Confident Communities

A guide to working together with African communities to reduce alcohol-related harms
Help us keep this toolkit relevant and up to date

People who have migrated to Australia from a wide range of African countries possess a rich diversity of languages, cultural values and practices, identities, experiences, personal and community resources.

The Hunter Multicultural Community Drug Action Team’s toolkit is intended to be a “living” document, driven by knowledge exchange, research developments and evolving community and generational needs.

Whilst the research and community consultation underpinning this toolkit have focused on African communities, some of the topics and strategies discussed may also be of use to those working with other community groups to address a range of alcohol and other drug issues.

We have created a Facebook page https://www.facebook.com/ConfidentCommunities for community members and those working with them to share learnings about the building of community, family and individual resilience to alcohol and other drug related harms. You can also email feedback and suggestions for toolkit improvement to info@damec.org.au

Tony Brown
Chairperson
Hunter Multicultural CDAT
Newcastle NSW
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The Licensed Material being used is for illustrative purposes only; any person depicted in the Licensed Material is a model.
Acknowledgements

The creation of this toolkit was overseen by a steering committee from the Hunter Multicultural Community Drug Action Team (CDAT). The Hunter Multicultural CDAT is made up of interested members of the community and representatives from Government and Non-Government Organisations. Its role is to identify drug and alcohol issues among culturally and linguistically diverse communities in Newcastle and surrounding regions and respond through effective and culturally sensitive prevention and health promotion strategies.

In particular, the contribution of the following people/organisations was crucial in the production of this toolkit:

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- Tony Brown, Chairperson, Hunter Multicultural Community Drug Action Team
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Introduction

How this toolkit was developed

Several strategies were used to create this toolkit:

a) A review of existing academic and grey literature to identify:
   (i) Best practices in culturally sensitive engagement strategies, and
   (ii) The contents of alcohol harm prevention measures that are likely to be the most effective and applicable to African communities living in Australia.

b) Preliminary meetings between CDAT members and key community representatives working with African communities in the Hunter area of NSW.

c) Consultations with African community members living in the CDAT area. A total of 48 men and women from six communities were consulted from October to December 2013.

d) Incorporation of practice wisdom reflecting on findings from the literature review and consultations.

e) Review of the final draft with local health/community workers and community members.

In this toolkit “African communities” refers to people from an increasing diversity of African countries who have migrated to Australia since the early 1990s. The term includes new and emerging communities who have migrated to Australia for a range of reasons, such as refugees, students or those joining family members.
Who is this toolkit for?

This toolkit is designed to help community groups and workers engage with African communities to prevent alcohol-related harms. Those that might find this toolkit useful include:

- Community Drug Action Teams (CDATs)
- Government-funded health services
- Migrant and settlement organisations
- Local Councils
- Community Development Workers
- Health Promotion Workers

How to use this toolkit

Africa is a huge continent with a vast range of different cultures and traditions. There is no ‘one size fits all’ approach to supporting African communities tackle alcohol-related harms. This toolkit aims to provide you with guidance on important issues to consider, however you will need to tailor engagement and intervention strategies to the particular needs of the group you are working with. No previous experience in working with African or culturally diverse communities is assumed; readers with more familiarity with African communities may wish to proceed to Engagement and Strategies and only review the first sections briefly.

Throughout the toolkit key principles are highlighted. Community groups are encouraged to use these in the development of their own projects

Whilst the toolkit concentrates on alcohol-related harms, many of the issues discussed are relevant for a range of substance use issues.
This toolkit takes a Participatory Action Research approach. Participatory Action Research is a combination of community participation and research that involves community participants as partners in the project; sharing decision making, planning, responsibilities and tasks. By creating opportunities for learning and empowering participants through their involvement in project activities, the aim is to create broader social change.¹,²

**Participatory Action Research Cycle**

Participatory action research involves an iterative reflective cycle of data collection, reflection and action in a 'corkscrew' movement.³ Groups focus on research that aims to determine the action that should follow, the effectiveness of this action is then reflected upon, and further research may be necessary such as to understand any other issues noticed or to identify ways to improve the response, upon which the process begins again.²,³
Engaging with African communities to address alcohol-related harms is a long term commitment, not a one-off project. It may take some time to build trusting relationships needed for meaningful engagement with community members. Sustaining partnerships beyond a single consultation or project also helps maintain accountability and increases the chances for enduring positive results.

