

Cultural Matter in the Development of an Interactive Multimedia Self-Paced Educational Health Program for Aboriginal Health Workers

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Abstract

Aboriginal and Torres Strait islander health workers are key providers of primary health services to Aboriginal communities especially in remote and rural areas. They are often overloaded with competing demands. There has been limited attention given to the maintenance and ongoing enhancement of their skills and knowledge following the completion of formal training. A culturally appropriated interactive multimedia self-paced health program as a mechanism to improve the accessibility and the use of scientific data and information for health purposes is proposed as a basic method for better supporting Aboriginal and Torres Strait Islander primary health care workers in their practice locations.

This paper explores different approaches for the development of a culturally appropriate interactive multimedia educational health program for Aboriginal and Torres Strait islander health workers and it also explore cultural matters concerning program development in the light of existing literature.

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Key words

Aboriginal and Torres Strait islander health workers, Aboriginal Australian health, Program development, Cultural contextualisation, Self-paced education program, Interactive multimedia.

Introduction

In the changing environment in which the health care system operates, training of health sector workers must go beyond the nominal acquisition of knowledge, skills and attitudes needed for traditional practice. Training should be adequately and constantly upgrading the health worker's skills in order to keep them up-to-date with changes (Thurab-Nkhosi 2000).

An interactive multimedia self-paced program as a mechanism to improve the accessibility and the use of scientific data and information for health purposes is proposed as a basic method for better supporting Indigenous primary health care workers in their practice locations. It would give them opportunities to independently control over their learning within an attractive and interesting environment, and improving their quality of healthcare delivery and overall health outcomes.

This study is motivated to create an up-to-date, culturally appropriate, interactive multimedia, computer-assisted educational health program for ATSIHWs, that would give them opportunities to independently control over their learning within an attractive and interesting environment, and improving their quality of healthcare delivery and overall health outcomes (Phillips 1997).

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Background and Context

Aboriginal Australian has a higher prevalence of most types of health conditions than non-indigenous people, and the burden of communicable diseases for them is far greater than for other Australians (ABS 2008; Trewin & Madden 2005) (ABS 2008). They face substantial problems in accessing appropriate primary health care services, due to large distances involved and the cost of logistics involved in transporting people to hospitals or clinics (Gruen, Weeramanthri & Bailie 2002). Cultural barriers are also regarded as major factor in reduced access of indigenous Australians to mainstream health services (QldHS 2007). Access to and coverage of basic health services to communities could be improved through assisting community members to provide certain basic health services to their own communities (Gruen, Weeramanthri & Bailie 2002; Lehmann & Sanders 2007).

Aboriginal and Torres Strait Islander Health Workers (ATSIHWs) are playing a very important role overall in health services and are considered key providers of primary health services to Aboriginal and Torres Strait Islander communities, particularly in remote and rural areas (Pacza, Steele & Tennant 2001). They are providing the link between their own communities and the health care provider, supporting both of them, helping to build trust, improve communication, and promote better health outcomes (Gerrard 2004).

ATSIHWs are often overloaded with competing demands. The pressure to know a little about everything is a common theme (Grant, M. 1992). Turdgen (2000) described the challenges facing ATSIHWs as *"the main problem is the huge expectation put on them. They are expected to understand complicated medical terminology in a foreign language with almost no education, as well as managing clinics and be clinicians, health promoters and education experts. All these responsibilities are rolled up into the one job"*.

There has been limited attention given to the maintenance and ongoing enhancement of ATSIHWs' skills and knowledge following the completion of formal education (Soar & Yuginovich 2006). Providing them with high quality education opportunities can be problematic. It can be a challenge to attend refresher courses, face to face education workshops, placement in clinical settings or updating seminars away from their community (CIRC 2000), (Collyer 2006), (Soar & Yuginovich 2006).

Much of the health program training for ATSIHWs has been directed from a white middle class perspective (Collins 1995). The mainstream cultural material designed for Anglo Australians is not always pedagogically appropriate for the unique needs of Aboriginal Australians (McLoughlin, C. & Oliver 1999). Providing ATSIHWs education and skills transfer, professional support, and a continued primary health care program to update their knowledge, would bring greater credibility to their role and would help turn them into a more skilled workforce able to make a more effective contribution (Gruen, Weeramanthri & Bailie 2002) (Haq & Hafeez 2009).

