Koori Kids’ Ears and Health

A Community Report from Onemda VicHealth Koori Health Unit

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# Glossary

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<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
</tr>
<tr>
<td>ACCS</td>
<td>Aboriginal Community Controlled Services</td>
</tr>
<tr>
<td>AMS</td>
<td>Aboriginal Medical Service</td>
</tr>
<tr>
<td>ATSIC</td>
<td>Aboriginal &amp; Torres Strait Islander Commission</td>
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<tr>
<td>CHS</td>
<td>Community Health Service</td>
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<tr>
<td>DHS Victoria</td>
<td>Department of Human Services Victoria</td>
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<tr>
<td>GVB Hospital</td>
<td>Goulburn Valley Base Hospital</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>KHLO</td>
<td>Koori Hospital Liaison Officer</td>
</tr>
<tr>
<td>M &amp; CH Nurse</td>
<td>Maternal and Child Health Nurse</td>
</tr>
<tr>
<td>MSP Rumbalara</td>
<td>Maternity Services Program Rumbalara</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council</td>
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<td>O ATSIH</td>
<td>Office of Aboriginal and Torres Strait Islander Health</td>
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<tr>
<td>RCH</td>
<td>Royal Children’s Hospital</td>
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<td>RWH</td>
<td>Royal Women’s Hospital</td>
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<td>SIDS</td>
<td>Sudden Infant Death Syndrome</td>
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<td>VAHS</td>
<td>Victorian Aboriginal Health Service</td>
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<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION

This research was part of a PhD undertaken by Karen Adams at the Onemda VicHealth Koori Health Unit, at the Centre for Health and Society, The University of Melbourne. It began in 2004 with the aim of developing and evaluating interventions or programs to reduce risk factors for ear infections in Koori kids. This report has been written to make available the results of the research for Community members and others.

The PhD is supported by a scholarship from the National Health and Medical Research Council and the Cooperative Research Centre for Aboriginal Health. The PhD research also received a support grant from the Office of Aboriginal and Torres Strait Islander Health, auspiced by the Victorian Aboriginal Community Controlled Health Organisation.

The research involved a survey, of parents and carers with Koori children less than six years of age, which asked about risk factors for ear infections. Knowing more about these risk factors can help target programs aimed at reducing ear infections. Risk factors for ear infections also relate to children’s general growth and development, and improving these can support ear health and the overall health of a child.

The results of the survey were workshopped with Aboriginal Community Controlled Services (ACCS) health staff, who then used the data to help inform programs that could be implemented to reduce risk factors for ear infections. At the time this report was written, the interventions were in progress and will be evaluated as part of the PhD research.

Queries about the research can be directed to Karen Adams.
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BACKGROUND

Koori kids and ear infections—what’s the big deal?
The World Health Organization (WHO) states that Indigenous Australians have some of the worst levels of ear infections in the world (Couzos, Melcalf & Murray 1999). Ear infections, which are also called ‘otitis media’ and sometimes ‘glue ear’ or ‘runny ear’, can start in young babies and can come and go or stay all the time. Ear infections are common in small children, but in Aboriginal and Torres Strait Islander children they are more likely to become ongoing or chronic and to be more severe (Leach & Morris 2001). Often people with ear infections can’t hear properly and are ‘hard of hearing’. The hearing loss may fluctuate, for example, it may be worse in the morning than in the afternoon. Babies and children can have pain from ear infections and pull or rub their ears. Sometimes they may not seem to have any pain (Gibney et al. 2005).

Hearing is important for babies, toddlers and children so they can listen, learn, talk clearly and learn to be social with people. These are important early building blocks for children to later go on and do well at school, have a healthy social life and get jobs. Often kids who have ear infections have slurred speech or mumble. Their speech can also be ‘delayed’, which means their speech is not the same as most kids their own age and is similar to a younger child’s speech.

Kids with ear infections can find it hard to hear what people tell them to do, so it is easy to think these kids are playing up and not listening. They can also miss important bits of social information (such as, for example, that people look at you and smile when they say hello) because they may not be able to hear which direction the sound is coming from and may not know where to look when people talk to them.

Ear infections in Victorian Koori children

There have been three documented studies of ear health in Koori children in Victoria. The first was conducted in 1980 with the Rumbalara Aboriginal Health Service. This study found that of 110 children less than sixteen years of age who had been seen by an audiologist at the hospital, 36% had been referred for further treatment (Wronska 1980).

Rumbalara also conducted the second study. This was a review of ear health screens conducted by the Rumbalara regional ear health program from 2002–03. Of a total of 274 children less than 12 years of age:

- 21% had a fluid-filled inner ear
- 5% had perforation or discharge
- 14% had hearing loss (Adams & Briggs 2003).

The third study was also a review of hearing screens. These screens were conducted in 2002 by the Gippsland Indigenous Regional Hearing Health Program based at the Ramahyuck Aboriginal Health Service. Of 126 children aged from zero to eleven:

- 5% had chronic suppurative otitis media
- 40% had a fluid-filled inner ear
- 7% had hearing loss (Adams, Dixon & Guthrie 2003).

