Original Article

The benefits of a tailor-made pilot primary health-care course for Indigenous high school students in remote Queensland

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Abstract

Objective: This study highlights the benefits of a tailor-made course for an Indigenous high school in a remote North Queensland community.

Design: Qualitative research study using a Grounded Theory approach to allow thematic analysis of participant’s responses to a researcher-administered, pre-defined, semistructured questionnaire.

Setting: Remote community college in Abergowrie, North Queensland.

Participants: Four male high school students and eight key stakeholders were interviewed over the telephone (n = 12).

Results: Thematic analyses of the feedback from students and stakeholders showed a variety of benefits from the course for Indigenous students: increased knowledge of health issues, greater awareness and interest in health career pathways, increased pride, self-esteem and self-confidence, positive role-modelling and leadership behaviour in the students, and hope for future career development. Weaknesses identified were mainly associated with a lack of resources and support for the course.

Conclusions: This study demonstrates that a tailor-made primary health-care education course can create opportunities for Indigenous people to pursue health careers, promote health knowledge and leadership skills, inspire pride and self-esteem, and strengthen links within the community.

Introduction

The Indigenous Health Gap describes the disadvantages experienced by Aboriginal and Torres Strait Island people that spans all arenas of health as well as the entire life cycle, with greater infant mortality, lower birth weights, more chronic diseases, poorer social and emotional well-being, and shorter life expectancy.1

A successful Indigenous model of health care, including the importance of primary health care, community ownership and a culturally appropriate workforce, can be provided if we have adequately qualified Indigenous health-care workers with cultural sensitivity.2

There is a shortage of adequately qualified Indigenous health-care workers outside of major cities, where 70% of Aboriginal and Torres Strait Islander (ATSI) people reside.3 In addition, there is an under-representation of ATSI people within the health industry. As of 2006, there were 4891 Indigenous health professionals (e.g. nurses, midwives, Indigenous health workers, doctors and dentists),4 making up 1.6% of the Australian health workforce.5

One way to improve the number of Indigenous people in the health workforce is to promote and maximise participation in health career pathways at the school, vocational training and higher education levels.1 However, given the education disadvantages faced by Indigenous children, improvements in basic mathematics, science and literacy have to be considered.3 The 2008 report ‘Pathways into the health workforce for Aboriginal and Torres Strait Islander People’ emphasises focusing on improving education, support and leadership across the schooling spectrum.5 There was also a strong emphasis on cultural safety, including having culturally appropriate health care information and a culturally inclusive health curriculum. Thus, it is

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essential that the education and health sectors collaborate closely and consider the cultural context when it comes to reform in the Indigenous health workforce.

This paper reports the outcome of a pilot primary health-care course conducted at St. Teresa’s Abergowrie College in North Queensland, describing student and stakeholder perceptions of the course and student attitudes to a future career in a health profession.

Method

Setting and design

St. Teresa’s Abergowrie College is a remotely located high school for boys located near Ingham, North Queensland. The college is the largest male Indigenous boarding school in Australia. The college has an intake of predominantly Aboriginal and Torres Strait Islander students from Cape York Peninsula communities, plus a small proportion from Papua New Guinea; all regions where Indigenous primary health care works play a critical role in ensuring better health outcomes for Indigenous people and communities.

A pilot ‘Certificate II in Aboriginal and Torres Strait Islander Primary Health Care’ course was offered in 2010 to 14 senior students and 1 Aboriginal teacher aide. This course was based on the Kimberley model – initially developed by Aaron Bulow and Michael Gleadow from Binnacle Training – and further refined in collaboration with an Indigenous health lecturer from James Cook University (JCU) and a general practitioner from Ingham. The course provides Indigenous students with an entry-level qualification to become Indigenous health workers. Comprising four terms of study over two years, the course covers topics including hygiene, infection control, health checks, community education, and liaison between communities, individuals and other health professionals. More course information can be found on the Binnacle Training website, at http://www.binnacletraining.com.au.

The course was delivered by a Binnacle Training educator (Michael Gleadow) with some occasional support from the JCU Indigenous health lecturer, the school nurse and a traditional owner working as a teacher’s aide at the college. The present study is the evaluation of this pilot course, primarily undertaken by the first author, who had no association with the developers of the course.