At the end of each section there are links to additional resources that explore the issues discussed in more detail.
Alcohol use amongst African communities

At the 2011 Census 337,823 Australian residents were born in Africa. Since the 1980s there has been a growth in the number of refugees arriving from Africa, as well as an increasing diversity of birthplaces among African migrants. Ethiopia, the Democratic Republic of Congo, Eritrea and Egypt have recently been major sources of humanitarian entrants to Australia. People born in Sudan remain a significant proportion of Australia’s African-born population due to past migration policies. Whilst many migrants from Africa settle in capital cities, regional areas are also important settlement destinations.

There are no population-wide studies that have recorded rates of alcohol-related harms across African communities living in Australia. Research in Australia and overseas suggests there may be lower rates of drinking among some African communities compared to the general population; although within communities there is diversity in consumption patterns, attitudes and knowledge of effects.

Alcohol consumption among African communities living in Australia is influenced by various religious, socioeconomic, cultural and individual factors. Alcohol is used for a range of reasons, including as a status symbol, to represent seniority, or as a way of socialising and expressing inclusion.
Some of the factors that protect against alcohol harms in African communities are common to other communities: healthy social networks, religious practices, social inclusion and connection with a supportive family. As with the general population, numerous harm reduction strategies are practiced by members of African communities.

Nevertheless, alcohol-related harms are an issue of concern in some African communities. Research has identified that alcohol is used to cope with settlement stresses, for instance:

- Not being able to find work and particularly for men, losing their traditional role as head of the family;
- Young people experiencing difficulties with schooling, due to lack of access to or disrupted education prior to arriving in Australia, and becoming disengaged from education and employment;
- Mental distress and anxiety due to these and other experiences including loneliness, social exclusion, discrimination, loss of identity. For those with refugee-like experiences, alcohol has been reported to be used as self-medication for the symptoms of post-traumatic stress disorder.

Alcohol related harms may also occur as communities are exposed to Australian cultural practices, such as young people drinking in order to ‘fit in’ at parties. Differences in acculturation, where young people are often reported as more quickly adapting to Australian culture, legal and social systems compared to their parents, leading to intergenerational conflicts, frustration, and young people’s disconnection from their family/community is also linked to alcohol consumption problems. For instance when problems arise, parents may be uncertain how to discipline other than by using methods from their home countries, however feel that this conflicts with Australian child protection laws. Such experiences are not only disempowering for parents but also leave the young person without adequate boundaries around alcohol use.

It has been noted that existing services may also not be able to meet the long-term and complex needs of those disconnected from family, community and vocational pathways, leading to lack of trust and hopelessness and consequently to ongoing problems with alcohol and drug use.


Preparation

Build your own capacity to work in a culturally competent way

Culture is a ‘lens’ that shapes what and how we see the world and how we understand our experiences. It influences the opportunities available to us, our behaviour and how we interact with others.²⁰

An inability to recognise and work with different interpersonal styles, values, lifestyles and viewpoints leads to poor relationships, and a failure to understand and address the needs of diverse groups.

