

case studies of community development in health



case studies of community development in health

*Edited by
Paul Butler
and
Shirley Cass*

CDIH

CENTRE FOR DEVELOPMENT AND INNOVATION IN HEALTH

CENTRE FOR DEVELOPMENT AND INNOVATION IN HEALTH

1993

contents

	Introduction - Paul Butler	5
1	Patchwork - bushfire education <i>Kathleen Millicer</i>	17
2	CORE - coalition of residents for the environment <i>Catriona Knotze</i>	27
3	The house party - study 1 <i>Kiwi Wong</i>	39
4	The house party - study 2 <i>Sida Douglas, Joanne Hackett & Kathie Walsh</i>	53
5	A tea trolley support service in a hospital oncology clinic <i>Marguerite Menon</i>	66
6	Strathalbyn and District Women's Health Project <i>Chris Ainsworth, Gaynor Hartvigson and Bronwyn Buddle</i>	75
7	Pap smears and breast self-examination for NESB women <i>Rita Prasad & Wafa Shinwari</i>	89
8	Women, disabilities and self defense <i>Rayleigh Joy</i>	101
9	The Ivanhoe Place health development project <i>Helen Ansems</i>	111
10	Community consultation on birthing practices <i>Fiona Gardner</i>	125
11	Community management training <i>Julie Statkus</i>	133
12	Workcover - life's easier on the dole <i>Jim Boyle</i>	145
13	Greenethorpe Village community project <i>Marnie Mason</i>	153
14	Walker St Tenant's Association food co-op <i>Elaine Kellerman, Marilyn Onafretchook and Glenice Kelly</i>	161
15	Is anybody listening? <i>Eileen Hooper</i>	171
16	Health promoting schools: establishing the process <i>Norma Livingstone and Trish Nove</i>	181
	Notes on contributors	192

Published by:

Centre for Development and Innovation in Health

March 1993

ISBN 0 646 13604 6

Copyright © 1993

Copyright in these case studies rests with the individual authors whose permission must be sought before their material can be reproduced.

Printed by Victorian Printing Pty Ltd
Blackburn Victoria

Cover Photograph: Ponch Hawkes

PRINTED ON RECYCLED PAPER

acknow-ledge-ments

This project was directed by a hard working Advisory Committee made up of the following members:

Jane Dixon	Marguerite Menon
Marj Quinn	Panyiota Romios
Wendy Hurlle	Frances Bonning
Tony McBride	Sue Rosenhain
Angela Taft	Maria Wright

In addition, substantial support was given by members of the CDIH network - Demos Krouskos, Onella Stagoll, Angela Hill, Cai Wilson, Mary Karavarsamis, Amata Hall, David Legge and Shirley Freeman.

We would like to thank the authors for being prepared to share their trials and tribulations in such a public fashion, and for accepting our editorial comments. The case studies were mainly generated through writing workshops held at 21 community health agencies around Australia. We also take this chance to thank the staff of those agencies who assisted in organising the workshops.

THIS PROJECT WAS MADE POSSIBLE THROUGH FUNDING FROM THE AUSTRALIAN GOVERNMENT VIA THE NATIONAL HEALTH PROMOTION PROGRAM

introduction

by Paul Butler

Reflecting on Case Studies

WHILE away on a weekend in the country, I was washing the breakfast dishes with a close friend, Tony McBride. Tony had brought a well known Australian public health journal, for light holiday reading, and we were bemoaning the lack of good community development projects in that journal, and indeed in most journals. We agreed that we needed a concerted effort on documenting the good work of community workers in health and thus Reflections was born.

The lack of documentation in our field demonstrates we are not taking time to reflect on our work, its value and how to do it better, and we are definitely not sharing our work widely. Indeed, having run twenty-one workshops on writing case studies in a space of eight months, it is clear we often don't even share our work within our own organisations.

The Reflections project aimed to encourage critical reflection in community development through the documentation and circulation of case studies. A case study is an account of a project which describes what went on, reflects on what went well, and not so well, and considers issues arising from a practice point of view.

A case study approach was chosen because, as Kelly and Sewell point out in their 1986 collection, "People Working Together", case studies have a universal appeal, "few people can resist a good story." Writing a case study provides the author with an opportunity to gain insight into their work, and reading a case study provides others with a chance to learn from those who have gone before.

Community workers are looking for supportive ways to consider and reflect on their work, but do not find current models of evaluation very useful. The development of case studies, within a workshop setting of peers, starts to provide an opportunity where people may be more open to constructive reflection and criticism of their work.

The workshop approach to writing case studies came after attending a workshop on writing for professional journals at Monash University's Human Resource Centre. It was clear that people gain strength from working together in developing case studies, rather than trying to write in isolation.

Evaluation Towards Doing It Better

Inequalities in health are due to inequities in access to resources and power and in opportunities for exercising a valued social role. Thus it follows that community development is not value free, rather, it is based

on achieving social justice and equity. Further, the collaborative nature with communities requires us to recognise that the goal is health and social justice and equity, not social justice in order to achieve health.

In fifteen years of community work, I have regularly experienced a sense of doubt about whether my work was making any difference. The outcomes of community development are difficult to see and the impact they make is often unclear, and thus, many of us are plagued with doubts about its effectiveness.

The traditional experience of evaluation for many of us in community work is that it is both oppressive and a waste of time. It is oppressive because it is forced upon us by funding and management bodies and we feel we have to justify ourselves, or that the material we provide will be used against us, or at least as a reason for not funding our project again.

We experience it as a waste of time because we fill in statistical forms and we write up reports and these are shelved, fed into the computer, whatever. There is certainly little sense in which we feel that something productive or useful to us will flow from this reporting.

Community development has inherent difficulties and it is vital that we develop our own methods for reflecting on our work in a way which is both constructively critical and supportive. We need some ways of looking at our work and asking **how could we do it better?**

The sixteen case studies in this collection illustrate Kelly and Sewell's argument that there are two sorts of learning from this reflective case study approach. The authors of the case studies learn as they reflect on what happened and gain insights into what went on. There is also the learning which readers achieve which may include different ways of tackling a particular health issue, or it may include insights into community development processes.

This process of documenting and distributing case studies of community development will improve the quality of our work. It will also help to contribute to a different culture, one which values the notion that time should be spent critically reflecting on our work.

The Reflections Project

Writing good case studies is a time-consuming task and there are significant barriers to workers documenting their projects. The barriers come in two main forms. The first form is that of finding the time and space to write down such work. The second barrier is that there is no culture in community work which supports taking time to reflect and write.

Workshops on Writing Case Studies

Reflections tackled these barriers in a number of ways. The main approach was to encourage the writing of case studies in a workshop

setting. We embarked on workshops around South Australia, Victoria and New South Wales in collaboration with twenty local agencies with an interest in health. Typically, workshops were two half day sessions, five weeks apart. The first session introduced a framework for writing a case study and participants started to map out their case studies. In the second session, the focus was on what each participant had written and on providing constructive feedback towards authors finalising their case study.

A key element of the workshop approach was the interaction amongst participants. Most people attending were experienced community workers and were able to quickly identify important aspects of each others work and to encourage and criticise in a constructive fashion.

Most workshops involved between eight and twelve participants from organisations in the area of the centre we were working with and nearly 200 participants from over 100 organisations took part. We provided workshop participants and other potential authors with a Writer's Kit.

The project also recognised that sometimes there is a great story, but nobody with the time or skills to write. In response to this, we recorded a limited number of stories directly onto tape and then transcribed and edited this material to provide a case study.

Illustrating Good Practice

In choosing which case studies to publish, we selected those which illustrated aspects of the community development framework (see below) and which highlighted the struggle of putting community development into practice.

We have published projects which illustrate good community development practice, regardless of the outcomes. It is our contention that while good practice does not guarantee intended outcomes, it will always result in positive achievements.

One of the drawbacks of the case study approach is its "snap shot" effect. Like a photograph, you cannot see what happened next, and of course community development often continues on. In the 1988 CDIH Resources Collection, we published a case study about a self help group in Port Adelaide tackling environmental problems. While that case study drew a picture of limited success and great struggle, subsequent developments documented elsewhere provide a more positive picture (Jocelyn Auer, 1989).

Case studies are clearly subjective and qualitative, and one person's success may be another's failure. This is most likely to be the case where a project has been controversial and involved conflict between parties. But this approach is also consistent with the values and philosophy underlying community development - there is no objective reality which can be measured and quantified.

Community Development Described

The term community development is the site of some struggle in the field. It is used to cover an enormous range of activities partly out of genuine confusion and partly out of substantial differences of opinion.

In 1988, we published "Community Development in Health: A Resources Collection," which provided community health workers with a range of valuable resource material. About community development, the Collection said this:

Community development is based on an understanding of these inequalities [in the health of different groups within our society]. People's health experiences are seen within the context of their social relationships. In this framework alienation and powerlessness are identified as linked to poorer health outcomes; having a sense of not belonging to the broader society, a sense of not having much control over one's destiny.

A developmental approach involves working in ways that facilitate people and communities developing their strength and confidence while at the same time addressing immediate problems.

The Resources Collection identified a community development approach as comprising three elements - a theory about health; a practice; and core values. The theory stated that people's health experiences were related to their social context and their social relations, and were not just a series of isolated incidences of treatable illnesses. The practice involved building consensus amongst the community and using strategies of empowerment such as providing communities with information, gaining resources, building community organisations, and developing the skills to work and organise locally.

The core values in community development are our old friends equity and social justice. Importantly, as noted in a subsequent CDIH Report, "Strengthening Community Health", this means social justice and health, not social justice for health.

Community development is thus a theory with values and a set of practices which aim to change the world. This changed world is one where people have a strong sense of belonging and a strong sense of control over their lives. The view of community development is that good health will flow from these outcomes.

Democratic Collective Action

Let's look outside CDIH for another definition:

Community development is a social intervention which, through the facilitation of democratic

collective action on the part of its clientele, seeks to maximize their sense of ability to affect their environment. This involves learning of organisation and critical analytical skills, as well as the creation or development of a sense of identity and solidarity among members and their representative organisations which will allow them to enter into the struggle to alter inadequate institutions and laws, or build new ones which will be more responsive to human needs.

Bill Lee, 1988.

Lee spent time with experienced community development workers in Canada asking them what they did and why, and developing an understanding of community development based on practice.

Lee emphasized that community development was about social change to remove inequalities in power which are the cause of the problem which people initially wanted fixed, and he identified six aspects of community development:

- involving people in struggle;
- building a sense of community;
- developing an organisation;
- achieving a concrete benefit;
- people learning new skills;
- fundamental social change.

A Framework of Community Development

After consideration of the afore-mentioned definitions, and in light of our own practice, Reflections adopted a framework of community development involving seven elements. In addition, community development must be understood as having core values, rather than simply being a tool which can be used in certain situations.

It is unlikely that any project or process will involve all these elements in their ideal form, but together they provide a framework against which projects may be considered as to whether or not they are community development.

The elements are divided into those which are more related to the process of the project, that is how it was carried out, and those more related to the objective of the project, its outcomes. These two categories clearly have some overlap.

Process Elements

Control of decision-making - community members participate to control the project and particularly to control the identification and definition of the issue.

Involvement in action - the project involves the community with the issue in action for change.

Development of community culture - the project contributes to a culture of groups of individuals taking responsibility for improving and protecting their area and services.

Organisational development - the project builds a new organisation or improves an existing one.

Learning - the participants are acquiring new skills, information and/or new perspectives on themselves, their community and their concerns.

Objective Elements

Concrete benefit - the project sees the achievement of some new or improved service or facility, or the protection of something valued by the community.

New power relationships - the project changes the social landscape of the community so that new and more equitable power relations are formed (this is also a process aspect).

Core Values

Community development is based on achieving social justice and equity. The goal is health and social justice and equity, not social justice in order to achieve health.

The Case Studies and the Framework

There are sixteen case studies in this collection and taken together they highlight the elements of the framework outlined above.

Control of decision-making

Three case studies - Workcover, Strathalbyn and Patchwork - demonstrate the highest levels of decision-making in the hands of the community. In particular, these studies demonstrate community control from the outset where the initiative was taken by the community, rather than by a community worker or health agency.

In these three cases, the projects built directly from the experiences of community members who then began to act collectively. In Workcover, a group of injured workers meeting regularly in a gymnasium where

they were recovering from injuries shared their frustrations and annoyances with the South Austraform Workcover system. They recognised the limitations of individual action and decided to act collectively to reform the Workcover organisation.

At Strathalbyn, Chris Ainsworth, a community member talks about how the "Environmental Health Action Group used to get together and talk about what projects we should tackle. Should we take over the local paper, should we take over the local dump, just sort of fantasize a bit."

In Patchwork, Kate Millicer, horrified by her experience of the tragic Ash Wednesday bushfires, starts by taking responsibility for her neighbours and finishes with her whole town involved and fundamentally altering the Victorian Country Fire Authority's approach to fire prevention around the state.

More commonly, both in the other case studies and generally, projects are initiated by community workers in response to needs they have perceived, or following consultations or surveys. At Walker St, community workers initiated a food co-op in response to resident concerns about lack of adequate, convenient, healthy and inexpensive food supplies.

Involvement in action

Community development is done by and with the community, not for the community. The Ivanhoe Place case study is a fine example of many similar projects where a community agency has facilitated and resourced the development of a public tenant's organisation. Typically these projects have very high levels of community participation in decision-making, project work and organisational administration.

Ivanhoe Place was no exception with the tenants involved in running the meetings, carrying out a successful and sophisticated neighbourhood survey, campaigning and lobbying and producing a regular newsletter.

Development of community culture

This element has struck me as more nebulous and more difficult to recognise using a case study methodology. The nature of the element makes it perhaps the most difficult to describe, and yet the Tea Trolley case study captures extraordinarily well a sense of responsibility being developed and a notion of community being built to replace oppressive fear.

Similarly, the initiative taken by the Bilingual Community Educators in the Pap Smear project in Brisbane demonstrates a willingness to take responsibility and provide constructive community leadership.

Organizational development

Altered power relationships often require a level of organization if they are to be successful and sustained. At Dandenong, residents fighting for a cleaner and healthier environment established the Coalition of Residents for the Environment (CORE) as a legal entity to provide an

organisation which could compete with government and business, both in public and in the courts.

At Merrylands East, as part of the Health Promoting Schools project, Community Action for Social Health (CASH) was formed, involving parents, school staff, community health workers and representatives of non health agencies, to build an intersectoral organisation to promote a healthy social and physical environment for the students.

Learning

As the workshops proceeded and case studies developed, we recognised learning as falling into two categories. The first was learning around the particular health issue or concern. An example was the skills and information learnt by women attending the disabilities and self-defense workshops at the Women's Health Centre in Brisbane.

The second learning was around working together, building organizations, developing campaign and lobbying skills, perhaps most obvious in the Ivanhoe Place case study. This second type of learning was also the explicit focus of the Community Management Training project at South Port in Melbourne. In that case, the community workers and the community developed a training program to develop the skills of community members sitting on Committees of Management.

Concrete benefit

The benefits arising from the projects described in these case studies were perhaps collectively their strongest aspect, and it may be that was part of the motivation for the authors. Case studies describing successful community work but ending with little positive benefit do occur, but we had more difficulty supporting their authors to complete the case studies.

The range of concrete benefits was wide, for example:

- a cleaner, safer, healthier physical environment (eg CORE and Healthy Schools);
- new or improved services (eg Carlton Psychiatric Support Program and House Party I & II);
- better food supplies (eg Walker St);
- education and skills development (eg Community Management Training).

New power relationships

Perhaps this element, more than any other, separates community development from other forms of health promotion. The difference between a support group and a community development project is that the latter challenges existing power arrangements.

In Ivanhoe Place, Helen Ansems quotes Labonte who describes community development strategies which:

avoid the victim blaming tendencies of health education by defining the social environment, rather than the individual, as the target of change and by putting residents in control of that change.

Community development recognises that groups are involved in social relationships and that there is often a need to change the balance of power in those relationships if the community's health is to be improved. At Ivanhoe Place, and at many other hundreds of public housing estates, residents as a group and as individuals are in a relationship with the State Department of Housing, and it is in this relationship that the balance of power needs to change.

In the Riverland, Jim Boyle and his group of injured workers recognised that their relationship with Workcover needed to change. The disabled women attending the self-defense course wanted more control over their relationship with the institution in which they lived. The women in Loddon were looking for more control over their bodies and choice of birth options, and the residents in South Dandenong wanted more say over toxic chemical plants in the neighbouring industrial estate.

Power and Decision-Making

This collection of case studies demonstrates the effectiveness of tackling health issues with a community development strategy. The concrete benefits achieved by these projects were real and lasting, though not always to the extent originally hoped for.

The changes in power relationships are also real but perhaps less has been achieved in this area. That this is more difficult, is to be expected and suggests that most people in powerful situations do not share the view expressed by Julie Statkus when she says "when power is shared, no one loses power - everyone becomes more powerful."

It may be however, that community development is more suited to tackling inequalities in power where the site of power is not too removed from the community. In this regard, the residents in Dandenong fighting for a safer healthier environment found it very difficult to have any impact on the statewide power structures around planning and the environment, even though they were able to significantly change the policy of the local Government.

These stories, taken with the case studies in "Action Speaks" by Baldry and Vinson, suggest that it is important to recognise when to move beyond local community development strategies to building social movements and developing coalitions across a wide range of communities.

The Ivanhoe Place case study also reminds us that when community development projects achieve a change in power relationships, they will themselves become a venue for struggle for that power which has been achieved.

The Ontario Prevention Clearinghouse, writing in their Community Development Resource Package say this about power:

Communities involved in the development process are likely to see a power shift that is not always positive. Power may become concentrated in a few individuals or amongst agencies and organisations, leaving them feeling more marginalised than ever. Or power can be misused sometimes for personal or small-group gain that is not conducive to problem-solving. As *we* seek the consensus on principles and needs that is essential in community development, *we* must realise that conflict is inevitable, that it can be resolved through compromise, through dividing responsibility or by shifting time-frames.

Perhaps the other thing to note in regard to power and conflict is how surprising it is that *we* community workers are so often caught off guard by conflict. It does not occur to us that not all of our community will support our work and that *we* personally may *be* held accountable. Experience gained through Reflections suggests that conflict in community development is quite normal and to be expected.

The other significant lesson is that the organisational and policy contexts within which community workers and agencies operate influences their ability to support community control over decision-making.

By way of example, during the case study workshops, it became clear that the adoption of national goals and targets for better health has set an agenda for many community health agencies. This central agenda however, restricts the ability of community workers to respond to local issues.

Increasing pressures to *be* accountable to funding bodies and the use of accountability tools such as Health Agency Agreements also tends to push community workers towards tackling approved issues and concerns, and means there is less opportunity to respond spontaneously to issues arising in the local community.

Good Community Development

Good practice in community development is about putting the elements of the Framework of Community Development in place in an effective way. It is quite possible that good practice will not achieve the outcomes of some concrete benefit and a more powerful community. A community development approach does not guarantee success as the

Strathalbyn Women's Health Group's attempt to take over the local tip, and Carlton's attempt to have a new psychiatric service funded, testify.

It is possible that community development could fail either because it was badly practised or despite being well practised. In the first instance, the community worker may have been half-hearted on key strategies of empowerment, they may not have ensured that participants were well informed, they may not have given adequate support for skills development so participants could not carry out tasks that *were* central to the project. That is, it fails because it is badly practised.

The second area of failure is more complex and seems more likely to involve inspection of the institutional relationships which are being tackled. As Lee pointed out, community development is about changing power relationships. This means that one institution must *be* prepared or convinced to share power for the project to *be* successful.

It seems likely that it is in this area that good community development practice may fail. That is, the institutions which the project aimed to reform or change resisted to the point where the community development project was a failure.

Returning to the Port Adelaide case study in the 1988 Resources Collection, following the end of the project aimed at improving the local environment, a resident is quoted as saying "The trucks still go past and there is still ash settling over my car and my trees are still dying."

The quote invokes a powerful feeling of alienation and lack of control. It raises the question that despite a range of successful outcomes and actions along the way - has the community development been successful on the key criteria of alienation and powerlessness?

The traditional answer to this question, and indeed the one posed in the case study, is that success needs to *be* measured in a variety of ways looking at all the outcomes. In Port Adelaide, the more positive outcomes *were* the development of a residents action group which gave residents a voice, the establishment of a local Environmental Health Management Plan with local input, and a successful public meeting which showed residents that their experiences and fears about their health and their environment were real and justified and not isolated incidents or paranoia.

In the cases of Carlton and Strathalbyn, strong community networks have been built, much information has been gained and the community may well *be* better equipped to tackle the next concern, or to take advantage of some change in circumstances to achieve the original goal.

At the end of the day then, some community development projects will tackle significant reform agendas and though well carried out, they will fail. Other projects will tackle much easier reform agendas and succeed. The question then becomes how do *we* judge the relative merits between such examples, or indeed should we?

The Future

I trust that this is the first of a series of collections which will document and reflect on the great work being carried out by dedicated workers and activists around Australia. My thanks and congratulations to the authors for providing these insightful views of their work.

References

Auer, J. 1989, Assessing Environmental Health: Some Problems and Strategies, Community Health Studies, Volume XIII, Number 4.

Baldry, E. and Vinson, T, 1991, Actions Speak, Longman Cheshire, Melbourne.

Community Development in Health, A Resources Collection, 1988, Community Development in Health, Northcote.

Community Development Resource Package, 1992, Ontario Prevention Clearinghouse, Ontario.

Kelly, A. and Sewell, S. 1986, People Working Together, Vol. II, Boolarong Publications, Brisbane.

Lee, B. 1988, Purpose and Meaning in Community Development, Unpublished Paper.

Strengthening Community Health, 1990, Community Development in Health, Northcote.



"The Patchwork Project is a Bushfire Safety Education Program carried out by the community for the community. We had chosen the name 'Patchwork' to convey the idea of many individuals contributing to a joint effort. Every woman grasps the significance of this immediately."

Kathleen Millicer

"Patchwork" - bushfire safety education

"Patchwork" - bushfire safety education

by Kathleen Millicer

How is it possible to encourage a whole township to take responsibility for its own safety?

Notes from my diary: February 1983

ASH Wednesday, (February 16th) one of the saddest days in Victoria's history. Huge areas devastated by bushfires. Human death toll - 71, and much destruction of stock and wildlife. Strange that it was Ash Wednesday in the religious calendar.

Merciless drought throughout Australia. Anglesea in the grip of stifling heat. Water restrictions imposed by Shire of Barrabool. Total Fire Ban across Victoria. Northerly winds increasing. Vegetation tinder dry.

Afternoon newsflash: "Bushfire at Deans Marsh, heading for Lorne". Wind thankfully not blowing in our direction.

Evening, wind changes from northerly to southwesterly. On TV, see fires in Macedon. No mention of Deans Marsh.

Must water garden. Outside sky orange. An almighty roar, then smell of fire and smoke.

A police car at our drive: "Quick, you've got ten minutes to get out. A huge bushfire coming straight towards us!"

What to take? The two cats, some food for them, a bit for us, a bucket of water, some wet towels, flagons of fruit juice. Afterthought: my toothbrush and tooth paste. Keep smiling!

Join throng, bumper to bumper down Great Ocean Rd. Most of the night stay on river bank.

Following day, return late. Our house is not damaged!

Need tranquillity. Alone to beach at dusk. Investigate hump shapes on sand - dead kangaroos. Fled back home.

Ignorance

In defence of my own ignorance, I can only say that I was born and brought up in England. We had only recently moved to Anglesea, which was my first experience of life in rural Australia. In the weeks following the Ash Wednesday bushfires, living in our silent and blackened environment, those of us who were left tried to come to terms with what

had happened. One hundred and twenty seven homes had been destroyed in Anglesea. I even considered returning to England. One thing was certain if I decided to stay, I was determined to learn how to live with the danger.

Precautions

I decided to stay and began to read everything about bushfires that I could lay my hands on. We installed every safety precaution recommended for houses. But I was convinced that there ought to be some kind of a bushfire safety project, which would allow for the participation of Anglesea residents, as well as the official Country Fire Authority (CFA) personnel. I began to wonder what could be done.

At the first meeting of the Anglesea Tidy Town Campaign, I intercepted the discussion about litter and raised the question of fire danger. This was ruled out of order.

Years passed, fortunately without further bushfires.

January 1991

On January 2nd there was a day of Total Fire Ban. The temperature soared and the northerly winds howled. In our part of the street, all the holiday homes were occupied, except one.

I went over to the empty home to look for hoses. I couldn't find any. I contacted the new owners in Melbourne and with their permission I bought some hoses and a water sprinkler. When I connected them the house was no longer defenceless.

The next day was even hotter. I thought of all the other homes which might be unguarded in Anglesea. Worse still, I wondered how many new residents, or holiday householders, might be as ignorant of the bushfire dangers as I had once been?

I presented a submission to the Anglesea Fire Captain. It was a visual presentation advocating the feasibility of a Bushfire Safety Education Campaign, combining the resources of the townspeople and the CFA. When he arrived at our house a few days later with a large quantity of CFA Bushfire Safety pamphlets, I was faced with finding some way of organising distribution.

Meals (and pamphlets) on wheels

As I do some of the Meals on Wheels rosters, I have lists of ladies on whom I can call. Instead of cheerful conversations about getting the dinners round town, I asked if they would deliver Bushfire Safety Pamphlets instead. Without hesitation they agreed. From that small start, fifty seven volunteers came forward. The Bushfire Safety message began to spread across Anglesea. Autumn arrived, bringing cooler weather and rain. The fire danger receded but the idea did not die.

Anglesea Community House

After the Ash Wednesday bushfires, the people of Tasmania had donated a building to rehouse an Anglesea family whose house was destroyed in the fires. When the house was no longer required for that purpose, the Shire of Barrabool made it available for the Anglesea Community House. I approached the House's Committee to adopt the bushfire safety project and they enthusiastically agreed.

We called a small meeting at the house to discuss a joint initiative in devising a Bushfire Safety Education Project by the CFA and residents. Our guests were the local and regional CFA personnel, our Shire's Fire Prevention and Human Resources Officers, and our Anglesea Councillor.

This Project was an entirely new idea and if it was to succeed, it needed the agreement of all concerned. We waited patiently whilst Anglesea Fire Brigade deliberated. When the Fire Captain told us they had approved our idea, we decided to launch the Bushfire Safety Education Project on the official opening day of an extension to the Community House.

Floating the Patchwork project

We had chosen to call our project "Patchwork", to convey the idea of many individuals contributing to a joint effort. Every woman grasps the significance of this immediately. The Patchwork Project is defined as a Bushfire Safety Education Program, carried out by the community for the community. It is an exercise in learning and caring.

We floated the notion of a logo for Patchwork and local artist Mrs Edith Lclwn took up this challenge and her design integrates beautifully the emblem of fire and our own locality which gives the outline of our coast and the Anglesea River. It could be adapted easily by any other locality who could incorporate their own geographical symbol.

We set up a visual display at the launch and this obviously had an impact because volunteers began to sign up on the spot. After the excitement of the launch was over, I faced once more the realization that having undertaken the task I had to fulfil the commitment. I had no illusions. It would not be easy.

The nitty-gritty

I made a call to the Shire of Barrabool and politely requested a large map of Anglesea. When I explained what it was for, the gentleman was so enthusiastic that he sent me two.

I kept one for reference and cut the other into segments. Each segment was a Group of volunteers and ideally, each area's Group had their own Co-ordinator.

Posters urging people to become volunteers, were put around the town.

Our Community House magazine, "Newsangle" also circulated information on the project.

As volunteers came forward, a street index was compiled. Using this index, in conjunction with the map segments, of which there were over thirty, it was easy to slot people into their area's Group. Each volunteer was only asked to work in the immediate vicinity of their own house.

Operation Patchwork

The Patchwork system worked like this:

1. Anglesea CFA sent pamphlets to the Community House;
2. Using information from the Group Book, the exact number of pamphlets was packed for each Volunteer and the households to be covered by that person worked out;
3. Pamphlet packages for each Group were delivered to the Group Co-ordinators;
4. Group Co-ordinators delivered packages to the appropriate Volunteers;
5. The Volunteers then did the house-to-house delivery.

Community Responsibility

Volunteers were also asked to be aware of anyone in their part of the street who would need help in the event of an emergency evacuation. This information was passed on to the Anglesea Community Health Centre, where records of such persons are kept on file.

Volunteers were also asked to report, to the Shire's Fire Prevention Officer, anything in their own area of responsibility which might be a fire hazard.

Our town map was beginning to look impressive as appropriate streets in the volunteer network were marked off, after pamphlets were delivered. The bushfire safety message was being spread throughout Anglesea.

Some of us, bursting with our newly acquired knowledge about fire safety, were feeling capable of defending our homes to the last inch of our hoses, when the summer disappeared, to be replaced by the coldest January ever recorded.

Official accolade

On February 5th 1992, Ms Teri Whiting, the first woman ever to be appointed to the position of Deputy Chairperson of the Victorian CFA, attended a meeting at the Community House with two of her officers from the Melbourne headquarters. The purpose of the meeting was to examine and discuss the Patchwork project.

Our visitors examined the display we had devised, showing what had been achieved, which included the extent of our network on the town map and the logo design. Following the meeting, a media release was issued, expressing Ms Whiting's approval of the Patchwork project and her hope that it would be adopted by other parts of Victoria.

Beyond our local boundaries

Having been asked to spread word of our methods across Victoria, Patchwork has appealed to all Community Houses across the State, to become affiliated. Through the network of Community Houses, we are now communicating with specific areas. There has also been an article about our work in the Newsletter of the Rural Women's Network magazine.

In addition, our Shire Fire Prevention Officer was invited by Melbourne CFA to attend a meeting of Fire Prevention Officers from all parts of Victoria, where he spoke of Patchwork armed with our supply of information and visual aids. He reported back "the good vibes", following his presentation.

Legwork diplomacy

The Patchwork Bushfire Safety Project is based on an alliance between residents and their local Fire Authority. In Anglesea this has been a fruitful collaboration and we have begun to explore the possibility of facilitating similar arrangements in other localities.

This process begins with an approach to the Community Houses, who then contact their own local CFA. Some brigades may be uneasy at first, after all it is a new approach. There may even be some objection to the name "Patchwork", particularly if word gets round that Anglesea Fire Brigade received a phone call from somebody asking when the sewing classes would be starting!

Update

House to house deliveries of pamphlets will resume again in the spring of 1992. We plan to hold discussion groups during winter to address questions such as:

- Who could make you leave your home in the event of an emergency?
- Would you go, or would you stay? Why?
- If you would go, what would you take with you?
- On a Total Fire Ban day, what advice should be given to school children who go to school outside the township?

Having identified the questions, we plan to bring in experts to provide further information and advice.

Some people in this town who are still traumatised by the events of Ash Wednesday, refuse even to discuss it. This part of Australia is one of the most bushfire prone areas in the world. But well before the onset of the next bushfire season, we hope to be better prepared than ever before. We can't change our climate, but we can learn to live with the dangers it brings.

Strange to look back to that boiling hot day when I checked the holiday home across the road, to see if it had a hosepipe. If there had been one there, the Patchwork project may never have been.