Using Information Technologies is a potential strategy for improving the education of ATSIHWs and the quality of care provided within their communities (Collyer 2006). Bridging the digital divide is understood as a critical opportunity to contribute to bridging the health divide between Aboriginal and non-Aboriginal Australians (Hunter et al. 2007); this is represented in Figure 1.

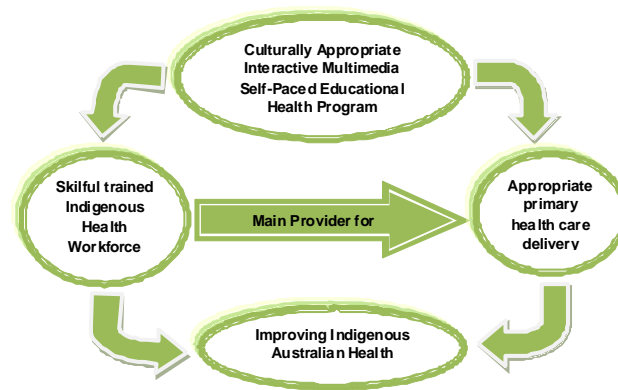


Figure1: The impact of Interactive Multimedia Self-Paced Educational Health Program

Information Technology, like all technologies, comes embedded with the values of the society which produced them (Dyson, Laurel E. 2004). Technology is only useful as an answer to health problems after being modified and adapted by a particular community to meet the conditions and values of that community including its cultural and spiritual values (Barlett 1995).

For new information to be accepted by Aboriginal societies, the process is more important than the content (Trudgen 2000). The cultural inclusivity in the design process needs to affirm the social and cultural dimensions of Aboriginal society in constructed meaning (McLoughlin, Catherine & Oliver 2000). Cultural inclusivity can be achieved through placing learning tasks in the context of the Aboriginal life or cultural experience, in order to allow learners to access learning resources in a manner that is matching their values, beliefs and styles of learning (Donovan 2007) (McLoughlin, C. & Oliver 1999).

Interactive Multimedia Program Development Approaches

The construction of educational software should be based on a didactic efficiency and advanced technology (Dagdilelis 2005). The interactive multimedia model can support structured multi-disciplinary development methodologies: the educational and the systematic approaches (Mooney & Bligh 1997b); this is represented in Figure 2.

Structure of Interactive Multimedia Self-paced Culturally Appropriate Educational Health Program

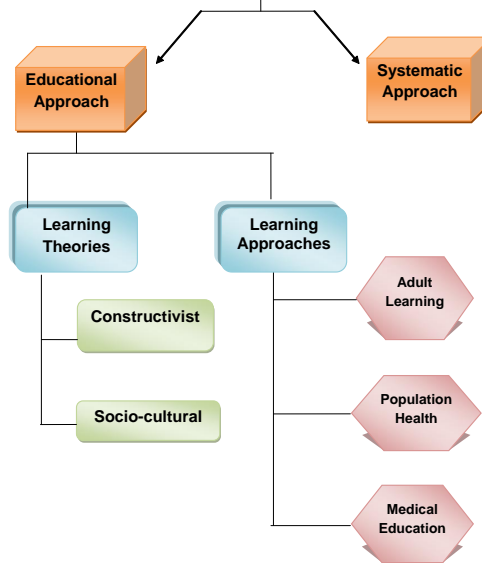


Figure2: Interactive Multimedia Self-Pace Educational Health Program Developing Approach

Designers must expand their perspectives to consider teaching and learning methods, establish principles, and identify the implications of the principles for interactive multimedia (Park & Hannafin 1993). These educational principles have been used as design guidelines, and information technology has been utilized to support and stimulate learners, and provide a variety of mechanisms to help produce the model's materials (Mooney & Bligh 1997b).

Educators and designers of instructional multimedia should adapt to the needs of different learners, subject areas and situations. They should use a variety of multimedia materials and approaches to provide a flexible learning environment meeting the needs of their learners (Alessi & Trollip 2001). The recognition of difference in learning preferences of Aboriginal and Torres Strait Island learners and the recognition of the need for change is important when developing appropriate educational programs (Donovan 2007). This paper discusses the way a culturally appropriate educational health program has been developed and the different approaches adopted.

