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Using the commons to facilitate health communication

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Communication is increasingly gaining attention as an integral component in ensuring evidenced-based public health is practised effectively.¹ A frequent finding is that Aboriginal populations find communication aimed at the broader population lacking in familiar content,² which creates communication obstacles.³ Aboriginal public health research frequently results in deficit health descriptions with little improvement, including communication, in public health evidence.⁴ Aboriginal public health evidence exists but does not include strategies as to how best to communicate this evidence.⁵ This article discusses the commons as a method to increase Aboriginal accessibility to both the Internet and health messages.

The commons is defined as “belonging equally to, or shared alike by, two or more or all in question”.⁶ In European history the commons originated in Roman law defining two distinct areas, the public, *Res publica* (schools, roads and libraries) managed by councils, and the private, *Res privatae* (clothing, utensils and equipment) managed by owners.⁷ For Aboriginal people the commons has similarity to custodianship. For instance, when describing the effects of mining one Aboriginal man said “when you dig a hole in that country you are killing me”,⁸ which can be interpreted that he and the land are a common and not separate *Res privatae* and *Res publica*. In human rights and communication areas, the commons is re-emerging, and putting focus on public need and responsibility that enhance social capital.⁹ Modern examples of the commons are free software on the Internet, free access to academic e-journal knowledge, and public paths and bike tracks.

In public health communication, the commons translates to spaces where information transfer and activity occur. These spaces are diverse, such as health services, websites, pamphlets, posters, T-shirts, schools, jails, television or sports arenas. That these are equally collaborative spaces is a false notion, with commons often dominated by a particular worldview. This is relevant for Aboriginal health, where commons are often dominated by non-

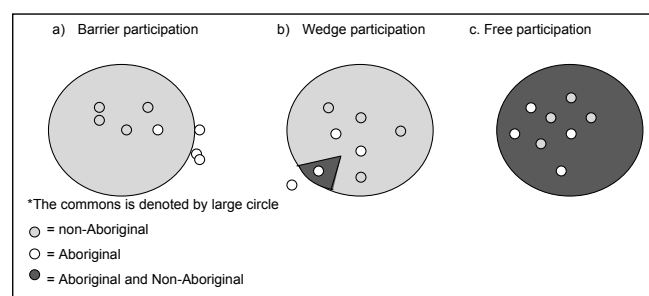
Aboriginal people creating unfamiliar spaces and impediment for Aboriginal participation (Figure 1a). For example, health clinics are often developed with minimal or no Aboriginal participation and feature an absence of Aboriginal presence thus creating participation barriers.¹⁰ As a strategy to infiltrate these types of commons Aboriginal peoples have created wedges of familiarity and entry (Figure 1b). For instance, health services may have an Aboriginal clinic or partnership to assist entry into the common.¹¹ Wedges can be used as levers to change the common, allowing Aboriginal participation with comfort and cultural safety (Figure 1c). The dominant common group can feel ownership and familiarity with the way the common exists. Attempts to improve participation for others involves exposure to different worldviews of how the common could exist and the dominant group may feel threatened by unfamiliarity.¹² When this worldview confusion occurs people make choices. They may decide the other group should adapt to the existing common and disregard or belittle other worldviews or they may make attempts to change and adapt.¹²

In 2009 we used the commons lens to design and build a webpage aiming to communicate diabetes management evidence¹³ to urban Aboriginal peoples. Undertaking the task were three Indigenous academics, with our combined experience working in Aboriginal health, education and multi-media sectors adding up to some 60 years in total. We also drew on partnerships with a variety of people and organisations to assist with the task.

