Age group differences in facial cleanliness among children in remote communities in Central Australia

Research report

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Ninti One Limited

ABN: 28 106 610 833

PO Box 3971, Alice Springs, NT 0871

Ninti One Limited contact:

Tammy Abbott, Senior Research Officer

tammy.abbott@nintione.com.au

Contributors to the report:

Tammy Abbott, Senior Research Officer and lead researcher
Steve Fisher, Technical Advisor and lead author
Amunda Gorey, Aboriginal Community Researcher

Additional research and review by Annum Shaikh, Public Health Specialist

We wish to acknowledge the contributions of their knowledge and experience made by local community residents from Mutitjulu, Ntaria and Papunya.

Our thanks to health professionals in Alice Springs who agreed to share their knowledge and experience with the Ninti One research team.

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1.0. Background

According to data generated from the work of Indigenous Eye Health (IEH), around 30% of Aboriginal children in the age group 0 to 4 years living in remote communities normally maintain facial cleanliness. Among children in the age group 5 to 9 years, a proportion of 70% of the population normally has clean faces. There is a marked difference between the two age groups.

For trachoma prevention programs to be effective, they need to be informed by a good understanding of the reasons for the difference. This knowledge will help target information towards increasing the entire proportion of children who have clean faces, but especially to increase the proportion in the 0-4 year age group.

The purpose of this paper is to present the findings of a study conducted on the factors that influence facial cleanliness of children aged 0-4 years in remote communities compared with children within age groups above four years.

2.0. Research design

2.1. Research questions

The following research questions were agreed between IEH and Ninti One as a basis for this phase of work:

1. Why is there a difference in rates of facial cleanliness within the 0-4 year age group in remote communities?
2. What are the specific factors that influence the difference in facial cleanliness within this age group and especially that cause a lower rate of cleanliness for around 70% of the 0-4 year group?
3. What are potential approaches to reducing the influence of factors that impede facial cleanliness and strengthening the factors that improve it for the 0-4 year age group?

The collection of data was orientated to these three questions. At the same time, the research team was alert to any information arising that indicated a need for new lines of questioning to be pursued.

2.2. Ethics approval

Ninti One was originally granted ethics approval by the Central Australian Human Research Ethics Committee (CAHREC) for its work on an evaluation of the National Trachoma Prevention Program on 20th September 2016.

Ninti One applied for and was granted ethics approval from CAHREC for the current project commencing on 5th October 2018. On 4th November 2019, we received further approval for an extension that enabled us to proceed with research on cultural influences on trachoma prevention.

For the work described in this report, Ninti One submitted an application for approval to CAHREC that was considered at its meeting of 19th November 2020. CAHREC provided conditional approval on 27th November 2020 and final approval on 3rd December 2020. We are grateful to CAHREC for providing a swift response that enabled the research to be conducted in December.

2.3. Data collection

2.3.1. Planned methods

The research was conducted over a period between late November and early February 2020. The Ninti One research team used data collection methods that both suited the preferences of participants and also enabled the research team to approach the three questions above from different directions. The methods we planned to use at the outset (but were amended as described in Section 2.2.2.) were as follows.

Case studies were intended to be prepared on the experiences of two families whose children have clean faces and two families whose children do not have clean faces, in each of three communities. This means that a total of eight families would participate. The plan was that Ninti One Aboriginal Community Researchers would spend up to a half day with each family, in their home, discussing with them their family routines and collecting data relevance to the three research questions.

A **focus group** was planned to be conducted in each of the communities to collect information in response to the three research questions. Participants will be adult Aboriginal people who have knowledge and experience of family hygiene practices and trachoma prevention in their community.

Interviews were planned with people in positions of authority or who have specialist knowledge of health services in the communities, such as clinic staff or board members of Aboriginal organisations. A minimum of four interviews in total were to be carried out.

In addition, the observations of members of our research team were important sources of data, especially those of Tammy Abbott. Tammy is a Western Arrernte, Pintipi and Luritja woman with extensive family and community networks across areas of Central Australia that have historically experienced high levels of trachoma.

The use of surveys was not required as we were seeking in-depth exploration of topics rather than the collection of simple data from a large number of participants.

2.3.2. Change of strategy

In Papunya, the first community we visited, participants showed some reluctance to be the subject of in-depth case studies. While it was entirely feasible to sit with parents and other family members, with their children, on their verandahs or in their front yards to talk about their daily routines, the process became more an interview than a case study. It was also clear that participants did not want to prolong the conversation.

The reasons for this reluctance could be summarised in the Aboriginal way as ‘shame’, which in this context refers to shyness and uneasiness at being asked personal questions by outsiders. Of course, memories of visitors from outside communities assessing the care of children are still vivid in the many

places. Despite the leader of the Ninti One research team having family and kinship relationships with two of the communities, we could still detect a level of unease in people we approached.

By contrast, our experience with conducting a first focus group in Papunya was entirely positive and provided a range of insights that directly served the research questions. Participants appeared much more willing to discuss the community in an objective way and were more comfortable discussing the subject as a group. We also noted that focus groups held in community premises were less intrusive than asking parents to meet with the researchers at home and therefore more likely to promote open discussion of the research questions.

As a result of this early experience in the process, the research team decided to shift the research strategy away from case studies and towards more focus groups and interviews. We organised a group from a third community, Mutitjulu, and invited Amunda Gorey into the team. Amunda is an experienced Aboriginal Community Researcher who enabled us to connect with further interviewees from her own community network.
Before this shift of emphasis, we were able to complete three short case studies of families with children with clean faces, which are provided in Section 3.9.

The changes to strategy also involved developed a second cycle of research to enable further exploration of the emerging findings from the first cycle. We approached five health professionals with knowledge and interests in social determinants of health and asked them the following questions using semi-structured interviewing techniques:

1. In your experience, are any of the factors affecting facial cleanliness more important than others? Please can you explain why.

2. Is anything missing from the list we have shown you?

3. Do you have any knowledge or suggestions as to why facial cleanliness among children might differ widely between remote communities in Central Australia?

4. What are potential approaches to reducing the influence of factors like those identified above?

Each key observer was provided with a short summary of key findings emerging from the first cycle, as a basis for questions 1 and 2 above.

2.4. Research participants

As the core work of the first cycle of research, the Ninti One team conducted three focus groups:

Papunya, 8th November, four women and one man aged 25-50 years.

Ntaria, 10th November, seven women aged 25-60 years.

Mutitjulu, 15th November, three women and two men aged 35-60 years (focus group discussion conducted in Alice Springs).

We conducted five interviews during the second cycle of research with:

A male general practitioner employed at the Aboriginal Health service in Alice Springs for almost twenty years and who has travelled to and worked from remote clinics across Central Australia.

An Aboriginal female nurse who works at the Aboriginal Health service in Alice Springs for over ten years. She now specialises in diabetes and has a lot of interaction with people from remote communities.

Two female clinic co-ordinators and nurses who work in the tri-state (NT, WA and SA) remote communities. Both were employed at Centre for Remote Health and are now working for Remote Area Health Corps.

A female trachoma specialist who is employed by the allied health section of the Department of Health of the Northern Territory Government.

As much as possible, we sought to engage participants from both genders in the research activities. It was important to ensure that both female and male perspectives were heard, especially as themes began to emerge that prompted people to share observations that were sometimes different in the way they were viewed by women and men. However, it is often the case that women consider child-related matters as a subject of most relevance to them and are also more willing than men to join focus groups and interviews. We recognise that women were by far the largest proportion of participants in the research.