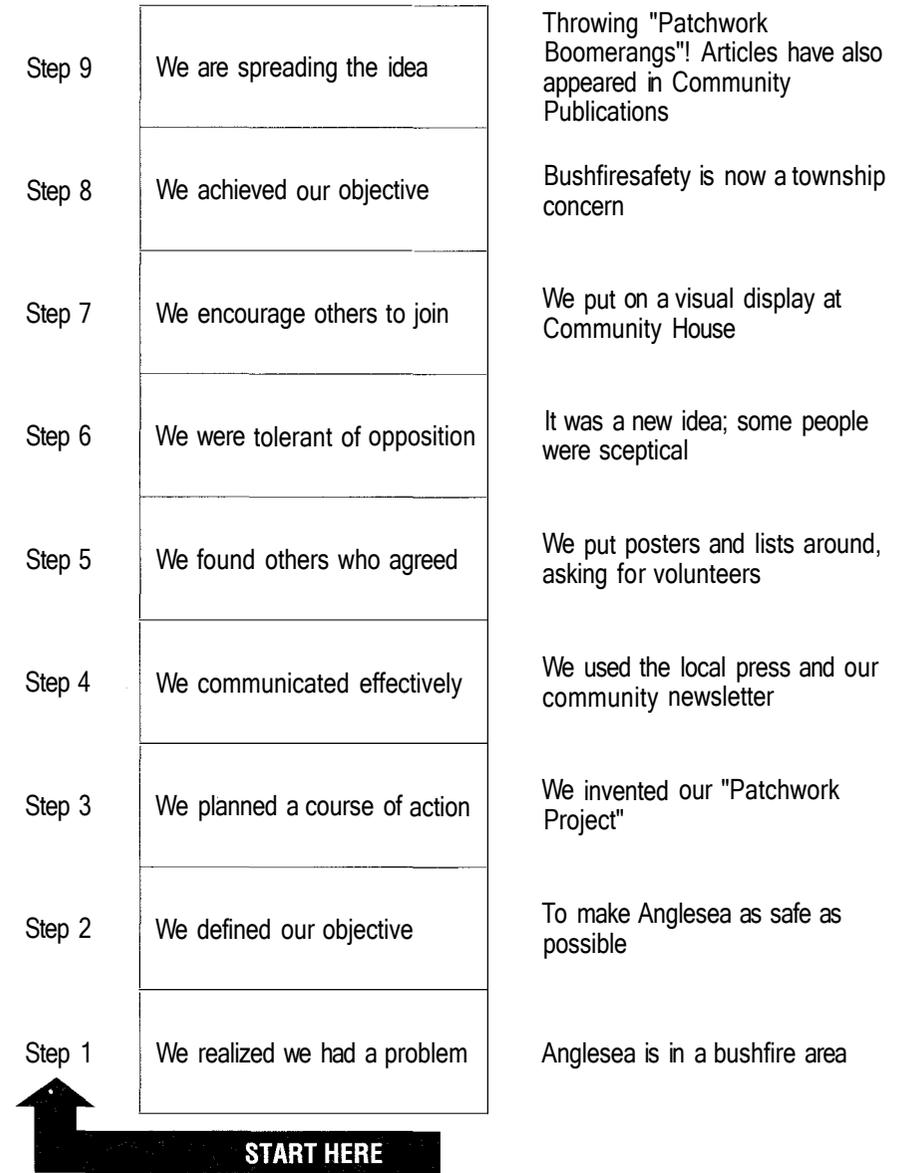
Postscript: February 1993

The Journal of the Health Education Centre, Barwon and South Western Region have published an article: "The Patchwork Project - A Legacy of Ash Wednesday". On the heels of this publication, that Health Education Centre asked me to participate in the Study Day at the Francis McKellar Centre, the day's theme being- "Programs that Work".

From start to finish there are nine steps in the Patchwork process. I feel that the nine step formula could be applied to any community project requiring the co-operation and support of residents. But the first and most important step, is to admit that a problem exists.

Anglesea Community House

How we made Patchwork work



2

*"The reality was that 'CORE'
had taken on big industry,
and that in industry and
government's scheme of things,
the rights of local residents to a
healthy and safe environment
were insignificant."*

Catriona Knothe

CORE - Coalition of Residents for the Environment

CORE - Coalition of Residents for the Environment

Catriona Knotlzc

Background

ONE of the first District Health Councils to become involved in tackling environmental health issues was the Dandenong and Springvale DHC. When I began working there as Executive Officer in late 1988, I found myself in the middle of their first project on environmental health.

Environmental health issues had not been prominent during the early eighties, and residents of Dandenong South had no history of being encouraged to participate in decisions affecting their own community.

The lack of community meeting places had also inhibited the development of initiatives by residents groups. The exception in all this was the Primary School at Dandenong South, which over the years had provided some focus for community involvement, through its efforts to support local families.

Profile of Dandenong and Springvale

These outer suburbs, 39k southeast of Melbourne, have a combined population of 140,000. While this part of Melbourne has pockets of affluence, it is ethnically diverse and predominantly working class. Dandenong and Springvale are home to seventy two different ethnic groups, comprising forty percent of the total population. Among the people who speak one of forty different languages, are large numbers who are struggling to make English their second language.

The concentration here of newly arrived immigrants - including refugees - is influenced by the location of the Enterprise Hostel in Springvale. On leaving the hostel, some groups prefer to remain in the area which has become familiar to them.

The "DOIZ"

A large number of manufacturing industries operate in an area of land known as the Dandenong Offensive Industrial Zone (DOIZ) based in Dandenong South. Where previously there had been tanneries, industries such as food processing now exist alongside high temperature toxic waste incinerators. Close by are houses and schools.

The concerns of residents in neighbouring Springvale about the likely effects on the health of their families, were taken up by the DHC as the

first environmental health project in the locality. A campaign against the expansion of a chemical plant was conducted and was successful in preventing further development which would have involved the storage of dangerous chemicals close to residents homes and parks.

This was the project which was underway when I commenced work for the DHC. When the report of that project was finally launched in June 1989, it raised the possibility of further local health issue targets. In doing so it highlighted a number of concerns residents had expressed about the Dandenong Offensive Industrial Zone.

"Healthy Localities" go green

Some impetus to address these concerns was provided later that year when the DHC was invited to join the Steering Committee for the City of Dandenong's "Healthy Localities" project. I became the DHC representative on that committee. Our brief was to identify a health issue of local importance and apply for a seeding grant to develop a submission for ongoing funding from the Municipal Association of Victoria.

With some pressure from the DHC and our informal links within the Council, the City of Dandenong chose environmental health as their focus for the Healthy Localities project. This provided the catalyst for renewed action and a new residents group called Dandenong Residents Action Group (DRAG), was established.

DRAG however was not the first group or agency which had concerned itself with the Zone. Its forerunner was a residents group called RAIP (Residents Against Industrial Pollution), which had been in existence for a number of years.

RAIP had been an active group, although in my opinion the group had not realised its potential to inform people of the pertinent issues in an understandable way. Furthermore, RAIP had managed to alienate people at different levels of government and statutory bodies.

Meet the key players

We carefully considered the venue for our first meeting which was held in July 1990, and chose the Primary School in Dandenong South. The school was well known to local families, since it attempted to fill the gap caused by lack of services and elements of its community out-reach gave it something of the function of a neighbourhood house. As well as this, some of its teachers who were Union members, were concerned about occupational health and safety issues.

Members attended from RAIP, DRAG, Springvale Community Health Centre, the Soroptimists (a local women's service club with an interest in environmental issues,) Dandenong Primary School Council, and Springvale Legal Service.

It was disappointing that no DHC representative came, and I therefore

became the Chairperson for the meeting. In the following months DHC's involvement continued to be restricted by the necessity for its members to fight for the continued funding of the DHC Program.

The key issues

The major issues emerging from the meeting were:

- the need for concrete understandable information as the basis for political action; and
- the recognition that the most effective avenue to political action (which would amount to a battle with the heavyweights in industry) was via the law.

The meeting recommended that we approach the Springvale Legal Service to provide us with the legal expertise we would need. It was also decided, that at further meetings, groups would be invited to send representatives in order to reduce numbers and maximise efficiency.

CORE

At the next meeting the Coalition of Residents for the Environment (CORE) was born. It comprised mainly residents who were members of the DHC, RAIP and DRAG, together with workers from the Springvale Legal Service and from the Springvale Community Health Centre.

The Springvale Community Health Centre had been involved with the DHC in the previous environmental health project and was seen to be a potential resource for the provision of medical and scientific expertise, in a community development context.

A preview of ongoing dilemmas

It was clear even at the original gathering of interested residents that everyone had a different level of understanding of the issues, which were very complex, and those people who considered that they had a better understanding were impatient to "get on with things". But it was not always the case that the so-called "Zone experts" were skilled at sharing information they had amassed, nor at mobilising people around the issues.

On the other hand many of those who came to the meetings had "stories", about things like horses with malformed hooves -and they were ascribing these abnormalities to the Zone. I thought it important to give these people a chance to tell such stories, although I must admit to feeling that things would have to get a bit more sophisticated if we were actually going to do something about the removal of dangerous industries. I realise now sophistication was not the answer.

Supporting CORE

I became one of the major resource people for CORE, together with a Community Project Worker from the Springvale Legal Service. This

seemed reasonable at the beginning, but we made it clear that our level of support would decrease over time.

I saw my role as assisting the group to remain focussed on what they decided to do. Given the complexity of the issues, I believed it was important for members of CORE to focus their energies on achievable objectives. I encouraged them to keep reviewing their activities in the light of their initial objectives. I also provided administrative support, for things like letter-writing and minute taking.

Women power

Shortly after CORE was formed, a woman from Dandenong South who was closely linked with the Primary School, phoned me on the suggestion of a Dandenong Councillor with whom the DHC had a good relationship. She wanted to know what she and other women living near the Zone could do to help. As she was reluctant to attend CORE meetings, I visited this woman and her friends. These women were not "Zone Experts", but they were soon to blow the issues wide open.

One of the women told me that she had heard a rumour that most of the teachers at the Primary School were transferring away from Zone. She had learned that an agreement had been negotiated between the Education Department and the Teachers' Union which included provision for early transfers of teaching staff.

Co-incidentally, a legal student from the Springvale Legal Service, who had begun to attend CORE meetings, had acquired some "leaked" information. This indicated that teachers from Dandenong South Primary School were indeed being transferred on the grounds of "anxiety over the possible risks of being near the Zone with its perceived health hazards."

Armed with this confirmation, the women had no trouble in getting local press coverage. The issue of the teacher transfers succeeded in getting the greatest political response thus far. The government advised that there would be a "health study" to examine whether or not there were health risks associated with living near the Zone.

Fall-out

Following the publication of this information, the school reduced its involvement with the Zone issue. My feeling was that the headmaster was under considerable pressure from the Education Department, since the school was about to lose about two-thirds of its staff, through transfers. This meant that it could no longer be called upon to act as part of the information network opposing development of the Zone.

CORE in action

By this stage three of the women who had been reluctant to join CORE, began to come to meetings. Again there were tensions because of different levels of understanding. At times I adopted an advocacy role

and got people to explain what they were talking about. One member in particular was especially verbose and would to allf confuse all of us. I encouraged people to confront language they didn't understand and to view it as a problem of the would-be communicators of information.

I found that although these three women who had joined CORE didn't think they had much to offer, they did talk straight from their hearts. At one point they decided to write a letter to the local paper about how they felt about the Zone, but they wanted me to check it. What they thought was an unsophisticated attempt to put their case, was in my view just what was missing from the whole debate. They needed me to say what they'd written was legitimate. I didn't have any trouble saying it was.

CORE was very active in the following months and one of the things continually energising the group was the involvement of the Springvale Legal Service. With encouragement, and a clear message from residents that they wanted legal help, the Legal Service set up an Environmental Task Group. This comprised law students, a solicitor, and a barrister who agreed to act for free. CORE would give the Task Group jobs such as researching whether there were any international laws that could be used, and the Legal Service would report back on progress at each meeting.

Toxic waste blocked

CORE had a major success early on, in its successful opposition - through the Administrative Appeals Tribunal - to a development that would have resulted in another toxic waste incinerator being installed at the Zone. This victory was important for CORE's profile in the community and for the Legal Service who were themselves breaking new ground.

Engineers and social health?

The City of Dandenong commissioned a report (known as the Kinhill Report) from an engineering firm on planning issues relating to the zone. The report barely acknowledged the obvious links between planning, zoning and people's health and safety. It was painfully obvious to residents that engineers have little understanding of public health issues.

Furthermore, residents felt that the City of Dandenong was out of its depth in the whole debate, and a puppet of the State Government's concerns to maintain industrial waste facilities.

CORE believed that it was critical to encourage residents to object to the Kinhill Report, and to encourage their local Councillors to see that they were being manipulated by the State Government.

Public meeting

With these things in mind CORE organised a public meeting. The networks we had established through the women living in Dandenong South, were invaluable in advertising this meeting and in mobilising petitions and letters to local government.

The meeting was well attended and it gave CORE members a feeling of accomplishment. They learnt a lot about holding a public meeting and also about each others skills.

Outcomes

Identifying and making allies was one of the strategies I encouraged the CORE membership to develop.

CORE was active in writing letters to the local media, to local, state, and federal politicians, to Unions who were potential allies (through Occupational Health and Safety concerns) and to the Olympic Committee (some water sports were to be held in water ways close to the Zone).

Dandenong Council also received many letters from residents who had attended the public meeting. Over time as a result of this informed pressure from residents, the Council became more responsive to their concerns.

While the action of CORE members contributed to changing the way Dandenong Council saw the issues, the impact on the State Government was much less successful. There were so many State Government bureaucracies involved, and none of them ever seemed to be sympathetic to the views of local residents.

The inaction of the Health Department and the Environment Protection Agency in particular, left residents with a cynicism I believe to be totally justified. These bureaucracies were clearly not committed to the development of a healthy and safe environment, despite their rhetoric and attempts to put the "con" into consultation.

CORE realises its strength

It was becoming obvious to CORE members, that taking on big industry would be a legal minefield, and if this was to go ahead, individual members would need to be legally protected. With the help of the Springvale Legal Service, CORE therefore set about becoming an incorporated entity.

Scientific expertise, was seen as complementary to legal assistance, and CORE attempted to negotiate the involvement of students from post graduate environmental studies at a large university. This worked well until one of the students in the proposed multi-disciplinary student team, became worried about his current and future employment with the EPA. The student proposal folded.

What price the government health study?

The question of CORE'S attitude to the health study the government had promised to carry out, caused some debate in the ranks of CORE membership. The DHC, myself included, opposed this study on the grounds that it would be used to prove that there were no health risks

associated with the activities which CORE was opposing. We felt that epidemiology would undermine the resident's case, rather than support it.

We discussed our reservations with CORE at length, and although CORE continued to support the study, they advocated strict guidelines. This was a good example of the way in which through sharing information we were able to influence outcomes. In this instance it led to an increase in the understanding of the complexities of epidemiology.

Decision making in CORE

Those who had been involved in the issue longer, tended to be the group's decision makers when the group first formed, but as new people became more confident, there was more debate. As a paid worker, I had considerable power to influence decisions because I had the time to gather lots of information, but it is not always simple to maintain the flow of information. There are fluctuations depending on your workload - you may have to miss a meeting or you may simply forget to tell people things.

My own role in the decisions made by the group, was an ongoing issue. Whereas I was prepared to advocate various positions, I did not think it was appropriate that I should vote on them. CORE members, however, wanted me to vote, as did the other worker from the Legal Service.

Another related issue was sexism. It was mainly the men in the group who had most information about the Zone, and some of these men were threatened by women in the group seeking to become more informed. This became even more complicated when personal animosity confused decision making, although this was never overt.

Group confidentiality

A major issue in group development arose when we found that one member was sharing information which we had agreed was confidential, with people in government departments (Local and State). This was not a malicious act, but arose because this person did not always support the line that CORE took and thought that CORE was being unreasonable.

CORE members became very concerned about this lack of confidentiality, with a number contacting me for advice. I suggested that as a group, CORE needed to review the roles and responsibilities of members, and this was done. The responsibility to maintain confidentiality was reiterated at a meeting; people were not to speak on behalf of CORE, without the prior approval of other members.

Achievements

In May 1991 I left the DHC and so my involvement with CORE ended. During the ten months of my association we had accomplished a lot and CORE had come to be seen as a group with some power, both by its members, and by some levels of government.

CORE was successful in four major ways:

- it helped stop the installation of another toxic waste incinerator;
- it mobilised a wide network of residents to act in a co-operative way;
- it was influential in changing the views of the Dandenong Council, so that it became more receptive to the views of residents; and
- it was a catalyst for the Springvale Legal Service to become active in environmental advocacy.

Frustrations

CORE'S major frustration was its inability to make a substantial impact on State government laws and processes which determined the planning and management of the Zone. Its failure to change these processes meant that in the future, every new unpopular development would have to be freshly fought, which situation - over the long haul - will usually defeat a resident action group.

Spin-offs

There were two other projects, which I assisted the DHC develop but which were implemented after I left. They were spin-offs from our involvement with the environmental health issue.

The first project involved the women in Dandenong South who wanted more information on technical aspects of chemicals and chemical processes associated with activities in the Zone. To meet ^{the} need we developed a full day workshop, with assistance from an institute of technology, which covered basic information on chemicals and chemical processes, toxicology, and epidemiology.

The workshop also included a section on "talking with technical people", which explored things to say to people who try and baffle you with science. So as well as providing technical information, we encouraged residents to insist that the "experts" speak to them in language that can be understood by non-experts.

The first of these workshops was so successful, that the second one was stacked with staff from companies based in the Zone. In their wisdom, the companies had come to realise that it was in their best interests to discover what the residents were learning about their operations and intentions.

The second project was the translation of the very legalistic planning process into consumer-friendly language. As the planning process stands, it is stacked against resident participation. One way of improving consumer's capacity to be involved in planning decisions that will affect them, is to provide information on how consumers can use the system.

Dilemmas for the community worker

I felt that my role was unclear to some CORE members, who wanted me

to participate equally with them, in making decisions. In retrospect I probably supported them too much, but I also wonder what would have happened without that support. I continually find this dilemma in my work - how much do you take on?

A worker's input can be very important but the trick is to be very clear about the reasons for your involvement, and its extent and duration. Beyond this the worker has to know how to transfer the skills and expertise that might be needed to sustain the project or initiate new ones, and indeed be certain that this transfer occurs.

A major dilemma I had at the time and which persists in my work, is the question of how the worker's input and intervention to ensure a group stick to its objectives, may actually dilute what the group is on about and what may be its energy and strengths. As workers with health or welfare training and with work experience we carry "baggage" about with us. This baggage can determine how we see problems and how we see solutions. We have to acknowledge that our own perspective may not be productive, and nor is it the only one possible.

Since I have left CORE, I understand the group has struggled to survive. As community workers, we have to acknowledge that we leave but the issues remain. The more we control the definition of the problem and solutions, the less will happen. When we leave, where does that leave the people we think we have "empowered"?

Were the issues scientific or political

In examining my contribution to the group I have wondered whether I might have been more effective had I possessed more scientific expertise about environmental health matters. It is possible though, that debating the technical issues may have distanced me from the reality of resident's concerns and clouded the fact that in the final analysis the Zone was a political issue, involving resident's rights to be informed about the health issues in their immediate environment.

I see now that technical information and "facts" are only a tiny part of a community worker's "bag of tricks". Our most important role is in mobilising political will. Votes count much more than facts.

The threat to the DHC Program's funding was a difficult context in which to work with CORE. The DHC knew that our involvement was politically sensitive at a time when we needed government support. Despite this, the DHC Committee stood firm in their belief that it should be involved in environmental health issues, since these issues had top priority for people living in the area. I did however, under DHC direction, make an effort to stay out of the public arena (eg not go to demonstrations). This probably strengthened CORE members' sense of their own autonomy.

What you take when you go

One of the most rewarding experiences that came out of my work on this

project was the relationship that developed with some of the women who lived near the Zone. These women were so clear about what they wanted and what they felt. Even though they went on to learn about" some of the complex issues associated with the Zone, the bottom line for them was that their families were suffering.

This relationship reinforced a theme that has been consistent throughout my time in community development: when other workers, or governments, or funding cuts, or boring administrative tasks get you down and seem to dominate the job, get out and work with the real world.

3

"The significance of natural networks in this conversion of the House Party into a Buddhist healing ceremony, cannot be overestimated. Since the origins of this woman's illness lay in her break with the beliefs and practices of her own culture, her healing could only be effected through the restoration of links with her own community."

Khai Wong

the house party - study 1

the house party

Khai Wong

The Malaysian experience

AFTER completing a degree in psychology at London University, I returned to Malaysia to find there *were* very few job opportunities in that field. However there was no shortage of work in the refugee camps, so I decided to get some training as *a* social worker in one of them. Planning to stay six months, I stayed ten to see through a commitment I had made to *a* communal garden project.

This period in the refugee camp completely changed the orientation of my work. It was here that I witnessed the way people can utilize the support available in their natural networks to help them make decisions. It was also in the camp that I met Australian Embassy staff who suggested that my experience working there might stand me in good stead for *a* job in Australia.

My application for residency involved a waiting period of four years and during this time I joined the Federation of Family Planning Organisations which is now an affiliate of the international network of Planned Parenthood Associations. It was here that I first encountered the House Party strategy.

I accompanied the Federation's field worker on trips to Malaysian towns and villages, where her first initiative was to discover a person willing to host a small gathering of friends and neighbours in her own house.

In this "tea party" atmosphere, she talked to the guests about their everyday lives in terms of their expectations and responsibilities for the life of the family. Inevitably the conversation touched on the burdens of unspaced families, giving her an opening to introduce the subject of contraception.

Muslim culture and custom forbids the use of contraception, but the relaxed atmosphere of the House Party made it possible for these Malaysian women to share experiences and to acknowledge each other's difficulties.

In this environment the field worker was able to explain various birth control options, empowering these women to make informed choices about how they might ultimately take control of their reproductive health.

I was impressed with the way they were able to share intimate details of their relationships within the family. It seemed to me that as *a* social arrangement, the House Party, which had none of the threatening clinical or judgemental overtones associated with more formal learning contexts, might be the key to reaching isolated communities.

Melbourne's inner suburbs

Several years later when I finally settled in Melbourne, I applied for a position at Fitzroy Community Health Centre as the Ethnic Access Worker. The job description attracted me through its emphasis on multi-disciplinary teams and its brief to identify the health needs of diverse populations.

On the day of my interview I walked around the neighbourhood with its high-rise flats, feeling I could relate to this environment, and given my confidence in creative counselling (though I am not trained as a professional counsellor) I was convinced that I had come for the right job.

I had been given some material about the programs initiated by Centre workers and was excited to find how much their philosophy and practice matched my own. All these things persuaded me to advocate the House Party as the strategy I would choose to use in my outreach work in that community. The Centre's response was positive.

The need

I was required to assist the non-English speaking community of Fitzroy to use the Centre's services. Until this time the Centre had not attracted many people from the diverse number of non-English speaking communities housed in the Ministry of Housing estates or in private housing in Fitzroy.

In particular, the population of the Atherton Garden's Estate (a large high-rise public housing estate in South Fitzroy), comprised many communities from different ethnic backgrounds - Australian, Chinese, Turkish, Hmong, Vietnamese, and other low-income and minority groups.

December 1986 figures showed nearly 80% of these residents to be people from a non-English speaking background, but the percentage of ethnic clients using the Centre was much less.

When I took up my job as Community Health Worker with an Ethnic Access focus, I learned that there had been very little participation by people from these communities in the Centre's sessions on women's health. Clearly a priority of my work would be to intensify outreach strategies which would link people to such programs.

Access and linking

The physical nature of the high-rise flats creates an environment where people can be more isolated than they would be in other circumstances. This situation is intensified for refugees and immigrants who have been separated from their natural networks and whose whole way of life has been disrupted through migration. In these circumstances people are easily rendered disempowered and disenfranchised.

For these reasons the process of "access and linking" needs to utilize the mutual support inherent in their natural environment and natural networks. The House Party processes can effectively link workers to the targeted community, the community to the worker, community members to each other and the community to specific projects.

It is important however for the worker to maintain the link and access initiated by the House Party and this should be followed up according to the needs identified within the House Party itself. It may *be* that members of the group would benefit from being linked directly to the Centre's services and *for* other agencies.

The process

The Ethnic Access worker identifies a "satisfied" client with whom she has had previous contact, in order to motivate the client to host a House Party meeting at her home. A satisfied client is one whom the worker has assisted with a problem and with whom she has established rapport and trust.

A satisfied client may be identified through your own casework, co-workers casework referral or - in Health Centre language - "hanging around". You may, for example hang around while mothers collect their children from school and making yourself known to some of them.

This client will be the host or hostess for the House Party and is then briefed in detail by the worker about the intended purpose and content of the House Party session. This involves encouraging the host to bring together people from her network, and clarifying whether other clients known to the worker could be linked to the party.

The subject of refreshments and the reimbursement of costs is discussed, and the decision made as to whether this is to be the responsibility of the host or the worker. When the date and time is arranged for the session, printed invitations are distributed to potential participants, about a week in advance, by the host and/or worker.

It is the worker's responsibility to arrange appropriate staff and an interpreter for the House Party session. On the actual occasion, the worker collaborates with the host to ensure that the environment in which any discussion takes place remains informal and supportive.

In our experience of House Parties conducted through the Centre, participants may raise issues of importance to them which cannot always be addressed adequately on the spot.

One such example of this was a party with some Vietnamese women who raised concerns about what to say to their children when they raised issues which highlighted contrasting notions of parental discipline between their own and the mainstream culture. Clearly such large questions cannot be addressed in one session. In this instance the group was linked to Parenting sessions at the Health Centre.

Questions which may facilitate the identification and clarification of such issues should be prepared in advance, in consultation with a worker from an ethnic background, who is sensitive to the cultural issues at stake in such conflicts. Such questions are therefore framed in terms which are culturally relevant to the members of a particular ethnic community. This task is integral to the House Party preparation.

The House Party itself involves the following procedure:

1. Briefing session with interpreter;
2. Introduction and warm-up activity;
3. Explanation of the purpose of the session;
4. Group interaction;
5. Identification of issue(s);
6. Conclusion and refreshments.

During my employment at the Centre, the House Party strategy was adapted to many purposes with the objective of bringing members of ethnic groups, who were previously remote from the Centre's community development objectives, within its ambit. Among these were sessions which linked the Vietnamese, Chinese and Hmong communities to the Centre's Nutrition project. Still others, facilitated access to the Centre's Parenting Program, a Vietnamese Youth support group, the new Dental Service and a Vietnamese Women's Domestic Violence Support Group.

One of the most valuable assets of this strategy is its adaptability. This capacity became apparent in my work with a Khmer woman in the example which follows.

Kampuchean house party

Cultural beliefs influence the way we communicate our health problems. This includes the way we present symptoms, when, where and to whom we go for care. Since we learn ways of being ill according to our culture it is important for health workers to understand culture and how it relates to "mental illness".

It may sound like a misnomer to call an occasion which was designed to address the complex "symptoms" experienced by a young sole parent from the Kampuchean community, a "party", but the occasion was experienced by all who were present, as a form of celebration.

I will refer to this woman as "K" to protect her privacy. K arrived in Australia in the eighties, via a refugee camp in Thailand. A refugee from the Pol Pot regime, she had left Kampuchea with a group of people, including a friend who became ill on the journey to Thailand.

During her childhood, some small gold pieces had been implanted in K's arms to provide her - in the Buddhist tradition - with spiritual

protection. She had these removed in the refugee camp to buy food for her sick friend.

I had already met K at the Centre, through her request for assistance in finding accommodation, when I was invited to accompany the Centre doctor on a home visit to her. He had been advised by the Infant Welfare Sister, that K was suffering from post-natal depression following the birth of her daughter.

At the time K's marriage had broken up and she was struggling financially and emotionally, to support a family which included two older children. She had no relatives in Australia, and believed the absence of an older woman during her confinement opened the way for evil spirits to enter her body at the birth.

After several meetings with K, I began to feel strongly that the origins of her disadvantages, were cultural and spiritual. Beliefs and experiences associated with her upbringing in an extended family with strong Buddhist traditions, and with her perilous escape from Kampuchea, had placed her under excessive pressure, which she could not be expected to manage in her present isolation.

In the Buddhist belief system, it is not safe to live beneath other people, and K's flat in the high-rise estate had two further levels of accommodation above it. Inside her own flat she was always conscious of the wrongness of this arrangement, which she experienced as a heaviness (depression) on her head, which only lifted when she left the flat.

A number of her own actions also troubled her. She had given up going to the temple which was too far away, and she had not been praying in her flat, believing it was inhabited by malign spirits who had taken control of her life. She attributed her physical symptoms (dizziness and weakness) to these antagonistic influences.

What struck me listening to K's stories, was that she had developed the superstition that it was her personal circumstances that forced her to discontinue her Buddhist practices, that may be bringing her bad luck in Australia. She had at one stage, consulted a Khru Khmer (healer) for treatment for a facial mole which then worsened. This outcome convinced her that this person was a false practitioner. At that point she threw away some religious images and her altar to the Buddhist deity.

I was convinced K was suffering from the effects of severe cultural dislocation and grief associated with post-war trauma rather than any post-natal psychosis. Since the gold was removed she had lost the spiritual power in her body. The cure for this condition did not lie in chemical palliatives but in the healing networks of her own community.

Sadly, what K had unwittingly relinquished, when she disposed of the ritual objects of her faith, was the spiritual connection with her upbringing - the basis of her confidence that she was a fit person to care for her own children.

Therefore, when K finally moved out of her flat - leaving the evil spirits behind her - we exploited the Buddhist custom of blessing a new dwelling and held a House Party coinciding with the first birthday of her baby daughter.

On this occasion a Buddhist monk conducted "Baci" ceremonies which invite the spirits to bestow good wishes and happiness on all present. K's guests included her children. We were also joined by an Australian doctor, whom I had invited, knowing him to have made a study of AswN beliefs and to have incorporated some of these elements into his Western medical practice. To my amazement he was so attuned to the meaning of the occasion, that he spontaneously knelt with the monk in prayer. This from a white man!

The House Party amounted to a healing ceremony, validated through the participation of members of K's own community, including her own children. As I had hoped, this had profound repercussions for her confidence as a mother and for the family's renewed identification with their own community.

K demonstrated the need for a Health Worker to be aware and sensitive to cultural issues involved in relating to "mental illness". If we had used a Western diagnostic framework, we would have labelled her as suffering "psychotic depression" and may well have followed the social worker's advice to seek a child protection order and taken her baby away.

The significance of natural networks in this conversion of the House Party into a Buddhist healing ceremony, cannot be overstated. The origins of this woman's illness lay in her break with the beliefs and practices of her own culture, her healing could only be effected through the restoration of links with her own community.

Domestic violence support group

Although there had been a local ethnic health worker at the Centre, who had encouraged Vietnamese clients to use the counselling service for financial and accommodation problems, there had not been specific counselling arrangements for people from this group who were currently experiencing domestic violence, or the after-effects of separation from violent partners.

However, such a group was functioning for "mainstream" clients, and we decided to run equivalent sessions for the Vietnamese women. We asked for briefing sessions from the workers who were running the mainstream Women's Support Group, as a prelude to using the House Party strategy to network the Vietnamese women together.

Our first session, where we hoped to motivate the women to talk, attracted ten women, who wanted to continue meeting as a group. They were however understandably nervous about meeting in any one

person's domestic environment so we subsequently conducted our meetings at the Centre.

To encourage examination of personal situations, we introduced a set of headings called the "3 P's", which was found to be effective in the Women's Support Group. Issues of safety, self-esteem and confidence were examined through a consideration of "Personal safety," "Tampering", and an account of anything the women were "Proud of".

In discussion with the Women's Support Group workers, we considered who we might approach to provide the Vietnamese women with culturally relevant support. Over a period of four months we ran eight sessions, during which time we invited a speaker from the Fitzroy Legal Service and a Vietnamese woman psychiatrist, knowing that doctors in the Vietnamese social system have very high status.

The session with the psychiatrist is interesting for the way it uncovered some of the complexities of ethno-specific involvement in development work. The psychiatrist talked to the women about the prevalence of domestic violence in the Australian Vietnamese community, compared to Vietnam. This very factual talk culminated in her conclusion that the women should not have left their husbands.

The women responded by telling her that having made the move away from their husbands, they had no intention of returning. The doctor was very surprised by this. She asked me if I was "splitting up families?", implying that I may have underestimated the importance of the family in Vietnamese culture.

But I had been working with a team of people who think very differently and whose practice gives social control "solutions" a wide berth. Listening to these women it was clear that for them the health issue was their survival following the decision to abandon their violent relationships despite their anxieties about the social stigma of being sole parents and its effects on their children.

This session led me to the realization that there is more to effective counselling than being an "ethno-specific" worker. In the final analysis what counts is a person's sensitivity to the wishes and experience of her clients. As an Ethnic Access worker it is not enough for me to be familiar with cultural traditions. I need also to be flexible enough to be comfortable with the issues as defined by people themselves.

