An urban Aboriginal health and wellbeing program: Participant perceptions

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**Student’s contribution: 90%**

Coordinating Supervisor signature…………………………………………………………………...
ABSTRACT

Issue addressed

An urban Aboriginal health and wellbeing program was implemented in 2011 to improve healthy eating and physical activity knowledge, attitudes and behaviours amongst a small group of local Aboriginal community members. The aim of this study was to evaluate the program on participant’s health and wellbeing.

Methods

A participatory action research method using photovoice was adopted. Following a period of familiarisation, 13 participants were each provided with a digital camera and asked to take photographs that represented health and wellbeing. Individual semi-structured interviews were conducted where concepts of health and wellbeing, as well as perceptions of the program, as depicted through photographs were explored. Interviews were transcribed and analysed thematically.

Results

The meaning of health and wellbeing for participants in this study was underpinned by components of prolonging life and social and emotional factors. Motivation for attending the program was dominated by social benefits. Improvements in healthy eating, an increase in socialisation and the ability to cope with stress were expressed. Positive feedback about program activities and staff was provided and barriers were identified.

Conclusion

This study has uncovered facilitators, motivators, barriers and benefits relating to participation in an urban Aboriginal health and wellbeing program through the use of photovoice, thus providing implications for future health promotion and research.

So what?

Promoting and addressing the social benefits, in addition to the intended outcomes on behaviour and anthropometric changes associated with health and wellbeing programs that target
Aboriginal people may help to increase and retain participation, thus improving the quality and duration of life for Aboriginal Australians.

**Key Words:** Aboriginal health, wellbeing, photovoice, evaluation.
This thesis would not have been possible without the guidance, support, commitment and patience of several people who in one way or another helped in the preparation and completion of this study. In honour of those who I would like to extend my utmost gratitude to I would like to represent one of your many contributions through photographs I have taken. After all a photovoice method was used for this study.

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LIST OF ABBREVIATIONS

HWB - Health and Wellbeing Being
NAIDOC – National Aboriginal and Islander Observance Committee
NMPHU - North Metropolitan Public Health Service
NSW - New South Wales
NT - Northern Territory
PAR – Participatory Action Research
QLD - Queensland
RCT - Randomised Control Trial
SA – South Australia
WA - Western Australian
Describing the Aboriginal Australian population

Throughout the literature the terms used to identify the first peoples of Australia include ‘Indigenous’, ‘Aboriginal’, ‘Torres Strait Islander’ and ‘Aboriginal and Torres Strait Islander’. In some cases more than one term is used when describing this population. For example, depending on the nature of the description; the Australian Bureau of Statistics (ABS) may use up to all four terms when describing the first peoples of Australia (Australian Bureau of Statistics, 2011). The term ‘Aboriginal’ will be used from here on throughout this thesis, unless directly quoting the work of another or describing the first peoples of another country and refers to Aboriginal and Torres Strait Islander people.
Chapter 1: Introduction

1.1 Introduction

Aboriginal Australians have been identified as a national priority population group for health interventions (Australian Bureau of Statistics, 2010; Australian Institute of Health and Welfare, 2008, 2010). Compared with other Australians, Aboriginal Australians suffer higher morbidity and mortality rates, shorter life expectancies, higher prevalence of chronic disease, injury, disability and mental health problems; are more likely to be overweight and/or obese, as well as engage more frequently in health risk behaviours such as excessively drinking alcohol and smoking (Australian Bureau of Statistics, 2010; Australian Institute of Health and Welfare, 2008; Thomson et al., 2012). The Australian government has aimed to address these disparities through the ‘Closing the Gap’ initiative that includes funding for health promotion interventions specifically to address Aboriginal health (Begley & Harald, 2005; Calabria, Clifford, Shakeshaft, & Doran, 2012; Chan et al., 2007), however there is a lack in the quantity and quality of evaluation studies being conducted and/or published, especially with culturally appropriate methods (Campbell, Pyett, & McCarthy, 2007; Clifford, Pulver, Richmond, Shakeshaft, & Ivers, 2011; Mikhailovich & Arabena, 2005).

To date, most published Aboriginal health intervention evaluations have focussed on sexual health (Guy et al., 2012; Mikhailovich & Arabena, 2005), alcohol, smoking, nutrition (Clifford et al., 2011) and general health and wellbeing (Bulman & Hayes, 2011; Davis et al., 2004; Mikhailovich, Morrison, & Arabena, 2007; Rowley et al., 2000). Many of these evaluated programs have stated the sustainability of the program (Mikhailovich & Arabena, 2005). Inadequate time frames, resourcing (Gray, Sagger, Sputore, & Bourbon, 2000) and inappropriate methods were major limitations to evaluation design and, hence, conducting rigorous evaluations (Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011; Mikhailovich et al., 2007).
Whilst there have been relatively few published evaluated Aboriginal community interventions, Huffman and Galloway (2010) identified common themes amongst many Aboriginal communities including the almost overwhelming issues of poverty, malnutrition, environmental contamination, inadequate clinical care and prevention services amongst many others. These social determinants are in large part responsible for the rapidly increasing lifestyle diseases and require an ecological community approach to prevention programs and any associated evaluation. Involving Aboriginal people and communities in research has continually been referred to as necessary for success (Huffman & Galloway, 2010; McDonald et al., 2010). Participatory action research (PAR) provides an appropriate framework to facilitate this necessity (Esler, 2008).

The concepts of PAR are based on collective action and are typically used to empower marginalised groups (Kendall et al., 2011; Liamputtong, 2009; Martin, 1996). PAR is an approach that is considered ethical for research with Aboriginal communities. An emerging PAR technique is photovoice which uses photographs as a conduit to engage communities. Photovoice, also known as Participatory Photography, was developed by Caroline C. Wang of the University of Michigan, and Mary Ann Burris of the Ford Foundation (Nairobi, Kenya) in 1994. Photovoice is a method which combines photography with grassroots social action. Participants are asked to represent their community or point of view by taking photographs, discussing them together and developing narratives to go with their photographs. It is often used among marginalised people and is intended to give insight into how they conceptualise their circumstances and hopes for the future (Wang & Burris, 1997).

The relatively unobtrusive nature of photovoice, together with its empowering capacity, makes it an ideal method to utilise in evaluations with marginalised groups such as Aboriginal Australians. Research incorporating this method has reported an openness and willingness of participants to discuss themes and provide feedback on issues relating to Aboriginal health based on photographs collected (Adams et al., 2012; Wilkin & Liamputtong, 2010).
The North Metropolitan Public Health Unit (NMPHU) located in metropolitan Perth, Western Australia provides free public health initiatives for Aboriginal community members. Two of these initiatives were the Health and Wellbeing Program and the Zumba Program, both part of the ‘Closing the Gap’ funding that fall under the broader healthy lifestyle programs targeting the Aboriginal community in the North and North Eastern suburbs of Perth, Western Australia.

The Health and Wellbeing Program was initially implemented in February 2011 as a 12-week program known as ‘A Taste of Exercise’. The aim of this program was to increase knowledge, skills and behaviour in regards to physical activity and healthy eating. The original 12-week program has transitioned to a longer term program comprising weekly sessions during school terms and is now known as the Health and Wellbeing Program. People from the Aboriginal community attend free of charge and engage in physical activities run by an Aboriginal sports association. Each session concludes with a healthy meal and a ‘yarn’ where stories and information about what is happening in community are shared.

As a result of a request from the community for a physical activity program to be run at an alternative time to the Health and Wellbeing Program, a Zumba class was established at the local recreation centre in November 2011. This program was offered once a week, free of charge and remains open for Aboriginal people in the community to participate. The program was initially established to cater for those who were unable to attend the Health and Wellbeing Program during the morning and for mothers while their daughters attended a young girls program at the same venue. Together, these two programs formed part of the healthy lifestyle initiatives that are offered to the community by the NMPHU. At present, there has been no evaluation published on either program.

1.2 Statement of Problem (Aim of study)

This study, through the use of photovoice, sought to evaluate an adult Aboriginal health and wellbeing intervention that offered a health and wellbeing program (physical activity and nutrition) and a separate exercise ‘Zumba’ class. Additionally, the study also sought to explore culturally appropriate methods in the evaluation of Aboriginal health related projects.
1.3 **Significance**

There is a lack of published evaluations on Aboriginal health programs using culturally appropriate methods. This study utilised photovoice to evaluate a health and wellbeing intervention offered to local Aboriginal adult community members in an urban setting. Through this study, an understanding of facilitators and barriers to practical aspects relating to participation in health initiatives, specific to this population, have been uncovered.

1.4 **Limitations**

- Purposive, convenience and snowball sampling methods were used for this study. Participants were asked to refer the researcher to community members who had also participated in either/or programs who may be interested in the project. Such sampling techniques may have introduced a source of selection bias to this study.
- Conclusion relating to the findings from this study may be valid only to the participants of the programs and the specific demographic population group sampled.

1.5 **Delimitation**

This study was restricted to the following:

- To be eligible for this study people must have participated in the Health and Wellbeing Program and/or Zumba Program offered by the NMPHU in Perth, Western Australia, at least once.
- Participants were aged 18 years or older at recruitment.
Chapter 2: Literature Review

2.1 Aboriginal health in Australia

In 2011 Aboriginal people comprised an estimated 2.5% of the Australian population (Australian Bureau of Statistics, 2012). Although this figure represents a small proportion of the total population, there exists a substantial gap in life expectancy between Aboriginal people and other Australians. Aboriginal people have higher death rates, lower life expectancy and are more likely to be hospitalised compared with non-Aboriginal people (Australian Institute of Health and Welfare, 2011; Thomson et al., 2012). For the period 2005 to 2007 the life expectancy at birth was estimated to be 67 years for Aboriginal males and 73 years for Aboriginal females (Australian Bureau of Statistics, 2009) Equivalent estimates for other Australians were 79 years for males and 83 years for females, a gap in life expectancy of 12 years for males and 10 years for females. In Australia, Aboriginal peoples’ life expectancy is shorter not only because of higher mortality rates for many diseases, but also because death from these diseases occurs earlier in life (Cotter et al., 2012).

In New South Wales (NSW), Queensland (QLD), Western Australia (WA), South Australia (SA) and Northern Territory (NT) combined, two-thirds of the Aboriginal population died before the age of 65 years, compared with one-fifth of the Australian population who died before the same age (Australian Institute of Health and Welfare, 2011)

In addition to lower life expectancy and higher death rates, Aboriginal people in Australia suffered a higher prevalence of chronic disease, injury, disability and mental health problems than other Australians (Australian Institute of Health and Welfare, 2011; Thomson et al., 2012). As shown in Table 1, during 2004 – 2008 the leading cause of death for Aboriginal people in NSW, QLD, WA, SA and the NT combined; during 2004 – 2008 was cardiovascular disease,
where Aboriginal people died at a rate 2.5 times higher than the rate of non-Aboriginal people (Thomson et al., 2012).

