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Engaging Indigenous students through school-based health education

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Summary

What we know

- Indigenous Australians, including young Indigenous people, are disadvantaged according to a range of health outcomes and morbidity profiles.
- Indigenous young people have access to a range of resources in their cultural, social and cognitive lives that educators can recognise and build upon.
- Schools are uniquely placed to teach the knowledge, skills and attitudes that underpin healthy living.
- Adoption of the World Health Organization's Health Promoting Schools framework, which uses a whole-of-school approach to school-based health initiatives, can lead to positive health outcomes for Indigenous students.
- Effective health education policy and practice recognises the:
 - mutual benefits for students of health and education initiatives
 - importance of students' engagement with, and achievement in, core curriculum competencies
 - significance of quality teachers and teaching
 - positive benefit of school connectedness
 - value of programs embedded within family, community and cultural contexts.



What works

Quality teaching and teachers lie at the heart of initiatives that have successfully enhanced Indigenous students' health and education performance. Positive health outcomes can be achieved when health education programs are:

- delivered and assessed within the context of the core school curriculum
- provided by trained and well-resourced classroom teachers
- implemented across a substantial time frame and through at least two Health Promoting Schools dimensions
- informed by local health issues, values and beliefs of individual students and their community
- delivered within the context of safe and supportive classroom and school environments
- underpinned by positive partnerships with parents, community members and health professionals
- designed and evaluated according to sound health and educational theory and practice.

What doesn't work

Past and current initiatives seeking to reduce the educational and health disparities of Indigenous youth have provided some clear indications of what does not work. These sub-optimal programs are typically characterised by:

- 'quick fix' strategies that adopt a 'one-size-fits-all' approach
- are ad hoc and lack processes for accountability and sustainability
- rely on external speakers or isolated individuals to deliver programs
- practices that reinforce deficit models of Indigenous students
- have limited or non-existent quality partnerships with Indigenous families and communities.

What we don't know

There are significant gaps in our knowledge about what works, for whom and in what circumstances. Currently, we have gaps in our understanding about:

- whether a number of specific health education practices contribute to positive health-related outcomes for Indigenous students
- barriers and facilitators that influence the successful detailed implementation of broader policy
- the development of health risk or resilience among Indigenous young people
- the overall impact of school-based health education (i.e. conclusive evidence is limited)
- what indicators are most effective in assessing the impact of school-based health education
- uniquely Indigenous approaches to the development of health literacy.

Introduction

Health education strategies and practices are critical to improving the health and wellbeing of Indigenous Australians. The Australian Government has recognised the health-promoting potential of schools through its advocacy of the World Health Organization's (WHO) Health Promoting Schools framework (NHMRC 1996). This framework uses a whole-of-school approach to school-based health initiatives. Schools are ideal for health promotion activities because of their close and regular student-teacher contact; coverage of formative years; sustained and reinforced program delivery; and the capacity to capture all children, irrespective of socioeconomic status, ethnicity or location (NHMRC 1996).

The health-promoting potential of education strategies and practices features prominently in the targets of the Australian Government's Closing the Gap strategy. They also underpin the building blocks of health, schooling, early childhood and safe communities (CoA 2009). Current Indigenous health statistics demonstrate a need for education, schools and schooling to be an effective strategy through which Indigenous health disparities can be addressed (AIHW 2011).



This resource sheet focuses on the delivery of school-based health education for Indigenous students in Australian schools and the effective strategies that support positive health outcomes for Indigenous students.

What we know

Motivation for sustained action: health disparities of Indigenous children and students

A 'general and large gap exists between the health of Indigenous Australians and that of other Australians' on all health indicators (AIHW 2010:29). Indigenous Australians, including Indigenous children and students, are disadvantaged according to a range of health outcomes and morbidity profiles that are well-documented elsewhere (see AIHW 2010, 2011).

In terms of physical health, Indigenous children and young people experience higher rates of infections and illness and are twice as likely to suffer from disability or long-term conditions as their non-Indigenous peers (AHMAC 2011).