WHO considers a population with more than 1% of chronic suppurative otitis media to have an ‘avoidable burden of disease’. It further states a population with more than 4% has a ‘massive health problem’ (WHO 1996). The results of these studies indicate a ‘massive health problem’ for Victorian Koori children. A number of these children experience hearing loss and likely fluctuating hearing loss from ‘fluid-filled inner ear’.
Risk factors for ear infections and how they relate to child health

There are many risk factors for ear infections and these include:

- being male
- being young
- being bottle-fed
- being in childcare
- being around other kids with runny ears or noses
- breathing in smoke, such as yandi (marijuana), smokes (cigarettes) or fires
- having a low family income and not enough money
- using a dummy, other than to go to sleep, after six months of age
- living in an overcrowded house
- not being immunised
- not being breastfed
- not having a good diet.

Generally otitis media is considered a disease of poverty and is associated with colonisation of Indigenous nations and poor access to health care (WHO 1996; New Zealand Health Technology Assessment 1998; ATSIC 1999; DHS 2003).

Many of the risk factors for otitis media are also risk factors for more general child health. Children admitted to hospital with otitis media can have other child health problems such as anemia (low iron in blood, usually from not eating enough good foods) and respiratory or chest infections (Chang et al. 2003). The pathogens (bacteria and viruses) that cause the infection in otitis media are also associated with respiratory infections (Leach & Morris 2001). This is why it is important to look not just at children’s ears, but more broadly at children’s family, social, health and developmental circumstances. Approaching ear health from this holistic approach is more likely to lead to sustainable results in improving ear health.

Programs for Koori kids and ear infections

Primary school nurse program

The primary school nurse program delivers a targeted hearing screening service to primary schools. Primary school nurses conduct a health assessment of all students in participating schools in their first year of school, provide follow-up contact with parents, respond to referrals from school staff regarding identified health issues for students at any year level and provide referrals to relevant health practitioners (DHS 2005).

The hearing screen relies on parents completing a consent form. On the form they need to indicate whether their child is Aboriginal and/ or Torres Strait Islander or that they are concerned about the child’s hearing. A screen may also be conducted if a teacher is concerned about a child’s hearing. The effectiveness of this method of detecting ear health problems in Koori children has never been evaluated.

Maternal and child health nurse program

The maternal and child health nurse program conducts ‘well child checks’, which include an assessment of language and hearing. A hearing loss risk factor assessment is also conducted at two weeks and eight months. This relies on children seeing the maternal and child health nurse for a ‘well child check’. ‘Well child checks’ are conducted for free when children are aged:

- two weeks
- one, two and four months
- one year
- one and a half years
- two years
- three and a half years
- four to five years.
The number of Koori families attending maternal and child health nurses is known to decrease as children get older (DHS 2004a). The program has never been evaluated for accuracy of detecting ear health problems in Koori children. Many of the aspects covered in this program (for example, parents’ smoking, child diet and breastfeeding) address risk factors for otitis media.

**Office of Aboriginal and Torres Strait Islander Health Hearing Program**

In Victoria there are four regionally employed Indigenous Hearing Health Workers. They are based at Robinvale, Shepparton, Framlingham and Sale in Aboriginal Community Controlled Health Organisations. The program is funded by the Office of Aboriginal and Torres Strait Islander Health (OATSIH). A project officer at the state branch of OATSIH assists the funded program as well as a range of other programs.

OATSIH’s National Aboriginal and Torres Strait Islander Hearing Strategy 1995–1999 describes the aims and objectives of the hearing program. The objectives of the strategy are to improve access to primary hearing health care programs for Aboriginal and Torres Strait Islander people, prevent ear disease and hearing problems, improve access to primary and secondary services, and to improve hearing health care for Aboriginal and Torres Strait Islander children aged zero to five years (OATSIH 1995). The program was reviewed nationally. One finding of the review was that the program had mainly addressed the identification and management of ear health problems in primary school-aged children. The objectives to prevent ear disease and hearing problems and to improve hearing health care for Aboriginal and Torres Strait Islander children aged zero to five years had been less well achieved (Commonwealth of Australia 2002).

**HOW WE DID THE STUDY**

**Reference group**

A reference group to assist the research was set up at the beginning of the project. The members of the group (see acknowledgments) include people from child health and research areas. The group met several times as the project progressed.

**Consultation with hearing co-ordinators and health services**

Each of the four OATSIH-funded Indigenous Hearing Health Workers was invited to take part in the study. At the time, three positions were filled and one of these was recently filled. Two Hearing Health Workers and the ACCHs they work for chose to be part of the study. One worker was based at the Kirrae Health Service in the Barwon South West Region and the other at the Rumbalara Aboriginal Co-operative in the Hume Region. Permission to undertake the study was obtained by the regional programs. Ongoing consultation with the ACCS involved in the study occurred throughout the project.

