

INNOVATION  
AND  
EXCELLENCE  
IN  
COMMUNITY  
HEALTH



INNOVATION AND  
EXCELLENCE IN  
COMMUNITY  
HEALTH

Edited by Paul Butler

CENTRE FOR DEVELOPMENT AND INNOVATION IN HEALTH

Published by:

Centre for Development and Innovation in Health  
POBox57  
Northcote  
Victoria  
Australia 3070  
Ph: (03) 482 2127  
Fax: (03) 482 1434

ISBN 0 646 18286 2

Copyright CDIH 1994

Copyright for 'Paps I Should' CDIH and HealthSharing Women, first published in 'Mapping the Models', CDIH, 1993, Melbourne.

Copyright of articles (except 'Paps I Should') rests with the authors. The authors' permission must be sought before the material may be reproduced.

Production by Waalimma Productions

Cover design and illustrations by Terminal Design

Printed by Aristoc Offset, Glen Waverley

Printed on recycled paper

## Award Sponsors

The projects described in this book are the winners of the inaugural Awards for Innovation and Excellence in Community Health. The sponsors of those awards were:

City of Melbourne  
GPO Box 1603M  
Melbourne 3001  
Ph: 6589800

Telecom Australia  
242 Exhibition St  
Melbourne 3000  
Ph: 8689608

The Sidney Myer Fund  
250 Elizabeth St  
Melbourne 3000  
Ph: 6633113

Victorian Health Promotion Foundation  
PO Box 154  
Carlton 3053  
Ph: 347 3777

Fitzroy and Carlton Credit Co-op  
314 Brunswick St  
Fitzroy 3065  
Ph: 419 4533

Exquisite - manufacturers of fine food  
230 Lygon St  
Brunswick East 3057  
Ph: 380 8788

Employ - publishers of Community Quarterly  
PO Box 1042  
Windsor 3181  
Ph: 525 3384

Prometheus Information - producers of HealthWIZ  
GPO Box 2319  
Canberra ACT 2601  
Ph: 257 7356

# Acknowledgements

This book is a record of the 13 projects which won the first Awards for Excellence and Innovation in Community Health. The Awards project was co-organised by CDIH and the Victorian Community Health Association (VCHA).

We would like to thank the following people who donated their time and wisdom as judges for the Awards:

Nancy Peck	Bruce Hurley	Jill Miller
Pete Whitecross	Helen Dooley	David Legge
Frank Meumann	Karen Murphy	Ian Lennie
Toni Schofield	Clare Shuttleworth	Jens-Peter Kunst
Chris Leon	Vivienne Pusey	Ethel McAlpine
Shirley Freeman	Paul Butler	

In addition, substantial support was provided by the following members of the CDIH and VCHA networks and we thank them for their assistance - Kay Black, Tony McBride, Angela Hill, Doug McManus, Shirley Cass, Demos Krouskos, Onella Stagoll, Gai Wilson, Maria Wright and Mary Karavarsamis.

We would like to thank the organisations and the workers and participants involved in both the 13 projects recorded here, and the many other projects which did not receive an award. These organisations demonstrated faith in CDIH and VCHA and our judging process and we hope that they all feel they were treated equally.

Finally, we would like to congratulate those organisations who nominated their projects on the very high standard of work which they had carried out.

The Awards project was financially supported by the Victorian Department of Health and Community Services.

This book was produced as part of CDIH's Reflections project. The Reflections project was financially supported by the Commonwealth Department of Health and Human Services' National Health Advancement Program.

We would like to thank the following members of the Reflections project's Advisory Committee - Wendy Hurle, Tony McBride, Eileen Hooper, Margurite Menon, Sue Rosenhain, Ruth Scharley, Angela Taft.

# Contents

	Page No.
Foreword - Shirley Freeman, Victorian Community Health Association	1
Introduction - Paul Butler, Centre for Development and Innovation in Health	3
The Finalists	11
The Projects -	
1 Paps I Should - Sue Farnan and Judy Gray Women's Health Service for the West, Centre for Social Health	15
2 Vietnamese Antenatal/Postnatal Project - H a Tran North Richmond, Collingwood and Fitzroy Community Health Centres Mercy Hospital for Women	23
3 Women's Health Information in 'Plain English' - Shannon Kerrigan and Julie Oberin Loddon Campaspe Women's Health Service	31
4 The Survivors Group - Deborah Bosworth, Andrea Bowles and Jane Coward Narre Warren/Berwick Community Health Centre	41
3 Inner South Housing Support Program - Kevin Sullivan St Kilda Community Health Centre	47

6	Massage and Older Women's Health - Monica Byrnes and Michelle Turner East Preston Community Health Centre	53
7	Homeless Young Persons Health Access Program - The Health Bus is a Fish - Catherine Hannon, Victoria McDonough and Linda Philip Inner South Community Health Service, St Kilda Base	61
8	'The Asthma Story' by the Wheezers - Anne Munzel, Kaye Graves, Mary Henery and Joan Maher Echuca, Bendigo, Northern District and Central Victorian Community Health Services	71
9	One Stop Body Shop 1993 - Helen Hill Sunbury Community Health Centre	77
10	Vietnamese Women's Domestic Violence Poster Project - Lee Kennedy, Heather Clarke and Helene Yong Inner West Community Network Against Violence Towards Women and Children	83
11	Needs Assessment of Former Residents of Great Southern - Susan Spurling Royal District Nursing Service Homeless Persons Program	89
12	Arthritis Phone Link - Jan Reilly Arthritis Foundation of Victoria	95
13	Young Women's Support Program - Kathy Heffernan Frankston Community Health Centre	101

# Foreword

*Shirley Freeman*

*Victorian Community Health Association*

Everyone who attended the presentation of the inaugural Awards for Innovation and Excellence in Community Health experienced something unique.

There were thirteen categories with over one hundred submissions from community organisations who had undertaken health projects or programs which were innovative and of high standard. The judging was difficult and the task for the interstate judges was immense. We extend our appreciation to them.

As well described by Gib Wettenhall in his media release "Unsung heroes of health . . . , whether it's 'bussing' services to homeless young people or offering group therapy to survivors of sexual abuse, community health services are at the forefront of taking health issues to people at risk." The Awards certainly have demonstrated this.

The Awards were a joint project of the Centre for Development and Innovation in Health (CDIH) and Victorian Community Health Association (VCHA) and will become an ongoing event. We acknowledge Minister Tehan, the Victorian Department of Health and Community Services and our sponsors for financially supporting the Awards.

# Introduction

*Paul Butler*

*Centre for Development and Innovation in Health*

## The Awards for Innovation and Excellence in Community Health<sup>1</sup>

In mid 1993, the community sector in Victoria was reeling from the speed and size of change. It seemed valuable to CDIH and the Victorian Community Health Association (VCHA) that we undertake a project that would highlight the best of the sector's work. We hoped that in exposing this work through an Awards program, we could support the morale of people working, both paid and unpaid, in the sector, and share the best of that work among a wider audience.

Organisations were invited to nominate projects they had worked on which they felt were innovative and excellent. Projects were called for in each of the following categories:

- |                                       |                               |
|---------------------------------------|-------------------------------|
| * Health promotion                    | * Community development       |
| * Community participation             | * Direct care                 |
| * Group work                          | * Planning & evaluation       |
| * Action research                     | * Koori health                |
| * Women's health                      | * Health of people from NESBs |
| * Young person's health               | * Older person's health       |
| * Health of people with disabilities. |                               |

The response was more than we could have hoped for in the first year of the Awards. There were nearly 100 nominations from all corners of Victoria. Many organisations had gone to some trouble in completing the nomination forms. They often provided vast arrays of supporting material for their projects or programs.

Taken together, the thirteen winning projects published here show that despite the difficulties of a rapidly changing environment and reduced funding, the community health sector is still managing to respond in innovative ways to health issues. These projects are inspirational in the way they display workers and agencies tackling the most difficult issues facing primary health (eg child sexual abuse, homelessness, teenage parenthood, domestic violence).

<sup>1</sup> The term "community health" is being used here to cover organisations and projects well beyond the institutional sense of the term. We invited not just community health centres, but also women's health services, neighbourhood houses and many other community based, non-Government organisations to enter the Awards project

The one category where the Awards program did not work was Koori health. Despite some interest from a number of agencies working with Kooris, we had no nominations in this area. This was a major disappointment and something to work on for next time.

## Innovation and Excellence

The notion of awarding projects for innovation and excellence owes no small amount to the currently fashionable idea of 'international best practice'. But how on earth can we relate the leading edge of primary health care with the lessons learnt on the Toyota production line? What does innovation and excellence mean?

As organisers and judges we were breaking new ground and using a somewhat subjective notion of what might be best practice in community health. While we believe that the thirteen projects described here are all exemplary instances of community health, it is more difficult to systematise what makes them so good.

## A Framework

In seeking a framework within which we might consider these examples of excellence, it is useful to consider two policy models. The first is that of Primary Health Care. The Primary Health Care Review<sup>2</sup> provided the following principles:

- \* Collaborative networking among agencies,
- \* Consumer and community involvement,
- \* A balancing of health care priorities between the micro and immediate needs on the one hand and the macro and longer term aspects on the other, and
- \* A partnership relation with the secondary and tertiary sectors.

The second policy model is the Ottawa Charter for Health Promotion<sup>3</sup> with the following principles:

- \* Building healthy public policy,
- \* Creating supportive environments,
- \* Strengthening community action,
- \* Developing personal skills,
- \* Re-orienting health services.

At CDIH we have written previously about the need to be explicit in also mentioning the much maligned principles of equity and social justice<sup>4</sup>.

2 National Centre for Epidemiology and Population Health, Improving Australia's health: the role of primary health care, Final Report of the Review of the Role of Primary Health Care in Health Promotion, by D Legge, D McDonald and C Bengler, NCEPH, ANU, Canberra, 1992.

3 WHO, Ottawa Charter for Health Promotion, November 1986.

4 P Butler & S Cass, Case Studies of Community Development in Health, CDII-I, March 1993.

## Collaborative Networking Among Agencies

Several winning projects demonstrate this networking. Paps I Should is a good example. The project involved a range of different agencies cooperating in different ways at different times. Three organisations were central to the project throughout- the Women's Health Service for the West, the Centre for Social Health and the Women with Disabilities Support Group for the West.

These three agencies cooperating show the notion that the primary health care sector includes both practitioners and agencies and consumers and community organisations.

When the Paps I Should video was being produced, other important agencies were brought in as partners (ie Melbourne University Dept of Community Medicine, Anti-Cancer Council of Victoria, Multiple Sclerosis Association, Victorian Dept of Health and Community Services). In addition, at different points in the project the authors talk about working with the Family Planning Association, the Royal District Nursing Service and the Western Community Health Centre.

The project thus demonstrates a high level of collaboration between a range of organisations. The outcomes of this collaborative effort include improvements to the training of practitioners at both undergraduate and postgraduate levels, improvements to the services delivered by the primary health care system and demonstration of a successful model of consumer involvement.

## Consumer Participation

Many of the winning projects display good consumer and community participation in decisions made about health services and health promotion programs. The Women's Health Information in 'Plain English' and Arthritis Phone Link projects testify to the value of using action research methods to involve participants. The Information project involved women in all aspects of the development, publication and distribution of the various brochures and posters produced.

Arthritis Phone Link is a project where the involvement of arthritis sufferers has altered the project's direction, obviously in a very successful way. Due to the reactions from the people with arthritis, the Arthritis Foundation fundamentally altered the nature of the project. From a project involving friendly visiting by volunteers it changed to a self help and networking project.

The Frankston Young Women's Support project also shows a high level of participation by young women in all aspects of the project's management and activities. Paps I Should had very strong involvement from women with disabilities and testified to putting in the hard work to support participation through building a base for marginalised population groups.

## Balancing the Macro and the Micro

The Primary Health Care Review<sup>5</sup> describes this principle as the need for balance across four polarities:

- Prevention, as well as diagnosis and cure,
- People's lives and their quality of life, as well as episodes of specific illness,
- The health of families, communities and populations, as well as that of individuals,
- Social, institutional and cultural strategies for better health, as well as biomedical strategies.

Several winning projects demonstrate aspects of this notion of balance across the macro and the micro, though few of them encompass the whole principle. The Survivors Group is first interested in helping survivors of child sexual abuse overcome the long-term psychological impact of that trauma. However, a second important outcome was the role that people who had been through the group were playing by running self-help groups and participating in public activities aimed at changing attitudes and awareness of such abuse.

The Survivors Group obviously involves the balance between quality of life and specific episodes of illness. The program was created because treating specific episodes and symptoms was an unsuccessful response to the long-term problems created by abuse.

The Wheezer's Asthma project shows a response based on working with a population group - school children - rather than just individual sufferers of asthma. The project works with all school children rather than just those who suffer from asthma. In doing so, it will raise the general awareness of what triggers asthma attacks and how to deal with them. Such broader knowledge can only help in creating safer environments for asthma sufferers.

The Vietnamese Domestic Violence poster clearly displays a social and cultural response to a health issue that is unlikely to be effectively tackled by a biomedical model. Indeed it has been argued that the biomedical approach to domestic violence taken in the past has, at the least, hidden the problem and prevented it being tackled effectively.

This balance between responding to the short term crisis presented by an individual walking into a service and responding to the broader issues and causes that contribute to the individual situations is characteristic of community health.

5 PHC Review, p.20

## Partnerships with Secondary and Tertiary Providers

This notion of partnership shows up less in this collection of projects. The Vietnamese Postnatal/ Antenatal project demonstrates a strong and effective partnership between three community health centres and two major public hospitals. However, no other project shows partnership with potential tertiary providers.

Changes to the funding arrangements for health care (eg casemix funding) may encourage greater cooperation between primary and tertiary providers as hospitals seek to reduce lengths of stay. Whether this is an opportunity for community health, or a threat to its population focus and prevention activity remains to be seen.

Hopefully the evolving notion of Health Promoting Hospitals<sup>6</sup> will provide an impetus and framework for tertiary providers to involve themselves in partnerships with primary health care services beyond the use of primary health as an outpatient clinic designed primarily to save money by reducing length of stay.

## Building Healthy Public Policy

Sindal<sup>7</sup> has pointed to the role which community health has played in advocating for healthy public policy. Community health has also played a role in supporting community groups lobbying for healthy public policy.

This principle is not widely demonstrated in this collection. The exception would be the Needs Assessment of Former Residents of Great Southern. This project is quite explicit in having the building of healthy public policy on homeless people as a central aspect of the project. The agencies involved were advocating for homeless people who were unlikely to be able to lobby effectively on their own behalf.

Other winning projects may have made contributions to the development of healthy public policy through their activities, though these are less clear. Programs that raise community awareness of issues (eg homeless youth projects, domestic violence and sexual abuse projects) may contribute to the development of healthy public policy.

## Creating Supportive Environments

Supportive environments are both social and physical. Often, community agencies are aiming to enhance existing family and community support systems rather than create completely new ones. There are however degrees in this matter. The Inner South Housing Support Program shows the creation of social support for a very vulnerable group - people with long term psychiatric disorders who have been homeless. This is a

6 Sally Fawkes, Hospitals Move into the New Age, Better Health Briefing, January 1994.

7 C Sindal, Health Promotion and Community Health in Australia, in Baum, Fry and Lennie, Community health policy and practice in Australia, Pluto Press and ACHA, NSW, 1992.

population group for whom the social support structures have almost totally collapsed.

The Asthma Phone Link is also about the creation of a support system among people suffering from arthritis. This is a more limited 'creation' than at inner south, as is the Survivors Group, which is providing a time-limited but intensive support structure within a therapeutic group setting.

## Strengthening Community Action

"At the heart of this process (health promotion) is the empowerment of communities, their ownership and control of their own endeavours and destinies". Clearly this is a strength of community health as displayed by these projects.

Most of the projects involved empowerment of their communities, though the community involved was not always a geographic community. The Arthritis Phone Link involves developing the community of people who suffer from arthritis. The Young Women's Support Network has young mothers as its community.

The empowerment strategies shown here include establishing networks and organisations through which individuals may come together to pursue their collective interests. In addition, the projects demonstrate improving the access to information and providing people with learning opportunities.

## Developing Personal Skills

Again we see several projects showing the provision of information, education for health and the enhancement of life skills. The Asthma Story provides children with information about asthma that will help those with asthma to better manage the illness. The Housing Support Project is providing people with long-term psychiatric illnesses with life skills that will dramatically improve their quality of life and their health.

The Women's Health Information in 'Plain English' project shows that providing information on health issues is a lot more complicated than simply printing another poster or brochure. That project's processes of participation and consultation were also about enhancing life skills for the women involved.

## Re-orienting Health Services

A social view of health places emphasis on the institutional and systematic structures that affect our lives. Many projects that received awards were aimed, at least in part, at changing some of these structures, both within and outside the health system.

Paps I Should involved reforming the training of practitioners so that they are better able to serve disabled women. It also involved lobbying health services to introduce equipment that would allow those services to provide pap smears for women with disabilities.

The Vietnamese Postnatal/ Antenatal project involved professional education for practitioners providing birthing services so that they would be more responsive to the needs of Vietnamese women. The Women's Health Information in 'Plain English' project included the production of a guide for other practitioners on how to produce such information.