Educational Approach

Developing effective materials that facilitate learning requires an understanding and appreciation of the principles underlying how people learn. One of the main and basic foundations of designing instructional Interactive Multimedia programs is the learning theories and approaches; and their impact on model design (Alessi & Trollip 2001). If multimedia is used to demonstrate the technical capabilities of a computer and not set in an educational context, the true value of multimedia is lost (Mooney & Bligh 1997a).

Theories of learning have been employed to produce measurably better instructions and to understand the function of multimedia in enhancing the learning experience for users and increase the amount of knowledge they retain (Hannafin & Peck 1988) (Villamil-Casanova & Molina 1996). By developing instructional design in accordance with the internal process of learning, a greater degree of confidence in the performance of the lesson may be attained (Hannafin & Peck 1988).

Constructivist, Socio-cultural learning theories

The Constructivist and Socio-cultural learning theories have been recommended to be used as the base for design of a culturally inclusive program for Aboriginal Australian learners (McLoughlin, Catherine & Oliver 2000).

The constructivist learning theory maintains that knowledge is not received from outside, but that people learn by actively constructing knowledge based on their interpretations of experiences in the world. By weighing new information against their previous understanding, thinking about working through discrepancies, and coming to a new understanding, they take final responsibility for their learning; therefore they need to have some control over their learning process (Hedberg et al. 1994) (Henderson 1996) (Ivers & Barron 1998) (Alessi & Trollip 2001) (Molenda 2002) (Dagdilelis 2005).

The constructivists argue that learning outcomes depend on the learning environment, the prior knowledge of the learner, the learner's view of the purpose of the task and the motivation of the learner (Hedberg et al. 1994).

Employment of constructivist principles in program design provides a new level of difficulty and challenge for the designers as they should consider the perceptions and previous experience of the learners including culturally shared perceptions, and ensure that the learning environment is as rich and interactive as possible (Phillips 1997) (O'Brien 2002). Interactive multimedia offer a discovery learning approach, which supports constructivist theory: Learners can create their own worlds (Abrams 1996).

The socio-cultural theory stresses the interaction between developing people and the culture in which they live and focuses on how cultural beliefs and attitudes impact how instruction and learning take place (Cherry 2011). This theory points out that learning is a form of enculturation which occurs in a social context, in which the individual is socialised through gradual participation in tasks, assisted by adults until full competence is attained and the accumulated achievements of particular groups shape the intellectual development of the individual (Henderson 1996) (Ormrod 1999) (McLoughlin, Catherine & Oliver 2000).

Learning Approaches

An issue that may be more important than the details of program content is the soundness of the learning approach (Cole & Engel 1975). Choosing the appropriate learning approaches to be used in the program development will depend on the type of learner targeted and their needs. In the search for learning approach which might be suitable for ATSIHWs' continuous professional education there are three learning approaches that will be adapted.

Adult learning

Theories of adult learning emphasize the importance of a learner identifying an educational need and planning to meet that need (Zeiger 2005). Three underlying assumptions have been stated in the report of Donald Brundage (1980) about the adults learning principles and their application to program planning:

- 1) The more an adult learner can be involved in the planning related to his/her own learning activities, the more productive those activities will be,
- 2) Program planning by experts or by teachers with no learner involvement tends to lead to subject-centred programs and theoretical problems and
- 3) Program planning carried out largely by learners with teacher assistance tends to lead to problems-centred programs (Brundage & MacKeracher 1980).

The national review of ATSIHWs training 2000 for improving access to education and training recommended the participation of ATSIHWs in planning the development of their training packages (CIRC 2000).

In the National Health interactive technology net development program Ernest Hunter emphasized the importance of engaging end users in the development and production of program material rather than being passive recipients (Hunter et al. 2007).

Other adult learning principles directing the choice of the program's goals, objectives and educational strategies can be summarised as follows: 1) Adult learners are typically autonomous and self-directed, and are motivated by education that has intrinsic value to personal goals and a sense of self, 2) Adult learners bring with them a great range of prior experience, and 3) The necessity to learn something must be clear to the adult learner before they will commit to learning it (Sisson, Hill-Briggs & Levine 2010).

Employing the adult learning approach in the program planning will help to accommodate ATSIHWs' needs and goals, and facilitate learning activities rather than imposing standards for performance and content (Grant, M. 1992). The model will be an open and flexible learning program, available in short self-instructional modules which can be studied by individuals at their own pace, place and time; and structured to give learners control over their learning (Harrison 1990).