**Survey questions and Koori health**

The survey was developed using a Koori model of health. An elder from Victoria offers this description of Koori health:

> Our health is determined by employment, connection to family and community, to housing, our connection to our land and our right to make decisions for ourselves. You fellas call it the ‘social model of health’—we just call it commonsense.

Melva Johnson, extract from speech at the opening of the Njernda Health House, Echuca, 2000.
An analogy that has been used to describe an Aboriginal and Torres Strait Islander view of health is that of a wheel (Atkinson 1992). In a wheel, the spokes make up the different parts of people’s health. If the spokes are strong, the wheel of health is balanced and works well. If the spokes are damaged or stressed, the wheel wobbles or is broken and the whole person is affected (Vickery, Clarke & Adams 2005).

Understanding hearing health in Koori children using this definition of health requires the ability to look at many facets. It involves being able to see health from a whole community point of view. Hearing health is related to individual children and to the family and community these children are connected to. These are connected to factors that are known to increase the risk of ear health for a child, family and community. A possible diagram of how this might look is provided below. This wheel of health shows different factors that could affect a child’s ear health; the factors can be positive or negative and are all connected. Some of the risk factors are changeable and some are fixed, such as age and gender. In this figure the circled risk factors are fixed.
The survey asked parents and carers about each risk factor for otitis media. The survey also asked parents and carers about their social networks for advice and support for relevant risk factors. The type of advice and support people received was also recorded.

Survey interviews
People were surveyed in Shepparton and in four communities in the Western District. Due to issues of confidentiality and small numbers of parents and carers, the four communities in the Western District have their data presented together. The researcher working with Aboriginal Health Workers approached parents and carers about the study and invited them to take part in a survey interview. The parents and carers were attending various services at each co-operative. These included antenatal care, maternal and child health care, playgroups and health promotion activities. Each interview lasted between fifteen and twenty-five minutes and the interviewed person received a $20.00 supermarket gift voucher for his or her time.

About the data
The survey results are listed under each risk factor. Some of the survey results use the 63 carer responses, while others use the 91 children under the age of five who the carers were asked about. Of the 63 carers, there were 60 carers who answered the questions about social networks of advice and support. Three carers did not answer the social network questions due to time constraints. Where children are represented in the social networks for advice and support (such as childcare), the questions were asked about the youngest child in the family.

Social network analysis
Often health research and statistics are based around having large numbers of people in a study. Many Koori communities have very small local populations. Some of the communities in this study had less than ten or twenty children who were under six years of age. Social network analysis is one research method that can be used with small populations to better understand their health circumstances.

The use of social networks is a common data analysis and management method used by Koori people for time immemorial. Social networks are often depicted in Koori artworks as part of oral history culture to describe connections to things such as land, communities and family (Hawkes 2002; Arts Victoria 2005). These artworks have similar structures to maps of social networks used in social network analysis.
Presented in the ‘what the study found’ section are maps of parents’ and carers’ social support for ear health risk factors. Social support is how people draw on resources to meet their needs (Un & Ensel 1989). Research has shown that having personal social supports improves health (Bush & Baum 2001). In this study the social support is advice and support for ear health risk factors. Social networks often influence people’s behaviors and attitudes. This depends on the types of opportunities people have to access different types of resources (Berman & Glass 2000). The social network maps shown here describe the types of resources parents and carers accessed for risk factors for ear infections. The maps also show when parents and carers had better success at drawing on advice and support.

Of particular interest in the social networks presented in the data are the Koori services (for example, Koori Hospital Liaison Officers, Aboriginal Health Workers, Koori Maternity Services Program, ACCS, Koori childcare services and playgroups). These services and the network ties of support and advice are circled in the figures. This highlights the people who would become weakly linked or disconnected from support and advice for their children without such networks (Lewis 2005). Groups in the network are given a particular colour (for example, all Shepparton carers are the same colour). An index of the colour meanings is provided.

RECOMMENDATIONS

The following are recommendations arising from this study in regard to strengthening both Koori children’s ear health, and their general health.

1. Implement initiatives to improve access to Maternal and Child Health Services, particularly later child health visits. For example, Maternal and Child Health Service outreach to Koori childcare centres, playgroups and health services, offer Maternal and Child Health Services from Koori health services and/or health promotion to increase later child health visits.

2. Offer families cost-free, community-based financial counselling (macro economic initiatives to improve financial security are also essential).

3. Implement initiatives to improve food security and support healthy eating. For example, subsidise healthy foods for low-income families, provide fruit and vegetable vouchers for low-income families and/or improve Koori-friendly resources for childhood nutrition.

4. Implement initiatives to support mothers in establishing and sustaining breastfeeding. For example, ensuring continuity of breastfeeding support from hospital to home, community-based, peer-support programs and/or breastfeeding promotion activities.

5. Offer families cost-free, community-based support to deal with stress. For example, counselling and stress-reduction techniques such as massage, play therapy, music therapy, and art therapy—as per community-identified need.