Our first task was to review the common of Internet diabetes information aimed at Indigenous peoples internationally via popular search engines (Google and Yahoo). We located a total of 11 websites. We found these websites mostly featured simply written evidenced-based material. Typically, this was communicated from a clinical voice (occasionally with an image of a clinician) with little or no Indigenous language. It was frequently aimed at individuals, while in contrast, Aboriginal worldviews often see public health as a family and community concern.¹⁴ The messages focused on ideal diabetic management with little information validating experiences of difficulty. Kinaesthetic and aural learning experiences were minimal and most assumed no existing knowledge about diabetes.¹⁵ The full scope of the common was rarely utilised, with an absence of audio, video, flash animation, gaming or circular navigation. Occasionally, websites were adorned with Aboriginal artwork paired with a clinical voice, created a jarring contrast. Aboriginal people have carried health messages for millennia through the familiar practice of oral communication,¹⁶ a complex process of narrative, engagement and deep listening that significantly embeds messages into memory through multiple mechanisms.¹⁷ In our review of the web material available to Aboriginal peoples with diabetes little information was presented in this style.

Improving participation in commons can be achieved by reducing unfamiliarity and psychological distance.¹⁸ For Aboriginal people this psychological distance is embedded in history and previous encounters of diminished common access. For example, on arrival colonisers declared Australia *Terra Nullis*, that is Aboriginal

Figure 1: Participation in the commons.*



people did not exist at all in the Australian common.¹⁹ Past management of Aboriginal people in the common is also relevant. For example, limiting participation in the common (segregation) or encouraging denial of Aboriginal identity for a place in the common (assimilation).¹⁹ Although all relationships between people or organisations have degrees of psychological distance, extreme psychological distance prevents access and participation.²⁰ For the dominant group in the common allowing others in means reducing psychological distance, as this “will decrease the sense of danger, lower barriers and self-defence mechanisms, and provide feelings that are real, genuine, more open, and trusting”.¹⁸ For the dominant group there is a temptation to create messages that are familiar and comfortable to them.²¹ However, these messages will not create familiarity and comfort for all.

We aimed to communicate the 10 steps for living well with diabetes by increasing their familiarity and decreasing the psychological distance for Aboriginal peoples. The first consideration was how to construct a familiar entrance point. For this we chose a hand-drawn warm colour palette kitchen. The kitchen is a place that many Aboriginal people are familiar with as a safe and informal space where people congregate to talk,²² a practice over many thousands of years.²³ We chose four diverse looking Aboriginal people with diabetes from different age groups and genders. This was to create a psychological closeness for a wide range of Aboriginal people and move from the individual to the collective. We asked how people managed their diabetes with regard to the 10 steps and videoed their narrative. We believed this narrative of practical information was less patronising and more helpful than telling people what they should do. We included struggle narratives to allow reflection on management and familiarity for people struggling to manage their diabetes. This was important as it is a reality for many Aboriginal people.²⁴ The narratives organically included family and community expressions of diabetes management; to increase familiarity we used Aboriginal health experts embedded in Aboriginal health worldviews. We focused tested materials with Aboriginal people with diabetes and Aboriginal Health Workers to ensure the messages were understood and familiar.

To encourage participation in the website, entertainment, engagement and use of adult learning principles have been included. One element of this was humour, a communication strategy familiar to Aboriginal people that aimed to relieve stress and enhance sharing and memory of narrative.²⁵ For example, we included humorous stories, condoms that giggle, undies on the clothesline, a comedian (Mary G Queen of the Kimberly) and audio of Aboriginal voices not usual to websites creating juxtaposition and humour. We also included engagement elements such as quizzes, games and interactivity encouraging exploration. These used Aboriginal language and gave people feedback on their actions in a fun way. Although not all elements related to diabetes, they aimed to increase familiarity. For instance, snake condoms (a popular Aboriginal health promotion product) were placed in the medicine cabinet to make it feel familiar and improve participation with other messages.