The psychiatrist explained that most of her own case work was with people in marital conflict. Thus she was offering these women counselling.

They did not, however, accept the doctor's offer of counselling realizing that her agenda would involve the restoration of their marriages and a return to the possibility of further abuse. It was clear the House Party had provided them with information which they chose to use for reinforcement of the decisions they had already taken.

Youth house party

The Fitzroy Council had been conducting a Social Issues Forum, which for some months had been considering how best to address the needs of Indo-Chinese youth. I proposed using a House Party as a way of making direct contact with these young people. A colleague, who worked as the Council's Leisure and Arts Officer, was keen to participate.

We hoped with the first party to create a link with a small group as the first step to building stronger communication between them and the Centre. Our primary interest was to discover their needs and concerns and what they saw as possible courses of action.

I spent the afternoon before the party with two of the young men who were to be hosts. They invited several friends to their high-rise flat, which seven of them shared. Their enthusiasm made me confident that the party would work. They were not attracted at all to any possibility of making this merely a social occasion - they wanted to use it as an opportunity to hold a more formal meeting. We structured the party accordingly.

Thirteen people were present, including two women from a local Vietnamese women's hostel. This made quite a crowd in the small living room and at first there was a feeling of nervousness and embarrassment. Not everyone spoke English, but people relaxed enough to talk freely about how they felt about living in Australia, and with a little interpreting help from each other, communication was quite good. A number of concrete concerns surfaced - with much clarity - in the discussion.

Issues for Vietnamese Youth

1. The need for English classes outside working hours.
2. Frustration at racist comments. Their desire to be accepted as Australians. (One girl commented that she felt "more Australian, than Vietnamese.")
3. Confusion about what was acceptable social behaviour to the mainstream culture, eg. the physical expression of affection between males, brought forth "poofter" insults.
4. Frustration at the lack of single Vietnamese women (It is easier for men to leave Vietnam than for women).
5. Loneliness and isolation/depression due to lack of family in Australia. Worries about their family back home. Ignorance of how to sponsor would-be immigrants, or deal with rejection of such applications.
6. Not understanding the law and their rights in Australia.
7. Mixed reaction to a proposal to set up an Indo-chinese Youth Club. Negative responses focussed on the likelihood that this would further

isolate them from the rest of the community, which was a problem since they enjoyed "all the same sorts of activities as Aussies".

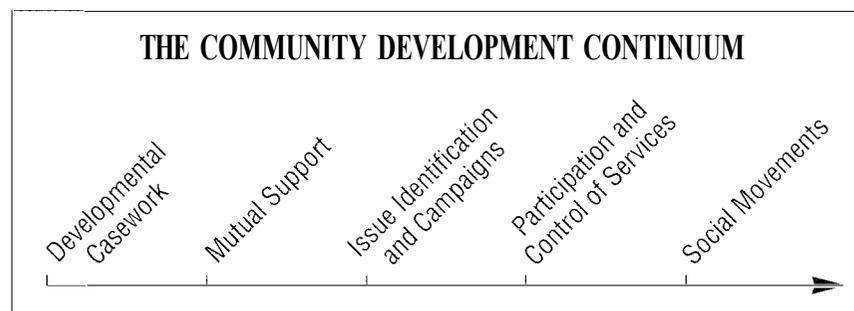
8. Interest in attending the Fitzroy Community Youth Club, though some who had done so, mentioned "feeling different/not belonging".
9. Concern that they were labelled a gang which the seven who lived in one flat adamantly rejected. They explained their reliance on each other for friendship and support. (This was obvious throughout the evening.)
10. Concern about finding jobs. None of them had heard about the Department of Education and Training or its Skillshare program.
11. No awareness of the existence of Vietnamese community workers, or local activities in which they could participate.

The group wanted to get things rolling for themselves and were keen to meet again. The party was immensely fruitful in identifying issues of concern to these young people, and through further House Parties we hoped to link them to local agencies which might answer some of their particular needs. The next House Party would involve someone from the Youth Club, the Legal Service, Skillshare and myself.

Community development

At Fitzroy Community Health Centre, we emphasized the need for outreach work, that is, overcoming the temptation to remain Centre-based and wait for people to come and see us. We found that through working with community members on their own territory we could hand back some of our professional power and develop a better understanding of the natural networks within the community.

Working to develop mutual support included strengthening family, friendships and neighbourhood networks, linking isolated individuals into existing social groups, or when this was not possible, forming new social groups on a self-help model. It entailed helping people shift their safety net from dependence on the unequal power relationship of caseworker/client to a more equal base amongst peers.



The community development continuum

The Community Development Continuum summarizes the philosophy which developed out of four years of community work by community health workers at Fitzroy Community Health Centre.(1)

Hmong community

Insofar as the Continuum describes "progress toward control over larger and larger realms of life", I found it a valuable tool for examining the achievements and potential of the House Party strategy.

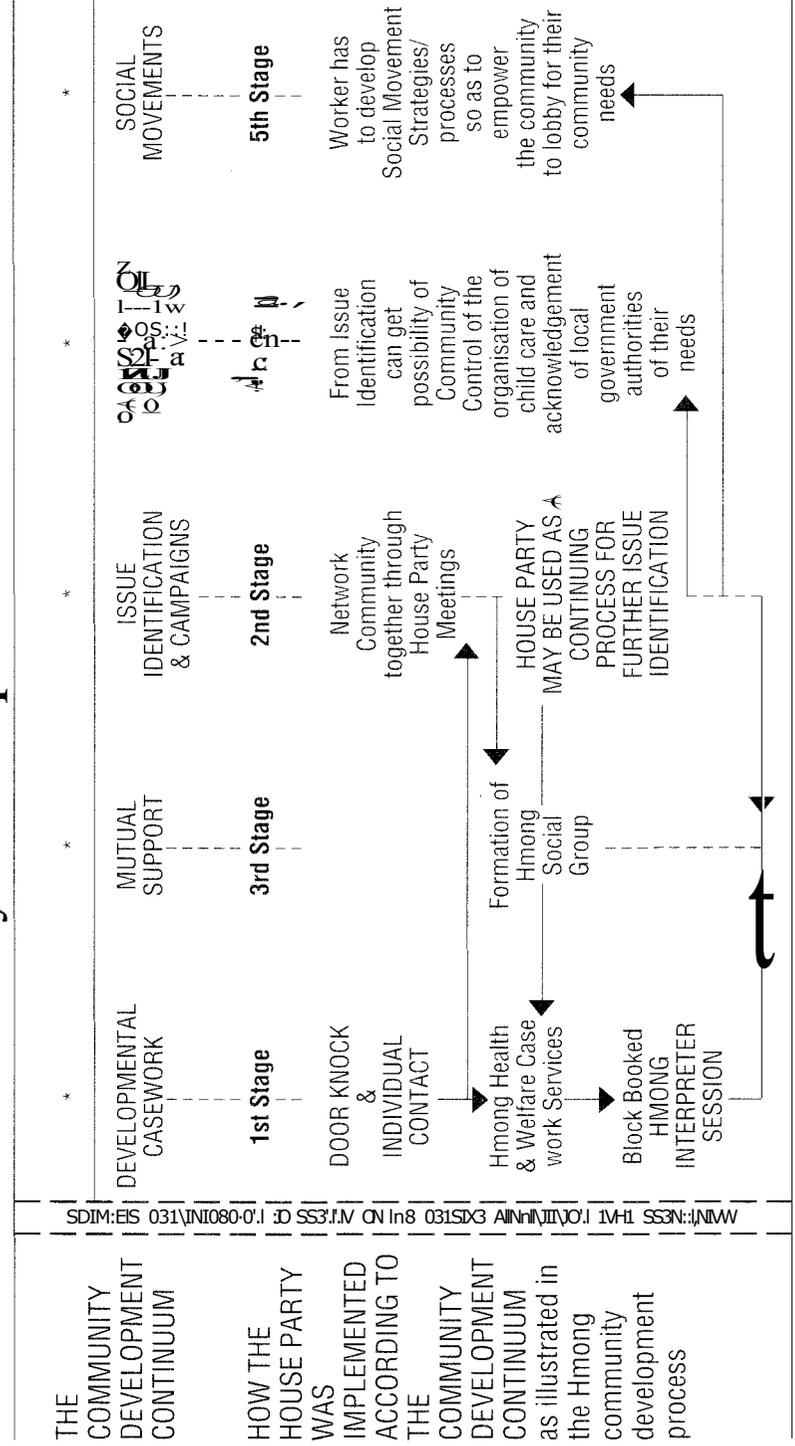
This can be illustrated in the case of my work with the Hmong community which developed into a low-key campaign to allow the community to be heard. Since this group had previously been so isolated, the party strategy was an excellent way of gaining access to their members in a familiar environment, without pressure. Other environments such as street marches and high profile campaigns would have by-passed the needs of this neglected community.

Their first House Party revealed that there were no Hmong-speaking community workers to assist members of that community.

Since this issue was a major stumbling block in the way of their access to information and services, I set about facilitating the placement of a Hmong-speaking bilingual worker to assist with the provision of a limited health and welfare service. I also lobbied the case for Hmong interpreters with the Central Health Interpreter Service and other government agencies. A mainstream worker from the Centre became engaged with the community on issues of child care.

The processes enabling change essentially derived from within the Hmong community. All these operations moved the Hmong community along the community development continuum, as can be seen in the diagram below.

The House Party Strategy within the Community Development Continuum



Conclusions

The House Party program provided effective strategies for reaching out to ethnic communities on behalf of the community development goals of the Fitzroy Community Health Centre.

The House Party processes facilitated:

- the creation of a *more* informed climate surrounding the Centre's services and activities;
- the involvement of communities with their natural networks;
- the building of trust in a comfortable atmosphere, in contrast to public meetings;
- favourable conditions for the identification of issues of pressing concern to community members.

My experience confirmed that this networking strategy is a culturally relevant way of reaching out to people from ethnic communities, especially non-English speaking women who are housebound and isolated.

Beyond this, the worker is rewarded by the opportunity to learn more about the community in which she works, at a deeper level than is possible in more impersonal settings.

1. From "The Community Development Continuum", Terri Jackson, Sally Mitchell and Maria Wright. Paper presented at the Second National Conference of the Australian Community Health Association, 15th April 1988.



"As an outreach strategy, the House Party Program has been particularly useful in Prahran in making initial contact with isolated groups from non-English speaking backgrounds."

*Sida Douglas,
Joanne Hackett & Kathie Walsh*

the house party - study 2

Sida Douglas, Joanne Hackett & Kathie Walsh

Profile of Prahran

THE social and economic demography of Prahran covers the broadest possible spectrum. It has one of the largest inner urban Ministry of Housing estates - mostly made up of high-rise flats in South Yarra, Prahran and Windsor - yet some of Australia's most expensive real estate can be found in this municipality, in South Yarra and Toorak.

It therefore follows that the services offered by *the* Prahran Community Health Centre must be targeted to those in greatest need, or "at risk" individuals and groups in the community. One such group are people from non-English speaking backgrounds.

Who lives there

People from non-English speaking backgrounds make up 21 % of Prahran's population. They speak more than 50 different languages, and many have settled in Prahran as new arrivals to the country, often as refugees.

In order to best *meet* the needs of people from non-English speaking backgrounds, and to co-ordinate resources and activities for the provision of services to these people, the development of a Multicultural Policy and Strategy was undertaken as a major Health Centre project in 1991.

An important element of the Multicultural Policy and Strategy was the identification of access and equity issues for people from non-English speaking backgrounds in their use of health and welfare services (specifically regarding access to the Centre, as well as more generally to other services), and the subsequent strategies that could be adopted and adapted to address these issues. Some of the strategies proposed were new, requiring development, while others were tried and *true* programs, services and activities developed and used successfully by other community health centres.

One such successful strategy used by the Fitzroy Community Health Centre for several years with different language and cultural groups, was the House Party Program.

From commerce to community

The House Party Program is similar to the "party plan" used in the commercial sector to sell a variety of goods (eg cookware, glassware, clothes, cosmetics, garden products). In fact this method of selling has been used to sell almost anything in Australia for 20 years or more, even sexual aids.

Used in the community sector, there is no selling involved, but the model is similar in that:

- party hosts and workers are known to each other, though the nature of their connections can vary greatly. The host and the worker may have had a worker/consumer relationship for some time, or they might have been introduced by another worker. What is significant is that some trust and rapport are already established.
- participants are all known to, and have been invited to the party by the host;
- the party is small, informal, and held in the host's home;
- participants are all known to each other, or they at least have some common connections;
- apart from the business at hand there is also a degree of fun and socialization involved, including the sharing of food.

The House Party Program differs from the commercial model in its purpose. Used by a community health centre, any number of health or welfare related issues can be placed on the agenda. Some examples, drawn from the programs implemented in both Fitzroy and Prahran, are:

- information on services provided by local agencies (eg local government, neighbourhood houses, housing services);
- the Telephone Interpreter Service and how to use it;
- contraception and reproductive health;
- linking people/groups to other programs and services (eg parenting groups, a domestic violence support group, family planning services);
- provision of specific services (eg back care and women's health);
- information on citizenship and voting rights.

Achievements

As an outreach strategy, which can be modified and changed according to particular groups and their identified needs, the House Party Program has been particularly useful in Prahran in making initial contact with isolated groups from non-English speaking backgrounds. It has also been successful in linking people and groups to a variety of local services thereby addressing some of the known problems and concerns around access and equity for these people.

Finally, it has been an important community development strategy. Some local groups have gone on to become autonomous - providing important social and educational services to their own communities, securing local funding to support their own cultural groups and activities, accessing local agencies and workers to provide services as needed and required.

Setting up the House Party program

Joanne Hackett

As the final year social work student on placement at the Health Centre in 1991, my community development project was to pilot the House Party Program in Prahran, running four parties over a period of 15 weeks.

The Program had already been identified as an outreach strategy to address the rights of people from non-English speaking backgrounds to:

- have access to information and resources about local services in Prahran;
- make informed decisions about their health and well being;
- have accessible and culturally relevant health services programs and resources provided.

Preliminaries

My work began by contacting local agencies and ethno-specific workers to narrow the target group down into more specific language and/or cultural groups.

Making contact with known community leaders or gatekeepers is the first step towards getting a House Party up and running for these people are the most likely to host a party. This initial contact might be through either direct service or client work where a relationship of trust and rapport has been established, or via less formal relationships. For example, where workers and local people are known to each other by their attendance at a local neighbourhood house.

In Prahran, making links with community gatekeepers was easier when there were also ethno-specific workers in the area - workers who shared a common language or cultural background, and who were already providing some services (usually casework) to these individuals/groups. Access to the most recently arrived, who were often also from minority ethnic/ cultural groups and for whom the provision of ethno-specific services was unlikely, proved much more difficult.

English language classes proved to be a good starting point, as did other non-language specific activities, such as information sessions at a maternal and child health centre.

By utilizing the introductions made by ethno-specific workers and making myself known at local English classes, trust and rapport began to be built.

As the likelihood of running house parties became more of a reality I began to collect information on what the content and purpose of the parties might be.

Initial barriers

Two issues identified early in the process were the lack of access to

services because of language barriers, and knowledge about what services are actually provided at local agencies - and if in fact people from non-English speaking backgrounds were welcome to use them.

I felt the need to resource myself in terms of the particular cultural groups I was working with - making myself aware of the cultural norms - the do's and don'ts. I read whatever health and welfare literature was available, and I talked to a variety of workers, both ethno-specific and mainstream, about their experiences in achieving ethnic sensitivity.

After local networking, finding hosts and resourcing myself, all of which took nearly ten weeks, I was ready to start running a few parties.

Accommodating realities

The next hurdle to overcome was the venue. Holding the parties at hosts' homes was not as straight forward as first imagined, and we found in Prahran that we needed to be flexible in our definition of a House Party.

For several groups it was not practical or appropriate to hold a party in their own home. For example, with a group of elderly Russian people living in high-rise bedsitter flats, holding a party at home was out of the question. In such circumstances other more suitable community venues were located and utilized successfully.

The use of other community venues also proved beneficial in terms of organizing childcare; children could be supervised close by in appropriate accommodation, thereby enabling their parents to fully participate in the party.

All in all, being flexible about venues did not prove to be problematic as community facilities, with which groups were familiar and comfortable, served just as well as people's homes.

The interpreter problem

Organizing interpreting services was the last major task to be completed before a party could be run. The availability of interpreting services was sometimes problematic. For example, when a woman interpreter was needed for a women's health program there was no-one available for three weeks.

Another issue which occurred when using interpreters was the concern that what was said in groups would be spread throughout that particular community. This is not a reflection upon the interpreter services provided, but rather it stems from a deep mistrust often felt by those people who are new arrivals and whose past experiences with officials has been far from positive.

Having the services of an interpreter who is liked, respected and trusted by a community is therefore vital for clear communication. This is even more true and important when the worker does not share a cultural background with the group.

The lack of translated material available in some languages also proved problematic. Some groups, particularly small minority ethnic groups, expressed a heightened sense of isolation when they learned of the amount of information translated into some languages, but not into their own.

Variable success

In six months from September 1991 to February 1992, workers and students at the Centre worked together to run parties with the local Laotian, Russian, Cambodian and Vietnamese communities, with varying degrees of success. Accounts follow which reflect on the most effective house parties - in the Cambodian community; and those which were least successful - in the Vietnamese community; attempting to account for these differences.

A success story

Sida Douglas

The Cambodians were one of the target groups since they came to Australia with the status of refugees, and were one of the more recent groups of new arrivals.

Prior to my appointment at the Health Centre in November 1991, some initial contact had been made with Cambodian people in the area by Joanne. This contact had been facilitated by an ethnic health worker employed by a nearby community health centre who was providing support to several Cambodian families in Prahran. I soon followed up these initial contacts, and by the end of November one woman had agreed to host a party.

The first step involved in organizing a party was to set a date and time, and it is worth noting that it took some time to negotiate these to suit all the people involved.

Familiar territory

At the group's suggestion the party was to be held at a local kindergarten because no-one felt particularly comfortable in offering their house or flat as the venue. The kindergarten was familiar ground and everyone felt quite comfortable going there. Negotiating the use of the kindergarten facilities was a relatively simple task involving a written request to the Committee of Management, which was approved without any problems.

Whilst organizing all the practical matters, I also asked the group for some ideas on the party's content - what they wanted to know. The request was for information and discussion on local services and how to access them. I undertook to track down any written information available in Cambodian.

Two days prior to the party I made some reminder calls to the host and other participants to remind them of the date and time, and to get some idea of how many people would be attending.

The party was scheduled to start at 3.30 pm. I arrived at 3.00 pm to set up the rooms. There was no interpreter needed, for being Cambodian myself, I shared a language with the group.

No-one had arrived by 4.00 pm and so a phone call to the host seemed in order. The host was pleased I rang and explained that everyone was running late because there was food to prepare and children to get ready. The party got underway at 5.00 pm but even then some people arrived later.

Cambodian community concerns

Once underway, the party went well. In attendance *were* six women, three men and 14 children aged between three months and 12 years. The session lasted for two hours and concluded with a wonderful Cambodian meal. The only hiccup was the number of children and their interruptions - having a childcare worker would have been ideal.

Issues raised at the party included:

- access to women's health services through the family planning clinic;
- the need and desire to form a Cambodian Group in Prahran;
- concern over the fact that their children would not *be* able to speak, read and write Cambodian, and the need to establish Cambodian language classes in Prahran - but with no knowledge of how they might do this;
- surprise that the Health Centre did not provide medical and dental services which they saw as crucial to their health. Preventative programs are not highly regarded as most Cambodian people are more accustomed to treatment than prevention.

Action plans for further work with the group in the short term, included facilitating access to the family planning clinic and ensuring the services of an interpreter for support, encouragement, and assistance for people using the Centre's services.

Sustained outcomes

In the medium to longer term, a support group was established. This group met fortnightly at a local recreation centre and was successful in obtaining funding through the Local Government's Community Grants Program. My role as a resource person to the group was to continue for six months - by which time the group would have become fully self sufficient. The group has formally established its purpose, aims and objectives.

In May 1992 a Saturday Cambodian language school, with 17 students,

was established. The class used the facilities at a local primary school with the services of a volunteer teacher. The group has plans to divide the class into two levels once another teacher can *be* found. They also anticipate more students once news of the class spreads. My ongoing involvement with the language school is to assist the group to locate available funding resources for their program.

Lessons for workers

Some of the important cultural issues that emerged from the House Party Program and subsequent contacts with the Cambodian group are:

- arriving early or late is quite common as punctuality is not a high priority for Cambodian people, particularly when attending meetings or in this case, house parties;
- choosing a familiar venue in which participants can feel comfortable is important. This will help to get more participants along;
- children are very attached to their mothers. It would be culturally inappropriate to invite only parents and not their children. Arrangements for child care must be included in any planning and should be discussed with parents when organising a party or similar event;
- always offer reimbursement for food and food preparation costs, although most people are happy to bring a traditional dish along and would be unlikely to accept any reimbursement;
- always ring people one or two days before the actual appointment date to remind them of the plans as they do not carry diaries.

Not a success story

Joanne Hackett

While developing the Centre's Multicultural Policy and Strategy, staff found that people from Indo-China who came to Australia as refugees were under-represented in the use of Centre services. They therefore became a target group for the House Party Program.

Through contact with other local agencies and with ethno- specific workers in the area, the Vietnamese community was identified as one of the larger groups whose members were under-utilizing a range of mainstream services.

The challenge

This under-utilization of services was attributed to the fact that Vietnamese people in Prahran travel to another nearby local suburb

where they can access a range of health and welfare services in their own language.

With the exception of two housing workers, there are no Vietnamese speaking workers in Prahran. Given these factors, the task of encouraging and supporting the Vietnamese community to use local services was likely to be difficult.

We hoped that by using the House Party Program as a strategy to reach out to this group, we could open up communication on some of these issues.

There were no known local gatekeepers or community leadt'rs in the area, therefore initial contact with the Vietnamese community required a different approach from the one usually undertaken to establish a house party. A general information session on local services was planned with workers from two other agencies, and I was hoping that this session would facilitate my contact with future house party hosts.

The information session was scheduled for a Sunday afternoon and was to be held in the office of a local community housing group on the Ministry of Housing estate. As a lead up to the session, pamphlets and posters were strategically placed around the estate and in local Asian grocery stores. The information session was also advertised on ethnic radio. A door knock of individuals and families living in the area was conducted by a Vietnamese speaking worker who delivered the pamphlets and invited people to attend. The response at that point was encouraging.

Attendance at the information session totalled one woman (and although she spoke Vietnamese, this was not her first language nor her ethnicity)!

Further attempts to contact the Vietnamese community have continued to produce similar results. The Vietnamese housing workers, whilst supporting the idea of the House Party Program, have not been abk to sell the idea to local people.

A second weekend information session - this time organized in response to a specific request about the lack of Vietnamese language classes in the area, only attracted four people.

Not belonging in Prahran

To date, it has not been possible to introduce the House Party Program to the Vietnamese community in Prahran. Our assessment of why the strategy has been less successful with this ethnic group is two-fold:

1. The Vietnamese residents do not regard Prahran as their community. The absence of ethno-specific health and welfare services in the area has Jed people to seek services elsewhere, and presumably to regard their community as being geographically elsewhere.
2. As a consequence of the above, gatekeepers and community leaders

have not emerged in the area, and so the usual first points of contact for the House Party Program have been missing.

Overview

As a strategy to reach isolated people and groups in the community, the House Party Program has, in the main, worked well in Prahran.

From the Centre's point of view it has proven to be an effective way of communicating with people and groups, building trust, and breaking down barriers.

For some community groups, it has been beneficial in providing access to a range of services and a forum for information sharing where it has resourced individuals and groups and supported and encouraged their participation in the life of their community. That some groups have gone on to create their own support/cultural groups and language classes, and have begun to access local resources and services are very positive outcomes of a program that is still new to Prahran, and still being developed. For those communities which remain unresponsive to the house party strategy, it will be necessary to develop and employ other outreach methods.

5

"Without exception, all patients and relatives identified other patients and relatives, rather than the doctors and nurses, as the most beneficial and important source for gaining meaningful information and caring support."

Marguerite Menon

**a tea trolley support service in a hospital
oncology clinic**

a tea trolley support service in a hospital oncology clinic

Marguerite Menon

THIS case study demonstrates the flexibility of a community development approach and the breadth of the notion of community. In this story the context is the highly structured and institutionalized setting of a major teaching hospital and the community are cancer patients, their friends and family.

Nature of the challenge

As the Health Promotion Officer at Western Hospital Footscray, I had the opportunity to trial the community development approach within the hospital environment. It is somewhat of an anachronism to imagine that people could be empowered to take control of their health and quality of life in this setting with its biomedical approach to illness management. The community development approach explicitly requires community involvement, a focus on quality of life issues, people empowerment and community action, hardly the stuff of large public hospitals.

This paper describes my experience during the four years in which I was involved in commencing and establishing the Cancer Support Group in the Hospital's Oncology Clinic.

Background

The Western Hospital sits within a low socio-economic environment where there is a large population of non-English speaking people. The majority of these people arrived in Australia as part of the post-war migration program and have spent much of their adult lives in basic manual, industrial and factory work. Many of these people still speak English imperfectly and although this was a major teaching hospital there were only three interpreters, speaking six languages, employed.

The beginnings - listening

During my first months in the position, many people in the hospital informed me of the need for better support for the cancer patients. Gradually I found myself the recipient of increasing complaints from all levels of health professionals including medical practitioners, nurses, domestic staff, pathologists, interpreters, pastoral care workers and chaplains.

Investigating these complaints, I spent time in various parts of the

hospital talking to patients, nurses, and relatives about the way in which care of cancer patients was perceived.

In a hospital environment, information gathered in this way is considered to be subjective, anecdotal and unreliable. However, I put a proposal to the Director of Medical Services, who was my "boss", to commence a tea trolley service for Oncology patients waiting for their outpatient appointments. The service would be a way of providing discussion, information and support for those patients waiting, sometimes several hours, to see the oncologist.

This Oncology clinic was held each Wednesday and 20 to 30 patients plus relatives sat in the waiting area from 9.00 am until their appointment, sometimes as late as 1.30 pm.

The tea trolley support service

The tea trolley was seen as the vehicle to develop a support network among the patients and relatives in the waiting room. The idea grew from the depressing waiting room environment where people sat silently in rows of uncomfortable looking chairs waiting for their doctor to see them.

Nurses were rarely observed to interact with the patients and the occasions in which they did were usually associated with identifying an item for clarification or following up a doctor's request.

The need for the cancer support group was identified during a survey of the hospital's service for chemotherapy patients. There were 21 people, representing a convenience sample of the staff, the cancer patients and their relatives surveyed, using semi-structured interviews.

The major complaint expressed during the survey from staff, patients and family members was the lack of someone to talk over the diagnosis and the treatment options so that patients had a chance to understand and decide what was best.

Patients and relatives identified the "lack of a caring human face" and "a person to look after me" as the important deficit. Without exception, all patients and relatives identified other patients and relatives, rather than the doctors and nurses, as the most beneficial and important source for gaining meaningful information and caring support. The sort of information and support which enabled them to understand, accept and cope with the diagnosis and treatment of cancer. As one patient summed it up:

"The only person that really understands what it is like is someone who has cancer and has been through it all."

All the cancer patients interviewed in the day ward and the Oncology Clinic recognised, appreciated and eulogized their "wonderful nurses and doctors", but they also expressed fear about being treated by health professionals. They identified professional health care as something

quite different to being treated as a human being with all the sense of loss, concerns about their lives, fears of diagnosis and dilemmas related to treatment decisions.

Establishing the support group

After extensive preliminary consultation with the staff, consultants, patients and relatives, I consulted the Anti-Cancer Council's Support Group Co-ordinator, the District Nurses and the local hospice. I persuaded the Director of Medical Services to give permission to trial a tea trolley service as the vehicle for providing care and support. This permission was granted "provided everybody agreed to it".

It took three months of careful negotiation and discussion to gain consensus that the trolley was worth trialing. From inception, I saw this as an opportunity to find out just how effective the community development approach was in practice, and whether it could deliver the empowerment it promised.

Most of the nurses expressed misgivings about something so "unorthodox" and "unprofessional". While I talked about "travelling on a tram with people to listen to their concerns", most of the professional staff discussed the "inability to provide proper information sessions" and "confidentiality". There was a great deal of suspicion expressed by the nurses about confidentiality being breached.

"You just can't really talk about cancer in the open waiting area. It's not private enough. People need to have their confidentiality respected and protected. They don't want you invading their privacy or asking them to talk about cancer."

The medical consultants were equally concerned.

"A support and information service.....and what about us doctors...when are you going to support us?" "We need care and support too you know."

Eventually the tea trolley was a reality, albeit at first with a notice firmly declaring "Oncology patients only".

"What does Oncology mean?" I asked.

I guess that is the language difference between health professionals and the general community. Perhaps this expresses the very reason why people with cancer feel deprived of knowledge and a human caring face when in fact their medical and nursing carers are so concerned and want to be informative. After all, you "almost need a degree to understand the jargon", as one person told me.

The tea trolley becomes the focus of the clinic experience

Gradually the tea trolley and my friendly, unobtrusive presence became

a fixture which excited no interest unless I was unexpectedly absent. My offers of a cup of tea or coffee became the catalyst for friendly conversation. Concerns expressed were something to share and explore.

About three months after the tea trolley appeared, I found "June", our first volunteer. This wonderful retired lady, who had a mastectomy 30 years earlier, had successfully experienced the whole range of cancer treatments including radiotherapy, chemotherapy and further surgery.

June had also nursed her parents through terminal cancer and was a local identity well known to a wide spectrum of "patients". Her fund of practical knowledge, her ability to listen, her openness about her experience of cancer, and her tips and practical wisdom born of personal experience, fundamentally transformed the tea trolley from a hospital support service into a community support and discussion network.

June tackled the local shopkeepers who began to send a steady stream of items to support the cancer patients. These donated items were sold through the hospital's informal network of staff to raise money for small articles for the patients such as wigs or scarves for people who had lost their hair during chemotherapy, and taxi fares to return home after the clinic.

Initially, June worked tentatively offering assistance and being very concerned about doing the right thing. However, gradually she became a familiar figure about the hospital, always willing, helpful and sympathetic and ready to be called on to visit someone or to follow up a patient by telephone.

After about six months, June and I found a husband and wife team, "Ken" and "Enid", who joined the developing support group. This time they were a patient and his wife from the clinic who lived in the local community. Gradually relatives began to be involved in the spreading telephone support network outside the hospital.

Eventually the local cafeteria provided a Friday haven for the co-opted fund raising group developed by June to plan their activities and telephone network strategies.

A network of patients, relatives and staff

By the time Enid and Ken joined the team about 18 months had elapsed since the initial permission to proceed was given. At first I had wondered if it was all worthwhile. I was determined to give this "community development" approach a go. I wondered if it made a real difference during the week, but when the patients arrived I always had no doubts.

The tea trolley became the hub around which a network of cancer patients, relatives and hospital staff who had gradually become participants, revolved. The patients and relatives swapped recipes, exchanged ideas, discussed the effects of various treatments and complications of chemotherapy, and swapped telephone numbers.

The chaplains dropped in for a while. The social worker and the district nurse came. The interpreter dropped in regularly to chat and stayed to socialize with and support non-English speaking people. Some nurses and a pathologist began to spend time gathering information, talking and generally chatting.

After a while the patients began to visit the clinic on days when they didn't have an appointment to "support my friend because he's expecting his pathology results". Polish, Maltese, Greek and Italian people were introduced and telephone friends were slowly developed. This gradually grew into a wide network of ethnic people supporting each other by telephone.

After a while I began to realise that things had changed. June and Enid bustled about providing cups of tea and chatting comfortably to familiar people. Ken sat chatting to the men who were regulars, and I was told who needed extra information or needed to talk about some worry.