6. Implement and continue initiatives to prevent family stress. For example, programs aimed at improving reconciliation and preventing family violence and separation.

7. Offer parents and carers at child health visits costfree, community-based support to give up smoking. For example, programs combining Quit short courses, brief intervention and cost-free nicotine replacement therapy and Zyban.

8. Offer families community-based support to establish and maintain housing security. For example, support to access public housing, become a home owner or to maintain housing stability.

9. Support Koori childcare centres and playgroups with access to adequate hygiene facilities, and infection control as per community identified need. For example, providing training for staff, ensuring presence of hygiene facilities, or assisting with infection control policy and procedure implementation.

10. Continue community-based Koori playgroups, childcare centres and health services as important sources of social support for families with Koori children.
WHAT THE STUDY FOUND

About the families

Who was surveyed?
There were 63 parents and carers surveyed. Of the 63 people surveyed, 57 (90%) were mothers. Others surveyed were fathers, aunts, uncles, foster carers and grandparents.

Ages of children
The 63 people surveyed were asked about the children under six years of age in their families, of whom there were 91. The children were fairly evenly spread across the age range of 0–5 years.

Figure 2: Number of children in each age group

Access to car, public transport, phone and Internet
All 63 people answered this part of the survey:

- 55 (87%) had access to a phone
- 52 (83%) had access to public transport
- 31 (49%) had access to a car
- 11 (17%) had access to the Internet

Occupation of carers
The 63 carers were asked about their main occupations. Most of the carers were mothers (46) or grandmothers (4). Twelve carers were employed in occupations other than carer and one person was retired.

Figure 3: Occupation of parents and carers
Childcare

Going to early childhood learning is good for children’s development and helps them prepare for school (Wilkonson & Marmot 1998). It also increases the risk of children having ear infections (WHO 1996).

Of the 91 children in the survey, 9 (10%) were under six months of age and ineligible for childcare services. There were 22 (24%) children who did not attend childcare, 25 (27%) who attended a childcare centre, 16 (18%) who attended a kindergarten and 19 (21%) who attended a playgroup. Of all the children eligible to attend childcare, 60 of the 82 (73%) children attended an early childhood facility. This indicates the importance of early childhood centres using methods to minimise the spread of otitis media between children. This is particularly important in a population where otitis media is high.

Figure 4: Percentage of children attending early childhood centres, n=91

Childcare advice and support

Parents and carers were asked about the advice and support they received in regard to childcare. In Shepparton/Mooroopna there are three Koori early childhood services, and in the Western District each ACCS that took part in the study has a playgroup. Most carers received advice, some from more than one source. The ACCS were often supplying childcare advice. Most parents and carers said they had transport support to and from childcare. For many people this support came from ACCS, friends and family, and Elders.
There were 60 parents and carers who responded to a question about the type of advice they had been given about childcare:

- 13 people had been given no advice
- 45 people had been given information about a particular childcare service
- 2 people had been told childcare was good for children.

Figure 5: Sources of childcare advice, Shepparton/Mooroopa

Figure 6: Sources of childcare advice, Western District

Figure 7: Sources of childcare support, Shepparton/ M ooroo pna
There were 60 parents and carers who responded to a question about the type of support they had been given for childcare:

- 16 people had no children in childcare
- 28 people said the type of support they were given was transport to and from the childcare centre
- 16 people said they received no support

**Immunisation (needles and shots)**

Of the 91 children, 88 (97%) were fully immunised. Immunisation in the Victorian Koori population has been estimated at 49% (12–<15 months of age) and 37% (24–<27 months of age) (DHS 2004a). This may indicate that Koori children attending ACCS are more likely to be fully immunised.

**Immunisation advice and support**

Parents and carers were asked about the advice and support they received in regard to immunising their children. Their responses are outlined below. Most people had received advice about immunisation and some people had more than one source of advice. Most of the advice in Shepparton/Mooroopna came from ACCS where a maternal and child health nurse is present one afternoon a week and there are nurses and a general practitioner (GP) every weekday. In the Western District, advice came from a variety of GPs and maternal and child health nurses. Many people had support to immunise their children, mostly transport support. Much of the support came from ACCS, family and friends, and Elders.

Susan Beckhurst (Medical Receptionist, Rumbalara Aboriginal Cooperative)
There were 60 parents and carers who responded to a question about the type of advice they had been given about immunisation. The responses were as follows:

- 3 people had been given no advice
- 52 people had been advised ‘when to immunise’
- 3 people had been advised ‘immunisation is good for baby’
- 1 person had been advised ‘what to do afterwards’
- 1 person had been advised ‘not to immunise’.

Parents and carers circled are those using Koori services.
There were 60 parents and carers who responded to a question about the type of support they had been given to immunise their children. They gave the following responses:

- 29 people had received no support
- 23 people had been given transport support
- 2 people had someone to look after the other children
- 3 people had a home visit from the Maternal and Child Health Nurse
- 1 person mentioned the government payment for immunising the child
- 2 people had someone come along and help them.