Cultural competence is a set of behaviours, attitudes, and policies that enable people, organisations and systems to work effectively in cross-cultural situations.²¹

Cultural Competence for Individuals ⁵, ²⁰, ²²-²⁴

Knowledge

- Awareness of one’s own attitudes and values, and the use of self-reflection to explore the influence of cultural identity on one’s own behaviour and beliefs
- Understanding of appropriate ways of communicating (both verbal and non-verbal)
- Knowledge of how cultures differ on key dimensions:
  - individualism/ collectivism,
  - hierarchy and power relations,
  - tolerance of uncertainty and ambiguity,
  - masculinity/ femininity

Attitudes

- Value for diversity
- Recognition that issues that arise are likely the result of misunderstandings, rather than rushing to make judgments

Skills

- Capacity to demonstrate empathy, tolerance and respect when interacting with people from other cultures
- Ability to privilege the community’s perspectives about how they define their own needs and problems
Individual cultural competence also needs to be supported by organisational cultural competence, such as:

- An organisational commitment to recognising diversity;
- Support for skills development (such as staff training);
- Policies and procedures for culturally competent service delivery (for instance access to and use of interpreters);
- Flexibility of service rules that allow for investing a longer time for engagement and outreach to build trust;
- Planning documents that incorporate cultural competence issues.\(^4, 25, 26\)

Cultural competence is best thought of as an ongoing developmental process and a goal for people, organisations and systems to aim for.\(^21, 27\)

Learn about the group you want to work with

Cultural competence requires knowledge about the community/communities you want to work with (target community), their needs, attitudes and expectations. Gathering some of this information (by speaking to service providers, local schools, community groups, religious organisations and by spending time with members of the community) prior to developing engagements strategies will also help you to plan your approach more effectively.
Some questions to ask about the community you want to work with include:

### Demographics

- How big is the group/community?
- Who are the community leaders or prominent community members?
- What different groups make up the community? Are there any divisions within the community (e.g. between religious or ethnic groups)?
- Where does the community live/work/go to school?
- What is the community’s English language proficiency, literacy (in English and first languages), and levels of acculturation (adaptation to Australian culture)? How do these vary between groups in the community?

### Social/Cultural

- What have been the community’s migration and settlement experiences?
- What image does the community have of itself? What image does it want to project onto the wider community?
- What are the historical, social, religious and political influences on the community?
- What are moral values and beliefs that community members hold?
- What is the role that family, social networks and systems play in supporting community members?
- What issues does the community see as problems?
- Who do members relate to outside of their community? Who is the community prepared to work with?
- What are the strengths of the community? How can these be drawn on?

### Background to the issue

- What are the norms, beliefs and attitudes (including stigma) about alcohol use in the community?
- Have there been any incidents linked to alcohol misuse that have affected the community? (e.g. drink driving, physical or verbal abuse against community members)
- Have community members sought help from government and non-government agencies on any alcohol-related concerns? Where have they sought help and what has been their experience?
Build relationships with stakeholders

Working in partnership allows access to a variety of knowledge, skills, expertise and resources that individuals or single organisations are usually not able to obtain on their own.

It is useful to connect to a range of people with:

- Relevant skills (e.g. local knowledge and experience) and interest in preventing alcohol-related harms; \(^{28}\)
- Good leadership capabilities, who are able to co-ordinate planning, undertake strategic work and bring people together; and
- Connections to key decision-makers and those who create/enforce policies. \(^{29}\)

This includes bicultural workers, interested community organisations already working with the target group and representatives from local communities. These partners can act as a ‘bridge’ to the target community, are already likely to have credibility with and the trust of community members, and can encourage community participation.\(^5\)\(^{,23}\) They can also help address language and cultural barriers. For example, communities that have experienced oppressive government rule may have negative perceptions about public services or research, however interacting with workers with shared background and experiences may help address these concerns.\(^{30}\)

It may also be helpful to connect with workers from other state or national areas with experience in working with African communities, who could provide advice or mentoring for your group.
Preparing to Act: SWOT Analysis

One example of a tool to guide you in planning your project is a SWOT (strengths, weaknesses, opportunities, threats) analysis. This is a simple way of exploring internal and external factors that could affect what you want to achieve. The SWOT tool is used to map out what are the strengths and weaknesses of your situation, organisation or project and what are the opportunities and threats facing it. A SWOT analysis can be used at any stage of an initiative. It can help with making decisions about the area you wish to target and should prepare you to act more effectively.