Patient advocacy

Where initially June had supported me, now June was in charge and I was supporting her. June organised me to talk to the people most in need of "your expert advice". I identified concerns, provided information and raised issues with the doctor via an informal note or brief discussion. This advocacy sometimes became more formal and involved some potentially serious health problems, complaints and worries.

For example people began to ask me to come in with them to act as a patient advocate because "I always seem to get mixed" up and "I don't feel I can say what I mean clearly". As patients left their doctor, June checked with them and identified those who needed further help, advice, assistance from the social worker or district nurse and who needed some help to collect the medication, find the X-ray Department, or get a taxi.

This helping hand was essentially practical in response to concerns voiced by the patient rather than an offer of assistance per se. In effect it was a practical follow-up enabling support, a helping hand, clarification of information partially understood, and community-based assistance.

The changed face of oncology

The support group changed the face of the Hospital's Oncology Clinic. Whereas patients and relatives used to sit all morning in silence, and despair, fear and death were palpable in the air, now there was a cheerful hubbub of conversation. People busily greeted each other, enjoyed a cup of tea or coffee while swapping recipes, discussed gardening information, shared telephone numbers, compared stories about surgery, and gave tips about how to cope with chemotherapy and what the radiotherapy at Peter McCallum was like. Migrants who could not speak English were introduced to others with like languages and the

interpreter was paged to come for a short chat to clarify concerns. In short, patients felt they were being treated like human beings and were able to care for each other.

Whereas previously patients had felt fairly negative about their treatment now there was a generally optimistic note. It was a wonderful thing to see a Greek lady's face change when she expressed fear about her recent mastectomy and I said to her:

"You need to talk to June. She had the same operation as you 30 years ago."

Sometimes the patients role-played what they wanted to say to their doctor. Sometimes they tried out questions they wanted to ask. Sometimes we identified a person who wanted to refuse treatment or who was terrified of the anticipated pathology results.

We listened and carefully facilitated a clarification of fears, anxieties and concerns. We talked about death if that was broached or swapped jokes about the daily trivia. In short, the support group dealt with people on their level of personal experiences and concerns.

After three years, patients who did not have appointments, regularly dropped into the clinic to support their friends who did. This was the only time in almost 30 years of hospital experience I ever saw this happen. These patients really cared about each other and formed a supportive community based on common experiences. They formed a wonderful support network focused around the activities of the, by then, four regular volunteers.

These cancer patients and their volunteers formed a strong support network and became friends in the true sense of the word. The medical consultants identified the value of this support. They expressed feelings that they were being supported in what was emotionally difficult work, and stated frequently that the positive climate provided benefits in the treatment of cancer.

One consultant began developing a similar group in his private practice. The nurses who were initially suspicious became the major support and the clinic certainly ran much more smoothly as the clerical staff frequently informed us.

Conclusion

Looking back over those four years, I can see the slow progression from an idea about needing support to a community-based and controlled support network all revolving around the simple idea of a tea trolley. I remember the Director of Medical Services saying to me on that memorable day when I first proposed the tea trolley service:

"What on earth would you want to do that for?!"

Originally, the Ottawa Charter provided the model and impetus for this

health promotion activity and I wanted to find out whether the community development approach would work in a hospital.

Network of cancer support groups

Gradually the advocacy led to developing a network of cancer support groups throughout the region in the community health centres to whom we referred the clinic clients. We linked the patients and relatives to the services available to them in the community and established the links between the hospital treatment for cancer and the community support, care and information services.

The Oncology clinic essentially reoriented its emphasis on disease and illness towards the direct linking and networking of those patients with their community support services. A supportive environment had been created in the clinic and extended out into the community where the volunteers and patients themselves were now in control of the telephone support network. Personal coping skills were being shared and learned in the clinic from those who had to learn them the hard way.

The community of cancer patients was strengthened and identified and supported its own. All this was happening through the facilitation, enabling and mediating activities of the local community volunteers at the minimal cost of one tea trolley for three to four hours each week.

And does the community development approach work?

Well it is now July 1992 and more than a year since I left to work elsewhere. Occasionally I go back to visit the Oncology clinic. The volunteers are in control and the clinic is working better than before. The consultants *come* to tell me how they would not cope without the support group and the patients are busy chatting, swapping stories and supporting each other. Yes, I believe it does work because here is the evidence.

But it isn't scientific evidence. It's anecdotal experience and human stories which tell the positive value which results from the long slow work of the community development approach in health promotion. Yes, in my experience it does make a difference, and that difference is empowerment for the people to whom it matters.

6

*"Women have demonstrated
that Primary Health Care is
the responsibility of individual
consumers co-operating
in groups."*

*Chris Ainsworth,
Gaynor Hartvigson and Browyn Buddle*

Strathalbyn and District Women's Health Project

Chris Ainsworth, Gaynor Hartvigson and Bronwyn Buddle

From aid to action

SINCE the early eighties, the shift in the function of Strathalbyn and District Neighbour Aid from service provider to community development agency, signified a totally different orientation to problems in social environments. This new orientation challenged the picture of residents as mere observers and consumers of services.

Strathalbyn and district

The Strathalbyn Local Government area covers some 1,253 square kilometres and has a population of 5,203. It has one of the highest growth rates in South Australia. The town of Strathalbyn is 58 kilometres from Adelaide and lies at the centre of a farming district. It has been an important servicing town for the surrounding rural community.

Pressures on families

There is a high degree of unemployment amongst women and youth. There are 2,600 females in the area, and 2,000 of these are aged fifteen years and over.

Many established farming families need to supplement their income through off-farm employment, which increases the stress on family and social relationships. As well as this, large numbers of new residents are obliged to commute to places of employment outside the district, creating mobility and isolation problems for families left at home for long hours.

The district has traditionally lacked any long term focus on preventive health measures as an integral part of primary health care. The significance of this is magnified when seen in the social context of the one third of households who rely on Social Security as their main source of income.

The Women's Health Project

In 1988, Neighbourhood Aid, under the sponsorship of the Strathalbyn District Council, applied for a Primary Health Care, Local Government grant from the Social Health Branch of the SA Health Commission. It received \$14,500 to employ a part-time Women's Health Co-ordinator. Council would administer the financial aspects, but Neighbourhood Aid would maintain responsibility for overall project management.

A request for more funds to make the Co-ordinator's position full-time, coincided with a policy initiative by the Health Commission to establish

a Women's Health Project in a rural area. The additional money was granted to Neighbourhood Aid to run the Strathalbyn Women's Health Project. Because of the way the money had been granted, there was a strange feeling that the Project hadn't arisen from a community initiative.

Feeding the idea

The Co-ordinator of Neighbour Aid, Debbie King, gathered together a wide cross section of women in Strathalbyn to discuss the project's potential. They included a female GP, women from the CWA and the Women's Agriculture Bureau, and younger women from play groups. We had our project officer, Kathy, and elected a committee.

During February and March 1989, 14 group meetings were held around the question: "Why Women's Health?". The notion of social health was raised with over 200 women who were encouraged to begin reflecting on their own experiences and concerns. Following discussion a questionnaire for the Women's Health Survey was distributed.

Women's health survey

We chose a survey as the most fruitful method of gathering information, rather than informal discussion. We felt that in close rural communities some women may have been reluctant to discuss personal issues in the presence of their neighbours. The survey was conducted between February and April.

Kathy distributed 300 questionnaires after her initial conversation with different groups of women. People were asked to provide a range of information: Why they went to the Doctor; why they didn't use specific services; what Health Centre they used; which ones they chose not to use; and what were their immediate areas of concern?

Meeting service providers

Kathy approached service providers individually or through group meetings, such as the Strathalbyn Hospital's Multi-disciplinary meeting. The Women's Health Questionnaire for service providers was distributed on these occasions.

Women's forums spawn specific projects

We decided to hold a series of three public forums with guest speakers. The forums were widely advertised in shops and local schools, and through Council and community newsletters, the radio and local newspapers.

It was these forums which generated the ideas around which action groups would focus their energies.

- a group of women discussed issues around parenting leading to a community creche and seminars on reproductive health;
- a group of women discussed environmental health leading to a

community garden and a recycling project (SWEEP) based at the local dump; and

- a group talked about mental health and the lack of counselling facilities. This group didn't survive but people from it went off into the two other action groups.

Individual interests/common goals

The forums confirmed that among these women there was a pool of common concerns. A desire to pursue specific interests persisted alongside the need for solidarity. At one of the forums we had about 30 women and though they were keen to work in action groups which were set up to address particular problems, they also wanted to continue meeting in the larger group.

No matter what issues were raised at these forums, the over-riding concern was that health services become more attuned to women's needs.

Learning about health

During the next 12 months, we ran health information sessions for women on reproductive health, and courses on massage and alternative therapies. The sessions on reproductive health included information and discussion on menopause, contraception, and breast self-examination. So even while the action groups were developing, the Women's Health Project was providing opportunities for women to explore their expressed life education interests.

What price the funding carrot?

Funding for the Strathalbyn and District Women's Health Project ceased in October 1989 and we began to research possible sources of further funding. The Rural Health Branch of the Health Commission eventually agreed to fund stage two of the project, so long as the money was channelled through the Strathalbyn and District Memorial Hospital.

Thus began a difficult but well planned and organised campaign to lobby all members of the Hospital Board. Women worked in pairs and were given a packet of information to prepare them for the lobbying process. Each pair visited one or two Board members. Two women were elected to make several presentations to the Hospital Board and to answer questions about the project.

We discovered that there were serious philosophical differences, on a number of fronts, between the Board and our members. It was extremely difficult for the Board members to move away from a medical model of treatment to a model of preventive and social, primary health care.

They certainly didn't want to conduct or promote alternative health treatments under their own roof. Our philosophies and perspectives, even on the broad issues of health care - let alone women's health - were miles apart.

Also, a major disagreement developed between us over management

models. The Board saw the Women's Health Project's management committee as having only an advisory role, whereas the Strathalbyn women wanted to retain their independence, power and autonomy. Since we were determined to continue working together to own the project, we decided to search for more appropriate funding.

The project runs on energy

We actually ran by ourselves for another 18 months without any money. It was the energy in the action groups and the women's groups that kept the whole thing going. When we lost our co-ordinator it meant that other people had to pick up on things that she had been doing. It was all just voluntary.

We started dealing with the Regional Health Association and talked to its Project Officer who visited our group a couple of times. We got the feeling, that if our group became wider and more regional, we would be able to get some money. That process took quite a long time.

We put in submissions to Canberra and received \$93,000 of the National Women's Health Policy funds. This was to set up a Regional Women's Health Service in the Adelaide Hills and Southern Fleurieu area. We employed one full-time Women's Health Co-ordinator and two part-time Community Health Workers.

We couldn't base the new Service in Strathalbyn due to the inability of the Hospital Board and the project management committee to reach a agreement on terms and conditions. The Service is now based in Mt Barker, but the Strathalbyn women have maintained a high degree of influence over the project's direction and the benefits should be seen in this community soon.

Benefits of the community development process

The Women's Health Project was one of the few enterprises on which the Council and Neighbourhood Aid collaborated successfully, both socially and financially. It is perhaps testimony to what can be achieved through a close working relationship.

Neighbourhood Aid has shown how much is possible through utilising the community development approach to the management of social change. By capturing the energy and skills of people and groups within the community and helping them achieve their goals and address their needs, Neighbourhood Aid has provided a way of managing social growth and diversity in the district.

Gains for women

Women have:

- demonstrated that Primary Health Care is the responsibility of consumers co-operating in groups;
- increased their participation in decision-making processes;

- gained representation on management committees at local and regional levels, including hospital boards;
- increased their knowledge about health problems;
- developed skills to instigate and promote preventive programs, to lobby for funding and services, to apply for grants and manage funds;
- increased their access to health information;
- met and made friends, removing previous isolation even within the township.

Strathalbyn Women's Education and Environment Project (SWEEP)

Chris Ainsworth

We thought it would be just fun and really powerful to have a group of women running the local dump.

We were worried about the big regional dump out of Hartley, which is destined to take rubbish from districts served by four local Councils. We didn't want to have that super dump in our local area, so we were looking at ways of extending the life of our own local dump and we thought, apart from the fun of doing it, that it would be really powerful to have a group of women running it.

A recycling strategy

For six months, six to eight of us had meeting after meeting. We researched and planned and got ourselves really well organised and we came up with a re-cycling strategy for Strathalbyn centred on a re-organisation of the local dump. We called our project SWEEP which stands for "Strathalbyn Women's Education and Environment Project".

When we went to Council we really wanted to have a super-organised plan, knock their socks off. We came with a community education program, a landscaping plan for the dump, a re-cycling scheme and a business plan. A lot of us had skills for doing these things and eventually we came up with this really good plan.

I was also a member of the Strathalbyn and District Council and was on the waste management committee. My involvement with SWEEP - unbeknown to the Council - gave me a foot in both camps (which made it tricky keeping out of ethical potholes!)

Tackling the tender

I remember this really historic moment in the Council chambers when three members of SWEEP came to present their tender to run the dump.

I was sitting on the other side of the fence, being a councillor. SWEEP's proposal was just so well presented and so well researched and organised that the Council were very impressed:

The difficulty was that they couldn't take that enormous leap into accepting the idea of a group of women running a dump. The way they tried to get out of it was to make the fact that we couldn't provide our own machinery, an obstacle.

The bloke that had been running the dump also put in a tender to continue working there. His tender was pathetic compared to SWEEP's, but the Council re-employed him anyway, even though he didn't intend to upgrade his own machinery.

We became quite dejected about it because we already had devised a roster of women to do the job. We talked about how our plan would generate employment and the possibilities for doing lots of scavenging and restoring things, and recycling. When the bloke started back again at the dump, the community and Council started to hassle him about his re-cycling plan and he didn't have one. He wasn't interested in recycling, and so, under pressure, about six weeks later he resigned.

Council's invitation to SWEEP

Many locals had heard of our plan and contacted us to ask if they could extend our project and join in (eg forage wood from the dump to make kid's furniture). It was difficult to negotiate this because some of the offers came from men and they were not used to dealing with a women's group. Apart from this, word was reaching us that some people were reluctant to support us because we were a women's group.

The tender came up again, and this time the Council invited SWEEP to re-negotiate, but they offered us a pittance to run the dump and it wouldn't have allowed us to implement our recycling strategy. We decided we weren't going to be unpaid workers, as women so often are, so we turned their offer down and the Council are now running the dump themselves.

The group went very quiet after this but SWEEP didn't die a natural death, and we might recharge ourselves and do something new. We did offer to *be* consultants to Council if they paid for a community education program to promote recycling in the community. We thought we should maintain our pressure on the Council to adopt a policy on recycling.

Since then there has been an election and the new Council have released a recycling plan and plans for other changes at the dump. The main thing is to pressure Council into not just talking about recycling but into actually putting some of their plans into action. They bought a whole lot of compost bins which they are selling to the public, but that is the only thing they have done really.

SWEEP's invitation to Council

In March, Neighbour Aid part- sponsored a public meeting on recycling

in Strathalbyn and approached SWEEP to co-sponsor the public meeting. We then invited the Council to launch their recycling plan so the general public *were* aware of their intentions.

Afterthought

My contact with Neighbourhood Aid as its Chairperson has been valuable because I have links with lots of different groups. Through Neighbour Aid I have seen groups achieve their objectives and so its motivated me to keep moving onto something new and something different. Being on Council also helped SWEEP, because I was able to observe how Council works and could be on the inside lobbying for the group.

Looking back, I think we could have actually got more community support. We could have run a big publicity campaign to get the community behind us. A lot of people in the community didn't know that SWEEP existed.

We had the dilemma that if we did the advertising, it really was doing our community education program. Our belief was that it was Council's responsibility to do this work, and if we did it for them, it would be the old story of women doing important work for *free*.

Council's attitude to recycling is gradually changing, and they are looking on it more favourably, and are more willing to take responsibility for it, whereas before they just shrugged it off. I guess now we are a watch dog who every now and then ask Council what they are doing about recycling.

Strathalbyn is a good size for community initiatives; you can feel the impact on the local Council of your efforts to influence things and also the impact of changes on your own life. There are a lot of committed people, and many of them are newer people to the town.

Postscript 1992

Two years later the Council is operating a Recycling Depot at the dump, which is managed by Council workers. The community can deposit recyclables there, free of charge. SWEEP's initiative sowed the seeds of a recycling policy for Strathalbyn. Certainly its our ideas and much of our information which is being recycled by the Council.

The Community Creche

Gaynor Hartvigsen

Many zoomen in the group were having their first babies and the discussion moved from birthing to childcare. A lot of us were new to the town so we didn't have a support network of family and relatives.

Needs

A survey by Neighbourhood Aid in 1985 indicated a need for both full-time and casual childcare in the district, but Strathalbyn did not qualify for government funding. The idea for the creche was revitalised in 1989 at an early meeting of the Women's Health Project.

We needed somewhere to leave the children if we wanted to go the dentist, or doctor, follow personal interests or have some child-free time. There were some other local people who were involved who didn't have families but were people with community spirit who could see the urgent need for childcare.

This group of women were also instrumental in lobbying the local hospital to update its Maternity Wing to include a double bed, a bath and refurbishings to create a more homely atmosphere.

Research

Initially, we didn't have any formal organisation, but we decided we wanted to set up a quality occasional childcare service three sessions each week. Once we decided to set up the service we did a lot of research, to ensure we would do it well.

We contacted established childcare centres, to learn about their policies on health and safety and about guidelines for setting up a creche and the required ratio of adults to children. We were very concerned to do it properly and to make it a reputable service.

Neighbourhood Aid provided the initial \$400 for the first insurance policy and provided a legal auspice for the creche committee.

It was clear we would need volunteers to run the creche, but we also wanted some continuity, so we'd try and have a committee member there for each session. There was a lot of fiddling around with rosters and volunteers because the committee was only about six people.

Government regulations prevented us from charging a fee for the service provided, so we asked parents for a donation of \$1.50 per child. To give some incentive to volunteers we allowed them to bank up child-care hours in lieu of this donation.

Teething problems

The creche operated quite smoothly when committee members were working, but often the volunteers didn't understand all the details of daily administration. Since we wanted to provide quality childcare, we were concerned to provide continuity in the care-giver and so the employment of a childcare worker became a top priority.

Money needed to be raised to employ somebody and much time and effort was put into chasing government funding, writing applications, and approaching local business for support. We couldn't afford the rate

for a qualified care giver, but were able to employ an unqualified care giver. The creche improved and more people wanted to use it. But to maintain the required ratio of adults to children, we still needed three or four volunteers on the three mornings a week we operated.

Raising the money and hiring Noelyne, our worker, was a valuable experience for us and for the committee. Through working on these tasks the group developed a togetherness.

Surviving success

The size and reputation of the creche is growing. There are 100 children on our books and people who have used the creche continue to come back to it. First it was word of mouth, but lately we have advertised in the local paper and produced posters.

Thinking back to our policy on the creche, from the beginning our main aim was to provide quality occasional child care and that has been achieved.

Through constant fundraising we have been able to employ a second caregiver. But the creche still runs at a considerable loss. Because we rely so heavily on volunteers who do not pay for childcare, the income from creche users doesn't cover the cost of wages, insurance, Workcover, phone, newsletters, toys and consumables. This puts extra pressure on the committee to continue fundraising and applying for grants to subsidize the creche.

When to step down

The creche can't survive if it depends on the present committee completely, because one day we will leave. Some people will drop out when they have new babies, and some when their children move on to kindergarten. We have discussed having elections for the committee, but some of us are afraid of stepping down, in case no-one else wants to step in - but you have to be willing to take that risk.

We are now in the process of becoming a separate incorporated body, which means that we will have an elected committee and the roles will be more clear cut. The future of the creche will depend on all the users having some input into the decisions taken by an elected committee.

The creche has proven itself over a decent period and it has earned a lot of recognition from within the community. In 1991 the Council gave us a one-off grant of \$400 which was really great. Their attitude is now more supportive but we would like to see a more long term commitment. Children's Services, including childcare, from the Council and we will continue to work towards this aim.

It is imperative that we succeed in getting Government funding because such a needed service should not be dependent upon the contribution of overworked volunteers - many of whom are caring for several children, holding part-time jobs and maintaining their involvement in other community services.

The Community Garden

Chris Ainsworth and Bronwyn Buddle

The Community Garden itself is a growing symbol representing environmental awareness and all manner of social concerns.

The original idea for the Community Garden came from the Environmental Health Action Group where a few of us talked about setting up a food co-op. One woman did a lot of research and somehow the notion was transformed into a community garden producing organic vegetables to sell at local shops.

The group's prime mover, Jayne Guster, had a vision of a community garden in her head. She hoped eventually to extend it by making the produce the basis for a community market.

We held a public meeting and formed a Garden steering committee of about half a dozen people and this group expanded to include some men as well - it was not a women's only group.

Work link grant funds gardeners

Bronwyn became involved in late 1989 after she read an advertisement in the paper about people seeking to start up the Garden. She attended the meeting and soon became involved as treasurer.

When she first started we were mainly trying to get grants. Bronwyn got some unemployed people together to apply for a Youth Initiative grant. We applied for the grant so that we could get other unemployed people involved and run a course. We also planned to buy some tools and a shed. The Initiative's Unit gave us about \$3,000.

Neighbourhood Aid helped the Committee put in for a Work Link grant. Nobody really believed our application would be successful, but we got \$71,600 to employ six long-term disadvantaged unemployed people for six months to receive training and to establish the original market Garden.

Work Link also provide money to employ a co-ordinator who would deal with the administration. Jayne was interviewed by Neighbourhood Aid for the job and when she was appointed, she negotiated with the Council to find some land for the Garden.

The Council gave us permission to use a reserve in one of the new sub-divisions not too far from the centre of town. The six workers began on the basics of the Garden, doing a lot of the hack work. They also embarked on a training program which included TAFE courses and relevant conferences.

Establishing the garden

With the Work Link and Youth Initiatives grants we had eight people

employed in establishing the Garden and it grew very rapidly. We took cuttings and raised seeds of herbs and vegetables. Irrigation was laid and the general plan of the picnic area, garden shed, pergola, indigenous species garden, paths, orchard and children's playground, became a reality.

We gathered food scraps, straw, weeds and manure and created an eight-bay compost system. To gather large amounts of food scraps we offered a local cafe a large rubbish bin and a twice-weekly collection service of their organic waste.

A communal market garden was planted out and the gardeners worked on their own plots as well. Three of those people still continue to rent their plots. The aim of the market garden was to raise funds for materials and ongoing costs.

There was also a lot of involvement from people who were general members – people who were available for working bees or fund raising events.

The Work Link grant paid for training and some major tools including a nine horse power mulcher which can be hired out by members. Fund raising was generally through regular stalls at fairs and in the main street of Strathalbyn. This was the only way we could manage to pay for the materials needed for planned projects. All support, no matter how small, whether in services materials, or cash, could only improve the project's chance of success.

The pace slows down

Since the establishing work finished, the pace at the Garden has slowed down. We started offering workshops on all sorts of horticultural subjects. At first the response was good, but when it dropped off we gradually phased them out, thinking we may do better in the future.

The response for individual plots has also been slow. It has been suggested that in a rural town like Strathalbyn, the need for plots is minimal due to the large town blocks, yet the lack of productive gardens in many of the surrounding houses suggests that lack of know-how may also contribute.

The Garden is now there for the community to use. The question is just how we can encourage people to use it. Presently we have seven plot holders. We hold gatherings once a month to meet, work, and discuss business over lunch. We continue to plant trees and shrubs, which are indigenous to Strathalbyn, around the border of the garden as well as on the adjoining Council reserve.

Members and friends call in to the Garden regularly and continue maintaining it. The beauty of this project is that you can get away from it and it continues to grow unattended. This, of course, includes the grass and weeds, but we've managed to keep on top of all that with some assistance from the Council gardener.

There have been other important aspects to the project including

establishing an indigenous native vegetation garden. With many of the local plants growing there it's a really good display. We plan to label the plants in order to promote knowledge of our beautiful native flora and encourage others to grow them - a mini Botanic Garden.

We have had a lot of assistance from the local "Trees for Life" group, in this development. It is a good service for the community and we plan to make a formal picnic area where people can stop and have lunch, since it is situated on a main arterial road. There is also a project in town for intellectually disabled people which built a raised garden bed at the Garden.

The critics

The general community didn't think we would get this far. Being a conventional farming district there was a lot of pressure against our "green" philosophy. The Garden had quite a difficult period during the Work Link employment project and came under a lot of criticism. Many people scoffed at the idea and Jayne and the Committee had a hard time coping with it.

It was quite discouraging to be criticised over where the grant money was spent, when much of it was being spent on training, wages and materials which helped support local retailers and the community!

We are just hoping our patience and perseverance lasts. We made the mistake of thinking that everyone would share our enthusiasm, but we have now changed our expectations of how much other people want to be, or are prepared to be, included.

The Garden committee should be admired because it has held its head high the whole time it has been criticized and put down by the community and has just kept on working. The Community Garden was an ambitious project to try in this community and it has had its difficulties, but it has also had its successes.

Over time, many of us found that we had overcommitted ourselves, and it was hard to maintain the level of effort the project demanded. Progress has slowed at present, but it is all set up down there and ready to be used at any level. I think it is in a period of renewal, waiting for the next available input of energy.

Meanwhile the Community Garden itself is a growing symbol representing environmental awareness and all manner of social concerns. It may be a little before its time, as have been many of the Strathalbyn Women's Health Group's initiatives, yet it is set up, being used, and a basis for further community education and enterprise in the future.

7

The fact that the sessions were conducted in their own mother tongue had allowed them to participate fully. Many said that now they knew about breast and cervical cancer, they would encourage friends and relatives to go to the cancer screening clinic, since "it wasn't so bad!"

Rita Prasad & Wafa Shinwari

**pap smears and breast self-examination
for NESB women**

pap smears and breast self-examination for NESB women

Rita Prasad and Wafa Shinwari

AN awareness raising project undertaken by the Women's Health Centre in Brisbane aimed to communicate the importance of pap smear tests and breast self-examination to women from twelve different ethnic communities. The project provides a model for health workers with NESB women to consider. It also highlights specific problems these women face in their encounters with Australian health services.

Project beginnings

Much of my preliminary work as the multicultural community development worker, at the Women's Health Centre, involved meetings with groups of women in various ethnic communities to work with them to identify their health needs and make decisions about how best to meet those needs.

Two facts emerged from these meetings:

- many women knew very little about breast and cervical cancer;
- conducting group sessions through interpreters is problematic when the information is of a sensitive nature.

The act of translating creates a barrier to effective communication between the group facilitator and the participants.

We therefore decided to organise an awareness raising project about breast and cervical cancer for NESB women, based on a Bilingual Community Educator (BCE) model. The BCE model trains women from ethnic communities to conduct information sessions in their own communities on specific topics in the appropriate language.

Objectives

Unfortunately *we* only had resources to conduct the project over a two month period, but we were clear about what *we* might achieve in that time.

1. To inform women of the importance of the pap smear test and breast self-examination in the following communities:

Chinese, Vietnamese, Spanish speaking, Greek, Italian, Serbian, Croatian, Filipino, Muslim, Samoan, and Tongan.

2. To increase the numbers of women from these communities who have pap tests, particularly their first pap test.
3. To identify barriers which these women face in having pap tests and to develop an implement strategies to remove these barriers.

Barriers

We aimed to increase the participation of women having pap tests and performing breast self-examination, by removing some of the anticipated barriers which included:

- the language barrier - via information in relevant languages about health services, pap tests, and breast self-examination;
- the cultural barrier - via a Bilingual Community Educator who is familiar with the culture of the group and therefore able to provide information in a culturally appropriate manner;
- the access barrier - by facilitating access to appropriate clinics through group bookings, and by providing an interpreter and transport.

Bilingual community educators

Initially the idea of the project was discussed with welfare workers in the relevant ethnic communities. A great deal of support for the project was evident. It was decided that women in the participating communities should put forward names of women who would be good bilingual communicators for selection as Educators through an interview process.

Selection criteria for the Educators included:

- an ability to communicate in English, as well as their native language;
- a background in nursing, teaching, welfare, or health education;
- a good knowledge of the networks in their own community.

By mid May, twelve women were selected and all were enthusiastic to get started.

Training and publicity

One full day training workshop was organised for the Educators by the Women's Health Centre. The training focussed on information about breast and cervical cancer and how to work in small groups. A representative from the colposcopy clinic at the Brisbane Royal Women's Hospital spoke about cervical cancer and pap smears and a representative from the Queensland Cancer Fund spoke about breast cancer and breast self-examination.

A lot of information was packed into one day. In hindsight it would have been better to have a two day training workshop so that Educators would have had time to reflect on the material and more opportunity to ask for clarification.

The Educators were given publicity material for translation. This comprised a flyer, a newspaper advertisement and a radio announcement, all giving details of the project.

The Women's Health Centre then printed publicity flyers in twelve languages. In addition, a studio booking was made at the ethnic radio station 4EB, where each Educator recorded a radio announcement in their own language.

For the remainder of June, the Educators and I contacted key people in the participating communities to seek their assistance in publicizing the project amongst members of their own community.

The multi-lingual radio announcements were played virtually on the hour on 4EB, for a two week period commencing at the end of June.

Organizing the groups

In response to the radio announcements and the flyers, arrangements were made for groups in the ethnic communities to meet with the Educators. Several took on enormous workloads in organising the groups. They visited church leaders, welfare workers, presidents of social clubs etc, to seek their support for the project.

The Italian, Muslim, Chinese, Yugoslav and Vietnamese Educators in particular, undertook the organising of groups themselves. With the other communities I undertook most of the organising of groups, venues and childcare.

Running the groups

Groups were meeting by July. In some communities the response to publicity was overwhelming. Groups were conducted in community centres, church halls, social clubs, private homes and ethnic and welfare organisations. Over a period of six weeks, eighty groups had been conducted in which seven hundred and sixty seven women participated.

It is worthwhile spending some time analysing the variation in the response of different communities (See Table one, page 94).

Communities from which we had a very high success rate, such as the Vietnamese, Italian, Croatian, or Chinese communities were more established and embrace several welfare and social organisations providing established networks into which we could tap.

In other communities, such as the Filipino, Samoan, and Tongan, the response rate was much lower as they were less established communities and there were very few networks through which we could make contact. In hindsight, as the multicultural worker, I should have done more work with these communities prior to the project, to build support and to encourage women to participate in the groups.

Table one - Participation by language groups

Language	No. of groups	No. of women
Arabic	2	21
Cantonese	5	36
Croatian	10	92
Farsi	6	38
Greek	2	21
Italian	16	161
Mandarin	3	24
Samoan	1	7
Serbian	7	82
Spanish	7	97
Tagalog	2	12
Vietnamese	18	170

Pap smears and mammograms

As the groups were being conducted, the feedback from the Educators confirmed that women were responding in a positive way to the information presented, and they indicated a willingness to have pap smears and mammograms. However, although they had been told where to obtain these services, they were reluctant to go by themselves. They cited language as the major barrier and gave examples of negative experiences with health services which they had used in the past.

For these reasons *we* decided to arrange group bookings for 20-25 women plus interpreters at the Royal Women's Hospital Breast and Cervical Cancer Screening Service, and the Family Planning Association.

Mobility

A major obstacle was how to get women who did not have their own transport to the clinics, when so many of them were nervous about taking public transport into unknown territory. We spent considerable time trying to find free transport. After numerous phone calls, *we* were fortunate to secure a free bus or driver from the following organisations: Avis, Logan, TAFE, the Worker's Health Centre and Eventide Nursing Home.

Visiting the clinic

From August 1991 to January 1992, we organised 210 women in 12 groups to have pap smears and mammograms at the Royal Women's

Hospital or the Family Planning Association. A number of issues which arose, highlighted the problems these women encountered in their attempts to utilise health services.

Language

Few of the women spoke English, so it was essential to arrange for interpreters to be present. However, their presence lengthened the whole procedure at the hospital which frustrated the hospital staff. Six weeks prior to the group's visits it was standard procedure at the Royal Women's Hospital for booking forms to be filled out by each individual booked into the clinic. The data was then entered into the computer records and files were prepared prior to the patient's attendance.