**Table 1: Top five leading causes of death of Aboriginal people, standardised deaths rates compared with non-Aboriginal people in NSW, QLD, WA, SA and NT during 2004 – 2008.**

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>Rate (per 100 000)</th>
<th>Rate ratio</th>
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<tbody>
<tr>
<td></td>
<td>Aboriginal</td>
<td>Non-Aboriginal</td>
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<tr>
<td>Cardiovascular disease</td>
<td>543</td>
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<td>Cancer</td>
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<td>181</td>
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<tr>
<td>Respiratory Diseases</td>
<td>152</td>
<td>51</td>
</tr>
<tr>
<td>Endocrine, metabolic and nutritional diseases (including diabetes)</td>
<td>135</td>
<td>22</td>
</tr>
<tr>
<td>Digestive diseases</td>
<td>96</td>
<td>20</td>
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</table>

(Thomson et al., 2012)

The disproportionate burden of disease amongst Aboriginal Australians is linked to more common health risk behaviours such as smoking, harmful levels of alcohol consumption and more likely being overweight or obese than other Australians (Australian Institute of Health and Welfare, 2011; Thomson et al., 2012). Aboriginal people were twice as likely to experience psychological distress, which stems from the stress, chaos, social exclusion, racial discrimination, social inequality, grief, trauma and abuse associated with colonisation and forced removal; having had an incredible impact on Aboriginal health, social and emotion wellbeing (Gee, Dudgeon, Schultz, Hart, & Kelly, in press; Zubrick et al., 2010). Many Aboriginal people live in disconnected spaces as the cultural mechanisms that held them together have been undermined. Many are survivors of the stolen generation. Such factors have contributed significantly to the poor health outcomes of Aboriginal today (Gee et al., in press; Zubrick et al., 2010). Additionally, Aboriginal people are five times more likely to be hospitalised for preventable conditions than non-Aboriginal people. Coupled with a
disproportionate burden of disease, Aboriginal Australians also experience greater disadvantage in regard to education, income, employment, housing, and access to health services (Australian Institute of Health and Welfare, 2011; Thomson et al., 2012) further compounding their ability to redress these inequities.

### 2.2 Health promotion evaluation with Aboriginal communities

Health promotion interventions to improve the health behaviours of Aboriginal people in Australia are not new and, over the years, a wide range of strategies at the individual, family, community and state level have been implemented (Begley & Harald, 2005; Calabria et al., 2012; Chan et al., 2007; Kowanko et al., 2009). However, evidence of the effectiveness of these interventions over the past 20 years has been limited as it has been largely descriptive in nature with limited and often inappropriate measurement tools for the Aboriginal population (Clifford et al., 2011; Gray et al., 2000; Mikhailovich et al., 2007; Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006). In addition to the lack of published measurement and intervention research, several reviews have concluded that most published evaluation methodologies have not been optimal in terms of rigour, leading to difficulty in concluding effectiveness (Clifford et al., 2011; Gray et al., 2000; Sanson-Fisher et al., 2006). For example, Chan et al. (2007) implemented a prospective study design to investigate the short term efficacy of a physical activity and nutrition based lifestyle intervention program on cardiovascular health risk factors among overweight urban Aboriginal Australians with and without type 2 diabetes mellitus. At six months follow up, significant reductions in waist circumference and diastolic blood pressure were reported. However, the omission of a control group limited the ability to attribute changes to the intervention and compromised the rigor of the study. The investigators considered introducing a control group, however community officials declined to participate in the study if it meant there was a group solely being measured and not permitted to participate in the program (Chan et al., 2007). This is one example that highlights some of the challenges of
transferring acceptable standards of research rigour used in the general population, to an
Aboriginal context.

Aboriginal health program evaluations are seemingly over-represented by methodological
limitations including lack of baseline data, self-reporting, self-selection, limited sample sizes,
non-randomised study designs, lack of a comparison group and non-validated instruments
(Clifford et al., 2011; Gray, Saggers, Drandich, Wallam, & Plowright, 1995; Gray et al., 2000;
Mikhailovich et al., 2007; Sanson-Fisher et al., 2006). Consequently such limitations impact on
research rigour with reviews having indicated that the outcome of less than optimal rigour can
lead to difficulty in concluding effectiveness of interventions and studies remaining unpublished
(Clifford et al., 2011; Gray et al., 2000; Mikhailovich et al., 2007; Sanson-Fisher et al., 2006).

To compound the methodological barriers encountered in the majority of the published
Aboriginal health research literature, there were also significant practical barriers encountered.
Practical barriers included inadequate time, resources; and evaluation funding limitations; all of
which impact the ability to conduct and evaluate programs (Gray et al., 1995; Mikhailovich et
al., 2007). For example, Ivers et al. (2005) assessed the effects of an anti-tobacco television
advertising campaign compared to other anti-tobacco interventions for Aboriginal people in
remote communities. A pre and post-test survey was employed that showed exposure to, and
recall of the, anti-tobacco television advertising, which was recalled more than any other
intervention. Although exposure to individual tobacco interventions was not associated with an
increased chance of cessation in the following year, a small number of smokers had given up as
a result of television advertising. However, due to funding that allowed access to only 3% of
communities in remote NT, the results were based upon a small sample size in potentially
unrepresentative communities (Ivers et al., 2005).

Rowley et al. (2000) provides a further example of the difficulties in evaluating Aboriginal
health programs in their evaluation of the ‘Looma Healthy Lifestyles Program’ in the remote
Kimberley region of WA. They employed a longitudinal cohort study rather than a randomised
controlled trial (RCT) due to an inability to randomise people or communities into intervention
and control groups. In the end Rowley et al. (2000) concluded that ‘a truly “randomised” design
is unlikely to be a useful model for Aboriginal community-based intervention, since communities and individuals choose whether or not to undertake such programs’ (Rowley et al., 2000, p. 143). From a scientific perspective, a RCT may be the desirable study design to determine the effectiveness of interventions, but in Aboriginal communities this may be at the expense of cultural sensitivity, which has proven paramount to the success of health programs and their evaluations. The western epidemiological, positive view of evidence competes with the need to use culturally appropriate research methods with an Aboriginal context. The *Looma Healthy Lifestyle* program is an example of this issue and illustrates the way in which the internal validity of the research can be undermined because of the tension between these competing processes. In part this is reflective of the experience of the researches who have published in this field and the limited number of rigorous research trials that have been completed (Rowley et al., 2000). These findings build the notion that evaluating interventions requires more culturally appropriate research methods.

The most successful interventions and evaluations with Aboriginal communities have adopted a participatory engagement approach with the local community allowing them to “own” the intervention and its evaluation (Shannon, Canuto, et al., 2001; Shannon, Young, et al., 2001). An evaluation of an injury prevention program in the Aboriginal community of Woorabinda, QLD, resulted in a significant reduction in injuries presented for medical attention. The most important reason provided for the success of the program was the support from the community who wanted to take action to address injuries occurring within their community. Continuous consultation and strong collaborations between the community’s leaders, elders and external research team underpinned the program’s success (Shannon, Canuto, et al., 2001; Shannon, Young, et al., 2001). This project amalgamated traditional injury prevention practices and incorporated Aboriginal beliefs and values to develop an effective measureable intervention.

It should perhaps be unsurprising that relatively few rigorously evaluated Aboriginal health promotion interventions exist. Quantitative methods generally require systematic procedures under the control of the researcher. This pre-requisite and the conduct of even well-meaning non-Aboriginal researchers has been seen as inappropriate and culturally insensitive as it does
not allow the community to have ownership over the research process and outcome (Humphery, 2001; Kendall et al., 2011; McDonald et al., 2010; Mikhailovich et al., 2007; National Health and Medical Research Council, 2003a). Successful quantitative research requires an understanding amongst participants that ethical research is a process that undergoes continual refining at many levels of society but is ultimately conducted and controlled by researchers. In many instances trust is implicit in the research process and its likely benefits to individuals and/or society. Evidence from the literature on Aboriginal health evaluations shows that this implicit trust in researchers does not exist and actively involving Aboriginal communities and having their support throughout the research process is important to ensure needs of the community are met and their culture is respected (Gray et al., 1995; McDonald et al., 2010; Mikhailovich et al., 2007).

The success of qualitative methods, for example; oral, narrative, storytelling or arts-based methods makes these techniques appropriate when working with Aboriginal people (Adams et al., 2012; Gray et al., 1995; McDonald et al., 2010; Mikhailovich et al., 2007; Taylor, Thompson, & Davis, 2010). In general, a PAR approach provides a framework that fosters and facilitates such methods (Esler, 2008; Mikhailovich et al., 2007).

### 2.3 Participatory Action Research

The concepts of PAR are based on participation, education and collective action and is used to examine the factors that contribute to the disempowerment of marginalised groups and identify strategies to address these factors. (Kendall et al., 2011; Liamputtong, 2009; Martin, 1996). As an approach PAR is considered ethical for research with Aboriginal communities as this method compliments the *Values and Ethics for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research* (National Health and Medical Research Council, 2003b), as well as guiding principles endorsed in the National Aboriginal Health Strategy (Hearn & Wise, 2004). These values and principles are summarised below (see Table 2).
Table 2: Summary of values and principles that compliment a participatory action research approach, by source

<table>
<thead>
<tr>
<th>Values and ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander health research</th>
<th>National Aboriginal Health Strategy</th>
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<tbody>
<tr>
<td>Reciprocity</td>
<td>Community Involvement</td>
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<td>Respect</td>
<td>Community consultation</td>
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<td>Equality</td>
<td>Community support</td>
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<td>Responsibility</td>
<td>Use of holistic understandings of health</td>
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<td>Survival and Protection</td>
<td>Project linked action research</td>
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<td></td>
<td>Sensitivity to social and cultural context</td>
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(Hearn & Wise, 2004; National Health and Medical Research Council, 2003b)

In PAR the above values and principles are embraced by encouraging community members to actively participate in the research process, from planning, collecting and reviewing data through to sharing and controlling the use of the findings. The underpinning rationale for PAR is to research ‘with’ the community rather than ‘on’ it (de Koning & Martin, 1996; Esler, 2008; Liamputtong, 2009; McIntyre, 2008). During the research process the community socially share their personal perspectives and understandings of the problems under examination to create new forms of knowledge and establish a new ‘social reality’. The researcher and the community work as a team in a reciprocal manner to produce new knowledge and research skills from each other. The community not only benefits from the research outcomes but also from the research process. The process fosters participation and cooperation and allows communities to take ownership of their newly created research skills and knowledge. In turn, the process encourages the community’s sense of empowerment to take control of their situation and builds confidence to stimulate change (Cornwall, 1996; de Koning & Martin, 1996; Esler, 2008; Kendall et al., 2011; Liamputtong, 2009; McIntyre, 2008).