## Equity and Social Justice

The principles of equity and social justice will be served where community health is working with those groups who are most disadvantaged and suffer the worst health status. These projects show that community health is tackling inequities in the way it is working on the most difficult social issues facing primary health today (eg child sexual abuse, homelessness, teenage parenthood, domestic violence).

Looking at the winning projects we can see examples of services improving people's access to health services. The Paps I Should project is improving access to pap tests for women with disabilities. It is doing this by both the provision of information to the women, and by reforming the health system through improved training for general practitioners and nurses, and by having services change the way they operate.

Similarly, the Vietnamese Postnatal/ Antenatal Project is improving the access of Vietnamese women to a wider range of birthing services and options. Again this is done by providing information to women about their alternatives, but also making the way those services are delivered more accessible through the provision of a bilingual midwife.

The two inner south projects demonstrate improving access to health services to population groups that have always found this hard. Homeless youth and people with long-term psychiatric disorders have been singled out in recent Human Rights Inquiries as groups that are massively discriminated against. The bus and the housing projects are excellent examples of improving access to health services.

Other projects that are improving access to services for particular groups were the Vietnamese Domestic Violence Poster Project, the Needs Assessment of Residents at Great Southern and the Frankston Young Women's project.

The evidence on health status outcomes is also promising. The Inner South Housing project reports that participants have got out of the revolving door between the psychiatric hospitals and the community. The older women at East Preston report improved flexibility and mobility and reduced use of medications. The Survivors Group report that participants

had improved psychological well being, better social skills and improved relationships.

In some cases the evidence on outcomes is not yet in, but will be considered when available. The Western Women's Health Centre has made arrangements with the Victorian cancer registry that will allow them to investigate the impact of their work on screening rates among women with disabilities.

## **Conclusion**

The inaugural Awards for Innovation and Excellence in Community Health have shown that community health at its best involves the principles of primary health care and the Ottawa Charter. It also shows that community health services are playing a vital role in tackling the major current social issues and their impact on people's health.

Our congratulations again to the winners, the runners-up and all the other workers who nominated their projects for the great work they are doing. Perhaps the most encouraging aspect of all this is that what we have seen in the first year of the Awards is probably just the tip of the iceberg - there is much more great work being carried out in the field. Hopefully we can hear about that in the near future.

# **The Finalists**

## **Vic Health Award for Health Promotion**

***SPONSOR: Victorian Health Promotion Foundation***

Winning Project: One Stop Body Shop

AGENCY: Sunbury CHC, CONTACT: Helen Hill

Runner-Up Project:

Osteoporosis Community Education Project

AGENCIES: Bayside Health Promotion Association

CONTACT: Sue Moulton (Frankston CHC)

## **City of Melbourne Award for Community Participation**

***SPONSOR: City of Melbourne***

Winning Project: Arthritis Phone Link

AGENCY: Arthritis Foundation, CONTACT: Jan Reilly

Runner-Up Project: Patchwork Bushfire Prevention

AGENCY: Angelsea Community House,

CONTACT: Kate Millicer

## **Healthwiz Award for Planning and Evaluation**

***SPONSOR: Prometheus Information***

Winning Project: The Wheezers - A n Asthma Story

AGENCIES: Echuca CHC & Bendigo CHC & Northern District CHC & Central Victorian CHC,

CONTACT: Anne Munzel (Echuca CHC)

Runner-Up Project: Mental & Emotional Health Project

AGENCY: Loddon Campaspe WHS, CONTACT: Robyn Jones

## **Exquisite Award for Young Person's Health**

***SPONSOR: Exquisite***

Winning Project: Homeless Youth Health Bus

AGENCY: Inner South CHS, CONTACT: Kevin Sullivan

Runner-Up Project: ADF Concoctions

AGENCY: Aust Drug Foundation, CONTACT: Sandy Shaw

## **Telecom Award for Older Person's Health**

### ***SPONSOR: Telecom Australia***

Winning Project: Massage & Older Women's Health  
AGENCY: East Preston CHC, CONTACT: Monica Byrne

Runner-Up Project: Older Person's Advisory Group  
AGENCY: Tarwin Lower & District CHC,  
CONTACT: Judy Carberry

## **Fitzroy & Carlton Credit Union Award for Women's Health**

### ***SPONSOR: Fitzroy & Carlton Credit Union***

Winning Project: Vietnamese Women's Domestic Violence  
Poster Project

AGENCY: Inner West Network Against Violence Towards  
Women & Children,  
CONTACT: Heather Clarke (Ooutta Galla CHC)

Runner-Up Project: The Little Clinic  
AGENCY: Ballarat CHC, CONTACT: Jenny Morrison

## **Community Quarterly Award for Community Development**

### ***SPONSOR: Employ***

Winning Project: Young Women's Support Program  
AGENCY: Frankston CHC, CONTACT: Kathy Heffernan

Runner-Up Project: Care for the Aged Program  
AGENCY: Mordialloc Aged Services Committee,  
CONTACT: Pat Mutimer (Mordialloc/Chelsea CHC)

## **Sidney Myer Award for Direct Care**

### ***SPONSOR: Sidney Myer Fund***

Winning Project: Inner Sth Housing Support Program  
AGENCY: Inner South CHC, CONTACT: Kevin Sullivan

Runner-Up Project: Hospital/Community Care for Homeless  
People  
AGENCY: RONS Homeless Persons Program,  
CONTACT: Judy McWilliams

## **Award for Group Work**

Winning Project: The Survivors Group  
AGENCY: Narre Warren-Berwick CHC,  
CONTACT: Andrea Bowles

Runner-Up Project: Rural Education & Training in Birth  
Information  
AGENCY: Loddon Campaspe WHS,  
CONTACT: Jude Jackson

## **Award for NESB Projects**

Winning Project: Vietnamese Antenatal Postnatal Support  
Project

AGENCY: Nth Richmond CHC & Collingwood CHC &  
Fitzroy CHC & Mercy Hospital,  
CONTACT: Ha Tran (Nth Richmond CHC)

Runner-Up Project: Self Help for Older Italians  
AGENCY: Italian Pensioners Club of Nth Fitzroy,  
CONTACT: V Ballestra

## **Award for Health of People with Disabilities**

Winning Project: Paps I Should  
AGENCY: Women's Health Service for the West & Centre for  
Social Health  
CONTACT: Sue Farnan (WHS)

Runner-Up Project: Me, Myself, a Women  
AGENCY: Bendigo Community Health Service & Loddon  
Campaspe Women's Health Service,  
CONTACT: Linda Beilharz (Bendigo CHS)

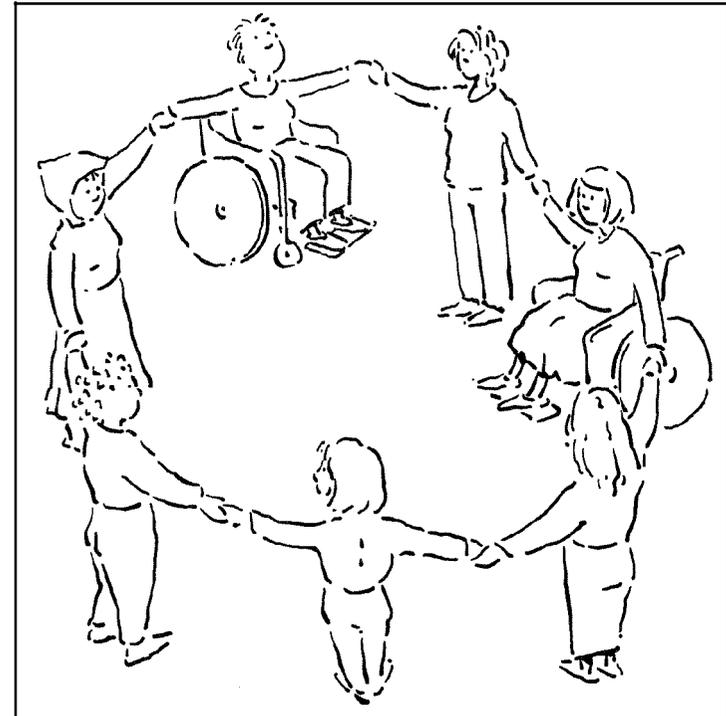
## **Award for Action Research**

Joint Winning Project: Women's Health Information in Plain  
English

AGENCY: Loddon Campaspe WHS,  
CONTACT: Jude Jackson

Joint Winning Project: Needs Assessment of Former  
Residents of Great Southern  
AGENCY: RONS Homeless Persons Program,  
CONTACT: Susan Spurling

## **PAPS I SHOULD**



**SUE FARNAN AND JUDY GRAY**

Women's Health Service for the West  
Centre for Social Health

# **Paps I Should**

*Sue Faman and Judy Gray<sup>1</sup>  
Women's Health Service for the West  
Centre for Social Health*

A particular achievement of the Victorian Women's Health Services program is the work it has done with women perceived by mainstream health services as "hard to reach" (eg young women, women from non-English speaking backgrounds and women with disabilities). This case study looks at how one service worked with women with disabilities to help them improve their access to Pap tests.

## **More Than a World First in Pap Test Education**

The Women's Health Service for the West has assisted the development of a support group for women with disabilities. In 1991, the Anti-Cancer Council of Victoria began its campaign 'Pap Test Victoria'. Members of the support group approached the Service about the difficulties they were experiencing in having Pap tests at local health services and in getting relevant information about cervical screening.

Experts recommend screening with Pap tests every two years for all women who have ever been sexually active. This should generally commence between 18 and 20 years and cease at about 70 years. At present, only 50% of cases of cervical cancer are prevented. However, it is believed that this would increase to 90% if all recommended women had regular Pap tests.

## **Pap Tests and Women with Disabilities**

Rates of cervical screening are particularly low among women over 50, rural and Aboriginal women and women with disabilities. Since women with disabilities represent 15.2% of all women this is of significant concern.

Pap tests are usually done with the woman on her back (the supine position), her pelvis raised and legs separated. Some women with physical disabilities, particularly those involving the legs or spinal cords, are unable to assume this position. Women whose disabilities are such that they are confined to a wheelchair need a special hoist that can lift them from the wheelchair to the medical couch.

The Service made a commitment to tackle this issue. However, we could not find any educational material that addressed the needs of women with

<sup>1</sup> This case study is based on a case study written by Gai Wilson and Kim Webster and published in Mapping the Models, The Women's Health Services Program in Victoria, produced by CDIH and the Women's Health Resource Collective, Melbourne, 1993.

disabilities. Members of the disability support group reported that existing material tended to have an emphasis on the physiological aspects of the Pap test. However they required information on how to negotiate the process of having a test and about alternate positions for taking the test. This was important for some women as their disability prevented them from assuming the conventional supine position.

Women with intellectual disabilities said that existing information was presented in a way that they could not easily understand. This meant that these women were having a Pap test without comprehending what the test entailed (raising issues of informed consent) or were not having tests because they were unaware of their importance.

### **Damned if You Do ... Damned if You Don't**

Members of the support group reported that their attempts to have Pap tests had been problematic. Very few doctors were aware of the different techniques involved in taking tests for women with disabilities.

Pap tests are particularly important for women once they have started having sexual intercourse. Some doctors were more than keen to take Pap tests for women with disabilities, assuming them to be promiscuous. Others resisted offering the test, believing that women with disabilities tend not to be sexually active. The reality is that the sexual practices of women with disabilities are as variable as those of other women.

### **A Cooperative Venture**

The Service decided to make a video that would be of use to students of nursing and medicine, to service providers, and to women, particularly those with disabilities. A working group was formed comprising representatives of:

- Women with Disabilities Support Group for the West,
- Women's Health Service for the West,
- Centre for Social Health,
- Melbourne University Department of Community Medicine,
- Anti-Cancer Council of Victoria,
- Multiple Sclerosis Association, and
- Department of Health and Community Services (Western Region).

Members of the support group were directly involved in researching, writing and editing the script. They also shared the task of acting in the video with professional actors. Their involvement in this capacity was important. Women in the group said that they often found portrayals of women with disabilities in conventional media unrealistic and difficult to identify with. We are currently translating the video into two community languages.

### **Using Women's Day-to-Day Experience to Change Medical Education**

Through the involvement of women from the support group, the project developed techniques for taking Pap tests for women with different forms of disability. These new techniques were documented on the video.

This new material will be incorporated into the undergraduate medical courses of both University Schools of Medicine and into the Family Planning Association's Nurse Practitioner Course. Intellectual disability services will use the video to help increase understanding about Pap tests and to ensure that women make informed decisions about the procedure. Consequently, the project will have a positive affect for thousands of women who will have contact with service providers in the future.

These achievements would have been impossible without the involvement of key organisations on the working group (eg the School of Medicine). Members of the group were familiar with the processes of change in their own organisations. They advised the Service on approaches that would be relevant and acceptable to their respective professions. Importantly, the involvement of the various groups in the project and their commitment to it, meant that they had an investment in making sure that its impact was felt.

### **Advocacy**

Through our involvement in the video, the working group became aware that women who were housebound by their disability faced particular problems in having Pap tests. Consequently, the Service negotiated with the Royal District Nursing Service (RDNS) to have several of its nurses undertake the Women's Health Service's and Anti-Cancer Council's nurse practitioner course. RDNS staff were then skilled to be able to provide Pap tests to women in their own homes, however they have not taken up this service.

We also discovered that no medical service in the western region had the facilities to provide Pap tests for women whose disability confined them to a wheelchair. Following lobbying from the support group, the Western Community Health Centre became accessible to women in wheelchairs. The Centre also began doing home visits for housebound women and targeted women with disabilities for their women's health clinic.

'Paps I Should' is the first video of its kind in the world. It will have a market, and therefore an impact, both nationally and internationally. While it is the tangible product of this project, its legacy can be seen in the development of new techniques for taking Pap tests for disabled women and in the delivery of services to women who are housebound. It shows in the sense of pride and achievement experienced by members of the support group.

Their involvement has contributed to improved self-esteem and confidence and has enabled them to develop research and production skills. The pivotal role played by the group provided opportunities for the development of leadership skills. Significantly, this project served as a positive model for other women with disabilities.

The Women's Health Service for the West, the Anti-Cancer Council and the Victorian Health Promotion Foundation jointly funded the video. Production costs were \$30,000, not including worker time from the Women's Health Service and the Centre for Social Health.

## **Woman to Woman: Peer Education in Cervical Cancer**

Broad-scale education campaigns aimed at encouraging Pap tests have had only limited success in reaching women with disabilities. Consequently, the project saw the need to develop other strategies which worked with women with disabilities in ways which they were able to understand and relate to.

A targeted approach involving a peer education model appeared to offer some potential. Peer education was pioneered in the Third World. It is based on the proven assumption that people are more likely to receive, understand and act on a health message if it is given to them by someone with whom they can identify. Peer educators are believed to have greater empathy with those they are working with and a better understanding of their needs. Importantly too, it provides women with disabilities with successful role models.

The Centre for Social Health and the Women's Health Service, in cooperation with the disabilities support group, embarked on the second phase of the project. This was a six-week course to train the women to conduct education sessions with other women with disabilities. Three women with intellectual disabilities joined the group at this point. They brought with them advocacy experience and contacts in the intellectual disability field. An added advantage was that two peer educators were from non-English speaking backgrounds. The program could therefore be conducted in two other languages.

The peer educators become very skilled at working with women with both physical and intellectual disabilities. The educators have worked with women who live independently, in institutions, and who attend training centres and employment centres.

The peer education has now involved over 160 women. Evaluation has been extremely positive, with women reporting that they have learnt more about the test, and increased their confidence to have Pap tests in the future. Arrangements with the Pap Test Registry will enable us to evaluate whether the program has had an impact on screening rates.

The peer educators have had an extremely positive experience of the program also. They have all increased in confidence markedly, and their ability to deliver a health message has improved accordingly. The women's courage in dealing with such 'private' health education material must also be commended.

A very tangible benefit to the women from the project is employment. Even in brighter economic times, women with disabilities are disproportionately represented on low incomes. Carers and mothers of women with disabilities will also receive support and education through the project.

The cost of the peer education phase of the project has been \$82,000. This figure does include worker time that had been specifically funded for this part of the project. This stage of the project has been funded by the Commonwealth Department of Health and Human Services.

## **Involvement of Those Affected -The Key to Success**

Critical to the success of the video and peer support program was the existence of a group of women with the experience of a disability, a knowledge of its impact in using health services, and the skills and confidence to work with providers and other women with disabilities.

The support group's strength was due to the extensive groundwork that had been undertaken by the Women's Health Service since its inception. As part of an affirmative action strategy, which also targets other marginalised groups of women, a position is designated on the committee of management of the Service for women with disabilities.

The Service's first representative, Effie Meehan, was also from a non-English speaking background. She served on the committee for its first four years of operation. Through her participation she acquired knowledge and skills that made her a confident advocate of the needs of women with disabilities in other service and community contexts. She ultimately gained employment in the ethnic disabilities field.