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Internal factors to consider include:

- Human resources: staff, volunteers, board members, target population
- Physical resources: location, building, equipment, technology
- Financial: grants, funding agencies, other sources of income (e.g. donations)
- Activities and processes: the programs you run, the systems you use
- Your reputation with the target community
## OPPORTUNITIES

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External factors to consider include:

- Existing efforts, programs and policies that address this issue (or similar)
- Community and community leaders’ attitudes and priorities
- Funding sources
- The target community’s needs and service demands
- The physical environment, such as accessible transport

After brainstorming and recording ideas, working through the following questions may help turn these ideas into a plan to guide your actions:

- How can we use our strengths to take advantage of the opportunities?
- How can we use our strengths to overcome the threats?
- What do we need to do to overcome the weaknesses before we can take advantage of the opportunities?
- How should we minimise our weaknesses to ward off the threats?

Conducting a SWOT analysis in collaboration with a variety of stakeholders can challenge assumptions, give a broader picture of the situation and deepen understandings of issues and problems to target. For example you may wish to explore:

- Do differences in age, English-language ability, education, stage of settlement and family situation between community members affect readiness to engage with alcohol harm prevention projects?
- How might the community’s experiences with similar organisations before arriving in Australia affect perceptions of your project? 23
- Centre for Culture, Ethnicity & Health, *Cultural competence series*.  
  http://ceh.org.au/culturalcompetence
- Community Toolbox, *SWOT analysis: Strengths, weaknesses, opportunities, and threats*  
- Waitemata District Health Board, *Toolkit for staff working in a culturally and linguistically diverse health environment*.  
  http://www.unodc.org/pdf/youthnet/handbook_eth
Engagement

One of the most common ways to engage with community members in order to identify their views about and visions for alcohol harm prevention activities is through a community consultation. Planning for this should begin at an early stage, as the process of identifying and engaging with community members may take a considerable amount of time, particularly if you are not familiar with community structures.\(^{33}\)

Identify Gatekeepers

If your group has little prior involvement with African communities, it is likely that you will need to seek the assistance of community leaders or gatekeepers. Approaching bicultural/bilingual workers and organisations with firsthand experience engaging with the community could help with identifying community leaders. These persons may also be able assist with setting up meetings with community leaders to explain what the group wants to achieve.

Examples of issues you may want to explore with community leaders or gatekeepers could include:

- Common languages spoken by community members and whether interpreters will be necessary
- The issues you would like to discuss with community members;
- Whether separate consultations should be held for different groups across and within communities (e.g. different religious or language groups);
- The appropriateness of using a particular research method or asking particular questions;\(^{34}\)
- Facilities where the community are accustomed to gathering and the best time(s) to hold consultations;\(^{23}\)
- Any assistance they could offer with community engagement;
- The likely level of attendance from the community; and
- How to evaluate the process.\(^{35}\)
It is important that consultations be broadened beyond community leaders. Only consulting with community leaders may mean that you do not get information about the range of experiences and views of a community (for instance if community leaders are all male) or may mean that you only receive an ‘official version’ of events. Some community leaders may not be aware of problems amongst groups that are less visibly experiencing difficulties.

Consultation participation should try to capture the diversity of the community. Strategies to enhance the accessibility of consultations to typically under-represented groups (such as women, young people, people with a health condition or mental illness) include:

- Choose familiar venues that people are comfortable with. Ideally these should be linked to public transport and be disability accessible;
- Convening gender and/or age based small groups;
- Provision of childcare;\(^{23, 35}\)
- Appropriate timing of events e.g. after-school hours or at a time of day that does not create additional safety concerns (especially for female participants);\(^{22}\)
- Allow plenty of time for advertising the consultation and identifying interested participants. For instance, cultural customs may require some women to include the male head of the household in decision making about their involvement.\(^{34}\) Parents may require reassurance about supervision or mixed gender activities;\(^{22}\)
- Some groups are less likely to have attended school compared to the community as a whole;\(^{37}\) therefore when giving explanations and seeking feedback use methods that do not require a high degree of literacy (in both English and the person’s first language).