For example, Indigenous children aged under 15:

- are 3 times more likely to be diagnosed with severe otitis media than non-Indigenous children (AHMAC 2011)
- experience some of the highest rates in the world of conductive hearing loss as a result of otitis media (Partington & Galloway 2005)
- are more likely to have oral health issues, with 50% more decayed, missing and filled teeth than non-Indigenous children (AHMAC 2011).

In terms of emotional well-being, Indigenous young people are 3 times as likely to report high or very high levels of psychological distress (AHMAC 2008).

- In 2001–02, the Western Australia Aboriginal Child Health Survey (WAACHS) found that about 1 in 6 (16%) Aboriginal young people aged 12–17 had suicidal thoughts in the 12 months before the survey. Of these people, 39% reported having attempted suicide (Blair et al. 2005).

- In the same survey, 24% of Aboriginal children aged 4–17 surveyed were assessed as being at high risk of clinically significant emotional or behavioural difficulties, compared with 15% of all children.

Indigenous young people also have statistically more health risk factors than their non-Indigenous peers:

- An estimated 65% of Aboriginal and Torres Strait Islander children aged 0–14 live in households with a current daily smoker, compared with 32% of non-Indigenous children (AHMAC 2011).
- Indigenous Australians aged over 15 are nearly twice as likely to be obese as non-Indigenous Australians (AHMAC 2011).
- Sexually transmitted diseases such as chlamydia and gonorrhoea have continued to increase, with notification rates for gonorrhoea among Aboriginal and Torres Strait Islander peoples aged 15–24, 38 times as high as for other Australians in 2006–2008 (AIHW analysis of National Notifiable Diseases Surveillance System cited in AHMAC, 2011).

Additionally, in 2008, 47% of Aboriginal and Torres Strait Islander Australians aged 15 and over smoked, and an estimated 17% of Indigenous people aged 15 and over reported drinking at chronic risk/high risk levels in the past 12 months (AHMAC 2011).

Notwithstanding these statistics, McNaughton (2006) argues that Indigenous children, as much as any other children, have access to resources in their cultural, social and cognitive lives, and that educators need to recognise these resources and capitalise on them. Remaining at school until Year 12 is known to be positively associated with health, with 59% of Indigenous people aged 15–34 reporting excellent or very good self-assessed health (Johns et al. 2010). By contrast, poor attendance has been associated with the adoption of risky health behaviours including earlier sexual experience, tobacco smoking and substance misuse (Blair et al. 2005). As Blair and colleagues (2005) argued, improvement of physical and mental health morbidities requires the expansion of human capabilities through programs that build Aboriginal empowerment, equality, sustainability and productivity. 'Evidence-informed' school-based health education programs are well placed to do this by strengthening Indigenous young people's general educational and health-specific knowledge and skills (Rowling 2009).



Health promoting schools

According to the World Health Organization, positive health outcomes for all young people can be achieved when schools adopt a Health Promoting Schools approach (Queensland Health 2001) and integrate action across three key domains:

- **Teaching and learning:** what is taught and how it is taught
- **School policy and ethos:** policies, organisation, and physical and social environments that contribute to the 'feel' of a school
- **School-community relationships:** partnerships that recognise the role and influence of families, community resources and wider community consultation.

The Australian Government encourages schools to adopt this whole-of-school approach to school-based health initiatives, including those that have a specific Indigenous student focus. The goal of developing students' health-related knowledge and skills is achieved through the Health and Physical Education (HPE) Key Learning Area. HPE is a priority of the phase three development of the Australian Curriculum (ACARA 2011). It will become a compulsory requirement for all Australian students from Foundation to Year 10 (ACARA 2011). HPE encompasses a broad range of extracurricular activities, such as school sport, camps and pastoral care programs, to support young people's engagement with healthy living practices.

What works

This section considers evidence across the three key domains of the WHO's Health Promoting Schools approach to assess what works in school-based health education to engage Indigenous students.

Teaching and learning

Quality teaching plays a significant role in promoting all students' health and wellbeing (Erebus & Minimbah 2008; St Leger 2006), including Indigenous students (CoA 2010a; HWC 2003; see also Box 1).

