CASE STUDIES

A collection of studies which illustrate the achievements of community development in health and offer insights into the approaches which community development workers take to improve health in their community.

Everyone tells us how much better we look, there's a youthful energy in our group; there is an enthusiasm, good will.

Community development is an ongoing and complex process. Once a group is set up it requires continuing support to consolidate.

Education alone is not enough – low incomes make it extremely difficult to stick to the right diet

For the first time they were able to pay bills when they fell due – they weren't trying to change the system, but rather to ease their own lives a little.

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Community Development in Healtl1

Case Studies

This Paper was prepared by the Community Development in Health Project during 1988 through a process which involved the circulation of several drafts and continuing discussion with community workers in the health field. Their contribution and that of numerous others is gratefully acknowledged although responsibility for the Paper remains with the Steering Committee of the Project.

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PREFACE

CASE STUDIES IN COMMUNITY DEVELOPMENT IN HEALTH

Case studies, which illustrate the achievements of community development in health, offer us insights to the approaches which community workers and groups take to improve health in their community.

The Community Development In Health Project ran a series of workshops in Adelaide, Sydney and Melbourne, where participants gave informal presentations of projects which they believed demonstrated the processes and issues inherent in using a developmental approach.

The workshops provided a unique opportunity for those involved to: reflect on the 'key lessons' that have arisen from their work; and for others, to learn from these experiences and affirm the legitimacy of their own work. It was obvious that these stories, told first hand, captured the often hidden motivations and personal sense of achievement which workers relate to community development.

The case studies that are included in this booklet were chosen because, each 'in its own right', shows the significance of this approach to communities that have defined health problems in a social context. Care has been given to ensure that the stories are communicated 'as told', and are accessible to the readers.

The stories are about people speaking for themselves, of their own health experiences and changes in their lives. They offer a powerful account of the role of community development.

Readers may like to refer to additional material in the ***Resources Collection*** for a detailed discussion of community development issues.

Finally, it needs to be mentioned that the studies gathered here represent only a small selection of the projects which we would have liked to include from across Australia.

lfopefully this booklet will encourage others to document and publish their experiences. By doing so, we can be confident that the achievements and lessons of community development will not be forgotten but rather, become widely known by those interested in health.

COMMUNITY HEALTH AND ENVIRONMENTAL ACTION

CLARE SHUTTLEWORTH and LESLEY SHORNE

This case study of environmental action is a study on the fragile nature of community development. It's a study from which we can learn a great deal.

A community concerned about Hie effects of living with heavy industry in their midst was angry and frustrated. In this context, the Dale Street Women's Health Centre managed to facilitate the development of a self-help action group. The group served to affirm the residents' concerns, giving them legitimacy and hope, and thus, gradually overcoming their sense of isolation and powerlessness. However, as the self-help group strengthened, tensions developed between it and the Centre.

Whilst the involvement of a women's health centre in local environmental issues is itself of interest, the real lessons emerging from this experience relate to the delicate tasks of building trust and handing power to the community.

INTRODUCTION

The Dale Street Women's Health Centre became active in the environmental concerns of the LeFevre Peninsula, Port Adelaide, in 1986. Although, traditionally, women's health concerns have not included environmental-related issues, the staff of the Centre on the LeFevre Peninsula strongly suspected that the nature and extent of the area's health problems were related to environmental factors. Thus, we as workers at the Centre, set out to work with the Peninsula residents in a community development framework to address the area's environmental health problems. This experience resulted in varying levels of success for the residents and workers, as well as some important lessons for all.

THE AREA

The LeFevre Peninsula is a mixed industrial and residential area, bounded by the sea to the west and the Port River to the east. The people in the area live, work and play right alongside heavy industry. It is by no means a wealthy area and includes a fair amount of public housing. Many residents own their own houses, which despite their average incomes, are homes that they are proud of. Many of these houses are located close to a chemical production area, where some relatively nasty, toxic substances are produced. There is a lot of heavy traffic going through the area - both trucks and railway; and a lot of noise, smells and pollution. For years residents have complained about this situation.

"... THESE HOUSES ARE LOCATED CLOSE TO A CHEMICAL PRODUCTION AREA, WHERE SOME RELATIVELY NASTY, TOXIC SUBSTANCES ARE PRODUCED."

In 1985 and 1986, there were two serious chemical spillages: copper chromium arsenateOl was spilt into the Port River at Gillman and one tonne of chlorine gas was leaked into the atmosphere at Osborne. There was widespread alarm amongst residenl5, the local fishing industry and environmentalists. The attitude of the companics and Government departments was that it had been the choice of residents to remain in the area. Of course, the reality is not that clear cut, as some have said:

'Why should we have to move when all we want is a safe living environment. 'Ol

Although these incidents highlighted the situation, the underlying uneasiness of the residents about the presence of toxic industry had been with them for years. Their concerns about the threat to their family's health, fuelled by the ever present reminder of chemical smells and the unrelenting stress of a continuous flow of heavy traffic, were robbing them of their right to create for themselves the home life they de.sired.

"... THEIR FAILURE: .. TURNED THEIR ANGER INTO FEELINGS OF DEFEAT AND DEPRESSION..."

They were angry, but their failure to bring about change - or even to gain some recognition for the legitimacy of their concerns - had turned their anger into feelings of defeat and depression about the whole situation. Hope had long since been replaced by scepticism and suspicion.

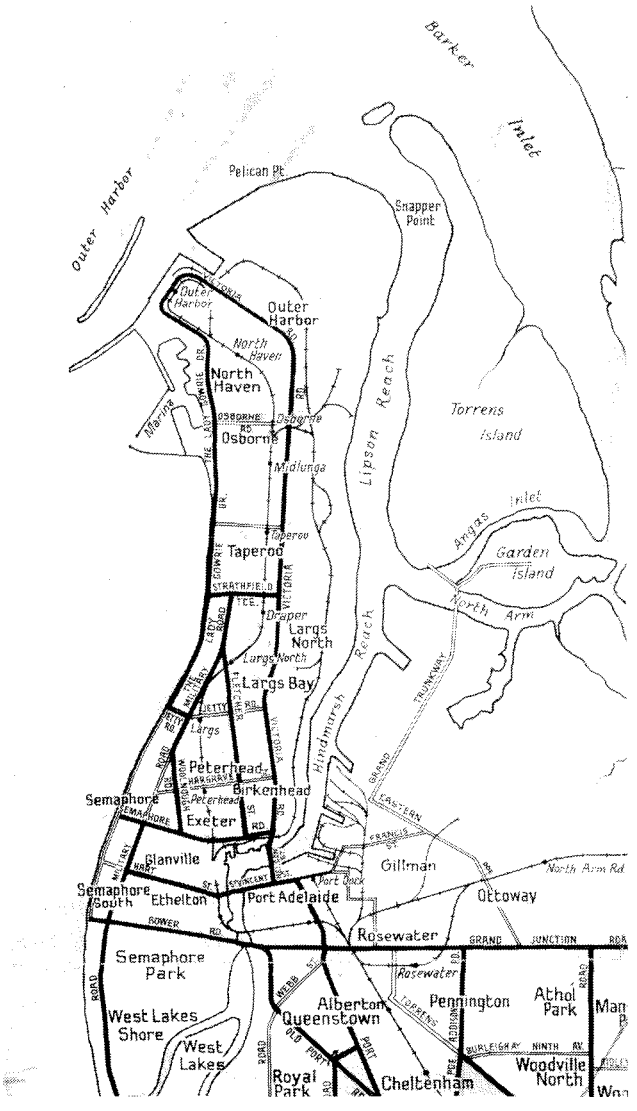
INVOLVEMENT OF THE CENTRE

It was in this context that the Dale Street Women's Health Centre became active. We became involved in this local issue for three reasons:

a) several of the Centre's workers lived in near-by areas and were, themselves, members of a community-based 'environmental health group' which was concerned about what was going on.

b) A journalist, who had been covering the chemical spills in the area over the years, had been in contact with the residents and was genuinely concerned about their well-being. He urged us to do something.

c) We had observed, from the women clients visiting the Centre, an unusally high incidence of respiratory problems, such as asthma and ear, nose and



throat complaints.

Thus we took up the challenge! Our suspicions of the prevalence of respiratory and bronchial symptoms have since been verified by statistical evidence m

"WE HAD OBSERVED AN UNUSUAL HIGH INCIDENCE OF RESPIRATORY PROBLEMS."

