In this section, we draw on practical examples and suggestions, primarily those discussed at the ‘Information for Action’ workshop, about how health professionals can encourage people to take a more active role in their health. These recommendations address the difficulty of putting ‘prevention’ messages into action. For example, some people are less likely to engage in health promotion and are less health conscious than others, or do not seek health advice or utilise services because they do not want others to know that they are unwell.

Heart health promotion should occur throughout life, and include pregnant women and children. Starting early in life is particularly important with Aboriginal people because heart disease generally affects them when they are much younger than other Australians. This requires substantially more collaboration between sectors.

The key considerations for successful health promotion and services with individuals, families and communities that emerged from participants’ responses include:

a. Community engagement  
b. Location of program/project/service  
c. Presentation of messages  
d. Content of messages

These considerations for good practice in health promotion and care require good organisational support to overcome practical challenges. They are discussed in more detail below.

a. Community engagement

Engaging and consulting with the community is fundamental, from the early stages of program development through to its evaluation. Consultation facilitates implementation and leads to community ownership and involvement. By this means, health providers understand better what works—and what does not—in health promotion and care. Health providers are thereby up-skilled, and the programs they deliver benefit from community support. Community ownership of programs builds community capacity, improves community awareness of health promotion and increases confidence in passing on information to others. Establishing good relationships with families and the community assists in disseminating information about programs and messages through word of mouth, in particular when ‘champions’ (often elders) who help disseminate information are identified. A good example of this is the District Aboriginal Health Action Groups (DAHAGs) in the Perth South Metro area, which played a key role in facilitating changes to services and programs. (See case study [Box 12])

Key messages

- Ensure effective community engagement to develop appropriate ways of promoting health.
- Consider delivery (where, how, with whom) as well as content when delivering health messages.
- Organisations must provide adequate funding and logistical support to people delivering health services.
South Metropolitan Health Service Community Engagement Process

The Public Health Unit at the South Metropolitan Health Service (SMHS) was able to enhance its engagement with the Aboriginal community by promoting the active involvement of Aboriginal people in their healthcare, with funding from the Council of Australian Governments’ (COAG) Closing the Gap initiative. Despite a national legacy of mistrust and broken promises about improving healthcare to Aboriginal people, the SMHS team’s innovative approach to engaging the community focused on strengthening existing relationships and building the community’s trust. A transparent communication process where information was shared, reviewed, fed back and discussed at meetings with a view to improving practice facilitated this process—an approach that continues today. The team’s vision also included the Aboriginal community leading the process of change and working in partnership with mainstream services and organisations including hospital services, local government and non-government organisations.

Each of the five districts in the SMHS area formed a District Aboriginal Health Action Group (DAHAG) consisting of community representatives nominated from the Aboriginal community and representatives from health services and agencies. DAHAG meetings were held quarterly, chaired by an Aboriginal representative elected by the community. The goal of DAHAGs was for health services, government and other stakeholders to commit to working in partnership with Aboriginal organisations and communities, to avoid tokenism and instead to move beyond talk to action. This required health providers to actively build relationships with community members, listen to their health concerns and act on appropriate recommendations to effect change.

Evaluation findings indicated that the community engagement process was effective and added value to improving the participation and involvement of Aboriginal people in decisions about their health care. There was very strong evidence that the community engagement process was driven and owned by the Aboriginal community, that the focus on community needs facilitated greater Aboriginal representation and involvement in decision-making about Aboriginal health care, and that the process built trust. The development of trust involved community representatives shifting from an initial position of distrust (based on previous experiences of being involved in consultations where nothing changed) to one of surprise that this community engagement process was making a difference by not being tokenistic, an attribute that has motivated members to continue their involvement. There was also strong evidence that DAHAGs were an effective forum for Aboriginal people to articulate their needs around health care, for the Aboriginal community and health service providers to discuss ways to improve Aboriginal health care, and to raise service providers’ awareness of Aboriginal culture and the need to provide respectful and culturally safe health care. DAHAGs provided an opportunity for health service providers to have access, meet and talk with the local Aboriginal community about their health issues and to establish and build trust and strong partnerships to improve Aboriginal health outcomes.

