likelihood of contacting the virus.

Barmah State Forest on the banks of the Murray River was the location for a unique information day called "Everybody's Business". This successful and productive meeting was the result of five years of planning and partnership between Aboriginal health workers and Aboriginal communities of Southwest NSW Health Districts and Victoria. Maria Williams, Aboriginal Health Coordinator of the then, South Western (Health) Region of NSW explained that the process of local community HIV/AIDS education began when the HIV/AIDS Coordinator, Dalton Dupuy, attended the Everybody's Business Conference in Alice Springs in 1991.

Dalton came back very enthused and motivated, with a commitment to work in Aboriginal communities on HIV/AIDS prevention/education but did not know where to begin. Maria went to the community and spoke to the elders, particularly the men, who then invited Dalton to a meeting. After this initial meeting, the elders decided that there was an immediate need for widespread community education. The elders suggested that sport was an excellent medium for health promotion so the local football team became involved. Through Health Department sponsorship they wore HIV/AIDS prevention messages on their jumpers and were educated about prevention so they could pass the message on to others.

In 1992 the first of three planned conferences was held in Leeton with over 200 Aboriginal people attending from local communities and across New South Wales. Information was shared and strategies developed. The main recommendation from all of these conferences was that the communities wanted their own Aboriginal HIV/AIDS educator. The result was the appointment of Sue Minniecon in October 1994. The whole process involved the initiative and actions of elders from three Aboriginal nations: Wiradjuri, Yorta Yorta, and Barkinji, working together and in partnership with Aboriginal health workers and the NSW Health Department.

### The program

In order to overcome barriers of time and distance, Sue Minniecon, the newly appointed Aboriginal Sexual Health Educator, organised a community education day. It was attended by community representatives, youth,

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elders and health workers who learned about the latest innovations in HIV/AIDS prevention and health promotion and who could then take the information and some initiatives back to their own communities. These culturally-appropriate programs cater for people from three years old upwards.

During the day's meeting a variety of Indigenous health promotion resources and strategies were demonstrated and displayed so that those attending could decide what would be suitable for adaptation and/or use in their own communities. Many aspects of AIDS prevention were discussed, particularly the notions of responsibility and changing behaviour patterns.

In partnership with Robyn Manzies, another employee of the Greater Murray (Health) Area, Sue Minniecon and health workers from Cummeragunja developed a series of information boards for community education. Once again, the consultation process was a vital learning tool for the community of Cummeragunja. The Boards covered issues such as STDs, Hepatitis B and C, and HIV/AIDS. The artwork was developed by the children of Cummeragunja. The boards are transportable and can be used in the class room or down by the riverbank. They have also been developed into posters and handouts.

In response to demand from the community, a series of workshops and camps has been held across the Greater Murray Area targeting different age groups. There have been other activities including a public event for World AIDS Day in memory of a man from the community who had died of AIDS and the use of a puppet show for children. The whole community is involved in each of these activities and each activity is linked with aspects of Aboriginal culture.

Sue has also coordinated five youth camps across the Greater Murray Area in the last two years. The purpose of these camps is to improve the social, physical, emotional and spiritual well-being of the participants and to enable them to provide peer education for their own communities. The camps were organised following consultation with relevant youth, community members and relevant health workers. The success of the camps has been aided by this process of listening to what the young people requested and by taking a holistic view of health.

Traditionally, sexual health was never discussed openly but educating and training our youth to deliver sexual health programs in their communities has been more successful as the community has a real sense of pride in their work and don't seem to be as embarrassed.

As Sue is the only Aboriginal Sexual Health Educator there was also a need to offer culturally appropriate training for the Aboriginal health workers and non-Indigenous staff in the Greater Murray Area. Cultural awareness workshops have also been offered to mainstream services so that they can meet the needs of Aboriginal people in a more appropriate and effective way. There has been an increase in the number of Aboriginal people who access mainstream services for sexual health services where the client's identity does not have to be disclosed. More than 900 people from hospitals, the police service, schools, and the Department of Community Services have attended the cultural awareness workshops.

## **Factors that contributed to the success of the program**

### **Better health strategies-a community development model**

The success of the program has been due to the consultation process and the development of partnerships between Aboriginal health workers, Aboriginal communities, Greater Murray Area Health Service, South West Centre for Public Health, NSW and Victorian Aboriginal Health Branches. Listening to what communities needs are regarding sexual health has been a critical part of the program's success. Offering ongoing, culturally appropriate training to Aboriginal health workers and mainstream workers, together with providing continuing support for them, has given them confidence in their work in this area.

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## Resources

The salary of the Aboriginal Sexual Health Educator and the work and training of the peer educators is paid from funding from the Infectious Diseases Branch, NSW Health. The Greater Murray Area Health Service provides vehicles, computer, administrative assistance, and venues for meetings, meeting the cost of refreshments and support. The program also received funds from the NSW Drug and Alcohol Directorate for the implementation of a range of activities.

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# Training for Aboriginal Health Workers in submission writing and project management

## Queensland University of Technology Queensland

*Beryl Meiklejohn*  
*Project Officer*  
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*Elizabeth Parker*  
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### Setting the scene and acknowledging some barriers to good health

Queensland's Aboriginal communities and Torres Strait Islander communities have infrastructures with vast differences. No two communities are alike. Each has its own language, culture, traditional food, spiritual past and other beliefs. Queensland today has many Aboriginal communities which grew out of non-Indigenous policies which were both damaging and traumatic. The ideologies underpinning these policies were racist and discriminatory and acted in paternalistic, segregationist and protectionist frameworks which were linked directly to colonisation. Each community today has specific needs and each community has a history which reflects the results of ethnocentric policies.