Tailor strategies to encourage participation from harder-to-reach groups
Build a relationship of trust with the community

Relationships of trust with community leaders and the broader target community are crucial in fostering and sustaining engagement. Particular efforts to build trust may be needed if community members are not familiar or comfortable with organisations asking for their opinion or involvement; or some may be reluctant to engage with groups if they have not seen any changes or benefits from previous involvement with services/projects. Steps to build trust include:

### Communication

- Being clear at the outset about the goals of a project and the likely outcomes of participants’ involvement. For instance, you could describe outcomes of similar projects, discuss realistic timeframes for systemic changes, and explain what will happen with any information people provide.
- Having open and clear communication channels among those involved, developing a shared language, understanding and vision for what aims to be achieved.
- Keeping community partners informed of project development issues (such as via meeting minutes and reports).
- Providing opportunities for participants to give feedback on the outcomes of any activities.

### Sensitivity

- Being aware of the power imbalance that can exist between mainstream organisations and smaller ethnic/religious/community agencies. Make efforts to involve these groups as equal partners, such as by learning about and adapting to their level of resources available and ways of working, asking agencies to be responsible for information-gathering activities (with appropriate training provided), or looking for ways to incorporate the project into the current work of partner agencies.
- Be conscious that trauma-related issues are likely to come up in discussions and will need to be addressed sensitively. You may wish to source additional training to enhance your understanding of and ability to respond to issues around torture and trauma, or seek support from agencies with expertise in working with torture and trauma survivors.
- One project used an ‘ethical auditor’ who was not involved in the project, but whose role was to ask questions about the ethical implications of actions/decisions made as the project progressed.
Alcohol use and stigma

Part of your preparation should help give you an idea of the likely level of difficulty you may encounter when exploring alcohol-related issues and how this may vary within the community.

An ability to address issues relating to alcohol use sensitively may be required. Particularly in communities that traditionally have had low levels of alcohol consumption, drinking may be viewed as a ‘shameful activity’, or there may be a lack of willingness to engage with those affected by alcohol misuse.15,17

Consider how to enhance the environment in which consultations are conducted to make discussing sensitive issues more comfortable. For instance, you could give participants a choice of facilitator from within or outside the community, or provide options for taking notes of conversations (other than electronic recording).23

Giving people the opportunity to share their concerns and have their questions addressed is also likely to be perceived positively by community members39, and groups could consider options to raise questions anonymously.

In addition, referring to the prevention evidence base (even if little has been done directly with the community you are targeting), can be useful to:

- Help with explaining the rationale underpinning potentially controversial issues, such as harm minimisation interventions;
- Allay concerns about the effectiveness of an initiative people are unfamiliar with or do not feel would succeed;40
- Diffuse tensions around culturally sensitive topics.4
• Centre for Addiction and Mental Health, *Culture counts: A roadmap to health promotion.*

• Centre for Multicultural Youth, *Considering consulting? A guide to meaningful consultation with young people from refugee and migrant backgrounds.*
  http://cmy.net.au/publications/considering-consulting-0

• NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Guidelines for working with interpreters – for counselling and health care staff working with refugees.*
Case Study 1: Hunter Multicultural Community Drug Action Team Consultations

In 2013 Hunter Multicultural Community Drug Action Team (CDAT) held a series of group consultations with local African communities to explore how they understood alcohol related harms in their community and if/how communities wanted help to address any issues identified.