It has been shown that PAR can be successfully used in Aboriginal health research (Adams et al., 2012; Esler, 2008; Fletcher et al., 2011; Shannon, Canuto, et al., 2001; Shannon, Young, et al., 2001; Tsey et al., 2004). An example is the Goreen Narrkwarren Ngrn-toura- Healthy
Family Air Project in Victoria which aimed to develop a smoke-free workplace policy within an Aboriginal community controlled health organisation (Fletcher et al., 2011). Through an iterative PAR process utilising the Aboriginal cultural form of conversation known as ‘yarning’, participants explored smoking in regards to emotional impact of smoking in general, smoking cessation at work and the development of a smoke-free workplace policy. From the beginning it was identified by participants that the topic of smoking was a sensitive issue because of its association to smoking related illness and death. However, due to the informal nature of the yarning sessions participants were able to speak candidly about the topic, which allowed them to work towards developing the smoke-free workplace policy. An anonymous online survey was also conducted which allowed for participants who were unable to attend the yarning sessions to share their input. To ensure ownership of the policy, participants were adamant about appropriate informal wording and the rationale directly relating to how smoking impacts their ‘mob’. The policy became official in 2010 and will undergo a participatory review in the future (Fletcher et al., 2011).

Another example where PAR has been employed was with the Yarrabah Men’s Health Group project in QLD, which aimed to improve the health and wellbeing of the Aboriginal men in the community by supporting participants to plan, implement and evaluate their activities via reflexive PAR approach (Tsey et al., 2004). Data was collected via participant observation, feedback boxes, informal discussions and in-depth interviews with participants facilitated reflection, program strategy refinement and action. As a result of participation in the program, participants expressed their sense of encouragement and hope for things to change in the future and increased their self-confidence to help others (Tsey et al., 2004).

2.4 Photovoice: A contemporary participatory action research method

An emerging innovative PAR method is photovoice where participants’ points of view on community issues are reflected upon through discussion of photographs they take (Adams et al., 2012; Wang & Burris, 1997; Wilkin & Liamputtong, 2010). The goals of photovoice are, firstly,
to enable participants to record and reflect community strengths and concerns. Secondly, photovoice aims to promote dialogue and knowledge sharing/production through the discussion of photographs within a safe environment. Lastly, photovoice aims to encourage participants to recognise there is a need for action to address the issues raised and provides an innovative strategy to communicate these issues to the wider community and decision/policy makers (Adams et al., 2012; Wang & Burris, 1997; Wilkin & Liampoutong, 2010).

Photovoice has been used to explore an array of health issues with Indigenous groups around the world (Berrang-Ford et al., 2012; Castleden, Garvin, & Huu-ay-aht First Nation, 2008; Higginbottom et al., 2011; Poudrier & Mac-Lean, 2009) and relatively recently amongst Aboriginal communities in Australia (Adams et al., 2012; Edwards, Coffin, & Lower, 2005; Henshaw, Eley, & Gorman, 2011; Liampoutong & Wilkin, 2010; Maclean & Woodward, 2013; Nelson, 2012).

Photovoice can be used in several ways to address the needs of any population, irrespective of the topic of interest. Typically, the stages of photovoice involve ethical and technical training to use cameras, the assignment of a task, a period of time to take the photographs, discussion of photograph representation in groups and finally dissemination of the findings (Castleden et al., 2008; Hergenrather, Rhodes, Cowan, Bardhoshi, & Pula, 2009; Liampoutong, 2007; Wang & Burris, 1997). However, as demonstrated by Castleden et al. (2008) the photovoice method can be adapted. A modified version of the photovoice method was used with the Huu-ay-at First Nation to explore community perspectives of environmental health. The photovoice method was modified to incorporate an iterative process comprising training, photograph assignment and interviewing on an individual and regular basis. Communicating progress on the evaluation to the community was described as being pertinent to the methodological success of the project (Castleden et al., 2008).

Published studies utilising photovoice in Aboriginal communities in Australia appear to be few, however, the numbers are increasing (Adams et al., 2012; Henshaw et al., 2011; Maclean & Woodward, 2013; Nelson, 2012; Wilkin & Liampoutong, 2010). Maclean and Woodward (2013)
incorporated photovoice for its cultural appropriateness when working with an Aboriginal community in Queensland, Australia, to explore values, knowledge, concerns and aspiration in regards to water management. The successful outcomes of the study demonstrated that the photovoice method was culturally appropriate as well as facilitated engagement and fostered empowerment (Maclean & Woodward, 2013). Another recent project was conducted by Nelson (2012) who explored young Aboriginal peoples’ perceptions of body health and physical activity in Queensland, Australia. Nelson (2012) confirmed that photovoice could be successfully used to understand ‘proper’ body image in an Aboriginal health context. It also extended that photovoice was a relevant and engaging method for use with Aboriginal young people (Nelson, 2012).

2.5 Summary

This review has highlighted that the published literature regarding Aboriginal health intervention research has been insufficient in terms of quality and quantity, especially with culturally appropriate methodologies (Campbell et al., 2007; Clifford et al., 2011; Mikhailovich et al., 2007). The PAR method has been identified (Esler, 2008) as culturally appropriate for use with Aboriginal health research (Mikhailovich et al., 2007). Furthermore, an innovative PAR method known as photovoice has been identified as engaging, empowering and culturally appropriate when researching with Aboriginal communities (Maclean & Woodward, 2013). Although there are a handful of published Aboriginal health intervention studies, a gap still remains in the literature providing evidence for the effectiveness of Aboriginal health promotion programs, particularly those that have used appropriate evaluation methods. As such, there is a need for more Aboriginal health intervention research utilising culturally appropriate approaches and methods to be conducted and published. The current study is based on contributing to filling the gap of Aboriginal health promotion intervention research by evaluating an urban Aboriginal health and wellbeing program.
2.6 References


Nelson, A. (2012). 'You don't have to be black skinned to be black': Indigenous young people's bodily practices. *Sport Education and Society, 17*(1), 57-75.


Chapter 3: An urban Aboriginal health and wellbeing program: Participant perceptions

This manuscript has been formatted in accordance with the authors’ instructions for submission to the Health Promotion Journal of Australia.
3.1 Introduction

Aboriginal Australians are dying younger and faster than non-Aboriginal Australians, with a life expectancy of 10-12 years less (Australian Institute of Health and Welfare, 2012). Aboriginal people suffer a higher prevalence of chronic disease, injury, disability and mental health problems; combined with a higher frequency of engaging in health risk behaviours, such as smoking and drinking at excessive levels than non-Aboriginal Australians (Australian Bureau of Statistics, 2010; Australian Institute of Health and Welfare, 2008; Thomson et al., 2012). While health promotion interventions have been implemented to address Aboriginal health (Guy et al., 2012; Ivers et al., 2005; Lehmann et al., 2003; Valery et al., 2010), reviews have indicated the quality and quantity of published intervention research, specifically with methods appropriate for Aboriginal populations, are insufficient (Clifford, Jackson Pulver, Richmond, Shakeshaft, & Ivers, 2011; Gray, Sagers, Sputore, & Bourbon, 2000; Mikhailovich, Morrison, & Arabena, 2007; Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006). With a paucity of culturally appropriate evaluation methods, photovoice has been identified as an acceptable method when researching with Aboriginal populations (Adams et al., 2012; Castleden, Garvin, & Huu-ay-aht First Nation, 2008; Wilkin & Liamputtong, 2010).

Photovoice is a form of Participatory Action Research (PAR) that encourages participants to actively participate in the research process (Esler, 2008). In the past, audits (Tyrrell, Grundy, Lynch, & Wakerman, 2003) and surveys (Ivers et al., 2005) have been employed to evaluate interventions amongst Aboriginal populations. Evidence is emerging to suggest that traditional methodological procedures may not be transferable to minority populations, such as Aboriginal people (Kendall, Sunderland, Barnett, Nalder, & Matthews, 2011). As a result, PAR is emerging as a popular evaluation approach as well as an ethical requirement (Mikhailovich et al., 2007). The unobtrusive and empowering nature of photovoice has made it a successful tool in researching experiences amongst Aboriginal populations where previously, it has been used to research the experiences of Aboriginal health workers (Liamputtong & Wilkin, 2010; Wilkin & Liamputtong, 2010).
This paper is contributing to filling the gap of Aboriginal health promotion intervention research by evaluating an urban Aboriginal health and wellbeing program. Two programs comprised the overall health and wellbeing intervention. The first was a health and wellbeing program that aimed to improve knowledge, behaviour and attitudes about physical activity and nutrition. The second, an exercise “Zumba” class provided a physical activity program in the afternoon as an alternative to the morning health and wellbeing program. A photovoice method was employed to investigate participant’s meaning of health and wellbeing, as well as determine the perceptions, effects and feedback of the overall intervention. A discussion of the overall findings and implications for future Aboriginal health promotion and research is provided.

3.2 Methods

The study was based on a PAR approach that employed a photovoice method. A combination of purposive, convenience and snowball sampling methods were adopted to recruit Aboriginal people who had participated in at least one of the health and wellbeing intervention programs offered in an urban community centre in Perth, Western Australia. In PAR, research participants are typically involved in the determination of the research question, how it will be answered and in what way results will be presented and disseminated. In this study, potential participants had already developed the intervention, established its content and likely benefits in partnership with the local North Metropolitan Public Health Unit (NMPHU), who funded the program. The researcher was introduced to participants of the project as someone who could assist in determining whether the expected program outcomes were achieved. To establish the researcher’s suitability, an integration and assimilation process was employed, prior to participant recruitment. This involved the Program Coordinator (NMPHU) introducing the researcher to all program participants four weeks prior to recruitment for the purposes of relationship and trust building. Once key group members, one including an Aboriginal Elder, acknowledged their support for the evaluation technique and how information would be collected, interpreted and presented, the researcher commenced recruitment. An information
session was held where potential participants were presented information about the research (Appendix A) and provided an opportunity to ask the researcher questions. Potential participants were given examples of photographs (see Appendix B) from previous photovoice projects (Bukowski & Buetow, 2011; Larson, Mitchell, & Gilles, 2001; Wilkin & Liamputtong, 2010) and shown examples of photo books (Ah-Won et al., 2010; Lawson et al., 2008) to help explain the photovoice method and the research approach. A first group of participants were recruited in person by the researcher at the end of the information session. Subsequent participants were recruited via snowballing, where existing evaluation participants referred the researcher to other program participants who were not present at the information session. The researcher arranged a convenient time and place with referred participants, individually, to recruit them in person. The researcher arrived at the final numbers of the sample when saturation in data was achieved.