Initially, we visited three key families to whom the journalist had spoken. These families lived in the same street and knew one another - they seemed to be prepared to take action and knew others in their neighbourhood whom they could mobilise. Eight families soon became involved. These people were not 'seasoned activists', but had the time and the motivation to take action. They included, mothers who were at home during the day and some men who were off work on workers' compensation: their lives and their family's lives had been strongly affected by the presence of toxic industry.

As staff at the Centre, we had a great deal of autonomy in setting our own priorities, so in February 1987 we decided to initiate a short-term, small-scale project, which specifically aimed at investigating the extent of problems in the area, and to find out whether there was any action that the Health Centre could take. As with all project proposals, we took this proposal to the management committee who approved the project, and as the Centre had made a small saving in the previous year due to a worker taking leave without pay, we were able to employ someone on this project for 20 hour/week for 3 months.

"THE WORKER BREW TOGETHER A GROUP OF CONCERNED RESIDENTS WHO DECIDED TO CALL THEMSELVES HELP."

We went back to the residents with this offer of assistance and left it to them as to who among them would be employed. They chose a local person who lived in the Osborne area, and who had previously been involved in attempts to tackle the industrial pollution. Her brief was firstly, to gauge the extent of the health problems, both physical and emotional, and secondly, to develop some strategies for dealing with them.

The worker drew together a group of concerned residents who decided to call themselves HELP ('Health in the Environment of LeFevre Peninsula'). Together, they devised a questionnaire on environmental health problems in the area. The questionnaire was based on the group's own experience of problems, and included the issues which they felt were most important to residents of the area. Using this approach provided the opportunity for the worker and for HELP to listen to some real stories about the residents' experiences, as well as raising consciousness about environmental concerns. A random selection of 120 households were surveyed, with 115 questionnaires being completed.

The results of the questionnaire were fairly dramatic, suggesting a disturbingly high level of health problems in the community, particularly, respiratory problems. Many respondents mentioned the fact that some, or all family members and neighbours were affected. There was a mixture of acute and chronic health problems, including: acute responses to accidental exposure to gas and dust waste; and chronic problems like sinus, asthma and bronchitis. Only 7 of the 115 respondents said there were no health problems in relation to the environment. One respondent to the questionnaire clearly summed up the situation:

"THE RESULTS WERE FAIRLY DRAMATIC. MANY RESPONDENTS MENTION THE FACT THAT SOME, OR ALL FAMILY MEMBERS AND NEIGHBOURS WERE AFFECTED."

"Sometimes living here's like being in the movie 'silkwood' only you're not acting, it's for real."C4)

FOLLOW-UP ACTION

HELP called a public meeting to present the findings of their survey(S); it was a very successful meeting

and it enabled a much wider cross-section of residents to have their say. This meeting, and the survey results, really set the ball rolling. It led to a lot of public exposure for the HELP group and, eventually, to Port Adelaide being included in the Environmental Health Management Plan, which the Health Commission in South Australia is currently piloting.

"... COMPLAINTS BY INDIVIDUALS NEVER SEEMED TO BE GIVEN LEGITIMACY."

Previously, long-term residents had experienced a sense of isolation - complaints by individuals never seemed to be given legitimacy. When someone rang to report a strong smell of chlorine, the Department of the Environment would respond with: "No-one else has rung". In taking group action however, HELP provided residents with much needed support and the opportunity to build confidence. As a group with a name, doors opened which had previously been closed to the residents as individuals.

"THEIR ISOLATION AND SENSE OF POWERLESSNESS WERE REPLACED BY A RENEWED HOPE THAT SOMETHING COULD AND WOULD, AFTER ALL, BE DONE."

The public meeting generated a tremendous level of enthusiasm - for the first time the residents' fears were given credence. The survey results, together with the attendance at the meeting, the exposure in the media and the response of the Government showed that their concerns were valid. Their isolation and sense of powerlessness were replaced by a renewed hope that something could and would, after all, be done.

THE RELATIONSHIP BETWEEN THE CENTRE AND HELP

From the start, we had envisaged our involvement as being short-term: as with any community development project, the workers must eventually withdraw. We planned to scale down our involvement after the public meeting, that is, we aimed to retain our support and commitment for HELP while becoming less active. Several issues arose however, which led us to withdraw our involvement sooner than expected, and leave the campaigning in the hands of the HELP group. These issues were related to the history of the area, the residents' perception of 'professionals', the way the HELP group developed and differing priorities and concerns. We have spent many hours reflecting and discussing these issues and the experiences and lessons learned from them. Our discussions raise important points for consideration by workers in community development.

THE ISSUES

One important issue which we faced was a growing suspicion of the Health Centre workers by local residents - suspicion to the extent of being perceived as spies and bureaucrats. This was very difficult to deal with. In fact, the group had become suspicious of any outsiders - with the exception of a few - who took an interest in their activities.

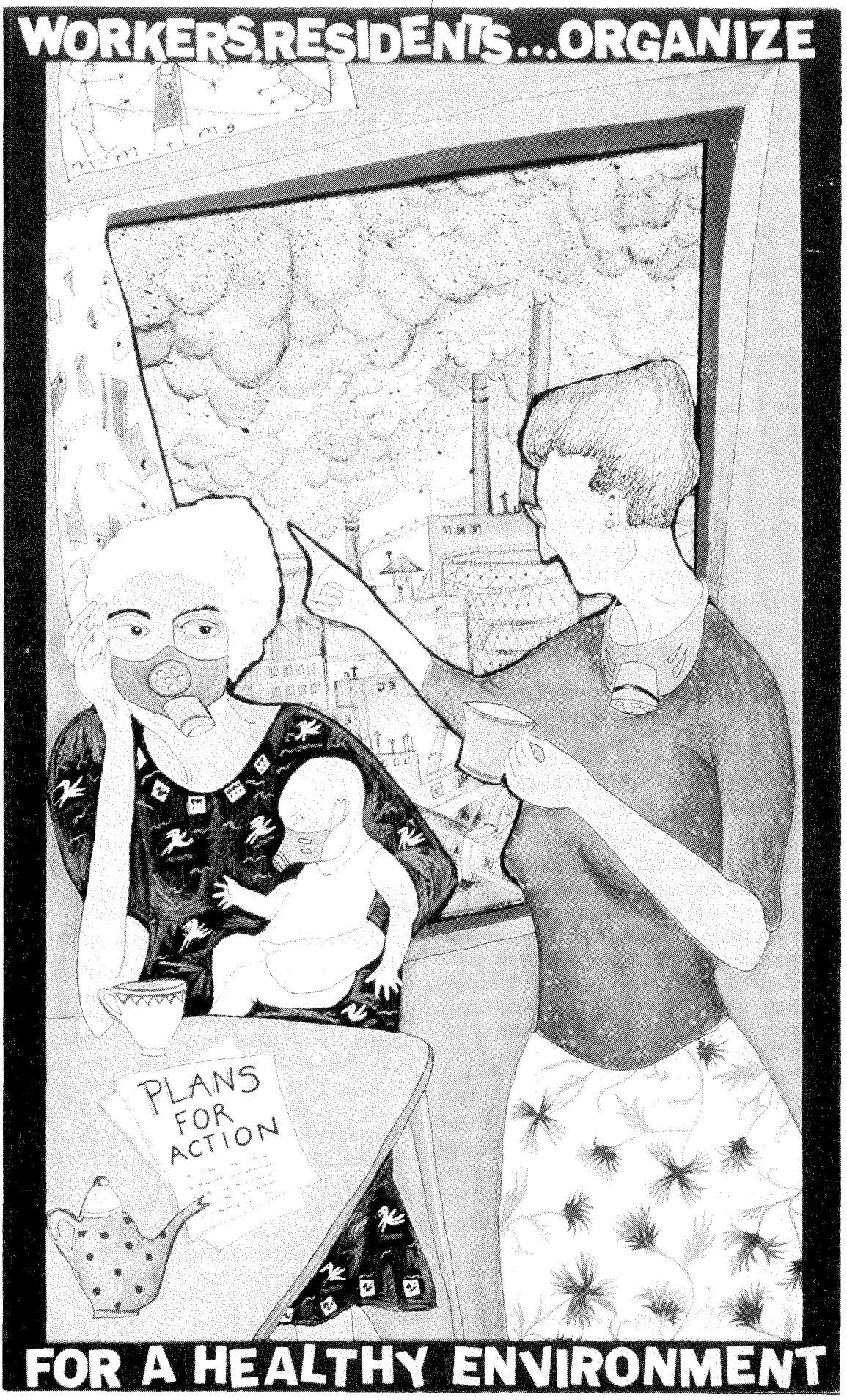
We had employed a worker from the residents' group and, although this gave the project a lot of momentum, it also caused confusion for the worker. Her 'split loyalties' may have contributed to the problems that we experienced in maintaining co-operation between the Centre and HELP.