Community engagement is important in both primary and secondary prevention. The experience of a cardiac event can be an opportunity to educate the individual, his or her family and the broader community. Health professionals need to include family members in the patient’s care so that knowledge of risk factors, early intervention and treatment needed by the patient can be shared with others in the family, who can both support healthy behaviours in the patient and reduce their own risks at the same time.

b. Location

Choosing a location for health services and programs that is familiar, comfortable, and culturally safe for Aboriginal people makes a big difference to an individual’s capacity to listen and absorb information. It is important that there is collaboration between the community and health services to identify and promote appropriate locations preferred by the community, ensuring community-owned and community-driven outreach programs. This does not necessarily require initiating community events or programs from scratch; in some cases it may be a matter of building on existing successful programs or existing community events, such as men’s camps and sports days. Offering multiple services from one accessible, convenient location has been effective, as demonstrated by people coming as a result of word of mouth from others already participating. The significance of social interaction in promoting health messages and behavioural change should not be underestimated.

The ‘Heart Health’ program developed by the Perth-based Aboriginal Medical Service (AMS) Derbarl Yerrigan Health Service (DYHS) is a good example of how providing a service in a new, culturally appropriate environment can improve participation in cardiac rehabilitation. Previously, the only cardiac rehabilitation program provided by Royal Perth Hospital (RPH) was on-site at the hospital. Through a joint initiative with the Heart Foundation, a program was developed at DYHS, which is located a short distance from RPH. It was a ‘game changer’, using a family-centred approach based on partnership between a range of services/agencies. The project has led to family members becoming more aware of cardiac symptoms and this is known to have been translated into action. One example was when an individual complained to his family of cardiac symptoms, and an informed relative (who had attended a heart health education session) immediately took him to the hospital nearby. Further, when the patient was discharged from hospital, support was available from the community as well as from ‘outsiders’ such as health professionals (See Part I, Box 8).

**Factors to consider when selecting location of a program**

- Select location where it is possible to offer food, childcare facilities, and transport/support to and from the location
- Ensure that events are welcoming, informal and fun and an opportunity to catch up with family and friends, making it more likely that people will come back
- Promote events that are jointly organised by health services and community organisations
- Organise outdoor activities (such as walks around the park): this allows easy interaction and can be an ice-breaker
- Improve access to recreation facilities including gyms or other exercise facilities
- Select facilities that are smoke-free zones and promote healthy eating, e.g., no chocolate/soft drink vending machines (including in schools and prisons)
- Encourage participants to bring along family members and friends
Aboriginal Lay Educators as Community Role Models for Cardiovascular Health Education

In the past few decades, despite large amounts of research and numerous health promotion campaigns, the cardiovascular health of Aboriginal Australians is still a major health issue. Clearly, it is important to identify and overcome the barriers that reduce the impact of Aboriginal cardiovascular disease (CVD) prevention programs.

Dr Julie Owen, an Aboriginal woman, undertook her own PhD research in the South-West of WA to identify some of these barriers to inform and develop an alternative, culturally sensitive method of delivering CVD health messages to Aboriginal people. From previous research, the importance of who delivers health messages and where they are delivered is very clear. Health professionals based in formal settings using technical medical jargon may alienate Aboriginal people and not communicate messages effectively. On the other hand, trusted peers, elders and friends within a social network are generally more able to ‘educate, motivate and advocate’ about heart health. The role of the Aboriginal Health Worker (AHW) is pivotal: AHWs are the interface between the western medical model and the Aboriginal community. However, the dual identity of an AHW (as a health professional and a community member) can actually be a barrier in some situations—family and community ties can actually hinder the AHW’s professional responsibilities.

The research involved setting up CVD education programs in three regional South-West towns with large Aboriginal communities, where there were AHWs who had completed a Heart Foundation specialised training course in CVD. Unfortunately, the AHWs were not generally able to translate this knowledge into practice or programs, due to heavy workloads, clinical demands and frequent resistance from the community (including antagonism between groups). A lack of confidence by some AHWs in organising findings and presenting messages was a barrier, with some feeling that they lacked credibility (e.g., if they were smokers who had to deliver a ‘quit’ smoking message).

A novel alternative strategy proposed by the researcher was to enlist and train respected community members as ‘lay educators’ from each town. The people recruited were carefully selected for personal experience of CVD and characteristics such as community-mindedness, self-confidence, willingness to maintain confidentiality, tact, a good sense of humour and ability to seek advice when needed. The people selected were trained in behaviours and healthy lifestyle for cardiovascular health at a 2-day retreat, which included lots of input and support from AHWs.