Population health

The term "Population health" focuses on populations as entities not only on individuals. Using a systematic population focused approach can have a greater effect on individual health outcomes than individual care (Wagner et al. 2001). This approach can be realized through emphasizing health promotion and disease prevention strategies at a population level and stressing the underlying social, economic, biological, genetic, environmental and cultural determinants of health of the whole population during program planning (Smith 2005).

The population health approach fits the Aboriginal and Torres Strait Islander Australian view for their health; they see health more holistically as including the physical, mental, social, emotional, spiritual and cultural well-being of the whole community, and not merely the absence of disease or infirmity. They believe that social and spiritual dysfunctions can be associated with the cause of illness. It is a whole way-of-life view and it also includes the cyclical concept of life-death-life (Hausfeld 1977) (Hamilton 1982) (NAHS 1994) (Barlett 1995).

A population health approach will be adopted in the structure of the program planning to ensure the population health perspective as well as the individual clinical perspective is included. The program content will focus on how to treat patients within appropriate guidelines and protocols as well as describing how to improve living conditions, nutritional status, environmental conditions, socioeconomic factors and any other risk factors that contribute towards a particular disease.

Medical education

The education content of a well-planned curriculum has more impact on learner satisfaction than the technology used to disseminate it (Sisson, Hill-Briggs & Levine 2010). A common approach in developing education and training programs is to collect existing material and to assemble what appears most useful and interesting (Vanderschmidt, Segall & Frostman 1997).

Designing a course for health professionals should have aims or goals, which meet the needs of the learners, patients and society. Kern's (1998) design of a six-step approach for this purpose (McLoughlin, C. & Oliver 1999) includes: 1-Problem identification and general needs assessment, 2-Specific needs assessment, 3-Defining goals and objectives, 4-Determining the educational strategies and the designing activities; 5-Implementing designed activities and 6-Evaluation and feedback (Kern 1998). This approach presents a step-by-step method, technique or way of developing training or educational courses.

Systematic Approach

The Interactive multimedia model design is based on a more iterative approach than traditional instructional systems design in which the information derived from needs assessments converts into a description of the project space and a concept map of the ideas that are to be included in the project (Hedberg et al. 1994).

A generally used way to address the numerous issues involved in the design and development of educational multimedia projects is to follow a systematic plan that outlines the analysis, design, development, implementation, and evaluation of the project (Ivers & Barron 1998) (Dagdilelis 2005). The systematic approach followed to produce these multimedia applications is the same regardless of the instructional delivery system (Orr, C.Golas & Yao 1993). This approach provides an easy to follow, step by step guide to creating a successful multimedia program (Cartwright & Cartwright 1999; Harrison 1999).

The complexity of interactive multimedia model software depends upon the context in which the software is used. Small interactive multimedia model programs, designed and constructed to enhance learning of particular concepts, have the advantage of being relatively simple to design and construct using low level software packages which require minimal levels of programming and development time (Kennedy & McNaught 1997).

Theorists have argued for a cultural dimension in the design process and the need to provide a cultural sensitive learning environment. In order to design a culturally appropriate instruction program for Aboriginal Australian learners, the instructional designers need to follow design principles and instructional methods that best match constructivist principles (McLoughlin, C. & Oliver 1999). The instructional design needs to be sufficiently flexible, reflect the particular culture, values and expectation of the target group and ensure that learning activities and tasks are designed to take learner needs and perspectives into account (McLoughlin, Catherine & Oliver 2000).

Cultural Matters in Program Development

Despite the fact that health related research has produced useful data on the extent of the problem within Australian Indigenous communities, this data was not translated into the appropriate interventions and many public health programs designed to be "culturally appropriate" proved to be less than effective in changing the health problem as intended. Ineffective intervention is due to separation of research data from human experience, lack of understanding of socio-cultural context in which the problems are constructed, and therefore the cultural context surrounding health problems lose its significant (Prior 2009).

Language barriers and the differences in culture and world views make it difficult to establish common ground between Aboriginal and non- Aboriginal constructions of illness, causation and treatment. The western biomedical model in the context of communication across cultures is conceptually limited, in terms of the way it looks at and deals with health and illness; and it is culturally relative in that it offers a particular rather than universally acceptable way of explaining health (Coulehan et al. 2005).