Without disputing that Aboriginal people and Torres Strait Island people are entitled to their history, many Indigenous people state that they are regretful that non-Indigenous Australians feel both threatened and guilty when confronted by the true account of Aboriginal Australia's oppressive and discriminatory history. It should be therefore acknowledged that the very first step towards any recompense must not be based on guilt alone. It needs to arise from recognition of the history of Indigenous Australians, followed by a tolerance of difference and endorsement of a preparedness to work together as equals, building partnerships which allow Aboriginal people and Torres Strait Island people to not only identify their own needs, but to take steps which address those needs in a community development way. This would mean developments and improvements in the infrastructure which support Aboriginal and Torres Strait Islander health advancement.

In many areas, we are beginning to see evidence of this, where Aboriginal and Torres Strait Island health teams, in partnership with other non-Indigenous medical and nursing staff provide primary, secondary and tertiary health care and health information and education to Aboriginal people and Torres Strait Island people. In many

parts of the country, Health teams cover vast areas with each member of the team usually having many roles. The needs of each community are as diverse as each community.

Aboriginal health workers and Torres Strait Island health workers are effective health educators in Aboriginal communities and Torres Strait Island communities because the health workers and the families belong to the same kinship group and have experienced the same history. Therefore health workers understand the grief, loss and pain lingering from the past. It has gradually been recognised by mainstream institutions that Indigenous health care needs to be delivered in emotive, empathic, innovative, yet culturally sensitive and culturally effective ways.

Nevertheless, although Aboriginal and Torres Strait Island health workers best understand the issues underpinning their own health status, there appeared to be a gap in skills and experience, when trying to tap into mainstream funding which enables health workers to develop programs which address health issues.

In 1994, Queensland Health recognised a need for Aboriginal and Torres Strait Island health workers to have training in submission writing and project management. Aboriginal people and Torres Strait Island people also acknowledged the need for training as one of high priority.

## The Program

The School of Public Health at Queensland University of Technology was invited to develop and conduct the training. An Aboriginal Project Officer, Ms Beryl Meiklejohn, was employed to assist Dr Elizabeth Parker to develop an educational program which was both culturally effective and culturally sensitive. Workshops were conducted to increase the submission writing skills and project management knowledge of Aboriginal and Torres Strait Island health workers using the principles of health promotion.

To ensure that the workshops addressed the needs of the health workers, a reference group was formed and a questionnaire was sent to over 100 health workers in order to identify the best methods of learning possible and to predetermine any cultural or other barriers. Based on the information gathered from the questionnaires a series of two-day workshops were developed. It also aimed to improve the participants' skills in writing funding submissions and to improve their confidence in submitting proposals for funding and to build upon the participant's knowledge about the requirements of funding bodies and about sources of funding.

Workshops recognised the diversity of languages, differences in Indigenous people's concept of time and the need for venues to be suitable to reduce cultural barriers to participation. The program addressed the specific needs of communities by feedback received from Health Workers. Workbooks were developed to use as a tool during the program and for use as a handy reference guide when working back on one's own community. The program was "hands on" experiential learning and was well accessed by Indigenous health workers and administrators from all over Queensland.

At the end of the workshop, participants were invited to submit applications for funding from the Health-Advancement Unit of Queensland Health. Proposals were addressed by the Health Advancement Unit, Queensland Health, the Aboriginal and Torres Strait Islander Health Policy Unit and the School of Public Health at Queensland University of Technology. Applications were assessed on merit. Unsuccessful applicants were given feedback and encouraged to re-submit.

## Achievements

A formal evaluation of the program is currently under-way. Nonetheless, there are useful indicators of the success of the program.

More than 120 Aboriginal and Torres Strait Islander health workers and administrators from throughout Queensland have attended workshops and the ages of participants have ranged between 17 and 60. More females than males have accessed the program, reflecting the ratio of female to male health workers employed in the health care services.

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The Aboriginal and Torres Strait Island health workers identified the health issues. However, they were uncertain as to how to access funding from the funding maze. In addition, because of the safe environment that the workshop created, health workers were able to ask the facilitator to demystify the jargon which is often seen and used on funding application formats. Learning was gained in a relaxed, non-threatening, friendly and culturally sensitive environment.

In all, 21 community group programs were funded and Indigenous communities benefited from the programs as they were identified as an issue by the community and the health workers. The funding of the programs ranged from \$800 to \$7,500. The participants were innovative, specific and varied in their program requirements and applications were received from all groups. Applications were received from men, women and young people and topics areas included nutrition, drug and alcohol, smoking, sexual health, home safety, dental health, a market garden, making choices easier. For example, cost-effective and health specific shopping and demystifying and understanding labels, human development and a program called “How to get your affairs in order”.

Specific funding was for:

- the purchase of a trailer to carry wheelchairs when taking aged people from a respite centre on bus outings (safety issues);
- the purchase of a trailer to carry lawn mowing equipment (serving a need in the community while at the same time, creating extra funds for a charity organisation);
- financing a bus trip for aged residents in care, allowing a visit of other nursing facilities (information gathering for better health promotion, safety and injury prevention strategies while at the same time filling a social need);
- producing an informational video on aerobics during pregnancy (addressing weight control, diabetes and heart disease in a non-confronting arena); and
- workshopping issues relating to domestic violence.

The participants gave excellent feedback and input which guided the development of the workshops and at the same time, evaluated the program.

## **Factors that contributed to the success of the program**

### **Funding and the vision for the future**

The community had clear ideas when it came to improving their health and Queensland Health recognised that Indigenous health workers have specific and unique needs, requiring them to be involved in the planning, the implementation and the evaluation of all projects.

An accompanying video is at present being produced which will be titled “How to get that Grant” and this educational resource will be available on campus at the Queensland University and at other community organisations.