The second part of the strategy was to ‘market’ the lifestyle and behaviour messages by adopting the traditional way of passing on information in Aboriginal communities: small, informal, cohesive gatherings of people in familiar surroundings (in this case, ‘HeartAware parties’ in private homes). These included heart-healthy food for participants, DVDs, flyers and games, with AHWs as ‘mentors’. As well as cultural sensitivity to size and location of meetings, another critical element for success was flexibility. An uncomplicated process to postpone and reschedule the gatherings at short notice was deemed important by the target group.

A number of HeartAware parties were held successfully and the program received strong support from the community. Evaluation of the program by the researcher showed that participants at the meetings acquired and retained important information about beneficial behaviours and lifestyles. The lay educators gained confidence in influencing the health of community, while health workers felt positive in their ‘mentor’ roles. Furthermore, it was clear that the messages from the
HeartAware parties had been spread to other community members by word-of-mouth. As an unexpected benefit, the model was informally adopted by community members: a group of grandmothers was able to set up similar meetings to share messages on youth alcohol consumption. The success of this process was partly due to the process of ‘action research’, in which both the researcher and the participants collaborate to generate knowledge and actions.

Source: Owen J. Development of a culturally sensitive program delivering cardiovascular health education to indigenous Australians in South-West towns of Western Australia, with lay educators as community role models (unpublished PhD thesis). Perth, The University of Western Australia; 2006.

**c. Presentation of messages**

It is important that health professionals are flexible in how they deliver health-related information and work together with Aboriginal communities to achieve this. This collaboration is important for developing understanding in the Aboriginal context about effective communication, building trust, and shared learning. Messages considered to be most effective are those that (i) are community-owned and delivered, using Aboriginal people rather than non-Aboriginal health professionals as educators where possible, and (ii) have early and ongoing support from community leaders. Getting young people involved can be a way to build capacity and increase confidence. Children can be involved in promoting health in their families. Similarly, trans-generational approaches to promoting health in children (involving parents and grandparents) can be effective, in particularly those involving a variety of modes of delivery such as the arts or multimedia. All health consumers have a right to high quality information (See Appendix 4: Australian Charter of Healthcare Rights).

Information needs to be practical, personal, and empowering. For example, blood pressure and heart beat checks (there is an app for measuring heart rhythm) can be used as opportunities for education. Information that is delivered in a way that encourages questions, is non-threatening and is enjoyable is more likely to leave them feeling they have learnt something that they value. Finally, visual recognition of the materials is crucial. Brochures, flags, pamphlets, magnets and T-shirts identifiable as Aboriginal-specific are all recommended. Many of these suggestions can be developed by investigating existing resources and building on creative approaches. Suggestions and resources can be found on the internet or through Aboriginal health networks. See also the list of resources in Appendix 5 of this Report.
The Western Desert Kidney Health Project

This project ([http://westerndesertkidney.org.au](http://westerndesertkidney.org.au)) is an excellent example of an Aboriginal health promotion project incorporating the principles of community engagement, culturally appropriate message presentation and thoughtfulness about location.

Cardiovascular disease is often associated with kidney problems and diabetes, particularly among Aboriginal people from remote communities. Both kidney disease and diabetes can begin early in life; they are often present even in the children from these communities. The high risk of developing kidney disease and diabetes in these communities is partly due to lack of access to fresh foods, loss of traditional healthy lifestyles, and limited exposure to important public health messages that the general Australian population take for granted.

The Western Desert Kidney Health Project, launched in 2010, is a prevention program designed to reduce the impact of these conditions in ten remote WA Aboriginal communities. The project is led by a senior Wongutha woman, who is a medical practitioner in the community and involves a multidisciplinary team of Aboriginal and non-Aboriginal health professionals, artists and community development workers. There has been close consultation with the communities through every stage of project development.

The team travels to each of the communities in two specially fitted ‘Healthy Lifestyle’ trucks. Health professionals in the mobile clinic truck offer testing for kidney disease and diabetes to everyone in the community. They use ‘point-of-care’ machines that give instant results, so that the clinical team can discuss the results straightaway with every person who has been tested, and arrange follow-up if a problem is detected. Also, the leaders of the team review the medical test results of the community overall and discuss these at a community meeting.