For a number of reasons, this procedure caused havoc with the hospital administrative staff, particularly at the Breast Clinic. Many of the names, such as Vietnamese and Chinese names, were entered incorrectly in the computer booking system and on the day, took a great deal of time to be retrieved.

Some women did not know their date of birth and therefore could not be included on the computer lists. The administrative staff did not display any sensitivity on this matter, and refused to book these women in. It was only when I intervened that staff members realised that in some cultures a date of birth is not significant, and agreed to invent a birth date for the sake of computer records. Generally this caused stress to the hospital staff and threw them behind in their work, aggravating the whole situation.

Not understanding the system

Most of the women who attended the group clinics had very little understanding of the administrative system, which led to much confusion. For instance, several women who had been booked into the clinic, and who could not attend on that date for whatever reason, sent a friend or relative along instead, and then reported at the next group session.

This led to the situation where at each group clinic, there were at least three to five women who had not been booked in for that particular day. At first the Breast Clinic simply refused to see these women.

This caused a great deal of trauma to the women concerned who had summoned a great deal of courage to attend the group clinic and felt very anxious about it. It was humiliating to be told in a condescending manner, to go home. Many women displayed their disappointment very openly and it took a great deal of my time to encourage them to renegotiate an appointment.

In hindsight, I should have done a lot more preparatory work with hospital staff to help them to deal more appropriately with these issues. These experiences highlighted the need for cross-cultural sensitization

training for hospital staff. As the group visits continued, the hospital staff became more accustomed to dealing with NESB women in a more sensitive and flexible manner.

The Breast Clinic was the worst offender in these matters. In both the Colposcopy Clinic and the Family Planning Association, the women were received warmly and the staff were very accommodating.

Were people affected?

This project affected a number of people in different ways. Many of the Educators stated at the final evaluation session that they felt they had personally gained from the project. Several of them had been feeling depressed about not being able to work in their chosen profession, since their overseas qualifications were not recognised in Australia.

They acknowledged that their participation had raised their self-esteem and increased their confidence, particularly since the project had involved them in fruitful communication with women from their own community.

Many of the women who participated in the groups, expressed their appreciation of the work of the Educators, and the fact that the sessions were conducted in their own mother tongue. This had allowed them to participate fully. Many said that now they knew about breast and cervical cancer, they would encourage friends and relatives to go to the cancer screening clinic, since "it wasn't so bad!"

The participating organisations also changed to some extent. Certainly their level of awareness of the problems experienced by NESB women in their attempt to access health services, increased. In the hospital clinics members of staff commented on the fact that they rarely see NESB women in their clinic and had no idea that there were so many of them. (We only brought in two hundred and ten women!)

The Family Planning Association was so enthusiastic about the project that they recently approached the Women's Health Centre to make a joint application for funding to continue the project.

Issues raised in the groups

- Reasons cited for not having had pap smears were lack of awareness of the procedure and/or of its significance. Women referred to their fear, embarrassment, shame, not wanting bad news, previous bad experience and lack of information about where to go.
- Most commonly cited sources of information about pap smears were family, daughters, TV, doctors, ante-natal clinics and our groups.
- Many women aged 45 and over, had not had a pap smear for 10 to 30 years as they believed it was no longer necessary.
- Many women expressed their unwillingness to approach their local

doctor for a pap smear. They referred to their embarrassment with their family doctor. They also said that they were ignorant of other options, and lacked confidence to seek out new service on their own, due to language barriers and their own anxiety.

- Very few women knew how to perform breast self-examination.
- The fear of cancer was discussed in several groups, but particularly in the Indo Chinese groups. The attitude to cancer was extremely fatalistic, women saying that they would rather not know if they had cancer, because there is nothing you can do about it anyway - if you have it, you will die.

Summary

The "Pap Smear and BSE Project for NESB Women". succeeded in involving a great many NESB women in a short period of time, on a very limited budget. We only had \$3,500 to conduct this program. With more funds we could have reached a greater number of women. The success of the project can be attributed to:

- hard work and enthusiasm by the Educators;
- providing information in a culturally and linguistically appropriate manner;
- publicity in relevant languages;
- flexibility in the use of local venues, in the provision of childcare, in assistance with transport, in the scheduling of times for group meetings, and in the use of interpreters at the clinics.

The BCE model is well worth considering in health promotion strategies with NESB women. There have been some unexpected spin-offs where some Educators have continued to conduct groups in their own time and where other community workers have utilized the idea of group clinics for their own communities. Meanwhile the Women's Health Centre is continuing its quest for funding to continue the project, or utilize this model to raise awareness about other women's health issues.

Bilingual community education

Wafa Shinwari

The effectiveness of the project to teach women from ethnic communities about the importance of pap smears and breast self-examination, run by the Women's Health Centre, owes much to the contribution made by the Bilingual Community Educators. Muslim women had the benefit of a bilingual educator with special training and commitment.

I am a veterinary pathologist with qualifications from my home country Afghanistan, and Australia. These include degrees from Kabul University and Queensland University in Veterinary Science, and a MSC from Queensland. Despite these qualifications I have been unable to find a job since my arrival in Australia eight years ago.

In October 1990, I met the multicultural worker, Rita Prasad, from the Women's Health Centre in Brisbane during a Health Care Interpreters Seminar, at which she was speaking. It was certainly the first time I had heard someone talk about NESB or migrant women.

I liked Rita's talk and I established links with the Women's Health Centre. From my experience I felt that the various ethnic communities would benefit a lot if there were bilingual community educators. I personally carried out this duty, on a voluntary basis, for the Afghan community whenever my help was required. But that was not satisfactory - I wanted to do something on a larger scale.

I am a practising Muslim woman, and I am committed to the Muslim community which, unlike some other communities, is not delineated by geographical, racial, language or nationality markers. This means that people from over fifty different countries, including all continents and sub-continents, are united for a unique reason, which is our religion Islam, and we are proud of calling ourselves members of the Muslim community.

When in 1991 Rita called upon me for involvement in the Pap Smear and Breast Self-Examination project as an Educator for the Afghan or maybe Farsi speaking community (people from Afghanistan and Iran), I thought I could do better and nominated myself as a Muslim Community Educator.

With the help of some interpreters I managed to work with Muslim women of various nationalities. The experience was rewarding for me, because there was some work for me to do which I enjoyed. I was able to deliver some useful information in a very friendly and culturally appropriate manner, to groups of women who showed enthusiasm and trust and of course this was reciprocal.

Although the payment was minimal, and in some cases barely covered transport costs, the experience was invaluable. As for an encapsulation of the cultural definitions of health and illness - it would take chapters

and books, rather than a page or two. However I have a few comments regarding the Pap Smear and BSE project.

With the help of a Pap Smear Kit from the Women's Health Centre and an actual size, home-brand model I made of the female reproductive organs, the technique and procedure of taking Pap Smears was demonstrated to groups of Muslim women. This helped them to understand the mysterious things which some ignorant doctors do to them without any explanation.

The information on cervical cancer prevention was particularly useful for those people who think that every cancer is untreatable and unpreventable - an irreversible disease which is best not mentioned.

The Arabic speaking group said they never mentioned the word for cancer in their language. Instead it is referred to as the disease "A'uudzubillaah" which means "I seek refuge from Allah (God)." But they will sometimes use the word cancer (the English word).

Other groups (Afghan, Iranian, Indonesian, Pakistani, Indian, Bengali, and Fijian) were different. They would talk about cancer in their own languages as well as use the Arabic term of "Sarrataan" and/or cancer itself.

Some people were uncertain as to whether they could catch the disease from a cancer patient. One message was unique amongst the groups with whom I worked, and that is that cancer is incurable, untreatable, unpreventable and irreversible; there is nothing you can do once you have a cancer. Death is the only outcome and it is a one way journey.

I would like to mention here that Islam is the religion of knowledge and reality and that Muslims who know and practice their religion are highly unlikely to come up with unrealistic definitions and myths. Therefore even when such beliefs and expressions are identified amongst Muslim communities, they stem from some other cultural origin and not from Islam.

8

"As the interview progressed, the different views of self defence became very clear. Jane envisaged self defense as a means of preventing violations to her rights. In other words, self defense encompassed broader issues than the prevention of physical abuse."

Rayleigh Joy

women, disabilities and self defense

Rayleigh Joy

I NVOLVING the community brings exciting new perspectives and ideas to projects. In this case study, Rayleigh explains how involving disabled women in the planning and running of a self defense course brought a new meaning to the notion of self defense. In hindsight, self defense can obviously mean something different to able-bodied and disabled people, and for the disabled women involved here, self defense included protecting violations to their human rights, as well as physical self defense.

Background

The Women's Health Centre in Brisbane was established in 1982. The Centre aims to promote women's health in a multiplicity of ways and health is seen to be more than just diagnosis and treatment. Health encompasses the psychological, physiological and sociological well-being of an individual and therefore, needs to be located and addressed in a social context.

The Centre provides a range of services such as a telephone information line, workshops aimed at increasing women's self awareness and improving their well-being, and a well resourced lending library. In addition, the Centre undertakes health promotion activities such as health education sessions at venues right around Brisbane, and community development projects such as providing health information to women of non-English speaking background. The Centre is also involved with policy making decisions concerning women's health.

In March 1992, the Centre was approached by the Spastic Welfare League to organise a self defense workshop for a group of women with cerebral palsy.

The Centre's Community Development Officer agreed to support the project and subsequently invited me, a social work student on placement at the Centre, to organise and run the workshop.

A feminist perspective on health and disability

The Centre aligns itself philosophically with the women's health movement which critiques modern medicine from a feminist framework. This critique of modern medicine is based upon the:

shared experience of individual women who came to realise that the beliefs held by doctors about the nature of women and the way medicine was

practised as a consequence of these beliefs, were very strong social forces for trivializing women's concerns, dismissing their needs and keeping them quiet and submissive.

(Shaw & Tilden, 1990, p.4).

Health is usually characterized and defined by a medical model of health and illness. The problem with this is that an individual's social arrangements are not taken into account, and as a consequence, their illness or problem may be perpetuated.

The Women's Health Centre posits that through education and information, women will gain knowledge of their environment, be it functional or dysfunctional, and thus be empowered to promote a healthy life style for themselves. The Centre, therefore, actively participates in educating and providing support to a range of women.

Women as a gender are marginalized, and often find their experiences of the health system dissatisfying, however, for women with disabilities, this marginalization is magnified.

For example, able-bodied women are often treated with paternalistic overtones when they approach a doctor about menopause, pre-menstrual tension, and depression, but for disabled women, paternalism may be the least violence experienced. They are often not even informed of bodily changes (eg menarche), and frequently they don't experience a normal bodily function such as menstruation, as they have been sterilized.

Women with a disability are often isolated, silenced and uninformed. Due to their isolation, they lack access to mainstream health facilities. For example, one barrier to their access, is transport. Women with disabilities have to book in advance for transport, which discounts any kind of spontaneity. Buildings often have barriers to access and social attitudes are also often barriers for women with disabilities.

Access to dignity and participation

It is often assumed that having a disability is very depressing. However, for many individuals with a disability, the main source of their sadness and frustration is the way they are treated as second class citizens.

This treatment is resented by people with disabilities who in fact want to be involved in decision making processes which affect their lives. Disabled people want to actively participate in their lives on a day-to-day basis. For example, with sterilization, often the choice, or more precisely, the decision making, is removed from the women involved "in her best interests".

Professionals, agencies and helpers involved with the disabled community often operate with inappropriate models or theories of disability. As a result, the assessments of the disabled community are

incongruent with their actual needs and wants. These misconceptions and inappropriate interventions further marginalize and silence the disabled as a group in society.

Numerous organisational and policy decisions are made independently of the policies on rights for the disabled. These latter policies contain empowering rhetoric, but it seems tokenistic in reality. For example, the disabled have the right to be respected and yet the medical industry is spending millions of dollars on producing new techniques for detecting imperfect foetuses.

While the disabled have the right to equal access, we still have uneven pavements and many buildings are still built with stairs as access, and maybe a ramp is added on later as an afterthought.

Getting started

My initial desire was to ensure that the workshop did cater for the needs and wants of the women. Following the Centre's philosophy of shared decision making and understanding, it was very important that the disabled women had input into how the workshop be shaped.

A search of relevant organisations and previously published material showed no previous examples of such a workshop. However, many organisations contacted, throughout Australia, expressed great interest in the project and its outcomes.

The women who were to participate in the workshop had been contacted already by the Spastic Welfare League. One woman, Jane Rowett, had agreed to act as their representative in the planning of the workshops.

Finding an instructor

The initial stages involved locating a suitable instructor, organising a meeting between Jane, the instructor, and myself, and organising a venue and transport for the women.

The League's worker had originally recommended a particular male instructor. However, after being unable to contact this person, I located a female instructor who seemed suitable. The League were agreeable to this change and so I arranged a meeting between the prospective instructor, Jane and myself.

It had already become clear in discussions with Jane, that her definition of self defense was different from the way we had been conceptualizing it up to that point. Jane and I spent some time discussing the qualities we needed in an instructor.

We were both concerned that the instructor would be able to validate the women's needs and be empathetic to them. We did not want an able-bodied professional who would wield authority, and act against the development of trust and opportunities for open discussion.

The instructor initially addressed her questions and attentions to me. I responded by then communicating to Jane. After a short time, Margaret and I began to feel comfortable with each other and equal participation was created. Jane and I had already met and written down questions which Jane wanted to put to Margaret. Having easy access to these questions clearly empowered Jane and allowed her to act effectively as the representative of the women.

A disabled person's view of self defence

This change in focus brought into question whether or not Margaret had the skills for the job. Margaret however assured Jane that she would also cover self awareness and assertiveness in the workshops. They concluded that physical self defense was of no use, considering their limitations, but that self awareness and assertiveness be included. Jane agreed that Margaret would be a suitable facilitator of the workshops.

The design of the workshops

As a result of Jane's interpretations of self defense and our perceived meaning, it was agreed that we divide the workshops into two parts. The first part would be with Margaret and incorporate self defense and self awareness, and the second part would involve myself running discussions around health issues.

We decided to run the workshop for two hours a week over eight weeks based and to charge a fee of five dollars per session. The League thankfully took responsibility in organising appropriate transport for the workshops.

Learning as you go

From the first workshop to the last, quite a few changes took place in the group's dynamics. The first workshop was very ad hoc and lacked formal organisation. While an informal orientation was beneficial to myself and Margaret, having not worked with disabled women before, it did seem to hamper group development.

We did not provide an opportunity for the women to introduce themselves and talk about what they were looking for. I had supplied name tags, but without a formal space for introduction and acquainting themselves, it was difficult to build an environment of equality and shared understanding.

In addition, the process of shared decision making was blocked. We did not consult the women as to what they conceived self defense to be, nor were they given the opportunity to indicate what they would like covered in the workshop.

In the time between the first and second workshop, Margaret and I met and it was agreed that I would co-facilitate all the workshop sessions. In

addition, we developed some strategies that gave more structure to the sessions without making them overly rigid.

Margaret and I agreed to designate 15 minutes of introductory time where the women would introduce themselves and state three things they wanted from the session. The following four weeks improved as the women talked more openly and seemed to feel more comfortable with Margaret and myself. The simple step of allowing space for introductions and stating wants, was vital in creating an environment conducive to open discussion and comment.

In the time between session one and two, the League's Support Worker contacted me to say that she would be attending future sessions. I was unsure as to why this would be helpful and there was no clear role for this person within the format we had developed. Over time this created some problems.

Self Defence - What did we do?

Considering the physical limitations of the women and their conceptions of self defense, Margaret was initially baffled as to what material she could present. However, as time went on and we all developed greater rapport and the women more clearly expressed their views, we were able to develop good presentation material and to promote discussion and encourage questioning.

The type of material presented in the workshops centred around activities such as:

- breathing - learning to relax and breathe in stressful situations;
- being mindful that life is your most valuable possession and responding in threatening situations accordingly;
- acquainting yourself with neighbours so they recognise when you are in distress, and making sure you and they are easily contactable;
- security systems - how they work and where to get them;
- actions to take when strangers make unwanted contact over the phone or in person;
- assertiveness skills and coping with unwanted company;
- coping with taxi drivers and how to deal with harassment, overcharging and ill treatment;
- some basic physical strikes to put off possible attackers;
- using wheel chairs as tools of self defense.

Assertive role play

Using role playing exercises helped the women to practice the self

defense steps. It also helped them become familiar with assertive behaviour, which is the rationale underlying self defense.

These exercises highlighted that women from institutional settings are not accustomed to thinking for themselves. They are not given the opportunity to make decisions about what food they will eat, when they will go to bed, who will come into their rooms or when they will go out. Taking initiative for themselves and being assertive, were, therefore, new experiences and needed to be learnt.

In weeks three and four, some of the women began to discuss problems they were encountering with institutional settings. It is important to remember that half the women lived in the community and worked in sheltered workshops, and the others lived in an institution for people with mental and physical disabilities.

When the women who lived in the institution brought up issues of harassment and denial of rights we spent some time discussing their problems and possible action they could take. However, the other women complained to the worker from the League, outside the workshop, that too much of the time was being given to matters other than self defense.

In retrospect

As noted, the women involved paid a small fee. It seemed that this made them more inclined to make comments on how the sessions were going. I was pleased to hear their feedback, and more so when it was critical or negative since this indicated that they were comfortable with the group and able to comment on it.

The issue of sticking to self defense and not getting off the track with either individuals or sub-groups was important. In future, I would spend more time at the start discussing what to cover, so that it would then be appropriate to ask participants to keep other issues for discussion at a later date.

The role in the sessions of the support worker from the League was always unclear to me. I was concerned that the support workers continual attendance had censored some discussion. In other words, as the support worker was a representative of the institutional agency, and someone who the women relied on, it was difficult for them to be critical about the League.

As it turned out, the women still felt able to be critical of the League's care. However, it seemed to me to be an example of how institutions and their staff are characteristically paternalistic. Paternalism functions to reinforce the ideology that disabled persons cannot cope in an independent manner in an independent setting. This was one of the very attitudes which I was hoping to challenge by adopting a community development approach to the workshops.

At the final workshop we provided an evaluation form which asked the participants to comment on the facilitators, the material presented, the venue, possible improvements and invited them to make critical comments.

Inspiring women

I found my contact with the women who attended the workshops to be inspiring. I had little knowledge or understanding of disability prior to this project. I learnt many valuable lessons. For example, social workers and the like often base intervention frameworks on the assumption that they are doing the right thing, that is, we have good intentions. I learnt the value of checking assumptions out.

Also I felt incompetent with the disabled women at first but through listening and understanding, I was able to improve my confidence. The women were sometimes difficult to understand, but they would persevere for as long as I would.

The self defense group was not an ongoing project and therefore, made little impact on the broader issues of women and disability. However, community development is an ongoing and complex process, involving small steps, such as providing knowledge to a few (as in the self defense group), to larger steps such as changing policies.

Through my involvement with this group of inspiring women, I was able to link into a national project researching access for women with disabilities who are subject to violence, and which is looking at their relationship with police, legal and support services. Through organising a meeting of those in contact with women with disabilities in Brisbane, a file of case studies and recommendations was gathered and sent to the project's researchers. In this way something of what we had learnt in our self-defense group could be passed on to women with similar needs, elsewhere.

9

"The community development strategies we adopted aimed at returning to the residents a sense of control over their lives. In the words of Labonte (1988), the strategies would 'avoid the victim blaming tendencies of health education by defining the social environment, rather than the individual, as the target of change and by putting the residents in control of that change'"

Helen Ansems

the Ivanhoe Place health development project

the Ivanhoe Place health development project

Promoting health through tenant action

Helen Ansems

CONFLICT in the group! How often does conflict between community members arise as the most anxiety provoking problem for a community worker? The Ivanhoe Place story explains how an effective Tenant's Association was set up in North Ryde and despite subsequent conflicts between groups of residents, had some success in improving living conditions and the safety and health of the residents.

Introduction

In May 1990, I was appointed project officer by Ryde Health Promotion Unit to work in a community development role in North Ryde. Over the next 13 months, I supported the efforts of residents on a new public housing estate to organise themselves into an effective voice and to lobby for the creation of a safer and healthier living environment.

The funding for the project was provided by the Northern Sydney Area Health Service and the project was managed by the Health Promotion Unit of the Ryde Hospital and Community Health Services.

The project recognised that many residents of the estate were disempowered by their poor economic circumstances, gender (most were women), age, lack of transport, inability to speak English, and that many were isolated from family and community supports on their new estate.

The community development strategies we adopted aimed at returning to the residents a sense of control over their lives and reducing their powerlessness. In the words of Labonte, the strategies would "avoid the victim blaming tendencies of health education by defining the social environment, rather than the individual, as the target of change and by putting the residents in control of that change" (Labonte, 1988).

Community development was seen by the project as "the process of working to create grass roots support for change, or to act as a catalyst to form appropriate organisation where one does not exist" (Labonte, 1988).

As project officer, I was given a broad community development brief to:

- consult with the community to identify the main areas of concern contributing to the health status of the community and to assist the community in addressing these issues;

- liaise with other local workers regarding the needs of the specified community.

The Ivanhoe Place Estate

The North Ryde public housing estate, built around Ivanhoe Place, was constructed between 1986 and 1990. The estate was built on an 8.16 hectare site close to Macquarie University and Macquarie Shopping Centre. The area comprised a mixture of light industrial, commercial and residential properties and educational institutions.

The estate consisted of 260 dwellings including 52 pensioner units, 126 walk-up one and two-bedroom apartments, and 82 attached three and four-bedroom townhouses.

This medium density estate was home to over 700 people, mostly young families, and yet on completion of the housing in 1990, no supporting facilities were provided. There was no playground, no community hall, no meeting place and no public telephone.

A child care centre had been built in 1986, but remained unopened in 1990 due to a disagreement (concerning the standard of the structure) between the Ryde Council and the government departments involved in the centre's construction.

A survey by residents in December 1990, as part of this project, showed that 40% of residents were born overseas. These people had come from 45 different countries and 36% of residents spoke a language other than English at home. The survey revealed that 37% of the residents were under 15 years old. The estate was a youthful, multi-cultural community.

Project Background

When I was appointed, a social work student on placement with Ryde Council had already spent two months moving around the estate. She had convened a regular intersectoral meeting of workers from community and government agencies who were providing services to the estate, called the Herring Road Community Development Group.

This group, along with some residents had organised a community get-together and the group had prepared information about local services in a kit that was distributed to residents at the get-together.

The staff of the Health Promotion Unit had regular contact with Ryde Council's Community Service Co-ordinator, and it was in these discussions that the need for a community development worker was identified.

This close and supportive liaison between the Council and the Unit continued throughout the project. The Community Services Co-ordinator was part of my Advisory Committee, which also included local residents, the Manager of Health Promotion and a pastoral worker (a Catholic nun). The Council staff also continued to convene the Herring

Road Community Development Group and were active in the planning and launch of the Ivanhoe Place Neighbourhood Survey.

Getting to Know the Community

The first few months were spent in establishing my role in the community, and in getting to know residents and gaining their trust. The residents hadn't requested support and so I felt I needed to prove that I could assist them.

The social work student introduced me to some residents, and I met others at the community get-together in June. At this function some residents expressed interest in forming an association, and it was these people who later became the core group of the first residents' committee.

I also met residents around their kitchen tables where they talked about problems they experienced on the estate and their dreams of making it a better place for their children.

Unfortunately, it wasn't possible to establish a project office on the estate. I was based at the Health Promotion Unit from where I made regular visits to the estate. I wasn't as accessible to the community as I would like to have been, but given no other choice, we made it work.

There was an advantage of working in the Unit however, which was the tremendous support from the Unit Managers, Bronwyn Healy and Silvia Marcello. This support was vital, particularly during challenging stages of the project.

A camera as a community development tool

Initially I found moving around the estate a difficult task. I hadn't worked on a public housing estate before, and I was new to Sydney. Although I had used community development strategies in my previous job in rural Victoria, this situation was vastly different. It took some time for me to feel comfortable and safe moving around the estate and even then some residents were wary of me. I found that my camera was a useful tool of introduction.

While residents didn't want to be photographed themselves, they were keen to have photos of their children. I moved around the estate, introduced myself to people and asked if they would like me to photograph their children. Most people were very happy to receive a photo and the copies I kept gave me a record of the face of the estate.

I also photographed areas of concern to residents such as the poor drainage, the vandalized child care centre and the undeveloped recreational areas. The photos acted to validate residents' concerns and they used the photos in lobbying for change. As time went on, I also took photos of meetings of the residents' group to show the growth and change in the group.

Forming the Residents' Association

In June I made contact with the NSW Regional Tenants' Council and organised a meeting between two of their active volunteers, who were also public housing tenant group representatives, and some residents from Ivanhoe Place.

This meeting was in a resident's home and while the group was small, they were keen to set up an association on the estate and to be affiliated with the Regional Tenants' Council.

The first meeting to form an association was held in early July and a steering committee was set up. The group called themselves the Ivanhoe Place Residents' Association.

The steering committee decided to adopt a very informal structure for their meetings as they were all new to meeting procedures. They asked me to chair the first meetings, and then as they gained more confidence, they rotated the chairing. The Secretary proved to be very able at minute taking and letter writing and was a great asset. The residents were very enthusiastic from the start as there *were* genuine problems on the estate that they wanted to tackle.

Issues to fight for

There were many issues of concern raised at the early meetings of the Association and although there were only 12 members on the steering committee, they were keen to take action.

Their concerns included:

- the child care centre - the first building on the estate, yet it was still unopened after four years and was being vandalized. It had also become a meeting place for people the residents considered to be "undesirables from outside the estate";
- the poor drainage in the backyards of the town-houses forced children to play on the streets;
- the areas set aside on the estate plan, as recreational space were undeveloped and full of dangerous construction rubble, again forcing children onto the streets;
- the streets (particularly Ivanhoe Place) were busy and had no speed deterrents to slow traffic - the combination of fast cars and children playing was a disturbing one;
- there was no public telephone box;
- there was no corner shop and there was no community meeting place.

Taking Action

By August 1990, the Association had written to many organisations and departments about their concerns. The issues that they felt most

passionate about related to their children. They wanted their children to grow up in a safe environment with decent recreational facilities. They lobbied with great determination.

They quickly became skilled at writing letters, talking to politicians and contacting the media, and once they had a sense that they could do something, they were unstoppable.

My role was mainly one of support. I helped the residents find information and contacts they needed and would occasionally play an advocacy role if they wanted me to. I felt that it was important that the residents were in control of the process of lobbying, of social change and of community development.

The phrase, "You can do it just as well as I can, have a go", was the most common I used.

From the early days of the Association, the residents wrote the letters when they *were* lobbying (they sometimes asked me to proof read them and make suggestions), the residents would make the media contacts and do the interviews (I would be asked to go over their notes beforehand), and it was the residents who contacted departments and politicians.

Ivanhoe Place Neighbourhood News

In August we started a monthly newsletter for the estate called the "Ivanhoe Place Neighbourhood News". The residents gradually became involved in its production. At first they collected contributions such as items of interest, recipes, and illustrations, and I would put the material together and photocopy it for them. The committee would distribute it across the estate.

I continually reminded the committee members that I was only employed for a year and that they needed to become involved in the production of the Neighbourhood News, if they wanted it to continue. By February 1991, they were producing the News themselves.

Like any community development project, it was not all smooth sailing and the conflict which was to become characteristic of the Association from December on, arose around the first issue of the News produced by the residents. The newsletter sub-committee were criticised for including "unauthorized" material in the News, and the News remained a central issue in the ongoing conflict.

However, despite conflict and resignations, the Neighbourhood News continued and was still being produced in mid 1992. More details about the News' development are contained in a paper available from this writer (Ansems 1991).

Ivanhoe place neighbourhood survey

By October 1990, the Residents' Association were actively lobbying for change. However, they had no statistical information about the estate to

Forming the Residents' Association

In June I made contact with the NSW Regional Tenants' Council and organised a meeting between two of their active volunteers, who were also public housing tenant group representatives, and some residents from Ivanhoe Place.

This meeting was in a resident's home and while the group was small, they were keen to set up an association on the estate and to be affiliated with the Regional Tenants' Council.

The first meeting to form an association was held in early July and a steering committee was set up. The group called themselves the Ivanhoe Place Residents' Association.

The steering committee decided to adopt a very informal structure for their meetings as they were all new to meeting procedures. They asked me to chair the first meetings, and then as they gained more confidence, they rotated the chairing. The Secretary proved to be very able at minute taking and letter writing and was a great asset. The residents were very enthusiastic from the start as there were genuine problems on the estate that they wanted to tackle.

Issues to fight for

There were many issues of concern raised at the early meetings of the Association and although there were only 12 members on the steering committee, they were keen to take action.

Their concerns included:

- the child care centre - the first building on the estate, yet it was still unopened after four years and was being vandalized. It had also become a meeting place for people the residents considered to be "undesirables from outside the estate";
- the poor drainage in the backyards of the town-houses forced children to play on the streets;
- the areas set aside on the estate plan, as recreational space were undeveloped and full of dangerous construction rubble, again forcing children onto the streets;
- the streets (particularly Ivanhoe Place) were busy and had no speed deterrents to slow traffic - the combination of fast cars and children playing was a disturbing one;
- there was no public telephone box;
- there was no corner shop and there was no community meeting place.

Taking Action

By August 1990, the Association had written to many organisations and departments about their concerns. The issues that they felt most

passionate about related to their children. They wanted their children to grow up in a safe environment with decent recreational facilities. They lobbied with great determination.

They quickly became skilled at writing letters, talking to politicians and contacting the media, and once they had a sense that they could do something, they were unstoppable.

My role was mainly one of support. I helped the residents find information and contacts they needed and would occasionally play an advocacy role if they wanted me to. I felt that it was important that the residents were in control of the process of lobbying, of social change and of community development.

The phrase, "You can do it just as well as I can, have a go", was the most common I used.

From the early days of the Association, the residents wrote the letters when they were lobbying (they sometimes asked me to proof read them and make suggestions), the residents would make the media contacts and do the interviews (I would be asked to go over their notes beforehand), and it was the residents who contacted departments and politicians.

Ivanhoe Place Neighbourhood News

In August we started a monthly newsletter for the estate called the "Ivanhoe Place Neighbourhood News". The residents gradually became involved in its production. At first they collected contributions such as items of interest, recipes, and illustrations, and I would put the material together and photocopy it for them. The committee would distribute it across the estate.

I continually reminded the committee members that I was only employed for a year and that they needed to become involved in the production of the Neighbourhood News, if they wanted it to continue. By February 1991, they were producing the News themselves.

Like any community development project, it was not all smooth sailing and the conflict which was to become characteristic of the Association from December on, arose around the first issue of the News produced by the residents. The newsletter sub-committee were criticised for including "unauthorized" material in the News, and the News remained a central issue in the ongoing conflict.

However, despite conflict and resignations, the Neighbourhood News continued and was still being produced in mid 1992. More details about the News' development are contained in a paper available from this writer (Ansems 1991).

Ivanhoe place neighbourhood survey

By October 1990, the Residents' Association were actively lobbying for change. However, they had no statistical information about the estate to

back up their arguments, as the estate had been built since the previous census. They wanted up to date information such as the number of children, the ages of residents, and the languages spoken.

The Association's committee also wanted more evidence of the issues of concern of the general population on the estate, particularly those who didn't attend meetings.

We sought and gained funds from the Ryde Council, with the support of Simone Schwarz, their Community Services Worker, and from the Northern Sydney Area Health Service, through Peter Whitecross, the Area's Health Promotion Co-ordinator. The funds were used to employ a consultant to assist the residents to carry out a survey of the estate.

Participatory research

Residents participated in every aspect of planning and carrying out the survey. Dr Kevin McCracken from Macquarie University (opposite the estate) was employed as the consultant. The Residents' Association set up a Survey Project Advisory Committee which met with Dr McCracken in early October to discuss the information to be collected and the method of collection.

It was decided that personal interviews conducted by residents of the estate would be the most appropriate strategy. A range of important topic areas to be considered for inclusion were identified, with the proviso that the interviews be relatively short. Keeping it short was seen as important to encourage residents to participate in the survey and to limit the time demands on the volunteer interviewers.