Underlying the residents' suspicions seems to have been the inevitable perception of an imbalance of power and access to information, which often surrounds paid workers working with the community. As workers, we felt that one of the most important processes which had been developed was the sharing of information between HELP and the Centre. It came to the point however, that they could not continue to share their information. It was at this particular point that we discovered our relationship with the group was on 'shaky ground'. We had wanted to borrow HELP's records (newspaper cuttings, letters and such) to prepare a paper on the role of lobby groups in health and were refused. When we confronted the group with this issue of information sharing, the group revealed its lack of trust in the workers and consensus could not be reached. HELP's reluctance to share information was due to their fears of being 'taken over' and being used for our 'greater glory'.

"UNDERLYING THE RESIDENT'S SUSPICIONS SEEMS TO HAVE BEEN THE INEVITABLE PERCEPTION OF AN IMBALANCE OF POWER ..."

These experiences reinforced for us the important step of establishing group norms in the process of building group cohesiveness and group development. Group norms need to be established around such issues as: information sharing; allowing each person to speak; respecting individual opinions and confronting individuals who do not respect these norms.

As previously mentioned, the local residents were very sensitive to potential professional exploitation of themselves and their experiences. Our experiences with the group has shown that sometimes people think in terms of: "What's in it for the worker?"; "Are we (residents) to feature in some research for a curriculum vitae?" We tried to avoid this attitude by getting to know key people in the community, gaining their trust and creating an 'in' into the community. Professionalism and the professional's training can get in the way - sometimes it's necessary to throw out ideas on how things should be done, such as how a meeting should be run, as it doesn't always apply. Status, positions and titles can be a block to co-operation. To work in a community development style, it is important to be prepared to hand over power - a


WORKERS, RESIDENTS...ORGANIZE
PLANS FOR ACTION
FOR A HEALTHY ENVIRONMENT

problem if one is too bound up in the issue and cannot bear to do oneself out of a job. In our experience, clarity of personal and professional reasons for involvement from the outset is essential.

Another issue which we had to confront was one of different priorities in health care. For example, in talking with residents about health problems, it was not hard for us (as health workers) to go off at a tangent about the epidemiologyC6) of health problems in the area; whereas the residents' priorities were understandably focussed around what affected their lives - the daily grind of indifference in a noisy, dusty environment.

Similarly, another issue was deciding on the priority of concerns. For people in the HELP group, concerns were varied and everyone had different agendas: for one, it was the truck going past, for another, it was one particular factory that was the problem. The Centre wanted to take a broader view and to pursue, for example, legislation or an Environmental Health Management Plan (a topic being discussed at the time in the Health Commission), and also to have an Environmental Health Worker employed for the whole area. However, this was difficult for the group to accommodate. It was essential, therefore, to do something about the noise, the dust and the trucks at the same time as taking on the broader issues. These priorities clearly demonstrated to us that there was a need to tackle the residents' environmental health problems at different levels.

"... ANOTHER ISSUE WAS DECIDING ON THE PRIORITY OF CONCERNS"

Linked to this issue of different priorities was the issue of different political perspectives. Under this heading would come - fear of the feminist cause. Although the Centre is well accepted and established in the Port region, as a Women's Health Centre we still experience some resistance. Some people could not conceive of working with the Centre. As happens in most community development projects, one finds oneself working with people with whom one would not usually be working. To have an agency, especially a women's health agency, involved in a residents' group can cause problems, especially as women's health has not traditionally included environmental health. The Centre considered it to be quite justifiable to take a social view of health, especially considering the number of women who live in the area.

"IT WAS ESSENTIAL, THEREFORE, TO DO SOMETHING ABOUT THE NOISE, THE DUST AND THE TRUCKS AT THE SAME TIME AS TAKING ON THE BROADER ISSUES."

In addition, we felt that we may have fallen into conflict with the Health Commission if we had needed to criticise their inaction. We feared that such criticism of our funding body might have jeopardised the security of our funding. We also feared that it would have been difficult to justify our involvement: our experience of community development work is that it is not quantifiable in bureaucratic Health Commission terms. Such a project as this is not measurable by the number of heads through the door or clients on statistical sheets. These accountability and evaluation problems are common in community health where resources are small and demand for one-to-one involvement is high.

"... ADVOCACY, DIRECT ACTION AND GROUP BUILDING PROCESSES SHOULD ALL BE EQUAL ASPECTS OF OUR WORK."

We have since discovered that our fears were, in fact, quite unfounded - the Health Commission would have been quite open to criticism and accepting of a community development approach!

Defining outcomes, and evaluating what has been achieved and for whom, was certainly a difficult issue. Especially in the context of the question: "Evaluation for whom?" - the residents? Government? Changes in the environment? Rates of occurrence of illness? And so forth. From the perspective of the residents it might be that nothing has changed:

"The trncks still go past and there is still ash settling over my car and my trees are still dying".m

The overall lesson is that there is no single priority or outcome; and for us as workers especially, the advocacy, direct action and group building processes should all be equal aspects of our work.

IN SUMMARY

The long-term inaction regarding their urgent problems - dust on cars, noise levels and so forth - has created a siege mentality in many of the residents, which led to the breakdown of co-operation and information sharing with the Centre. This breakdown has become a major issue - especially for the workers at the Centre. HELP is currently at a precarious stage, but in terms of community development, such a stage in the life of a group may represent a crisis or it may be part of the process of a group gaining independence and consolidation.

Our involvement in this ongoing environmental issue has had many positive outcomes. A self-help group has developed which has provided mutual support and legitimacy for the residents - it has given them a voice and, to some degree, a certain sense of power. Residents' concerns have gained recognition at Government levels and their neighbourhoods have been included in the proposed Environmental Health Management Plan.

The Environmental Health Management Plan has not only had involvement from us, but also from HELP and another environment group. So the Plan

has direct 'consumer' involvement and retains a resident focus.

"(THE) SELF-HELP GROUP HAS ...PROVIDED MUTUAL SUPPORT AND LEGITIMACY FOR THE RESIDENTS - IT HAS GIVEN THEM A VOICE AND, TO SOME DEGREE, A CERTAIN SENSE OF POWER."

Finally, as workers, we have learned some valuable lessons about the processes of community development.

Dale Street will continue to be involved in the area of environmental health, as it is something to which the Women's Health Centre has a commitment. So much momentum has gathered, it would be a pity to lose it.

FOOTNOTES

1. Copper chromium arsenate is a chemical used to preserve wood, for example in the treatment of pine for fences. It is quite deadly and Port River, where it was spilt, is a vital breeding ground for both fish and sea birds.

2. Quote taken from the Residents' survey conducted in Osborne, Taperoo, North Haven and Largs North suburbs on the Lefevre Peninsula, during April - May 1987, by the Dale Street Centre worker and the HELP group.

3. See: South Australian lc!ealth Commission, Epidemiology Branch, "Respiratory Conditions Among Residents of the Lefevre Peninsula", draft only, December 1987.

4. As per (2) above.

5. The subsequent report written was entitled, If You Don't Like It, Move!, A Preliminary Environmental Health Survey of the Northern Lefevre Peninsula, by the HELP group, June 1987.

6. Epidemiology - history of a 'disease'(s) or epidemic which is prevalent in a community at a specific time.

7. Quote from survey - as per 3 and 4 above.

Skills which arc essential for the perfect Community Development Worker!