At the start of the project, the CDAT agreed on a uniform strategy to be implemented by the different members involved in the various consultations. Services that had a long history of supporting local African communities were chosen as locations for consultations. Consultations were held on weekends and at other times that would not clash with potential participants’ work or educational/TAFE commitments.

Invitations were issued through local service providers and community leaders. It was expected that different communities would have differing perspectives on alcohol-related harms and issues of concern; therefore each community (grouped by nationality) was allocated their own consultation time. For communities where there were sufficient numbers, separate consultations were held for men and women.

Meeting format

At each meeting written consent to participate was obtained from each person. Basic demographic information including country of birth, language spoken and length of time residing in Australia was also collected for each person through a questionnaire. Even though attempts were made to phrase these questions in a way that did not require a high level of English literacy, some participants still required support to complete their answers.

Each consultation was facilitated by one member of the CDAT, with another member taking notes during the session. Key community members also assisted with facilitation where available. A qualified and accredited interpreter was used at each consultation.

At the start of each consultation the facilitator discussed the purpose of the meeting; explained that the answers would be recorded; reiterated to participants the confidential nature of the consultation; and assured participants that further activities would depend on what communities would like to see happen.
Questions for group discussion

1. Do you see harm to yourself, your family, or your community from alcohol? How?
2. What do you, your family and your community do to keep safe [from alcohol-related harms]?
3. What would help you, your family and your community to manage these issues?

Feedback to the group

Before finishing, a list of the main discussion points was fed back to the group for verification. If there was agreement on future strategies within a group, commitment to working with the community on these issues was confirmed by CDAT members.

Participants

48 people from six different countries participated in the consultations. The number of female participants was almost one-and-a-half times that of men. A quarter of those consulted were aged between 17-24 years. The majority of participants had lived in Australia more than three years. Approximately three-quarters of participants were currently studying or working.
Results

Each group (different cultural communities, as well as male and female groups within communities) had a different perception of the harms relating to alcohol use in their community, although most groups stated that alcohol misuse was not a common problem. Some issues appeared to be particularly important to certain groups, such as unemployment, needs when adjusting to a new society, or child protection issues.

Education was commonly mentioned as a way to help communities, although there were many differing perspectives as to what education should be provided and how it should be delivered. Several groups also described families, friends and the community as key for supporting people who have used alcohol in a harmful way.

Uniformity of needs and preferences among African communities should not be assumed
Be guided by the results of the consultation

Community needs and priorities identified through your consultation should guide where to target your efforts. Acting on participant feedback also demonstrates to those involved that their contribution is respected and helps with the development of trusting relationships.

Continuing to ensure that community members are involved in all levels of the project (including planning, developing and implementing the intervention, monitoring and evaluating the results of the project) will help make sure the project is meeting the needs of the local community and can enhance a sense of ownership in the project. For example, community members could produce ‘storyboards’ depicting the community’s ideas about solutions to local problems at a meeting with key stakeholders. Or, culturally adapted program materials could be tested with representatives from the intended audience to make sure the final product incorporates the norms and beliefs of the community.
What existing evidence is there?

Substance misuse prevention programs should be based on sound evidence on what works. Results from the small amount of existing evidence that is available from African communities, as well as from broader research into substance-use prevention with diverse cultural groups, suggests the following strategies could be useful:

i. Family based interventions that teach parenting skills and work to improve family functioning may help to address important risk factors. There is evidence from systematic review of family prevention programs that they can be effective across a range of diverse communities.

ii. Research has shown that alcohol health promotion campaigns that reflect the dominant culture are often not directly transferable to communities with different cultural norms. ‘Culturally adapting’ programs to the needs of the target community/communities aims to improve the comprehension, acceptance and impact of interventions.