## **Broadening the Influence of Women with Disabilities**

With Effie's help, staff of the Service developed a broad consultative process to establish a support group for women with disabilities. The establishment of the group involved extensive negotiations with institutions and community based services. These agencies were sometimes reluctant to commit the resources needed to help women's involvement (eg by providing an attendant to travel to the group where required). The Service's effective negotiations and the subsequent success of the group set a precedent for similar activities by other organisations.

Subsequent support from these agencies has been integral to the success of the group.

Initially the group provided assertiveness training for women with disabilities. However its role broadened to include health education and discussion, personal development, recreational activities and skills development. It is supported by a steering group involving representatives from the Service, the support group itself and a local disability rights agency. Its aim is to promote the group's skills in self-management and to get resources to ensure its ongoing survival.

As well as meeting the needs of its members, the group has played a critical role in ensuring that the Service's general activities include planning and attention to the special needs of women with disabilities. As the Pap test project shows, the group has also been directly involved in developing programs specifically targeted to women with disabilities.

## **VIETNAMESE ANTENATAL /POSTNATAL PROJECT**



**HA TRAN**

North Richmond Community Health Centre  
Collingwood Community Health Centre  
Fitzroy Community Health Centre  
Mercy Hospital for Women

# Vietnamese Antenatal /Postnatal Project

*Ha Tran*

*North Richmond Community Health Centre  
Collingwood Community Health Centre  
Fitzroy Community Health Centre  
Mercy Hospital for Women*

The Vietnamese Antenatal/Postnatal Project is a joint project between three inner city community health centres and a major maternity hospital. The project is for two years and has three main aims:

- To outreach and liaise with existing services,
- To increase options of care for Vietnamese women in child-birth, and
- To provide appropriate antenatal/postnatal education for these women.

The project has three components - outreach, clinical and psychosocial support, and education.

The outreach program reaches isolated women through call card distribution, media publicity, posters and inter-agency liaison. Clinical and psychosocial support is provided through home and hospital visits, individual consultation and a 24-hour telephone service.

This support is accompanied by education sessions, individual consultation, and audio and written material. The latter includes a set of audio tapes in Vietnamese on antenatal/postnatal education. Cultural awareness training to health professionals and the community is provided through consultation, lectures and written resources.

The estimated cost of the project over two years is \$80,000 funded by the Commonwealth Birthing Services Initiative.

## **Innovation and Excellence**

This project employs and integrates the following concepts in its planning, implementation and evaluation:

- Inter-agency cooperation where one worker is based both at an institution (hospital) and a community based organisation (community health centre). Within this context, liaison is effective and there is a good working relationship between the hospital and the centres.
- A bilingual worker who serves the community of her own background. Apart from the language advantage, there is

better understanding of the cultural and social situation and the women's support networks. For example, with the understanding of Vietnamese and Western practices in childbirth, the Vietnamese midwife can explain some confusion that the new mother may have over the different ways to care for her baby.

- One worker providing health care in various capacities, such as:
  - \* Clinical care
  - \* Psychosocial support
  - \* Liaison
  - \* Education

The contact from one aspect of care supports the management of other aspects. They enhance each other's effectiveness and efficiency. For example, during antenatal check up sessions, the midwife can give mothers information about classes.

- The worker is the client's companion in the management of her care, providing guidance and support and empowering her to make her own journey.
- The Australian health care professional and the non-English speaking background client learn from each other's distinctive ways of living and caring for mother, baby and family.

The project was undertaken because Vietnamese women are the largest child bearing group among non-English speaking women and because existing services for mothers and babies are under utilised by Vietnamese women.

## **Outreach Program**

The outreach program provides information about the service as well as educational material to women who are isolated in the community. Awareness of the project and its services is created among Vietnamese women and health and welfare services by the following activities:

- 10,000 business cards were printed and distributed to hospitals, community health centres, Vietnamese welfare agencies and Vietnamese doctors, pharmacies and shops,
- Information in Vietnamese and English newspapers, and promotion on ethnic language radio stations, and
- Visiting and speaking to health care agencies that have many Vietnamese mothers.

## **Clinical and Psychosocial Support**

To provide appropriate services, a client's profile was created. Information was obtained at the first antenatal visit/interview and postnatal visits. Data was collected from July 1992 and was analysed in May 1993. From the results of this study, the following services were initiated:

- First antenatal visit interviews,
- Hospital visits,
- Home visits/consultation at community health centres, and
- 24-hour telephone consultation.

At the first antenatal visit interview, our objective is to orient mothers to the hospital system and to introduce options in the management of pregnancy and childbirth. This involves interviewing Vietnamese women at their first antenatal visit to the hospital where:

- They are introduced to different options of antenatal and postnatal management (eg shared care, family birthing unit),
- There is orientation to the hospital and the hospital system, and
- Education in pregnancy, breast feeding and pap Tests is given.

Leaflets with information about what to do at each visit to the hospital have been produced in both languages and are distributed to mothers. From July 1992 to May 1993, 194 mothers were interviewed.

The hospital visits meet the mothers' needs during hospitalisation, organise follow-up care after discharge and provide psychological/social support as necessary. Daily visits (except Wednesdays and weekends) are made to all patients in postnatal and antenatal wards at the Mercy Hospital, and to shared care patients at the Royal Women's Hospital. During these visits:

- Delivery and postnatal information is collected,
- Specific needs are assessed and relayed to ward staff,
- Going home talks are given,
- Advice on contraception is given,
- Follow-up management arrangements are made, and
- Psychological support is given and referrals are made when necessary (eg home help).

Follow-up visits to the Royal Children's Hospital and special care nurseries are made to babies with special needs. Between July 1992 and May 1993, 215 mothers were seen in the postnatal wards and 213 mothers were seen in the antenatal wards, with an average of two to three visits per client.

The home visits and consultations provide follow-up to patients with special needs after discharge; provide support and reassurance for the care of the mother and baby; set up liaison with local community services (eg maternal and child health nurses); and provide and help with antenatal shared care programs.

Home visits are provided to mothers with special needs (eg breast feeding problems, premature babies), and to mothers who request visits. Both antenatal and postnatal patients are visited but most home visits are made to postnatal patients. From February 1992 to May 1993, 502 home visits were made to 180 patients in the following categories:

- Antenatal visits - 109 (21.7%)
- Postnatal visits - 153 (30.5%)
- Visits related to care of baby - 109 (21.7%)
- Visits for family planning - 14 (2.8%)
- Counselling, support visit - 65 (13%)
- Emergency calls - 7 (1.4%)
- Hospital visit calls - 45 (9%)

Consultations are provided at all community health centres, mainly for the management of mothers under the antenatal shared care program, family planning and emotional support.

The 24-hour telephone consultation is the most appreciated service. It gives the mothers, especially those who are isolated and have no family support, the security of having someone whom they can always contact. The service uses a mobile telephone and an average of 40 telephone calls are received each month. The concerns included bleeding in pregnancy, signs of labour, various common problems in the newborn and more administrative matters such as appointment making.

## **Education**

The objectives of the education component are to:

- Provide antenatal and postnatal education to Vietnamese women,
- Provide family planning education,
- Encourage/adapt cultural practices among Vietnamese women,
- Explain and introduce Australian (Western) practice in childbirth to Vietnamese women, and
- Provide information about the Vietnamese women in Australia and their cultural practices in childbirth to mainstream health workers and students.

Up to May 1993, six courses of antenatal and postnatal classes have been run. Each course has 12 sessions and is run on Friday evenings from 5.00 pm to 7.00 pm. Class content includes:

- Aspects of antenatal management,

- Care of the newborn,
- Care of the mother in the postnatal period,
- Family planning, and
- A hospital tour.

Doctors, physiotherapists, dentists and maternal and child health nurses are invited to deliver classes in their disciplines. This is organised partly for information delivery and partly to introduce the members of the multi-disciplinary care team to the women.

Antenatal and postnatal classes not only provide information about childbirth and pregnancy, they also:

- Familiarise the women with English language - although the classes are held in Vietnamese, equivalent English terminology, and common phrases used in hospital are also taught,
- Provide explanation and adaptation of Vietnamese customs in the Australian environment - it is a medium for the women to share their own beliefs and practices, and
- Provide the benefit of group support.

On average there are ten women in each class, and the number of husbands varies from zero to five in each class.

Informal education is given during the first antenatal visit, hospital visits, home visits and consultations at community health centres.

Information regarding both the project and about breast feeding has been broadcast on Vietnamese radio programs.

Education is not restricted to the mothers and fathers of the babies, but the mothers, aunts and sisters of the women are also involved. Older women have influence on the woman in childbirth. They have been contacted in groups and individually at Collingwood, Fitzroy and North Richmond Community Health Centres. Their experience and knowledge of childbirth practices is shared and discussed and in return, Australian practices are explained to them.

Education of health care workers and students is provided through:

- Individual consultation,
- In-service lectures to hospitals and organisations,
- Occasional lectures to schools of nursing, and
- Presentations at conferences and seminars.

## **Resource Development**

During the project, information has been collected on Vietnamese childbirth practices and beliefs from such sources as printed material, meetings with older Vietnamese women and shared information in antenatal classes. Translated material has also been collected for distribution to women, however most of this material is difficult to

understand and some is inaccurate, probably due to the difficulty of translation.

The project has produced education tapes with text in Vietnamese and English covering all the topics from the antenatal and postnatal classes. These tapes, produced with the assistance of local maternal and child health nurses, provide information for those women unable to attend classes, and for illiterate women.

Finally, a booklet *Maternity Care for Vietnamese Women in Australia* has been produced to provide information about Vietnamese women, in general and in childbirth, for Australian health care workers.

## Conclusions

The project has proven a success and has confirmed the need for this service among the Vietnamese community. Positive responses and interest in the project came from both the community and health care agencies, not only in the inner city, but throughout Melbourne.

There is an increasing population of Vietnamese child bearing women in Melbourne, and some women who recently migrated to Australia are isolated due to language barriers, culture shock and lack of family support. Evidently a service such as this is essential in areas where there is a high concentration of Vietnamese (eg inner city suburbs, Footscray, Sunshine). It is difficult to predict how long Vietnamese women will continue to need this type of bilingual service, but now the need is high.

Although mothers can be referred to welfare services in hospitals and the community, the intricacy and delicate nature of the various situations have shown that a Vietnamese social worker who can provide psychosocial support while working alongside the midwife, is invaluable.

There are only two practising Vietnamese midwives in Melbourne. A campaign to raise awareness and understanding of the role of the midwife among young Vietnamese women is essential to encourage the choice of midwifery as a career.

This project shows that a bilingual midwifery service is a much needed and effective model of care for Vietnamese women. Perhaps similar models can be adapted and used among other ethnic groups in Australia.

## WOMEN'S HEALTH INFORMATION IN 'PLAIN ENGLISH'



SHANNON KERRIGAN AND JULIE OBERIN

Loddon Campaspe Women's Health Service

# **Women's Health Information In 'Plain English'**

*Shannon Kerrigan and Julie Oberin  
Loddon Campaspe Women's Health Service*

Based in Bendigo, the Loddon Campaspe Women's Health Service was set up in 1989 and covers a vast area of central Victoria. Staff are committed to valuing each woman who approaches the Service, whether by mail, telephone or in person. Women are encouraged to be involved in the Service through its working groups, subcommittees and networks. This involvement of women, along with use of the Service's programs, means that workers have contact with an average of 40 women each day.

In early 1992 the Office of the Status of Women funded the Service for a project to produce women's health information in 'plain English'. The Service undertook the project in response to daily requests from women for more information on a range of health issues. Women were looking for information that was accessible and readily and cheaply available. An earlier comparable project that produced three booklets on Endometriosis in plain English was popular, had received much positive feedback and had sold 500 copies.

The key aims of the project were:

- To involve women from the community in producing the information,
- To produce five women's health information resources in plain English, and
- To draw up guidelines on how to produce women's health information in 'plain English' using action research.

These guidelines would document valuable practical skills, experience, methodology, evaluation techniques and a theoretical framework for the project. This would help other services or workers to undertake similar work in the future.

The Service aimed to produce the information using an action research methodology involving women from Koori or non-English speaking backgrounds and from rural, isolated and low socioeconomic groups. The project was to be completed in one year. Shannon Kerrigan and Julie Oberin were employed in a 'job share' position to design, facilitate and write up the project.

By mid 1993, the Service had successfully used an action research approach to achieve the aims of the project. Seven 'plain English' resources and a guide for other workers *Guidelines for Producing Women's*

*Health Information in Plain English Using Action Research* had been produced.

The project also successfully raised awareness of the need for more health materials in 'plain English'. This was achieved through magazine, journal and newspaper articles and radio interviews. A successful forum on women's health information in 'plain English' was also held.

The qualitative outcomes produced by the action research approach have been invaluable in the success of the project. Women reported being empowered through:

- Greater access to knowledge about themselves and a range of health issues,
- A greater sense of ability to make choices about their health needs, and
- A real feeling of ownership of the project.

## **Involving the Women**

Our aim was to involve women in producing the information. We approached organisations that were representative of women from rural, NESB, Koori and low socioeconomic backgrounds. These included several adult literacy groups, neighbourhood houses, the Tarrengower women's prison, a family welfare agency and an Aboriginal organisation.

Not all of our contacts led to the establishment of a group and we had difficulty in reaching many of the women we would have liked to have worked with. This was in part due to the necessity of working through other workers and often not meeting the women directly. In contrast, the women we talked to directly all took up the offer of becoming involved.

There were other reasons that may explain our failure in engaging some groups of women. These included adult literacy tutors who were 'protective' of their students and lack of interest from families already having difficulty coping and from Aboriginal women in Bendigo.

Women with so called low literacy skills were also unlikely to identify themselves because of the stigma and embarrassment attached. It is unlikely that they would express interest in being involved in a project aimed at producing written resources. While we began the project with an emphasis on literacy skills, this was later reassessed.

Despite these problems, we succeeded in engaging groups of women from the Long Gully Community House, Maryborough Living and Learning Centre, Echuca/Crossenvale Neighbourhood group and the Tarrengower Prison. Through these groups we successfully involved women from rural areas, low socio-economic backgrounds and one woman from a non-English speaking background.

Although not working with any women who identified themselves as having low literacy skills, we felt some women fitted into this category. In

practice, the emphasis on literacy was secondary to issues of isolation, educational disadvantage, low income levels and the limited choice of services in rural communities. The label 'low literacy' serves to put the blame for the information needs of some women on to the women's limited skills. This denies the responsibility society has in providing accessible information to all groups. It can also cover up the many disadvantages these women experience.

## **Producing the Resources**

The project produced seven health information resources in 'plain English':

*Women and Doctors: A Guide to getting the most from a visit to the doctor* (A4 pamphlet)

*Women and Doctors* (A3 poster)

*Don't make me laugh I'll wet myself: Urinary Incontinence in Women* (A4 pamphlet)

*Abortion - 10 Common Questions Answered* (A4 pamphlet)

*Abortion* (A3 poster)

*Abortion* (Wallet card)

*Menopause* (Book)

In producing the resources, we wanted to make sure that the literacy levels were appropriate to the women's skills. We circulated questionnaires on the draft productions to adult literacy groups, community houses, the Women's Health Resource Collective and the Loddon Campaspe TAFE College. We specifically targeted the questionnaire to adult literacy groups and community houses in the region. Ninety questionnaires were returned.

The literacy tutors and house coordinators talked to women about their responses (in a safe and confidential environment), and as a result we received a lot of useful information. Women using community houses are generally representative of women from our target groups. As such, feedback received from these groups was valuable in ensuring the text was appropriate and accessible.

In a project of this size we could not meet the needs of women with intellectual disabilities, specific learning difficulties or who are so called 'illiterate'. For many of these women written resources may not be the best format in which to present information. We interpreted 'low literacy' in a broad sense and focused on women who had limited knowledge of medical language and how to use the medical system.

## Identifying the Issues

As the project aimed to produce information on issues relevant to rural women, we took each group of women through a process of identifying their own health issues. Some groups did this very quickly, while others took more time to choose an issue that was relevant to the whole group. Many women required time to talk about experiences in the medical system related to their own health issues before they could focus on the resource production. In the end all the groups felt comfortable and excited about their choices.

The style, focus and content for the productions evolved as the groups talked about their own experiences. In collaboration with the project workers, an issue around which the women wanted to produce information was chosen early on and the details developed as the work evolved. A range of possible formats was presented to the women for their consideration. Some women found examples of resources that they liked and used these formats to model their own productions.

## Womens Ownership of the Productions

Each meeting with the women had an evaluation component and we held a formal evaluation session at the end of the work with each group. This ongoing evaluation helped ensure our work was appropriate to the needs of the women.

We put a lot of thought into the values and philosophies that were the basis of our work practice. We reflected regularly on our work and encouraged the women in the groups to give us feedback on this. The responses of the women in the final evaluation supported the effectiveness of our approach in achieving the stated aims.

Almost without exception, the women felt:

- They were well resourced to undertake the tasks,
- Comfortable in the groups,
- Their opinions were valued,
- Able to speak openly and honestly in the group, and
- Their involvement had made a positive contribution to their lives.