To be eligible for the study, participants were required to have attended a minimum of one session of one or both of the programs. Participation in the study involved four sessions. The first session involved educating participants in how to use a digital camera safely and included training of mechanical and ethical use of the camera (see Appendix C for training guide) (Castleden, 2007). Each participant was provided a pack containing an information and consent form, digital camera (labelled with an asset number), camera diagram, homework card (Photovoice Hamilton Ontario, 2007), several copies of a consent form requesting permission to photograph another person and a participant contact details and demographics form (see Appendix D). Participants were provided with a camera for up to two weeks and asked to take photographs that represented what health and wellbeing meant to them, places where they were physically active and places where they spent time with friends and family. Follow up phone calls were made one week following the training to determine their progress and offer support.

Following the return of cameras the photographs were printed. One set of photographs and a CD containing an electronic copy of the photographs were given to each participant to keep. A second set of photographs were labelled with unique ID codes. These were used to prompt participants as part of individual semi-structured interviews (see Appendix E for interview
guide) (session 2). The interviews commenced by having participants group their photographs in accordance with specific questions relating to health and wellbeing, physical activity, friends and family; and the health and wellbeing program. This was followed by a semi-structured discussion around key themes. At the conclusion of the interviews participants were asked to select several significant photographs to present back to other participants at a later focus group. As part of the participatory approach, each participant was provided with a summary of the interview findings and an opportunity to amend them to ensure a true and accurate representation was made (session 3). The final stage of data collection (session 4) involved two focus groups, one for each of the programs. Photographs chosen during individual interviews were presented to the group and main themes of the interviews were discussed to refine the researchers’ interpretation of emergent themes. Where participants were not able to attend the focus groups, the researcher emailed a written summary of the main themes and followed up participants with a phone call to discuss these themes.

Interviews and focus groups were recorded with permission of participants. Where permission was declined notes were written. All recordings were transcribed verbatim. To protect the identity of participants, each participant was asked to choose their pseudonym. The data was analysed by a thematic analysis and all responses are grouped to avoid individual identification. Two researchers independently reviewed transcripts and discussed the themes that emerged. A coding hierarchy was created using the discussion guide, concepts from the literature, and themes emerging from the data. Ethics approval was granted by The University of Western Australia’s Human Research Ethics Committee (RA/4/1/5994) (Appendix F) and the Western Australian Aboriginal Human Ethics Committee (452) (Appendix G).

3.3 Results

Initially, 16 adult Aboriginal community members agreed to participate in the photovoice research. Three participants withdrew as a result of heavy work commitments and/or private
reasons. The final study comprised of 13 participants. Eleven of the 13 participants attended all four sessions. Two participants were not able to attend the final (focus group) session due to personal reasons, however were able to provide feedback via phone call. Table 3 summarises participant demographics and their program affiliation.

Table 3: Summary of participant demographics and program affiliation

<table>
<thead>
<tr>
<th>GENDER</th>
<th>AGE</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25-50yrs</td>
<td>51-75yrs</td>
</tr>
<tr>
<td>Male</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Female</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

*HWB = Health and Wellbeing

Meaning of health and wellbeing

Overall, participants described health and wellbeing in terms of longevity through the absence of infirmity, within a socially supportive family and community environment. The importance of family and friends was a dominant theme in discussions around health and wellbeing. Families were large and extended to several generations, impacting upon the meaning of health and wellbeing to participants. All participants, or someone in their family, were burdened with an ailment, the most common being diabetes. There was also an expectation that diabetes was an unavoidable outcome for Aboriginal people. Nonetheless, amongst these participants there was a strong sense of personal responsibility to prevent or manage their own diseases so they could live longer for their families and/or for their community. For one participant it was her number one priority in life and she predominantly took photographs of her children playing as they represented the importance and purpose to live longer (see Figure 1).

Participants also described health and wellbeing from a health behaviour perspective with, for example, eating healthy being important to help prevent or manage injury or disease. One female participant took a photograph of a variety of foods including fruits and vegetables and
discussed the benefits of including such foods in your diet on overall health and wellbeing (see Figure 2).

**Figure 1: Live Longer**

“It’s about the future and being healthy and be around as long as I can for the kids for when they get older. You can see them to do well in how they grow up and in the future what they’re going to do.” (Female)

**Figure 2: Nutritional food**

“Food that’s good for your body, lettuce, carrots, cucumber, potatoes, and pumpkin, a bit of everything are really good for your health and wellbeing. It’s a must, see you’ve got all your vitamins and minerals so that you can fight all the diseases” (Female)

**Social and emotional factors**

Social interaction and emotional attachment emerged as consistent themes amongst participants’ meaning of health and wellbeing. Most frequently it was described having a connection with others through relationships and bonds, especially with family and friends. It was not always clear whether relationships or bonds were a means to achieving health and wellbeing, or health and wellbeing itself. However, the feeling of support, sharing stories and including/helping others was described as uplifting the mind of participants which, they felt, contributed to their meaning of health and wellbeing. Four participants felt that life without connections with others would be sad and lonely. A male participant described the reciprocal act of including and helping others as being ‘blessed’.
"I think sometimes the world itself is shut in, we live in our little world, but we have to make our world fit other people into it. When you do something for somebody you are blessed, you might not be given money for doing it, but because you help someone in trouble and they acknowledge it, you just thank god for the opportunity. Means to be blessed is when you’re happy in your heart, you’re happy in your mind, you’re not self-centred and selfish, you learn to care for other people. And they’ll in turn care for you too.” (Male)

Perceptions of the health and wellbeing programs

When asked to use their photographs to describe how they felt about the programs they attended, participants overwhelmingly viewed the program’s activities as primarily a social gathering, although the Zumba Program had a greater direct engagement in being physically active. The programs were described as fun with a place to be physically active. The physical activity and nutrition program was specifically described as a place to learn about different foods. Participants of both programs expressed how enjoyable the activities were and emphasised how being physically active at these programs did not feel like they were doing exercise because of the fun they experienced. A female participant discussed her perception of exercise relating to the Zumba Program.

“I always thought exercise had to be going out and doing jogging on the treadmill and it was all hard yakka. Zumba was the first actual exercise that I’ve enjoyed. Once you get into it you can’t lose, you don’t care and you get past the shame, how you look that really self-conscious thing. You lose yourself in it and it’s just great, it’s fun and I love it. I walk away feeling good and I feel even better the next day.” (Female)
The opportunity to socialise, meet new people, interact and spend time with family/friends was a very common reason for attending both programs.

“Part of the fun of the programs was getting to know other people and being able to have a yarn, share stories and information about what was happening in the community. It was exciting because we meet friends there then you can get to know people ‘cause if you’re throwing the ball to someone you need to know who you’re throwing the ball to. Then we have a discussion around the table, people bring their ideas, they share their experiences with us.” (Female)

The physical activity and nutrition program in particular was described by participants as a place where the ‘oldies’ were an inspiration. A husband and wife aged over 65 years old who attended the program on a regular basis were described by other participants as inspirational role models. The inspiration to others contributed to enabling participants to engage in the program on both physical and social levels. The husband expressed his purpose for attending the program:

“I think that’s one of the reasons why I come here, I want to encourage others, often with the challenges later on if that old guy can do it I can do it, you know, well anyway it’s possible.” (Male)

**Effect of the programs**

Objective measurement of changes brought about by attending the programs was not conducted as part of this study. However, participants reported changes they experienced as a result of
attending the programs. Seven out of ten participants of the physical activity and nutrition program said they had changed their eating habits as a result of the nutritional education they received. Changes included swapping coke for water, white bread for multigrain/whole meal bread, full cream for skim milk, grilling meats instead of frying them; reducing or eliminating sugar, fats or salt; and increasing intake of fruits and vegetables. A female participant described an example of the changes she had made to her diet and her experience during the nutrition classes.

“I would try not to have so much junk food, more healthy food. I have smaller portions and I’ve cut down the plate size. They showed us meals, a burger, fries and a drink. They showed all the fat. They had different coloured things to represent fat, salt, sugar, added it all up, put it on this tray and they say this is all the fat, sugar and salt you’re having from that meal. They showed healthier ways to have them meals without all that fat, salt. Like grilling your meat and having potatoes baked or drinking water. They showed what’s got less salt and sugar, have light milk. Now I don’t have milk in my tea, it tastes better. I eat differently, healthier now.” (Female)

Participants of the overall health and wellbeing program also reported an increased opportunity to socialise because they attended the program. Attending the program provided an additional time and place where participants could interact with others make new friends and spend time with existing friends that would not have occurred otherwise. For some participants it was the only opportunity they had to spend time with certain friends. Participants valued the opportunity to be part of an organised group and looked forward to catching up and interacting with others. A female participant described her experience of making friends at the program.
“I’ve made a few friends. You see them and say hello, how are you going? I’ve met more people than I knew before coming here. When I see them around it feels like you’re known in the community and you can have a yarn with them.” (Female)

The six participants who attended the Zumba Program reported increased ability to cope with stress. Five out of the six participants all worked at the same organisation. Their employer supported their attendance at the Zumba Program by allowing them to finish work an hour early on Wednesdays to attend the class. The five participants believed that without the support of their employer they would not attend the program and would instead be sitting at their desks and not engaging in any vigorous physical activity during the working week. All Zumba Program participants thought there were mental health benefits from both the physical activity they engaged in and the fun associated with participating. Being able to enjoy the exercise relieved stress for participants. All agreed that Zumba broke up their working week, resulting in feeling re-energised and able to face the rest of a stressful working week. A female participant described her experience of the effect of exercising at the Zumba Program.

“It’s like you dance it all off, you go crazy, you walk out and think oh that was full on, it was great. You walk out and you feel like OK I can handle another day. Whenever we missed that one session all week we’d be feeling like oh gee, I feel little bit down and I’m down again. Work is behind us encouraging staff to go and participate, there are not a lot of work places that allow that” (Female)

When prompted to discuss why the programs had such a positive impact on their ability to cope with stress participants said that high levels of stress were a part of life and that the physical activity of Zumba was vigorous and felt like it was releasing that stress. When explored further, participants believed that stress was only unhealthy if people did not know how to deal with it.
Typically they referred to using social strategies involving interacting with other people, talking and debriefing life situations as well as being physically active (walking, dancing, cooking or cleaning the house). The two programs provided a period of time during the week where both of these coping strategies could be achieved. A male discussed his perception of stress.