Health workers supported each other while gaining new knowledge. The project was supported by both Queensland Health and the Queensland University of Technology with the provision of vehicles, computer support, administration assistance, cost of transport and accommodation where applicable, cost of venues for meetings and workshops, cost of refreshments, cost of producing the video and support in general.

### **Better health strategies-when duplicating the wheel makes good sense**

Programs of this nature could easily be duplicated in other Australian States. By encouraging community members to be pro-active and take action and by involving Aboriginal health workers, administrators, medical and nursing staff and members of the community from all types of organisation and of all ages and gender, each having equal input and support, much is gained.

## Health worker involvement, community links and partnerships

From the beginning, the program had an Aboriginal Project Officer working in partnership with community members, Queensland Health and the Queensland University of Technology. The health workers and administrators who attended the workshops were able to develop submissions based on the needs of their own communities. The involvement of Queensland Health meant that funding was available for suitable applications.

The Project has resulted not only in increased availability of information and knowledge, but also in understanding of the issues from all perspectives, lower incidence of emerging health issues, sharing of information, increased support networks and new partnerships.

# Control of Japanese Encephalitis

## The Torres Strait Islands North Queensland

*Phillip Mills*  
*District Manager*  
*Thursday Island Hospital*

*Poi Pensio*  
*Manager, Public Health Unit*  
*Thursday Island Hospital*

### **The reality, the environment and the risk factors**

There are 14 communities on 13 Torres Strait Islands. Although there is no reliable census data, the estimated population of the outer islands is in the region of 3 000 people and isolation can either hinder health care, or as was the circumstance in the case identified below, isolate further contagion. As always, the health workers work incessantly to overcome barriers to health and risks to community. The case study below highlights an example of the important role of Indigenous health workers where their dedication was no exception.

During 1995, an outbreak of the mosquito borne virus, Japanese Encephalitis (JE) claimed three lives in the Torres Strait Islands and a new outbreak was detected on Badu Island. In addition to death, JE can cause severe infection of the brain. A serological survey of all the Torres sector communities showed that JE activity was widespread throughout the outer islands but was not detected on Thursday Island or the northern peninsula area.

### **Better health strategies-prevention makes good sense**

A concerted effort to prevent further deaths and/or brain damage and of further outbreaks of the virus, included the implementation of many innovative strategies and extensive collaboration among many people and organisations in the Torres Strait.

The Executive Officer at Thursday Island Hospital, Phillip Mills, was responsible for coordinating the intervention in the Torres Strait. The Tropical Public Health Unit of Queensland Health, and the Commonwealth Department of Health and Family Services provided technical support and funding to develop a mosquito-control program, to educate community members about the disease and the ways it spreads, and to develop a mass vaccination program. Above all, the intervention program had to address the problem in a culturally appropriate manner.

Pigs and wading birds are important hosts of the virus and are often associated with outbreaks of JE. Unlike Malaria, it is unlikely that humans can transmit the virus. Humans are an incidental host and speculation is that the virus was carried to the area by wind blown mosquitoes or illegal importation of infected pigs from West Papua New Guinea or migrating birds from Papua New Guinea or Indonesia.

## Threats to public health-local level issues identified

Medical and nursing staff were alarmed when two deaths were confirmed to be the result of the JE virus. The health workers were informed about the risks and about the threat of further deaths to other community residents.

Subsequently, the health workers consulted with the island communities including the outer isles, informing each resident of the risks to each person who was not immunised against the virus. Each community decided to take action and encouraged all residents to be immunised.

Specific issues were:

- the local people blaming most of the problem on black magic (Pouri-pouri);
- there was a distinct lack of understanding about JE;
- until there was the first death people were reluctant to move livestock away from housing.

## The outcomes

The vaccination of the residents of the outer islands took place in December/January and a very high proportion of people were immunised. An animal monitoring system is in place. Many other strategies such as developing plans for new backyard piggeries, surveying and cleaning of drains and septics, monitoring flow of septics, treating breeding swamps with insecticides, screening of houses, monitoring rain downfalls and securing funding for environmental health workers to name just a few. In addition, action is being taken to monitor the breeding cycles of mosquitoes, pigs and other livestock.

There have been no further deaths from JE.

## Factors that contributed to the success of the program

### Intersectoral involvement to address social and physical risk factors

- A multidisciplinary meeting was held on Badu Island as part of the early response to the outbreak. The meeting discussed the “causes” of the outbreak and was able to develop a comprehensive approach that would address each of the causes of the problem.
- An intersectoral workshop was held involving
  - the Department of Primary Industries (DPI);
  - Torres Strait Regional Authority (TSRA);
  - Australian Quarantine Inspection Service (AQIS); and
  - Torres Sector Public Health Service/Tropical Public Health Unit Cairns (TPHU).

Each of these departments/organisations was able to offer both technical assistance and resources to assist in preventing the spread of the virus.

- Technical advice was obtained from the Centre for Disease Control, Atlanta, USA.
- Federal funding met the cost for the JE vaccine and Queensland Health met the cost of administration.

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## Health worker involvement, community links and resources

Other measures which the health team undertook at this time were:

- education on personal protection measures (repellents, mosquito coils, bed nets);
- outline of the vaccination program;
- two local posters and t-shirts were developed;
- information pamphlets in English and local languages about JE and vaccination consent forms;
- cooperation with the local media, radio and newspaper so the team could broadcast pertinent articles about the prevention of JE, the vaccination program and the do's and don'ts associated with the vaccination;
- the do's and don'ts were:
  - not to leave the clinic for thirty minutes after receiving the vaccine;
  - not to drink alcohol for two days after the vaccination;
  - to remain within ready access of medical care for ten days following the vaccination.