Box 1: Deadly Choices

Deadly Choices is an 8-session program designed to encourage Indigenous people aged 13 and over to be positive role models and mentors in reshaping health, lifestyle and physical activity among their family, friends and networks. Designed for urban Indigenous people in south-east Queensland, the Deadly Choices program is delivered by Indigenous young people and informs participants to stay strong and healthy and maintain healthy lifestyles, make healthy choices and be physically active. Topics include leadership, chronic diseases, smoking, nutrition, alcohol and substance misuse, sexual health, physical activity and Medicare and health check information.

Beginning in 2010, the program has been delivered during regular classroom time in 5 high schools and a local youth detention centre. Information gathered indicates that young people have increased their knowledge of chronic diseases and the risk factors as a result of this program. Qualitative data suggest that young people enjoyed the physical activities of each session and gained knowledge which helped them to make healthier choices. For example, one young person noted:

This session was really good. I learnt different stuff about the bad results of doing drugs and alcohol. This program has potential to bridge the gap between health and education for urban Indigenous young people.

Source: Nelson, Heard, Lander & Lacey, 2011

Classroom-based health education that develops students' knowledge and personal and interpersonal skills is a fundamental pathway to student health and wellbeing (Erebus & Minimbah 2008; Nutbeam 2008). A considerable body of research and evidence has established the characteristic features of effective school-based health education (Basch 2010; CoA 2010a; Erebus & Minimbah 2008; St Leger 2006; Rowling 2009). Effective programs are:

- embedded in the core school curriculum
- taught by trained and well-resourced classroom teachers



- focused on health knowledge and health literacy competencies
- action orientated, providing opportunities for students to practice and acquire intra- and inter-personal skills within the context of health issues
- built on core literacy and numeracy competencies
- authentically assessed and included in student achievement reporting protocols
- sustainable through sector and school level policies and accountability processes
- strategically planned to meet students' developmental age, needs and local health issues
- informed by parents, community members and local health professionals.

Teachers are a critical component of effective school-based health education for Indigenous students (Dobia & O'Rourke 2011). Classroom teachers, with their specific knowledge of students, can deliver health knowledge and skills through student-centred teaching, respond to specific needs and create the caring relationships that underpin school connectedness and Indigenous students' wellbeing (ACU National & Erebus 2008; St Leger 2006; CoA 2010a; Dobia & O'Rourke 2011). Importantly, Indigenous young people have reported that schools and their teachers are the preferred and most frequently accessed source of health-related information and skills (Arabena 2006; Blair et al. 2005).

Given the critical role that teachers play in quality school-based health education, investment in the professional development of school leaders and teachers has been an essential component of program implementation (Mulford 2011; Dobia & O'Rourke 2011). Successful health-related initiatives, including those that have focused on Indigenous students' social and emotional wellbeing (CoA 2010a), literacy and numeracy skills (HWC 2003; Luke 2009), transition into schooling (Erebus & Minimbah 2008) and teaching students with conductive hearing loss (Partington & Galloway 2005), have all grounded their work in the development of quality teachers and teaching. Across the breadth of these studies, effective teacher professional development addresses:

- awareness and recognition of Indigenous cultures
- strategies to incorporate Indigenous knowledge into the curriculum

- creation of high expectations of Indigenous students' achievements
- capacity to recognise and adapt to the specific learning styles and needs of each student
- creation of classrooms that respect diverse ways of interacting
- supporting students' engagement with mainstream educational environments
- creation of positive and informative relationships with parents and community members
- collection and analysis of contextualised evidence of teaching and learning.

In Australia, the *Community Matters* (CoA 2010a) component of the *Mindmatters* mental health and wellbeing professional development initiative (CoA 2010b) provides the most comprehensive overview of effective teaching approaches that support Indigenous students' engagement with health education. The teaching approaches advocated in *Community Matters* reflect the major principles of learner-centred approaches to teaching (Wright et al. 2004) and the participatory learning that empowers students' health literacy and health activism (St Leger 2006). Learner-centred approaches:

- recognise and explore the health knowledge, skills and values of each learner
- provide authentic health-related learning and assessment experiences
- employ inquiry, decision making and problem-based strategies to learning
- are underpinned by high expectations of students (Wright et al. 2004).

These teaching and learning approaches find further reinforcement from the *What Works* (What Works 2010) foundational principles to improve educational outcomes for Australian Indigenous students. These principles advocate a three-step process that includes building awareness, forming partnerships and working systematically.