Ninti One chose not to record digitally the focus groups or interviews as we felt that doing so could impede the openness and flow of the discussion. Instead, we made notes in each case and used them as a basis for the team to analyse the data collected.

In summary, the changed research strategy comprised two research cycles in the following way:

First research cycle	**Second research cycle**
Three case studies of families with children with clean faces in Papunya Three focus groups of community members, one for each of the communities of Papunya, Ntaria and Mutitjulu Three interviews with key Aboriginal observers living in Alice Springs and with experience of remote community life	Interviews with five key observers who are Aboriginal and non-Aboriginal health professionals based in Alice Springs and with experience of services to remote communities

The three communities chosen for the research are those with which Tammy has strongest kinship and family connections, enabling the research team to more easily gain support for the research and access to individuals and families than would be feasible for such a sensitive subject in communities with which we had no existing connections.

2.5. Avoidance of bias

We avoided bias in the study through applying lessons from previous research we have conducted on trachoma prevention. In line with good social research practice, it was important that the themes and questions we introduced to participants in the research activities above were presented in a way that

did not prompt a particular response. We therefore followed a strict protocol to refrain from leading or suggestive questions and avoid introducing bias into the research.

In every case, we facilitated a discussion that enabled participants to give us their views on behaviour and facial cleanliness, including how it influences the responses of individuals and families to public health information and messages on the prevention of trachoma.

We wish to make the important point that the data collected through this study includes many observations on the behaviours of parents that imply negligence of their children. These comments were made in response to the research questions to which the study directed its efforts. The comments made here are not a reflection on Aboriginal people generally but focus on the proportion of the population whose children under the age of four years lack facial cleanliness. Therefore, they do not present the many consistent examples of care and support for children and young people that occur in remote communities.

3.0. Data analysis

3.1. Strategy applied to analysis of data

Previous experiences of Ninti One in collecting and analysing qualitative data have shown that a thematic approach is most effective. In practice, this means that we identify themes emerging from the research as a whole and then organise the data under each theme.

Once we had found participants willing to discuss the subject of facial cleanliness with us, most were direct and unhesitating in providing their observations on the subject. Each of the three focus groups and the interviewees quickly understood the purpose of the research and the clarity and speed of their responses to our questions showed they had significant personal knowledge to share on the subject.

The quotations at the start of each theme are remarks made by one of the research participants. We have chosen them as being reflective of the broader focus group discussion or interview around the theme. All other quotations in italics are the words of research participants in the first cycle. In other words, they come from Aboriginal people living in the communities of Papunya, Ntaria and Mutitjulu. They are unattributed to individuals in line with the ethics approval described in Section 2.5. Each quotation separated by a line break is that of a separate individual, not a continuation of comments from the previous person. Residents of Santa Teresa participated in the second cycle of research.

3.2. Factors affecting rates of facial cleanliness

This section presents the data collected for the first two research questions in this study:

Research Question 1: Why is there a difference in rates of facial cleanliness within the 0-4 year age group in remote communities?

Research Question 2: What are the specific factors that influence the difference in facial cleanliness within this age group and especially that cause a lower rate of cleanliness for around 70% of the 0-4 year group?

Distractions caused by mobile phones, alcohol, drugs and gambling

They are on their phones all night

Three-quarters of participants referred to parents whom they believed were distracted from keeping their children clean by other priorities. Use of alcohol and ganja (marijuana) were mentioned, as well as gambling, which keeps people up late and therefore means they are still asleep when young children wake up in the morning.

> *Parents sleep in the morning, usually to between 10 and 1pm. The kids wake up and there's no parent. The kids over five go to school unclean and hungry.*
>
> *Some parents walk around drunk with their kids. Safety is an issue.*

You have parents who think that their kids are old enough to fend for themselves at the age of 12-13 and this is what we see everywhere, in town and out on community. Those parents just want to go and drink in town and this is the lifestyle choice they have made. They want to enjoy their life now.

The biggest influence on the priorities of young parents was considered by participants to be the use of mobile phones.

They play games and go on social media until the early hours.

Their eyes get sore from looking at the screen.

A key observer commented that people are often living a routine where 'their clocks are flipped'. This means that they go to sleep late and so do their children. Another said that mobile phones are addictive and so the current generation of parents are exposed to a new challenge to their ability to care for their children.

In considering other priorities that parents may have, the age of children becomes significant. Children under four years old tend to be more dependent on their parents caring for them in the morning. Those of five years and older are more able to fend for themselves and often have an existing morning routine they follow, involving a shower and breakfast.

Older kids wash themselves and go to school. They know what to do. Younger ones need their mothers.

Schools have showers, towels and everything kids need to wash. They show the kids what to do. The little ones at home get missed out, except if they go to pre-school or FAFT (Families As First Teachers)

When kids go to school, they learn about how to clean themselves (4 years and older), some parents clean their kids and some don't, other family and friends clean them sometimes.

So, if parents are still asleep around what might be called normal breakfast time (say, between 7am and 9 am), children of five years and above are better prepared to get themselves ready for the day. If other adults are present, then they may choose to help the child but there is less work involved in the morning routine for a child above four years than one who is younger. So other adults are more easily able to help out and the absence of parents does not lead to the child missing out on a wash in the morning. It is also worth noting that not all adults are able to care for children:

If the grandparents are old, it is hard for them to look after the kids because they might be tired or sick themselves.

One focus group participant made the point that children over the age of four years are more conscious of themselves and their hygiene. It could be that they are following the example of older children around them.

In seeking data relevant to some of the comments above, it is useful to refer to the National Health Survey, 2017-2018 (ABS, 2018), which shows that examining, 21.2% of the population of the NT exceeded lifetime risk guidelines for alcohol consumption, as compared to the national level of 16%.

According to the NT Gambling Prevalence and Wellbeing Survey (Northern Territory Government, 2018), the risk of problem gambling is the highest in Northern Territory, compared to other jurisdictions in Australia. Community attitudes indicate that 25% of adults have a positive view towards gambling. Although the patterns of gambling are changing in NT, increases have been noted in the number of people experiencing problem gambling and harm from another person's gambling.

Shortcomings in parenting skills

Young parents don't know how to look after their kids

The most common response to research questions 1 and 2 among participants in this study was that some parents lack the skills and knowledge required to look after their children properly. This observation applies in particular to parents in the age range 16 to 21 years.

> *Some parents are too young*
>
> *The lazy parents are the teenage parents. These parents are often born to teenage parents themselves. The teenage parents feel that it is their parent's responsibility to look after their children because they remember that they were looked after by their grandparents or other family when they were little.*

There is a correlation between the ages of parents and the better facial cleanliness of children above four years. Parents of children above four years are usually aged over twenty years and may have learned more of the parenting skills they require by the time the children are over four.

> *The parents start to get better when they reach 25 years old. That's when they are adults.*

The subject of parents being too young to know how to look after children was made repeatedly by participants throughout the study. Commentary was sometimes sympathetic:

> *Young parents get judged and people are always talking about them. So they don't go around the community with their child.*

The implication of this comment is that being judged by others means that parents become withdrawn and therefore receive little interest or support in their parenting from other people.