The main goal of program development should not be just to create an interactive multimedia model for ATSIHWs but also to ensure that the model promotes Aboriginal approaches and values (Robbins 2007). In a study of learning preferences for Aboriginal learners, Barners emphasises that several aspects of Aboriginal culture practices were evident and could impact on their learning (Barners 2000). For Aboriginal learners, the creation and inclusion of Aboriginal perspectives in instructional design is an important dimension and a means of recognising and integrating cultural knowledge (McLoughlin, Catherine & Oliver 2000).

Cultural Localisation

Cultural Localisation is a means of incorporating the values, styles of learning and cognitive preferences of the target population (McLoughlin, C. & Oliver 1999). Environmental factors such as socio-cultural backgrounds, experiences in upbringing and earlier educational experiences will have an impact on Aboriginal learning styles (Milton & Vozzo 2010). Over the last two decades the most influential theory of Indigenous education has been Harris' Aboriginal Learning Styles theory (Dyson, Laurel Evelyn 2002).

Harris (1980) observed Aboriginal communities in the Northern Territory for two years and based on this research, identified five major traditional informal learning style or strategies (Harris 1980). He concludes that the learning styles and the ways in which Aboriginal learning styles differ from mainstream non-Aboriginal learning styles are:

- 1) Learning by observation and imitation,
- 2) Learning by personal trial-and error,
- 3) Learning in real life activities performed by the learner,
- 4) Context specific learning and,
- 5) Person orientated (Harris 1980) (Duggan 2009).

Barners offer an insightful perspective on Aboriginal learning preferences summarised in the following:

- 1) Aboriginal learners are more group oriented, and less concerned with personal achievement,
- 2) They prefer to learn in a holistic way by having an overview, then major headings prior to detail,
- 3) They prefer the use of diagrams and visuals to help explain written text,
- 4) They prefer to learn in practical settings,
- 5) They prefer oral to written (Barners 2000) (Milton & Vozzo 2010).

Researchers found that computer education fitted with this perceived learning style theory and Aboriginal learning preferences, appeals to Aboriginals' visual-spatial strengths through the use of colourful graphics. This requires little writing and so suits an oral cultural background, and allows learners to take greater charge of their own learning (O'Donoghue 1992) (Dyson, Laurel Evelyn 2002) (Duggan 2009).

To make the computer software and the computer instruction more culturally appropriate for Aboriginal people, the software design must take into account the learning styles of Aboriginal people. It must have more graphics and be less text based, be self-paced, with instant rewards and have an absence of negative remarks (Steen 1997). Learners should not be expected to have advanced computing skills, but development of information literacy skills need to be integral to the learning outcomes (McLoughlin, Catherine & Oliver 2000).

Cultural knowledge base

The initial phase of education in any new program is based upon the learner's background knowledge, which is a sum of all abilities acquired as a result of exposure to earlier learning experiences (Fedak 1999). An understanding of cultural knowledge base or "Pre-existing knowledge" is especially important when one culture is trying to share unfamiliar or new information with another culture. This means the new knowledge taken to traditional Aboriginal people should build on their existing, culturally accepted truths and knowledge base and must be intellectually thorough or it will be rejected (Trudgen 2000).

To enable more effective and successful treatment, it is important to acknowledge and work together with the Aboriginal understanding of health, rather than assuming the superiority of the current medical system (Behrens 2007). Particular consideration should be given to the indigenous Australian concept of health in the program development (Fleming & Parker 2007). Collins suggests

incorporating elements of traditional and cultural aspects into the health service for Aboriginal people: " *the NT Aboriginal Health Worker training program emphasised a bicultural approach where the best elements of both cultures are incorporated into health services*" (Collins 1995).

Cultural contextualisation

Cultural contextuality should be realized in order to provide learners with interactive learning packages that reflect the multiple realities of their society and their own experiences (Henderson 1994). Henderson emphasises that instructional design cannot, and does not, exist outside of a consideration of culture, and conceiving cultural contextualisation as a variable of consequence in interactive multimedia model instructional design is justifiable (Henderson 1996).