“Stress is always there. It’s just how you deal with stress and getting over your stress. Stress can come in all shape and all form....it’s good too, ‘cause you’re getting out in the fresh air and you’ve got a lot of time to think while walking, ‘cause in the car you could turn the music up and drive along pretending it’s not there, and when you come back the problem is still there, whereas if you’re running and walking, you’ve got time for yourself and processing it all, get it off your chest basically. Play a bit of footy every week and you’ll have a healthy inside life.” (Male)
Participant feedback

Participants were asked to choose and then discuss photographs that described how they felt about the programs. Participants provided a positive reflection about the activities they participated in as part of the overall Health and Wellbeing Intervention. The physical activity and nutrition program participants discussed their enjoyment of the variety of team sports presented each week, which included ‘Metcha Bomba’ (Aboriginal hockey), basketball and volleyball. Without the variety of activities, participants felt the program would probably become unappealing and boring. In addition to team sports, participants provided suggestions for new activities to be implemented, such as outdoor hockey, basketball competitions with other community groups, Pilates, tai chi, yoga, 10 week challenges and health camps. Some participants were interested in being monitored for their blood sugar levels so the program could provide information and advice based upon the test results. A female participant described the benefits of implementing monitoring as part of the program.

“I think if everybody had their own little booklet you can write in what they weigh, BSL and blood pressure and any other comments. They can keep track. You might say “Oh your sugar level is four” and they’ll think “well what does that mean?” and then you can explain to them... Or if it’s high, if it’s over eight then you know that they need to cut down their sugars...there’s information that you can learn from. Like if your sugar is going up then you know OK something’s got to change.”

(Female)

The participants of the physical activity and nutrition program also provided positive feedback about the program staff predominantly about the style of team sport delivery, which was highly regarded by participants. Participants felt that the structure of delivery worked well for them. One female participant described this style as “they do, you do, then we all do” (Female).
Participants also provided positive comments about the style of education delivery, the practicality of advice and use of visual aids worked especially well for this group. Being able to see and practice/do things in person, such as the nutrition and healthy eating class, was better than if someone had just spoken to them about healthy eating. The practical style of learning enabled participants to consider issues in a different light. If the classes were solely theory based, someone talking up at the front of the class or giving everyone a book to read, participants felt they would have lost interest. A female participant discussed her view on visual aids.

"We had the visual aids when we talked about salt, fat and sugars. We looked at the portion sizes and the food pyramid then we got into reading labels and budgeting knowing how much you could get for that amount of money, and the healthier choices. I think the visual aids were right on the money. We all had a huge big bag of spoons and we all had to make up a meal. So if someone got a Big Mac Value Meal and someone else got a pizza. We all had to make up how much fat, sugar or salt it was, and we were shocked, like wow, that’s really what she eats, you don’t think of that when you’re doing it. I think you’d lose them (without the visual aids), it wouldn’t be effective. That is far better than people who often come in and say yeah, do this, do that, do that. I think visual is really important, and they would get so much more out of it." (Female)

The physical activity and nutrition program participants expressed that they would like to see more people coming to the program. They identified personal barriers such as injuries, operations and work commitments as reasons why participants have not been able to more regularly attend the program. A female participant explained how her physical ailments made it hard for her to attend the program.
“I wish I could just do more. But I can’t, because of this (arthritis) I just love sports. But I just can’t do it because of my wrist…. too difficult…because at certain angles that it hurts. And I won’t know it until I do it.” (Female)

Access to transport was also identified as a key barrier for others in the community to attend the program. Participants said that Aboriginal people in the community may not be able to afford public transport and some did not have their own transport, i.e. own a car. To address the transport issue participants suggested introducing a free bus service that could go around to certain locations in the community, pick up and drop off people for the program. A female participant explained her view about transport issues in the community and the benefits of implementing a bus pick up/drop off service.

“A lot don’t have transport or it’s a bit far from where they are to walk, or sometimes they don’t have money to come on the bus. If you could pick them up, bring and drop them off they’d look forward to. Maybe if they had a bus service for people who have got no transport. If you get the council… I think they have big buses. They do for the seniors and disability.” (Female)

Participants identified possible relationship issues, as barriers to attending the program, including confrontational issues between participants and staff; and family feuds. If a participant of the program had an argument or a misunderstanding with staff, the participant may not feel comfortable to return to the program for a while, or at all. Sometimes disagreements or grudges are held between families within the community. If a participant turns up to the program and sees another participant from a quarrelling family then they may turn around, leave and not return until the argument is resolved. Participants were clear that there was not much that could be done to address relationship issues as a barrier to attendance. Participants requested that
anyone new to the program needs to be aware or informed and then sensitive to such issues. Participants also identified the high death rate in the community as a barrier to regular attendance, explaining that it was not just the immediate or extended family that were affected, the impact flows out to the wider Aboriginal community. When someone passes showing respect and being there for the family takes priority to attending programs. A male participant explained what he felt was the magnitude of suicide in the community.

“*In this last 12 months I guess that there was a rough guess about 20 or 30 Aboriginals committing suicide, terrible things. And this really tears the heart of the Aboriginals.*” (Male)

All participants of the *Zumba Program* suggested the instructor was crucial to the success of the program. Participants felt that, depending on the instructor, the class could be a very different experience and sometimes it was not very satisfying from a physical exertion perspective. When asked to describe their ideal instructor preferences included having an instructor who is confident teaching Zumba, is able to explain the moves and teach the routine to the group in stages (repeating and building upon the previous stage). Additional preferences included someone who could incorporate different impact levels to cater for beginners through to experts and stick to the time schedule. A female participant described her preference in a future instructor.

“*Someone who is confident instructing the Zumba, who obviously can speak to the ladies, ’cause we have older ladies in our group, and some of the moves they do are young moves (gyrating moves). But I think that’s more of if you want to tone up your bum and thighs. I’m always up the back and I just laugh, ’cause I know what them old girls are thinking about like I don’t do this, they’re like what is this here.*
It’s not a move that they would normally do, whereas a younger person who’s dancing might feel more comfortable.” (Female)

Participants were also asked about encouraging more people to attend the overall Health and Wellbeing Program as weekly attendance numbers were inconsistent. One week there would be 10 people, the next week only two people and at most 20 people attended at one session. Participants discussed that usually it is the same people who attend on a regular basis, which was great to see, however it would be nice to have an increase in attendance numbers and to see some new faces. To address this issue, participants discussed current and proposed promotional strategies. Current strategies included flyers distributed home to parents via children at school, word of mouth and a poster displayed at the local Aboriginal Medical Service, which may not be wide reaching enough. Both Zumba and physical activity and nutrition program participants had similar views on the promotion of the programs. Key strategies included developing a community activity calendar, advertising in GP surgeries, direct referral from GP’s, advertisements at local community centres and events such as National Aboriginal and Torres Strait Islander Day Observance Committee (NAIDOC) week, as well as individually canvassing people when the opportunity presented. A female participant discussed the need and benefits of developing a monthly community activity calendar.

“*It seems to me everyone’s doing everything (advertising) individually, instead of as a whole. We deal a lot of sports here. If they had one calendar ‘cause there are so many things. Just say what’s on, then people can see what’s on this day, they don’t book something else, to find out what’s going on in this area, about the events and promoting it to everyone. Even if it was an online calendar and someone was responsible for just updating it when an event come along, and people could just go on and go oh there it is”* (Female)
3.4 Discussion

This research used photovoice to examine participants’ meaning of health and wellbeing, as well as exploring their participation in an urban Aboriginal health and wellbeing intervention. The results suggest that the Aboriginal people in this study have a broad understanding about the concept of health and wellbeing, although there remains a strong belief in the inevitability in acquiring a chronic disease. Health and wellbeing, to participants in this study, meant being physically healthy and preventing or managing a chronic disease such as diabetes, so they could prolong their life. In addition, the results of this study also found social aspects of health, such as connectedness with family, friends and the community was the most dominant dimension of health and wellbeing and its link to participation in physical activity and the health and wellbeing programs. Participants’ view of health and wellbeing in this study appeared similar to the findings of Reilly et al. (2008) where sense of control over physical health outcomes was an important component to health, although the social component of health was dominant. Unlike views of health and wellbeing as a resource for everyday living, health in this study was both a reason to be connected and a consequence of being connected to other people. In contrast, Reilly et al. (2008) examination of participants’ concept of health extended beyond this study, which included components of history, relationships with mainstream and connectedness with place and land.

The prolonging life component of participants’ meaning of health and wellbeing focussed on preventing morbidity and/or mortality, which supports the biomedical view of health. The biomedical view of health is centralised on the absence or presence of disease (Australian Institute of Health and Welfare, 2012). The definition of health has evolved beyond the biomedical view where contemporary meanings differ but refer to health as a resource for everyday living. The Aboriginal definition of health is holistic and focuses on the whole-of-life, encompassing the physical, social, emotional and cultural wellbeing of the whole community (Australian Institute of Health and Welfare, 2012; Ricciardelli et al., 2012; Social Health Reference Group, 2004). Despite participants in this study describing health and wellbeing in two-dimensional terms, in reality, participants most probably have a wider perception of what...
health and wellbeing means to them that encapsulates the holistic and interconnected definition of Aboriginal health. It is possible that the two-dimensional meaning of health and wellbeing found in this study could be attributed in part to the photovoice method. Interviews with participants were driven by their choice of photographs and what they chose to discuss. The content of these photographs predominantly represented healthy eating, family and/or social and emotional factors. Therefore participants’ discussions were focussed on those components. If participants had taken and chosen photographs to discuss other components of Aboriginal health then it remains possible that additional factors may have been included in their overall meaning. Such a limitation was acknowledged by Castleden et al. (2008) where ‘access to that which was not photographed is denied and subsequently not discussed in the photovoice interview’ (p. 1402). To address this limitation, during the interviews the researcher asked participants what other photographs would they take if they had another chance to represent their meaning of health and wellbeing. Using this technique provided opportunities to discuss broader concepts of health than can be captured in a photograph. Nonetheless, participants in this study maintain health and wellbeing to mean the absence of disease or infirmity, as well as a strong social connectedness to help deal with the stress of daily life.

The role of social support amongst participants in this study appeared to form part of the coping mechanisms of dealing with stress, particularly through seeking counsel from friends and family and through the organised program group activities. Social support from friends and family; as well as those from organised groups provided a forum for counsel, encouragement and information sharing. This perspective was also observed by Reilly et al. (2008) and demonstrates the value of family and friends, especially during times of stress.