Other comments were those of frustration:

> *People don't make time to clean kids, too busy thinking about themselves. Why have kids if you can't look after them – they should think about birth control.*

An important observation made by over half the participants in the study was that children often resist direction from their parents.

> *Even little kids are the boss. Their parents can't tell them what to do.*
>
> *Kids cry when it is shower time so they don't have to do it.*

Parents give their kids the phone to keep them quiet.

The kid is the boss and gives the orders, even 6-8 year olds. .

Young parents can't handle looking after kids when they cry or behave badly.

It can be difficult to discern a difference that this resistance to direction from parents might make to children aged 0-4 years as opposed to those over four years old. We pressed participants to make a distinction and their responses were that many children of all ages resist washing or being washed.

Many kids don't want to wash. So sometimes it just doesn't happen.

Some kids have been spoiled since they were babies.

There was a strong sense from participants that the normal life of children in the community is one of being dirty through eating messy food, playing in the dirt, running around in dusty conditions all day, having a 'snotty nose' and generally being exposed to the environment of a remote community in Central Australia. For the smallest children, four years and under, even crawling or toddling around in the yard or around the house leads to the same result. It is acceptable and normal for children to have an unclean face, because desert community life is by nature dusty and dirty.

One focus group described how even the most vigilant parent would find it a challenge to keep up with the number of times that the faces of their children need to be wiped or washed. If keeping faces clean is not uppermost in their minds then levels of facial cleanliness are not going to be maintained by parents, simply because it is hard work. And if children resist and run away, then it becomes harder. As one observer said to us 'Mothers tend to drown (under the responsibility). They are not wading through it'.

In the comments we heard throughout the research about shortcomings in parenting skills, there are two inferences. The first and most direct argument from participants was that many parents have children at an age when they are not ready to handle and cope with the responsibilities and the work required. One key observer said she believes parents should be comfortable with bringing up children but she is not sure that some parents really are comfortable. Another said that children need a lot more education and guidance from their carers about hygiene and how to maintain good health.

According to Figure 1 below, the proportion of first-time mothers who were younger than 20 years of age was much higher among Aboriginal people (41.5%) compared to those among non-Aboriginal people (12%).

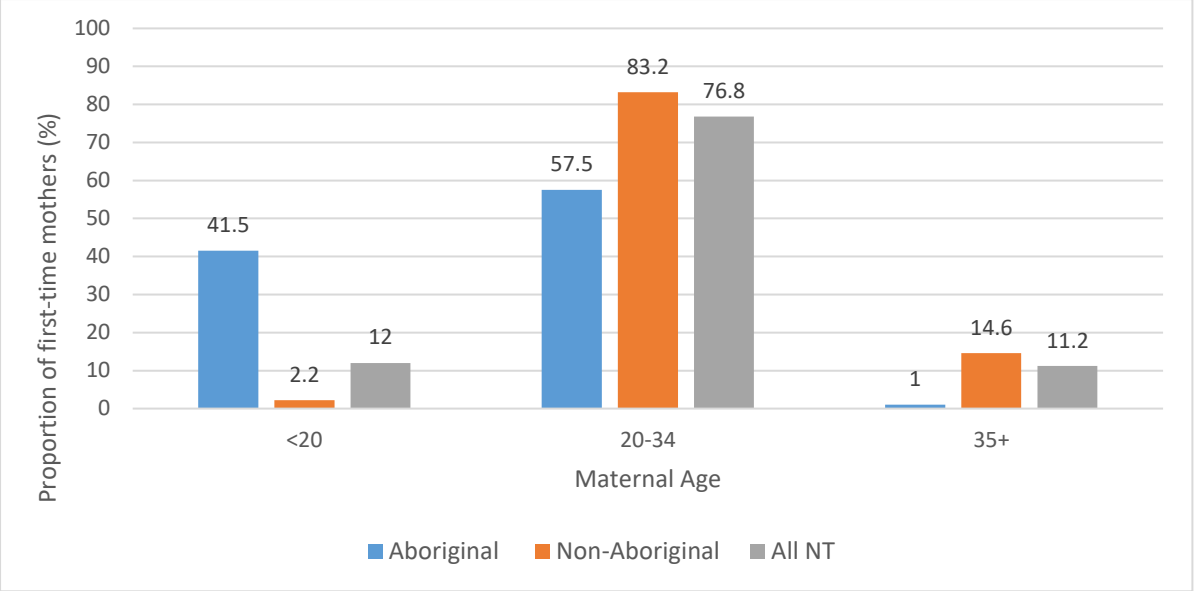

Figure 1: Distribution of maternal age by Aboriginal status, NT mothers, 2017 (Li & O'Neil, 2020)

A second and less direct inference from data collected during the first cycle was that parents are unable to manage the behaviours of their children in an effective way. The relevance of this point to facial cleanliness is that children avoid washing and parents are unable to discipline them to ensure it happens on a regular basis. The impression we took from the comments was that mothers are often struggling to cope with the work required, including setting and maintaining a structured washing and eating routine with their children.

Figure 2 below shows the proportion of single-parent families in the three communities. For the Northern Territory as a whole, 30.2% of all families have a single parent (ABS, 2016). Proportions of single parent households are significantly higher in Ntaria and Papunya.

	Ntaria	Papunya	Mutitjulu	Northern Territory	Australia
Number of families (%)					
Aboriginal single parent families	24 (37.5%)	33 (47.1%)	12 (30.0%)	37.2%	45.9%

Figure 2: Distribution of Aboriginal single parent families (based on PHIDU, 2020)

Very few participants pointed to the high number of single-parent families as being a reason for this problem and it could be that the community does not expect men to play an active role in child care anyway. The research team made an assumption that lone parents are likely to be less supported in their parenting practice than those in couples because two parents are more able to share decisions and should be able to agree on routines. However, it is important to note that many young mothers live with and/or receive support from female family members like their mothers and aunties.

Low motivation of parents

Some parents just don't do what they are supposed to do

The accusation of parental laziness was a comment we heard frequently when we asked participants to tell us the reasons why so many children under four years old have dirty faces.

> *Parents are lazy, simple as that.*
>
> *They stay in bed until late and they don't get up and look after their kids.*
>
> *Parents get up and go out. They dump the kids with aunties and grandma.*
>
> *Mothers of these kids don't care.*
>
> *Fathers are missing.*
>
> *Mothers are lazy in the community and I feel sorry for those kids. These kids want to be with friends and other family members that have a clean home. They don't really like being at their home and so they try to sleep at clean houses all the time.*

A participant in the second cycle of research felt that people have low motivation to care for children for many reasons, including:

- That they transfer the care of children to grandparents, which means the parents do not feel they need to be involved. There are cultural obligations within families where it becomes the responsibility of others such as aunts and uncles to discipline children and give guidance, which also removes the parents from childcare responsibilities
- A history of non-Aboriginal people working as health workers and on occasion taking over responsibilities by going into homes and doing work for parents
- The concern parents have that they are somehow not doing the work of childcare properly and so they step aside and let health workers do it instead
- The reality that parents often lack information. New parents living in places where English literacy is high might receive pamphlets from clinics or be given printed materials by nurses and midwives. By contrast, in remote communities information tends to be provided orally and then relies on the parents to retain the knowledge and apply it in practice.
- Parents can be busy with feeding and entertaining other kids in the house and so hygiene may not be a priority.