**Ear infections and health services**

Four (4.4%) of the 91 children currently had grommets. A further 4 (4.4%) had continuous ear infections. This gave a total of 8 (8.8%) children experiencing a chronic form of otitis media. This is an indication of ‘known’ chronic otitis media rather than ‘actual’ chronic otitis media. Research has shown that parents often have difficulty identifying ear problems in young children (Watkin, Baldwin & Laoide 1990).

**Sick child advice and support**

Parents and carers were asked about the advice and support received if a child was sick. Their responses are outlined below. Most parents and carers had received advice about ‘what to do’ or ‘what was wrong’. Much of this advice came from ACCS. Over half the parents and carers had support, much of it transport support, from ACCS, family and friends, or Elders.
There were 60 parents and carers who responded to a question about the type of advice they had been given when their children were sick. They gave the following responses:

- 3 people had been given no advice
- 50 people had been given advice about ‘what to do’
- 7 people had been given advice about ‘what was wrong’.
There were 60 parents and carers who responded to a question about the type of support they had been given when their children were sick. They gave the following responses:

- 29 people had no support
- 24 people had transport
- 2 people had ‘someone to talk to’
- 2 people had help to look after their other kids
- 2 people had help to make appointments
- 1 person had help to pay for petrol to get to the hospital.

**Breastfeeding**

Of the 91 children, 22 (24%) had never been breastfed. Of children 3 months of age and over (85) there were 44 (52%) children breastfed at three months. Of children 6 months of age and over (78) there were 21 (27%) children breastfed at six months. Victorian Maternal and Child Health data in 2004-2005 found a slightly higher proportion of babies fully or partially breastfed at 3 months (59%), and a higher proportion fully or partially breastfed at 6 months (47%) (DHS 2005). A study with 116 Melbourne Koori women in 1997 had a lower proportion of 15% of babies never breastfed, and similar proportions at 3 months with 50% breastfed and at six months 32% breastfed (Holmes, Phillips & Thorpe 1997).

The parents and carers said they had stopped or not started breastfeeding because of: not having enough milk (14), feeling like it was time to stop (8), baby not sucking well (7), mother too tired (7), baby born prematurely (7), to be able to do things without baby (6), too hard (6), sore nipples (4), mastitis (4), baby wouldn’t latch on (3), to return to work (3), mother became sick (3), baby was fostered (3), worrying about drug taking and contaminating the breast milk (3), mother not comfortable with breastfeeding (2), child preferred bottle (2) thrush (1), biting (1), child refusing breast (1) baby having reflux (1), baby lactose intolerant (1). Four mothers were currently still breastfeeding.
Breastfeeding advice

Parents and carers were asked about the advice they received for breastfeeding. Their responses are outlined below. Many parents and carers had received breastfeeding advice mostly to do with initiating breastfeeding. None reported receiving advice about how to sustain breastfeeding, although 6 people had been told it was good for babies. Mostly advice came from services, particularly midwives. At Rumbalara a maternity services program has been established and the link between the program with the local hospital can be seen in Figure 18.

Figure 18: Sources of breastfeeding advice, Shepparton/Mooroopna

![Breastfeeding advice diagram for Shepparton/Mooroopna](image)

There were 60 parents and carers who responded to a question about the type of advice they had been given about breastfeeding. They gave the following responses:

- 10 people had no advice about breastfeeding
- 40 people had been given advice about how to breastfeed
- 6 people had been given advice that breastfeeding was good for baby
- 2 people had been given advice about how to get baby to latch on
- 1 person had been given advice about how to express breast milk for tube-feeding
- 1 person had been given advice about how to care for cracked nipples.

Breastfeeding support

Parents and carers were asked about the support they received for breastfeeding. Very few parents and carers had received support for breastfeeding. The majority of support came from services and Elders.

![Breastfeeding support diagram for Western District](image)
There were 60 parents and carers who responded to a question about the type of support they had been given about breastfeeding. They gave the following responses:

- 50 people said they had no support
- 7 people said they were given encouragement
- 2 people had someone to look after their other kids
- 1 person said they had someone who generally ‘helped out’.

### Bottle-feeding

Of the 91 children, 58 (64%) had been bottle-fed for longer than the recommended 12 months of age. Bottle-feeding is associated with increased risk of ear infection and also tooth decay, anemia (not enough iron) and obesity (Bonuck & Kahn 2002; Victorian Government 2004).

### Bottle-feeding advice

Parents and carers were asked about the advice they received for bottle-feeding. Their responses are outlined below. Many parents and carers had received advice about bottle-feeding, particularly about what to use and bottle care. No one reported advice about when to stop bottle-feeding a child.
Figure 22: Sources of bottle-feeding advice, Shepparton/Mooroopna

There were 60 parents and carers who responded to a question about the type of advice they had been given about bottle-feeding. They gave the following responses:

- 23 people said they had received no advice
- 27 people said they had been advised ‘what to use’
- 6 people had been given bottle care advice
- 2 people had been advised what formulae to use
- 2 people had been given advice about tube-feeding.