## Partnerships and teamwork

- Every outer island community has a health centre staffed by local health workers and five of the centres have resident registered nurses.
- Medical services are provided by medical practitioners from Thursday Island visiting on a two to four weekly basis.
- Two mobile teams, each vaccinating seven communities, administered the JE vaccine.
- Each team consisted of the local health workers, who were invaluable as interpreters, a doctor and at least two registered nurses.
- A nurse remained behind with each community for three days after vaccination to treat and monitor adverse reactions (although no serious adverse reactions occurred).
- Vaccine was recommended for all residents over one year of age on the outer islands unless they had proven immunity and all residents who would be living and working on the outer islands during the 1995-1996 wet season for the equivalent of 30 days or more.
- People with a past history of major allergic reaction or who were currently pregnant were advised not to have the vaccine.
- Vaccination is now routine for new residents and for children turning one year old.

Local people and health workers liaised with the community to demonstrate the need for the project.

Other resources available from management were: staff time, vehicles, computer, administration assistance, transport, venues and refreshments for meetings, support which involved community elders and respected people of high standing in the community. Much of the work was carried out by volunteers.

# The Western Australian Smoking and Health Program

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## Introduction

The health of Aboriginal people is significantly worse than that of non-Aboriginal people. A contributing factor to the poorer health status of Aboriginal people is the high prevalence of drug use, in particular, tobacco. Tobacco is a significant cause of premature mortality and morbidity in this group.

Smoking prevalence among Aboriginal people is higher than for the general Western Australian population. A 1989/90 Australian Bureau of Statistics (ABS) survey found that in Western Australia, 69 per cent of male and 42 per cent of female Aboriginal and Torres Strait Islander people smoked.<sup>4</sup> The Australian Bureau of Statistics found in 1994 that 48 per cent of Aboriginal people throughout Western Australian smoked compared with 28.2 per cent of the total WA population.<sup>5</sup>

While it is acknowledged that significant improvements are required in all aspects of Aboriginal health status in this State, reducing the prevalence of smoking among Aboriginal people is an area where great health gains can be made in terms of reduced morbidity and mortality.

The 1994 Report of the Task Force on Aboriginal Social Justice recommended the development of a comprehensive program directed specifically at reducing cigarette smoking among Aboriginal people. This recommendation was reiterated in the 1995 Report of the Task Force on Drug Abuse. To that end the Smoking and Health Program of Health Promotion Services at the Health Department of Western Australia runs the Aboriginal Smoking Project which aims to develop culturally appropriate resources and programs for Aboriginal people, and in the longer term, reduce the prevalence of smoking among the adult and youth Aboriginal populations in this State.

The primary target group is Aboriginals aged 18 to 45 years. The secondary target group is Aboriginal health workers.

## Strategies and resources

The Smoking and Health Program through the Aboriginal Smoking Project aims to raise awareness of the health effects of smoking among Aboriginal people; and to encourage Aboriginal leaders and health professionals to make the reduction of death and disease caused by smoking-caused illnesses a priority.

4. Australian Bureau of Statistics. *Western Australia's Aboriginal People-1991 Census of Population and Housing*.

5. Australian Bureau of Statistics. *National Aboriginal and Torres Strait Islander Survey 1994. Additional Supplementary Data*.

Strategies and resources produced to date include:

## 1. **Aboriginal QUIT Newsletter for Aboriginal health professionals**

To coincide with the QUIT campaign in 1994, an Aboriginal QUIT newsletter was developed targeting Aboriginal health workers. The newsletter aimed to encourage health workers who smoked to quit smoking, as well as to inform them about the health effects of smoking. At that time a high number of health workers smoked. Health workers are seen as positive role models in Aboriginal communities, and play an important role in promoting a healthy lifestyle. Consequently, the Smoking and Health Program considered it important that strategies be developed to encourage them to quit smoking and to take part in major campaigns like the QUIT campaign.

The newsletter gave information about smoking, informed health workers of the available resources and who to contact for assistance to quit. A competition was also run to encourage those health workers who smoked to try to quit. The benefits of giving up smoking were also reinforced in the newsletter.

Since the introduction of the newsletter in 1994, the prevalence of smoking among Aboriginal health workers in Western Australia has reduced. More than half the health workers in various regions have quit (based on anecdotal information). This is extremely encouraging considering the amount of pressure and stress that these people work under. Many Aboriginal health workers say that they smoke because they feel it helps them to cope with difficult situations at work and in their everyday life. Offering encouragement and support to health workers is a positive step towards their quitting smoking; and encourages confidence in their ability to help others in the community who want to quit too.

## 2. **Aboriginal Quit radio advertisements for Aboriginal adults**

Another strategy initiated by the Smoking and Health Program has been the production of Quit radio advertisements targeting Aboriginal adults. These advertisements feature Aboriginal actors and use humour to convey their message. This was a first attempt at delivering a Quit message to Aboriginal people using a mass media strategy. This strategy has become a core component of the Quit campaign, and is seen as an effective means of delivering the Quit message to Aboriginal people, and for promoting a quit attempt.

The radio advertisements are aired over a three-week period during the Quit campaign, which begins in the last week of May and runs into the first two weeks of June each year. This coincides with World No Tobacco Day on 31 May, which is also promoted as Quit Day and a focus for planning a quit attempt. The advertisements are aired on regional stations throughout Western Australia and on commercial radio stations in the Perth metropolitan area. The advertisements convey to Aboriginal people the benefits of giving up smoking and tips on how to stay a non-smoker. The radio advertisements aim to raise awareness of the health risks associated with smoking in Aboriginal communities.

In 1994, the response to these radio advertisements was positive and encouraging. The advertisements even generated their own publicity with coverage on a number of media outlets including press, radio and regional television.