Cultural adaptation is more than using people, language, music, locations and other items familiar to/preferred by the target audience in program messages and materials. It also involves incorporating the cultural, social, psychological, environmental and historical factors that influence health behaviours in different cultural communities. This could include understanding how members of the target community perceive the cause, course, and treatment of health problems; and taking into account how religion, family, society, the economy and the government influence the community’s behaviour.
Evidence also suggests the following aspects are important when culturally adapting programs:

a. Community participation in the creation of the program’s messages;\textsuperscript{44}
b. Being faithful to the core components of any existing, evidence-based programs used;\textsuperscript{45}
c. Considering how different cultural values/elements combine together to affect alcohol use;\textsuperscript{46}
d. Ensuring interventions are of a sufficient intensity to create behaviour change

e. Targeting multiple levels for cultural adaptation (i.e. individual and family)\textsuperscript{47}

iii. There is strong evidence that regulatory and economic strategies targeting the environment and systems that influence drinking behaviour are effective in reducing alcohol consumption and related harms.\textsuperscript{48} Further consultation with African communities could identify how these strategies could be used to best address community needs.

As relatively little research has been done into what are effective alcohol prevention measures with African communities living in Australia, local groups may need to think creatively about actions to implement. The knowledge and experience of community representatives, bicultural workers, or agencies already working with the target group can also support you in determining strategies.
Take a holistic approach

Harmful alcohol consumption is influenced by complex relationships between individual risk and protective factors, as well as environmental and societal factors that affect health more broadly. A single intervention or single sector will only have a limited impact on preventing alcohol-related harms. Community groups will need to consider strategies across a range of different domains: individual, interpersonal, community, macro.

Alcohol misuse is also linked to a range of other health and risky health behaviours (for instance mental illness, early school leaving) with many common social origins (such as social exclusion, family relationship problems). Community groups should collaborate across a range of sectors, such as education, public health, vocational services, criminal justice, child welfare and mental health to create a comprehensive and sustained response.

Use multiple strategies that can complement and reinforce each other
Factors Influencing alcohol-related harms

Individual
- Attitudes
- Human development experiences that influence well-being, behaviour and skills
- Mental Health Issues/ Trauma
- Acculturation

Interpersonal
- Parenting
- Family harmony
- Friend/peer culture

Community
- Community cohesion and social capital
- Social and cultural values
- Religious practices

Macro
- Education and employment policies/systems
- Institutionalised racism
- Housing policies
- Health system
- Laws, regulations (e.g. drink driving, alcohol availability)
- Alcohol pricing policies
- Media/ Advertising
Build the community’s capacity to tackle the issues it defines as important

Projects should focus on building strengths and capacity in the community to enhance protective factors against alcohol misuse.

Some suggestions for incorporating these activities into projects include:

- Consultations could identify the resources that already exist in the target community to address alcohol-related harms.
- Supporting trained peer educators to develop the skills of community members.²
- One Australian project established a youth advisory group consisting of youth leaders and disengaged young people, which was a successful forum for discussing issues of social exclusion, alcohol and drugs and refugee experiences.⁴
- Working in partnership to build the capacity of local services to work with African communities.⁴ For example, fostering conversations between community members and local police to improve information sharing and understanding around issues such as alcohol, parenting and the law.
- Employing community members as researchers to determine the impact of a new policy or initiative. Community researchers should be appropriately supported (such as by providing education in substance-use awareness and research techniques).³⁰
- Community information/education sessions could include opportunities for members to practice exercising their rights in order to resolve difficulties.³⁹
- English language classes can be used to teach community health issues and students could produce health promotion materials as part of class exercises.²³
Case Study 2: Educational workshops with a community sports group

Health workers were finding it extremely difficult to involve young male migrants in healthy living programs, and noticed that this group tended to have little contact with health professionals. A community sports club whose membership was mostly made up of young men from African communities needed financial support to participate in the regional soccer competition. When this club approached a local NGO for assistance, the organisation accepted on the condition that the team agreed to participate in an education program.

Drug and alcohol and mental health workers from the Hunter New England Local Health District presented six interactive education sessions with the group on weeknights when training was held.