Participants from the current study referred to positive role models, specifically people from older generations who lead healthy lifestyles and whom participants looked up to as inspiring. The inspiration of older people contributed to enabling participants to strive for a healthier lifestyle. Reilly et al. (2008) mirrored the role model concept as people who participants looked up to and learnt from. Moreover, Huffman and Galloway (2010) described the vision of role models, in Aboriginal health context, as a “window into future possibilities” (p.357).
Participants’ motivations and feedback of the health and wellbeing programs in this study were found to be positive in regard to the classes creating a comfortable environment and providing a forum to establish and support connections with others. Relationships with others contributed to participants’ motivation to attend the program as well as the sense of belonging and culturally safe environment where participants felt ‘no shame.’ The results of this study showed that connectedness with others helps to enable and facilitate motivation and participation in physical activity and nutrition programs. These findings were similar to others; Canuto, Spagnoletti, McDermott, and Cargo (2013) and Mercer, Riini, Hamerton, Morrison, and McPherson (2013). Canuto et al. (2013) identified participant perceived barriers and enablers to attending a 12 week Aboriginal women’s physical activity and nutrition program in South Australia via a mixed methods approach. While their impact evaluation results have yet to be reported, they did report that attendance was influenced by personal health (injury/illness), logistics and competing obligations (work/study/family) (Canuto et al., 2013).

Furthermore, Mercer et al. (2013) evaluated the process and short-term outcomes of a nutrition and physical activity program within an Indigenous health context in New Zealand via a mixed methods approach. The study found that community practices were adaptable to meet community needs by incorporating culture; combining healthy eating, increased physical activity and measurements of achievement. However an unexpected finding in the current study was that participants’ motivation to attend the program was largely driven by social aspects. This extended beyond simply helping with motivation to attend and enjoy the program to socialisation with others from community being the main outcome or benefit of attending the program. The sense of connectedness and reduced social isolation that participants gained from the program far outweighed the engagement in physical activity and nutrition they may have experienced. These results reinforce previous findings of Mercer et al. (2013) who showed that behaviour changed during the program, but more importantly that being part of a group provided motivation, incentive and encouraged accountability to make behaviour changes.

The current research has demonstrated that the overall health and wellbeing intervention has positively impacted participants’ connections with others. The program has facilitated and
empowered participants making new connections with others, as well as fostered those that
existed. The socialisation aspects of the program may have contributed to the positive effects
the program had on participants, as well as the connections they had with other attendees,
friends, family or program staff. The social component of the physical activity and nutrition
program appeared to play an important role in participants reporting they made changes to their
eating habits and the Zumba Program participant’s ability to cope with work stress. Having a
connection with others and the sense of belonging meant a great deal to participants as it was a
major component identified in their meaning of health and wellbeing; as well as throughout
every theme of the results. This finding reinforces previous literature stating that having
connections with others is a protective factor for Aboriginal social and emotional wellbeing
which is an important component to Aboriginal health (Closing the Gap Clearing House, 2013;
Gee, Dudgeon, Schultz, Hart, & Kelly, in press; Zubrick et al., 2010). The findings also suggest
that health and wellbeing programs that focus their intended outcomes on behaviour and
anthropometric changes may miss the more important social connectedness benefits of the
program for Aboriginal people.

A summary of how participants perceived health and wellbeing as being able to prevent or
manage disease and strongly influenced by connectedness with family and friends is presented
in Figure 3. Having such connections was a motivating force for attending the health and
wellbeing programs. The engagement at these programs also fostered these connections. Within
this evaluation participants were expectantly favourable towards the program, however
motivated to attend for social reasons, such as sense of community connection and belonging
with friends and family, more than for the engagement in the program content. The current
schema resembles the socio-ecological model developed as part of the Connect Program which
illustrates how suicide can occur within the context of, and impacts, relationships, community
and the larger community (Baber & Bean, 2009; Bean & Baber, 2011; National Alliance on
Mental Illness, 2013). In community partnership and consultation, this socio-ecological model
was developed to help identify risk and protective factors to improve the response to suicide
(Baber & Bean, 2009; Bean & Baber, 2011; National Alliance on Mental Illness, 2013).
The method of this study provided an alternative path compared to previous research. Wilkin and Liamputtong (2010) conducted camera training with participants as one group. Castleden (2008) incorporated ongoing data collection and analysis and Adams et al. (2012) conducted camera training and discussion of the photographs in groups, however supplemented the process by conducting individual interviews with participants to discuss the stories behind their two most significant photographs. This study has added another dimension to the adaptability of the photovoice method that supports the necessity for research methods to be flexible when working with Aboriginal populations (Kendall et al., 2011). In addition to the group training, individual training sessions were held to accommodate participants who were unable to attend the group. Individual interviews were conducted to ensure privacy for each participant to ensure that group
discussion was not a barrier for discussing sensitive issues. Interviews were arranged at times and places convenient for the participants to accommodate for their other obligations. The flexibility of these methods also optimised participation and helped to achieve saturation of the data. During the familiarisation phase the researcher observed that attendance fluctuated on a weekly basis. Had the researcher confined the camera training and initiation of the project task to one group session, as well as not adopt a snowball recruitment method the participation rate of the overall study would have been significantly less and saturation would not have been achieved. On the other hand, accommodating to participant’s other obligations or impromptu events by rescheduling training and interviews did prolong the data collection period. However this was necessary to ensure that all willing participants could be involved in the project.

Similar to other studies (Castleden et al., 2008; Maclean & Woodward, 2013; Wilkin & Liamputtong, 2010), this photovoice process was found to be culturally appropriate, innovative, engaging and empowering for participants. Through the power of the visual image, participants were able to freely and openly communicate their perceptions of health and wellbeing as well their experiences of the overall health and wellbeing intervention. Using visual combined with oral methods is complimentary to Aboriginal culture (Wilkin & Liamputtong, 2010). This study’s protocol has built research capacity and understanding amongst participants who felt they had made a valuable contribution to the research process. Overall participants were proud of the work they had completed and subsequently a collage of their photographs was made and has been displayed at community events.

3.5 Limitations

The results of this study should be interpreted with consideration for several limitations. Firstly, the PAR approach is based upon reciprocity between the researcher and participants, and provides scope for participants to determine the focus of the research. Therefore, themes emerging from the data may not always align with the initial aims and objectives proposed by the researcher. In this study, the use of photovoice provided further autonomy to participants to
deviate from the original aims of the research, as they were free to take photos of their choosing. As a result of this approach, the results of the study should be considered in the context of the participants having considerable influence on the direction of the data collection, interpretation and findings. Recruitment of participants into this study occurred following a process of the researcher attending program activities and building trust with participants. As such, it is possible that the presence of the researcher may have been a barrier for some people attending the program. Furthermore, attendance records were not accessible to the researcher. Results of this study need to be interpreted in light of the fact that although participation eligibility criteria was to have attended at least one session for either program, a participant who attended more frequently than others may have been more likely to participate in the evaluation and/or have a different perspective of the program specific questions. For example a negative event may have occurred during one session that a new participant had attended, which may have impacted them returning to the program and/or providing positive feedback. Therefore, participants in this study may not fully represent all people attending the health and wellbeing programs.

3.6 Conclusion

The results of this study have provided evidence that Aboriginal people comprehend the broad concept of health and wellbeing, but have a fatalistic belief in the inevitability of acquiring a chronic disease, particularly heart disease and diabetes. The results also revealed the profound importance of family, friends and community as the most dominant dimension of health and wellbeing, particularly as motivation to engage in healthy behaviours. The results of the evaluation of the Health and Wellbeing intervention suggest the program activities were secondary to the opportunities for social connectedness with existing family, or other Aboriginal people. Participants held positive views towards the health and wellbeing programs they attended, particularly the culturally safe environment and community connectedness created. Any benefits accrued as a result of attending the health and wellbeing programs related to social and mental wellbeing, with physical health benefits from participating in physical activities within the programs a secondary benefit. Importantly, attendance and motivation to participate
were largely unrelated to personal health benefits and more likely to be influenced by the commitment and desire to see other group participants. Finally, the photovoice method and process in this study was found to be culturally appropriate and adaptable for participants’, which is consistent with previous literature (Castleden et al., 2008; Wang & Burris, 1997; Wilkin & Liamputtong, 2010), and given participant reluctance to write or be interviewed, this method gave time to build trust and rapport with the researcher.

3.7 Recommendations

As social aspects were a dominant motivating factor for participants to attend both programs it is recommended that future health and wellbeing programs that target the Aboriginal population may benefit from considering promoting the benefits of, and provide opportunities/facilitate social connectedness, as well as the behaviour and anthropometric changes. In doing so, this may increase and/or retain participation numbers, thus improve the quality and duration of life for Aboriginal Australians.

3.8 Acknowledgments

The research team acknowledges and thanks the North Metropolitan Public Health Unit for introducing the researcher to the programs’ staff and participants; and assisting with recruitment. We are also grateful of local community organisations involved and the valuable contribution of the participants. This study was conducted on Nyoongar country.
3.9 References


Appendix A: Participant information and consent forms
Health and Wellbeing Program: A photovoice project

Participant Information Sheet

We would like to invite you to help us with a project about the Health and Wellbeing Program and/or Zumba Program that is being run at the Herb Graham Recreation Centre.

Please take time to read this information. If you would like to know more please ask us to tell you before you sign the permission form.

What is this project for?
The project is for you to share your thoughts about the Health and Wellbeing Program and/or Zumba Program, so we know the strengths and weaknesses of these programs and learn what works better to improve Aboriginal health.

Do I have to be involved?
It is your choice if you want to be involved. You can change your mind later if you want to with no reason.

What is involved and how long will it take?
If you want to be involved, there will be four sessions:

1. The first session is to show you how to use a digital camera safely.
   • We will ask you to take photographs of things that show what health and wellbeing means to you.
   • You can take the camera home with you for up to one week to do this.
   • This session will take about 20 minutes.

2. The second session is to print your photographs and have a one-on-one interview about your photographs and your feedback about the Health and Wellbeing Program and/or Zumba Program. This will take no longer than 1 hour.

3. The third session is for you to check that what we wrote is true to our conversation.

4. In the fourth session we would like to talk with all participants’ about their photographs and program feedback as a group. You can choose which photograph to use. This will be the last session.

How will the information be used?
This information will be published but no names will be used. Photographs will not be used, unless you give us permission.

What are the benefits in participating?
• You can have your say about health and the Health and Wellbeing Program and/or Zumba Program in a safe environment.
• You can learn skills that you can use again for other programs
• Everyone will get a copy of their photographs.
• We can make something with your photographs like a photobook, posters, have a photo exhibition in the community to share your story. The choice is yours.
• Your input will be valuable to the future of these programs and other programs to improve Aboriginal health.

What if I feel uncomfortable?
• If you feel uncomfortable at any time in the project, we can stop or you can leave without a reason.
• You can bring a friend or family member to your interview.