Within and beyond the core curriculum, sport and physical activity have often been promoted in schools as tools for engaging Indigenous young people in health-promoting behaviours. For example, the Australian Football League's (AFL) Kickstart program aims to partner with Indigenous communities



to improve employment, education, health and participation outcomes for Indigenous people (Dinan-Thompson et al. 2008). Qualitative evaluations have been positive (Dinan-Thompson et al. 2008), but little is known about the ongoing effects of ‘fly in, fly out’ programs. In addition, some researchers argue that sport has been (mis)promoted as a cure-all solution to complex social problems and that those Indigenous people who do not engage in or enjoy sport may be neglected (Kickett-Tucker 1997; Nelson 2010).

School policy and ethos

Positive engagement with school ensures Indigenous students can benefit from the opportunities posed by quality school-based health education (Bourke et al. 2000; Godfrey et al. 2001; Erebus & Minimbah 2008). Schools that are successful in promoting Indigenous students’ connectedness and engagement with school provide (Dockett et al. 2006):

- a visible Indigenous presence at the school
- opportunities for students to express and maintain their Indigenous identity
- strategies to invite and value family and community involvement
- flexibility which encourages diverse family–school connections
- respect for Indigenous families and the strengths they embody
- access to mainstream educational curricula, complemented by opportunities to engage with Aboriginal languages and culture

- high expectations of the learning capabilities of Indigenous children
- organisational flexibility; for example, so that Indigenous children are placed in school groups where they have fellow Indigenous classmates and do not run the risk of isolation
- access to appropriate health services and health checks before entering school
- opportunities to view school as a worthwhile and a positive place to be.

Additionally, the sustainable delivery of school-based health education for all students, including Indigenous students, depends on schools including health-related goals and educational achievement in their accountability protocols (McCuaig 2008). Evaluations of successful education and health initiatives in schools have consistently emphasised a sustained focus on program assessment and improved accountability through system performance measures that are linked to improved student learning and wellbeing (ACU National & Erebus 2008; HWC 2003).

Finally, successful health-related programs in schools have ensured that health and education sector policies facilitate the provision of health service by professionals who work in school communities (Fasoli & Johns 2007). Services such as health checks, nutrition programs for families and hearing assessments directly meet Indigenous students’ health needs, and consequently, improve their ability and motivation to learn before entering school (Dockett et al. 2010, see Box 2).

Box 2: Both Ways Children’s Services Project

The Both Ways Children’s Services Project involved Indigenous and non-Indigenous researchers working with 6 communities in the Northern Territory. The childcare service of Community A demonstrated the successful characteristics of partnerships between health and educational organisations. This service:

- was located in the grounds of the community’s school
- established partnerships with health-care professionals located across the road who provided daily health and nutrition programs and a weekly general health check

- engaged school teachers to conduct a nutrition education program
- emphasised and involved grandmothers as an explicit acknowledgement of their place in traditional child-rearing practices
- increasingly developed its role in helping children to prepare for school, as coming to the service was also seen as a good way to introduce children into the practices of the school
- gained much support for keeping the program running through their alliance with the school.

Source: Fasoli & Johns 2007.



School-community relationships

Whether in urban or remote contexts, the planning and decisions underpinning successful health initiatives in schools involve positive family and community engagement from the outset (Coffin 2009; Parker et al. 2006). Positive partnerships occur when schools and their teachers adopt a strengths-based perspective of Indigenous students, families and communities (Dobia & O'Rourke 2011). Adopting a strengths-based approach involves acknowledging and affirming the skills and knowledge that Indigenous children and young people bring to school (McNaughton 2006). Such approaches also begin with the premise that although statistically, Indigenous young people may be at greater risk of ill health, many Indigenous youth are already engaged in healthy behaviours and need to be encouraged to continue to stay healthy (Nelson 2010, see Box 3).