A number of discomforts with Aboriginal familiarities in the common were expressed within the clinical partnerships formed to develop the website. The first was a denial that Aboriginal people entered the common (Internet). This was quickly dispelled with data that indicated 50% of Aboriginal people in urban areas had broadband access at home with proportions of other Internet access opportunities, such as work or school unknown.²⁶ The second discomfort was the non-clinical nature of the website dialogue and lack of professional qualifications of those communicating information. A further discomfort was the presence of narrative about poorly managed diabetes experiences with this interpreted as inadequate representations of diabetes management. Often we provided an interpretation of how the 10 steps had been embedded in the website which clinicians were blinded to. In contrast, our focus testing of the website materials with a variety of Aboriginal people with diabetes revealed understanding of the 10 messages. It was important that we addressed these discomforts to manage psychological distancing and this meant assisting our partners to adapt to a new worldview of the common.

If a market preserves by ownership and a zoo by containment, a tribe preserves by crowdsourcing. First you have to distribute the job to more people which means giving up a bit on the ownership paradigm. The less well known but just as important second part is connecting those distributed people, which means giving up on the containment paradigm.

(Lippiloto, 2009)

Sharing the common requires significant investment. It means not just consulting with people about what they want but seriously considering how to create better structural access into commons. We recommend that health messages consider psychological distancing and familiarity in their construction and evaluation. It may be helpful for public health advocates to partner with education and marketing expertise to enhance their success in communicating evidence. This article focused on public health messages and Aboriginal people, however, this method of looking at participation has relevance for other groups. The How's Your Sugar website is currently under process and survey evaluation and the findings of this will be reported at a later date. We believe we have placed a wedge of participation in web-based public health communication for Aboriginal peoples and hope that the lowest common denominator will continue to be lifted.

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Highlights in this Issue

In 2003 Dorothy Broom warned that free trade agreements could jeopardise important public health programs in Australia, including Medicare, public hospitals and pharmaceutical regulation.¹ The Editorial by Fergus Woodward and Alistair Woodward draws our attention to the proposed free trade agreement that involves Australia and New Zealand, the Trans-Pacific Strategic Partnership Agreement. They warn that such agreements focus on economic values, but may also be employed by industry lobby groups to undermine key public health programs, such as regulation of pharmaceuticals and plain packaging of cigarettes. It is not clear that increased economic benefits, if realised, will benefit health. Greater transparency is needed in these trade negotiations and a greater role for public health.

In the October issue we published a call to standardise data collection on smoking during pregnancy.² Marco Aurelio Peres and colleagues call for a reduction in methodological differences in comparable birth cohort studies which follow a cohort for many years, making them expensive, time-consuming and rare. They analyse two cohort studies of oral health, one from Dunedin (New Zealand) and one from a very different setting in Pelotas (Brazil). Comparison between these ongoing studies shows, for example, that consistent low socioeconomic status means compromised oral health. Better coordination would help clarify the evidence for interventions like fluoridation, access to dental care and better oral hygiene, and the negative effect of smoking on oral health.

Finally, in our Letters to the Editor, we draw your attention to a well-coordinated response to a natural disaster. Vivek Eranki and colleagues show how health services and local government coped with the effects of Cyclone Yasi in Far North Queensland. This area is cyclone-prone but Cyclone Yasi was the worst in recorded history, comparable with Hurricane Katrina. Preparations included closing Cairns Base Hospital and transferring patients to a secondary facility where four babies were safely delivered and various other needs were addressed. There were no fatalities directly linked to the cyclone.

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- 1 Broom D. Big yellow taxi, or, unhealthy terms of trade? *Aust N Z J Public Health*. 2003;27:271-2.
- 2 Rattan D, Al Mamun A, Najman JM, Doi SA Smoking during pregnancy – need for consistent Public Health data in Australia. *Aust N Z J Public Health*. 2011;35:406-7.

The editorial team wish you a peaceful, healthy and festive summer holiday. We thank all authors who submitted papers to *ANZJPH* in the past year. Our particular thanks go to Gavin Mooney who co-ordinated and edited the 12 contributions on 9/11 in the August issue. We also thank our stalwart reviewers who are listed on pages 595-6. Those reviewers who contribute well beyond the usual academic expectations are marked with an asterisk and we encourage you to note your star status in your CVs.