1. To be in touch and able to listen to the community.

2. To be able to pick one's way through the bureaucracy and avoid being knifed or swallowed up in the process.

3. To know how not to get lost in the local concerns and to keep a broader view.

4. To have heaps of contacts.

5. To be 'thick skinned' but still be sensitive to people.

6. To be clear about what one can do and what one cannot do.

7. The ability to, not only have these skills, but to be able to teach them as well.

8. Group skills - skills in handling difficult people.

9. Gallons of gall.

10. The ability to gain credibility and legitimacy.

11. To have a political and philosophical framework worked out beforehand.

12. To be flexible; to be able to throw all the rest out of the window when need be.

13. To write excellent submissions.

14. To know people in the local press and to be able to get articles in even though the deadline is long past. Plus other media skills, for instance - one needs to know what to do when the "7.30 Report" rings up and needs an opinion on the spot.

15. Last and most important, is that one has to be able to identify any of these skills in someone else so that they can start doing them when exhaustion sets in. Which leads to the last point - enthusiasm can be a real problem - wanting to race away, but having to lasoo oneself and hold back.

Clare Shuttleworth has been involved in community action on industrial and environmental health issues as both a resident and worker in Port Adelaide. Clare is currently Co-ordinator of the Dale Street Women's Health Centre.

Lesley Shorne works as a Medical Officer at the Dale Street Women's Health Centre. Amongst other issues, Lesley has worked on a primary health care approach to environmental problems - this social view of health involves looking at the total person: where they live and work, as well as their physical symptoms.

A DEVELOPMENTAL APPROACH TO FINANCIAL PRESSURE

DIANNE DIXON

The fundamental realisation behind this community developmental project was the recognition that illness can sometimes be a symptom of financial pressure.

Once the connection had been made, the health workers involved saw the need to develop a community response to this situation and one of its causes: the credit cycle.

By developing a 'Savings and Loans' program, which was managed by the people it served, the workers sought not only to break the credit cycle, but also to empower those involved.

The self-help group which evolved from this program experienced the same difficulties that the program itself sought to overcome: they were unable to raise sufficient finance and encountered difficulties in retrieving loans. As a resu lt, the program changed to become a budgetting and savings scheme - in this form it was still able to provide advice and a sense of control to its low income members.

In terms of community development, this project demonstrates the need for commitment and the fact that it can take a long time for the community to come to terms with the skills and processes involved in achieving lasting outcomes.

INTRODUCTION

The Committee of Management of the West Heidelberg Community Health CentreO) has had a long history of supporting and initiating community-based programs. The Committee has always seen health care as involving a great deal more than listed in the Health Minister's portfolio: 'anything' affecting people's health has been considered to be the concern of the Health Centre. The Committee has supported community development as a legitimate means for tackling these 'health problems', and encouraged the involvement of local people in the running of programs. Thus, in the late 1970's when doctors and social workers recognised an emerging pattern of illnesses related to stress, poverty and financial worries, the idea of tackling the financial concerns of clients was not considered to be outside the realm of health.

West Heidelberg, located in the northern suburbs of Melbourne, was originally the site of the 1956 Olympic Games Village which housed the athletes. After the games were over, the area was converted to public housing. Today, the majority of residents are Ministry of Housing tenants, though some have long since bought their homes from the Ministry. A large proportion of residents are on social security benefits and those who work are on relatively low-incomes.

THE CREDIT CYCLE

People on low-incomes are often caught up in a vicious cycle: they tend not to have cash reserves or savings so that even when basic household items such as fridges break down, they find it difficult to get the cash (for example, a hundred dollars) together to service or replace the goods. If the goods do need to be replaced, people are forced to buy on credit from large department stores at huge interest rates.

In West Heidelberg, many people found themselves caught up in this cycle. In the late 1970's some large department stores began using very high pressure sales practices - the residents were prime targets. Once a loan had been taken out, a salesperson would be on the door-step each week to collect the repayments and of course, it was the salesperson who got paid at the expense of the rent, gas and electricity bills which arrived through the mail. Consequently, as people fell into rent arrears, trouble with the Ministry of Housing - even evictions - became a common part of the whole disaster.

The doctors at the Centre shared the Committee of Management's broad view of health: they were fully aware of the financial situation of many of their patients. They were seeing lots of people suffering from depression and headaches, which they suspected may have been related to financial pressures. As all the staff at the Centre worked as a close multi- disciplinary team, there were regular 'case' conferences and referrals between doctors and social workers - the connection between poverty, financial stress and illness became obvious.

"... THE CONNECTION BETWEEN POVERTY, FINANCIAL STRESS AND ILLNESS BECAME OBv1ous."

The credit trap which people in West Heidelberg were falling into was becoming common-place through-out Victoria and a movement against compa-

Photographer Gina Fiske

nies pursuing such practices was developing right across the State. This movement encouraged the Health Centre, especially the Financial Counsellor, to take action, and as the Centre's Committee of Management was supportive of a community-based approach, they responded to this financial stress-related problem by establishing a 'Savings and Loan' Program.

THE PROGRAM: THE EARLY DAYS

The Centre initiated the 'Savings and Loan' Program in 1979; the aim of it was to break the cycle so as to enable people to get out from the credit squeeze. It was based on another project running in Melbourne at that time at the Action Resource Centre in Fitzroy.

Originally, the proposal was that people be encouraged to save money for a set period of time, and thereby gain eligibility for a small loan when they needed to purchase something. It was also to encourage some forward planning and budgetting.

The Centre's Financial Counsellor was involved in setting up the program by gathering the people, who \Vere coming to the Centre for financial counselling, into a group to manage the program. They became known as the Consumer Awareness Group (CAG) and were themselves involved in the same credit cycle. They were the people making decisions about who would be eligible to get a loan; the Financial Counsellor had no right of veto.

"JUST AS INDIVIDUALS WERE FINDING DIFFICULTY IN RAISING MONEY, THE PROGRAM ITSELF ALSO ENCOUNTERED PROBLEMS IN GENERATING SUFFICIENT MONEY."

With funding from Community Services Victoria (Family and Community Support Grants: FACS), CAG was able to employ a co-ordinator for four hours per week. The role of the co-ordinator was to oversee the program, to receipt money, arrange payments and so forth.

PRACTICAL DIFFICULTIES

The 'Savings and Loan' Program ran for about eighteen months, but it wasn't long before practical problems appeared. Just as individuals were finding difficulty in raising money, the program itself also encountered problems in generating sufficient money for the loans when payments into the fund were small; as well as the problem of building up funds when repayments were slow. People, staff members included, were encouraged to donate or loan money to the program. In fact, John Cain (the current Victorian Premier), who was working at the West Heidelberg Legal Service at the time, was one of the first people to contribute. Despite this inflow, there was still insufficient money to make the program self generating. If a person saved two dollars per week for thirteen weeks, they became eligible for a hundred dollars, interest-free loan, but the question was - where was the balance of seventy-four dollars to come from? Once a loan was given, this money was tied-up for a long time, for example, on such a loan, repayments were at two dollars per week for thirty-seven weeks.

"THE GROUP NEVER REFUSED ANYBODY A LOAN BECAUSE THEY DID NOT HAVE THE HEART TO KNOCK BACK ONE OF THEIR OWN."

In addition to these problems of generating enough funds to fuel the loans and maintaining an adequate cash flow, further difficulties arose out of the community management approach which had been adopted. The group never refused anybody a loan because they did not have the heart to 'knock back one of their own'. On top of this, they experienced real trouble as a community group in trying to get hard-pressed members to repay their loans.

A NEW DIRECTION

Eventually in 1982, because of the problem of generating and maintaining sufficient money, the group decided to change the direction of the program.

PholO<Jrapher Gina Fiske

Rather than continue with the struggle and frustration of maintaining the 'Savings and Loan' Program, a budgetting service was established in its place.

The aim of this new service was to enable people to organise and plan their finances, and perhaps even reach the point of planning twelve months in advance. It is a common experience of people on low-incomes that income often docs not match financial demands. For instance, a family may have a week or two without bills and have just enough money to get by. Then a bill comes in and takes half of their pay packet, and if several bills come in together, then something, say gas or electricity doesn't get paid, and eventually this results in disconnection. So in setting up the budgctting service, the group was saying to the community that there was a need to put some money away each pay period, even if it meant that when a bill came in, there was only half of the money put aside for it - this was something.

Those joining the budgctting service met weekly with a Financial Co-ordinator and learnt how lo budget and deposit savings, no matter how small. The service would, on their behalf, make their larger payments such as, rent, gas and electricity. It was actually quite difficult lo convince people of the need lo put a little bit of money away on a regular basis, but after using the budgctting service for a while, they began to sec the benefits. For many it meant that for the first time they were able to pay bills when they fell due - they weren't trying to change the system, but rather to case their own lives a little.

