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

Background

According to data from the National Trachoma Report (Australian Trachoma Surveillance Report 2019. Kirby Institute, UNSW Sydney NSW 2052), 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.

The purpose of this paper is to summarise 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.

Research design

Research questions

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

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?

Ninti One was granted ethics approval for the research by the Central Australian Human Research Ethics Committee (CAHREC) on 3rd December 2020.

Data collection

The research strategy comprised two research cycles of data collection:

Cycle 1:
Three case studies of families with children with clean faces in Papunya

Three interviews with key Aboriginal observers living in Alice Springs and with experience of remote community lifein their community.

Cycle 2:
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

We wish to make the important point that the data collected through this study includes observations on the behaviours of parents that imply neglect of their children. These comments were made in response to the research questions. They do not present the many other consistent examples of care and support for children and young people that occur in remote communities.

Data analysis

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.

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.

Themes

Distractions caused by mobile phones, alcohol, drugs and gambling

They are on their phones all night

Shortcomings in parenting skills

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

Low motivation of parents

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

Self-identity leading to avoidance of frequent washing

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

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

Some parents have expensive clothes and the kids are still dirty

Housing deficiencies and overcrowding

Too many people living together

Potential strategies to increase facial cleanliness

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, 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 (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.

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Findings

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. 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 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.

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.

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.

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. 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.