Another participant said that there are expectations among health services that families have low motivation. So a cycle is established where parenting standards are expected to be low and therefore go unchallenged by health professionals. As a result, parents do not strive to do better. The inference the research team takes from this comment is that an underlying culture of underachievement is established for the care of children.

The experience of the research team in remote communities is that often the word 'lazy' is a simple accusation that can mask a range of problems that individuals may be facing. Hearing the word

immediately leads us to wonder what else might be happening in the lives of an individual or their family. People may be affected by mental health problems. They could be sad or depressed for reasons associated with family or relationship problems. They could be affected by long-term grief.

Participants in research can often help shed light on those issues, as was the case here. Some comments we heard pointed to factors affecting motivation:

> *Some young mums ore heartbroken. So they sit waiting for their partner to come back.*
>
> *Parents might be lazy because they are depressed because they are fighting with other young women for their partners (jealous fights). They fight on Facebook and physically too.*

An insight from the experience of a key observer in the second cycle of research was that there is a clear distinction between families that get up in the morning and get their children ready for the day and those that do not. She believes that motivation is not as much a problem as parents not having the ability to care for their children.

One key observer said that she finds that people with a strong religious faith tend to be healthier and have healthy babies. She feels the reason is that they are more hopeful for a better life.

Another observer noted that poor cognitive awareness is evident in some people from remote communities and can be a barrier to them achieving changes in their lives, including becoming capable parents.

The subject of poor mental health affecting the behaviours of parents was raised by participants on three occasions. Certainly, mental health indicators for Aboriginal people living in remote areas show higher levels of vulnerability to mental health problems. The 2014-2015 ABS National Aboriginal and Torres Strait Islander Social Survey discovered that 33% of adult respondents had high or very high levels of psychological distress, specifically 2.6 times that of non-Indigenous adults. Also, 29% of the respondents, aged 15 years reported having a long-term mental health condition. Of those aged 18 years and over who reported a mental health condition, the most commonly reported was depression (72%), followed by anxiety (65%), behavioural or emotional problem (25%) and harmful use of drugs or alcohol (17%).

According to the National Health Survey, 2017-18, anxiety-related conditions were the most commonly experienced mental/behavioural condition in Northern Territory, affecting 10.7% of its population. One in thirteen (7.5%) had depression or feelings of depression.

According to the Burden of Disease and Injury Study in the Northern Territory, 2004-2013 (Northern Territory Department of Health), Disability-Adjusted Life Year (DALY) rates, a measure of overall disease burden, for the Aboriginal population in Northern Territory, were higher across all disease groups. Their rates were 6.6 times higher for mental and alcohol disorders for Aboriginal people than for the non-Aboriginal population. Mental health and alcohol-related conditions were the third leading disease group that caused a non-fatal burden of disease.

The National Mental Health and Wellbeing Survey 2007 provided evidence that adults in the NT are at higher risk of alcohol misuse with 25.5% of NT adults exceeding the National Health and Medical Research Council lifetime risk guidelines for alcohol consumption in 2011 - 12 compared with 19% for Australians overall (ABS 2012a).

Between 2011 and 2015, suicide was reported as the leading cause of death for Aboriginal and Torres Strait Islander persons between 15 and 34 years of age, and the second leading cause for those 35 – 44 years of age[3]. Death from suicide amongst Aboriginal people is reportedly almost three times higher than for non-Indigenous people in the Territory, with an age standardised rate of 26.2 deaths per 100,000 compared to 14.9 deaths per 100,000 for non-Indigenous persons over the period 2013 to 2017 (ABS 2018).

Turning to the implications for the daily lives of children of those parents who are affected by low motivation towards the care of their children, we asked one focus group to describe the life of a typical small child that they knew and who always had a dirty face. This was their response:

> *He might be wandering around all night. He is hungry during the day and asking at houses for food. He hangs around with other kids of different ages. They are always fighting with each other and being cruel. His parents don't like their own kids. They go to and from Alice all the time. They are always smoking ganja, drinking and gambling. Stoned and busy on their phones. Playing games and social media. They leave the kid with his grandma. The father is not around.*

To reiterate an earlier point, participants shared their observations on parenting practices of a proportion of people in the community and not all of them. They were responding to our questions about the factors that might prevent some people from acting on trachoma prevention messages. So the comments presented in this report should be considered indicative of a minority of families only.

Self-identity leading to avoidance of frequent washing

They don't want to be seen as acting like a white person

In our previous research on cultural influences on trachoma protection (Ninti One, 2020) we noted that many people in remote communities feel great pride in their identity. They describe themselves as Aboriginal people living in the bush according to traditional ways and customs. Their sense of identity means they are not necessarily open to changes encouraged from outside or from what is often called 'mainstream' Australia.

The same subject arose in one of the focus groups we conducted, with Mutitjulu people living in Alice Springs. This group is aware of the differences in the ways in which people present themselves as they are frequently encountering family and friends both in the community and in Alice Springs. Their view was that people take much less care of their hygiene when they are in the community.

> *If people have a job or go into town they will clean up and present themselves better.*
>
> *I believe it's the lifestyle choice of people. People don't wash when they are at home and don't have to go anywhere, they don't present as clean unless they have to, meaning, if they come to town or if they get new clothes, they have a shower and put their new clothes on.*
>
> *Parents are tired in the morning and feel like they don't have to clean their kids unless they are going into town and are in the public face.*

One key observer working in Alice Springs noted that many men use the shower on his premises, perhaps supporting the point that people tend to present themselves better when they are away from their home communities.

Among all the participants we met, there was a high level of concern about the situations they described and how they affected children. But they felt unable to influence the behaviours of the parents.

> *Many people say nothing for fear of being labelled a coconut* (an insult that accuses a person of being black on the outside but white inside).

In this sense, Aboriginal people who want to intervene to support better care of neglected children face the same cultural barriers as those that act against higher standards of hygiene more generally in the community.

Poverty, high living costs and spending choices that do not prioritise children

Some parents have expensive clothes and the kids are still dirty

In this study, we define material poverty as the inability to gain access to resources needed to sustain a minimum quality of life, food security, health and decent housing. Maintaining personal and household hygiene represents a significant cost to people in remote communities whose disposable income may be low and where local prices for key commodities like washing products are often much higher than average prices across Australia.

Undoubtedly many families in remote communities are materially poor by Australian standards. We frequently recorded responses from participants on this subject.

> *Some people have nothing at all in their houses.*
>
> *They live from payday to payday. So they might buy soap and shower gel on one payday but if it runs out they have to wait until the next one.*
>
> *Shower gel is too expensive in the community store. If they go into town, they will buy it there, like at Kmart. But if not, how can they afford it?*

Poor living conditions, lack of security, poor services and the lack of means to purchase soap and other hygiene products are significant barriers to Aboriginal people being able to act on the 'clean faces, strong eyes' message that is widely visible in remote communities throughout Central Australia.

In a generally prosperous Organisation for Economic Cooperation and Development (OECD) member country like Australia, this is a confronting situation. However, it is also a delicate subject because poverty does not necessarily reflect the full picture. In some communities where levels of unemployment and under-employment are high, causing people to be dependent on welfare payments, average incomes may be bolstered by royalty payments from land-use agreements associated with Native Title legislation.

Figure 3 below presents average incomes for the three participating communities. It illustrates the point about average income in the case of Mutitjulu, which benefits from national park royalties and

has an average personal income significantly higher than the other two communities (although still 16% lower than the average for Australia as a whole). Of course, average income figures can mask poverty level incomes among some individual and families.