"... IN SETTINII UP THE BUDGET-TINQ SERVICE, THE QROUP WAS SAYING... THAT THERE WAS A NEED TO PUT SOME MONEY AWAY EACH PAY PERIOD... "

It was quite clear of course, that budgctting did not give people any more money, but it did give them a little more control over their lives, and more skills to manage the little they had. It certainly was not a solution to poverty. However, people felt less pressured and were no longer falling into debt. An important side benefit of the service has been the fact that the Ministry of Ilousing, the gas and electricity authorities became more co-operative when they started receiving regular payments so that there were fewer evictions and bankruptcies.

"... BUDGETTINQ DID NOT GIVE PEOPLE ANY MORE MONEY, BUT IT DID GIVE THEM... MORE CONTROL OVER THEIR LIVES... "

Today, as in the early days, all the people who arc making decisions in this program arc those who arc also participants in it; apa11 from the l Icalth Centre's Financial Counsellor, the program has not used any outside expcrls. In 1983, the program took in approximately fifteen hundred dollars in deposits from the members every week: it has since risen to its current level of three thousand dollars per week. Although there arc about a hundred people on the books, there arc about sixty who use the service on a regular basis, that is, depositing money. The service received funding from the Department of Consumer Affairs and the people who arc employed via this grant arc people who have been with the scheme since its beginnings.

"... ALL THE PEOPLE WHO ARE MAKING DECISIONS IN THIS PROGRAM ARE THOSE WHO ARE ALSO PARTICIPANTS IN IT... "

NEW PROGRAMS

The budget service has been operating successfully for the last six years. CAC has not attempted to re-establish the 'Savings and Loan' Program. Ilowcvcr, about twelve months ago, the Committee of Management of the Community Ilcalth Centre established a new loan program as a pilot program.

"... THE COMMITTEE OF MANAGEMENT PUT UP THE CAPITAL FOR THE NEW (LOAN) PROGRAM... "

The Committee recognised the need for a loan service as well as a budgctting service. It is inevitable that people will need lo take out loans, and for people on low-incomes, the only financial services willing to give loans arc those which charge exorbitant interest rates. So in an effort to provide a working alternative, the Committee of

Management put up the capital for the new program.

The loan program is administered by a Loans Panel which consists of three Committee representatives (local people); a Health Centre staff representative and a member of CAG. Although each representative has the same degree of influence, the input from CAG is invaluable in terms of past experience and working knowledge. The Loans Panel is totally autonomous in decision-making, that is, the amount and allocation of loans. Changes in policy and criteria for taking loans are decided upon in conjunction with the Committee.

"THIS PROGRAM GIVES PEOPLE THE OPPORTUNITY TD TAKE OUT LOW·INTEREST LOANS FOR BASIC HOUSEHOLD ITEMS ••• "

This program gives people the opportunity to take out low-interest loans for basic household items, such as furniture and white goods (fridges and so forth). People can borrow up to five hundred dollars, with interest charged to cover inflation. It has been linked to the budgetting service in that repayments of the loans are made through this service. Although initial applications for loans are accepted from people who are not members of CAG, it is compulsory for them to become members. Loan repayments are variable in that repayments can be adjusted to suit people's financial circumstances at the time - this is a realistic approach if the program is to work. Protected from an unreachable goal, those involved in the programs experience, perhaps for the first time in years, a sense of success - an essential first step toward taking some control over their own future.

CAG has recently introduced a 'Christmas Club' Program. Christmas is an especially difficult time for people, so the 'Christmas Club' is an effort to encourage people to start saving a couple of dollars a week, so that by Christmas, they have a hundred to a hundred and fifty dollars to spend. There are currently about forty families involved in this service. In an 'Anti-Credit Christmas Campaign', CAG also negotiated with a local toy warehouse to sell toys at cost price on a layby system. (In 1987 more than four thousand dollars worth of toys were sold).

COMMUNITY DEVELOPMENT IN HEALTH

In hindsight and after discussion with the Health Centre's Manager, there are certain 'lessons' which the West Heidleberg experience brought out that are useful to outline here. The advantages of having a program such as this, based at a Community Health Centre are manifold. Being part of a comprehensive group of inter-related and cross supporting services and programs, people are more inclined to 'give something a go', and to recognise that it can be done. Just accepting that an ordinary group of 'non-expert' people can run a program such as this, without creating the impression that it is amazing or extraordinary in any way, is probably one of the most important aspects of a community development approach. This recognition of the background culture results in a 'snowballing' effect because people see that anyone can do it.

One of the barriers which must be overcome in establishing a community development project is the attitude that:

"That's not health - what has it got to do with the Community Health Centre to be running this sort of program?".

Our advantage was that the Committee of Management of the Health Centre had decided that anything which is affecting your health is their business.

Another barrier is that some people say that:

"It takes too much time - we're here to deliver services, we can't divert staff to do this sort of nonsense".

Again, the management must be persuaded that the provision of services by experts is not the only approach.

In fact, community development should be recog-

Photographer Gina Fiske

Phol01.Jrapher Gina Fiske

nised as an approach, or philosophical position, rather than a 'project'. It is particularly devastating when people say:

"Well, we already do community development - all our programs are community development - that's why we're here".· or

"That's our community development project over there and Fred's our Community Development Officer, no-one does that sort of thing because Fred's the community development person here".

Very often the participants themselves have been made to think that way, too.

" ••• COMMUNITY DEVELOPMENT TAKES TIME - MORE TIME THAN EVEN THE WORKERS INVOLVED INITIALLY IMAGINE."

This experience makes one thing abundantly clear: community development takes time - more time than even the workers involved initially imagine. We've been working on this project since 1979 and it's still developing.

The success of the program has been, to a large extent, due to the commitment shown by the low-income residents. They have gained the skills and resources necessary to assist others to budget, but it has taken years to achieve. The residents' involvement and their improved skills have only been possible because of our Committee's faith in the principles of community control, and its belief that people's health is, in part, a function of their circumstances and the pressures which they face. Community development is often stifled by a lack of time in which to demonstrate results - this project has demonstrated that real, lasting outcomes can be achieved.

" ••• THE PROGRAM HAS ••• ONLY BEEN POSSIBLE BECAUSE OF OUR COMMITTEE'S FAITH IN THE PRINCIPLES OF COMMUNITY CONTROL ••• "

FOOTNOTES

1. The Community Health Centre offers medical, counselling and legal services; it is managed by a Committee of Management which is comprised of members from the community who are elected at the Annual General Meeting.

Dianne Dixon originally worked as a Financial Counsellor with the West Heidelberg Community Health Centre. After leaving to raise her family, Dianne returned to the Health Centre as the CAG worker.

THE COMING OUT OF OLDER WOMEN

JAN ANDERSON and YON/ LUXFORD

Older women in our society are doubly disempowered - both as women and as older people. The pilot project described here sought to tackle these barriers in the context of health. This case study is based on a paper presented at the Australian Community Health Conference by Daina Neverauskas, former Co-ordinator of the Southern Women's Health and Community Centre in Adelaide.

Wide consultation and participatory workshops were the tools used in this pilot program which sought to overcome some of the isolation and stereotyping which surrounds older women. The workshops were an affirming experience - for many women, their denial of age and illness were overthrown; self-esteem was renewed and there were some improvements to their health.

Ongoing contributions have arisen from the program in the form of the development of a self-help group; an older women's festival and the publication of a handbook, so that others elsewhere can repeat the process.

INTRODUCTION

In 1986, the Older Women's Health Project was piloted by the Southern Women's Health and Community Centre (SWHCC) in South Australia. The outcomes of this Project were many - two series of workshops for older women; an extensive consultation with older women about their health; the growth of a self-help group; greater awareness of, and attendance at SWHCC; and a health and wellness manual for working with older womenO). Underlying these results was the 'real' outcome: the Project successfully brought older women together in a way which enabled them to challenge the stereotypes which plague their lives. This was most powerfully demonstrated by the culmination of the Project - the first Australian Older Women's Festival - attended by over four hundred women who talked, sang and celebrated being old!

The older woman in our society is subjected to a range of harmful and negative stereotypes, which can contribute to ill-health as seriously as any physical complaint that she may be experiencing. This stereotypical view portrays the older woman as physically unattractive, socially dependent, asexual and suffering from varying degrees of physical and mental disability.