## **Aboriginal youth**

The Smoking and Health Program has also targeted Aboriginal youth to reduce the prevalence of smoking among this population group. Figures from the 1994 National Aboriginal and Torres Strait Islander Youth Survey indicated that almost half (48 per cent) of Aboriginal youth (aged 15-24 years) are smokers. In Western Australia the average percentage of Aboriginal youth who smoke is 53.9 per cent compared to the national average of 48 per cent. This is of considerable concern.

Youth strategies developed to date include a competition to promote non-smoking messages and the use of young positive Aboriginal role models to help educate youth in schools and the community about the benefits of not smoking. Another strategy has been the production of posters depicting young Aboriginal non-smoking

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role models. These were produced to promote a healthy lifestyle among Aboriginal youth. Aboriginal role models were chosen from a variety of sports popular among Aboriginal people. The role models also represented different regions in Western Australia so that young Aboriginal people from different communities could relate more immediately to them. The posters were used to encourage young people to remain non-smokers and to be positive role models for others in their communities.

### **Aboriginal sport star swap cards**

Another initiative of the Health Department of Western Australia's Smoking and Health program has been the creation of Aboriginal Sport Star Swap Cards. Capitalising on the craze in swap cards the cards promote a health message by using young, positive Aboriginal role models. The Aboriginal Swap Cards were an Australian first and are proving to be an effective way of promoting better health among Aboriginal youth in Western Australia.

### **Aboriginal non-smoking training manual**

The production of a non-smoking resource manual for Aboriginal health workers has been the most satisfying project to date, and represents the culmination of nearly three years' work. The Gnummari Wa Non-Smoking Manual was a collaborative project involving the Health Department of Western Australia's Health Promotion Services, the Perth Aboriginal Medical Service, the Marr Mooditj Health Worker Training College and metropolitan Aboriginal health workers from Community Health.

The manual was produced for Noongar Aboriginal health workers in the southern region of Western Australia and in the Perth metropolitan region. However, it can be adapted so it is culturally appropriate to other Aboriginal groups which exist in Western Australia. It is an invaluable resource which informs health workers about smoking and its health effects, the benefits of quitting, who to contact for assistance in quitting, raises awareness of smoking issues and highlights the high prevalence of smoking by Aboriginal people in Western Australia.

The Smoking and Health Program regularly conducts workshops with Aboriginal health workers to explain and encourage the use of the manual. Workshops are being conducted throughout the State.

### **Support for national programs**

The Aboriginal Smoking Project also supports national initiatives through membership of the Working Party on Indigenous Tobacco Control Initiatives set up at the National Tobacco Control Summit held in April 1995; and through submissions on Indigenous tobacco control initiatives to the Health Australia Review.

### **Evaluation**

Evaluation of the Gnummari Wa workshops and the Aboriginal Quit radio advertisements has been conducted. There has been a positive response to the Gnummari Wa workshops. It has been difficult, however, to evaluate the success of the radio advertisements because of a poor response rate to the survey questionnaire.

Evaluation reports on the Gnummari Wa workshops are completed by all participants at the conclusion of each workshop. This enables immediate and comprehensive feedback on the content and presentation of the workshops. Participants have found them to be informative and relevant and have felt encouraged in their own quit attempts.

Questionnaires on the radio advertisements were sent out with instructions to Aboriginal health workers to complete them. Unfortunately, the response to the mail outs and follow-up calls has been poor. As a consequence, evaluation of the radio advertisements is based largely on anecdotal feedback.

This experience, however, has highlighted the need for personal approaches in the evaluation of strategies involving Aboriginal health workers.

## Conclusion

Tobacco is a major cause of premature death and illness for Aboriginal people. However, it will only be through the concerted and combined efforts of Aboriginal and non-Aboriginal health agencies and Aboriginal leaders that significant improvement to Aboriginal health will be achieved.

While the high prevalence of smoking among Aboriginal people represents a challenge to the Smoking and Health Program, and other key health agencies in this State, we continue to look for ways of working together and with Aboriginal communities to address this issue.

## Acknowledgements

The authors wish to acknowledge the assistance of Claire Thompson (research) and Perin Wood (editorial) in the preparation of this article for publication.

# The Gubba Binbee nGoodjida Inda Diabetes and Nutrition Project

## Rockhampton Queensland

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### Setting the scene

Rockhampton is situated approximately 38 kms inland from the Capricorn coast. Although Rockhampton is a city its location means that it is remote from other major centres. It has a population of 66 000 people. The Central Regional Health Authority reported that the Indigenous population represents about 3 per cent of this population. However, the population of the Woorabinda community (1200-200) means that the Indigenous population of the Rockhampton Health District, Central Region represents 6 per cent of the total population of that district. The Rockhampton Health District, Central Region encompasses the Capricorn Coast, Woorabinda, Mount Morgan, Blackwater and all places in between.

Woorabinda is situated approximately 160 kms inland from Rockhampton. Mount Morgan is situated approximately 35 kms from Rockhampton and is serviced by the Aboriginal and Islander health teams of Rockhampton in partnership with other non-Indigenous health services. Each of the communities serviced by these teams has widely differing health needs.

The health teams from Rockhampton and Woorabinda have been working closely with their communities to provide primary and secondary health education to Aboriginal and Islander people in Rockhampton and Woorabinda. The poor health status of Aboriginal and Islander people is well known. Their socioeconomic status is a major contributing risk factor that places them at such a large health disadvantage. There are wide differences in birth weight, life expectancy, hospital admissions, rates of chronic disease and serious health problems between Indigenous and non-Indigenous Australians.

## Identifying a major health problem

Diabetes affects 30 per cent of the people in some Aboriginal and Islander communities, four times the percentage of non-Indigenous people. The prevalence of diabetes in the Central Queensland Region was 19.4 per cent (diagnosed) at the last screening carried out by Aboriginal Health Teams in 1991/92. More than 90 per cent of the people screened were at higher than average risk of heart disease too.