Bottle-feeding support

Parents and carers were asked about the support they received for bottle-feeding. Few parents and carers reported support for bottle-feeding.

Figure 23: Sources of bottle-feeding advice, Western District

Figure 24: Sources of bottle-feeding support, Shepparton/Mooroopna
There were 60 parents and carers who responded to a question about the type of support they had been given for bottle-feeding. They gave the following responses:

- 48 people had received no support
- 3 people had never bottle fed
- 7 people had been given help to wash bottles
- 2 people had someone who generally ‘helped out’ with bottle feeds.

**Food**

**Introduction of solid food**

It is recommended that solid food should be introduced to children no earlier than four months and ideally not before six months of age (NHMRC 2003). If solid food is given to children too early it can cause food and skin allergies, poor growth and problems with the digestive system including the stomach, intestines and bowel (Victorian Government 2005).

**Introduction of cow milk**

It is recommended that cow milk be introduced to children after 12 months of age. Cow milk has higher levels of protein, salt, potassium and calcium than breast milk or formula (NHMRC 2003). If children have cow milk regularly before 12 months of age, it places extra strain on their kidneys (Victorian Government 2005).
Vegetables
It is recommended that children aged four to seven years eat between two to four different types of vegetables a day (NHMRC 2003). There were 20 children who were aged four to six in this study. Of those, 3 (15%) ate less than two types of vegetables, 12 (60%) ate less than four types of vegetables and 8 (40%) ate four or more types of vegetables. Of the 69 children over 12 months of age, 48 (70%) ate less than four types of vegetables and 13 (19%) ate less than two types of vegetables a day.

Fruit
It is recommended that children aged four to six years eat one to two serves of fruit a day (NHMRC 2003). Of the 20 children aged four to six years in this study, all but one (5%) child ate one or more pieces of fruit a day. Of the 70 children over 12 months of age, 21 (30%) ate less than two pieces of fruit a day.

Nutrition advice and support
Parents and carers were asked about the advice and support they received for child nutrition, and their responses are outlined below. Most had received advice about nutrition, generally about when to introduce solid foods. A smaller number had been given advice about good foods for children. Parents and carers reported very little support for nutrition.
There were 60 parents and carers who responded to a question about the type of advice they had been given about child nutrition. They gave the following responses:

- 14 people had received no advice
- 24 people had been given advice about when to introduce foods
- 17 people had been told about foods that were ‘good for kids’
- 3 people had been given advice about foods for attention deficit disorder (ADD)
- 1 person had been advised to wake the baby up to feed more
- 1 person had been advised about anemia and food.
There were 60 parents and carers who responded to a question about the type of support they had been given about child nutrition. They gave the following responses:

- 56 people said they had no support
- 2 people said they had help with shopping and cooking
- 1 person said they had help with shopping
- 1 person had a home visit from a maternal and child health nurse who provided nutrition help.

**Dummies**

An increased risk of ear infections has been found in children who use a dummy, other than to go to sleep, after six months of age (Niemela et al. 2000). Dummies have also been found to reduce the risk of sudden infant death syndrome (SIDS) (Alm, Lagercrantz & Wennegren 2006).

Of the 91 children in this study, 67 (74%) children used a dummy. Of this 67, there were 36 (54%) children who used a dummy, other than to go to sleep, after six months of age.

**Dummy advice**

Parents and carers were asked about the advice they received about dummies. Their responses are outlined below. Mostly parents and carers reported having no advice about using dummies. Parents and carers who had been given advice had mostly been advised not to use them.
There were 60 parents and carers who responded to a question about the type of advice they had been given about dummies. They gave the following responses:

- 40 had been given no advice
- 12 had been given advice not to use them
- 3 people had been told they were not good for teeth
- 2 people had been told they were not good for the child
- 1 person had been advised to give the baby one if it wanted it
- 1 person had been advised that they were good to use
- 1 person had been advised that they weren’t good to use when breastfeeding.

**Smokes**

Of the 63 parents and carers surveyed, 52 (83%) were smokers. Most parents and carers had been advised that smoking was not good for them. Advice came from services, Elders and family members, particularly people’s children. Very few reported having had support to give up smoking. In Shepparton/Mooroopna the Rumbalara Aboriginal Health Service had run a short course for the last two years about how to give up smoking. In this area there was a noticeable difference in support from the GP at Rumbalara and from the short course compared to the Western District.

**Smoking advice and support**

There were 60 parents and carers who responded to a question about the type of advice they had been given about smoking. They gave the following responses:

- 10 were non-smokers
- 6 were given no advice
- 38 had been advised to give up smoking
- 6 people had been advised not to smoke near children.
There were 60 parents and carers who responded to a question about the type of support they had been given to quit smoking. They gave the following responses:

- 10 were non-smokers
- 6 people had been offered support through a co-operative QUIT course that included free nicotine replacement therapy
- 2 people had been offered free nicotine replacement therapy patches
- 2 people had used nicotine replacement patches
- 1 person had been offered support and encouragement to give up cannabis
- 1 person had used Zyban
- 1 person had been given help to go ‘cold turkey’.
Financial security

The 63 parents and carers were asked about their ability to pay a large bill for $500.00. Of these, 1 (2%) person said they could easily cope, 6 (10%) people said they would be able to cope, 54 (87%) said they would struggle to cope and 1 (2%) said he or she would not cope.