Overall, Figure 3 indicates that many individuals, especially in Papunya and Ntaria, are living at an income level significantly below the poverty line. The OECD defines this level as half the median household income of the total population (ACOSS/NSW, 2020). Applying this measure to Figure 3, the poverty line in Australia in 2016 was $331 per week for an adult. The average income in Papunya was therefore $115 per week below the poverty line and in Ntaria it was $84 per week below the line.

	Hermannsburg (Ntaria)	Papunya	Mutitjulu	Northern Territory	Australia
Median **total personal income** (weekly)	$247	$216	$559	$871	$662
Median **total household income** (weekly)	$778	$1,053	$1,111	$1,983	$1,438

Figure 3: Median income distribution: Aboriginal and Torres Strait Islanders in NT and Australia (2016 ABS Census of Population and Housing)

Two focus groups and one key community observer talked about the spending choices that parents make. Their opinion was that lack of money is certainly a problem for some families, but that other people do not spend their money in a way that prioritises the health of their children.

> *They buy nice clothes in town using their Basics Card but the kids still look dirty.*
>
> *Some parents spend money on grog* (alcohol) *and don't buy clothes for their kids when they need them.*
>
> *The higher Jobseeker Allowance under COVID and their access to superannuation made the situation worse in some cases because some people wasted their money.*

A key observer in the second research cycle suggested that some people may be choosing more expensive hygiene products rather than the cheaper ones, meaning that they are able to afford less. Another observer said that in her experience poverty and overcrowding are the key factors because they mean that people are living in distressful environments.

These observations are relevant to our focus on age differences. Younger children are less able to voice their needs and are not under the same peer pressure to present themselves a certain way as children who are spending time with others, both at school and around the community. Parents are therefore more freely able to make spending choices when children are young that they are when the children reach school age.

Housing deficiencies and overcrowding

Too many people living together

As we noted in previous research (Ninti One 2020), poverty is also reflected in living conditions, including participants mentioning blocked toilets, dirty houses, laundry and bathroom sinks being blocked. Dogs were described as sleeping on blankets that people use. Crowded housing was a topic raised on several occasions and one that is familiar to anyone who has lived or worked with people from remote communities.

Similar comments arose during this research:

> *If there are a lot of people staying here, sometimes there's not enough towels.*
>
> *There's no shampoo or hot water available because of so many people in one house.*
>
> *In the winter when it is cold, people only shower a couple of times a week.*
>
> *Houses are not cleaned.*

One key observer said that many people 'want their homes to be nice, they see it on the media'. But the problem is that overcrowding prevents them improving their homes.

The table below provides figures on average occupancy per house for the communities that are the focus of this study compared with the Northern Territory as a whole and for Australia.

	Papunya	Mutitjulu	Hermannsburg (Ntaria)	Northern Territory	Australia
Average household size (persons)	4.6	6.4	2.6	2.5	2.9

Figure 4: Average household sizes

According to National Aboriginal and Torres Strait Islander Social Survey 2014-15 (ABS, 2015) over half (52%) of Aboriginal and Torres Strait Islander people in Northern Territory were living in a dwelling that was overcrowded (requiring at least one or more extra bedrooms) in 2014.

The statistics in Figure 1 do not imply that overcrowding is as severe as participants in the research has indicated to us. Having seen for ourselves signs of overcrowding in the houses we visited, we believe that the presence of visitors tends to mean that some homes are overcrowded for lengthy periods, even if the numbers of people living permanently at the address is within the capacity for the house.

In this context, mobility could also be said to be a factor in facial cleanliness. Aboriginal people living in remote areas travel frequently for cultural or family obligations or to access services in town. This

means they are often staying with family members in locations where the amount of space and facilities does not provide for a comfortable stay. If children are part of the travelling group, then it becomes harder to keep them clean.

> *Families don't always take spare clothes, soap and toothbrushes with them.*

Mobility features as a theme in many studies of Aboriginal health, employment, housing and education. Although we believe it to be less important than other factors affecting facial cleanliness, it is relevant here because it has an impact both on numbers of people staying in houses and also the ability of travelling families to access the water and hygiene products they need to keep their children clean.

3.3. Potential strategies to increase facial cleanliness

We put the third research in this study to all participants:

Research Question 3: What are potential approaches to reducing the influence of factors that impede facial cleanliness and strengthening the factors that improve it for the 0-4 year age group?

Responses from participants in the second cycle were more comprehensive because they are health professionals for whom strategies for health promotion are part of their work. The data collected is summarised below.

Direct educational support for individual families

When asked what could be done to improve facial cleanliness, a large majority of participants in the first cycle favoured direct educational support to parents. Their reasoning was that poor facial cleanliness of their children is part of a broader set of shortcomings in parenting skills and commitment.

> *People need support everywhere, not just in community but in town too. They need programs to help them make the right lifestyle choices. These programs should be teaching them in their home and in the community and in town, they should also talk to them about making good choices.*

Often called case management in a social work setting, individual and tailored support of this kind was favoured by participants in all three community focus groups.

We specifically asked second cycle participants for their suggestions against this research question because we believed they would have relevant experience from a health or service provider perspective. They made many comments, which we have grouped into two further categories; community initiatives and better use of existing agencies and programs. The wording provided is taken directly from interviews and edited for clarity.

Community initiatives

Communities need consistency. Staff working in or visiting the communities tend to come and go, therefore support from the community level itself is required. This implies that local people will participate directly in the delivery of programs through working in schools and clinics and other areas relevant to community health and well-being.

One observer described a trachoma prevention program that involved a barbecue and soap-making activity in which everyone, including parents, carers and children became involved.

On the basis that information is power at the community level, program reports on health should be published and available to the community, so they can see what progress is being made.

People need to take greater ownership of their communities, so that services are more closely tailored to needs. For example, clinics should be open in the afternoon when people are more active.

It would make a difference if community stores could reduce their prices, including subsidising essential food and hygiene products.

Better use of existing agencies and programs

Schools are often an important source of support to children and their families. They can make a difference and they are consistent. There could be scope for getting schools more involved in trachoma prevention. One observer referred to a hub approach that involved a holistic approach with schools and clinics. A successful example was cited from Areyonga, where the school and clinic worked together on health promotion programs that generated community support.

More programs like the Australian Nurse-Family Partnership Program (ANFPP) would be beneficial to addressing situations where basically children are becoming parents. The program empowers and informs first-time Indigenous mums or mums whose partner is Aboriginal or Torres Strait Islander and supports them and their families. The ANFPP works by having specially trained Nurse Home Visitors and Family Partnership Workers regularly visit first-time mums-to-be, starting early in the pregnancy, and continuing through to the child's second birthday. The Nurse and Family Partnership Worker work together with the expectant mum, identifying strengths and opportunities, delivering program content and supporting a healthy pregnancy and confident parenting. The FPW plays an essential role, bringing an understanding of the local Indigenous community and ensuring the program is delivered in a culturally safe way (ANFPP 2021).

More anti-natal programs would educate families about good parenting practices, especially in situations where there is no follow-up with mothers after they leave hospital following the birth of their child. One participant suggested that a connection or 'touch base' should happen as part of post-natal check-ups. She also argued for more programs like 'Stay Strong' to be delivered by AMRI or Menzies. Education should be provided to parents on maintaining their home and controlling their use of mobile phones.