Diabetes has a devastating impact on the health and lives of Aboriginal and Islander people and their communities with high rates of complications often leading to premature death. The disease affects the Aboriginal and Islander populations at much younger ages than the non-Indigenous population.

Before white settlement, however, the diets and lifestyles of Aboriginal and Islander people meant that they were in excellent health. Preventing the onset of diabetes, and/or preventing the development of complications of diabetes means working within an Aboriginal and Islander definition of health-life is health is life. All aspects of people's and communities' lives must be addressed if health is to improve.

The prevention and management of diabetes among the Aboriginal and Islander populations, therefore, mean that the health services needed must be culturally appropriate and acceptable to Aboriginal and Islander peoples.

## The environment and barriers to good health

The socioeconomic status of Aboriginal and Islander people places them at a disadvantage both in terms of their living environments and their health. There are enormous pressures associated with everyday living, with social, political, emotional, and mental health problems as well as the problems associated with physical illness. Some people have so many problems that they feel overwhelmed and do not know where to start or what options they have to solve the problems. Because Aboriginal people and Islander people do not see their health as a priority they tend not to ask for help until they are faced with a crisis.

In the case of diabetes, this increases the likelihood of complications and, as pointed out earlier, the rates of complications and premature death from diabetes are very high. Many Aboriginal and Islander people associate hospitals and medical attention with death, thus deterring them from attending mainstream health care services.

However, it is also the case that many Aboriginal and Islander people in rural and remote areas do not have access to any specialised health care services for diabetes or its complications. Even when mainstream services are available however, many Aboriginal and Islander people are reluctant to use them for fear of being judged and criticised. And many health professionals believe that the changes (in lifestyle) that are necessary to manage diabetes are too difficult for Aboriginal and Islander people and therefore, avoid giving advice and support to their Aboriginal and Islander patients. As a result, many Aboriginal and Islander people avoid attending services until they have already developed serious complications.

Finally, Aboriginal people and Islander people living in Woorabinda and Mount Morgan must travel to Rockhampton in order to receive specialist care for their diabetes.

## Meeting national standards by reducing risk

The National Action Plan-Diabetes to the year 2000 and beyond<sup>6</sup> identified Aboriginal and Islander people as populations with specific needs and requiring particular attention in order to prevent and control non-insulin-dependent diabetes (NIDDM). This placed the needs of Aboriginal and Islander people on the national agenda and highlighted them as a priority target group.

The plan included the goal to reduce the prevalence of NIDDM in Aboriginal and Torres Strait Islander populations.

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6 Nutbeam D, Thomas M, Wise M. *National Action Plan for Diabetes to the year 2000 and beyond*. Canberra: Diabetes Australia, 1993.

The recognition of national priority provided a mandate for the Gubba Binbee nGoodjida Ina Diabetes and Nutrition Program.

## The Program

The Gubba Binbee nGoodjida Ina<sup>7</sup> Diabetes and Nutrition Project began in 1993. A full-time clinical nurse consultant/diabetes educator, Teresa Hazel, and a full-time Aboriginal health worker, Nicole Seaby, had worked closely together previously to develop a pilot program entitled 'Diabetes and Nutrition for Murri People of Central Queensland.' The pilot program aimed to:

1. influence Aboriginal and Islander people diagnosed with diabetes, and their families, to adopt lifestyle patterns consistent with the prevention and control of diabetes and diabetic complications; and
2. empower the Aboriginal and Islander health workers of Central Queensland to conduct community-based diabetes education and monitoring.

From the pilot program it was found that a Diabetes and Nutrition Program was needed. The content of the program needed to include:

- culturally appropriate education about diabetes, that helps people to understand what causes diabetes, what they need to do to manage diabetes effectively, and how they might change their lifestyles to reduce their chances of getting complications; and
- culturally appropriate educational resources that had been developed with members of the community.

The program needed to:

- be adaptable to suit individual learning styles and different needs;
- not only teach people what to do but assist them to make changes in their lifestyles;
- encourage people to establish support groups to help in making and sustaining changes in their lifestyles;
- involve key community members so that they could reinforce the learning about lifestyle changes; and
- use experiential learning activities.

The pilot program also pointed to the need for

- a positive, non-threatening, non-judgemental diabetes education service; and
- links between the program and a wide range of community activities.

It was decided that camps would be an appropriate learning environment, and that transport would be needed to enable people to attend. The camps and all other activities needed to be at times and on days that were convenient for the people to attend.

Above all, the program needed to recognise the history, cultures, languages and lives of the Aboriginal and Islander people who would attend.

The Aboriginal health worker and the clinical nurse consultant carried out a wide community consultation. Based on their findings, they developed a culturally effective education program (including a diabetes education booklet) based on an assessment of community needs. The Aboriginal health team-Rockhampton implemented the program at educational camps, and the book covered topics such as 'what is diabetes?', 'why do Murri people have a lot of diabetes in their families?', and provided advice on how to manage the disease. The book used visual learning techniques so it did not intimidate people who had reading difficulties. Clients

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7. *Gubba Binbee nGoodjida Ina* means 'you understanding good sugar' and comes from the language of the local Aboriginal tribe, Darumbal.

responded well to the book, finding it a helpful accompaniment to the education sessions. However, Aboriginal and Islander people learn best by experience so much of the education is presented in practical sessions.

As well as attending the camps, people were invited to join and encouraged to attend support groups that are held regularly. The support groups tend to be used most by women, although men are encouraged to attend.