The evaluation used a qualitative ‘grounded theory’ approach to develop concepts out of data collected in participant interviews, with thematic analysis used to inductively extract themes from participant responses in one-on-one interviews. Ethics approval for the evaluation was granted verbally by the Abergowrie College school principal and in written form from the Catholic Diocese of Townsville.

Participants

Following approval, 8 key course stakeholders and 14 students who undertook the course were approached to participate in the evaluation. These individuals were verbally informed about the project and about the topics to be covered in the interview process. The stakeholders interviewed included the Indigenous adviser and course educator, the two directors of Binnacle Training who initially helped develop the course, the traditional owner of the lands around Ingham, a teacher aide at the college, the school nurse and course educator, the school principal, a local general practitioner, and the community liaison officer for the college. Therefore, all participants were considered information-rich cases that allowed the research questions to be adequately explored.

Data collection and analysis

One-on-one interviews were conducted between September and October 2010. Of those approached, eight key stakeholders and four male students chose to volunteer for the telephone interview. Interviews involved a limited set of pre-defined, open-ended questions functioning as prompts to provoke discussion combined with brainstorming opportunities. The first author conducted the telephone interviews. Questions included asking the participants to describe their association with

What is already known on this subject:

- There is an under-representation of Aboriginal and Torres Strait Islander people working across all health professions, which inhibits the servicing of Indigenous health needs.
- Few strategies to enhance the Indigenous health workforce have targeted students at a high school level.

What this study adds:

- This study demonstrates a successful strategy that can be undertaken at a secondary school level that encourages Indigenous students to pursue careers in the health workforce.
- Such programs should be implemented in other remote communities to increase the Indigenous health workforce.
the Certificate II in ATSI primary health care; what they believed the course has achieved for students, course staff and local community; what the benefits and weaknesses have been of the course; and how the course could be improved. Interviews were initially handwritten and were later transcribed into electronic format. While every effort was made to write down the participant’s comments verbatim, including the use of shorthand notations by the first author, we cannot, however, confirm there was no loss of data with this method.

Initial analysis involved reading through the electronic transcripts repeatedly, using immersion to develop a high level of familiarity with the data, manually coding the data into separate summary concepts or key words, and categorising and linking these into recurrent themes. In this way, all transcripts were organised around emerging themes. After data were grouped thematically, emerging themes were checked with further participants. Unique quotes from a participant were included in the results section text if the quote succinctly illustrated concepts held by the majority interviewed.

Reliability and rigor

The level of participation during interviews was high, and all participants enthusiastically shared their views and experiences. Consistency was enhanced by having the same facilitator involved in all interviews. Both the interview facilitator (X.P.) and another author (S.S.) were involved in the analysis. Using the list of predefined questions, a ‘theory-saturation point’ was reached where new interviews no longer produced new information; this occurred after four student and eight stakeholder interviews. A mix of key stakeholders and students allowed some degree of methodological triangulation.

Results and discussion

The analysis of the data produced five themes around the benefits of the course: improving students’ knowledge of health; increased student interest in a health career; encouragement to maintain the student’s pride, self-esteem and self-confidence; promotion of positive role modelling and leadership in the students; and creation of hope and encouragement in the students (refer to Table 1 for a more detailed summary of the identified themes). While students did not identify any weakness of the course, the eight stakeholders commonly mentioned three areas which may affect the expansion and/or long-term viability of the course: lack of resources and support (both human and material), challenges with delivering the course in a remote location,
and certain limitations of the course being Certificate II level but problems with upgrading it to a Certificate III.

**Improving students’ knowledge of health**

Given that the primary aim of the course was to educate students about health-related issues, it was unsurprising that every respondent identified an increase in health knowledge and awareness as a major achievement of the course. The kind of knowledge included theory-based topics (e.g. hygiene principles) and practical skills (e.g. measuring blood pressure). A holistic concept of health was emphasised and the issues surrounding Indigenous health were also explored in the course.

