Health Education

Health promotion for Aboriginal communities

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A culturally-orientated, community-based and community-controlled approach to health promotion has been put into effect in the Pitjantjatjara Homelands and elsewhere in subcentral Australia.

There are five key areas for action in health promotion, especially in developing countries: strengthening the skills of the individual; strengthening community action; creating supportive environments; building public health policies; and reorientating health services (1). In the remote Aboriginal communities of the Pitjantjatjara Homelands (2) in central Australia a comprehensive approach to health promotion addressing all these elements was developed in 1988, focusing initially on the prevention of AIDS and subsequently encompassing a broad range of problems. Formerly, public health education programmes were not very successful: educators were not Aboriginal or were not trained in health promotion, and messages were often delivered in culturally inappropriate terms.

Strategies

Traditional media, Aboriginal local community health educators, and videos were used at regional level through focus groups involving a consortium of all the major health services providing care to the communities. At the local level, both formal and informal community meetings, not always with the participation of health staff, identified specific strategies that would allow certain subgroups to be reached. In addition to the objective of preventing the introduction and transmission of human immunodeficiency virus in target communities and groups, the programme aimed to link education on AIDS with that relating to other sexually transmitted diseases, to develop culturally appropriate messages and media, and to make the development of community-based educators a priority (see box on p. 26).

The male elders were particularly concerned to preserve the traditional law and practices of their community, and requested a series of restricted meetings on AIDS and the law, to be facilitated by a senior male elder and the most senior male doctor available. The conduct of secret ceremonies was modified in order to diminish the possibility of transmission.

For adult men and women, single-sex meetings were conducted by trained Aboriginal community-based educators, with or without the help of non-Aboriginal health staff in accordance with the wishes of the population.
Women's groups organized their own ceremonies as well as meetings on AIDS facilitated by female health workers.

The Aboriginal community health educators were local health workers or other community members who had been trained during workshop sessions led by Aboriginals with a basic knowledge of AIDS transmission. In addition to learning the essential facts, the participants were shown how to discuss them in relation to matters of vital interest to Aboriginal people, namely the preservation of the law, the land and the family. They were also taught how to express their messages in the form of Aboriginal dot paintings, the best of which were mass-produced as posters.

In Aboriginal society, much education takes place during informal discussion among small groups of people (3). Against this background, community educators selected by family groups can clearly play an important role.

In order to reach the youth, torn more than other groups between Western and traditional culture, special health educators were selected by their communities or by the young people themselves. Songs and videos were used, featuring both Aboriginal bands and preventive messages developed at regional level in association with the other Aboriginal health services.

The youth in remote communities, affected by unemployment, boredom and the breakdown of traditional family ties, were particularly given to promiscuous sexual behaviour and petrol-sniffing. In response, activities were undertaken by community councils, church groups, schools and the health services with a view to creating a healthier emotional environment for young people. Youth workers were employed, discos and church rallies were organized, and efforts were made to strengthen family groupings, employ young people in local industries and involve them in traditional hunting and ceremonial practices.
Non-Aboriginals were reached through meetings with local nurses and doctors and through Western-type videos. So as to counter misinformation, panic and prejudice generated by certain categories of people, notably missionaries, young schoolteachers on short-term contracts, community advisers and itinerant tradesmen, repeated efforts were made to disseminate basic information in a suitable form.

Access to counselling on sex-related matters was made easier by providing separate men's and women's rooms in all health clinics. In a few clinics an expressed wish for confidentiality was met by installing a buzzer system. It was agreed to make condoms available at no charge, both in the counselling rooms and also from health workers who could be contacted at any time. Outreach patrols were given the task of taking health education to remote locations.

The Pitjantjatjara Council and the local community councils helped to strengthen public health policy. Certain established rules were supportive, for instance those banning alcohol in the Homelands and controlling the entry of non-Aboriginals. The councils were kept fully informed about programme activities, antibody screening, the monitoring of the activities of non-Aboriginal minors, and other matters. Discussions were held on the likely health benefits of a projected high school in the Homelands and of improved prospects for youth employment locally. In Alice Springs the Pitjantjatjara Council worked with Aboriginal communities to encourage healthy youth entertainment and the control of alcohol.

**Moving ahead**

The evaluation of messages and materials was better achieved by convening small focus groups than by issuing individual questionnaires; that of the organization and implementation of training workshops involved feedback from participants and facilitators, and led to the introduction of modifications. Feedback was also obtained from health workers, who reported people's views and misunderstandings. Condom distribution and venereal disease levels were also monitored, high-risk groups being screened for HIV.

Although non-Aboriginal facilitators left the programme, AIDS promotion continued informally in accordance with local custom. More formal meetings were occasionally held when local Aboriginal community educators felt them to be necessary. In the long term, the prevention of AIDS clearly depends on the building of an environment in which the healthy choice is the easy one.

After the community health educators had demonstrated their competence during their initial rounds of providing AIDS-related education, workshops were held with a view to widening their skills to include the use of traditional painting styles in the promotion of the treatment of pneumonia and gastroenteritis, the prevention of diabetes, the importance of sanitation, and other matters. The Nganampa Health Council, covering the entire area of the Pitjantjatjara Homelands, undertook a comprehensive programme to improve the environment, and certain community health educators became active in this field. Culturally appropriate community education techniques were incorporated into the Aboriginal health workers’ formal curriculum.
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References

Why young girls start smoking
The process of becoming a smoker is complex, and is intrinsically linked to social and individual motivations. Most young people try smoking for several reasons, including: stimulation and challenge (rebellion against parents or society, curiosity, excitement); to create an identity and satisfy need for self-esteem – to feel good, appear more adult and sophisticated, and look better; and to belong to a group, to be approved and accepted by friends who smoke and to avoid peer group disapproval or rejection. Many young girls also regard smoking as a way of keeping slim.

Furthermore, adolescence is often a period of rebellion and smoking is one of the risk-taking behaviours that may appeal to young girls. Smoking is often associated with alcohol and drug use as well as sexual activity in female teenagers. While these behaviours are frequently concurrent, the motivating factors can be diverse and depend on the environment.