This message has been approved by the University of Western Australia – Human Research Ethics Committee. RCF RA4415884. The Human Research Ethics Committee at the University of Western Australia requires that all participants are informed that, if they have any complaint regarding the manner, in which a research project is conducted, it may be given to the research supervisor (Associate Professor Michael Rosenberg, telephone number (08) 6488 4654) or, alternatively to the Secretary, Human Research Ethics Committee, Registrar’s Office, University of Western Australia, 35 Stirling Highway, Crawley, W.A. 6010 (telephone (08) 6488 3703). All project participants will be provided with a copy of this Information Sheet and Consent Form for their personal records.
Health and Wellbeing Program: A photovoice project

Participant Consent Form

We would like to invite you to help us with a project about the Health and Wellbeing Program and/or Zumba Program that is being run at the Herb Graham Recreation Centre in Mirrabooka.

Please take time to read this information. If you would like to know more please ask us to tell you before you sign the permission form.

Your input is very important and the information you share will provide feedback for the programs so we know the strengths and weaknesses and learn what works better to improve Aboriginal health.

By signing this form you give your permission to be involved in this project and agree to the following statements:

1. I have been given information, both verbally and in writing, about this project and having had time to think about it. I am now able to make an informed decision to be involved.
2. I have been told about the potential benefits and known risks of taking part in this project. I understand what this means to me.
3. I have been given the opportunity to have a member of my family or a friend with me when this project was being explained to me. I have been able to ask questions and have had all my questions answered.
4. I know that that I can choose to be involved. I know I can change my mind later, without a reason.
5. I accept that by taking part in this project, that any information about me, including the photographs I take, during the project may be used in relation to this project only, and that my name and other identifying information are not used.

<table>
<thead>
<tr>
<th>Participant name</th>
<th>Signature of participant</th>
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<table>
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<tr>
<th>Researcher name</th>
<th>Signature of researcher</th>
<th>Date</th>
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Further information
If you have any questions please contact:

Yolanda Andrews
Project Coordinator
School of Sport Science, Exercise and Health
University of Western Australia
P: (08) 6488 1378 E: yolanda.andrews@uwa.edu.au

This message has been approved by the University of Western Australia – Human Research Ethics Committee, REF RA4/4/15994. The Human Research Ethics Committee at the University of Western Australia requires that all participants are informed that, if they have any complaint regarding the manner in which a research project is conducted, it may be given to the research supervisor (Associate Professor Michael Rosenberg telephone number (08) 6488 4654) or, alternatively to the Secretary, Human Research Ethics Committee, Registrar’s Office, University of Western Australia, 35 Stirling Highway, Crawley, WA 6009 (telephone (08) 6488 3703). All study participants will be provided with a copy of the Information Sheet and Consent Form for their personal records.
Appendix B: Examples of photographs taken for other photovoice projects
Examples of photographs taken for photovoice projects

Photograph taken by an Aboriginal Health Worker woman in Victoria.

“This is a friendly environment but we also want to be friendly to the environment. Part of healing ourselves is healing our environment, especially for Aboriginal people if your environments in a sick state you sort of take it all in, the vibe. So if we can keep our environment friendly and beautiful then it helps your own health.”


Photograph taken by a young Aboriginal woman in Carnarvon, Western Australia

“With this photo I’d say "Don’t be Foolish, the signs are there, there’s pictures around to show you that it is here and play it safe. Well, like, the pictures are there, OK, so they know that the disease is here. It’s actually in the community of the town itself, so, knowing that people put pictures up like that to warn the people, just to jog people’s memories all the time, like when they’re drunk and they stagger around with a man and they walk past and they look, and....oooh, I’d better go and get a condom...or something like that.”


Photograph taken by a Maori woman in Auckland, New Zealand

“a blanketed sofa sheltering a dog. However ‘a barrier to her cousin accessing secure housing was his dogs: He has tried going indoors and it did not fit in well, because the majority of indoors that he was living at couldn’t cater his dogs.’ Dogs were so important to the participants that they said they would continue to live outdoors if their dogs could not go with them; which poses a challenge for homeless service providers”

Appendix C: Camera training guide
Health and Wellbeing Program: A photovoice project

Camera training guide

Facilitator materials
1. Participant consent forms (pink)
2. Information Sheets (white)
3. Camera packs
4. Examples of photographs taken for photovoice
5. Photovoice books
6. Pen and notepad

Participant camera packs contain:
1. Participant detail slip and envelope
2. Participant information sheet (white)
3. Participant consent form signed (pink)
4. Photograph of someone else consent form (blue)x10
5. Camera/USB/plug/case
6. Homework slip card
7. Camera diagram
8. Pen

1. Introduction
Hi everyone, thank you for coming to the camera training for the photovoice project. This is going to be a lot of fun and everyone is going to learn some new skills. We are going to do this project so you can have your input on telling us what your experiences are of the Health and Wellbeing Program and how things can be done better in our approach to addressing Aboriginal health.

You have all been given a camera pack and during today's session I'll show you all how to use the camera safely and give you the 'homework' task which is going to be very easy and it won't take up much of your time.

Each pack contains all the materials you will need to do this project. Could you all please take out the white envelope which has a form in there? Could you all please fill in your details so I know who has which camera and so I can contact you to see how you are going in the next few days? When you are finished please put the slip back in and pass the envelopes to me.

⚠️ Check contact numbers are filled in

2. How to use the camera (mechanics)
So has anyone used a digital camera before? Not everyone has used a digital camera before so I'm going to go through the functions with you. If you already know how to use a digital camera maybe you could help the person next to you as we go along. You all have a picture in your pack which shows you which button does what – just in case you forget.

1. Power on/off
2. Capture
3. View
4. Delete
5. Zoom
6. Charge

Everyone can have a practice. Is everyone comfortable working the camera? If you would like more practice I'll come and see you after and we can go through it together.

3. Homework
Can everyone now please take out the white slip with the yellow faces? This is your is going to be your homework over the next few days. All you have to do is take photographs of things that show what:

1. Health and wellbeing means to you
2. Places where you are physically active
3. Places where you spend time with friends and family.

Let’s try and come up with some of the kind of photographs you would take.

**Go around the table for suggestions.**

You can choose how many photos you would like take. You can be creative as you like with this task. The good thing is the choice is yours of what photograph you take. Before I send you off there is some important stuff we all need to consider and remember when we are doing this homework.

### 4. Safety comes first

Now that you all have a camera to borrow, you are all now in a position of power. So it is important to remember that your safety and the safety of others come first. Please turn over your white slip and we can go through these important points everyone needs to consider. Don’t worry if you forget, it is all there for you on the white slip

(a) Please don’t take any photos of things that looks risky or illegal. Think about if you are doing something risky would you like it if someone took a photo of you doing that? Use your judgement.

(b) It is very important to remember to respect other peoples’ privacy. Not everyone likes to have their photograph taken. So the respectful thing to do if you would like to take a photograph of someone is to ask their permission **first**. Tell them the homework you have to do, what it is for and why you would like to take their photograph. Don’t worry, if you forget, everything they need to know is on the BLUE form. Remember it is their choice to let you take a photograph or not. If they do give you permission please ask them to read and sign the BLUE form. Keep this blue form in your camera pack so I can collect these off you later. If the person says no, then thank them for their time and move on.

**⚠️ Role play example of someone who does AND does not give permission.**

(b) The same goes with other people’s property. Not everyone will like a photograph taken of their things, so it is respectful to ask first. Put yourselves in their shoes and think how would you feel if someone took a photo of something you wanted to keep private? You don’t need to get a form signed for this; it is just respectful to ask first.

(c) If you are walking around with the camera and someone aggressive comes up to you and wants to take your camera, stay calm, don’t try to fight them – just give up your camera. Don’t worry; you won’t get in trouble from me. I can replace your camera if something happens to it. Your safety is more important than the camera. However please call me if anything like that happens.

(d) And lastly always remember to take care of your camera, keep it stored in your camera case or the plastic pack

### 5. Conclusion
Are there any questions before I let you go today?

Everyone can take the camera home and bring it back next week. I will call you in a few days to see how you are going and then again to remind you to bring the camera with you next week. If you finish early please give me a call or send me an email so we can organise a time to print your photos and then a time to meet to talk about your photographs and your experience of the Health and Wellbeing Program.

Thank you everyone for your time today. Remember to be creative and have fun!
Appendix D: Participant pack
Camera Diagram

- Zoom/make closer or far
- Screen
- BACK
- Move to next photo
- Delete
- Show photo
- FRONT
- Battery cover
- Lens/Eye
- On/off
- Shutter/snap
Health and Wellbeing Program:  
A photovoice project

‘HOMEWORK’

Please take some photographs that show:
What health and wellbeing means to you
Places where you are physically active
Where you spend time with your friends and family

Don’t take any risks (no photos of anything illegal)
Be respectful – always ask permission before taking pictures of people. They need to sign the BLUE consent form
Ask permission before you take a photo of someone else’s personal property (house, yard, car, stuff)
If approached by someone aggressive, stay calm, do not resist, give them the camera. You will not get in trouble by project staff
Keep your camera and materials together in your plastic case
If you have any questions please call Yolanda on (08) 6488 1378 or email yolanda.andrews@uwa.edu.au

Participant contact details
Name:
Best contact phone number:
Gender (Male/Female):
Age (optional):
Do you identify as Aboriginal (Yes/No)?
Camera ID number:
Health and Wellbeing Program: A photovoice project

Permission to take a photograph of another person form

What does the person with the camera want to do?
- I am taking photographs for the Health and Wellbeing Program: A photovoice project.
- I would like to take photographs that represent what health and wellbeing means to me.
- If it is ok with you, I would like to take a photograph with you in it.

How will my photograph be used?
- Your photograph will be used to show and explain what health and wellbeing means to me.
- We can give you a copy of your photograph if you would like one.
- I, as part of the photovoice project team will be given a copy of these photos. These may be used in a presentation to the other participants in the photovoice project so we can all talk about health and the program.
- Your photograph may also be used in others ways like in a newsletter, report or any other publication that is related to this project only, nothing else.

Will my details and photograph be kept confidential?
- All personal information like your name, location and experience will be kept private.
- Your photograph(s) will be given a unique number so that no one can be identified.
- All hard copy information collected will be kept in a locked filing cabinet. All computerised information will be locked by a security password.
- All records will be kept at the School of Sport Science, Exercise and Health during the project and in a locked archive for seven years when the project is finished.

Do I have to have my photograph taken?
- No, you do not have to have your photograph taken if you do not want to.
- It is your choice.
- You can change your mind later if you want to. Please contact the photovoice project team and they will remove and/or delete your photograph. You do not have to give a reason why.

What do I do next?
If you give permission to have your photograph taken please turn over the page.