We wanted to change their way of thinking about health, which used to be very negative. They learned how health relates to culture, living and family. (Course Coordinator)

I learned that Indigenous history changed the way we view our lifestyle and our health. I learned that health is everywhere, not just in the hospital. (Student)

Studies indicate that a culturally safe learning environment improves the retention and outcomes for ATSI peoples. The incorporation of Indigenous history, values, knowledge and experience into the curriculum, which was a strong point of this course, is known to improve participation and the likelihood of success of education and health interventions. Acquiring health knowledge had a flow-on effect that resulted in benefits for the rest of the school community. This was brought about especially by various health promotion activities led by students in the course, including creating posters and giving talks to the other students. Participation in this course was enthusiastic, and the students involved described it positively.

We did a project on hygiene and keeping the environment clean; basic things like that. The other boys, they think we’re doctors or something. (Student)

The school nurse also noted improved cooperation in the clinic as a direct result of the course. In addition, the health knowledge was also brought back home to the students’ hometown communities, many of which were located in remote areas.

[This course is] about taking a group of student and giving them a skill set to take back to their community, not just to pursue a career in the health industry. (Residence Manager)

**Encouragement to maintain students’ pride, self-esteem and self-confidence**

Pride was something that was not just identified in the students but was also apparent in the course staff and the greater community. The teachers also noted an improvement in self-esteem and confidence in the students, in particular as the semester went on and they began to embrace the course more.

I think the teachers, they feel strong. (Student)

Families and community members come up to congratulate us. They are very proud. (Student)

Engagement of parents and community leaders is recognised as essential to the success of an education program. Students may have experienced suboptimal learning experiences in their lives; receiving support and approval could be a key factor in breaking potential negative inter-generational cycles.

**Promotion of positive role modelling and leadership in students**

The course also promoted role-modelling behaviour and leadership in the boys, which had a very positive influence on the other students at the school. This was identified by the staff as well as by participating students.

It has made a number of leaders out of the boys. (GP Liaison)

Some of the Grade 8s look up to us as role models. (Student)
It is well known that strong leadership and self-determination facilitates positive outcomes in education and health interventions. As such, a course that provides the scope to develop and promote leadership can only be a positive thing.

Creation of hope and encouragement in students

For most of the people involved, the course has given them encouragement as a tangible option to help close the gap. This gave those involved a real sense of achievement and satisfaction.

This program is now the focus of this school and has provided a new direction for the school. It feels like we’re closing the gap. (Course Coordinator)

Perceived weaknesses of the course

The course deliverers had concerns predominantly related to a lack of local support for the course. While the course was funded by the Department of Education, Employment and Workplace Relations, course deliverers felt additional human resources and medical equipment were needed to assist in its delivery. Other challenges involved the delivery of the course in the remote location of Abergowrie and advantages/disadvantages of a Certificate II-level course. These challenges are not easily resolvable and may affect the future viability of the course.

There is . . . only one Indigenous deliverer – me – and I am a female. We need male representation. (Indigenous Health Lecturer)
Lack of resources – not enough medical equipment. (Teacher Aide)
It’s a unique program, so we’re restricted in who we can recruit to deliver the program – there is a shortage of course deliverers if the model is to expand. And we need [funds] to be able to place the boys in communities and get them to teach at primary schools. (Course Coordinator)
The isolation results in decreased access to work experiences [for the students], and makes it difficult to get role models out there – especially male role models. (Residence Manager)
Certificate III is required for entry for work in Queensland, but it has increased science requirements and more demanding literacy; it’s not appropriate [for the students] and doesn’t suit their needs. They may not have enough maturity to deal with a Cert III level right now. (Course Coordinator)

While the qualitative nature of the study means the findings cannot be generalised to other populations, the richness of the data warrant further Indigenous health studies of a similar nature.

Conclusion

If policy-makers are truly interested in bridging the health discrepancies between the Non-Indigenous and Indigenous groups in Australia by improving the Indigenous health workforce, then this study is timely as the findings highlight the benefits of tailored-made programs for Indigenous students in remote Australia. The Certificate II ATSI primary health-care course being offered at the St Teresa’s Agricultural College exposes Indigenous students to the possibility of pursuing a health career and has numerous secondary rewards such as promoting health knowledge and leadership, inspiring pride, and strengthening links with communities. Longitudinal follow-up evaluation of this program should identify whether this is an effective strategy for building the ATSI workforce in North Queensland, and thus, in closing the Indigenous health disparity in Australia. However, the course faces several serious challenges that threaten its expansion and perhaps even long-term viability.

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References


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