Suggestions for improving the meetings included longer session times, reducing the discussion time and keeping more to the topic. The following is a sample of the responses we received:

*"We feel comfortable in the group because we do things related to us, women's things."*

*"I felt my opinions were valued and accepted for example the advertising style I suggested. This made me feel creative. I didn't really see me as a creative person till this."*

*"I have never been able to say anything about my life, but in this group I can."*

*"I now feel more comfortable to chat with my doctor. I even talk about his kids. I never did this before."*

*"Two hour sessions would have been better."*

*"I feel more comfortable with having incontinence and know more about myself"*

*"I didn't think we would be able to do it but we did."*

Halfway through the project, clearly the women really did feel a sense of ownership of the resources. Many women started to call them "our pamphlet" etc. and actively began to contribute to and control the direction of the resources. The obvious sense of pride they exhibited at the public forum highlighted the ownership they felt. This component of the project was clearly empowering for these women.

## Increasing Public Debate on Literacy Issues

One objective of the project was to increase public debate on literacy issues. This involved publicising the project and its outcomes and literacy issues in appropriate media and organising a public forum on women's health information in plain English.

We also raised the issue of women's health information in 'plain English' through publication of articles about the project:

- Four articles in the *Loddon-Mallee Adult Literacy and Basic Education Newsletter*,
- One article in the *Healthsharing Reader*,
- Regular updates in the *Loddon Campaspe Women's Health Service Newsletter*,
- Three interviews on radio 3-CCC and Bendigo FM Education Broadcasters,
- An article in the Education Section of the *Bendigo Advertiser*, and
- An article in the *Action Research Issues Journal*.

We also held a public forum, *The Women's Health Information in 'plain English' Forum*, attended by forty people.

For a project with a relatively small size and scope, we made a significant contribution to the public debate around equitable access to information. The comments from the public forum showed a lot of interest among workers in hospitals, community health centres and welfare organisations. We also received many requests for written information about the project itself and we have spoken to a number of health workers seeking help with initiating and producing similar resources.

Several workers have consulted us on using action research. This method has impressed these workers as an empowerment model. We delivered a lecture to the Welfare Studies students at Loddon Campaspe College of TAFE on action research using this project as a model. Comments from both the students and the lecturer were extremely positive.

## Distributing the Resources

It was important to distribute the resources produced so that they would reach the women who needed the information. Again, an important part of the project was asking women how best to do this. We consulted all the women who worked on the resources and attended the public forum. They were asked about where they received their health information and where they thought they might find it most convenient to receive it.

Most women received much of their information from their general practitioners, but they also got it from community health centres, women's health services and support groups and services. However, contacting these groups and services usually occurred after the women had identified a problem and were seeking out more information. Many women said they would like to receive more appropriate information from their doctors and thought doctors could provide much more of this.

Other places women thought they would like to get health information included:

- |                    |                                   |
|--------------------|-----------------------------------|
| * Hairdressers     | * Chemists                        |
| * Hospitals        | •• Letterboxing                   |
| * Community houses | * Within the prisons              |
| * Bus shelters     | * Posters on SEC and street poles |

Although there were some unusual ideas, we believed all of them were worth pursuing to assess their feasibility. The suggestion of providing information at hairdressers elicited a most enthusiastic response and we felt it had real potential to be developed further.

We used the current distribution networks in the women's health field in Victoria and are negotiating for the resources to be listed in the resource catalogue of the Women's Health Resource Collective. Hundreds of copies have been sold this way and 2,000 copies of the pamphlet *Women and Doctors* have been provided to Breast Screen Victoria.

A more comprehensive strategy of encouraging doctors and hospitals to provide more appropriate information would make a great contribution to the health of the users of their services. This was supported by the enthusiastic response of the health and welfare professionals who attended the public forum. This should be tackled by future work in this area, particularly as these are the primary sources of health information for most women.

## Evaluation of the Project

A key objective was to evaluate the process and outcomes of the project and to document the theoretical framework and methodology of the project as a whole.

The rationale for the project has been documented in *Guidelines for Producing Women's Health Information In 'plain English'*. We developed an appropriate evaluation strategy for this project that fitted the comprehensive project framework we designed. This included philosophies, aims, objectives, strategies and evaluation questions.

The project was evaluated through an evaluation component at each meeting, final group evaluations, evaluation of the project as a whole and a widely circulated questionnaire about the resources produced. This included all the women in the groups and those attending the public forum. In all forums the evaluation covered both the processes we used and the resources produced.

Evaluating the work in the groups resulted in many constructive criticisms, useful suggestions and valuable insights. We incorporated many of these into our ongoing involvement with these women. Responses to the questionnaires about the resources confirmed their appropriateness and contributed to refining each publication and achieving a high standard.

Evaluating the quality of the experience for the women who worked on the resource productions was not so easy. However, responses received in the group evaluations were overwhelmingly positive. We felt the action-based, practical nature of the work the women undertook as extremely successful in engaging interest in the project and maintaining involvement. A lot of women's health issues were discussed during the work and supplementary information was provided on many of these.

Compared to the experience of other workers who run programs with women from community houses, this project was very successful in maintaining enthusiastic support. We believe this action research approach may have potential for broader application in the health area.

The position being job-shared was a great advantage to us personally and to the project's outcomes. It allowed us the opportunity to discuss our work with someone who was focused on the same issues. We could challenge each other, identify and resolve dilemmas, find creative solutions to problems and help in the consciousness raising process. Working together enabled us to better understand the links between theory and practice. Our complementary skills enhanced the work of the project, especially as much of what we have done has not been attempted in this way before.

## Conclusion

The responses from those involved in this project have been overwhelmingly positive in relation to both process and outcomes. Women reported their involvement in the groups as a positive and empowering experience. Comments on the resources produced show they will make a significant contribution to the range of 'plain English' materials available.

Judging by responses, the *Guidelines for Producing Women's Health Information in Plain English* will also be well received. The guidelines will contribute in a practical way to the production of more 'plain English' health materials.

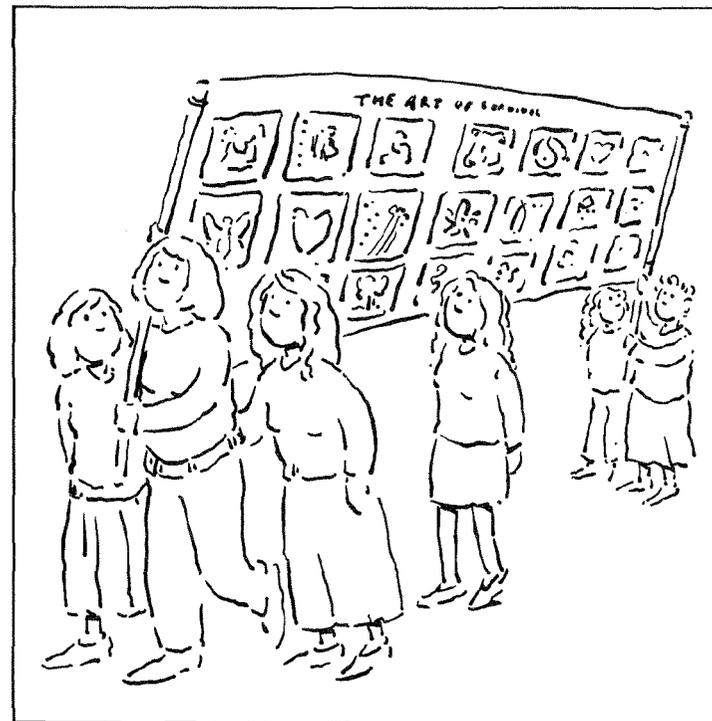
If women are to make decisions about their health needs, then they must have the information required in an accessible format. Many women were not offered choices when they turned to the medical system for assistance. Women said risks and side effects were not mentioned and the possibilities of other options or opinions were not presented. The information given was often difficult to understand and did not adequately answer the concerns they had. This highlights the need for women to be more involved in reshaping the 'knowledge' about women's health issues generally, and to be more involved in challenging many of the views of the male dominated medical profession.

This raises the need to effect change in the broader health system. Although not the experience of all women, the attitudes of many doctors are a hindrance to women getting appropriate and adequate health information and choice in decision making. This shows a discrepancy between the doctors' view of their role and the way women want their health needs provided for. Changing this involves raising the consciousness of some medical professionals in relation to gender issues, access to information and patients' rights. They need to be encouraged to inform women of the range of services and resources available in the community that could help women with their health information needs.

By using an action research approach in this project, change was facilitated in the women's experiences that may then affect the medical profession; ie. change from the bottom up. However, we recognise the limited scope of this project in raising the consciousness of general practitioners and many others working within the broader health field. It is important that this be addressed by future work in this area.

The outcomes of this project show that action research is a most appropriate methodology to achieve the desired qualitative outcomes. However, for the methodology to be effective it must be consistent with an appropriate theoretical framework in order to achieve socially just outcomes. Implicit within all methodologies are theoretical assumptions and values. It is important that this be recognised.

## THE SURVIVORS GROUP



**DEBORAH BODSWORTH, ANDREA BOWLES AND JANE COWARD**

Narre Warren/Berwick Community Health Centre

# The Survivors Group

*Deborah Bodsworth, Andrea Bowles and Jane Coward  
Narre Warren/Berwick Community Health Centre*

We initiated the Survivors Group in 1992. It had become obvious that there was an increase in the rate of disclosures of child sexual abuse in adults attending our Centre. We were receiving referrals from people attending groups at the Centre such as Stress Management, Personal Development and Parenting. This was in addition to people presenting for personal counselling.

The Narre Warren/Berwick Community Health Centre is in a rapidly expanding area in the south eastern suburbs of Melbourne. It is an area where there is a high proportion of young families with young children.

## **Innovation and Excellence**

The Survivors Group program was a sixteen week program combining the two highly skilled areas of group therapy and child sexual abuse issues. The program provided a safe environment to address the issues paramount to survivors of child sexual abuse.

The program was in an area of mental health inadequately addressed and frequently neglected. The length of the program - sixteen weeks - allowed for internalisation of skills development (eg self esteem, anger management, establishing trust). Two programs have been completed with 100% retention of participants on both occasions. Many participants have subsequently successfully gained employment or returned to study.

The size of the group (eight to ten participants) allowed for the development of trust and group identity. This was expressed in the development of the Banner Project which was symbolic of collective strength and pride. This was a new experience for group members.

The group setting is a unique environment in which to tackle the fundamental issues of child sexual abuse; ie. alienation and trust. Skills developed within the group to address these specific issues cannot be acquired as rapidly within individual counselling.

It was a cost effective program as it provided an intensive, focused, therapeutic intervention over sixteen weeks. This contrasts with traditional long term therapy and periods of hospitalisation. Frequently in the past these clients have been misdiagnosed or ineffectively managed (eg labelled as psychiatrically ill or drug dependant), and the presenting condition treated without addressing the underlying cause.

Pre-service training does not provide adequate education in the issues of child sexual abuse.

The program aimed to:

- Provide a structured therapeutic healing group for adult survivors of child sexual abuse,
- Present information and allow for adequate exploration of previous dysfunctional strategies and the practising of more positive life skills for the future, and
- Undo the damage caused by being a powerless child within a dysfunctional family/caregiver system where reality testing is poor.

## Strategies

We interviewed each person referred to the group to assess their needs and match them to the group process. The client's readiness to address survivor's issues and the ability to be a group member was assessed. Some people were already clients of the Centre and in these cases no formal interview was involved.

The program involved a sixteen week group with a three week break after week eight. We aimed to have about eight members in each group and participants were encouraged to give group attendance a high priority.

Each group was co-led by two qualified staff members. These staff had completed appropriate, specialised training by attending a course run by the Centre for Social Health (formerly Social Biology Resources Centre). In addition, staff received regular supervision for the duration of the program from Malenka Polkowski who had provided the initial training at the Centre for Social Health.

Before the start of the groups, participants received a personal invitation to confirm a place in the group. This also allowed us to give them a gentle reminder of the need for regular attendance. A requirement of participants was for individual counselling as a complementary process to address individual issues.

The group involved a small amount of formal teaching to present normative information (eg overheads, handouts, homework and suggested reading from Community Health Centre library). Experiential teaching occurred through small and large group discussions, role play, brain-storming and other techniques.

Group maintenance was achieved by facilitation skills - leaders encouraged participants at all times to contribute to all discussions and provide support for each other. Group leaders were responsible for addressing and following through the very painful issues that arose within such a highly specialised group (eg dealing with dissociation, withdrawal, extreme distress, inappropriate expression of anger).

Staff used specific and relevant counselling skills to provide support within the group and also in following up individual members who experienced crises.

## Program Outline

<i>Week one:</i>	<i>Remembering, believing it happened.</i>
<i>Week two:</i>	<i>Understanding that it wasn't your fault.</i>
<i>Week three:</i>	<i>Where did I come from? How did it change my life? How did I survive?</i>
<i>Week four:</i>	<i>Trust, anger.</i>
<i>Week five:</i>	<i>Breaking the silence.</i>
<i>Week six:</i>	<i>Confrontation.</i>
<i>Week seven:</i>	<i>Dealing with your family now.</i>
<i>Week eight:</i>	<i>Decision to heal.</i>
<i>Three week break.</i>	
<i>Week nine:</i>	<i>Grieving and mourning.</i>
<i>Week ten:</i>	<i>Creating safety.</i>
<i>Week eleven:</i>	<i>Dealing with crisis.</i>
<i>Week twelve:</i>	<i>Nurturing yourself.</i>
<i>Week thirteen:</i>	<i>Learning to trust yourself.</i>
<i>Week fourteen:</i>	<i>Managing your sexuality.</i>
<i>Week fifteen:</i>	<i>Resolution and moving on.</i>
<i>Week sixteen:</i>	<i>Celebration.</i>

When all the strategies were combined the proof of their effectiveness was provided by the high level of group support and trust established and also by the 100% attendance of participants for the duration of both groups.

Group members each developed a symbol of strength that later became the Banner Project. Each person's symbol forms part of a permanent patchwork banner, to be added on to, named 'The Art of Survival'.

The estimated cost of the program - \$2,500 - included staff time, training and supervision during the program. It does not include time for the original planning and recruitment or the individual counselling.

## Outcomes

The program's outcomes were very positive. Along with the 100% retention of participants over both the courses run, the comments from them following the programs were very positive:

- Improved social skills,
- Less isolation,
- More confidence,
- Able to be assertive,
- Increased self esteem,
- Positive coping strategies,
- Acquired feeling of freedom and self-acceptance,
- Improved parenting ability,
- Improved quality of significant relationships, and
- Ability to trust others.

Some participants confronted abusers and others who had failed to protect them as children. Some made police statements regarding criminal aspects of abuse/assault.

Two participants have completed the Facilitators Training Course run by the Domestic Violence and Incest Resource Centre. This provided them with the skills to establish a local self help / support group. Such a group has now been set up and meets weekly at the Centre.

Some participants took the 'Art of Survival' banner on the 1993 'Reclaim the Night' march through Melbourne.

## **Acknowledgments**

We would like to acknowledge the following in the development of our program:

- Centre for Social Health (formerly Social Biology Resources Centre),
- Domestic Violence and Incest Resource Centre,
- Malenka Polkowski- contract educator at the Centre for Social Health for sharing her expertise,
- Gillian Johnson for her initial encouragement and sharing her knowledge,
- the Community Health Centre Committee of Management for their commitment to supporting our program,
- Glenys Porter - who as our Manager encouraged us at every stage, and
- *The Courage to Heal Workbook* by Laura Davis.

## **INNER SOUTH HOUSING SUPPORT PROGRAM**



**KEVIN SULLIVAN**

St. Kilda Community Health Centre

# Inner South Housing Support Program

*Kevin Sullivan*

*St Kilda Community Health Centre*

The Inner South Housing Support Program is a joint initiative of the St Kilda Community Health Centre, the Ministry of Housing, Health and Community Services (Psychiatric Programs) and the St Kilda Rooming House Issues Group. A staff of 23 workers attached to the Centre's Mental Health Team provide extended hours support to people living in a group of flats in St Kilda.

The Centre has long had a strong commitment to local residents with psychiatric disabilities. This program was undertaken because of the high incidence of homelessness and acute hospital admissions in the target group.

The program involves:

- Extended hours support tailored to the individual needs of severely psychiatrically disabled people,
- In-house support available directly during week days from specifically allocated staff,
- After-hours support provided by an on-call system,
- Staff negotiate with tenants to decide the level of support necessary over time, and
- Housing and support for each resident, available for an indefinite period if so required.

Nine flats were used in the program and were spot purchased by the Ministry of Housing and Construction for \$800,000. The St Kilda Rooming House Issues Group provides stock and rental management services to the residents of the flats. The Group decides what rent is paid *by* residents.

## **The Model**

The program provides long-term housing, support options and community integration for people with severe disabilities associated with long-term mental illness who have been homeless. It also aims to enable the psychiatrically disabled people in the program to optimise their quality of life in the setting of their choice.

Consistent with the Mental Health Team's broader target group, the program provides support to people with a severe disability resulting from a long term mental illness. They are people who are frequent users of hospital or community based psychiatric services. They are homeless or at

risk of becoming homeless at the time of referral and they have a base in the Inner South (the suburbs of Port and South Melbourne, Prahran and St Kilda).