Evidence of the successful employment of a strengths-based approach can be found in a collaborative research project conducted with the Victorian Aboriginal Health Unit. This project explored and addressed risk and resiliency among urban Indigenous youth (Holmes et al. 2002). Initial survey and focus group findings resulted in The Dulap Bininang Meeting Place, which was designed to address Indigenous young people's wellbeing and their concerns about confidentiality and self-consciousness. Genuine partnerships with Indigenous and non-Indigenous health, education and sporting staff enabled the provision of recreational activities, homework tuition and nutritious meals.

Findings from the project were made available to local schools to enhance their understanding of local health-related risk factors, particularly those surrounding the uptake of smoking, which were incorporated into local primary schools' health education messages. As this project demonstrates, school and community health programs that seek to influence Indigenous young people's health outcomes are enhanced when consideration is given to the young people's own perceptions of health and when community resources are strengthened to respond appropriately to Indigenous young people's health needs and concerns.

Box 3: The meaning of health and physical activity in the lives of urban Indigenous young people

This qualitative research study followed 14 urban Indigenous young people aged 11–13 for 3 years as they undertook the primary-secondary school transition. The findings highlighted the diversity within this group of young people in their engagement in sport and physical activity. They engaged in a broad range of physical activities and organised sports both in and out of school, alone and with family and friends.

Health was generally defined and evaluated in terms of something one does, such as eating vegetables, drinking water and being active, rather than more biomedical terms such as the absence of disease. Although some young people acknowledged family histories of chronic diseases such as diabetes, they did not define their own health in these terms. In their commentary, they drew on messages of 'eating well and being active' and of 'risk', but did not appear to engage with 'the Indigenous health crisis' unless directly asked about this. Nearly all contested the idea that culture or 'Indigeneity' negatively affected their health, asserting that ill health was due to individual choices.

Schools offered important sites for physical activity and sport, through informal physical activities during lunch breaks and after school, health and physical education lessons, and organised school sport.

The insights provided by this group of urban Indigenous young people did not produce a neat, simple view of health and physical activity in their lives. There was often complexity and contradiction within and between participants' comments. These findings indicate that a range of approaches to physical activity policy development and programming is required for Indigenous young people.

Source: Nelson 2010.



What doesn't work

Past and current health education initiatives have provided a clear indication of what does not work for all Australian students, including Indigenous students (St Leger 2006).

Failed programs:

- employ 'quick-fix' strategies that adopt a 'one-size-fits all' approach
- are ad hoc and lack accountability and sustainability
- rely on external speakers and isolated individuals to deliver programs
- reinforce deficit models of Indigenous students
- have limited or no quality partnerships with Indigenous students, families and communities.

Health-related initiatives in schools can unwittingly reinforce views of Indigenous young people as disadvantaged. Although health-related programs are increasingly drawing on educational theory to guide practice (St Leger 2006), strategies often emphasise health promotion notions of intervention that seek to address a perceived crisis. Such approaches tend to focus on isolated health or risk behaviours which contradict the language of schools that focuses on building general knowledge and skills (St Leger 2006; Jourdan et al. 2010).

This situation is complicated further in relation to the health challenges facing Indigenous youth. The potential incongruence between the contexts of health education and the daily lives of some Indigenous Australians may result in superficial compliance to policy in an attempt to 'tick a box', without any substantial empowerment (Iwama 2006). In much of contemporary educational policy there is an absence of reference to, or acknowledgement of the complexity and diversity of Indigenous young people's lived experiences (Nakata 2002).

Indigenous school-based health education also experiences a range of barriers in common with mainstream Australian health education. Research suggests that implementation often lacks cohesion, risks duplication and fails to address issues such as the coordination of policies and practices (ACU National & Erebus 2008). Education and health professionals alike have argued that school-based health initiatives,

including the delivery of HPE, have failed as a result of low status in a crowded curriculum, few trained health education teachers, lack of resources, ad hoc health service partnerships and gaps between policy and practice (NHMRC 1996; Ridge et al. 2002; Macdonald et al. 2008). Schools have tended to rely on external agencies or 'one-off' presentations that are topic-specific, rely on novel resources and involve professionals who have no knowledge of the school program, students or community (Macdonald et al. 2008).