The interview schedule

A draft interview schedule was prepared by Dr McCracken and discussed with the Residents' Association, and representatives of the Council and the Health Promotion Unit. To keep it short, most of the questions were posed in a "closed" format however a number of open ended questions allowing residents to have their say in their own words were also included.

Potentially sensitive topics such as marital status and income, were excluded as it was feared they would result in many residents refusing to participate. The schedule resulting from these discussions was pre-tested and found satisfactory, a few minor wording changes being the only alterations needed.

Interviewers

Fourteen residents were recruited to serve as interviewers. They were familiarized with the interview schedule and procedures to follow in conducting the interviews at a training session led by Dr McCracken.

Special emphasis was given to obtaining bilingual interviewers to ensure that non-English speaking residents were included in the survey. I

contacted the Co-ordinator of Ethnic Health Services for Northern Sydney and we established two main strategies:

- Ethnic Health Workers worked with us to identify resident interviewers fluent in the required languages; and
- the Health Interpreter Service (HIS) was used in instances where resident interviewers were not available.

Ethnic Health Workers helped recruit Arabic and Armenian resident interviewers, and the residents recruited Polish and Spanish speaking interviewers. These bilingual interviewers completed Dr McCracken's training session.

A Chinese Ethnic Health Worker completed one interview required with a student, while interpreters from HIS assisted me interview two Persian speaking and two Vietnamese speaking families. HIS was also booked for interviews with three Korean families, but when contacted, the families preferred to use their teenage children to interpret.

The use of resident interviewers was also a strategy to reduce social isolation by linking together estate residents who spoke a common language. All the ethnic interviewers reported that they enjoyed the task and frequently stayed with residents to talk after the interview was completed.

Conduct of the survey

The interviewers were allocated areas of the estate and told to interview an adult member of every household in their area. To maximize survey coverage, interviewers were asked to make up to three visits to each dwelling to contact the residents.

Several strategies were used to encourage residents to participate in the survey:

- information about the nature and purpose of the survey was distributed prior to the survey in two editions of the News;
- interviewers wore official identification badges;
- interviewers introduced themselves as neighbours (eg "I live in the next street - I'm from your Residents' Association); and
- residents were assured that responses would be treated in strict confidence.

To ensure confidentiality, no names or addresses were registered on the interview schedules. Once completed, the schedules were sealed in envelopes and passed on to Dr McCracken for analysis.

All told, 208 of the estate's 260 dwellings (ie 80%) were successfully surveyed. A number of households refused to participate, but most of the missing households were due to not being able to make contact.

We were very happy and impressed with the high rate of participation in the survey and the interest amongst residents which this demonstrated. Residents interviewed other residents as neighbours, and friendships and contacts were made.

The non-English speaking residents *were* carefully considered in the planning of the survey and the strategies aimed at ensuring their participation were successful. The Neighbourhood News was an important source of communication to the residents about the survey and the reasons for it.

We had planned to carry out the survey during the last two weeks of November. However, problems in administering the survey led to the period being extended to the end of December. These problems were:

- the timing of the survey - just before Christmas - was not ideal for many interviewers and residents;
- the interviews frequently took much longer than the planned ten minutes to complete;
- several interviewers dropped out - there were only three out of ten who finished the last survey on New Year's Eve; and
- some residents - particularly working people, were difficult to contact.

The report on the survey was prepared by Dr McCracken and launched in May 1991 at a time and with a guest list which were carefully planned for maximum political effect. The estate was in a swinging seat held by the Liberal Government and the launch was a week before the NSW election. Politicians from all parties attended, as did over 50 people from community organisations and Government departments. The Minister for Housing was guest speaker.

Members of the Residents' Association were involved in the planning of their launch, designed the invitations and acted as hosts. They also conducted tours of the estate following the launch.

The Association's Secretary at the time of the survey spoke on behalf of residents. She clearly reiterated the findings of the survey, including the need for a local shop, improved drainage, child care facilities and play areas for children. The Secretary articulately pointed to the poor planning of the estate in respect to the lack of social supports for the residents and expressed the lessons that the Minister and politicians could learn from the mistakes made. "*We have a lovely home, but... nothing else*".

In his speech, the Minister for Housing promised that the issues of drainage, the child care centre and the development of the recreational areas would be addressed - some of them have been.

Some wins for the residents

The meetings of the Association were being held in different homes in

different streets, to encourage new members and by December 1990 there was a lot of action.

The steering committee had achieved some wins in lobbying to have the child care centre opened. They managed to get broad media coverage about the state of the centre in local and metropolitan newspapers. The Shadow Minister for Community Services visited the estate with the ALP candidate for the May state election, and following her visit, things began moving. In particular, the Department of Community Services began looking for another auspicing body for the centre.

The survey was also successfully underway, however there was growing tension in the Association. A recently joined member of the committee, who was undertaking further studies, judged the committee's structures according to her previous experience and criticised the chairing of the meetings, the "unresolved agendas" and claimed there was inadequate financial accountability.

Steering committee members were in turn critical of this member for not doing her share, particularly as she had signed up as an interviewer for the survey, but had then not participated.

The first AGM of the Ivanhoe Residents' Association

The Association's first Annual General Meeting was held in December 1990 and resulted in the election of an Executive Committee who had great difficulty in working together. The Committee struggled along in a very tense way until March 1991, when the Association split over disagreements about the Neighbourhood News.

By March, the Association had several successes:

- the child care centre was to be opened later in the year;
- a telephone box had been promised by Telecom;
- new traffic signs had been erected at the entrance to the estate; and
- the survey had been successfully completed and the launch planned.

There was, however, friction in the Association Executive, in fact the Secretary and the President had refused to work with the Vice-President. Active members had realised that the Association provided an effective vehicle to improve their social and physical environment, and, as a consequence, competition for the top jobs became acute.

These residents, traditionally so disempowered by social disadvantage, fought hard to maintain the influence they had, and the control their positions in the Association afforded them.

In an effort to defuse some of the friction, I organised a series of conflict resolution workshops for any interested members of the Association. However, midway through the series, they had to be cancelled because the conflict had escalated - the workshops had come too late.

The Association splits

The conflict and tension continued from December to April, and people became emotionally drained. They had to see each other daily, because of the density of the housing, and lines were drawn across the whole estate.

I also came under attack and was challenged about many issues including my lack of impartiality.

At a meeting in April, following a dispute about the Neighbourhood News, a tenant worker from the Regional Tenants' Council was asked to chair a committee meeting "impartially". At that meeting, five members, including the President and Secretary resigned.

I made efforts to mediate with key people from both groups, but no reconciliation was reached. I repeatedly encouraged the residents who had resigned to go back to the Association, however they said that they felt too emotionally drained to continue.

In November 1991, some of the residents who resigned from the Association, started a new group called "The Macquarie Park Residents and Community Progress Association". This group has continued and in May 1992 started their own newsletter.

Finishing the project

Due to my close relationship with the original group of members, my relationship with the new Committee was a strained one by the end of the project. I supported them while they finalised the constitution, which had been started in March, and while they published a brochure on the Association. However, when the Health Promotion Unit offered to continue support for 1991 /92, the Association indicated that it was not needed. One member of the Association was quoted as saying "they did not need to be tied to mother's apron strings any more".

Furthermore, when I provided information to residents outside the Association who were organising a Spring Fair, the Association wrote a letter of complaint to the Health Promotion Unit!

Successes and frustrations

As a result of this project, Ivanhoe Place public housing estate has two residents' associations, there are structures in place that help reduce social isolation for residents and give residents access as a group to the Department of Housing and other agencies.

The residents clearly identified their needs, learnt skills and made new contacts as a result of the Neighbourhood Survey.

The change and growth could also be seen in individuals as they worked to change their social environments. Like the mother of five who had never worked outside her home, who ably gave press interviews and

lectured the Minister for Housing about the need to plan the social environment when planning housing.

Another resident, who I accompanied during the survey because she did not want to do interviews on her own, is now Secretary of the Association, editor of the Neighbourhood News, and frequently represents the residents with the Department of Housing.

Through the changes that occurred during the 12 months of the project, the residents proved their ability to influence and change their social environment in a positive way. Some of these changes were:

- the child care centre was opened in August 1991, and is available for evening meetings;
- the drainage on the estate underwent extensive repairs in 1991;
- a public telephone box was installed;
- two resident newsletters were being produced on a monthly basis; and
- the Neighbourhood Survey was successfully carried out providing valuable statistics and identifying concerns for lobbying.

My biggest frustration as a worker was my inability to assist residents towards a resolution of the conflict which caused the split in the Association. Some of the most talented original members resigned because of the ongoing criticism of their work, and because of the conflict which left them emotionally drained. I was unable to encourage them to effectively deal with their opposition.

It was frustrating to watch the confidence, which they had developed during the days of lobbying for the opening of the child care centre and in conducting the survey, being eroded by other residents.

Another frustration was that the initial decision of the steering committee to have an informal meeting structure (eg. rotating chair, general agreement on issues rather than formal motions), became a major point of criticism against them.

Community development in health - through action

There *were* some lessons from this project for me. Using an indirect style of working and giving the residents control of the project at an early stage, brought strong commitment by residents to the group. Explaining that I was only a short term support, led to residents not becoming overly reliant on me and leaving the project was a less painful process than it might have been.

I learnt that when surveying, using participatory research methodology is a successful way of gaining co-operation from a group who traditionally are difficult to access.

I learnt that if people have identified their major concerns they are committed to participating in action to tackle those concerns.

I have learnt that people have untapped abilities that can be nurtured to bring about social change. I also learnt that broad objectives are vital to enable a worker to work with the real concerns of residents.

Next time

If I was starting again on this project:

- I would make sure that a developing group had access to training, particularly regarding meeting skills and chairing, in its early days;
- I would make sure that the worker and residents had an opportunity to develop conflict resolution skills early in their history before crises arose;
- I would make sure that I had a good support structure in place for the worker, including someone with the experience in community development in public housing; and
- I would liaise more closely with experienced community workers outside the health network.

Postscript:

As I wrote this in August 1992, I have heard that some members of the Macquarie Park Resident's Association attended a meeting of the Ivanhoe Place Residents' Association and there was further conflict. The process of community development is a tumultuous and ongoing one.

Acknowledgments

I would like to extend my thanks to the members of Management Committee including:

- the resident representatives;
- Peter Whitecross, Co-ordinator of Health Promotion, Northern Sydney Area Health Service;
- Simone Schwarz, Community Worker, Ryde Council;
- Bronwyn Healy and Silvia Marcello, Unit Managers, Ryde Health promotion Unit; and
- Margaret Purchase, Sister of Charity;

Finally, I would like to thank the residents of the Ivanhoe Place estate.

References

Labonte R., Social Inequality and Healthy Public Policy, Community Quarterly, 13, 1988.

Ansems H., The Development of the Ivanhoe Place Neighbourhood News, Unpublished, March 1991.

McCracken K., The Ivanhoe Place Neighbourhood Survey, Ryde Hospital and Community Health Services, March 1991.

10

"Confidentiality is more of an issue in rural areas where being publicly critical of a health worker is much more difficult than it is in the city. People were keen to give their views, but only if they could be sure it wouldn't harm their relationship with others in the town."

Fiona Gardner

community consultation on birthing practices

Fiona Gardner

Consumer initiative

SEVERAL women who had recently given birth approached the Loddon District Health Council in July 1989, to express concern about their experiences. The District Health Council is an advocate for consumers on health issues and involves consumers in the planning and review of health services, and it was clearly the most appropriate body to contact.

The women were unhappy about several issues, particularly the lack of choice in Bendigo (the major centre of the Loddon District) about how to give birth, and the attitudes of staff. These views reinforced concerns that had previously been raised or felt by members of the District Health Council's Committee of Management. Subsequently, the Council decided to set up a Working Party to review birthing issues.

A couple of months later, the Victorian Minister for Health announced a Statewide Review of Birthing Services. The Council felt that results from the local review could usefully be fed into the Statewide one, particularly in providing a rural perspective.

Working party attracts wide interests

There were many different interests in birth in Loddon and many opposing points of view. As soon as the Council decided to form the Working Party, representatives of different interest groups started lobbying to be involved. The Council decided that as many groups as possible should be represented so that:

- all points of view could be heard;
- no-one felt excluded from the process;
- the resulting report would (hopefully) reflect agreement and suggest future directions.

The Council's Executive Officer wrote to all organisations and groups that might have been interested. This included a range of consumer groups such as Nursing Mothers, Birth Support Bendigo, Childbirth Education Association, Stillbirth and Neonatal Death Society, and professional groups and organisations such as the two Bendigo Hospitals, obstetricians and general practitioners, and the Health Department.

Nearly all groups wanted representation and the Working Party began with a membership of 17 including six District Health Council

representatives. The issue of rural representation (ie. from beyond Bendigo), was not considered.

Working party aims

The Working Party identified its aims which were broadly to:

- i) identify existing birthing services and intervention rates in the District;
- ii) consult with consumers and providers about their experiences and views;
- iii) review government and agency policies.

Soon after the Working Party formed in September 1989, the Council's Executive Officer left. Extra funding was found through the Health Department for two of the Council's Committee members to share the workload of resourcing the Working Party until a new Executive Officer was appointed.

The Working Party decided on a two-fold approach:

- Consultations with consumers in Bendigo and three small rural towns selected as representative of the District.
- A questionnaire to be distributed to consumers through Maternal and Child Health Nurses, community consultations and general publicity.

The consultation process

The Working Party was very conscious of working with people from each town in planning the consultation. To make sure the consultations were appropriately carried out in rural areas it was decided to call a meeting of local providers and representatives of community groups in each town to plan the meetings. Two social work students on placement with the Council were also assisting the Working Party at this stage.

The workers who attended the planning meetings in each town varied, but generally included the Maternal and Child Health Nurse and Community Health Worker. However, while people were happily to be involved in the planning, in two of the towns they were reluctant to take an active role in the meeting itself. Very few women came to the meetings in the three towns.

Face to face criticism

Clearly, for both workers and consumers there were difficulties in being critical - particularly in public - of local providers and services. After all, as they pointed out, if you criticized the only doctor in town, you were likely to get a cool reception on your next visit.

Similarly, it was hard to criticize people you might be playing tennis with the next week or the parent of your child's best friend.

Language may have also been a problem - some of the participants,

particularly the students, tended to use "buzz" words which community people were not familiar with and found somewhat alienating.

Data from the questionnaire

The questionnaire took considerable time and energy for the Working Party to develop, but was enthusiastically received by consumers. Given that it was anonymous, people could afford to be open in their praise or criticism.

Six hundred questionnaires were distributed and 232 women filled in the six pages. Over half the respondents made many comments, with some people adding another page so that they could express their views more fully.

By this stage (February 1990), I had started as the Council's new Executive Officer and we began collating and analysing the results. The results were frequently positive, with the more critical comments falling into three main areas.

Desire for more control over the process of birth

People wanted access to information which would allow them to make their own decisions about preferred procedures - "I've had four pregnancies. I've lost three and have three children. Each time I've learnt a lot more, but each time I've been treated like a fool who knows nothing about my body and my babies".

Interest in a greater range of choices about birthing

"It is nice to be able to say what you want and how you are going to do something (without others giving their opinions). It is the patient's choice if she does or doesn't like something, and providing it doesn't affect the well-being of the foetus, it should be adhered to without question".

Staff attitudes and practices

"It would be nice to be attended by the same midwife or nurse instead of dozens of different ones (all of whom have different ideas on everything) - it leaves you confused as to how to do things especially when it's your first baby".

Reporting on the review

By the end of April 1990 the results had been collated. Several Council Committee members and I volunteered to write up sections of the report. This was time-consuming, partly because of the opposing views represented on the Working Party. Particularly with the recommendations, there was often considerable debate about both the content of a recommendation and how it should be expressed. The aim was to reach decisions by consensus - easier at some times, than others! Eventually, for nearly all issues, acceptable wording was agreed upon.

Input from rural providers

Towards the end of this phase, Council Committee members and I visited the three rural towns involved. Our aim was to meet with local providers and representatives of community groups, present a summary of the Issues from the report and encourage discussion of these.

These meetings were very productive. They were well attended by local providers and generated considerable discussion about birthing issues. The sessions were deliberately held before the recommendations were finalised (and there was plenty of time for that!) so that input from providers could be considered.

Some new issues were raised, for example, General Practitioners felt their role in birthing was being discouraged as the number of obstetricians increased.

The most positive aspect of these meetings was that providers often pushed other providers to consider the issues from the report. It was also useful for us to be there as outsiders from the town and therefore more able to raise difficult questions.

By the end of October there was agreement on the final version of our findings which was then sent to the printer. The report was launched in early December.

In January 1991, a small number of people from the Working Party met to talk about the report and how to ensure that the recommendations were implemented. The group decided to:

- i) seek funding for a worker with the newly established Women's Health Service to carry out some of the suggested activities; and
- ii) request the Health Department to auspice an ongoing Committee given that many of the recommendations required their involvement.

By this stage, many of those originally involved in the Working Party, now 18 months old, had become exhausted by the process. Those remaining were primarily consumers.

Issues arising

1. The value of having a Working Party with consumers and providers.

Although the wide representation on the Working Party often made it difficult to reach agreement, everyone felt there were many benefits. People understood each other's point of view better by the end of the project. The process of reaching a compromise about recommendations meant that the report was owned by everybody, and because there were many consumers (two thirds of the group including Council members), they were rarely intimidated by the professionals. Throughout the project the views of consumers, as expressed in the questionnaires, kept us on track. The wide representation of the Working Group gave it legitimacy in the eyes of both consumer and provider groups.

There were obviously disadvantages too - a lot of time had to be spent in reaching agreement on the issues. The need to compromise could have meant, though it didn't in this case, ending up with a report and recommendations which were so watered down that they don't address the issues. Having the right balance of consumers and providers may be a key component in our success.

2. Who owns the report?

One of the potential issues was who owned the report? If the District Health Council had disagreed with the report or its recommendations, who would have made the decision about what to do with it? Ideally this should have been sorted out before the project started.

3. Complexities of working in rural areas

The project reinforced the importance of not assuming that all rural communities are the same. The consultation strategy for consumers worked well in one town, but not in the other two.

The results confirmed this. In one town, new mothers were expected to stay in hospital for as short a time as possible, so that they could return to the farm and help out. In another, mothers were encouraged to stay in hospital for as long as possible to be rested before returning home.

The boundaries between consumers and providers are more permeable in rural areas than in the city. Living in rural communities, individuals are seen as people with many potential roles, rather than one particular role. So the doctor, for example, as well as being the doctor, is a neighbour, your tennis partner (or opponent), worships with you on Sunday, and also shops in the local supermarket.

The fact that roles are not as clear-cut as they tend to be in more urban areas may result in people being seen in a more rounded way, but may have had disadvantages for this project. People may have felt the need for more privacy in the expression of their feelings and viewpoints. A whole set of inter-relationships may be disconnected if they have a major disagreement in one sphere of their lives.

Confidentiality is more of an issue in rural areas where being publicly critical of a health worker is much more difficult than it is in the city. People were keen to give their views, but only if they could be sure it wouldn't harm their relationship with others in the town.

For these reasons, seeking change in rural communities needs to be carefully planned. It is particularly important to seek support from a range of groups and individuals, making sure that you have included people who have credibility in the town. Newcomers, who are often the ones who desire and initiate change, may not yet have established their credibility, so their involvement must be balanced with others.

It is essential to involve both providers and consumers for several reasons, partly because the boundaries between them are tenuous; partly because

change in the town will affect both and so must involve both; and partly because they will have to continue to live and work together afterwards.

The strategy of generating conflict and polarizing people to encourage change is very threatening in rural areas. People often feel they have too much to lose from open conflict.

Issues of lack of choice for people in rural areas were also very evident in the project. There was often only one or two doctors doing deliveries in the town, therefore birthing options were limited, and distance made coming to Bendigo difficult for many.

How to Ensure Follow up

One of the fears of the Working Party was that the report would be published and distributed and then nothing would happen. Project funding often does end at this stage and there may be no one with the time or energy to ensure follow up. In some ways this was easier in this project in that there were a number of very committed consumers who were determined to pursue the issues.

Women's Health Service inherits the project

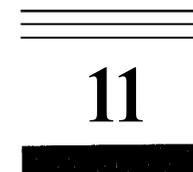
The District Health Council was also prepared to stay involved in the short term, but felt that its role was to initiate rather than implement and that eventually it would be more appropriate for another organisation to be involved. The obvious organisation here was the Women's Health Service, so the Council approached that Service's Co-ordinator and Committee. The workers from both agencies and some of the consumer representatives put together a successful submission to the Victorian Health Promotion Foundation for a follow up worker for a year to be based at the Women's Health Service.

This follow up project was successful and, in fact after the first year, another submission was granted to carry out related work. At the same time, the Council approached the Health Department about establishing an ongoing panel to act on the recommendations from our report. Again this was made easier because the Statewide Review had coincided with the Loddon review.

One of the recommendations of the Statewide Review was that a panel be established in each Region. Due to the Council's involvement in the local review, the Council and members of the Working Party were able to encourage the development of this panel.

Our experience suggests the value of making sure that there are workers and consumers involved in projects who will be able to continue working on implementation afterwards.

Alternatively, projects employing workers need to build in time for implementation rather than finishing once (or before!) a report is produced.



"I became interested in the issue of community management training. This stemmed from discussions with several residents who had approached me for support and information. Their concern was to understand and fulfil their roles as committee members in a professional manner."

Julie Statkus

change in the town will affect both and so must involve both; and partly because they will have to continue to live and work together afterwards.

The strategy of generating conflict and polarizing people to encourage change is very threatening in rural areas. People often feel they have too much to lose from open conflict.

Issues of lack of choice for people in rural areas were also very evident in the project. There was often only one or two doctors doing deliveries in the town, therefore birthing options were limited, and distance made coming to Bendigo difficult for many.

How to Ensure Follow up

One of the fears of the Working Party was that the report would be published and distributed and then nothing would happen. Project funding often does end at this stage and there may be no one with the time or energy to ensure follow up. In some ways this was easier in this project in that there were a number of very committed consumers who were determined to pursue the issues.

Women's Health Service inherits the project

The District Health Council was also prepared to stay involved in the short term, but felt that its role was to initiate rather than implement and that eventually it would be more appropriate for another organisation to be involved. The obvious organisation here was the Women's Health Service, so the Council approached that Service's Co-ordinator and Committee. The workers from both agencies and some of the consumer representatives put together a successful submission to the Victorian Health Promotion Foundation for a follow up worker for a year to be based at the Women's Health Service.

This follow up project was successful and, in fact after the first year, another submission was granted to carry out related work. At the same time, the Council approached the Health Department about establishing an ongoing panel to act on the recommendations from our report. Again this was made easier because the Statewide Review had coincided with the Loddon review.

One of the recommendations of the Statewide Review was that a panel be established in each Region. Due to the Council's involvement in the local review, the Council and members of the Working Party were able to encourage the development of this panel.

Our experience suggests the value of making sure that there are workers and consumers involved in projects who will be able to continue working on implementation afterwards.

Alternatively, projects employing workers need to build in time for implementation rather than finishing once (or before!) a report is produced.

"I became interested in the issue of community management training. This stemmed from discussions with several residents who had approached me for support and information. Their concern was to understand and fulfil their roles as committee members in a professional manner."

Julie Statkus

community management training

Julie Statkus

A traditional dilemma for community workers has been how best to work with community committees. Sometimes there is a nasty feeling that they might be providing token representation and management. How do the community members on these committees feel about their role and the ever increasing demands for accountability which are being made on them by Government Departments?

South/Port's residents

South Melbourne and Port Melbourne municipalities have traditionally been working class areas with a high population of blue collar workers and informal networks. This is now changing as new residents discover the joys of living close to the City of Melbourne and the beach. With a combined total of 17,000 residents, there is also a high proportion of aged residents, people who live alone, and public housing tenants, many of whom are on low incomes.

Both long-term and newly arrived residents and workers identify strongly with the area creating a strong sense of community. But there are many residents who require services to enable them to continue to live in South/Port and to participate in activities of their choice.

Meeting these needs are several local services and groups funded or supported by one or more of the three tiers of government as well as several self-help groups. These groups and services evolved from issues specific to the local population and are managed by community committees involving resident participation.

Links and networks

Due to the high level of local commitment, the old Temperance Hall in Port Melbourne was refurbished to become the Liardet Community Centre. The Hall houses the Port Melbourne Neighbourhood House, several local self-help and Senior Citizen groups and a number of community groups.

South Port Day Links and South Port Volunteer Network are two of these groups. Day Links works in linking residents into local services and groups, and with other residents of their choice - primarily with those in the Home and Community Care target population - frail older people, younger people with disabilities and those caring for them.

The major role of Volunteer Network is to place volunteers into local

community organisations. Both groups, like most in the area, operate under the direction of community based committees of management.

Training for community management

While working for Day Links, I became interested in the issue of community management training. This interest stemmed from discussions with several residents who had approached me for support and information. Their concern was to understand and fulfil their roles as committee members in a professional manner.

As a worker in the area for three years and as a member of several committees, I could identify with the uncertainty expressed by residents, particularly since as a paid worker, I have access to training, which is not normally the case for voluntary participants on committees.

In response to these concerns, the Co-ordinator of Network, Mary Jurus, and I decided to seek support for a project with the following goals:

- to source and obtain funds for committee training;
- to develop a training program;
- to ensure that skilled facilitators were obtained;
- to establish times, dates, venues and other practicalities associated with running the workshops.

The aim was to develop and arrange facilitation of a series of workshops for people who were on committees or who were interested in being involved in community management. We hoped that through the workshops, they would learn new skills and feel more comfortable about their roles as committee members.

The funds

Mary and I applied for a Community Support and Recreation Grant from South Melbourne Council. The Council had encouraged groups to develop joint projects. We applied for \$2,000 for volunteer training and to produce a volunteer directory. \$1,500 was allocated and agreement was reached that Day Links would handle the financial details.

Planning the training with the trainees

The Day Links Committee of Management approved our participation in this project and we had been notified that funds were available.

We sent a letter to several local committee members, workers and a community development student, who lived locally and had been working on other projects at the Liardet Community Centre, inviting them to help develop a training program. Among the residents who received the invitation were those who had approached me earlier for information and support. The response was overwhelming. Participants jointly chose the time most suitable for them to come to a planning

session and 11 people attended. Each person was asked to suggest something about committees that they wanted to know more about and responses were written on a whiteboard. We went around in a circle until each person had identified their areas of concern.

I spoke about the available funds and we discussed general housekeeping details such as the times and dates of the workshops, and how many to run. The content of the workshops was decided by the participants working through the issues on the whiteboard and grouping similar ones together. Six categories were identified and Mary and I agreed to find facilitators for the workshops.

Choosing the facilitators

We chose facilitators because of their specific skills in certain areas or because they were recommended. The facilitators were not known locally as we recognized the value in having uncluttered relationships so that participants felt freer to express themselves.

A major concern was to ensure that participants felt comfortable in the workshops and able to express their views in safety. The physical environment was also a consideration. We found a warm room and organised a break in each workshop session. Facilitators were carefully chosen and every effort made to ensure that the material was presented in a way that people could relate to.

Participant involvement

Members of 11 local groups participated in the workshops. These were:

- Learn for Yourself
- South Port Day Links
- Women's Group
- Share and Care
- Toy Library
- 3 Public Tenant Groups
- South Melbourne Senior Citizen's Centre
- Port Melbourne Neighbourhood House
- South Port Community Nursing Home.

Worker involvement

From the outset, participants were involved at every level of the project, while Mary and I tried to work as tools of the participants. We dealt with housekeeping items such as publicity, inviting facilitators and participants, welcoming them and ensuring morning tea was available. I collected names and telephone numbers of participants at each workshop. I also took notes during each session and collected handouts.

Mary and I attended the workshops as participants. During the course of the workshops Mary resigned from Network and another worker took

her place. It was useful for two workers to be there to ensure that all of the practicalities occurred.

Italian and Greek workshops

I initially hoped to include two workshops specifically for the Italian and Greek speaking groups, which *were* the only non-English speaking groups who used the community centre. However, because of lack of access to interpreters with specific skills and our limited time and funds, it was not possible.

While this was disappointing I subsequently applied for and received funds for further training from Port Melbourne Council. These groups can now be approached to *see* if committee training would be useful to them.

The training sessions

The sessions and topics covered in them were:

1. Role and Purpose of Committees
 - identified issues and expectations of participants
 - considered committees and what they do
2. Responsibilities of Office Bearers:
 - the key features of committees;
 - how people get on committees;
 - responsibilities and management group tasks;
 - dilemmas of office bearers - some solutions;
 - how people *become* office bearers;
 - issues arising from office bearer roles;
 - specific questions.
3. How Your Committee can Plan and Evaluate:
 - identified issues;
 - the planning process;
 - things to *be* considered;
 - setting goals for evaluating;
 - planning and evaluation - an ongoing process;
 - methods of planning and evaluating.

4. Decision Making, Sharing Tasks and Assertiveness Training:

- identifying what makes a good group;
- questions to address.

5. Organizing an Annual General Meeting:

- planning Annual General Meetings;
- planning public meetings.

6. Setting up Committees and Where to go for Information:

- clarifying aims and goals;
- membership;
- a model for planning;
- action planning - six weeks goals;
- definitions and objectives;
- incorporation;
- contacts and resources.

How participants felt about the training

The feedback from participants after the training was very positive. One participant said that at *her* committee meeting, she had used a strategy that she had learnt during one of the workshops. Participants spoke freely and mixed comfortably with the facilitators and the other participants.

Some of the participants have taken on key roles in their groups while another withdrew from a group. I believe that each of us learnt *more* about the skills involved in working on committees. One participant reported that her committee now had two people in every major role. People *were* also looking at alternative ways of doing things.

Group cohesion

In one workshop, a participant became unwell and needed to leave urgently and required transport. The situation was resolved with minimum stress to him and the other participants in the workshop. The sensitivity of the facilitator was very helpful to the situation.

Other participants collected his information and contacted him later to let him know about the rest of the workshop. It was at this stage that the group appeared to have developed cohesion. For *me*, as a worker, this was great as it showed that it was possible that people who only appear to have one thing in common can work as a team.

Outcomes

At the conclusion of the last workshop participants were given "Certificates of Achievement" and asked what they would like to see continue. The comments were:

- develop and make available training kits;
- record the process of the workshops;
- workshops for specific ethnic groups;
- workshops for workers on what to expect from committees;
- further volunteer workshops covering:
 - being a treasurer;
 - job sharing on committees;
 - job descriptions & time frames;
 - preparing funding submissions;
 - managing change;
 - joining a new committee.

A training kit

Following the training sessions, some of these ideas were tackled. To maximize the possibility of this wonderful experience being undertaken by others, a Training Kit is being prepared which reflects what the workshops covered. Copies will be made available at no charge for local community groups or individuals to use as a resource for their committees. Albert Park and Port Melbourne libraries and the workshop facilitators will each be sent a copy.

Treasurer's workshops

I invited 14 treasurers, and people who were considering being involved in financial responsibilities for local groups, to a small meeting to plan for the future. One treasurer, Michael, is on several management committees and had been finding himself stretched. He was gradually withdrawing from some of these committees but finding it difficult because of his commitment to each of the groups and the difficulty of finding a replacement.

I've went through a similar process as at the start of the workshops, that is, each person present saying what she or he wanted. As a non-treasurer, I thought a support group which met regularly would suit their needs. However the treasurers said that would not be useful to them at all and that they needed help with problems as they occur. This provided a reminder for me that all decisions need to be made by the people concerned.

Michael generously agreed to make himself available one morning per week to assist with queries. It is anticipated that more residents would be encouraged by this to take on financial responsibilities and develop new skills. It would also provide the opportunity for Michael to free himself from some of his commitments. It is hoped that Committees will find it easier to recruit treasurers knowing that support will be provided. Advertisements were placed in both council directories advising them of this new support facility.

While we didn't tackle the issue of job sharing on committees, following the workshops, some participants who were involved in forming a new group instigated the sharing of office bearer's jobs.