The formal criteria for being involved in the program are that a person:

- Is between 18 and 64 years of age,
- Has a severe disability associated with a long-term mental illness,
- Is a frequent user of psychiatric services,
- Requires access to frequent, active daytime support but is able to manage with on call support overnight, and
- Is homeless or at risk of becoming homeless.

The program is provided with support and direction from the community by a Steering Committee comprising representatives of a range of community agencies. Residents are selected by the program's Steering Committee based on the criteria set out above.

At the time of referral, potential residents may be isolated and difficult to engage, therefore support workers are assertive in this process. They go to prospective residents with the aim of engaging and assisting them in the process of referral and integration.

## **Strategies**

During daytime, the Housing Support Workers provide disability supports where necessary for each resident. Support is designed to enable residents to make the best use of available community resources and to avoid duplicating other available services. Skills development occurs in-house based on individual or group need (eg a cooking lesson in a flat may involve one or two residents, cooking in the environment in which they will apply the skills learnt).

Support also aims to enable people to further their recreational, social and vocational interests in their community. Through their links with the broader community, the workers help residents access relevant activities.

Workers are available after hours and on weekends on an on-call basis. Each flat has a telephone and residents can contact staff via a mobile phone. The workers encourage residents to develop their own problem-solving skills and to use appropriate community services after hours. However, they are available to respond to emergencies or provide direct support if required.

Residents in the flats are offered support at a level and for a period which suits their needs. Given the enduring nature of their disabilities, they are likely to need help should they decide to move from the flats in the future. If this does occur the Housing Support Team will continue to offer case management and/or support to the individual concerned. At this time it may also be that the broader Mental Health Team provides support with the Housing Support Team.

Residents are the tenants of their flats. Both they and the workers recognise the rights and responsibilities associated with that, given that the housing is covered by the Residential Tenancy Act.

St Kilda Community Health Centre employs and manages support workers for the program. There is a formal agreement specifying the roles of the Centre and the St Kilda Rooming House Issues Group.

A range of treatment agencies may be involved subject to residents' individual needs. The Inner South Community Mental Health Service is a significant agency for treatment. General practitioners, private psychiatrists and other health service providers are also available to residents.

The support workers have a broader relationship with the local community. Through this they provide the community with information about the project, develop access to the community for those living in the flats and consult with community agencies regarding their needs in dealing with individuals living in the flats.

## **Outcomes**

While the project is not yet two years old, there are already important outcomes:

- The nine flats provide increased housing options for members of the target group,
- A non-medical model of support has been instituted,
- A strong inter-agency network has been established,
- All ten people previously homeless have remained in the housing provided for over twelve months,
- Hospital readmission rates are virtually nil, and
- Residents' quality of life and living skills are improving.

There are now 40 people on the program's waiting list, testifying to the program's initial success and to the need for this level of support in the community.

## **MASSAGE AND OLDER WOMEN'S HEALTH**



MONICA BYRNES AND MICHELLE TURNER

East Preston Community Health Centre

# Massage and Older Women's Health

*Monica Byrnes and Michelle Turner  
East Preston Community Health Centre*

Twenty women aged 48 to 80 participated in a six-month program to address common issues affecting their well-being. These were:

- Decreasing mobility,
- Increasing social isolation,
- Decreasing incomes, and
- Decreasing access to services.

The women decided to do regular exercise and learn massage as a group. At the conclusion of the program, the physical and social health of the women showed marked improvement. They continued to meet weekly and twelve months later were teaching new group members massage and exercise skills.

## **Innovation and Excellence**

The women recognised their common issues and decided how to address them. They were involved in choosing the masseur, writing the submission for funding to the Victorian Health Promotion Foundation and deciding what evaluation they were willing to participate in. The group was mixed in age, cultural background and living circumstances.

At the end of the six months, meeting weekly for three hours, the women had developed independent massage and exercise skills. They had measurably improved health and mobility, confidence to educate their peers in massage and exercise, and had formed lasting friendships and social support among themselves.

Twelve months later, the group continued to meet weekly, welcoming new members and producing a monthly newsletter. They were going out to other groups to tell about their program and to demonstrate their skills.

The Massage and Older Women's Health Project's aims were:

- To increase older women's access to, and make available the services and supports not readily affordable by those on lower incomes,
- To increase the women's confidence and independence in controlling their health through active participation in exercise and massage and the sharing of knowledge and skills gained through the program, and

- To increase older women's awareness and interest in maintaining and improving their health and well-being.

The project's target group was older women living in the City of Preston, the majority of whom are over 50 years of age.

East Preston Community Health Centre held a women's health day in 1989. At this day a group of women formed a women's health interest group. These women worked to inform themselves on specific health related topics. They did this through bringing in outside speakers and sharing their own experiences around the topic.

Encouraged by the success of these sessions, the women decided to develop a long term project to address some of their shared health issues. Thus, the massage and exercise project was born.

## **Strategies**

The women met once a week at the community health centre for three hours. Gentle exercise, exchanging ideas, socialisation and learning relaxation techniques were the focus of the first hour. The women were encouraged to practise the exercises and relaxation techniques at home.

The second two hours were learning and practising massage. We had devised a massage program after consultation with the women that focussed on their requirements. Evaluated as it was implemented, we made changes to the program as requested and required.

Course content included theory on the following topics:

- *equipment required,*
- *positioning the client,*
- *basic anatomy,*
- *physical and psychological effects of massage,*
- *effects of massage on the elderly,*
- *contra indications of massage, and*
- *relaxation techniques.*

Practice content of the course included:

- *sitting back and shoulder massage,*
- *selfabdominal massage,*
- *whole body massage,*
- *face, chest, back, arm, leg and foot massages,*
- *massage for common complaints, and*
- *relaxation.*

At the end of the massage program, women received a 'Community Massage Certificate'. The entire program relied on the full participation and control by the women involved. As staff we facilitated and provided resources, practical information and skills for the women.

A project management committee was formed that included ourselves - community health nurse and masseur - and five women from the group. We met regularly to review the progress of the program and to devise questionnaires to evaluate participant satisfaction and the appropriateness of presented materials. Changes were made in response to the group's needs.

## **Adult learning**

Our original expectations of how women would progress did not consider their ages, background or culture. Nor did it allow for the women lacking confidence or mistrusting both themselves and us. The first few weeks dealt heavily with allaying the women's anxieties - from disrobing to whether they were doing things "right or wrong". Some women found the theory work hard going. A lot of encouragement was necessary.

We reassured the women that "right and wrong" were not issues. That as long as they looked after themselves, by recognising their fears and respecting their own limitations, they would eventually feel safe enough to exceed those limitations.

We discussed at length how they thought they learnt best. Because their education was predominantly a 'step by step' system, unlike the more self-directed learning of today, they needed to have us teach them slowly and clearly. Consequently, we no longer concerned ourselves with the fact that we were not going to cover all the material planned.

Most of these women had been brought up to give and not to receive. Whether that is attributable to generation or because they are women, we were not sure. But one of the greatest leaps the women learnt was how to receive. Once they did this and once they felt safe, their learning capacity accelerated and the whole atmosphere of the group changed.

This change happened gradually over the first ten weeks. Changes that occurred extended further than just their learning capacity - it tugged on their self-esteem. More women in the group started to wear make-up. Their faces wore smiles more often and they commented a lot about how they felt more confident and physically well.

These women were learning a new skill. They started to take more control in the classes by encouraging one another, demonstrating techniques to each other, asking more questions and not being afraid to express their need for space (eg not participating but just observing). If we were reviewing a massage they felt confident in, they would do a different massage, for practice.

Occasionally we would test their memories and not hand out notes when demonstrating a massage. So when they practised, they would have to depend on themselves and others to remember what had been shown. They did amazingly well, needing minimal prompting.

We did cover all the proposed program and more. We even discussed how the women thought they would operate the group after the course finished.

This course was the first of its kind for older women - based on the Northcote Hydrotherapy and Massage Group for Older Women - where a masseuse supervises the women on an ongoing basis. The difference with this group was that the women became skilled enough to continue without supervision - to the extent of supporting and sharing their knowledge with any new members of the group.

The women have learnt all the practical material as documented. Their capacity to retain the information and direct their learning towards their massage techniques has been tremendous. The standard of massage was sufficient for them to share their knowledge with friends, family and the community on a non-professional basis. However, had any of the women wished to do a follow-up course at a recognised School of Massage or Tactile Therapies, we would have recommended them highly.

## **Outcomes**

Twenty women participated in the program that ran for 27 weeks. Their average age was 65 and the mean attendance was 22.25 weeks. Pre and post program flexibility and medication regimes were measured. There was a mean improvement of 78.75% for all stretches that included calf, hamstring, groin, reaching up and reaching behind back and neck.

Each participant kept a personal journal throughout the program recording any physical or psychological effects they felt due to participating in the program. Fourteen women provided summaries of their journals.

Two women remained unchanged on blood pressure and medication regime. Thirteen women had lower blood pressures, but medications remained the same. Two women (out of an original four) had ceased taking sleeping tablets. Five women (out of an original eight) decreased their level of pain-relieving medication for arthritis and headaches.

One woman ceased all medication for hypertension. Her post blood pressure reading was lower than when she was on medication.

The project was funded through a grant of \$5,000 from the Victorian Health Promotion Foundation. The original 1989 women's health day was also funded by the Foundation.

Following the initial program, new members joined the group and original members have been teaching them massage and exercise. More women wanted to join the group, however, because of space and equipment limitations, i.e. available massage tables, the women in the group decided to maintain numbers at around 20. This was especially the feeling of the original members who felt overwhelmed with trying to

consolidate what they had learnt while undertaking to teach new members.

The women produce a monthly newsletter. They contribute 50 cents each week into their own account to cover the costs of their oils, guest speakers and travel costs for members to attend workshops on areas of interest to the group.

## **Discussion**

The direction of the group following the initial program and funding was discussed at length with the women involved and the Centre's committee of management. Irrespective of what direction this group now takes, the evaluation showed that the women were committed to maintaining the focus on gentle exercise, massage, relaxation, social support and learning and practicing preventive health measures.

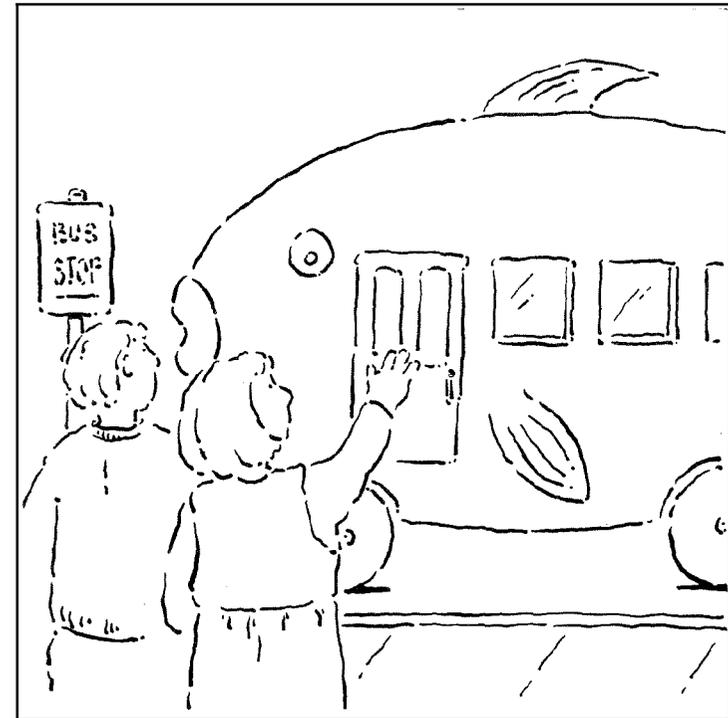
During the original program, participants were asked about the appropriateness and content of what was being taught. Subsequently they made decisions about what they want and what they are willing to do - it became a self-help group. They could run independently from any involvement by Centre staff other than having a contact for Centre organisational details.

Interaction with other women's groups has been planned by the group so that they can 'spread the word' about the benefits they have gained through regular massage and gentle exercise.

The process, impact and outcome evaluation have shown that this project has met all of the expected outcomes. It has made it possible for a group of older women to:

- Develop independent massage and exercise skills,
- Experience measurable improved health and mobility,
- Make friends and establish necessary social supports, and
- Feel confident to educate their peers in massage and exercise techniques.

## HOMELESS YOUNG PERSONS HEALTH ACCESS PROGRAM



CATHERINE HANNON, VICTORIA McDONOUGH AND LINDA PHILIP

Inner South Community Health Service, St. Kilda

# Homeless Young Persons Health Access Program – the Health Bus is a Fish

*Catherine Hannon, Victoria McDonough and Linda Philip  
Inner South Community Health Service, St Kilda Base*

The health bus started life as a dull white commuter van. Once it had been adopted by the Homeless Young Persons Health Access Program (HYPHAP) it was converted and transformed by a community artist and students from Ardoch/Windsor College into an exotically coloured tropical fish.

The health bus provides an outreach service to the streets of St Kilda at various times during the day and night. It seeks to make contact with homeless and at risk young people in their own environment. The bus offers them a safe, supportive and appropriate service. For young homeless people, it is often their first contact with the health care system.

The model of service delivery utilised is innovative and unique. A collaborative approach to staffing the health bus with workers from health, welfare and youth agencies has been effective in creating links with agencies. This allows for good co-ordination, networking and structural links.

## Background

In 1989, the Burdekin Royal Commission was held into youth homelessness in Australia. The Commission found that young people who were homeless (or at risk of becoming homeless) did not access health services until problems were critical. It found that this could be for a number of reasons such as:

- Feeling disempowered or alienated by mainstream health services,
- Not owning a Medicare card,
- Having no money or
- Simply not knowing where to go.

The health bus aims to access young people on the street and attend to their health needs through primary treatment and referral to appropriate health services. Originally four workers were employed for the Program team. This included mental health funding which was time-limited.

There are many different definitions of homeless young people. One we adopted is:

*"... Homeless young people are those in any form of temporary accommodation - staying with friends, relatives or teachers, in refuges, emergency accommodation, in other SAAP (Supported Accommodation Assistance Program) services such as youth housing services, etc - as well as boarding houses, hostels and of course those without any shelter - on the streets, in squats, caravans, etc."*

David MacKenzie, 1993.

Young people are defined as those under 25 years of age.

## Aims of the Program

The aim of the Program is to improve the health of homeless young people in St Kilda. Specifically, the objectives are:

- To ensure that young people in St Kilda with health problems have access to health services,
- To provide a health assessment, health education and referral service to young people through the use of the health bus,
- To provide a health education service to the local secondary schools, and
- To actively engage a broad range of local service providers in the planning and implementation of the program.

## About the Bus

The work done on the bus is varied and often requires of its staff a variety of skills and roles. It includes health assessment, treatment and referral, health promotion/health education, advocacy, information and resourcing on local services such as drug and alcohol services, emergency accommodation, empathic general practitioners and the Community Health Centre services. Other work involves crisis intervention, counselling and support.

The health bus is driven around the streets of St Kilda and is parked at different locations where young people are. Where appropriate, a trestle table with health education material and a promotional board is displayed advertising staff skills and issues of interest.

A twelve-seater hi-ace bus was fitted with cupboards to hold stock, a bench, a tap, sink, lights and a mobile phone. The bus was then painted to look like a bright fish by a community artist and young people from the then Ardoch Windsor School for young homeless students.

A communication book is kept in the bus and an account is written at the end of each outreach session. This allows documentation of daily contacts and any information needing to be passed on to other health bus workers. It is also potentially useful as a historical record. A statistical sheet is also filled in at the end of each session.

The stock carried on the bus includes clinical equipment ranging from resuscitation, respiratory and wound care to skin infestation and gastrointestinal treatments, condoms and lube, tampons and pads.

The bus currently provides outreach services three times per week. Two of these sessions are from 2pm to 6pm in the evening and one from 10pm to 2am on Friday nights. The bus also visits two local secondary schools each week. One on Thursday and one on Friday providing health education, resourcing, counselling and support to individuals and groups.

## Staff

A social worker and a community health nurse are employed on a part-time basis on the Program. The health bus uses a collaborative model of providing health care. Generally two workers are on the bus each shift. This includes a Program worker who takes responsibility during the shift and a youth worker from a community agency or a health worker from the St Kilda Community Health Centre. The Centre has sought a General Practice Grant to have a general practitioner working on the bus in the near future.

A range of youth and welfare agencies contribute their staff time and expertise to the health bus, as well as workers from the Centre. This collaborative model allows for a number of people from different disciplines, from the health and youth welfare professions to work together. This not only creates an excellent community development approach, but also adds to the holistic nature and expertise of the health bus service.

This model works well for everyone, as it enables workers from community agencies the opportunity to carry out outreach street work and allows direct access to many potential clients. It provides a very effective use of networking and community resources, providing a very cost effective service.

## Coordination

A health bus workers' meeting is held once a month for workers to exchange knowledge, skills and information. An advisory group meeting is held bimonthly to provide program advice.

The success of the bus has largely been due to the workers' preparedness to spend time on the street generating a profile and developing trust among young people. The following anecdotes reflect the actual contact with young people and show the range of issues presented to workers on the bus.