## Outcomes

Before the establishment of the program only very limited attention had been given to promoting awareness of diabetes among Aboriginal health workers and the Aboriginal and Islander communities. Nor were any culturally appropriate services available for people at risk of or with diagnosed diabetes.

As a result of this initiative, the Aboriginal and Islander Health Service-Rockhampton now offers diabetes education in support groups, home visits and in clinical settings. The Aboriginal and Islander health workers have expressed the need for continuing education about diabetes and nutrition, building their knowledge and skills in support of the program in the community.

Rockhampton Aboriginal Health Service conducted three camps-one each for Rockhampton, Woorabinda, and Mount Morgan. The camps had a combined total of approximately 30 participants in the first year. The process evaluation has indicated a high level of satisfaction among clients, with participants expressing a desire to continue the camps and camps have since been held regularly for people from each of the three areas.

It is difficult to estimate the number of people who attended the diabetes education support groups as numbers fluctuated. However, each support group had approximately six to ten participants, and six groups were conducted in each area during the three-month pilot program. In all, 18 support groups have been conducted. Home visits were conducted regularly but were restricted by human and financial resources.

The Aboriginal and Islander people have expressed the desire to learn more about diabetes, a desire to be healthy, and the desire to be involved in all the activities because they are offered in a friendly, comfortable, and culturally-acceptable environment.

In addition, among the people who have attended the program a mean HbA<sub>1c</sub>\* of 8.5 was achieved (8.0 = good control) and the median value was 7.1. There has not been sufficient funding to establish a full-scale experimental design to evaluate the program's effects. An HbA<sub>1c</sub> machine was purchased to help participants to achieve better/normal control of their diabetes. During the pilot program the machine was used during home visits and at the support group meetings. HbA<sub>1c</sub> measurements were taken to evaluate individual clients' glycaemic control. The measures taken by the machine were shown to be an excellent way of involving clients in self management of their blood sugar levels.

## Resources

Queensland Health's New Initiatives program provided the initial funding for 16 months. The funds allowed the employment of a full-time Senior Aboriginal and Islander Health Worker and a quarter-time Clinical Nurse Consultant (Diabetes Educator). There was an additional \$2 000 for program development and implementation.

This funding was used to identify the most effective methods to improve diabetes control and nutrition in these Aboriginal and Islander communities.

Such has been the success of the program, it now has sustained funding from the Aboriginal Health Service in Rockhampton. Management and health workers provide significant support to the program.

However, above all, the Aboriginal and Islander people, themselves, have used and supported the program.

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\* Blood test which indicates degree of diabetes control.

## Factors that contributed to the success of the program

### Better health strategies

The program addressed issues of lifestyle and behaviour change as a priority to empower Aboriginal and Islander people to control diabetes and to reduce their likelihood of developing complications.

Working with communities in this way is not new to health workers. This strategy has been crucial in delivering optimal primary health care education among Aboriginal and Islander people. By recognising the importance of community members taking an active role in their own health care, in partnership with Aboriginal and Islander health workers, medical and nursing staff, a strong sense of community ownership is developed. This, in turn, means it is more likely that people can succeed in making changes in their lives, including working to ensure that the health care services they need are available.

The program has also demonstrated the importance of developing support networks within communities and between Indigenous and non-Indigenous health professionals.

### Recognising community needs

The pilot program enabled the Aboriginal Health Team-Rockhampton to identify the communities' needs and to discuss, with members of the communities, ways in which these could be met. It meant, for example, recognising the need for services to be culturally acceptable, for them to be accessible, and for the services and education to be provided in ways that supported learning and did not judge or criticise people. The pilot program then allowed the Aboriginal Health Team-Rockhampton to work with the community to develop a program and services and to check with the community whether these were acceptable and useful.

The program's success depends upon people participating. Unless the program was acceptable and accessible it would have been impossible for it to succeed. The principles of primary health care that guided the development of the program mean that it is likely to be sustainable for a long period.

### Health Worker involvement and partnership with the community

Aboriginal and Islander health workers have played key roles in the development, and implementation of the program, and hence, in its success. Their knowledge of community issues ensured that the real problems facing people in their everyday lives were considered when the program was being developed.

Their commitment and energy in promoting the program in the community and their role in educating clients and following up people in their homes greatly enhanced the effectiveness of the education and services. They continue to provide support to people who attend, and assist people to develop their knowledge and skills in preventing and managing diabetes. Without their active involvement the program could not have succeeded in achieving its aims and objectives.

In addition to being strong advocates for the program the health workers have liaised between the community, the health care service providers, and between the government and non-government organisations (Indigenous and non-Indigenous) that have important roles to play in controlling diabetes. The health workers have ensured that there has been effective communication among all the groups involved.

# What has been learned?

## some principles of good practice

The projects presented in these case studies are just some of the positive examples of action to promote the health of Indigenous communities around Australia. Many things can be learned from examining the reasons that these projects have succeeded. Much more remains to be learned about ways to improve the health of Australia's Aboriginal people and Islander people. Nonetheless, based on the experiences of the projects outlined in this volumes of case studies it is possible to identify some principles of good practice.

### Needs identified by communities

All programs were developed out of needs which were identified by the community. In some cases (e.g. the Garden Kai Kai Project) the idea came directly from community members; in others (e.g. the Ngua Gundi—Mother/Child Project; the Smoking and Health Program) the Aboriginal health workers discussed the information that was available about health issues affecting their communities with the communities. Together they decided whether the issues identified in the statistics were of concern to the community. In the case of Japanese Encephalitis, a deadly disease required urgent action.

In every case, Aboriginal or Islander health workers played key roles in working with communities to identify concerns and to establish whether people wanted to take action. Agreement to act came from within communities rather than from “above” or outside. The programs were designed or tailor-made to suit the needs and circumstances of individual communities.