"OLDER WOMEN ARE SUBJECTED TO THE PREJUDICES OF BOTH SEXISM AND AGEISM."

Older women are subjected to the prejudices of both sexism and ageism and, as a group, are often ignored by women's health programs. Being old and female places women in a situation of 'double jeopardy' - in terms of maintaining a psychological sense of 'well-being' and, in maintaining quality of life - decent housing, adequate income and social involvement.

BACKGROUND

The Older Women's Health Project was developed as one attempt to counter some of the prejudices and disadvantages to which older women are subjected. It originated from an idea that Yoni Luxford and myself (then health workers at the Centre) had for a project for older women caring for their families at home. The idea was extended so as to better suit the funding guidelines and thereby maximise our chances of receiving funding (which is another issue in itselfl) The SWHCC agreed to oversee the Project.

"THE PROJECT GREW BEYOND OUR EXPECTATIONS IT WAS, INDEED, AN EXAMPLE OF COMMUNITY DEVELOPMENT."

In the beginning, the details of the Project were very loose indeed. We really didn't know what specific issues would be included in the program, but we were very clear about one thing - that the content would be decided by the women themselves, and that we would seek their participation from the beginning. In addition we hoped that the Project would:

- work from a feminist perspective<z>;
- address the whole issue of age and ageism; and
- look at the way the health system deals with older women.

In the early stages we didn't set out to conduct a community development project, but rather, simply to provide an additional service - it was to be a pilot community health project. We aimed to develop a health and wellness program for women around the age of sixty years and over, in consultation with older women in the community. As it turned out the Project grew beyond our expectations and looking

back, we can see that it was, indeed, an example of community development.

AN OVERVIEW

The pilot Project developed into an eight-week program which was held at the SWHCC in Noarlunga (an outer suburban area thirty-five kilometres south of Adelaide) and following this, a two-day workshop program at the rural seaside town of Goolwa (eighty kilometres south of Adelaide). Both programs sought to confront some of the myths and stereotypes which discriminate against older women, while at the same time' providing information on local resources, as well as practical health prevention measures, which could be taken up by the older women themselves. The latter included issues such as nutrition, housing options, grief and loss, security and safety, exercises and relaxation techniques.

"THE WOMEN WERE ENCOURAGED TO SHARE THEIR EXPERIENCES, AND... ISSUES AND PROBLEMS OF PARTICULAR IMPORTANCE TO THEM..."

The women participating in the programs were encouraged to share their experiences, and to discuss a variety of issues and problems of particular importance to them, in a relaxed and supportive atmosphere.

In keeping with the philosophy of the Women's Health Centre, the program emphasised a social view of health. We felt that the program would have greater effect if it focussed more so on preventative health measures, as a locally-based initiative could have little impact on the structural dimensions of ill-health, such as, low income and poor housing. However, the groups were run at a 'political' level in terms of increasing women's awareness of their position in society. We covered issues such as, how women could have impact upon Local Government and lobbying for political action. Thus, in the short and long-term, the Project was able to have an impact on the structural dimensions of ill-health, as some of the older women became involved in things like, 'Community Housing For Older Women', caring for carers and so forth.

COMMUNITY CONSULTATION

Before any decisions were made on the program content, we undertook an extensive process of community consultation. The aim of the consultation process was to ask older women what they saw as the major health related issues confronting them in our society.

"WE CONSULTED WITH ABOUT THREE HUNDRED AND FIFTY OLDER WOMEN IN THE COMMUNITY"

We consulted with about three hundred and fifty older women in the community through two public meetings, and talked to existing groups like the Country Women's Association, Senior Citizens' Clubs and others. We asked questions such as: "What is your definition of older women?" "Is there any other term of address that you think is more appropriate?" and "List as many issues or concerns that you have as an older woman, now and for the future, about health and wellness". We received massive publicity (on radio, television and newspapers) and, as a result, we got lots of phone calls and many women visited the Centre for further information. Out of the public meetings we established a working-party which consisted of five older women and five workers; this became the core group to actually oversee the Project, in both Noarlunga and Goolwa.

This great response from the older women was primarily due to the personal contact made by the workers. This approach had benefits for both the older women and us. The older women were pleased to be directly consulted as it was obviously an important issue for them. It gave them a chance to see that they really could have direct contribution (and therefore, power) into the decision-making process and structure of the Project. It also gave us the opportunity to demystify the stigma often attached to women's health centres - as radical feminist 'dives'!

"IT GAVE THEM A CHANCE TO SEE THAT THEY REALLY COULD HAVE DIRECT CONTRIBUTION (AND THEREFORE, POWER)..."

CONCERNS OF OLDER WOMEN

Both public meetings were recorded on tape and several comments are worth noting as they are informative in terms of the women's recognition of ageism as experienced in their daily lives:

"Because of bodily changes we may not be as fit as we used to be but we do not want to be treated as imbeciles. After all, we do have minds and for most of us they still work very well."

'The trouble with many doctors is they tend to say, 'that's just a part of growing old', or 'what do you expect at your age'. We don't want doctors to focus on our age. We want to be listened to and our real health problems recognised."

The question which brought some of the most heated debate, however, was one which asked the women whether they thought of themselves as 'old'. The women were evenly divided on this issue and included those who preferred 'mature' or 'senior' and vehemently maintained: "you're only as old as you feel". Others felt they were older women and argued that it was the most appropriate term, as 'mature' covered too wide an age group: "you can be mature at twenty or thirty".

Finally, it is important to mention one other issue - loneliness - which was mentioned with some

frequency at these meetings. Some of the women had experienced the loneliness that widowhood and living alone for the first time in many years can bring. It was at the Goolwa meeting, however, that the women were most explicit about their varying experiences. Several felt the need for a group which would enable them to say how lonely they were and to discuss issues that were normally not raised in their daily lives. They felt that although they had friends and family, this was not always enough - they often "put on a brave face" with these people and then "went home and cried". They felt it was important to meet with women of their own age who would understand these feelings. It was during this discussion that one woman, in some distress, made the following statement:

"I have a lot of close friends, but no intimate friends. I have a bank manager and accountant for advice. But sometimes I need someone else to really talk to."

It would seem, therefore, that these women had experienced a type of loneliness that demands an empathy which is not encountered in most social exchanges. The women's frankness at these meetings confirmed our intentions to facilitate this type of discussion amongst program participants.

"... THESE WOMEN HAD EXPERIENCED A TYPE OF LONELINESS THAT DEMANDS AN EMPATHY WHICH IS NOT ENCOUNTERED IN MOST SOCIAL EXCHANGES."

The older women expressed anger too. Although most women did not see themselves as feminist ("yes, I'm a feminist - I love wearing pretty clothes" or "I don't want to be a man"), they were certainly angry at the way they were treated in society and the way society neglected them.

"We don't want to be told by someone else that we can't do something just because we are 'too old'. It should not be assumed that we don't want to go to a rock concert. We want to be asked."

"We are often made to feel old - like non-persons really - by some shop assistants. Particularly at cosmetic counters."

From these issues and others raised at the public meetings, the content of the two pilot courses was determinedC4)_

THE PROJECT

Forty-eight women attended the public meeting at Noarlunga, however, we could only accept fourteen for the pilot Project, as we were limited by space and needed to keep the group down to a manageable size if there was to be maximum participation. These fourteen women were randomly selected to take part in the eight-week pilot Project. Sessions of two and a half hours were held one afternoon per week.

We felt that this random selection was the fairest method for choosing the Project participants, especially as we already knew some of the women. We chose a figure of fourteen as groups usually have a twenty percent drop-out rate, and older women, in particular have unpredictable commitments, such as family, caring for sick spouses and so forth. We hoped that this would always leave us with a working group of ten - which is exactly what happened!

"WE WERE... SENSITIVE TO THE FACT THAT WE WERE YOUNG WOMEN... INITIATING A COMMUNITY HEALTH PROGRAM FOR WOMEN WHO WERE AT LEAST TWICE OUR AGE..."

We were extremely sensitive to the fact that we were young women (around thirty years of age) initiating a community health program for women who were at least twice our age (between the ages of fifty-four and seventy-two). Not only was there a huge age difference, but also there were vast differences in life experience. From the two groups of women (Noarlunga and Goolwa): twelve were married, eight were widowed and two divorced; the majority were Australian born, with nine being British born, one American and one German. Most of the women were on pensions, with a couple living on superannuation benefits and three dependent on their husbands' wage. Almost all the women were in their own homes, with three in public housing and two in private rental. The women from Goolwa all appeared to know each other and it seemed to be a more closely knit community.