## A Day on the Bus . . .

The bus made contact with a young woman who worked in the sex industry. She was very distressed as she had been raped and robbed by a client. She didn't want to tell the police as previous experience with them resulted in her being charged for prostitution. We spent time with her and arranged follow-up the next day. We also linked her into the Prostitute's Collective.

Fitzroy Street was very busy as usual. Two men approached the bus with superficial stab wounds. Their wounds were dressed and they were referred to a doctor.

A client wanted information about coming off heroin. Information and referral was given.

A couple of requests for up to date facts on Hepatitis C.

A man recently out of Royal Park Hospital had run out of medication. We referred him to his treating doctor.

Spent time counselling a woman who had previously been hospitalised for anorexia. Linked her into a counsellor.

A woman asked us about groups for incest survivors and we referred her to a local agency.

Many people, young and old, with dental problems. They opened their mouths and revealed decay, abscesses, halitosis. These clients didn't have money for a private dentist or the energy to wait a few years to be seen at the dental hospital. Fortunately we could refer the young people to the Community Health Centre's dental service.

The nurse examined a two year old boy whose parents brought him to the bus as he had been bleeding from the nose.

The night progressed on with several people inquiring about accommodation, food, support, blood tests, legal advice, mental health enquiries, rape issues, family problems and sexual health issues.

Three young NESB women approached the bus at the local secondary college for information about the pill for a school project. After some discussion one of the women said that she had unprotected sex on the weekend. She went to her local doctor to get the morning after pill and a prescription for the pill. Her doctor told her that she was too young and should only be on the pill when she is married. Her other friend didn't use contraception during her period as she thought she wouldn't get pregnant. I spent time with the women discussing these issues, made an appointment for them at the Health

Centre's Choices Clinic and arranged to see them the following week.

'D' is a 22 year old man. He presented at the bus requesting to have his blood pressure checked. His face and body were marked with numerous cuts and abrasions which he said were the result of having been beaten up. He had recently been released from gaol and said he is currently using heroin. He appeared to be under the influence of heroin at the time.

He explained that he had no housing since being released from gaol and had been sleeping on his sister's lounge-room floor. He told us that a good friend of his had committed suicide by hanging earlier in the week.

We supported 'D' by assessing and dressing some of his wounds, checking his blood pressure, exploring housing options with him and counselling him about his friend's suicide. We also assessed the extent to which he was at risk because of his friend's suicide.

We provided 'D' with information about a Young Adults Housing Service and offered to contact them with him there and then. He declined. We also gave him the number of Crossroads' Housing Network. 'D' had not heard of these services and was reassured to know there might be options for him there.

He was not felt to be at risk of suicide although he was very sad about his friend's death. We provided 'D' with information about the Health Centre's counselling service and the local young persons' Mental Health Service.

'R', a 26 year old woman who lives in a boarding house in St Kilda requested information about the health aspects of her work in the sex industry. She also wanted to find her own flat to get some privacy she couldn't get in the boarding house.

We provided 'R' with information and written advice about sexual health and she took some condoms and information about the Prostitute's Collective. We also explored her ability to afford housing which was very limited. We gave her the numbers of a couple of housing options in the area and information about bond and rent assistance.

'V' is a young aboriginal women (about 18) living in Cleve Gardens in Fitzroy Street. She fell into a fire about two weeks ago and sustained extensive second degree burns to her leg. Initially she was treated by a local general practitioner but 'V' had not followed up her treatment because she had found the GP judgmental about her living with the 'parkies' and her heavy use of alcohol. The community health nurse on the bus dressed the burns and has since kept contact with 'V' to assess and manage the wound.

In the six months from January to July 1993, the bus had 1732 recorded contacts with young people, most of them between the ages of 15 and 25. Major reasons for contact included support and counselling, health information and education, health assessment, treatment and/or referral and contraceptive supply.

### Accessing Homeless and 'At Risk' Young People

The health bus is accessible to young people. It has been effective in making contact with the target group, particularly during the school visits and late night sessions. Most workers said it has been particularly successful in accessing those in the 20 to 25 age bracket and in targeting marginalised and at risk young people:

*"These people don't use local services as they are on the run, therefore bringing these services to the streets is a positive aspect."*

Many of the workers stated that the bus has been accepted by young people and has been successful in building relationships. Young people get to know the bus from seeing it around on regular outreach sessions which builds confidence, credibility and trust which then encourages regular use of the service.

This has enabled young homeless people to gain access to health workers which is a significant achievement.

Many of the bus workers report an increase in the effectiveness of health services meeting the needs of young people due to the increased availability of a young people's mobile health service. The health bus provides information, advice, treatment, immediate practical assistance and is able to respond to the target group's needs through direct service delivery. It has been fruitful in raising young peoples' awareness of health issues. Education through the use of health promotion and school visits has been very effective.

The visibility of the mobile service and the brightly coloured bus has made the service easily identifiable and given it a local presence that appears to have built people's confidence to use the service.

*"Young people's knowledge of the health bus has increased as they keep coming back."*

Word of mouth has increased publicity of the bus as a good service. Many young people know the bus and have expectations of its use. Even if they only use it to get condoms or tea and coffee, a relationship is being developed with the service.

The bus has filled a huge gap in service delivery for young people. They can get free of charge a range of health services, advice and support without having to go through channels that they often find overly formal, alien and judgmental.

There is however a concern that young people don't always access the Community Health Centre or other services used in referral and that it is hard to follow up if young people don't keep appointments.

### Networking and Liaising of Local Agencies

*"You could study the bus as a mechanism for linking isolated agencies effectively. I have been involved in programs that have tried to do this in other ways and have been unsuccessful. It appears that painting the bus as a fish, providing a shared focus and jamming three people that don't know each other together into a hi-ace on the streets of St Kilda is a very effective way of linking agencies."*

Many contributing workers have commented on the effectiveness of the unique and innovative collaborative approach of the bus. They have used words such as "outstanding", "great" and "very positive" to describe the success of the model. It has been consistently stated that the model has developed links with agencies allowing effective coordination, networking and structural links. Cooperation and coordination of and between services has been paramount and includes local agencies, general practitioners and hospitals.

The project has been able to bridge a gap between workers and between services. In turn, liaison and referral between workers and agencies has increased dramatically. The project combines "a range of information, disciplines and personalities" and has allowed workers to bring their range of expertise and skills on to the streets, and share them with other workers:

*"It is a good use of St Kilda resources through collaboration and joint agency work."*

### Increased Skills, Knowledge and Expertise

Workers on the health bus claim their skills such as clinical skills, listening, counselling, advocacy and referrals were being fully used on the bus. Some state they have developed new skills in assessment. The bus has enabled workers to gain outreach experience that has increased their understanding of young people's health needs and elicited ongoing commitment to work with young people.

Through the work on the bus young people have become visible to workers and this has decreased workers' fear of young people:

*"The community tends to believe that disadvantaged people are hopeless. Some are doing great things and coping really well with difficult circumstances. It's good to get a big picture."*

There has been an increased awareness among workers that health is more than physical and that collectively and holistically workers can

address young people's needs. Through information sharing, workers have learned a lot from each other. For example, many welfare workers claimed their knowledge of health issues has increased dramatically.

### **Conclusion**

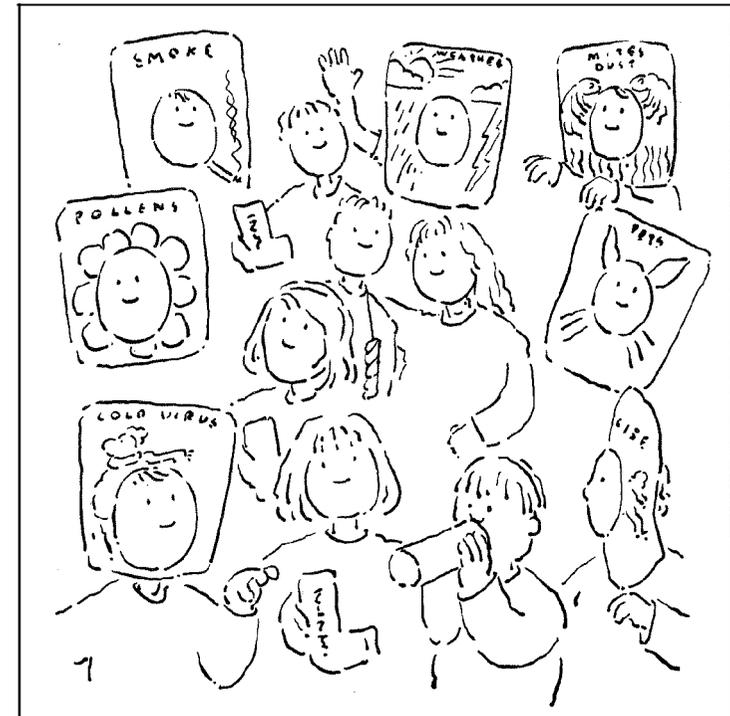
The program has worked very effectively in developing dialogue between health and youth workers. It has built structural links between local services and has gained a commitment of workers from a broad range of agencies, creating a very cost effective program.

The bus has been very successful in reaching young homeless people in their environment. Workers have made contact, built relationships, and established trust and rapport with young people. Now a local presence in St Kilda, the bus has been received very positively by young people. It has also filled a gap in service delivery.

Future funding of the bus program is unclear. If the program is lost it would have a significant impact on young homeless people as they have come to rely on and have expectations of the bus service. It would be unfortunate to lose a program that has demonstrated that it is a successful model for meeting the health needs of homeless young in St Kilda.

As funding for the program nears its end there is still no confirmation from the relevant Departments of its continuation. Its future depends solely on the government's commitment to young people's health.

## **'THE ASTHMA STORY' BY THE WHEEZERS**



**ANNE MUNZEL, KAYE GRAVES, MARY HENERY AND JOAN MAHER**

Echuca, Bendigo, Northern District and  
Central Victorian Community Health Services

# 'The Asthma Story' By The Wheezers

*Anne Munzel, Kaye Graves, Mary Henery and Joan Maher  
Echuca Regional Health - Community Health Division, and Bendigo,  
Northern District and Central Victoria Community Health Services*

The Asthma Story is a short play that teaches children about the nature and effects of asthma. The play uses costumes, mime and an external narrator. Children perform the play during an asthma education program in the classroom. The kit for the play contains audio tape, script guidelines for presenters, masks, costumes and teacher's notes.

The project's developers (the Wheezers) were all providing asthma education to parents, teachers and students in primary schools in central and northern Victoria.

The Wheezers saw a need to have an educational resource that involved students in active learning that would stimulate discussion of the many issues surrounding asthma. It was important that such a resource could be used independently by teachers and non-health professionals. The need for such an educational device was highlighted by the facts that:

- One in five children have asthma and asthma is the most common reason for school absenteeism,
- The increase in morbidity and mortality in adolescents highlights the need to educate pre adolescent and upper primary school age children,
- The authors' understandings of learning theory were confirmed by the classroom experience - mainly that children remember more if they are active participants in learning. Peer and family influences along with the individual child's attitude to asthma are factors important to good management.

The program goal is to increase primary school children's knowledge about asthma and asthma management. It is directed at all children between nine and 12 years of age regardless of their asthma status.

During the developmental phase the authors consulted with the community and a wide range of health professionals. The play was trialled before grade five students, videoed and critically reviewed and appraised by program developers. This provided a firm base for the production of one hundred units of the play.

Identifiable outcomes were the increased knowledge of the following:

- Common triggers of asthma,
- Methods of managing trigger factors,
- The purpose of a peak flow meter, 'preventer' and 'reliever' medication, and
- Understanding by non-asthmatics of the implications of being an asthmatic.

## **Innovation and Excellence**

The innovative and excellent features of this program are:

- The learning is experiential and enjoyable,
- Encouragement of full class participation and peer support,
- Reinforcement of the self management message within a factual, written and audio information package,
- Recommendations for follow-up discussion and optional parent involvement, and
- Comprehensive evaluation for participants and presenter (teacher).

The play is packaged in a kit that contains durable and high quality educational material and is supported by the Asthma Foundation of Victoria.

The kit was developed taking into account the fundamental principles of health promotion, community development and participation, the latter being critical in programs for young children. The evaluation procedure built into the kit ensures that the impact of the program can be assessed and successful use demonstrated.

The estimated cost was \$7000 in program production costs in addition to a considerable amount of preparation and planning time by community health staff

## **Launching 'The Asthma Story'**

The project was launched at the 1993 National Asthma Educators Conference in Adelaide. It was presented to around 200 delegates involved in asthma education at a variety of levels. The play is intended to be mimed by school children, but for the launch, twelve adult conference participants took the chance to turn the clock back and revert to their childhood. Without any dress rehearsal, the play was easy to present, with participants acting out the story being told on the tape. Participation and responses from the adult audience were spontaneous and consistent with the children's involvement seen in the pilot school presentation of the play.

Among resource materials available at the Conference, the Asthma Story received an overwhelming response and was seen as most innovative and

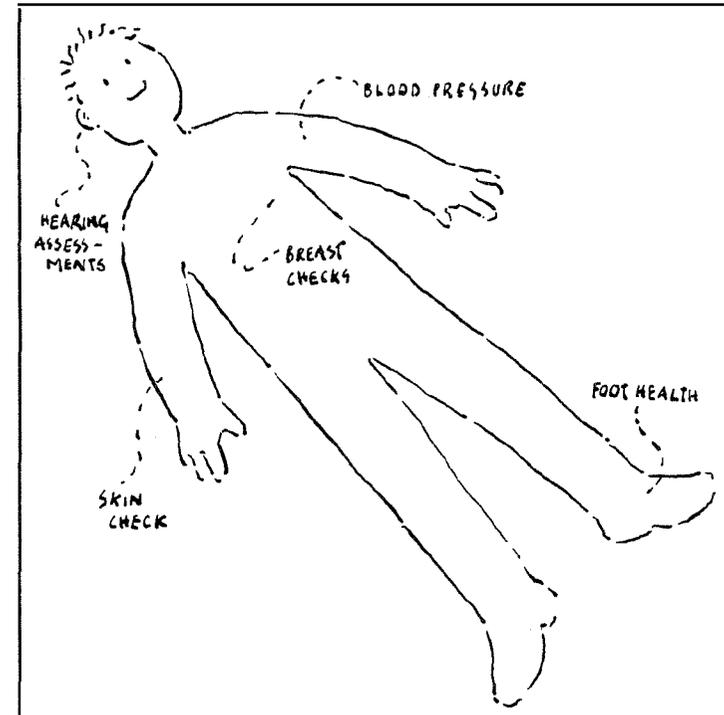
impressive. The number of kits sold after the performance confirmed its acceptability. The Asthma Foundation of Victoria is helping to market the kit to assure its widespread usage throughout Australia. Sales have been so successful that a second production run is being planned.

## **Acknowledgments**

The 'Wheezers' wish to acknowledge the support and encouragement of the following organisations in what has been an exciting and challenging project:

- Allen and Hanburys,
- Fisons Pharmaceuticals,
- Radio 3BO fm, 93.5 Victoria,
- The Asthma Foundation of Victoria,
- Cactus Grafix,
- Srnarkprint Bendigo,
- Northern District Community Health Service,
- Echuca Community Health Centre,
- Central Victorian Community Health Service (Maryborough),
- Bendigo Community Health Service,
- Mrs Sheryl Russell, Cohuna Primary School,
- Special thanks to Mrs Bronwyn Rees and Mrs Helen Campbell (BCHS administrative staff) for word processing and proof reading.

# ONE STOP BODY SHOP 1993



HELEN HILL

Sunbury Community Health Centre

# **One Stop Body Shop 1993**

*Helen Hill*

*Sunbury Community Health Centre*

The One Stop Body Shop is an annual two-day program. It offers the community of Sunbury the opportunity to have health screening of their choice. The Centre runs the program on the Sunday and Monday of the weekend coinciding with the Sunbury Community Fair. Participants can have a healthy heart check (BMI, blood pressure, lung function, blood cholesterol and dietetic advice). Other screenings offered are Pap test, breast checks, eye health test, fitness test, hearing test, stress test, skin cancer check and testicular cancer check, plus a broad range of information. Professional staff are available to give a brief consultation following the results.

## **Innovation and Excellence**

The One Stop Body Shop idea was consumer driven and originated out of a postnatal mum's group. Their request to the Community Health Centre was to have a "one stop, check everything, spot" to avoid arranging numerous occasions of babysitting. The need was assessed, the ideas gained support and a program was developed and thereafter titled 'One Stop Body Shop'. It has since become an annual two-day event. The instant and ongoing annual success of the program encourages the Centre to review and evaluate annually.

Many local and visiting professionals are employed or volunteer their time to help with screenings. All staff, and over 100 volunteers, are involved in the production of the One Stop Body Shop. They are rostered for a minimum of two hours or multiples of two hour sessions.

Acknowledgment and certificates of appreciation are given to everyone who participates or supports the One Stop Body Shop. A formal de-brief and the presentation of the collated results is held one month after.

There is also involvement of local and state government health agencies and promotions, displays and professional support from the Sunbury community. An average of 540 people is screened each year and the approximate time for each individual to 'go through' is two hours.