This message has been approved by the University of Western Australia – Human Research Ethics Committee, REF RA/6/1/5964. The Human Research Ethics Committee at the University of Western Australia requires that all participants are informed that, if they have any complaint regarding the manner in which a research project in conducted, it may be given to the research supervisor (Associate Professor Michael Rosenberg telephone number (08) 6488 4654) or, alternatively to the Secretary, Human Research Ethics Committee, Registrar’s Office, University of Western Australia, 35 Stirling Highway, Crawley, WA 6009 (telephone (08) 6488 3703). All study participants will be provided with a copy of the information Sheet and Consent Form for their personal records.
By signing this form you give your permission to have your photograph taken and you agree with the following:

1. I have been given information, both verbally and in writing, about this project. I have had time to think about it. I am now able to make an informed decision to have my photograph taken.

2. I have been given the opportunity to have a member of my family or a friend with me when this project was being explained to me. I have been able to ask questions and have had all my questions answered.

3. I know it is my choice to have my photo taken. I understand that I can change my mind without a reason.

4. I accept that by having my photograph taken for this project may be used in relation to this project only, as long as my name and other identifying information are not used.

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<thead>
<tr>
<th>Participant name</th>
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<tbody>
<tr>
<td>Participant parent/guardian name (if participant is aged under 18 years old)</td>
<td>Signature of parent/guardian</td>
<td>Date</td>
</tr>
<tr>
<td>Researcher name</td>
<td>Signature of researcher</td>
<td>Date</td>
</tr>
</tbody>
</table>

Questions and further information?
Thank you for taking the time to read this form. If you have any questions please contact:

Yolanda Andrews
Project Coordinator
School of Sport Science, Exercise and Health
University of Western Australia  
P. (08) 6488 1378  E. yolanda.andrews@uwa.edu.au  
Delivering a Healthy WA
Appendix E: Interview guide
Health and Wellbeing Program: A photovoice project:  
Interview guide

Materials:
- Guide
- Pen
- Photographs (x2)
- Notebook
- Category Cards
- Audio recorder (x2)
- Post-it notes
- Sticky dots (red and pink)
- Release of photographs form (yellow)

Interview preamble
Thank you for helping, being a part of this project and giving up your time to be here for this interview. If it is ok with you, I’d like to record our conversation on this recording pen so I can give you my full attention and listen to what you have to say. This means I will also be able to look at your photographs and talk to you; rather than worrying about trying to write everything down and possibly missing anything important you might say. It also means that I can listen back on your interview to make sure what is written down is true to what you have said. There are no right or wrong answers to any of the questions I am going to ask you. This is all going to be about what you and other participants think about health and the HWB program. If there are things you don’t want to talk about, that’s ok. Even if you tell me something today, think about it and then realise you don’t want anyone to know about that bit of information, just let me know and I can take that bit out. During the interview, if you want to take a break or start to feel uncomfortable, just let me know and we can stop.

After everyone has finished their interviews, I will need a few weeks to sit and go through all the interviews so I can put all the information together. Everyone involved will be invited to get together as a group so we can present the main themes back to the group. During this group meeting, everyone will be able to have their say about what these issues mean for the program and it will also be the time where you can all decide as a group what you would like to make with your photographs.

Everything you tell me today will be kept private. The only people who will get to see the information you give me during this interview is me and the project team. If we need to use any of your comments or photographs we will not use your real name. You can pick a fake name.

At the end of the project, everyone will be given a summary of the results. Do you have any questions before we start? Do you give me permission to record our interview?
Sort photographs

Ok let’s start by sorting your photographs into the groups of question you had to take them for:

1. What does health and wellbeing mean to you?
2. Places where you are physically active
3. Places where you spend time with friends and family

⚠️ Use group cards to categorise photographs

Interview questions

Ok let’s start with the photographs in the Health and Wellbeing section.

1. Please choose a photo from the HWB section. Please tell me about this photo.
   • What is in the photo?
2. Where was this photo taken? (Castledon, 2007)
3. Why did you take this picture? (Castledon, 2007)
   • What does this picture mean to you? (Castledon, 2007)
4. When you hear those words, what comes to your mind?
5. So you said that health and wellbeing means ............. to you. Are any of these factors represented in your HWB photos?
6. Are any of these factors (ref Q4) addressed/part of the HWB program?

⚠️ Repeat questions for Physically Active and Friends and Family

To extend the conversation:

1. What are some of the good things (enablers) that influence/impact/effect/help your health and wellbeing?
2. What are some of the bad things (barriers) that influence/impact/effect/don’t help your health and wellbeing?
3. If you had the chance to take a photo again, what would it be?
HWB Program

1. Do any of your photographs represent the HWB program you attend?
   • If you were to take photographs to represent the HWB program, what would they be of?

2.0 If you were to tell your friends about the program, what would you say?
   • If you were to promote the program, what would you say?
   • Why do you come?
   • What do you like about the program?
   • What makes it easy/comfortable for you to participate?
   • What parts work well for you? (Murphy et al, 2004)
   • What do you do during the program? Have you incorporated these in your normal life? How?

2.1 Are any of these features represented in any of your photographs today?
   • What kind of photographs would you take to represent these features?

3. If you were to run this program, how would you do it?
   • How would you run it to address Aboriginal health specifically?
   • How would you organise it?
   • What do you like/don’t like about the program?
   • What makes it easy/difficult for you to participate?
   • What parts work well/not well for you? (Murphy et al, 2004)
   • If you could do anything to the program to make it better, what would you do?

4. Since you started going to the program, what lifestyle changes have you made?
   • Is there anything you do differently now compared to before you started doing the program?
   • What was it that helped you make this change?
   • Are any of these changes represented in the photos you have here already?
   • If you could take photos to show the changes you have made, what would they be of?
Wrap up

Ok we are nearly done.

As previously mentioned, the final session of this project is to get everyone involved in this project to come together and share their most significant photos and talk about the issues or main themes that have come up during the interviews.

1. Could you please pick two photographs from each section that are most significant to you and that you would like to share and talk about with the rest of the group?
   
   □ Ask participant to place a PINK sticker on each photo chosen.

   Also mentioned at the information session, the project team will not use any of your photographs to tell others about this project unless you give permission. There may be instances where we would like to use the photographs to help tell others about the project in newsletters, reports, in my thesis and in presentations, however your real name will not be used.

2. Are there any photographs here that you don’t want us to use?
   
   □ Ask participant to place a RED sticker on each photo chosen.

3. If we need to – do you give us permission to use the photographs that don’t have a red sticker to help tell others about this project in things like newsletters, reports, in my thesis and presentations, so long as we don’t use anyone’s real name?
   
   □ Ask participant to sign a photograph release form.

4. What fake name would you like us to use?

Feedback

1. What did you think about doing this photovoice project?
   
   • Training/homework
   • Did you like/not like it? Why/why not? (Castledon, 2007)
   • Would you do it again? (Castledon, 2007)

2. What did you think of this interview – looking at the photos and talking about what they mean to you? (Castledon, 2007)

3. Do you think this is a suitable method when working with Aboriginal people?
   
   • Why/why not?

4. Is there anything you’d like to add at this time? (Castledon, 2007)
Thank you for your time today. When I finish interviewing everyone, I will need to have a few weeks to go through all the information. I will contact everyone again to arrange a group meeting so we can go through the common themes together and you can all decide what you would like to make with your photographs.

Do you have anything else to add or ask before we leave today?

Thanks again for your time. Bye.
Appendix F: University of Western Australia Human Research Ethics Committee approval letter
Our Ref: RA/4/1/5994

Associate Professor Michael Rosenberg
School of Sport Science, Exercise & Health
MBDP: M408

Dear Professor Rosenberg

HUMAN RESEARCH ETHICS OFFICE – RECOGNITION OF ETHICS APPROVAL FROM ANOTHER HUMAN RESEARCH ETHICS COMMITTEE

Project: Health and Wellbeing Program: A photovoice project

Thank you for your correspondence enclosing the necessary documents to facilitate recognition of the ethics approval for the above project granted by an external Human Research Ethics Committee (HREC) registered with the National Health and Medical Research Council (NHMRC).

It is noted that you have ethics approval from WAAHEC, approval number 432.

The UWA students and researchers identified as working on this project are:

UWA Researchers:

<table>
<thead>
<tr>
<th>Name</th>
<th>Faculty / School</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>Associate Professor Michael Rosenberg</td>
<td>School of Sport Science, Exercise &amp; Health</td>
<td>Chief Investigator</td>
</tr>
<tr>
<td>Assistant Professor Rebecca Rahman</td>
<td>School of Sport Science, Exercise &amp; Health</td>
<td>Co-Investigator</td>
</tr>
<tr>
<td>Dr Roz Walker</td>
<td>Telethon Institute for Child Health Research</td>
<td>Co-Investigator</td>
</tr>
<tr>
<td>Dr Peter Buzzacott</td>
<td>School of Sport Science, Exercise &amp; Health</td>
<td>Co-Investigator</td>
</tr>
</tbody>
</table>

Student(s): Yolanda Andrews

Although The University of Western Australia reserves the right to subject any research involving its staff and students to its own ethics review process, in this case, the Human Research Ethics Office has recognised the existing approval of the external HREC. The project is exempt from ethics review at UWA and the involvement of the above-listed researchers has been authorised. Any conditions for the recognition of the external HREC’s existing approval are listed below:

Special Conditions

None specified

You are reminded that it will be the responsibility of the approving HREC to ensure compliance with all ethics requirements and to monitor and report on the project. However, should any relevant ethics issues arise during the course of the project, you should inform the Human Research Ethics Office of The University of Western Australia.

If you have any queries, please contact the HREO at hreo-research@uwa.edu.au.

Please ensure that you quote the file reference – RA/4/1/5994 – and the associated project title in all future correspondence.

Yours sincerely
Appendix G: Western Australian Aboriginal Human Ethics
Committee approval letter
15th February 2013

Dear Michael,

RE: HREC Reference number: 452
Project title: Health and Wellbeing Program: A photovoice project

Thank you for submitting the above research project which was considered by the WAAHEC at its meeting held on 12th February 2013.

I am pleased to advise that the WAAHEC has granted approval of this research project. WAAHEC approval is granted from 12th February 2013 pending your agreement of the following conditions:

1. **Conditions**

   - The WAAHEC will be notified, giving reasons, if the project is discontinued before the expected date of completion.

   - The Coordinating Investigator will provide an annual report to the WAAHEC and at completion of the study in the specified format. This form can be found on the AHCWA website (www.ahcwa.org).

   - The approval for studies is for three years and the research should be commenced and completed within that period of time. Projects must be resubmitted if an extension of time is required.

   - Publications that arise from this research are to be provided to the WAAHEC for review prior to submission for dissemination.

   - That the Aboriginal and Torres Strait Islander community are formally acknowledged for their contribution to this research project.