Figure 39: Percentages of ability to pay a large bill for $500.00

Parents and carers were also asked if they had run out of food in the past 12 months and been unable to buy more. Of the 63, there were 32 (51%) who had run out of food and could not afford to buy more.

Figure 40: Percentages of food security

Financial advice

Parents and carers were asked about the financial advice they received. Their responses are outlined below. About half the parents and carers had sought financial advice, mostly from financial counselling services. Of those who sought advice, about half had sought advice about managing debts.

Figure 41: Sources of financial advice, Shepparton/ Moorooepna
There were 60 parents and carers who responded to a question about the type of financial advice they had been given. They gave the following responses:

- 35 people had received no advice
- 11 people had been given advice about how to manage debts
- 9 people had been given advice about how to manage money
- 2 people had been given advice about lending money
- 1 person had been given advice about saving money
- 1 person had been advised not to waste money
- 1 person had sought legal advice.

**Social and emotional well-being**

The 63 parents and carers surveyed were asked about potential stressors in their lives. Their responses are listed below:

- 23 (37%) said they had experienced racial discrimination in the past 12 months
- 26 (41%) said they had been worried that a family member would experience violence in the past 12 months
- 22 (35%) said a family member had experienced violence in the past 12 months
- 32 (53%) had a family member who had been removed from the family (this included grandparents, parents, the person surveyed, their children or foster children they cared for).

**Houses**

The 63 parents and carers surveyed were asked about the type of housing that they lived in. One (2%) person owned a house without a mortgage, 7 (11%) people owned a house with a mortgage, 32 (51%) people rented from a housing authority, 18 (29%) rented from private rental and 5 (8%) people lived with other family members. A question about housing stability/security was not asked but it was noted during survey interviews that a number of parents and carers reported having recently moved.
Overcrowding of people in a house is one risk factor for otitis media. High overcrowding has been defined as more than two people per bedroom and moderate overcrowding with more than 1 and less than 2 people per bedroom (Dept of Housing and Regional Development 1994). Of the parents and carers in this study 25% (16) had 1 person per bedroom, 57% (36) had more than 1 and less than 2 people per bedroom and 18% (11) had more than 2 people per bedroom.

**Housing support and advice**

Parents and carers were asked about the housing advice and support they had received. Their responses are outlined below. More people had obtained advice about housing rather than support. All people who had housing support had obtained it from ACCS.

**Figure 44: Sources of housing advice, Shepparton/Mooroopna**

**Figure 45: Sources of housing advice, Western District**
There were 60 parents and carers who responded to a question about the type of housing advice they had been given. They gave the following responses:

- 36 people had received no advice
- 15 people had been given advice about how to apply for rental housing
- Six people had been given advice about how to find a rental house
- 2 people had been given advice about housing loans
- 1 person had been given advice about how to buy a house.

**Figure 46: Sources of housing support, Shepparton/Mooroopna**

![Graph showing sources of housing support for Shepparton/Mooroopna]

**Figure 47: Sources of housing support, Western District**

![Graph showing sources of housing support for Western District]

There were 60 parents and carers who responded to a question about the type of housing support they had been given. They gave the following responses:

- 53 people had no support
- 3 people had help to find a house
- 2 people had help to fill in forms
- 2 people had help to provide proof of identity.
COMMUNITY DATA ANALYSIS WORKSHOPS

Two workshops were held with staff from the relevant Aboriginal Community Controlled Health Organisations involved in the project. Staff from three services (one staff member was on maternity leave from a fourth service) met at the Ballarat and District Aboriginal Cooperative to look at the survey results. A second workshop was held in Shepparton at the Rumbalara Aboriginal Co-operative. At this workshop staff gave feedback about the study results in between work commitments.

Western District

The Aboriginal Health Workers present at the workshop looked at the survey results for each of the risk factors for ear infections, and recorded their analysis of each one on butcher's paper. These are listed below.