Community engagement is the key. People need to be supported and empowered. But the clinics do not have the capacity for that kind of work. A funded AMS (Aboriginal Medical Service) would be more beneficial in supporting the community.

3.4. Case studies of family routines for children with clean faces

We stated in Section 2.2.2. of this report that the reluctance of families to provide in-depth case studies led to a shift towards focus groups and interviews as the primary means of collecting data. We also became aware that it would be difficult to identify and speak with families whose children have dirty faces.

Before making this change to our plans, we were able to collect three case studies of families with children with clean faces, which are presented below.

Family 1: Mother (around 19 years old) and child (two years old). Grandmother also present. The interview was conducted in Luritja and Arrernte languages.

A typical day starts with mother and baby waking up around the same time. Mother washes the child and they have breakfast. If mum feels lazy, then grandma looks after the child while the mother sleeps in for a while.

Usually, grandma goes to work and so the mother takes over caring for the child. She has another child aged three who is living with other family members at Lajamanu.

Often, the mother takes her child to the store, visits her sister and grandmother and comes home after that. They might go for a walk around the community, sometimes with other family members. In the afternoon they might watch television.

Later in the day, after work, grandma usually cooks the evening meal. But they sometimes take it in turns to look after the child and to cook the meal. Mother might go over to the oval around 8pm to watch people playing sport. Then she has a cup or team or Milo before going to bed around 9 or 10pm.

The mother explained that she keeps her child clean, mostly through having a shower every day. Sometimes there are no clean towels and so she uses clothes to dry the child after washing. She also washes the child after she plays in the dirt around the house.

The mother is aware that other people in the house are no so clean and do not wash their kids in the same way. But she wants her child to be clean like she is. This means keeping the child's dirty nose clean too.

When the child gets older and goes to school, there is cleaning gear and toothbrushes there.

Moving to the subject of other people in the community, she would prefer not to comment as it is a sensitive subject. Some people clean their kids and other don't. But at school kids are getting a wash each day and the workers at childcare also make parents clean the kids and check they had breakfast before they arrive.

Family 2: Father (mid-30s) with children of various ages over five years. Interview conducted in English.

The father explained that the family has a daily routine that keeps the kids clean through washing in the morning and before going to bed:

> *In the morning, they go straight to the shower, then have breakfast and then go to school. We make sure they wash before they eat as well, so their hands and faces are clean. We don't want them getting sick because of that.*

The family lives in Whyalla, South Australia, and is visiting relatives in Papunya, which is where they are from originally.

> *Community standards (in both places) sometimes mean that some parents don't look after their kids properly, including not changing their clothes regularly. In our case, when kids come home to play with our children we ask them to wash first to avoid passing on germs.*

The father said that part of the problem is that children resist getting washed. They don't like it and prefer to stay dirty. However, he said that older children are probably more aware of the need to keep clean. Younger ones under four years are not clean if the parents are not looking after them properly.

> *Some older parents are better at looking after their kids. Younger ones are lazy and sleep more.*

The father considers himself to be an older parent and that he is more aware of the need to keep children clean. He has been employed at the school and the clinic in Fregon, so has knowledge about the need to keep clean. He also keeps his house clean.

Family 3: Mother (35 years old) with children aged 1, 7, 13 and 14 years. Interview conducted in English.

The mother described her daily routine as follows:

> *I wake up, change the child's nappy, shower him and we have breakfast together at home (the older kids have breakfast at school). Then I go to childcare and stay there with the youngest.*
>
> *If I am at home I do washing and visit family. We sometimes go swimming at Derwent Creek. In the evenings we have supper.*
>
> *In the afternoons I often watch TV. I go to bed around 8 or 9pm.*

She described the house in which her family lives as having around twelve people living there, some of whom sleep on the verandah. She said that the verandah area and the yard is very dirty. There are no fans on the verandah.

She is aware that keeping clean helps avoid sickness. She grew up knowing that and so keeps standards high for her family. But she would prefer not to comment about other families as it is a sensitive subject.

When asked about the facial cleanliness differences that apply to different age groups of children, the mother said that no children are willing to shower, regardless of their age.

4.0. Findings and discussion

4.1. Limitations

This research was designed and implemented to ensure that the findings were available in a relatively short space of time, meaning weeks rather than months. Travel in remote areas of Australia is expensive in time and travel costs. We therefore chose to define the scope of the research to be short and focussed, to ensure that we were able to produce findings against the research questions within a reasonable timeframe of around ten weeks from the commencement of the community-based work.

The limitations of this research are therefore that we conducted focus groups with people from three communities, compiled three family case studies and interviewed nine individuals who were in a position to provide a professional perspective on our initial findings. As a result, the research was focused rather than extensive and the data reflects knowledge we gained from a relatively small sample of participants.

4.2. Level of concern about parenting skills and behaviours

In conducting focus groups and interviews and collecting data for case studies, rarely did the Ninti One team meet with participants who had not considered the question of parental skills and behaviours and their effects on the care of children. This is a subject that concerns and agitates many local people, as well as health care professionals based outside the communities. They see a proportion of families not caring for their children to a standard they consider suitable and they feel unable to do anything to improve the situation.

The problem of shortcomings in care for children is therefore well recognised in the community. Poor facial cleanliness is considered one result of the issues participants perceived around the youth, skills and motivations of parents of children with dirty faces, as well as social problems affecting their capacity to care for their children.

An assumption the Ninti One team makes in analysing the data from this research is that the responsiveness of adults to trachoma prevention activities (such as messaging) will also affect the children for whom they are responsible. It is a reasonable assumption to make because adults purchase soap for the household, prepare their children for the day ahead and model behaviours for younger people in the family. This is especially true for 0-4 year olds, who are less able to respond to trachoma prevention messages directed towards children through, for example, Milpa the goanna, independent of the adults in their family.

This assumption also appears, from the reactions we received from participants in the research, to be one that they considered reasonable.

4.3. Factors leading to poor facial cleanliness among 0-4 year old children

Here is a brief list of the key factors that impede facial cleanliness among 0-4 year old children:

- Distractions to parents caused by mobile phones, alcohol, drugs and gambling
- Shortcomings in parenting skills
- Low motivation of parents
- Self-identity leading to avoidance of frequent washing

- Poverty, high living costs and spending choices that do not prioritise children
- Housing deficiencies and overcrowding

These factors can be grouped into three categories:

1. **Parenting skills and behaviours**; relative youth of many parents, lifestyle, distractions, priorities and choices
2. **Social and economic realities of remote communities**; poverty, cost of living, poor housing, overcrowding
3. **Pride in identity**; resistance to behavioural changes promoted from outside that do not align with self-identity.

This study found that most people from remote communities consider parental skills and behaviours to be the category that has most influence on the facial cleanliness of children. It also helps explain the difference in levels of cleanliness between the under-four and over-four age groups (further explored in Section 5.4. below). Pride in identity influences parental behaviours while the social and economic realities of remote communities place demands on families that some parents are unable to meet.

It is useful to explore the reactions of key observers presented with the list above as part of the second cycle of research. All expressed strong agreement with it. The only additional suggestion was that the amount of health promotion messages can be overwhelming for people in communities, especially when they are dealing with several issues at once and feel unable to cope with the information.