Australian Aboriginal people are not a homogenous group (Behrens 2007). Cultural contextualisation in program development can be achieved through consultation and working with representatives of the target population and community elders who provide an understanding of social and cultural constraints (Travers et al. 2006). Australian Aboriginal elders are traditionally the carriers of knowledge, culture and traditional healing methodologies that are passed down to future generation through oratory, dance and song (Behrens 2007).

In the Aboriginal culture a collective wellbeing rules over and above individual wellbeing, family responsibilities take precedence over individual health needs, illness is associated with social and spiritual dysfunction, and a person is seen as the collective of mind , body and spirit ; therefore the Aboriginal medical system seeks to provide a meaningful explanation for illness and to respond to the personal, family and community issues surrounding illness (Saethre 2007) (Behrens 2007).

Program designers had a difficult task to cater for the needs of Indigenous learners through the management of the interface between Indigenous community contexts and knowledge, and those of academic knowledge (Milton & Vozzo 2010), they should incorporate the skills and value of the Aboriginal community, and can influence material and symbolic culture in creating and developing interactive multimedia, in order to create a unified and authentic learning environment (McLoughlin, Catherine & Oliver 2000).

It is important to communicate at the appropriate level for the Aboriginal population and to understand appropriate communication and cultural differences for example through adapted pictograms and diagrams as opposed to just verbal communication when designing culturally appropriate information packages for ATSIHWs (Swain & Taylor 2005).

The educational software should be designed in a suitable way for disseminated information between individuals as Aboriginal people commonly share learning experiences in small groups , thus reinforcing the social and collaborative focus of learning, and removing any risk of embarrassment of being wrong (McLoughlin, Catherine & Oliver 2000) (Dyson, Laurel Evelyn 2002) (Duggan 2009).

Knowledge sharing can be fostered by designing a stories module to be used by ATSIHWs in their health education and promotion roles within their own communities.

An associated website can provide further new information that builds on that given on the CD meaning that health care professionals will be able to access a wealth of pertinent information regardless of their geographic location (Geissinger 2001).

Oral cultural backgrounds

With free and full access of Aboriginal people to information and knowledge about the world around them in a language they can understand, they will be better able to take more control of their own lives and they will themselves create interventions to deal with the problems they face (Trudgen 2009). In Aboriginal society, communication should be "heart to heart and mind to mind", this communication is like hearing the inner soul of a person (Trudgen 2000).

Acknowledgement of Aboriginal' learning as a cultural activity and fosters cultural security through respect, oral communication and traditional story telling are important contribution factors in success with Aboriginal learners (Foster & Meehan 2007). Aboriginal cultural is traditionally oral (Dyson, Laurel Evelyn 2002) (Berg 2011). Learners coming from oral cultural backgrounds might not be able to fully engage with a text-based medium so the use of third party visual and audio tools would be required (Duggan 2009).

The narrative format has been a traditional way of teaching in many cultures (Gjedde 2005). The story telling is considered as an integrated learning approach with a holistic view in which knowledge is integrated into social contexts, and it has been proven successful in Aboriginal education (Werner & Bower 1982) (Grant, S., Hendriks & Dyson 2007), and it has always been part of the practice of adult education (Clark & Rossiter 2008).

Starting the program by discussing a realistic health problem in the form of a story makes more sense to health workers, in term of what they have already experienced (Werner & Bower 1982). Storytelling and the use of narrative in interactive multimedia programs can offer ways of engaging with the material at different levels (Gjedde 2005). A story teller could mention some issues briefly, or elaborate on details- what to do, how to do it, when, where, and perhaps why (Berndt 1982).

Conclusion

The proposed plan is to develop an interactive educational multimedia health program culturally relevant to Aboriginal health workers, to be used in their practice locations. This program could provide support for Aboriginal and Torre Strait islander Australian Health workers in their practice locations.

A review of the published literature has identified the ideal approaches for the development of an interactive multimedia self-paced educational health program. It recommends the adaption of socio-cultural and constructivist learning theories. Adult learning, population health and the medical education approaches will be used as methodologies for program development.

The systematic approach towards a culturally appropriate program for Aboriginal health workers needs to be full of cultural dimension in the design process and to provide a cultural sensitive learning environment.

Evidence from the literature suggests that culturally localisation, cultural knowledge base, cultural contextualisation and oral cultural backgrounds are the main points of concern in the development of a culturally appropriated program for Aboriginal and Torre Strait islander Australian Health workers.

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