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Aboriginal Health Worker Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to phone, transport and Internet</td>
<td>Most had access to a phone; few had access to Internet; half had access to a car (leading to transport issues).</td>
</tr>
<tr>
<td>Family stress</td>
<td>A lot of people had some kind of stress.</td>
</tr>
<tr>
<td>Financial security</td>
<td>Accessing agencies and family for support was often about financial trouble. Most people had run out of food and were also not able to pay a large bill.</td>
</tr>
<tr>
<td>Housing</td>
<td>Most people lived in housing authority houses. Support for housing was mostly from Aboriginal cooperatives.</td>
</tr>
<tr>
<td>Childcare</td>
<td>People had good access, especially to playgroups. Lots of advice and transport support.</td>
</tr>
<tr>
<td>Smoking</td>
<td>Nearly everyone smoked. Not much support to stop. People mostly had been given advice to stop smoking.</td>
</tr>
<tr>
<td>Bottle feeding</td>
<td>Not much support, what there was came from families. Advice was mostly about starting bottle-feeding. Children were bottle-feeding too long.</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Not much support at all. Advice was about early stages and introducing food. Kids were mostly getting enough fruit, easy to prepare and kids like it. Kids not eating enough vegies, generally harder to get kids to eat than fruit, and vegies need more preparation time.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Everyone got some kind of advice on 'how to breastfeed'. Midwives were important in giving early advice. Advice was mostly 'how to', not how to keep on doing it. Not a lot of support.</td>
</tr>
<tr>
<td>Dummies</td>
<td>Most had no advice; those who got advice was that dummies should not be used.</td>
</tr>
<tr>
<td>Immunisation</td>
<td>Good numbers of kids immunised. Everyone got some advice about immunisation. Most people had support, particularly with ‘transport’.</td>
</tr>
<tr>
<td>Ill child</td>
<td>Plenty of advice on 'what to do'; all had received advice. About half the people had support.</td>
</tr>
</tbody>
</table>

Tania Geier (Aboriginal Health Worker, Winda Mara Aboriginal Cooperative) with sister Melissa (Heywood Koori Community)
At this workshop the data were put up on a wall in the staff room for people to see. Staff members came and made comments about the data during their spare moments at work. The researcher then recorded staff comments and thoughts, which are listed below.

**Staff comments**

- Most of the advice about nutrition was for young babies and not many people had support with nutrition.
- GPs at Rumbalara were providing a variety of advice.
- Connections between the local hospital, the Rumbalara Maternity Services Program and Maternal and Child Health Nurse were present in the network.
- People were experiencing poor financial and food security and family stress.
- Information about dummies is conflicting. One study has shown dummies are preventative in SIDS. They have also been shown to increase risk of otitis media if used continuously after six months and can create nipple confusion in breastfeeding babies.
- There were high smoking rates. The QUIT program at the cooperative was giving people support for smokers to give up. The GPs at the cooperative were giving people advice and support about giving up smoking.
- Immunisation rates and advice about ‘what to do’ with sick kids seemed to be going well for people using Rumbalara services.
- The childcare centres run by the community were providing connections for people.
- Visits to the maternal and child health nurse by Koori families drop off as babies get older; this may be connected to more ‘early’ advice being given (for example, introduction of food) and less ‘later’ advice (toddler foods, when to stop bottle feeding) given to mothers.
Planned interventions

Western District

Each of the Aboriginal Health Workers was employed at services that had playgroups where parents and children attend. The workers thought that the playgroups offered an opportunity to address some of the issues raised in the study. It was suggested a program could be run over a number of weeks with each playgroup. The program’s aim would be to address issues identified in the study. It was planned that the researcher would meet with each playgroup coordinator and the Aboriginal Health Worker to discuss the possibility and logistics of running a program.

Shepparton

The Rumbalara Aboriginal Co-operative has a Maternal and Child Health Nurse who holds a ‘drop in’ clinic every Tuesday afternoon. Many of the issues raised by the study related to aspects of parenting and child health of older babies and children. It was suggested that offering an incentive and awareness raising of later ‘well child checks’ may improve these areas. To do this it was suggested a show-bag be given to parents bringing children over 12 months of age for ‘well child checks’, with items included in the show-bag that related to improving weaker areas found in the study. The times for checks and the offer of a show-bag would be advertised through childcare centers, kindergartens and at Rumbalara. The aim of the intervention would be to increase numbers of later visits for 12 month and older well child checks. It was planned that the researcher with the Maternal and Child Health Nurse and Executive Manager of Rumbalara would compile a list of items for the show-bag.
Problem areas to be addressed by the interventions

Maternal and child health
- Koori visits to Maternal and Child Health Nurses for ‘well child checks’ reduce, as children/babies get older.

Nutrition
- Parents given early advice about how to breastfeed and not how to sustain breastfeeding.
- Parents not given support for breastfeeding.
- Parents given early advice about bottle-feeding and not about older babies and bottle-feeding.
- Parents given early advice about nutrition and not about nutrition for older babies or children.
- Parents not given support for nutrition.
- Low levels of vegetables in diet.

Smoking
- High levels of smoking.
- Low levels of support to stop smoking.
- Limited advice about how to give up smoking.

Stress
- People reported poor financial and food security.
- Many people reported stressors of family violence and separation.

Financial security
- Not many people had received financial advice, particularly for preventative financial planning.

Housing
- While it was noted that home ownership and financial security/income were identified problems, it was considered outside the scope of this small project to address these issues.
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To obtain copies of these reports please go to the Onemda website: www.chs.unimelb.edu.au/koori