## **Management**

Management of the program is developed in three phases - planning, implementation and collation of results and evaluation. Each staff member is allocated tasks in each phase by being involved in sub-committees of logistics, marketing, sponsorship and catering. Coordination of the overall health promotion is by the Centre's community health nurses.

The philosophy of the One Stop Body Shop is to encourage the ethic of self responsibility and self management of each individual's health through offering choice, information and consultation. Participants are empowered by receiving an individual health assessment. From these results they can seek referral to appropriate professionals for follow-up. Local general practitioners report that many people do this.

The program aims to provide an opportunity for people over sixteen, who are members of the community of Sunbury, to participate in a personal health awareness program and to encourage participants to take responsibility and possible further action on the screening results.

### Strategies

Key aspects of the One Stop Body Shop are:

- Presentation of multiple screenings at an appropriate, comfortable, accessible venue to the community of Sunbury and Shire of Bulla,
- Presentation of accurate, simple information,
- Confidentiality of results,
- Efficient recording and follow-up, and
- A friendly, professional manner through the encouragement of a cohesive team approach.

The One Stop Body Shop is well publicised through posters, advertisements in local papers and community newsletters, word of mouth and networking by staff. The One Stop Body Shop is open at the Sunbury Community Health Centre on the Sunday of the Sunbury Fair from 10.00 pm to 4.00 pm and on the following Monday from noon to 8.00 pm.

In 1993, the following health screenings were available:

* Blood pressure	* Blood glucose and cholesterol
* Skin cancer check	* Height/weight/body mass
* Eye health	* Testicular abnormalities
* Lung function	* Fitness testing
* Foot health	* Hearing test
* Breast check	* Pap test
* Oral hygiene check	

In addition, talks were given on the following topics:

- \* Emergency first aid
- \* Understand asthma medication
- \* Blood pressure readings - what do they really mean
- \* Laparoscopic surgery explained
- \* How to feel better by exercising
- \* Demonstration of seated massage technique
- \* Keep your back healthy

There were also static displays and information stalls on a range of subjects. These included:

* Anti Cancer Council	* Oral hygiene
* National Heart Foundation	* TRANX
* QUIT & cigarette model	* Young person's health
* Asthma Foundation	* Stroke prevention
* Arthritis Foundation	* Massage and aromatherapy
* Men's & women's health	* Sports medicine
* Naturopathy	* Senior's health
* Sunsmart	* Alcoholics Anonymous
* Al-Anon	* Drink driving
* Family planning	* Health book stall
* Stress management	* AIDS/STDs
* Health food display	* Drug & alcohol
* Youth advice	* Broadmeadows Legal Service
* Commonwealth Rehabilitation Services	

In 1993, the One Stop Body Shop attracted a record attendance of 656. There were 155 pap tests, 302 blood tests, 240 hearing tests and 102 fitness tests. Increased community awareness about testicular cancer led to an increase in the number of men requesting this check. Twenty-five percent of those who had this test were referred for further medical advice.

Screening results are valuable for both reinforcing that people are healthy and for identifying where people need to take some further action. Some results were (percentages of people tested, not people attending):

- 37% exceeded the healthy cholesterol range recommendation,
- 18% had blood pressure which "could be better",
- 12% referred for follow-up skin cancer checks,
- 3% referred for further investigation following pap test,
- 12% referred for further hearing examination,
- 13% referred for further breast examination, and
- 41% referred for further vision examination.

### Outcomes

The program is evaluated using a confidential one page questionnaire. Typical responses in 1993 were:

*It's a great idea, thank you.  
Very happy with the way the whole thing is conducted.  
Thanks for your assistance.  
Everyone was very helpful.  
It was great.  
It was fun.  
Excellent range of information available.*

There is an increasing awareness by the community of health issues, problems, lifestyle risk factors and better understanding of the

relationship between these and the possible development of chronic debilitating disease.

The need to employ a female doctor at the Centre was an outcome of an earlier program and hence we have done so. Following the success of the One Stop Body Shop, the Shire of Bulla asked the Centre to tender for the 'Healthy Heart Screening Program' conducted for their employees. We have won this tender for the last two years.

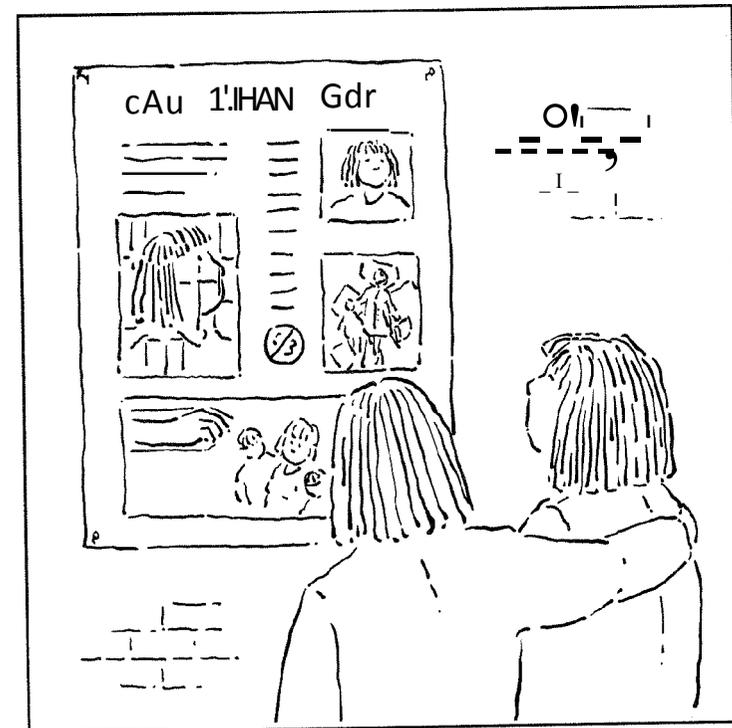
The program opens the Centre to the public and has led to improved liaison with local general practitioners, local government and other community health agencies. The success of the One Stop Body Shop model has raised interest from other community health centres, resulting in supportive consultation between centres.

Evaluation reveals people are willing to pay a small amount to attend an annual health screening program for monitoring their own health. They have also led to requests for ongoing educational programs that are being conducted (eg breast self-examination, vaginal health).

The One Stop Body Shop is a good team building activity for the Centre's volunteers, staff and Committee of Management members. Volunteers offer to work with us on a year to year basis. Interest from the community commences about two or three months before the program.

The program is self funded through sponsorship (Caltex, Quit, Sunbury Private Hospital and Coles in 1993) and charges for pap tests and blood tests. The cost to the Centre is staff time only, estimated at \$15,000 per annum.

## VIETNAMESE WOMEN'S DOMESTIC VIOLENCE POSTER PROJECT



LEE KENNEDY, HEATHER CLARKE AND HELENE YONG

Inner West Community Network Against  
Violence Towards Women and Children

# Vietnamese Women's Domestic Violence Poster Project

*Lee Kennedy, Heather Clarke and Helene Yong*  
*Inner West Community Network Against Violence Towards Women and Children*

Domestic violence occurs world-wide to women and children of every culture and class. A group of Vietnamese women from Kensington and Flemington, working with community artist Tanya Court, designed a poster to help women from non-English speaking backgrounds gain access to support. The poster provides important information about domestic violence directly to Vietnamese women.

Members of the Vietnamese Domestic Violence Support Group designed the poster. The Group offers advice and support to women who are experiencing or who have recently left violent domestic situations.

The project was funded by the Health and Community Services Department, the Stegley Foundation, the City of Melbourne, Flemington Community Centre and the Kensington Community Health Centre. The Inner West Community Network Against Violence Towards Women and Children sponsored the project.

## **Innovation and Excellence**

This project promoted change for many Vietnamese women by publicly acknowledging a problem they are ordinarily prevented from speaking about. The women involved with the project shared their experience of domestic violence with other group members and Vietnamese women in the broader community. They distributed information on a previously taboo subject. Domestic violence support groups for women from non-English speaking backgrounds are very rare and, to our knowledge, this project involved the only Victorian group for Vietnamese women.

The Poster project was excellent in both its processes and outcomes. Participants were involved in decision-making at all stages beginning with "Should there be a project?", and ending with picking the venue for the launch and distribution details. The outcomes have far exceeded our expectations with a highlight being the provision of training to Victorian Police Cadets. Unforeseen results such as this one have shown us that the poster has a life of its own with outcomes yet unknown!

## Innovation & Excellence in Community Health

The project aims were:

- To work with an existing group of Vietnamese women to raise the profile of domestic violence issues,
- To produce a poster focussing on what women would like to say to other women about domestic violence, and
- To raise the level of awareness of domestic violence both within the Vietnamese community particularly and in the broader community.

Vietnamese women were the main target group of the project, but also the general Vietnamese community.

The project was undertaken to overcome a lack of information about domestic violence for Vietnamese women. These women are generally prevented from seeking help and support on this issue. The idea came from a brainstorm for future strategies at a meeting of the Inner West Community Network Against Violence Towards Women and Children. The Network is an organisation of community workers in the inner western suburbs of Melbourne.

### Strategies

We consulted members of the Vietnamese Support Group about whether they wanted to participate in an arts-based project. With the Group's support, we successfully sought funding from the Stegley Foundation (a charitable trust fund) and the State Government's Community Education Taskforce.

Members of the group participated in a training workshop based on the NSW Core Training on Domestic Violence. This is an approach to domestic violence devised by Heather McGregor and Wendy Styles. Staff from the Domestic Violence and Incest Resource Centre ran the workshop. This required considerable organisation and negotiation as it had only been previously run in English.

For ten weeks members of the group met weekly with Tanya Court, a community artist employed by the City of Melbourne's Cultural Development Branch. Together they explored issues surrounding domestic violence within their community and developed images which reflected them. A poster, and a postcard which was used as an invitation to the launch, were created.

A project steering committee was set up to oversee the project. The members of the committee were:

- Helene Yong - Bilingual Support Worker at Dousta Galla Community Health Service,
- Tanya Court - Community Artist,
- Bin Dixon-Ward - City of Melbourne Cultural Development Branch,

- Lee Kennedy - Inner West Community Network, and
- Carol Volpe - Flemington Community Centre.

Strategies used to raise the level of awareness of domestic violence within the Vietnamese community and more broadly included:

- Hosting a high profile launch,
- Seeking widespread media coverage via a media release, and
- Distribution of the poster as widely as possible.

Project participants were involved in evaluation throughout the project. They were also involved in key decision-making through the Vietnamese-speaking support worker.

### Outcomes

The major outcome of the project was the poster itself. Two thousand copies were distributed to doctors, community health centres, migrant resource centres, maternal and child health centres, Vietnamese shops and businesses and many individual agencies (from Victoria and interstate) who requested copies. Distribution was throughout the inner western suburbs - Kensington, Flemington and North and West Melbourne - and in Footscray, Richmond and Springvale where there are large Vietnamese populations.

The poster has increased Vietnamese women's access to information about domestic violence. Women who participated in the project have learnt many new skills, gained confidence and are all able to provide more information to their community on this issue than when they started. Group members offer support to other Vietnamese women experiencing domestic violence.

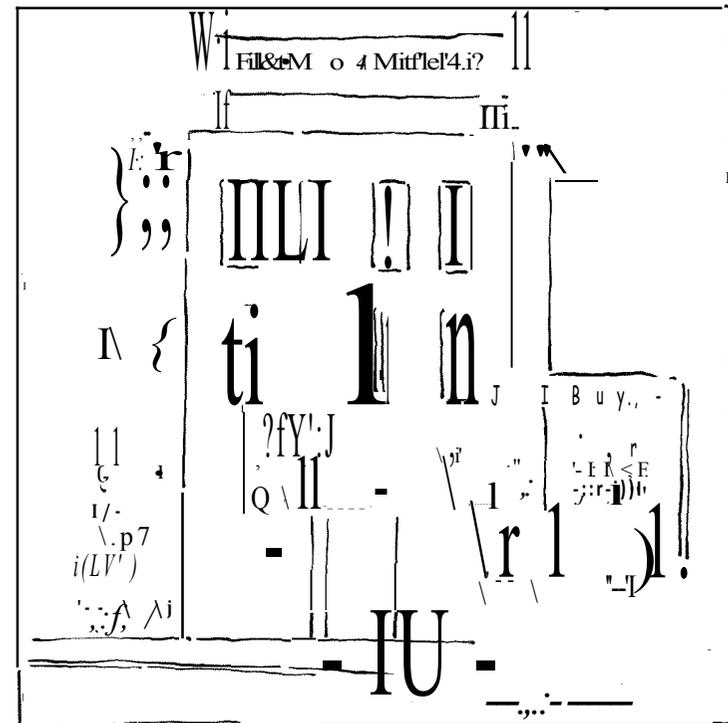
A very successful launch was attended by approximately 100 women. Well known researcher on domestic violence Rosemary Wearing was a speaker. Loan, a Vietnamese woman who participated in the project also gave a very stirring speech. Media coverage of the launch was good including a daily paper, two local papers and two ethnic radio stations.

Domestic violence as an issue to be tackled has gained a higher profile in the inner west because of the publicity surrounding the project.

An invitation was issued to the Vietnamese women involved with the project to talk on ethnic radio and participate in a talk-back session on domestic violence. So many calls were received that they issued a second invitation. The Vietnamese-speaking worker was invited to participate in a training session, for Victorian Police Cadets about dealing with domestic violence within the Vietnamese community.

The estimated cost of the project was \$10,000.

# NEEDS ASSESSMENT OF FORMER RESIDENTS OF GREAT SOUTHERN



**SUSAN SPURLING**

Royal District Nursing Service Homeless Persons Program

# Needs Assessment of Former Residents of Great Southern

*Susan Spurling*

*Royal District Nursing Service Homeless Persons Program*

In 1991, residents of the Great Southern Hotel in central Melbourne were at risk of becoming homeless due to the hotel's refurbishment. Community involvement ensured residents were temporarily located. March 1993 saw the residents again at risk. Intensive lobbying resulted in the employment of a project worker and an extensive needs assessment of the remaining residents.

## **Innovation and Excellence**

Before this project, many people living in the city's low cost hotels did not use and were not aware of services that were available to them. Nor did they appreciate that they had rights as tenants.

This project:

- Prevented many people from becoming homeless,
- Helped residents move into appropriate, affordable accommodation, and
- Raised public awareness of the need to maintain low cost accommodation in the inner city.

## **Strategies**

The Great Southern Hotel was one of several inner city hotels in Melbourne providing low cost accommodation. Residents were often marginalised men and women on the fringe of becoming homeless. In 1991 there were 80 residents at the Great Southern, about 60 considered permanent, most of whom were frail aged or who had disabilities.

In May 1991, the hotel was sold. The purchaser planned extensive refurbishment with the stated aim of providing accommodation for both the budget traveller and low income people.

The future of the then residents became a matter of prime concern to groups such as the Royal District Nursing Service Homeless Persons Program (RDNS HPP), the Inner Urban Housing Council, the Council to Homeless Persons, the Inner Urban Supported Accommodation Services and Hanover Welfare. Identifying the needs of residents in inner city low

cost hotels culminated in a report (by Council to Homeless Persons) - The Hotel Project - in July 1991.

The various agencies formed the Great Southern Working Party. Intensive lobbying of government, Melbourne City Council and private enterprise resulted in the purchaser agreeing to the short term employment of a worker to relocate residents.

With the assistance of the Melbourne City Council, negotiations proceeded with the purchaser who agreed:

- Having regard to concerns about possible loss of low cost accommodation, to conserve this form of accommodation within the Great Southern for a minimum period of ten years,
- To complete refurbishment within twelve months, and
- To allow those permanent residents the right to return to the refurbished hotel (without discussion as to revised tariffs) and to provide all assistance to residents during temporary relocation.

In August 1991, the purchaser reaffirmed the undertaking that residents could return at the completion of the new construction.

By the end of September, all residents had been relocated, most choosing to remain in the inner city. To help with the relocation, RONS HPP and Hanover Welfare contributed worker time and the purchaser agreed to pay some rental subsidy for some residents until the hotel reopened.

In February 1992, RONS HPP received funding to expand its work in the central city including providing support to the former Great Southern residents. Ongoing support was provided by a community health nurse and strategies were developed to reunite former Great Southern residents who were now living at the Kingsgate hotel and other places in the central city.

This support included regular meetings with residents and recreational activities. Contact with former residents included the delivery of health care, linking with generic services such as meals on wheels and the continued support of other relocated residents.

Early in 1993, disquieting rumours began to circulate and on 24th February, the purchaser announced that the Great Southern Hotel had ditched its commitment to low income accommodation. It would now become an "economy style, international hotel" catering for tourists and business travellers. What was thought to be a cast iron assurance was not.

Short term funding for a worker to assess and document needs was obtained through the generosity of Hanover Welfare Services and Council to Homeless Persons. RONS HPP agreed to second their community nurse based in the central city to undertake the research.

The results showed that most residents were very distressed at what had occurred over the previous eighteen months and were frightened about their future security. A recurring theme was the feeling of being treated like a second class citizen. Many said that if they had originally been told that returning to the Great Southern was not an option, then they may have made other plans at that time.

For the women living at the Kingsgate Hotel, options were very limited. The only other low cost hotels in the central city were unsuitable for many reasons and their preference was to continue to live in the central city.