Some participants had said they wanted a record of the process and I also wanted it recorded. This case study, I believe fills both the needs of those participants and myself.

Did the project achieve what it planned?

I believe the training sessions achieved the goals set out. The aim was to empower the participants with new knowledge, and to reinforce how much they already knew. In addition we aimed to assist them in identifying that the concerns they had were not as a result of personal failure, but were issues of concern for others as well. The workshops also provided the environment to instil individual confidence to tackle different roles on their committees. A new awareness arose regarding jobs they had previously considered beyond their capabilities.

People appeared to feel more confident in the group as the workshops continued. Some participants who were initially concerned about their vulnerability by being in a group, gained confidence. This was very exciting and possibly the most valuable outcome for me as a worker involved in the project.

While I believe the project has had positive outcomes it is too early to judge to what extent. We had requests for the information on planning an annual general meeting, and several groups called asking when the Training Kits would be ready and whether they could have one. A further indicator of success is the subsequent granting of extra funding for volunteer training from Port Melbourne Council.

I enjoyed being part of this project because of the process whereby participants had control from the beginning and continue to determine outcomes. I suppose the only disappointment I had was that not enough people had the opportunity to participate. Eleven groups were represented but others may be involved as a result of the Kits and future training.

It would be a shame if others could not benefit from the positive things we learnt. We hope that local committees will work through specific issues identified in the workshops so that participation in management

can be enjoyable and a learning experience as well as accomplishing the goals of the organisation.

Further evaluation

The Community Development student who participated in the workshops is facilitating a piece of research as part of her course requirement. Her major aim is to ascertain what effect these workshops have had on the varying management committees and subcommittees in South/Port. This will provide further information to assist with future planning.

Other resources

While researching information for the training sessions, I came across some other resources. Different groups have various ways of making management more user friendly. One group has planned a workshop - "Becoming a Committee Member" - prior to a general meeting and others provide new members with an orientation program. Some groups provide Introductory Kits which include background and current information and the rules of the group.

There is also training available from various sources and in different forms. Victorian Council of Social Services Management Support and Training Unit and People Projects (a community-based training agency) provide training at some cost. The Volunteer Centre of Victoria has an extensive library as well as being a useful resource on where to go for assistance and information.

Is it possible to make committees work better

Many community groups depend on funding from government bodies and trusts which expect a high degree of accountability as to how their funds are used.

I have concerns that members of committees of such groups do not appear to have sufficient resources to enable them to fulfil their legal and accountability obligations, as well as accomplish what they set out to do in the first place, and all get along with each other as well. It seems a lot to expect from a group of people who are brought together because of a specific issue.

The Social and Community Services Industry Training Board has recently been examining the training needs of volunteers. I hope that one of the outcomes will be that unpaid members of committees have access to relevant ongoing training without cost to them.

However, there are disadvantages as well as advantages in working within the committee structure. The "Community Management Handbook" published by Victorian Council of Social Service identifies several advantages and disadvantages of committee management.

The listed advantages are:

- input into decision making;
- tailored to include a range of people with different skills;
- scope and flexibility;
- staff and consumer involvement;
- accountability to membership;
- ability to respond to local issues;
- ability to control local resources;
- more people using the service; and
- likely to be more effective;

VCOSS list the disadvantages as:

- power relationships distorted or unbalanced;
- potential build-up of staff power;
- potential lack of staff and consumer input;
- potential lack of accountability;
- potential for a weak membership base; and
- potential lack of expertise.

It can also be difficult to attract management committee members who are prepared to accept the responsibilities of the position.

Working with an Incorporated Association and a committee of management appears to be the type of organisation that is accepted as most likely to be eligible for funding from both government and trusts. I understand that incorporation as an association was first set up to give individuals legal protection. It also allows for each group to decide on the rules and the decision-making process that suit its needs. But it could also be said that incorporation has provided for more outside control of community groups.

As a community development worker I prefer to work in a structure that provides for the decisions to be made by those people who will be affected by their outcomes.

It was rewarding to observe how much the participants enjoyed taking control of their own experience. Where this process is facilitated and monitored in a sensitive way, many of the difficulties associated with committee of management structures can be alleviated.

When power is shared, no one loses power - everyone becomes *more* powerful.

12

*"We felt that the people we had
approached thought that we
were a minority and if they
ignored us we would go away-
they could not have been further
from the truth!"*

Jim Boyle

Workcover - life's easier on the dole

Jim Boyle

From injury to insult

BEING on Workcover can be a very degrading and traumatic experience for injured workers. They face negative stereotypes running them down on a daily basis, including families and friends. They are quite often in constant pain and may be on continuous medication for a number of years. To add to the obvious problems, they have to face inefficiencies with the Workcover Corporation and its employees.

This case study will explain how and why we formed the Riverland Workcover Action Group. It will give an insight into the process we are using to tackle the system so that Workcover recipients may get a fairer deal in the future.

What is workcover

Workcover was set up in 1986 by the South Australian Labour Government to replace the previous worker's compensation system run by private insurance companies. The Government felt they could come up with a better compensation scheme that would get injured workers back to work more effectively and cost efficiently.

The Riverland

The Riverland is an area in South Australia near the border with Victoria and runs along the Murray River. The area is populated by a mixture of nationalities and much of the employment available is manual labour, on fruit orchards, farms and in factories and workshops. With this type of work there is a high incidence of major work injuries with 80% of these being spinal. Due to this there are quite a few people on Workcover for lengthy periods.

Meeting like-minds

During 1991 a number of Workcover recipients, including myself got to know each other while attending the local gymnasium as part of our rehabilitation process. We swapped stories about some of the problems we were experiencing with Workcover.

The major problems long term Workcover recipients seemed to experience included:

- lack of support for ourselves and our families;
- weekly payments which are less than unemployment benefits;

- payments arriving up to six days late;
- reimbursement for medication/treatment costs taking up to three months;
- not having our rights and entitlements explained to us.

There were many other smaller problems experienced while we were on Workcover that collectively caused undue stress, further to the original injury.

Some of us had sent letters and approached various Government Ministers about these problems. We had also complained to Workcover. These complaints fell on deaf ears. We felt that the people we had approached thought that we were a minority and if they ignored us we would go away - they could not have been further from the truth!

I was also a member of the Riverland Health and Social Welfare Council's Executive Committee. The Council was set up and funded by the South Australian Health Commission. The Council had a voluntary committee and two paid staff - a full time Executive Officer and a part time Administration Officer.

The role of the Council was to identify problems experienced by people in the areas of health and welfare. Once these problems were identified we would then try to implement strategies to eradicate them. In 1992 there were four Health and Social Welfare Councils in South Australia.

Forming an action group

In November 1991 I brought the problems raised by myself and others at the gymnasium to the attention of our Council's Executive Officer. He pointed out that we had a lot of people fighting the system individually, and if we formed an action group with the guidance of the Council, we may have a better chance of getting some changes made.

A meeting was then held between three Workcover recipients and the Executive Officer. We decided to set up a small action group to investigate how widespread these issues were, and exactly what the problems were.

Small beginnings

Due to fears of repercussions, we chose not to advertise on a large scale, but put up some posters in waiting rooms of local doctors, physiotherapists and chiropractors advertising a meeting. From that meeting we came up with a group of about ten people that had similar problems, and were eager to do something about them.

The Group's aims were:

1. to get some changes made within the Workcover system;
2. to start a support group to help Workcover recipients; and
3. to change the public's attitude of people on Workcover.

Using the Healthwise system of identifying common issues and developing strategies, we came up with a list of problems that needed to be addressed, a vision for a better Workcover system and goals for how the vision might be achieved. This was done between December 1991 and January 1992 during which time we held four meetings. We then prioritized these problems and worked out how we could get some changes made.

Priority issues

The following is the list of priority issues we came up with:

- wage reductions of 20% after being on Workcover for 12 months;
- irregular payments - weekly wages arriving up to six days late and amounts changing without the required 21 days notice;
- Workcover not giving any emotional support to either the injured worker or their families;
- applications of pay outs to spinal injuries unfair (eg a leg injury can get a higher amount than a permanent spinal injury);
- no free legal advice was available;
- Workcover not informing injured workers of their rights and entitlements;
- need for financial support to provide care for injured workers since partners often had to give up work to stay home and look after their spouse;
- wages not adjusted with wage rises or CPI increase;
- reimbursement for travelling and medical costs could take up to three months;
- Workcover losing documents (eg receipts).

Vision of an effective Workcover

If everything that was wrong with Workcover was fixed:

1. It would be easier to get back to work.
2. There would be more personal contact with case workers at Workcover and better feedback from them.
3. There would be a fairer wage system - no 20% cut after one year, and payments would be regular. Alternatively, there would need to be cost effective weekly payments at a fair level and this level should be maintained (similar to Victoria). Injured workers on low wages would get the same concessions as pensioners.
4. CPI rises would be automatic.

5. Personal and professional support would be provided for families of workers.
6. Wages would be paid directly into bank accounts if desired by the worker.
7. There would be financial support for partners who have to give up work to care for injured workers.
8. Rights and entitlements would be explained to people when they first went on Workcover.
9. Realistic re-training/work experience with work prospects would be provided, and workers would get full wages while doing re-training.

Goals

To eradicate most of the above problems, we believed the following things needed to happen:

- The Workcover Act needed amending to produce a fairer wage system. The Government would adopt a similar system to Victoria and have a minimum wage so that recipients did not have to live on less than unemployment benefits.
- There would be support groups set up for people on Workcover.
- Workcover would appoint a worker's advocate to the Riverland area, to inform recipients of their rights and to inspect workplaces.

Taking action

The first thing we did in our fight was meet in late February 1992 with the Honourable Terry Roberts, member of the South Australian Legislative Council and member of the Select Committee Into Workcover, and David Gray - Worker's Advocate for Workcover recipients.

We told them our stories and problems so that they would have an insight into what it is like to be on Workcover. They told us that some of the problems we mentioned had already been identified and steps taken to eradicate them, but that this process would take some time. We felt that this was going to make our job easier, but we decided that we would work just as hard on these issues to make sure that they were eradicated completely.

Some interesting facts emerged at our meeting with Roberts and Gray. The meeting had been organised by the Council's Executive Officer and prior to this nobody in our group was aware that Workcover had a Worker's Advocate. Had we known about this person we may have been able to solve some of our problems much faster. He informed us that he gave preference to people who were either in unions or from non-English speaking backgrounds.

We were shown a Workcover pamphlet explaining the rights and entitlements of injured workers. Not one person in our group had ever seen this pamphlet before, and it seemed to us that Workcover did not want injured workers to know their rights.

Making contacts

Our next step was to inform all the unions relevant to our area of our existence. We then started writing to Workcover and parliamentarians, pointing out the problems we were experiencing and also offering solutions and/or ways to prevent these problems arising. The response to those letters was favourable.

We suggested to Workcover that they make changes to the medical certificates they used. A copy of the certificates had been given to the doctor, the employee and Workcover but were not marked to show who kept which one. We suggested that the employer should also receive a copy of the certificate and that it should be clearly indicated on each certificate who would receive it.

Workcover informed us that they were testing a new certificate with exactly those changes and enclosed a copy so that we could examine it.

Our next step will be to make an appointment with the Chief Executive Officer of Workcover and bring our problems to his attention. We will be asking him to address these problems and implement some changes to eradicate them. If we do not get any satisfaction we will then go to all the relevant Ministers and to the media to force some action.

A support group

In May 1992 some of our group felt that things were going too slowly so they applied themselves to the task of setting up a support group. This was probably the best move to make, because it created an active support group to help people on Workcover to get what they were entitled to.

They also helped set up groups in other areas of the state so that Workcover recipients in those areas would know what their rights and entitlements were.

This group has applied for funding from various Government Departments and Unions. They have also applied for funding from Workcover. The Workcover Act has a clause stating that they may support organisations that provide assistance to injured workers, but so far they do not appear to have supplied any such support.

In summary

The Riverland Workcover Action Group is only in its early stages but we shall keep fighting to get some changes made to the system. We have seen that people now sit up and take notice of us, and we now have a

feeling of self worth. That alone has made this whole exercise worth every minute put into it.

We feel that if we force some changes, people on Workcover could be treated with the same respect as the unemployed. Pressure on injured workers would then be reduced and they would not be frightened to admit they are on Workcover. We do not want hand outs. All we want is a similar system to Victoria's where there is a level below which wages cannot be reduced, and that Workcover provide real support for injured workers. With this combination an injured worker would be able to feed their family and keep their dignity.

In these ambitions we are only insisting that Workcover honour the claims made in its pamphlet "Workcover - Rehabilitation Information for Workers".

"WHAT IS WORKCOVER'S PURPOSE?

To limit the cost, in money and in suffering, of illness or injury due to work. To help prevent accidents at work by making workplaces safer. To ensure injured workers have enough money to live on. To put injured workers quickly and safely back into work.

HOW WILL WORKCOVER DO THIS?

By helping injured workers as much as necessary to prepare for their return to work, through a rehabilitation program. By paying enough compensation to meet the needs of injured workers, regardless of what their injury is, so they can follow a rehabilitation program without worrying about money. By deciding quickly about compensation claims. By doing all this without a need for a long court case."

13

"I went to Greenethorpe with value judgements about living there - I discovered that people there don't necessarily feel the same way."

Marnie Mason

Greenethorpe Village community project

Marnie Mason

As part of my job is to be Community Nurse for Greenethorpe Village, I thought it would be useful to get to know the Village better. If we as health education or community workers want to be of value to a community, we should know that community first.

Greenethorpe is a small village with a population of about 140, in the Central West of NSW. It lies between the towns of Grenfell, Cowra and Young and is mainly surrounded by wheat and sheep farms.

Planning the Needs Survey of Greenethorpe Village began in February 1989. At that time there was emphasis within the Central West Health Promotion Unit on the value of community development initiatives and community needs surveying.

Greenethorpe's reputation with health workers

Greenethorpe had been identified by health workers as a community in which "it was hard to know where to start". It was a Village that had a reputation for being unresponsive to health initiatives, despite appearing to have considerable problems. Health workers had seen changes, with the community appearing to become more isolated and less financially viable.

Many of the Village residents were thought to have recently moved from Sydney without extended family support. Lack of public transport, no local access to medical services, and fragmented community services (eg residents used schools, recreation services and shopping in each of the three larger towns around them), were thought to be possible social issues.

Community needs survey

Community health workers agreed that the true nature and extent of issues in the Village were difficult to assess from the outside, and that a community development project, incorporating a Needs Survey, should be carried out.

At an initial meeting involving Anne Cobham (Community Nurse), the District Nurse, Social Worker and myself (Health Promotion Officer), we agreed on the project's aim and methods:

- To create opportunities for the people of Greenethorpe to explore and express needs of the area and seek ways of providing for these needs.
- This process would be open to ongoing challenge and discussion.

At this early stage, staff members undertook to talk informally with key people in the Village to share our plans for the project and to seek their ideas.

Interviewing key people

By March 1989 we had a tentative list of key people who we felt it would be valuable to interview or call together to seek out views on the project and on Greenethorpe. The list contained office holders (eg school principal, policeman), and contact people (eg post mistress, publican, CWA President). The list also included other people who had been identified as having some overview or insight into the Village, but who held no formal office or position.

Anne Cobham and I visited the Village several times and interviewed 16 people. While the list changed a bit as we went along, we tried to cover a wide range of people.

The nature of the interviews also varied, sometimes they were by appointment, sometimes not. We followed no formal interview structure, but generally sought peoples' views on life in Greenethorpe, on the Villages' networks, on its services and on the needs. It proved a good balance to have an outsider - myself - with no preconceived ideas of the Village, as well as Anne, who was known and respected by local residents.

We kept brief notes and jottings as we talked with people, and then wrote up detailed notes after the interviews, and these were used as a basis for future planning. The following extracts of impressions recorded after some of the interviews provide an insight into our feelings at the time.

"I found this visit most useful in gaining a fresh view of the town - and particularly as Marnie was able to ask questions in an objective manner. The group of people we spoke to were mainly new to the community and appear motivated to contribute and make the town work for them - they all quoted each other as important influences in the town and had a deal of contact with each other" (Anne).

"I felt the value of the needs survey was as an excuse to really talk and find out attitudes - as Anne said, though she had been coming to the community often over the last several years. She gained so much knowledge about the Village in those few hours that she didn't have before - much of which was positive suggesting that the community wasn't as badly off as many outsiders perceived it to be - certainly this may be due to the fact that at this point we have only interviewed new, involved residents" (Marnie).

"I feel it has been a valuable and necessary process to involve and consult with many of the key formal

and informal leaders in the community. I feel the acceptance Anne has, plus her skills with all people, provide us with a key to activating the community. It seems that there are many people who are motivated to contribute to Greenethorpe in order to provide more for themselves and others. Their efforts could be co-ordinated if some of the "them vs us" barriers were broken down. If we are to allow this to happen, we need to tread gently..." (Marnie).

Insights from interviews

These preliminary interviews provided us with the opportunity to consult with key community members, to involve them in the process of the project and to invite them to be further involved in plans. The major issues raised in the interviews were:

- division between town and country residents and problems with integrating new residents, many of whom were perceived to be non-workers;
- division between those who drank and those who didn't, with the pub as a central social point for many;
- the "country" parents domination of the Parents and Citizens Group, and communication barriers between organisations in the community.

On the basis of these results, we decided to survey each household in the Village to ensure all sections of the towns' people were heard.

Surveying households

With the help of the Research Officer from the Health Promotion Unit, a draft survey was developed. It was agreed that an adult member, chosen at random, from each household should be interviewed.

We sent a thank-you to the key people who had been interviewed, a copy of the draft survey and an invitation to review the survey at a lunchtime meeting. Many useful comments were made by community members who attended the meeting and adjustments or inclusions were made to the survey accordingly. With the insights of Village residents, it was decided that interviews should be conducted by outside community health staff rather than local people – because of issues of privacy and confidentiality.

There was also lively discussion at the meeting on the issues of transport and communication, especially the notion of a Village newsletter.

A news sheet informing the community of progress and plans was distributed to each household through the Post Office, as well as being available at the Village shop.

Survey interviews

After finalising the questionnaire, the Research Officer held a training

meeting with the interview team. The team consisted of community health workers associated with Greenethorpe including four nurses, a dental therapist, an alcohol and drug worker, a social worker and myself.

Equipped with clip boards, maps, and questionnaires, the team conducted the interviews over three days, with some night work needing to be done to reach a few households. Most householders were aware of the project and very willing to participate. Only two households out of the 48, chose not to answer the questionnaire.

At a meeting to process the questionnaires, the team shared their impressions from their participation in the survey. The major conclusions were:

- We had developed a better understanding of what the key issues are for Greenethorpe residents: poor transport, poor drains, lack of medical and emergency services.
- We had learnt about the Village's social networks:
"Some groups and individuals want to keep to themselves"; some are interested in "interaction and self help"; in some there are "elements of loneliness".
- There was a more positive perception of life for Village residents amongst health workers.
- Health workers had gained insights, and found new clients. They appreciated seeing families in their homes with their children, seeing "how they lived", and that they were "happy". They also discovered something of the skills of the local people.

The real Greenethorpe comes to light

The data from the interviews was collated by the team and a report prepared. A summary of the survey results was written and this formed the basis for a news sheet which was distributed throughout the Village in early December.

This extract from the news sheet captured the key survey findings:

The survey showed that most people interviewed enjoyed the peace and quiet of Greenethorpe, the lifestyle associated with country living and the people in the village. Some less cheerful comments related to problems of transport and isolation, lack of services - especially recreational, medical and garbage collection - and the difficulties of "gossip" in a small community.

The mystery and magic of the process

Reflecting on the Greenethorpe Village Project and its outcomes, it seems that much has happened alongside the project. Formal follow-up meetings between community health workers and the key people, to act

on the survey findings, were infrequent, but since the survey many developments have occurred, including:

- a regular Village news sheet;
- establishment of a children's club/youth group providing weekly activities;
- negotiations with the State Rail Authority about a bus stop to service Greenethorpe, and
- negotiations with the Shire Council Health Inspector over sewerage and drainage.

Some developments have taken place with input from the community health workers involved in the survey, some have been developed entirely by Greenethorpe residents.

It is impossible to gauge what part the process of asking the community and then reflecting back its answers, played in bringing about these outcomes - perhaps the Village residents would have acted anyhow, perhaps being asked prompted action, perhaps power is gained from being asked!

We suspect the "official" survey and results gave interested residents validation or ammunition to act, when before they may have been cautious about taking over. Certainly the getting together of Villagers seemed to help them identify their own strengths and skills, and the mechanisms that could support them in their efforts to bring about change.

Ask, listen and learn

The process of asking and listening also seemed to bring about a change in those conducting the project. Attitudes previously held towards Greenethorpe and its community by the community health workers involved in the survey shifted. Anne Cobham attributes this shift to "having a better understanding of the Village's networks and a greater appreciation of the skills of community members". She feels that these positive insights changed the way she approached her work in the Village:

"I am prepared now to allow them to be and to facilitate, rather than feeling I should be taking control. I feel a greater respect for the community and have more courage to attempt things there".

Perhaps this greater confidence can also be attributed to Anne feeling that the survey process increased her credibility and heightened her profile in the community.

I went to Greenethorpe with value judgements about living there - I discovered that people there don't necessarily feel the same way. For Anne and I, appreciating and learning from the skills of others in the interview team, as well as those in the community, has led to growth - being open to the joys of life in Greenethorpe and to the strengths and skills of its residents has led to a reminder of the traps of judgement.

"It would be difficult to set up and run a co-op like this without having a tenant worker around to support the project... Though, having been through it once, if those of us who are residents went somewhere else, we could do it because we've now got enough knowledge and information ourselves.

*Elaine Kellerman,
Marilyn Onafrethook and Glenice Kelly*

Walker St Tenant's Association food co-op

Elaine Kellerman, Marilyn Onafretchook and Glenice Kelly

Background

WALKER Street is a small Ministry of Housing estate at the city end of Northcote with about 500 residents. Built in 1960, the estate has 108 flats in three storey blocks. Twenty one of the flats are single person units, housing mainly older people, and the rest are two and three bedroom family units.

In 1982, we formed a Residents' Association made up of interested people from all over the estate who meet regularly. Our aim is to enable residents to gain greater control over their own living situation and to take increasing responsibility for decisions affecting the neighbourhood.

Since 1982 we have set up a Community Flat, an After-school Program, a Youth Club, a Camping Program and a Social Club, all organised and run by parents on the estate. We receive some funds each year from the Ministry of Housing to employ a tenant worker and to cover some running costs.

The brainwave for a Food Co-op

In 1987, our previous tenant worker got this brainwave that we start up a food co-op for our estate and for other estates in the area. He had read about similar projects on big housing estates overseas, so he wrote to some in England for information about how they had gone about organising their co-ops.

The idea was for low income families to purchase the necessary everyday items on home territory, instead of having to go to a big supermarket. The co-op would be close and convenient for people on the estates.

Some residents thought local shops were too expensive and that it was a good idea for convenience sake, especially for the elderly people living on the estate.

Survey

The Residents' Association agreed to investigate the food co-op, and we surveyed every unit asking people:

- would you use the food co-op?
- would you be prepared to give some time as a volunteer to help run the co-op?

- what do you think are the priority items for the stock of the co-op?

It was quite a task, because we wanted to get a response from everyone, and that meant being prepared to go back if people were not home at first call. Two or three members of the Association spent two days, visiting every flat. The vast majority of residents said the co-op was a good idea, that they would help with the work of the co-op and that they would patronize it.

The survey results made us very optimistic about the co-op's prospects - only the residents in two or three flats said they weren't interested. Most residents said they thought the co-op should carry basic household items plus fruit and vegetables.

Large scale plans

Our original idea for the co-op was very big. We visualized using the After-school Program room, which is a big room, and working on a very large scale. Following the survey we put in a submission to the Victorian Health Promotion Foundation (Vic Health). We asked for \$140,000 to furnish the co-op and to purchase a bus, and other equipment. Our submission also addressed issues of nutrition and healthy eating. We planned to run classes on these subjects.

On top of setting up an alternative food supply, we also hoped to create employment within the estate by offering volunteers some payment. We felt that it would be good to pay them because unfortunately in our society, volunteers are often exploited. Residents who work with the Association do lots and lots of work, and most times other people just take it for granted.

But we were forced to rethink all this when we learnt that food co-ops were not within Vic Health's guidelines. Our submission was rejected outright and we received no funding at all.

Pruning hopes

After the Vic. Health rejection, we sent a submission to Community Services Victoria. This time we asked for only \$3,000 and we received \$2,900. One of the difficulties was that we hadn't really worked out a fall-back plan when the first submission failed, and there is a big difference between \$140,000 and \$3,000! It meant going back and starting from scratch again to plan the whole food co-op. The Community Services grant arrived in September 1988 and the Association formed a sub-committee to plan how to use this money. The sub-committee had five residents on it, and this has remained about the same throughout. The sub-committee was responsible for shopping, serving and keeping up stocks. Glenice joined the Association as our tenant worker about this time and has supported the sub-committee's work since then.

Most of 1989 was spent planning and we couldn't get started until the

Association moved into new offices and rooms in October. The new rooms, called the Community Facility, were at the bottom of a three storey block of family units roughly in the middle of the estate.

The Community Services grant was to buy equipment only, and couldn't be used to purchase food or pay wages. Its very unrealistic to give money to a food co-op when you're not allowed to spend any of the money on food. Fortunately Preston/Northcote District Health Council (DHC) gave us about \$500, which we spent on food as our initial stock.

A small room in the community facility was set aside for the co-op, and the Ministry of Housing put in the shelves. We purchased the fridges and a freezer and were ready to start.

The reality of helpers

The survey said 92% of residents would volunteer time to run the food co-op. Looking back, people must have found it hard to say no while we were standing there, to the question about voluntary help. When it came to the crunch of opening the doors and getting things organized, it was the sub-committee members who did most of the work - other people came and went.

That was a real problem because you tend to rely on the same group of volunteers all the time and they get drained and feel that the pressure is always on them to help out. Co-ordinating the work of the co-op and keeping it running needs a dedicated group of people.

Stocking the shelves

We started off with as much variety in the goods as we could afford. We tried to have a few different types of canned goods, and a few bits and pieces in the fridge, and to expand from there, and we were determined to encourage people to use the co-op by only having a small mark-up.

A group of us headed off to Shepparton one day and filled the bus with canned goods from the canneries up there and bought bits and pieces on special. One of the other food centres at the tenant group in Reservoir gave us some contacts that they use which were reasonably priced as well.

So initially we stuck to canned goods, and cleaning products - household items that you use every day. After the first big stock-ups, one member of the sub-committee, Robyn, has done most of the routine shopping - she is our bargain hunter. She gets her jeep and wanders up the street whenever she sees any specials in the paper. Some days we took the community bus down to "Cash and Carry" and to a new supermarket which had a lot of cheap goods when it opened.

As the co-op is not a registered business, it is not possible to buy from wholesalers, so often large amounts of specials are bought from big supermarkets.

Day to day

Initially we had a roster for staffing the co-op. We planned to open every day from 9.00 am until 4.00 pm and for a couple of hours at night. But we couldn't open at night because there weren't enough volunteers who would come down of a night time and you needed two people on in the dark for security reasons.

The roster system soon fell in a great heap, mainly because people might sit there all day without any customers coming in, or there might only be a few, so the interest waned. But we have been able to stay open every day since we started from 9.00 till 4.00.

Not having an enormous number of customers, it has been possible to either run the co-op in combination with the other activities at the community facility, or with our specific staff and volunteers. Normally there are a number of residents around the facility most of the day.

It is still the same group of people from the sub-committee who are doing the work. Glenice opens the co-op up in the morning when she gets to work, and Elaine locks it up at 4.00 pm. If there is no tenant around to serve, Glenice will do it.

Pension days are always good days for the co-op, because people will buy a heck of a lot, they stock up, every second Thursday. In between times, people tend to just come down and get bits and pieces they have run out of rather than going up to the little corner supermarket and getting nipped-off. It is easier to muck down here or send one of the kids down.

During the summer we do good business with the kids from our After-school and Holiday Programs, who want drinks and icy poles. Most goods in the co-op are sold at a very small mark-up -only one or two cents. The only thing that makes any real profit is something we pick up as a bargain, say at a new store or supermarket. They might be selling soft drinks at 60 cents a bottle and we mark it at \$1.10, which is still cheaper than the price at the milk bar, but we've made 50 cents profit on each bottle. But on most items we're just covering costs.

Misconceptions

Interestingly enough, the only people on the estate who do not use the food co-op are the older people. You don't very often see them come over and buy things, though when we first thought about it, it was their needs in particular that we imagined the co-op would serve. We thought it would be easier for the older people to come down the stairs here, rather than having to walk all the way to Westgarth or go up to the Northcote Plaza or places like that.

In the beginning a couple of older ladies came over and bought packets of tea bags or biscuits, but that tailed off and they haven't been over since. It may be that a lot of their families do the shopping for them at the supermarket.

It is often kids who get their mothers in to the co-op. The kids will come down, have a browse, go back home and tell mum what's here, and then she'll send them down with money to buy something. But it is a handy little shop. I think most people on the estate would agree with that.

Learning the business

You need a pool of money that is not tied up in stock sitting on the shelves. When we ran out of money, Glenice went through the book of Trust Funds and we sent off twenty submissions.

We received \$2,000 in 1991 from the Sydney Myer Trust which was a one-off grant that was auspiced through the DHC. This was important because we needed to expand our stock, but we had a cash flow problem. You spend all your money on shopping and because your mark-up is so small you don't have enough of a float to do a really big shop and get it fully stocked and have a little back up money in the bank. You need quite a lot of money to replenish the stock.

We've been lucky to have some support from Northcote's ex-Mayor, Cr Bill Connors, who also came down before he finished his term and gave us \$400 to replenish our stock. He'd visited us a number of times and was very keen to see what was happening. That's the only support we had from the Council and none from any other community groups except for the DHC.

You learn the ropes

It would be difficult to set up and run a co-op like this without having a tenant worker around to support the project. It's the workers like Glenice who have that knowledge of different avenues to tap into. Though, having been through it once, if those of us who are residents went somewhere else, we could do it because we've now got enough knowledge and information ourselves.

Apart from supporting the sub-committee and opening up the shop, Glenice also helps with the books, as part of her overall responsibility for the Association's book-keeping. This is done in co-operation with the Association's Treasurer.

It would also be difficult for the co-op to survive if it wasn't part of the Association's offices and rooms. To survive on its own would require more dedication by other residents.

Moderating the health kick

In the survey, residents were asked what they would like sold in the co-op? Some said it should be all health food - there were a few people on a real health kick. Then there were the people who would say, "well there are children on the estate and they need icy poles and lollies." Kids would rather eat a lolly pop than a muesli bar and they can have their healthy food at home; I mean that's where they get three meals a day.

So we compromised and have half good and half not so good, but it works. A lot of kids come down after school with their dollar and buy a can of soft drink, (its 30 cents cheaper than walking over the road to the milkbar) or a lolly or an icy pole.

Accepting the small-time

It's really a competition at this stage with the milk bar or the local small grocery shop. We would not even be in the race against big supermarkets like Coles. The only way we could compete with them would be if we had a huge room and could stock vegetables, meat, bread, milk and cream so people could come and do their whole shopping.

It is very difficult to work with fresh food. We don't have the transport to collect it and we don't have the facilities to keep it either. There are also a lot of regulations about selling these sorts of items, which are difficult to meet. It would be great to sell bread and milk - there were many people when we first opened who would ask for bread and milk and we'd have to say "No, we haven't got any".

Job satisfaction

We stay interested in the co-op and the Association's other activities because we live here, and its for our benefit. We try to be on the main committee not just the food co-op sub-committee because we feel someone's got to do something for the estate. We get our satisfaction knowing that we are doing something. It is for everybody.

The original co-op submission asked for funds to put on a co-ordinator and some helpers and to provide for some allowance to volunteers. When we were doing the submission we told people we could be getting some money to pay volunteers and a lot of them said, "no you don't have to pay us, we'll do it because we want to do it, we'd love to do it, and help you out", so of course we wrote that down.