Although evaluation of the Project was a funding requirementCs), we felt that since this was a pilot program, it was important to evaluate from the beginning. Therefore, prior to commencing the program, pre-group interviews were held with each participant. Initially we felt that the evaluation was important to find outcomes; to use the information to re-evaluate the sessions (for example, the two-day workshops) and to make sure that the group content constructed from the public meetings was still relevant to the fourteen randomly selected women. In hindsight, the pre-group evaluation gave us valuable health/social information about the participants. It also gave the women, themselves, a chance to 'sus' us out and to feel more responsive to the Project.

"... IT WAS IMPORTANT TO EVALUATE FROM THE BEGINNING TO MEASURE OUTCOMES. IN HINDSIGHT, THE PRE-GROUP EVALUATION GAVE US VALUABLE HEALTH/SOCIAL INFORMATION ABOUT THE PARTICIPANTS."

At the pre-group interviews, participants were given a list of topics to be included in the program and were asked to nominate the five which they anticipated finding the most useful. Massage, relax-

ation exercises, support services and agencies, general information about the ageing process and ways older women are portrayed in our society, were some of the most popular choices. Following the workshops, participants were asked this question again. Most topics received an average score, which indicated that they were more useful than not. It is interesting to also note that the session on security and self-defence was unanimously chosen as the 'most useful' by participants - although this was not anticipated by the women during the pre-group interviews.

During the Noarlunga program we found, as mentioned previously, that some women experienced difficulty in maintaining continuity in attending all eight sessions. This was one reason why we took the alternative approach of a two-day workshop program with the women at Goolwa. As well as the fact that the Goolwa women expressed the desire for a shorter program.

AGE DIFFERENCES

As there was a thirty years age difference between the oldest and youngest participant, we asked the women if they had any concerns about the age variations:

"At first, when I saw May, I thought because she was about the oldest, she might feel left out. She used to doze off quick, but she wasn't made to feel any different."

"I thought it (age) was irrelevant. If a person felt the need to come and wanted to come I don't think it mattered."

"It (age) didn't have any effect on the group. They (the other women) were gorgeous really. I don't know whether some of them were really old, but some of their ideas were. I felt like a spring chicken by comparison - but they were gorgeous. And Gladys, she was in her seventies, but the energy she spread around. She was amazing. And some of them were religious but I'm not and you can't turn it on and off But there wasn't any that didn't fit."

Regarding their different backgrounds, one of the women commented:

"Although there were different values in the group - some were religious, some were old fashioned - it didn't make any difference. It just shows what women can do if they stick together. Despite all the different values, we have so much in common."

A GROUP FOR WOMEN

We asked the participants if they felt that there were any benefits in being in a 'women only' group:

"I think it made you feel as though a lot of women have similar troubles and that you can sort them out and talk about how to overcome a lot of your problems."

"Well, I suppose because you can talk more freely about things that, even today, are not generally discussed in mixed company. There are things that really concern only women. Some things don't really concern men - some things we experience."

CHANGES IN ATTITUDE

In the pre-group interviews participants had already indicated how they felt about being an older woman in our society. At that stage they focussed on issues such as loneliness, the invisibility of older women and their feelings of being 'devalued' by society. They were also divided on whether there were many advantages to having reached this time in their lives.

"THE REMAINING EIGHT WOMEN FELT THE PROGRAM HAD MADE SOME CHANGES TO THEIR ATTITUDES."

In the post-group interviews, the women were asked if the program had changed any of these attitudes and, if so, how? Four of the women felt it had made little change: two because they had already adapted to and were enjoying old age; one woman (aged fifty-six years) replied that she did not 'feel old'; and the other woman maintained that she still did not like to talk 'too much about being old' (she was aged eighty-five years). The remaining eight women felt the program had made some changes to their attitudes and their comments included:

"Yes, I feel more confident and I think it's been good for me. I felt wanted and needed. It's given me a lift. You feel that somebody cares about you I suppose."

"Yes, I've dropped ten years (this was followed by laughter). Especially after the last session - trying to do a barn dance with rubber sole shoes on a carpet. And I was supposed to take a man's part! (followed by more laughter)."

"Yes, I think of myself as being a bit more important. I don't mean important. I don't know the word really. I feel better than I did before I went."

It is relevant to note also, that participants were asked what their attitudes to the Women's Health Centre were now that they had been attending on a regular basis. Previously only three of the fourteen women had ever attended the Centre. Now their replies were unanimous and the comments below give some indication of their tone:

"I think it's (SWHCC) a necessity. It's something that the women here need. It's very useful and it's nice to know. The girls are friendly and you feel as

though they're pleased to talk to you."

"I think it's fantastic - one word, fantasticl I heard about the Older Women's group on the radio. I had never been to Southern Women's before... I didn't know there was a place as dynamic as this place... There is such a lot going on here. And it's warm and friendly."

These responses show that this type of initiative, which is firmly based on the principle of community consultation, can bring people into community health centres who would normally not think to use them. This is particularly evident when compared to the women's more hesitant attitudes before the program began, such as: "I thought it was a place women from broken homes go".

PARTICIPANTS' 'GAINS' FROM THE PROJECT

In the pre-group interviews, the women were asked what they expected to gain from the Project. At that stage they focussed primarily on the more traditional aspects of a community health program, namely, information on diet, exercise, services in the area, as well as friendship and discussion. According to the post-group interviews, these expectations were met almost without exception. One woman felt she would have enjoyed more recreational activities and hoped that this would be rectified in the future.

Many of the women felt that the program had surpassed their expectations, as the following responses illustrate:

"Yes, I felt that a course like this which gave older women a chance to do something about their health, or whatever is very important to them, was good."

"Yes, the ideas and the extra studies. [The women were given 'homework' after some of these sessions and a variety of reading matter.} I'd like to do a study course. I always felt I wanted to do something."

"My mental attitude has really altered. I feel strong... I didn't expect to get this good feeling - this strong feeling - so quickly. I can't believe it's only two months. It has really changed my life."

The women were also asked if they had changed their behaviour in terms of regular exercise or diet. The majority had used the stretching exercises learnt during the program, and at least half felt they were maintaining them on a regular basis.

THE SELF-HELP GROUP

The women who attended the first public meeting but who missed out on taking part in the pilot Project, went on to establish a self-help group called 'FAD' - the Friendship and Discussion group. Yoni and I felt that we 'owed' these women something for their enthusiasm and support. We felt that it was unfair not to provide some forum for them to keep meeting, so we encouraged and initially facilitated them into forming a group. After our initial facilitation we had an almost negligible input into the group - the women took control of the group and are still running it on their own. In the beginning the group used to meet once a month for a discussion afternoon and a shared lunch. Today, it meets twice weekly and has doubled in size. The group is quite active - various members are volunteer workers at SWHCC and some have ongoing involvement on the Committee of Management. In fact FAD is campaigning SWHCC to constitutionally change the age of retirement for Committee members to over seventy. Members currently have to retire from the Committee when they reach seventy years of age.

"THE WOMEN WENT ONTO ESTABLISH A SELF-HELP GROUP CALLED 'FAD'..."

It was the FAD group which came up with the idea of an 'older women's festival' when someone saw an article about one that had been held in London. They talked about this amongst themselves, then talked to us and reached the point where they set up another committee to get the festival off the ground. That committee took the role of getting funding, planning the festival and again, was largely the initiative of the older women with some assistance given by health workers. It was a huge success, there were about four hundred women who turned up! Another festival is planned for 1989.

"IT WAS THE FAD GROUP WHICH CAME UP WITH THE IDEA OF AN 'OLDER WOMEN'S FESTIVAL' ... THAT WAS A HUGE SUCCESS, THERE WERE ABOUT FOUR HUNDRED WOMEN WHO TURNED UP!"

Shirley Stott Despoja, a journalist with "The Advertiser", reported her impression of the festival (6):

"There were nearly four hundred women between the ages of fifty and eighty five planning a revolution. They were Jed up of being disregarded or patronised, humored by politicians, told by doctors that they had to put up with things because that's what old women do; and of being dismissed as LOLS (kids lingo for little old ladies).