### Partnerships between Indigenous health workers, communities, and non-Indigenous health workers

Each of the projects included in this document has included the development of effective working partnerships. In each case, the Aboriginal and Islander health workers have worked in partnership with their communities and in partnership with non-Indigenous health workers or organisations (e.g. Clinical Nurse Consultant in the Gubba Binbee nGoodjida Inda Diabetes and Nutrition Project; Queensland University of Technology; a range of sectors including quarantine in the Japanese Encephalitis case).

The partnerships between Indigenous and non-Indigenous health workers appear to have been particularly important in each case, with each respecting and needing the other's support, knowledge, and skills and each being willing to share these. While all programs have support and guidance from non-Indigenous administrators, it is the Aboriginal and/or Torres Strait Islander health workers or Health Teams who manage each program.

Each of these programs relies on a supportive, autonomous partnership with non-Indigenous administrators. The success of the partnerships has been based upon individuals' willingness to examine, explore and maybe even change their attitudes to another cultural belief or system. There has been obvious trust and respect between non-Indigenous and Indigenous staff and each party is able to explore and question decisions about the running of the program. That is: there is a meeting half way between both people and a recognition and valuing of each person's culture. Each party is learning from the other.

## Resources and organisational support

Each of these programs began with a grant or short-term funding, or with funding gathered from a range of sources. However, as a result of their success, each of the programs has been able to secure ongoing funding from the auspicing organisation—a community-controlled health service, government health services, or a university, for example. However, funding remains a significant problem and many of these programs are sustained at the cost of enormous strains on already tight budgets.

In almost all cases, too, the projects have received considerable “support-in-kind” including salaries, cars, and funds for tools, the production of resources, hire of equipment and venues.

## Implementation in the control of communities and Indigenous health workers

All the programs have used statistics in their development or in evaluation. However, in each case, these have been introduced and explained by the Aboriginal and/or Torres Strait Islander Health Workers. In this way, community members are able to use the figures to enhance their own understanding of the project, and/or what they have contributed to the development of the evaluation protocols.

The programs have been implemented in community settings, using locations, role models, and timing that has suited community members. Health workers have been sensitive to the history of Indigenous people—both the history of colonisation and its effects on people’s health, today—and the history of Indigenous people’s experience of mainstream institutions, including hospitals and community health settings. Non-Indigenous people have also had access to the programs even though the programs have been developed with and for Indigenous communities.

All programs have produced resources—information kits, video, media presentations, drama and theatre productions, swap cards, brochures or posters. Once again, *all* resources were produced with input from the community so that people feel a sense of ownership and each is specific to their own area.

## Outcomes

Each of the projects has identified the outcomes that have been achieved. These outcomes are not all measurable changes in mortality or morbidity (although the Japanese Encephalitis Program did halt the progress of a potentially deadly virus). And the Gubba Binbee nGoodjida Inda Diabetes and Nutrition Project has obtained initial results that are clearly linked with reduced likelihood of mortality or serious complications from diabetes.

It is critical, however, that the success of such projects not be judged only in terms of their effects on mortality and morbidity. First, none of the programs has been running for sufficient time for such significant changes to have been achievable; second, none has had enough funding to enable evaluation of outcomes at that level; third, it is critical that success be judged by communities, themselves.

These projects confirm the findings of many other health promotion interventions. That is, they confirm that a series of intermediate outcomes<sup>8</sup> must be achieved before it is possible to reduce mortality and morbidity. The outcomes achieved in these projects include all elements of the Ottawa Charter:

- changes in the ways in which health services are organised and delivered (reoriented health services);
- improvements in people’s knowledge, skills and changes in health behaviours (increased personal skills);
- changes in people’s living environments and in their collective sense of self esteem (supportive environments);
- increase in communities’ involvement in action to improve their health (community action); and
- changes in public policy.

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All programs have been evaluated in culturally effective ways but there seems to be a lot of discourse around evaluation. The projects have pointed to the growing need for funding to support the development of effective evaluation frameworks that can be used by communities and the health workers (Indigenous and non-Indigenous) to judge the “success” of their work. Such a framework has been published, recently, and represents a large step forward in this regard.<sup>9</sup>

## Sustainability

Although time was initially allocated to each project and time-management skills were obvious, in each case it has become increasingly hard for Indigenous health workers to maintain the program while juggling all the other demands of their jobs. A high level of personal commitment is required of the health workers involved in developing, implementing and maintaining projects such as these. In many cases, when the initial funding has been withdrawn, the projects have continued only because of the personal commitment of the people involved.

Experience in promoting the health of Australians in a wide range of communities has shown that, in order to bring about and sustain changes for health it is necessary to have resources (including designated staff) that are committed to promoting health. Whenever there is competition between the demands of acute care and promoting health, the acute care role always takes priority. While primary health care offers the most sustainable, effective model for providing health care services and for integrating these with action to promote health, a recent review pointed to the need for staff to have a clear mandate to work on health promotion programs, and for additional resources to be available to enable this.

The successes achieved by these projects can be sustained only with the continued allocation of resources, among which the most important is staff time.

In summary, these projects provide new hope for improved health in the future. There is pride in their achievements and a keen sense of identity being nurtured among the younger generation. There is growing respect between Indigenous and non-Indigenous team mates for their assistance, dedication and energy and a sense of purpose felt by all. In addition, there is a boost in everyone’s self-esteem, with ultimately better health outcomes for all.

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8. Nutbeam D. *Health outcomes and health promotion: defining success in health promotion. Health Promotion Journal of Australia* 1996; 6(2): 58-60.2.

9. Colin T, Garrow A. *Thinking, listening, looking, understanding and acting as you go along. Alice Springs: Council of Remote Area Nurses of Australia, Inc. 1996.*

# The National Health and Medical Research Council

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