Finally, sustainability of school-based health education has been compromised when program motivation and energy comes from dedicated but isolated individuals scattered across the education system (NHMRC 1996). Program sustainability within Indigenous communities has been particularly susceptible to staff turnover, with researchers drawing attention to the lack of quality and ongoing professional development for staff (HWC 2003). In short, the burn-out and turnover of key individuals whose time, effort and training underpin successful programs compromises progress and results (HWC 2003).

What we don't know

Australian research, policy and practices indicate that there are 'significant gaps in knowledge about what works, for whom and in what circumstances' (Johns et al. 2010). Currently there is little nuanced understanding of the specific health education practices that contribute to positive health-related outcomes for Indigenous students. In particular, there is a need to enhance knowledge of the barriers and facilitators that influence the successful detailed implementation of broader policy across the diverse remote, rural and urban school communities in which Indigenous young people are educated.

In relation to the health and wellbeing of Australian Indigenous youth, researchers argue there is little documentation of the 'development of health risk or resilience among Aboriginal youth' (Holmes et al. 2002:1269). Current knowledge does not provide insight into the place and meaning of health and health-promoting behaviours, which over time affect the health of young people and their adoption of the healthy or unhealthy practices that prevent or lead to chronic diseases.



More generally, although progress has been made, evidence of the positive impact of school-based health education remains inconsistent and inconclusive. A major gap in program assessment continues to be the development of the indicators that are most effective in assessing the impact of health education programs (St Leger 2006). Evaluation of program impact has been further compromised by the disparities between policy intent and implementation in school communities (McCuaig 2008). Currently, there is little 'reliable information about how much and how well HPE is implemented in schools around the country' (Daube et al. 2010).

With respect to the emerging advocacy of health literacy as a core component of school-based health education, researchers have specifically raised concerns regarding the limited exploration of young people's health literacy capabilities and their acquisition of health literacy knowledge and skills (Nutbeam 2008). Even less is known about a uniquely Indigenous approach to the development of health literacy (Johns et al. 2010).

Conclusion

Nationally and internationally there is increasing recognition of the reciprocal benefits posed by health and education for young people. In short, healthy young people are better learners, and educated young people live healthier lives, including Indigenous young people. Schools in particular are well placed to deliver the knowledge, skills and attitudes that underpin healthy living as they provide early and sustained access to Indigenous young people who are establishing their lifelong health pathways. However, current Indigenous health statistics demonstrate a need for a more effective delivery of health education to Indigenous young people through Australian schooling.

Australian schools can provide effective health education when well-trained teachers, who understand the specific strengths, needs and values of their students and the local community contexts, deliver programs through the school's core curriculum. Schools can support Indigenous student health and education achievement through the creation of safe and supportive learning environments that respect Indigenous culture and create positive

partnerships with families and community members. Importantly, achieving the sustainable delivery of health education programs for all students, including Indigenous students, is dependent on the inclusion of health-related goals and student achievement in education sector accountability protocols.

Nevertheless, in much of contemporary educational policy and curriculum practice there is little to no acknowledgement of the complexity and diversity of Indigenous young people's lived experiences (Nakata 2002). In particular, school-based health education curriculums have traditionally provided a 'generalist' response, targeting adolescents as if they were a uniform population, rather than recognising the diversity among young Australians and their individual communities. Applying this approach to Indigenous people runs the risk of generalising Indigenous cultures. The challenge for current and future school-based health education strategies is to acknowledge these complexities and the disadvantage experienced by many (but not all) Indigenous young people, while simultaneously identifying their strengths and resiliencies (Nelson & Hay 2010).

Efforts to provide evidence-informed, school-based health education can be enhanced through clearer understandings of what works, for whom and in what circumstances. The significant contribution and role of context and cultural specificity indicates the need for a richer and more nuanced understanding of the principles underpinning effective implementation of broad policy at the closer level of individual remote, rural and urban Indigenous school communities.




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Abbreviations

HPE	Health and Physical Education
NAPLAN	National Assessment Program—Literacy and Numeracy
WHO	World Health Organization

Terminology

Indigenous: 'Aboriginal and Torres Strait Islander' and 'Indigenous' are used interchangeably to refer to Australian Aboriginal and/or Torres Strait Islander peoples. The Closing the Gap Clearinghouse uses the term 'Indigenous Australians' to refer to Australia's first people.

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