One key observer in the second cycle of research took the view that some factors are connected because they are part of way of life and a set of living conditions that are detrimental to health. She noted that children often appear more unwell these days than in the past. Older children sometimes have tooth decay, which is not usually expected in their age group. Others, even from being young babies, can develop ear infections and appear more vulnerable to ear infections due to living conditions.

Another participant in the second cycle felt that overcrowding and related socio-economic problems are an important influence on the ability of parents to keep their children clean. Mobile phones are a major distraction, as is gambling, because it takes some parents away from childcare altogether. She felt that mental health problems and domestic violence are factors in facial cleanliness and should be acknowledged in this study.

Another key observer referred to domestic violence as a factor and that jealousy was central to most cases. He argued that more programs are needed like 'Jail awanti' delivered by Kenny Lechleitner at Congress. The Jail awanti program works with men who are incarcerated and on continues on their release from prison. It aims to teach men how to deal and overcome their issues and how to treat women more respectfully. He believes that more programs should be delivered for men on how to respect women and develop better male role models in communities.

Again drawing on second cycle participants, one person felt that the lack of housing, the need for people to sleep rough (which here refers to sleeping on verandahs, for example), and poor mental health (such as depression) leads people to stop looking after themselves and reduces their motivation more generally. The reasons can sometimes be acquired brain injury and excess alcohol usage.

As we describe in Section 4.0. below, strategies designed to overcome these factors will need to be targeted to specific groups that have been unresponsive to trachoma prevention programs to date, despite the high level of awareness of trachoma that exists in remote communities.

4.4. Age distinction in facial cleanliness

This study focused on seeking to understand the reasons why data on facial cleanliness shows much higher rates of dirty faces for 0-4 year olds than 5 years and above. We arrive at four findings:

1. Children who attend school starting at five years old are taught to wash and provided with soap, water and towels. Under-fives, if they are not attending pre-school, often miss out on the routine washing that only begins for most children during the school years. Schools often wash children because many often arrive unclean and therefore not suitable for a group or classroom setting.

2. The school environment is generally clean and orientated towards learning. There are limited opportunities for children to become dirty during the school day and, if they do, staff direct students to wash. Again, the 0-4 year olds do not benefit from the school environment and so most children in this age group spend their days in the less clean surroundings of their family home and yard or other locations in the community itself.

3. When they first have a child, parents are often teenagers of between 15 and 19 years. By the time the children reach five, they are older and more competent as parents, having learned the necessary skills and also matured beyond the typical preoccupations of the teenage years.

4. Some parents are unavailable to care for children when they are awake in the morning. This is due to the parents often being asleep until mid or late morning. Children of five years and older are often able to fend for themselves and may have already developed good habits of washing and getting ready for school. Other adults in the house may help them. Children of ages 0-4 years require care from an adult and if the parents are not available then the morning washing routine often does not occur.

Overall, the picture that emerges from the data is that a proportion of children of all ages are not being cared for in a way that ensures high levels of facial cleanliness. For the 0-4 year age group that is not yet attending school or able to fend for themselves during the critical morning period, the result is that, in some communities, a high proportion does not have their faces cleaned regularly or frequently.

4.5. The challenge of cultural change

Aboriginal people in remote communities have been provided with advice from outsiders for generations. Where that advice is considered to be uninformed by knowledge of local realities or simply meddling by ‘mainstream’ or settler Australia in the business of Aboriginal people, it falls on deaf ears.

It is worth referring to our previous research on cultural influences on trachoma prevention (Ninti One, 2020), which brought to light many insights relevant to this report. For example, on the online platform Sharing Culture (2013), Professor Marion Kickett argues that there is a misconception

surrounding Aboriginal culture and identity in relation to hygiene and living standards. As a Noongar from Australia's South West, Kickett recounts experiences visiting family on reserves where it was believed that living in a dirty house was 'all part of being Aboriginal'. Keeping clean was perceived to be a white person's behaviour, and those that did keep clean were judged for trying to emulate white people. In this regard, the notion of cleanliness is seen as conflicting with Aboriginal identity. This observations ties in with data we collected during this study too.

Similarly, medical anthropological research conducted by Kate Senior in Ngukurr in the Northern Territory found that Aboriginal people were somewhat resistant towards health behaviours that were deemed to be 'Munanga [European]' (2003: 32). This included the 'obsessive interest in hygiene' or walking as exercise (2003: 264). Kickett however argues that the belief that dirtiness as an inherent part of culture has been used as an excuse for poor living conditions and has subsequently resulted in the devaluing of Aboriginal culture.

In addition, Kickett postulates that the stereotypical view of Aboriginal people as 'dirty' held by many non-Aboriginal people has also contributed to this belief. By being repeatedly labelled as dirty, it has become a characteristic that many Aboriginal people identify with. As such, the dichotomy between Aboriginal as dirty and 'White' as clean is a significant factor that hinders hygiene practices. If the practice of keeping faces clean is incompatible with how Aboriginal culture and identity is understood, then trachoma messaging needs to explore ways that encourages Aboriginal people to keep faces clean without diminishing their sense of identity.

Also referred to in previous research by Ninti One on cultural factors affecting trachoma prevention, a 2015 brochure produced by South Australian housing organisation Shelter SA is revealing. Scrutinised for its messaging 'How will you look after your house whitefella way', it further reinforces the ideology that in order to be clean, Aboriginal people need to become more like white people. As such, promotional material and messaging needs to be aware of this pushback towards hygiene and its association in order to be effective (Ashford 2015).

The data we have collected indicates that some Aboriginal people consider regular washing as being contrary to the way they have always lived and prefer to conduct their lives. High levels of personal hygiene are a notion that comes from the white person or settler way of life. Advice of this kind is not always welcomed, even if the connection with infections that lead to trachoma and other diseases is made clear.

4.6. Differences in levels of facial cleanliness between communities with comparable socio-economic and environmental conditions

A proportion of residents in communities where trachoma is endemic are affected by social problems that have a direct impact on their capacity to keep their children clean. It is beyond the scope of this study to quantify that proportion, but responses from participants in the study show that this group of vulnerable or affected people is significant in number.

These social problems, most of which have been mentioned earlier in this report, include:

- Unplanned pregnancies of young women, leading to them becoming mothers before they are ready for the responsibilities of being a parent
- High proportions of lone female parents
- Compulsive and addictive behaviours associated with alcohol, marijuana, gambling, mobile phone use and social media

- Underlying conflicts driven by rivalries and jealousies around relationships between families and individuals
- High levels of stress caused by poverty, overcrowding and the ever-present 'humbug' of people bothering others for money or other favours
- Pressures on mental health resulting from low future prospects as well as the history of dispossession, discrimination and marginalisation that uniquely affects the self-esteem of Aboriginal people in remote communities. Many people feel 'stuck' in a situation they can do little to change
- Lack of money or spending choices that do not prioritise the cleanliness of children.

This study did not point to a lack of occupation and purpose affecting the motivation of individuals and so we do not include unemployment or under-employment in the social issues we have identified above. In other contexts, it would most likely be one of the critical social problems affecting the community, but in remote Australia high levels of unemployment and welfare dependence are considered normal. It is therefore not surprising to the research team that the subject of occupation did not arise in the data we collected and was not mentioned at all by participants.