Residents of the Great Southern had a strong sense of community and this was eroded with their relocation to different places. During the eighteen months that residents lived at Kingsgate, the Working Party had organised various functions to try to re-establish community feeling, but with little success. The feeling among residents was that everything would be back to normal when they returned home - the Great Southern.

Housing and welfare workers now have the feeling that the exercise of trying to maintain low cost accommodation at the Great Southern was a waste of time and money. There are also far wider implications.

What is the future of other low cost accommodation in the central city? How much more low cost accommodation is under threat of 'development'? There are 300 plus low income people residing in low cost hotels in the central city. There is a postcode 3000 program that aims to attract 10,000 new residents into the central city, yet there is no provision in this plan for the future needs of low income people.

The approximate cost of the project between 1991 and 1993 was \$10,000.

## ARTHRITIS PHONE LINK



JAN REILLY

Arthritis Foundation of Victoria

# Arthritis Phone Link

*Jan Reilly*

*Arthritis Foundation of Victoria*

As experts in their own daily care, people with arthritis support and advise each other using the telephone. Their own stated wants are the criteria upon which the worker links them to other people in similar situations. Continuing participatory action research<sup>1</sup> has provided the basis for Phone Link's direction and structure. Participants report significant improvement to their emotional, mental, and/or physical health because other participants "really understand" how it feels to have arthritis.

## Service Aims

Arthritis Phone Link developed in response to phone calls to the Arthritis Foundation suggesting that many isolated callers were unable to find the support they wanted from existing services. It aims to reduce the unpleasant self-reported 'alone-ness' experienced by them and links them to others in similar situations, according to their own expressed wants.

It is specifically for people with arthritis who feel 'alone' in any way, either physically or psychically, particularly women with inflammatory arthritis (who are sometimes quite severely physically restricted by it), but also including other groups such as those contemplating surgery.

## Innovation and Excellence

The process of developing the service, the developed service and the current procedures are the result of a participatory action research process. This process continues, changing and modifying procedures according to the expressed desires of the participants (ie people with arthritis who feel, in any way, alone).

In the initial stages of consultation, the participatory process allowed people with arthritis to tell the coordinator whatever was important to them about their experience of the condition. From this emerged many issues, among them being the feeling that only other people with arthritis really "know how it feels" and that transport was a cruel problem. As a

<sup>1</sup> For those not familiar with this term, Wadsworth in *Everyday Evaluation on the Run* (1991) defines it as follows: "Action Research ... is action which is intentionally researched and modified, leading to the next stage of action which is then again intentionally examined for further change, and so on ... research can be thought of as following a cycle or spiral of action, reflection, questioning, researching hunches, drawing conclusions, evaluating options and planning further action, then taking the new action, and reflecting again and so on" (p. 63), and "Participatory action research is collaborative: it involves those responsible for action in improving it, widening the collaborative group from those most directly involved to as many as possible of those affected by the practices concerned." (p. 64).

result people with arthritis chose the telephone as a means by which those feeling alone could share support with others like them.

The amazing popularity of the service, within which the paid worker interviews and links people and records data, testifies to the accurateness of the initial research and to the continuing capacity of people to "know what is good for them". The project is innovative and excellent in both content and process.

## Strategies

Strategies were explicitly developed from the process of participatory action research. Initial research allowed people with arthritis to relate what they thought was important about themselves, their lives and their arthritis. A structured questionnaire was found to be very restricting and a more empirical approach using open questions proved more fruitful.

Once people began to speak the interview invariably took about two hours; they were allowed to speak for as long as it took for them to feel finished. As a result, people shared intimate details and expressed their anger about certain issues. These extended interviews gave the researcher people's own views of their lives. From there Arthritis Phone Link developed.

Each new participant now has an extended individual interview of this type in the comfort of his/her own home. This allows the worker to link people appropriately according to their wants. Each person has an individual contract with the service. As much consumer participation as possible (given that participants are often very restricted in mobility) is incorporated, including a monthly advisory committee where participants meet with the workers. People have given of themselves in ways that fit with their own ideas and capacities, according to their own desires and frequently very creatively.

A computerised data base is kept with the help of several participants. The worker records the data given by each participant (including opinions and 'wish-lists') including only the data that people say is appropriate to record. From this information links are made and the ideas of each person seen in the context of all other participants. Continuing change and development can then occur in response to the data on both program and individual levels.

## Outcomes

The number of participants has grown exponentially, news of it travelling mostly 'word of mouth'. Following two years of development there are about 200 participants. Diagrammatically, Victoria would be covered with a grid of phone links.

At some stage each participant is asked to report on the usefulness of their link. These details are recorded in the data base. Most reports are enthusiastic:

*"Now I know I am not crazy! Someone understands me!"*  
*"No-one has ever listened to me properly before"*  
*"I feel much better about my hip replacement now I've spoken to Mr . . ."*  
*"I go to water exercise with J . . . now I have someone to go with"*  
*"She saved my life!"*  
*"It's been a God-send"*

The service has evolved to include the skills and experience of its participants. They report that it is wonderful to be able to feel useful. Some examples:

- The inclusion on the Phone Link advisory committee of any participant who wishes to come. Some come very regularly; others come occasionally. All contribute.
- Lunches every three months in different suburbs. Each participant will eventually have one near them. These are talkative, cheerful occasions with lots of information sharing and participants having a chance to meet each other.
- A seminar on sexuality held at the Foundation in response to participants' views.
- One participant interviews all country participants, records data about them and is involved in matching them.
- One participant convenes gatherings of people with rheumatoid arthritis.

There is a feeling of enthusiasm and a 'sense of belonging' amongst participants about being involved in a service that consciously uses their expertise.

The estimated cost of the service was \$43,000 for the first two years and is projected to be \$30,000 from July 93 - July 94. This includes the cost of the computer hardware. Because participants support each other the program is extremely cost effective.

## Conclusion

I have become convinced that most people, if consulted, can be relied upon to know about what will help them (and similar others) in the management of their own conditions within their own life situations.

While they may not be able to suggest the form of support, they can suggest its nature. Such as knowing that it is only other people with arthritis who really understand, although they may not have actually known how mutual support could be best organised.

Participants have joined this service for a variety of personal reasons but mostly due to physical and transport difficulties. A few attend arthritis self help groups as well; the Phone Link is not seen by them as something to do instead of going to a group but as another choice. Others just say they prefer to relate on a more intimate 'one-to-one' basis.

New referrals to the service now average one a day. I believe that with any form of active advertising referrals would more than double; however it does not seem fair to publicise a service if there is not time to adequately deal with each new participant, especially as participants say that time for initial home visits, good follow-up and on-going, back-up support, is essential.

There are other specific areas for which the Phone Link service may be suitable (eg people for whom arthritis may have meant the loss of a relationship). It may be appropriate, at some time in the future, to consider paying local coordinators in specific localities, or for specific groups (such as all people with a specific disease). Parents of children with arthritis have recently also become involved, and have found telephone contact very useful.

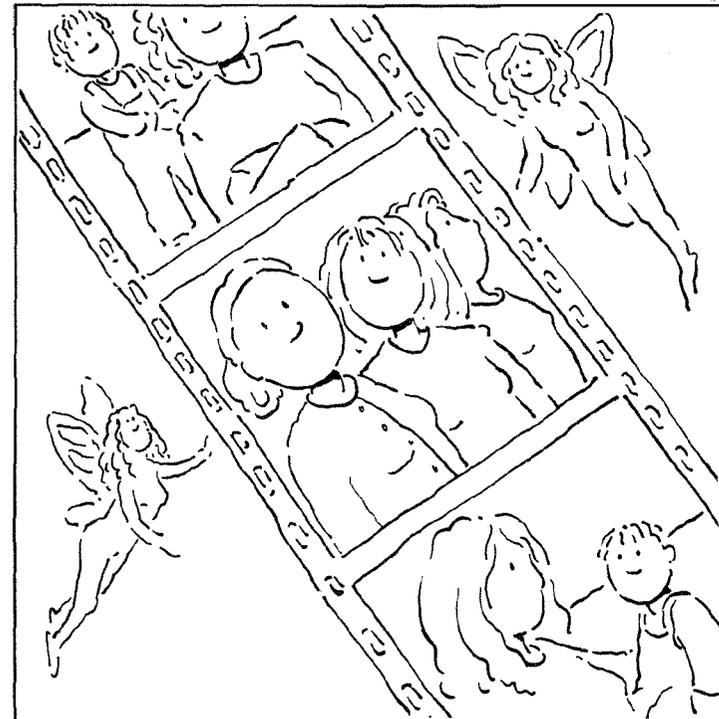
If we continue to operate in a way that allows for real individuality within the framework of the commonality of experience, the good ideas of participants can continue to be acknowledged and incorporated. This will be to the benefit of those people for whom having arthritis has meant physical and/or mental and emotional restriction. It will also continue to provide for them a low cost option to costly psychological services aimed at treating the depression that may result from feelings of loneliness, uselessness and helplessness.

### **Acknowledgments**

Many people gave help of a special nature during the evolution of arthritis Phone Link, some of them despite severe mobility restrictions of their own. Dr Yoland Wadsworth advised on the participatory action research process and provided me with moral support. Joan Byrne was generous in sharing her knowledge, wisdom and support, as were Janet Gillson, Jenny Malcolm and June Southwell who consistently attended advisory committee meetings despite their own difficulties. The Stegley Foundation, the Myer Foundation and the Hugh D Williamson Foundation financed the program.

The participants allowed me into their homes and often their very personal experiences and feelings, and provided an excellent springboard against which I could bounce ideas. They also gave me 'tea and sympathy'. The Arthritis Foundation of Victoria was patient in allowing time for the form of the program to evolve. The Foundation's staff were, and are, generous in sharing their vast knowledge and experience.

## **YOUNG WOMEN'S SUPPORT PROGRAM**



**KATHY HEFFERNAN**

Frankston Community Health Centre

# Young Women's Support Program

*Kathy Heffeman*

*Frankston Community Health Centre*

The Young Women's Support Network is a team of young mothers aged 18 to 23. They provide support to other young women on a one-to-one basis and through workshops at local schools. These workshops are on topics chosen by young women such as sexual health, harassment and teenage pregnancy. The women also produced a health education video - *Sex, Babies and Videotapes*.

## Introduction

Frankston is a large outer bayside suburb of Melbourne at the top of the Mornington Peninsula. It has many young people and is an area where young people are at risk of becoming homeless.

In 1991, the Frankston Community Health Centre applied for and received funding from the Burdekin Homeless Youth Program to work with women in the 15 - 25 age group. This group were not using services available to pregnant women and new mothers. The Centre had also identified that young women were at risk of homelessness due to abusive relationships developed from a young age.

The project aimed to increase use, by homeless and 'at risk' young people, of the services of the Centre and to develop preventive health programs for 'at risk' groups of young women.

## Strategies

The strategies used in the project included:

- Development of a teenage antenatal program,
- Development of a young mum's support group,
- Development and implementation of a training program to enhance the skills and knowledge of the young women involved in the program, and
- Ongoing and continuous evaluation of participants.

## Developmental Phase

In late 1991, I was approached by two young mothers through the Frankston Youth Resource Centre about support for young mothers. We decided to set up a young mother's support group and scheduled a first meeting for early October. We arranged some publicity in the local

newspaper, but after a few months there were only three regular members, and group members felt they were going nowhere.

In January 1992, we reviewed our progress and identified the positive and negative aspects of the group. It was agreed to continue but to adopt some new strategies. These included increased publicity using a pamphlet and another newspaper article; meeting new members through an initial home visit involving myself and a member of the group followed up by a phone call; and adopting a buddy system with new members.

### Peninsula Birthing Services Network

Besides supporting the young mother's group, a provider group was formed called the Peninsula Birthing Service Network. The Network decided to hold a symposium for other health providers looking at the issues of teenage pregnancy and parenting. One issue to be covered was setting up support groups for young mothers and the Network invited the young mother's group to participate in the symposium.

As the mothers involved were a bit overwhelmed with the thought of talking to a group of professionals, we adopted the idea of videotaping them telling their stories and afterwards they could answer questions. The response to the presentation at the symposium was very positive and boosted the morale of the group.

### Sex, Babies and Videotapes

The video is a short documentary (23 minutes). It examines the issues confronting young teenage mums in the outer suburbs of Melbourne. On the video the young women talk openly about their experiences of pregnancy, abortion, childbirth. They also discuss the effects on relationships with their families, friends and boyfriends.

The video could be used as an educational resource in schools or as a professional development tool in tertiary institutions. It would also be valuable for agencies wishing to address the issues of young women's access to services.

An educational guide for both young people and professionals comes with the video. The video is available from the Centre for \$45 and all profits are used to support programs for young women in Frankston.

### Young Women's Health Day

Through the production of the video, new women became involved in the group that now had about twelve regular members. Group members decided to try the video out as a resource for young women still at school.

The Young Women's Health Day was already a regular event for the Centre, although peer education strategies had not been used previously. We planned three workshops involving six members of the group and

hoping to reach year nine and ten girls from local schools. The video was shown and the young women took the girls through a process of values' identification and provided information on pregnancy and its effects on their lives.

The reactions from girls at the workshops were very positive:

*It was good because of the way the girls expressed themselves.  
It really made me understand how hard it is to be a young mum.  
I learnt that mothering is hard, to wait, set my goals and strive for what I want.  
I learnt to be careful with contraception and to be really supportive of anyone around you that gets pregnant.  
It has helped me a great deal, to look after my body, to think of my feelings and to use contraception always!  
Well, I wanted to have a baby when I was 16, but I don't think I will.*

### Taking the Mountain to Muhammad

Due to the lack of attendance at the symposium by midwifery staff from the nearby Morningside Peninsula Hospital, we decided to go to them. The young women were invited to address 35 midwives as part of their inservice training. The women presented the video and told their own stories of their birthing experiences at the hospital. Both positive and negative experiences were presented and the discussion seemed very constructive.

Subsequently, the young women presented their video to the Australian Association of Adolescent Health National Conference in November 1992. The young women answered questions and the result was reflected in the sale of the video both interstate and within Victoria.

### Karingal Young Mums

The group had undergone some changes and a lot of energy had gone into the video and educational presentations. The women decided that the group needed a change of venue and that they wanted to have total control. In other words they did not want me to come to the group ("no offence" they said).

This was a great move for the group and my involvement was to change. They wanted to continue with the peer education programs and with new members of the group involved they also wanted to develop some skills. My role was to support them with the group, when I arrived, and to facilitate separate meetings to develop the idea of a training course.

The Karingal group planned a number of activities and attendance was reasonable given the change of venue. However the group finished after two terms as many women were caught up in the training program and did not feel they needed the support group any more. There was also a feeling that they should be involving really young mothers aged sixteen to

nineteen. Many of this age group felt intimidated by the older women who were now becoming a lot more assertive.

### **Peer Support Training Course**

There was a lot of interest in the group to expand the areas of one-to-one support and peer education. The project worker for a training program for young women offered by the YWCA was invited to meet the group. She outlined the YWCA program that encouraged young women to offer one-to-one support in a hospital setting both post and antenatally.

Together we developed the content of the training course, identified potential workshop presenters and possible funding sources. \$2,700 of funding was secured from the City of Frankston, Women's Health in the South East and the Felton Bequest.

We finalised the course, organised speakers and booked venues along with childcare and lunch. The course ran for ten weeks, every Tuesday for a full day. Sixteen participants were confirmed and all were equipped with folders to collect all the information they would acquire.

A major component of the course was communications skills. This was covered in ten sessions each morning of the course facilitated by the Centre's psychologist. Other topics covered included:

- |                     |                     |
|---------------------|---------------------|
| * Birthing          | * Domestic violence |
| * Managing money    | * Parenting         |
| " Cleaning syringes | * AIDs/STDs         |
| " Legal issues      | * Aromatherapy      |

The evaluation of the course revealed very positive reactions and feelings among the women that they were more confident and could be of help to other young women.

### **Young Women's Support Network**

The women who had completed the course decided to call themselves the Young Women's Support Network. They identified three areas of work for the Network:

- One-to-one support,
- Health education workshops, and
- The teenage mother support group.

The women negotiated with the Centre about support for their work. This was important since funding for my position was to end in October 1993. The Network agreed to meet monthly with support from the Centre's community health nurse.

Ongoing support from the local Women's Health Service in the way of free training places in the 'How to Run Groups for Women' workshop was also organised. The young women's health worker from the Service

subsequently used the Network in providing workshops in the Dandenong area.

The Network has several activities planned including:

- Young Women's Health Day 1993,
- Health education workshops in schools,
- Development of referral procedures for peer support, and
- Participation in a new youth health service in Frankston.

The approximate cost of the program was \$3,000 excluding worker time. Young women's use of the Centre has increased by 30% since 1991. This rate should continue to increase as the program develops.

The project has met the original objectives and has successfully reached a hard to reach group of young people who did not use traditional health services. It focussed directly on the experiences and issues identified by young women from the local area. Participants have been directly involved in the evaluation and development of the project since its inception.

It has provided individuals and group opportunities for growth and has had a significant impact on access for all young women to local services.