Participants expressed appreciation at being able to meet professionals in a more relaxed and friendlier environment (outside of school or health care settings), and felt comfortable in asking questions about a range of issues that concerned them. A coordinator noticed players switched from bringing alcohol to bringing soft drinks to enjoy after the game.
• Australian Drug Foundation, *Preventing alcohol and drug problems in your community.*
  http://www.druginfo.adf.org.au/reports/pr-communities

• Centre for Addiction and Mental Health, *Culture counts: Best practices in community education in mental health and addiction with ethnoracial/ethnocultural communities: Phase one report.*


• The Victorian Foundation for Survivors of Torture Inc & Centre for Multicultural Youth, *Responding to challenges of misuse of alcohol and other drugs by young people of refugee backgrounds: Reflections from two projects.*
  http://library.bsl.org.au/jspui/handle/1/4132
Build the knowledge base about effective alcohol-harm prevention campaigns with African communities by evaluating your project. Evaluation should be part of your overall strategy development and is not an afterthought at the end of a project. Care should be taken to use methods that are appropriate for literacy levels and community preferences. For instance newly arrived refugees may be reluctant to use paper-based evaluation.²²

Two types of evaluation that you may wish to consider are:

**Process Evaluation**

This is part of good reflective practice. It involves assessing what worked, what needed improvement and why.⁵¹ Whilst results can tell you how satisfied participants are with the strategy, this may not give an accurate indication of how effective the project was at meeting its objectives.⁴¹

**Outcome evaluation**

Outcome evaluation assesses what changes have occurred in the community and whether the project has achieved what it set out to do.⁵¹ For example, measuring levels of awareness, attitudes, intention or behaviour before and after implementing a project to identify any changes. Partnering with a university or other research organisation may provide you with expertise and resources to conduct a high quality outcome evaluation.
Make evaluation relevant for your target community

Evaluation provides an opportunity to explore how well the preferences and needs expressed by the target community were responded to. For instance, a process evaluation could explore what alterations needed to be made to the project to respond to disclosure of other issues as trust is built, or to unexpected events impacting on the community. The indicators and statistics chosen in an outcome evaluation should measure what progress has been made towards the goals the community wants to achieve (e.g. skills-building, increased community strengths).

Make sure results and lessons learnt from undertaking the project are available to others, including community members themselves. For example, results could be translated into community languages or community partners could present the results orally at a community meeting.23
  [http://www.biomedcentral.com/1471-2458/14/1315/abstract](http://www.biomedcentral.com/1471-2458/14/1315/abstract)

- NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, *Community Development Evaluation Manual*  
Support and guidance for alcohol-related issues

The *Australian Guidelines to Reduce Health Risks from Drinking Alcohol* published by the National Health and Medical Research Council recommends:

- For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury.
- For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion.
- For children and young people under 18 years of age, not drinking alcohol is the safest option.
- For women who are planning a pregnancy, are pregnant or breastfeeding, not drinking alcohol is the safest option.

Alcohol and drug telephone information services in each State/Territory:

**ACT**
(02) 6207 9977

**NSW**
(02) 9361 8000 (Sydney)
1800 422 599 (NSW country)

**NT**
(08) 8922 8399 (Darwin)
(08) 8951 7580 (Central Australia)
1800 131 350 (Territory-wide)

**QLD**
1800 177 833

**SA**
1300 131 340

**TAS**
1800 811 994

**VIC**
1800 888 236

**WA**
(08) 9442 5000 (Perth)
1800 198 024 (WA country)
• Australian Government Department of Health
  www.alcohol.gov.au

• Australian Guidelines to Reduce Health Risks from Drinking Alcohol

• Standard drinks chart
References


35. NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors. *STARTTS community consultations manual.* Sydney: NSW Service for the Treatment and Rehabilitation of Torture and Trauma Survivors, 2006.