Artists travel to each community in their own truck, along with the clinical team. They assist people from the communities to develop their own stories about illness and health, using the local people’s own language, images and visual media (e.g., sand painting). The visit ends with a small community event in which the new artistic creations are celebrated in a way that integrates stories of local Aboriginal culture with health knowledge. This promotes culturally appropriate understanding about healthy living and how to build people’s skills and achieve change at a community level. (An example of a practical outcome is the establishment of gardens to grow fresh food.)

Also, the team advocates on behalf of the community to government agencies and community organisations. Furthermore, they publicise the project using the media and by writing articles for health research journals.

There is already evidence from a pilot study that the project can succeed, both in engaging the community and in improving health status. People from the communities have enthusiastically engaged in the creation of art works and celebrated the community events. Furthermore, some people have been able to lose weight or reduce their blood pressure or cholesterol.


Also:
Different means of communicating messages

**Arts, for example:**

- Hip hop—gives a different approach that is fun, engages young people so they own the message and gives them hope for the future, thereby building capacity and confidence
- Use a performer, e.g., a clown, so learning is fun; can also act as an ice-breaker when getting people to talk and share stories
- Participant-created performances are both educative and develop participant skills and confidence

**Multimedia, for example:**

- Video clips (especially if generated by Aboriginal person, e.g., Mary G).
- Web-based, for example children can use Photoshop to both learn and apply messages
- Animation or pictures, perhaps as a phone application
- Apps or SMS messages to remind people about appointments, medications, and support lifestyle changes

**Interactive, for example:**

- A cookbook that modifies traditional recipes
- A book of Aboriginal games
- A culturally appropriate game targeting Aboriginal children (e.g., the SNAP into life project* [http://www.snapintolife.com.au/])
- Walking groups
- ‘Yarning it up’ (group discussion and support) programs are effective, for example, even a person who is still smoking and wanting to give up can talk about harm minimisation such as only smoking outside to avoid exposing their children to tobacco smoke
- Hands-on fun activities/community events to promote health, for example at sporting carnivals
- Using relevant imagery to chart progress, e.g., recording number of steps walked as distance covered if walking the Canning stock route

*SNAP: smoking, nutrition, alcohol and physical activity
d. Content of messages

Health-promoting message content can support both primary and secondary prevention, encouraging people to attend to health issues early to prevent illness or slow its progression. To optimise meaning and relevance, health messages need to be developed and reviewed regularly (and improved if necessary) in collaboration with communities.

**Developing message content**

- Personalise and simplify the key health promotion message for each individual
- Address a range of comorbidities rather than just focusing on heart disease alone
- Present messages clearly and provide other opportunities to further explain or discuss the messages
- Include messages that increase practical knowledge and skills (e.g., the cost of accessing health care and budgeting)
- Embed health messages in ways that are practical, and age- and skills-appropriate. For example, primary school children can have toothbrushes and toothpaste in the classroom to learn about oral health; a men’s shed can offer men support; walking groups can bring women and/or men together in a health promoting activity
- Try to use positive messages rather than negative messages that can generate fear/anxiety

These examples of strategies for promoting health require good organisational support, as they can present challenges to staffing and logistics. The next section documents how organisations can support health workers in delivering programs and services.
**Group-based physical activity**

The Aboriginal Healthy Women’s project, implemented by the Women’s Health & Family Services, was first funded in 2008 by the Department of Health, Western Australia (WA). This project operated in different community settings in Perth, WA. The main aim of the project was to increase Aboriginal women’s participation in physical activity thereby promoting physical and mental health and well-being. This was achieved by providing Aboriginal women with opportunities to:

- learn new skills
- participate in physical activity sessions based on women’s preferences in safe and culturally appropriate environments
- link to mainstream services
- advocate on behalf of Aboriginal clients groups, and
- seek alternative arrangements to continue/sustain the program activities past the funding period.

A physical activity program comprising a series of exercise classes in two community-based settings in the southern part of Perth was evaluated in 2011. In the Aboriginal Healthy Women’s project, staff members used a community development approach and recognised the need for flexible programs. This not only helped the program better address participants’ needs, but also allowed staff members and participants to establish a trusting relationship. This trust further provided participants with a supportive environment, and helped them to feel comfortable, empowered and confident. Additionally, the use of group-based activities provided participants with a sense of community and gave participants additional peer support. Most groups comprised women of a mixed age range, and participants often brought their children and friends into the classes. One of these groups originally had classes in a local recreation centre but they requested that the local Council assist by providing access to a community hall. The Council responded positively and the women now have their own space for the exercise classes after hours.