But it has been very hard getting any new people involved. It might have made a difference in getting help if we could have paid them, but it doesn't worry us that we are not paid. Either you do want things like the food co-op or you don't. You either really want to do it or you don't, regardless of the money. If it's to improve the life of people on the estate, I think voluntary is great. Well that's what the majority of the things we do around here are anyway. They are voluntary, we do for the people here.

With most of the Association's activities, it is usually the same group of people who are on the security committee, the social committee, the lot. That's the way it is, isn't it?

The future

It's not feasible for the food co-op to expand unless the whole

community facility expands. We're now looking for an upstairs to be put on, but I don't think we're going to get it. We'd love it if that could be done.

It would be good to have an umbrella organisation which bought all the stock for food co-ops and low cost shops like this. What we're looking at is the Second Harvest Project which has been successful in Western Australia. Our shopping would be easier and it would be cheaper because that organisation would have access to really cheap food through the wholesalers.

The main group would do the buying and have the stock in a warehouse and we would ring through with our order and it would be delivered. There's quite a strong interest in this idea. Apart from our group here there are other groups in Northcote, Reservoir and East Preston which want some sort of central source of supply.

We think what we have done here with the food co-op has been excellent. It may not be providing a service to the extent that we hoped for initially, but its still providing some service and the tenants use it. You never do anything perfectly, but at the moment it's paying for itself. If other groups are thinking of starting up a food co-op, our advice is to be prepared for a lot of hard work to start with. Wark together and stay dedicated. When you're asking for money or looking for support, keep pushing - we're very famous for that here. You have to keep trying because you can only make it better.

"My experience of working at the Health Centre had made me aware of the number of people with psychiatric disabilities asking for assistance with a variety of issues... The stress suffered would often lead to a relapse, missed medication and re-admittance to hospital. I frequently felt frustrated at not being able to give each person the intense contact they often required."

Eileen Hooper

is anybody listening?

is anybody listening?

Eileen Hooper

THE Carlton Community Support Group was formed at a public meeting to discuss ways of providing community support for people with a severe psychiatric disability living in and around Carlton.

Background

In May 1989, a letter from the Carlton Senior Citizens was received by the Carlton Community Health Centre. The letter explained that the Co-ordinator of the Senior Citizens was spending a lot of time and energy with people with psychiatric disabilities. Although these people were over fifty five years of age and therefore eligible to be part of the club, she did not feel her commitment to the total membership allowed her sufficient time to devote to this group.

The Health Centre was asked to take steps to establish a similar type of service to one operating in North Melbourne -the Macaulay Community Support Association. Macaulay provided an outreach service to people living in Flemington, Kensington and North Melbourne. Their target group were people who have a primary diagnosis of a non-organic psychosis.

Macaulay visits people in their homes or in hospital and support is provided. The support consists of assistance with psycho-social skills, self-esteem problems, use of local services, community understanding, and empowerment.

As the Community Development Worker employed at the Health Centre I began talking to other workers in the area of Carlton to assess the extent of the problem.

Inner city Melbourne

The suburbs which were involved in this community development project were Carlton, North Carlton and Parkville. They are inner city suburbs and together had a population of about 22,400. The suburbs cover a small area in the Municipality of Melbourne City. A relatively small proportion of the area is housing, due to the presence of hospitals, the University of Melbourne, Melbourne Cemetery and parks.

The three suburbs were quite different with Carlton (population 9,000), having a high proportion of people (42%) in high density public housing, a large number of people from non-English speaking countries, and a high proportion of low-income families.

North Carlton (population 8,000) had 40% of people renting privately and about half the population owned or were buying their house. A smaller percentage of people included those from high income households, or people born overseas. In Parkville (population 5,400), because of the residents of Royal Park Hospital and Melbourne University, there were very few public tenants, a large number of people living in private rental accommodation, and many people born in Malaysia (mostly tertiary students).

A proportion of the Ministry of Housing accommodation is one bedroom and bedsitter flats. These were traditionally reserved for the elderly but in recent years they were being occupied by younger people on invalid pensions or with some degree of disability.

From disadvantage to disability

My experience of working at the Health Centre had made me aware of the number of people with psychiatric disabilities asking for assistance with a variety of issues. These included accommodation and financial difficulties, relationship problems, isolation, loneliness, difficulty in managing daily activities, and stress induced by having to cope with these situations.

The stress suffered would often lead to a relapse, missed medication and re-admittance to hospital. I frequently felt frustrated at not being able to give each person the intense contact they often required.

Although there was a Community Mental Health Clinic in Carlton, it was not engaged in outreach work. If a client did not keep an appointment at the clinic, there was rarely a follow-up even if the person was on a Community Order.

The Clinic was often a symbol to the ex-hospital patients of a medical institution and clients would be resistant to engage with such a service. In addition, people discharged from hospital, where all services were provided, were often sent home to flats where they lived alone with no services. Feelings of isolation which they experienced were intensified by the fear and distrust they felt from neighbours. All this would make it difficult for them to find the motivation to attend a clinic.

Worker frustration

Speaking with workers from agencies in Carlton, the feelings of frustration at being unable to adequately service the needs expressed, were also experienced by other generalist workers.

Fortunately the workers in Carlton often have contact with each other through working on different projects together. Therefore, since this issue was recognised as a priority, in July of 1989, workers began having regular meetings to discuss ways of addressing the problem. We were aware that the problem existed across all age groups and in fact many younger people were experiencing difficulty. The problem was also

affecting other residents, neighbours and families of people with psychiatric disabilities who were sometimes frightened and distressed by the behaviour of someone nearby or in their care.

This would occur when a resident with a psychiatric disability would have a psychotic episode which would be followed by admission to hospital. Sometimes police and/or doctors would be called. These incidents also led to some residents being fearful when others returned from hospital, leading to the alienation and isolation of the discharged person.

Government policy without legs

In addition, there was Government policy to contend with. Under the guise of "Social Justice" - a policy which we all applauded, the case for allowing people to leave institutions and take their place as members of the general community, ie de-institutionalisation, had been completely convincing. However the realities of recent practice suggested that "people had arrived in the community but the funding to support them had missed the bus!"

The consensus amongst community workers was that some form of community support was required to sustain people returning to the community, possibly modelled on Macaulay. We felt strongly that the decision to establish such a scheme should involve as many people in the community as possible.

Going public

In November 1989 a public meeting was called to canvass support for a submission seeking funds for a community support project based on the Macaulay model. The meeting was very well attended by workers from other agencies, politicians and Melbourne City councillors, but local residents were conspicuous by their absence, despite extensive publicity for the meeting. There was a strong feeling at the meeting that further community consultation should be sought in order to ascertain the likely level of participation in the type of community support program which we envisaged.

A steering committee was formed with the aim of producing a submission for funding to employ a project worker to consult the community, assess/confirm the need, and to make recommendations as to the most appropriate service for Carlton. We had all perceived the need but we had no actual data. The submission was written and forwarded to the relevant State Government Department - the Office of Psychiatric Services, in December 1989.

The steering committee began meeting again in February 1990. As well as some residents, the committee included representatives from the Carlton Community Health Centre, Carlton Contact (a neighbourhood house), Carlton Estate Residents' Association, the Church of All Nations,

the Mental Health Clinic, the Ministry of Housing, Macaulay, Melbourne City Council, Office of Psychiatric Services, St Jude's Church, Hanover Centre (a homeless person's service), Royal District Nursing Homeless Persons Service, and the Police Community Resource Centre. The roles of members of the steering committee were police personnel, nurses, social workers, community development workers, ministers and residents.

Problem of representation

The lack of general community representation, in contrast to the broad organizational representation, can be explained by the sensitivity of the issue. People initially did not want to be identified as having a psychiatric condition and their anxiety level rose considerably when asked to be part of the group. This highlighted again the problem of workers not having enough time to adequately encourage people to participate.

The rest of the community was also reluctant to be involved. When interviewed individually during a door knock, people were often sympathetic to those with psychiatric disabilities and did not want to be identified as complaining or causing unnecessary distress to others, but there was some confusion as to how they could contribute.

Steering committee objectives

The steering committee's paramount objective to establish some form of Community Support Program for people with a psychiatric disability has remained intact, but during the two and a half years of its existence the means by which this objective might be achieved has been open to review.

In 1990 the objectives of the steering committee were:

- to encourage the community to be involved;
- to obtain funding for a project worker.

Securing community involvement had specific and understandable problems and it was accepted that this must become a long-term goal for the project. However two and a half years later there are five members of the community and six workers on the steering committee.

Securing funding has necessitated continual lobbying of relevant authorities and people with influence.

In May 1990, the steering committee arrived at a further objective: to collect statistics and write an interim report to strengthen our case.

Early in 1990 the steering committee began meeting monthly, working together to both obtain support for the first submission and to gather data in support of our case for a support program.

Further submissions for a project officer were presented to the Victorian Health Promotion Foundation and the ANZ Trustees, both without success.

It was decided that a community discussion paper be prepared on the basis of the data being collected, to be presented at a public meeting for discussion.

The steering committee was well aware that the discussion paper would not represent a comprehensive analysis of the situation in Carlton, but given that it was being carried out by workers already working to capacity according to their roles in various agencies, it was felt that the report could only assist in reinforcing perception of the need for a support program.

Data confirms need

For the report, data was collected from the Office of Psychiatric Services and sixteen other agencies in the area. The question asked of these agencies included:

- in the last six months, how many client contacts have you had?
- how much time did this involve?
- what sort of service might you or your clients like to see in Carlton?
- any other comments?

The results highlighted the urgency to address the unmet needs of people with psychiatric disabilities.

The interim report and in particular the informal research was not meant to be conclusive, but clearly demonstrated that this ever increasing client group would benefit from the proposed support program.

The interim report also emphasized the frustration and feelings of inadequacy felt by some workers, not only due to lack of time, but also due to a lack of expertise in the area of psychiatric issues.

Report to the community

The interim report was presented at a community lunch/public meeting on November 13th, 1990. The launch was well attended once again and this time more residents were present.

The meeting resolved that the steering committee write a submission to the Board of Management of the Carlton Community Health Centre to request funding for a project worker to investigate the needs and priorities of people with psychiatric disabilities living in Carlton and to make recommendations for the planning and establishment of an appropriate support program.

A submission was prepared by the committee and presented to the Centre's Board of Management in November 1990.

Funding hitch

At the Centre's Board meeting in November, a decision was made to contribute a proportion of the funds needed for such a project, on condition that the Office of Psychiatric Services provide at least 50 % of the funds needed for a viable project.

Almost simultaneously a letter was received from the Office of Psychiatric Services informing the steering committee that the first application for funds for a project worker was unsuccessful. The year ended in a state of uncertainty, with all concerned wondering where we would go from there.

Early in 1991 the steering committee met to discuss the next step. Although dispirited, the members of the committee recognised that even though there was little hope at this stage of obtaining funding, the problem of supporting the residents with psychiatric disabilities was not going to disappear. Those people were still requesting assistance and workers were still attempting to provide a service which they felt was inadequate. Therefore the committee decided to continue fighting for funding.

There were many ideas from the Office of Psychiatric Services about how workers might be able to achieve, either together or independently, programs in our agencies to address the problem. However, the fact remained that without an increase in resources, there was no way we could increase our workload in jobs to which we were already committed.

Rumours were heard that the committee may manage to secure funding for part of the project but there was nothing definite, so we decided to continue meeting and to encourage politicians to write support letters to assist the project.

To cover all eventualities, Macaulay was approached and the request made that in the event of funding being granted, and the steering committee not being incorporated, that they auspice the project; "auspice" in this instance meaning that Macaulay hold the funds, but that the steering committee administer the funds. Macaulay consented to this arrangement and have continually provided support and advice throughout the process.

Limited funds skew aims

In June 1991, the committee was suddenly informed by the Office of Psychiatric Services that \$14,540 would be made available for a project worker to assess the need for a psychiatric support service in three high-rise blocks of flats in Lygon Street, Carlton.

Although the group was very grateful for the grant, it was clear to members that to ignore residents in other high-rise and walk-up flats, and other residents in public and private housing in Carlton would not

only be foolish, based on our knowledge of the problem, but would also be discriminatory and label some high-rise flats as problem areas.

Following a community development model we felt that many people in the community would benefit from this project, not only through being involved in its implementation, but also in its maintenance. As a consequence, when approached, the Health Centre granted \$10,460 on condition that the project serviced the areas of Carlton, North Carlton, and Parkville.

The work began in earnest, and decisions had to be made quickly. These involved defining tasks for the project worker's job description, finding a place for the worker to be based, making a choice of conditions of employment, and conducting a search for an appropriate person.

Project worker's goals

In October 1991, after interviewing several people, Stephen Ziguras was employed as a consultant to work with the committee for six months:

- to consult with the potential client group, their families, the wider community and relevant community agencies to examine the need for a support program;
- to identify the most appropriate form of service provision by consulting with existing community support programs and other related groups, and to prepare a report identifying the need and recommending a support program;
- to plan, in co-operation with related service providers, for programs which will specifically meet the needs of the clients as defined in the reports; and
- to detail organizational structures necessary to implement a community support program, and to write a submission for funding for the appropriate community support program.

A sub-advisory group was formed, consisting of three workers and members of the community, to work closely with the project worker during the six months and report back to the steering committee.

More community consultation

During this period a community lunch and two forums were held to discuss the issues with residents. All advertising was prepared in five community languages, interpreters were present, and all discussions were well attended by residents.

Enthusiasm had been regenerated and in April 1992 the research was completed and the report launched by a Melbourne City Councillor, John Hammond, and Gerry Hand, a local Federal parliamentarian, both of whom had been consistently supportive during the previous two years.

Recommendations

The excellent report found that there was a need in Carlton for a psychiatric support group as an alternative to the Mental Health Clinic and recommended a model similar to the Macaulay Program be adopted. The main recommendations were:

1. Apply for funding from the Office of Psychiatric Services to establish an assertive outreach support program for people with psychiatric disabilities living in Carlton, North Carlton, or Parkville (Priority: immediate).
2. Work with the Victorian Department of Housing and Construction and St Jude's Church in the establishment of housing for people with psychiatric disabilities (Priority: short to medium term).
3. Support and encourage Mental Health Clinic to take a more assertive role in going out to the community when responding to crises (Priority: immediate).
4. Encourage the Office of Psychiatric Services to ensure that the community sector has better access to psychiatric hospital admission data (Priority: medium term).
5. Explore the possibility of setting up an informal drop-in program, one or two mornings a week (Priority: long term).

At the end of the research there was a small sum of money left and at present we are considering employing a worker for a few hours a week for about six months to establish contact with several people in Carlton with psychiatric disabilities, in order to assist them in developing psycho-social skills and link them with other agencies.

The steering committee has been consistently supported by all agencies in the area and residents. Information and minutes of the meetings are circulated to about fifty people throughout the area, to anyone who has shown interest in the project.

The submission was finalised and presented and at present, the steering committee have requested meetings with the Director of the Office of Psychiatric Services and the Minister of Health to discuss the submission. We await developments with interest.

The author: Eileen Hooper is Convener of the Carlton Community Support Group

References:

Ziguras, S. "Is Anybody Listening", Carlton Community Health Centre, 1992.

Patmore, M. "Public report and Discussion Paper", Carlton Community Health Centre, 1990.

"The project demonstrated that opportunity should be provided for community representatives to identify health concerns as they perceive them, establish a representative group to identify strategies and evaluation for proposed activities, and include all community sectors in the implementation."

Norma Livingstone and Trish Nave

health promoting schools: establishing the process

Norma Livingstone and Trish Nave

COMMUNITY workers often say community development is about getting the process right. Community development is also criticised for spending too much time on process. The Health Promoting Schools project demonstrates that getting collaboration and co-operation does involve putting in a lot of time on process at the start, but that such time will be rewarded through effective action and community participation.

Seeking a model of good practice

Health Promoting Schools aims to improve the health of children in schools and has been piloted at Merrylands East Primary School in Sydney's west. The pilot project was a collaboration between the Western Sydney Area Health Promotion Unit and the Department of Schools Education.

It was intended to demonstrate the benefits of this approach by developing one school as a model of good practice which other schools might adopt.

At Merrylands East this project called for a conscious, co-ordinated combination of activities providing children with healthy school, home and community environments.

Promoting collaboration for wellness

Health Promoting Schools is a World Health Organisation initiative and promotes a collaborative approach towards addressing diseases of this generation. This collaboration is often between people and organisations who have not met this way before. The project targets not only the school itself, but also the environment and community around it.

Focusing on health as wellness and incorporating emotional, physical, environmental, social, spiritual and economic well-being, health is seen as being created in schools, in work places, in families, in leisure, in communities, and in everyday life.

The Schools Project uses the Ottawa Charter definition of health promotion as "the process of enabling people to increase control over and to improve their health". The Charter sees health as not being the sole responsibility of the health sector and recognises the role everyone has to play.

Beginning the process

The project's beginnings were in early 1991 when the World Health Organisation launched the Health Promoting Schools project in Europe. At the same time in health in NSW, school nurses were being "apprenticed" into health promotion approaches, and it seemed that children especially offered great potential for disease prevention.

In education, schools were developing new curricula and policies, especially in Personal Development, Physical Education and Health.

However, while health promotion staff at Western Sydney were ready to act, other health workers were not keen to take on a new project. A concept focusing on and allowing time for process was seemingly too nebulous for people with already full workloads. Schools and teachers were also wary of increasing commitments.

Collaboration was seen as taking time, and there was uncertainty as to its benefits. There was a need to see how such a project could enhance existing commitments. There was also uncertainty associated with a project aiming to empower others through an untraditional approach which did not fit neatly into more conservative health and school systems.

In addition, Health Department and Schools Education compete for the same state government funding, and Education policy aims to minimize outside people in classrooms. Both of these issues were potential barriers to project commitment in uncertain times.

With this mixed background, the 14th International Health Education Conference took place and helped clarify and validate the Health Promoting Schools approach. Research showed that collaboration with the community was crucial for effective school health education.

The Health Promotion Unit decided to go ahead with Health Promoting Schools and adopted the following project goal:

To develop a structure and set of procedures whereby Health Promotion and schools work effectively together toward a better health status for the whole community. This will involve the development of specific objectives in relation to the above health issues in collaboration with individual school working parties.

Developing the partnership

Negotiations with Schools Education began with the recognition that ongoing support and maintenance of the project was dependent on gaining commitment at several levels: Cluster Director, principal, teachers, parents and other community representatives.

Negotiations with "middle management" was seen as high enough in the hierarchy to influence decision makers and not too high to be aloof from the needs of schools, teachers, and pupils. It was therefore important that initial contact be made by personnel with credible teaching backgrounds, sensitive to and able to allay fears, concerns and potential barriers which could be associated with the project.

The Health Promotion representative in these negotiations had the advantage of knowing Area Health and Educational consultants from previous work with schools.

The Health Promoting Schools concept was translated into Education language as affirming and reinforcing the new student welfare policy. This allowed Health Promotion and Schools Education to move forward with a mutual purpose.

After several meetings between health and education representatives, education staff were able to sell the project to the Regional Director. This led to a signed agreement between the Area Health Service and Schools Education to pilot the project in three primary schools. This later became only one school when funding was reduced.

Selecting the school community

The pilot school needed to be representative of Western Sydney, with around 50% of students from non-English speaking homes, a cross-section of economic backgrounds, an enthusiastic principal, supportive Cluster Director, and supportive health staff in the Local Government Area.

The Director of Curriculum Development for the West canvassed likely schools, and negotiated again with Health until finally Merrylands East Primary School was chosen as most closely meeting the criteria.

The principal agreed to commit himself and the school to the project and the final proposal was put through the Western Sydney Area Health Service, to the Director General of Schools Education in the Western Sydney Metropolitan Region for approval and ratification.

The Area Health Promotion Unit funded a part-time project officer to administer and work on the project.

Merrylands East

Merrylands East is in the City of Holroyd in Sydney's western suburbs. The Primary School provides infants and primary school education to 360 boys and girls aged from five to twelve. Sixty-five percent of students are from non-English speaking backgrounds.

The school had a willing and enthusiastic principal practising democratic school management and with a commitment to holistic health and child growth and development. It also had interested staff and a supportive Cluster Director.

The principal participated in the first NSW Health Promoting Schools Network meeting held at the Health Education Unit at the University of Sydney and was enthused by the statewide interest in the concept. After the meeting the principal and staff committed their time to further setting up the project with the project officer and establishing the pilot project at Merrylands East.

Contacting the community

The project officer began by contacting community representatives who influenced health. This included police, housing, churches, library, transport, Council, health and service organisations.

Raising awareness and an understanding of the project amongst the school and surrounding community was the initial focus of the project officer. There were many hours spent on the phone, arranging one to one meetings, developing and distributing flyers, letters, programs, and media releases.

Interest was gained from the local Community Health Centre, who intended to evaluate the project's success by any increase in the Centre's use. However, there were some reservations on the choice of school with community health staff preferring other "more health conscious" schools. The community health staff were also concerned to not increase the School Nurse's workload.

Involving the community in a collaborative way

The end of 1991, with Christmas approaching, was not a good time to introduce a project which involved the school in any extra activity, however the ground was laid with an introductory Health Promoting Schools flyer sent to parents alerting them to the project for 1992.

A meeting with teachers clarified the concept, especially health as wellness, and the value of maximizing resources through collaboration.

Creating an understanding of the concept was further expanded through 11s1ts, phone calls and talks to a broad sector of the community. It was important to speak about how health is defined as wellness, and the importance of each person's contribution.

Many individuals and organisations, thinking in traditional "health as freedom from disease" terms, had not recognised their links to health and were therefore undervaluing their contribution. Bringing together community representatives who influenced health was the next step towards establishing a collaborative network.

The first workshop

The project officer began planning a workshop for early 1992 to provide a forum for the School and the extended community to meet, exchange health related information and increase understanding of the project. It

was hoped involvement in this workshop would lead to ongoing commitment to the project.

The workshop agenda was developed by the project officer and modified after discussion with the principal, the local health education officer, and a community worker from Holroyd Council. Particularly significant was dividing the proposed one day workshop into two workshops and adding the bribe of lunch or morning tea.

To provide a familiar and non threatening environment the School Library was chosen as the venue for the workshops and for all subsequent meetings. This was a conscious shift to encourage parental and local community involvement in health outside traditional health settings.

Representatives from the Merrylands Police, Anglican Church, Area Health Promotion Unit, Holroyd Council, SHAREING (a self-help group), Cumberland Women's Health Association, Merrylands Community Health Centre, School Parents, and the principal (teachers were happy to be represented by the principal at this time) attended the first workshop. This expanded at the second workshop to include representatives from Youth Aid the Catholic Church, and other parents.

The objectives of the workshops were to:

- establish recognition of health as wellness;
- promote understanding of the Health Promoting Schools concept; and
- promote the model of working to maximize resources by utilising an integrative, collaborative approach to improving health.

At the first workshop an explanation of health as wellness was followed by a presentation of the concept using a case study approach. A good understanding of the project was demonstrated by participants.

Benefits of networking

Twenty five people attended the first workshop in March, and by the end of the meeting networking had already begun. One of the major achievements was the participants' realization they had something to offer the project.

Other benefits were officers of different departments and organisations recognizing how they could link with each other to produce better health outcomes. A Council Environmental Officer, recognizing health as an environmental issue, invited a health representative, who recognised environment as a health issue, onto his committee.

A church representative pointed out that attendance at the workshop was not representative of the whole community. Students from non-English speaking backgrounds were 65% of the school pupils but were

not represented at the workshop. The group decided that involvement was in itself a health issue and looked to the next meeting to resolve this.

People at the workshop committed themselves to meet again to help identify school and community health concerns and to establish some realistic strategies towards addressing them.

Promoting Arabic involvement

Over 35% of the pupils from non-English speaking backgrounds attending Merrylands East are Arabic. Towards increasing communication with the Arabic community, the Australian Lebanese Welfare Society was contacted for advice and support.

Support from the Society extended to representation at meetings, translation of flyers for parents and messages in school newsletters, as well as being available to interpret for parents.

Twenty participants arrived for the second workshop, and amongst those present were two cultural representatives. Unfortunately the second of these arrived part way through the meeting, and left shortly after she realised that there *were* no interpreters or others of her nationality present.

Second workshop - identifying health needs

The second workshop in April aimed to identify health needs as perceived by the participants. A group process was used which ensured all participants were involved and confidentiality could be maintained. All responses were equally valued, and the process also gave a measure of participants understanding of "health as wellness".

Health concerns seemed not to be easily identifiable as participants concentrated on the unfamiliar task of individually listing their health concerns. Care had been given to careful wording of the question which, with background information, would discourage disease based responses (no such responses were received).

Health concerns were recorded as participants had written them, then placed under loose headings and these headings were then prioritised by participants. Those which gained most support were: Nutrition, Cultural Awareness, Parenting Education to meet special needs (such as significant male modelling for boys) and Environmental Support, which included weather and sun protection, a pedestrian crossing, and head lice.

Establishing an organisation

At this second workshop, there was discussion about how to set up a working party to carry out the project. One representative wanted the specific frequency of meetings and specific number of representatives to be known. Names like "committee" and phrases such as "terms of

reference" had counter productive connotations for some participants and time was spent looking for alternative language.

An unexpected outcome of the discussion was to devote the first three months towards establishing the group, a process which was to ensure consolidation of the group itself.

An expected outcome of the workshops had been that a small representative group would meet on a regular basis to work at tackling the health concerns from the workshop in a collaborative way. However, the response was greater than expected with 95% of the representatives wanting to join the working party. Two organisations were unable to continue on the working party but asked to be kept informed of progress.

A report summarizing the workshops was sent to everyone on the original mailing list. This report, similar to minutes, included the date and agenda for the first working party meeting. It was also a method of keeping people in touch until a regular form of contact could be set up. Parents were advised of the project's progress through the regular school newsletter. This proved to be an important way to keep members involved.

The first working party meeting was chaired by the project officer who offered to do so, with school support, for the first three months. After that time it was anticipated that members would know each other sufficiently well to nominate office bearers. They would also have the advantage of practical project experience. The school provided administrative support.

At the second workshop, the Working Party decided to defer the prioritisation of identified health concerns, preferring to demonstrate the effectiveness of different sectors of the community working together to achieve a common goal. This could best be done by choosing a small achievable project that could produce maximum results in the short term.

There were two general and one extraordinary meeting over the next two months.

CASH - Community Action for Social Health

Developing a sense of ownership, the working party called themselves the CASH Group - Community Action for School Health, and "Group" to better reflect the working relationship of members. The CASH Group's purpose, mission, and terms of reference were all discussed, drafted and agreed on by members.

The originally identified issues were confirmed by CASH and it was agreed that resolution of these issues, within a given time frame, was to be a form of evaluation.

Having established itself, CASH recognised the project would gain credibility, especially among parents, if the process was demonstrated to be successful. It was decided this could best be done quickly in a small project with wide appeal - such as head lice.

"Nit Busters"

A successful program which eliminated head lice from the school would gain parental support and interest and validate the process of intersectoral collaboration. An extraordinary meeting was arranged to plan and implement "Nit Busters".

It was decided to approach the problem in an educative and informative way. A co-operative working team was set up with CASH members each taking a task with the intention of involving others. A lighthearted approach was adopted to help breakdown inappropriate stigma associated with head lice.

Organised to run until the end of the second term, the program aimed to:

- get rid of head lice and keep them away;
- give parents and students factual information about head lice and treatments;
- develop CASH as a cohesive group;
- demonstrate the Health Promoting Schools process, particularly intersectoral collaboration;
- develop personal skills, supportive environments and healthy policies.

The CASH Group needed to inform itself of the current knowledge of when and where head lice occur, how they were transmitted, and methods of control and treatment. Consequently a literature review was done.

The incidence of head lice needed to be determined. This was achieved by a CASH member observing the scalps and hair of all pupils over two days, as she showed each pupil where the lice live and lay their eggs.

Information from the literature review was given to pupils, parents and teachers through addresses to two school assemblies, a Parent's Club meeting and a teachers meeting. Information on head lice control was also sent home in the school newsletter.

The head lice information was reinforced by holding a Nit Busters poster competition. Pupils were encouraged to make posters showing how to look for and treat headlice. Prizes were donated by local stores for first, second and third categories in each of the infants and primary sections.

Finally, six weeks after Nit Busters started, the result was determined by the teacher of each class examining each pupil and reporting the results to CASH.

Parent participation

Since the first general meeting parent participation had grown from two to seven (following Nit Busters), with others requesting minutes. Uncertainty was replaced with enthusiasm. Group members prepared the minutes for distribution and members were contributing productively at meetings and were eager to use previously unrecognized or under-utilized skills.

Health Promoting Schools was well underway at Merrylands East Primary School. People and sectors were now joining together and pooling resources to better the health of the community instead of working alone frustrated and unsupported, initiating one-off activities which may not have been followed through by others. Teachers could see their efforts in the classroom supported by parents and the community, such support being essential for health behaviour change at school.

Reflections

Health Promoting Schools was based on the Ottawa Charter principles, with intersectoral collaboration as a major component. It was important that the project was initiated with a clear understanding of health as wellness, incorporating emotional, physical, environmental, social, spiritual and economic well-being, and was directed at improving health in general.

It was helpful that the initial health liaison person understood the education system and had worked in that setting before. The Health Promotion representative had a teaching background, and had the advantage of having worked with educational representatives on previous occasions.

Finding the common ground between health and education was important in establishing a partnership. This emphasized a collaborative pooling of resources rather than increasing stresses and strains. The Health Promoting Schools concept was translated into education language which affirmed and reinforced the new student welfare policy documents.

It took time to introduce this concept, especially building health networks which encompassed non-traditional health sectors of the community. It showed community members that they do have something to contribute to the health and well-being of their school and community.

The project demonstrated that opportunity should be provided for community representatives to identify health concerns as they perceive them, establish a representative group to identify strategies and evaluation for proposed activities, and include all community sectors in the implementation. Representatives (CASH Group) gradually become the project's catalyst as health professionals withdrew.

notes on contributors

The case studies in this collection were mostly written in 1992. We have listed below the involvement of the authors at the time of writing the case study.

Rayleigh Joy was a social work student on placement at the Women's Health Centre in Brisbane.

Khai Wong was a community health worker, specialising in ensuring access for ethnic groups, at the Fitzroy Community Health Centre in inner suburban Melbourne.

Helen Ansems was a Project Officer with the Ryde Health Promotion Unit, a division of the Northern Sydney Area health Authority.

Catriona Knothe was the Executive Office of the Dandenong-Springvale District Health Council, in the outer eastern suburbs of Melbourne.

Elaine Kellerman and **Marilyn Onafretchook** were community activists with the Walker St Residents' Association, while **Glenice Kelly** was the Association's Tenant Worker. Walker St is in Northcote, an inner northern suburb of Melbourne.

Kathleen Millicer was a resident in Anglesea, a seaside town on Victoria's south west coast, who became actively involved with the Neighbourhood House as a result of the project.

Eileen Hooper was the Community Development Worker at Carlton Community Health Centre in inner suburban Melbourne.

Rita Prasad was the Multicultural Community Development Worker at the Women's Health Centre in Brisbane. **Wafa Shinwari** was a Bi-Lingual Community Educator who became involved with the pap smear project.

Norma Livingstone and **Trish Nove** were health promotion workers with the Western Sydney Area Health Promotion Unit.

Marnie Mason was the Health Promotion Officer with the Central West Health Promotion Unit in Orange in NSW.

Julie Statkus was the Co-ordinator of South Port Day Links in Port Melbourne, an inner suburb of Melbourne.

Chris Ainsworth, **Gaynor Hartvigson** and **Bronwyn Buddle** were community activists with the Strathalbyn Women's Health Project.

Jim Boyle was a member of the Riverland Health and Social Welfare Council and the founder of the Workcover Action Group.

Sida Douglas and **Kathie Walsh** were community health workers with Prahran Community Health Centre, while **Joanne Hackett** was a social work student on placement at the Centre.

Fiona Gardner was the Executive Officer of the Loddon District Health Council, based in Bendigo in central Victoria.