There are many communities in Central Australia where trachoma is not endemic and yet similar social problems to those summarised above also exist. The question of why rates of facial cleanliness might be lower in those communities is not one of the research questions towards which this research is orientated. We did not visit those communities nor speak to anyone with specific knowledge of experience of them.

However, we did use the opportunity of the second cycle to ask interviewees about this subject. One person observed that the size of a community makes a difference. Larger communities are more prone to poor hygiene standards compared to the smaller communities. The main reason is that people are not as closely related in larger communities and so there is less family monitoring of other family members. Another person also pointed to the larger communities being more vulnerable to low standards of hygiene. She had seen places where people are living in tents and having to walk to fetch water or wash their face. Sometimes they forget or it may not be a priority.

Another observer suggested that there are differences in the acceptability of poor facial cleanliness in some communities compared to others. The same applies to the level of care and supervision provided to children, which can vary from community to community depending on local standards. He notices that many children are aware of how to clean themselves with soap and water. It is community expectations that are important, so they are encouraged to do so.

One person we interviewed for the second cycle suggested the differences between communities could be generational (meaning that some communities have larger numbers of younger parents than others) or that some places have better access to services such as playgroups and groups for mothers and babies. She also believes that leadership is more effective around parenting issues in some communities compared to others.

One observer made a comment that was implied by other people with whom we spoke; 'you can lead a horse to water but you can't make it drink'. The point being made is that families are aware of the trachoma prevention messages and the need to keep the faces of their children clean. The problem is that there are many factors that prevent them taking the necessary action.

5.0. Conclusion

The research questions that frame this study have led to findings that link low rates of facial cleanliness with a myriad of pressures on families and especially young parents. In concluding this report, we provide a summary of factors relating to poverty and disadvantage, the social context and conditions that prevail in many remote communities and the skills and knowledge of parents. We go on to make recommendations for the way in which strategies for direct support to families might be designed, leading to improvements in facial cleanliness and consequently the long-term eye health of their children.

5.1. Poverty and disadvantage

Many Aboriginal people in remote communities in Central Australia face multiple deprivations. The clearest indicator of this problem is the low average income for people living in remote communities in Central Australia. The average individual income in Papunya is 35% below the level considered by the OECD to be the poverty line in Australia and in Ntaria it is 25% below the poverty line. Of course, an average figure does not reflect individual family circumstances and mitigating factors that may reduce the impact of low incomes on individual families (such as low housing rents). However, it is impossible to avoid the conclusion that people living on this level of income will face challenges every day in meeting their basic needs.

Where people are very poor in material terms and the cost of living is generally high, their priorities will be skewed towards securing the necessities of life. While coping with worries about unexpected bills, repaying debts and meeting obligations to family members, the work of keeping active children clean in a dry and dusty environment takes on lower importance. Desert living is dirty and keeping clean takes effort. As a result, young children, and especially those not attending school, largely remain unclean. The data we collected through this study shows that the change in levels of facial cleanliness that occurs for children over the age of four is due to that age group being less dependent on their parents to care for them. They mostly go to school, are required to wash by school staff, and are influenced by different norms than those that apply to young children who spend almost all their time at home.

5.2. Social context and conditions in remote communities

Individual income is one measure of the challenges of community life, but it is the overall context that compounds the problem for families with children. Houses often have more people living in them than they are designed to accommodate. As a result, pressures on space are high and demands on washing facilities, soap and towels are greater than they should be. Homes are more noisy, people come and go sometimes late into the night and the home environment is often characterised by stress and distress. Distractions from mobile phones, alcohol, gambling and other addictive behaviour affect the ability of parents and their children to follow a routine. As a result, looking after themselves and their children becomes neglected as regular sleep patterns, washing routines and meal times are not maintained.

The often squalid living conditions and multiple hardships that exist in remote communities demand action far beyond trachoma prevention. Levels of mental ill-health, family violence and alcohol and drug abuse in remote communities are significantly higher than those for the country as a whole. This study characterises the situation for many remote community Aboriginal children as one of impoverishment where they live in overcrowded homes with parents who are distracted and unable

to look after them properly. Personal hygiene products like shower gels are expensive to buy locally and washing their children regularly is not a priority for many parents, especially those in their teens, given other issues they face. As a result, for the under-five age group in particular, they are vulnerable to infections, including trachoma.

5.3. Parental knowledge and skills

Along with material poverty and social issues within the community, shortcomings in parental skills and capacities are the third factor identified through this study that affects the facial cleanliness of young children. Over four in ten first-time Aboriginal mothers in the Northern Territory are teenagers and over three in ten families have a single parent, invariably the mother.

The responsibilities on and expectations of young women can be very demanding. It is not surprising than many lack the skills and knowledge to even begin to be effective parents. As teenagers, they experience the distractions and fluctuating energy levels that are common for their age group. Maintaining the facial cleanliness of their children is often not a priority and the results are apparent for the age group of 0-4 years. By the time they reach five years, children are less reliant on their parents. In any event, by then parents are older and more competent. Family sleeping and washing routines may be more stable and children better prepared for each day.

5.4. Strategies for positive change in facial cleanliness

In considering recommended strategies that could be adopted, this study shows that poor facial cleanliness is influenced by social, economic and cultural factors. It cannot and should not be decoupled from attention to those issues.

This is a strategic matter for any initiative that seeks to either promote better health or reduce vulnerability to ill-health. A program that concentrates mainly on the delivery of public health messages without sufficient insight to the lives of the recipient population could be said to be supply-led rather than properly responsive to needs. In other words, it focusses mostly on delivering information to targeted groups. Tilting the emphasis of trachoma prevention work towards closer engagement with and understanding of families who are unable to respond to trachoma prevention messages would improve the targeting of support and information.

A priority strategy should be direct educational support to parents who are struggling with their parenting skills and choices. Framed as a case management model, it would represent the most effective and targeted means of promoting behavioural, knowledge and skill changes that will also lead to higher rates of facial cleanliness among children, especially those in the 0-4 year age group.

Importantly, a direct support model would strengthen community engagement around trachoma by empowering parents to take greater control of their own well-being and that of their children. Collaborative work between existing agencies and local people, as well as the adoption of co-design principles, would mobilise existing community concern about care for children into positive action.

There is also scope for pre-conception educational work aimed towards teenagers who may be suffering from the lack of opportunities in communities. Providing more targeted support to them to think through the responsibilities that come with parenthood would help reduce situations like the many instances of young parents being unable to cope that were shared by participants in this study. Existing programs such as the Australian Nurse-Family Partnership Program are examples of initiatives

that could be extended or replicated to support young parents and tackle shortcomings in their knowledge, confidence and skills.

At the same time, it is critical that any new strategies should acknowledge the issues surrounding parents' mental health, to which the data pointed. They include low motivation, use of drugs and alcohol, addiction to gambling and phone use. One approach could be to create more ways for parents to have greater contact and communication with their peers, especially as a means of reducing isolation and the associated pressures on their mental health. Supporting parents to prioritise self-care is part of a process of improving their ability to look after their children too.

Any support directed towards improving facial cleanliness through individual tailored work with families must be Aboriginal-led and supported by the community itself. There exists deep-seated concern among many Aboriginal people in remote communities about shortcomings in care for young children. For these complex issues to be tackled, for parents to be supported and empowered and for the eye health of children to improve as a result, community backing will be critical. Ultimately, adopting new and refreshed strategies around parenting will improve the eye health of children in remote communities.

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