They don't intend to see retirement village developers and walking frame manufacturers become the chief beneficiaries of the public money that will be spent as the great plans for coping with the greying of Australia gets a head of steam.

Ageism is about to be attacked as vehemently as sexism and racism, and by women who feel the headiest liberation of all, that of having nothing to lose and much to gain. There is no-one so radical as someone who feels this way. The female submis-

sion of a lifetime, the inhibitions of domesticity, the restraint of famities and job, no longer apply to older women and they are celebrating the fact.

Students of revolutions will know that other revolutions have been careless about their activists, regarding them as expendable in the cause. But the older women's revolution is about caring for each other, and I suspect it will continue as it has started, with loving attention to body and spirit. [1]

IN SUMMARY

The manual, the FAD group, the festival and a commitment from the SWHCC to maintain a worker involved with older women, were all ongoing contributions which arose from the Project. Our role was very much acting as a catalyst or facilitator, providing the information and co-ordinating as much as possible. We think, more importantly, that the reason it worked so well and continues to work now is because, from day one we were committed to participation - really listening and doing what the women said. The effect of the total Project - the public meetings, the workshops, the self-help group, the festival and the publication of the handbook - brought about an incredible emotional change in many of the women.

In a speech at the opening of the festival, one of the women said:

"If you'd talked to me about older women 12 months ago - I would have said, 'I'm not old'. But today I'm proud to say I'm an older woman. [1]

"THE EFFECT OF THE TOTAL PROJECT••• BROUGHT ABOUT AN INCREDIBLE EMOTIONAL CHANGE IN MANY OF THE WOMEN."

We believe that one of the most important factors of our success was our basic assumption that we were all equals. We had to keep pulling ourselves up and making sure that all the time we were listening to the women. We acted on the information we gained and the women, throughout the Project, were able to take action themselves.

FOOTNOTES

(1) Anderson J. and Luxford Y., Women Growing Older, Southern Women's Health and Community Centre, South Australia, 1987.

(2) Whilst a feminist framework laid the foundations for the Project, we were careful to accommodate the ideals and values of the participants, the majority of whom did not consider themselves feminist.

(3) STAGES OF COMMUNITY CONSULTATION

(i) Two public meetings - Noarlunga and Goolwa.

(ii) Discussion with already existing groups, for example - Senior Citizens, Country Women's Association and YWCA.

(iii) Establishment of working party for Project (major health-related problems for them):

5 older women who attended meeting;

2 workers SWHCC

1 worker Noarlunga Health Services

1 member Management Committee SWHCC

Co-ordinator SWHCC

Program design by workers in consultation with committee - 8 week pilot program.

(iv) Pilot program at Noarlunga - 14 women randomly selected from public meeting attendance.

(v) Development of FAD - Friendship and Discussion group from public meeting.

Group meeting every fortnight, with support from health workers.

(vi) Evaluation - ongoing.

(vii) Older Women's Festival

FAD - idea of older women's festival inspired by similar day held in London March 1986. Sub-committee formed of interested women to co-ordinate:

5 women from community

3 staff SWHCC

1 staff Local Council, aged care

1 staffTAFE college

1 staff Noarlunga Health Services

Tasks: 1. Funding

2. Planning of Festival.

Over 400 women attended - all over 60.

(viii) FAD - Self-help group now continues to meet fortnightly. Two older women are members of the Management Committee and older women's issues continue to be addressed by the Centre.

(4) Course Content Of The Two Programs:

Health, Wellness and Ageing: The Social Aspects of Ageing; Health, Wellness and Ageing: Physical Health; Self Protection; Loss and Grief; Stepping Out: Exercise and Recreation; Sexuality; Housing and Accommodation; Minor Tranquillisers:lmplications; Decision-Making Processes; Networking; Relaxation, Movement and Massage.

(5) McColl, M., It Was Nice To Be Asked, an evaluation of a community health program which was developed for and with older women. Southern Community Health Services Research Unit, April 1987.

(6) Despoja Stott S. "The Advertiser", 4 March 1987.

Jan Anderson formally worked at the Southern Women's Health and Community Centre and is now at the Dale Street Women's Health Centre. At both Centres Jan has been involved in the establishment of older women's groups.

Yoni Luxford is a Community Health Nurse who has worked in the areas of women's health; home birth - midwifery; and Aboriginal health. Yoni is committed to working and learning with women who give voice to their real experiences.

Daina Neverauskas was the C',0-ordinator of the SWHCC. Daina was on the working party that guided and supported the Older Women's Project. She is currently a Project Officer with the South Australian Community Health Association.

FACILITATING TENANT ACTION

SALLY MITCHELL, GAIL PRICE AND BERNADETTE McMENAMIN

The following case study presents the development of a tenants' association on a high-rise public housing estate as a long, slow struggle in building trust.

Flat by flat. floor by floor, the workers canvassed every family - making no promises. but ottering to work alongside the tenants in their struggle to tackle 'the system'. Small, achievable wins paved the way toward a growing confidence among the tenants in their ability to bring about change.

The project, spanning six years. was built on the realisation that conventional healtn services could have little impact on an isolated community living in such appalling physical conditions. The case study demonstrates that successful community development must be based on a commitment to build links between people. and to ensure that the entire process is owned by the participants themselves.

THE EARLY DAYS: SALLY MITCHELL.

BACKGROUND

Flemington is an inner city suburb of Melbourne with large, high-rise public housing estates built in the 1960's. Each of these high-rise towers provide accommodation for one hundred and eighty families, totalling over four thousand people on the estate. The people living on the estate are mainly on low-income. There are large ethnic communities, including Spanish-speaking, Indo-Chinese and Arabic-speaking people. In 1982, when the Flemington Community Health Centre (FCHC) was getting involved with the tenants, the Flemington high-rise estates had the shortest waiting list of any of the Ministry of Housing (MOH) estates; people who desperately needed housing were being sent there, even though they might not have had any links with the area at all. Consequently, the people were very isolated and 'disenfranchised'.

The FCHC was established in 1978 as a sister Centre to the Kensington Community Health Centre. In 1982, the Centre was operating from a small house in Flemington. The Centre staff comprised of a community health nurse, a social worker, three bi-lingual health workers, a receptionist and a visiting podiatrist - there were no doctors. In addition, workers funded through other sources were based at the FCHC such as the legal service worker. All these workers' were involved in the initial development of the Flemington Tenants' Association (FTA). At the time, I was working as a social work student on placement with the FCHC and also became involved in this project.

IDENTIFYING THE PROBLEM

It was probably due to the fact that there were no doctors and that the FCHC operated from a 'normal-looking' house, that people didn't strongly identify the Centre as being a 'health centre'. People who came from the nearby Flemington high-rise estate would drop-in for a coffee and to see one or other of the workers. In this 'drop-in' atmosphere, they were happy to wait for staff members, even though they knew that the worker wouldn't be back for one or two hours. People were coming to the Centre for a range of things, such as complaints about fellow tenants or the appalling physical conditions of the flats and laundries; information on local services in the area; financial assistance; concerns about their kids; and other basic health problems. Often people came in to get one of the workers to make a phone call for them or to sit with them whilst they made calls. Tenants told of the dreadful loneliness of moving onto the estate; of how scared people were to go out at night; of the appalling physical conditions on the estate, such as the flooded laundries· and they'd seek advice on problems which, in less' fragmented communities, would be answered through normal community networks - for example - parents of a teething child would seek advice from the Centre as they lacked the usual personal networks which would have informed them that problems associated with teething were normal.

"...THE UNDERLYING PROBLEM BEING EXPERIENCED BY PEOPLE WAS SOCIAL ISOLATION•••"

We began to realise that the underlying problem being experienced by people was social isolation, and that their visits were because of their need to have contact with people more than anything else. It also became apparent that many of the health problems which people were experiencing, such as depression, were linked to the physical conditions in which they were living. On top of these problems

was an all pervading atmosphere of impotency: "There's nothing we can do to change things". People felt helpless - they'd learnt that it was useless to approach the authorities.

We identified these as the major problems which were affecting the health of the tenants, and thus decided to make them the top priority for the Centre and take action!

Traditional ways of working with the tenants (working on individual problems one - by - one) seemed inadequate. We felt that tenants needed to talk to each other and share their problems.

As the majority of the concerns which we heard from the tenants were tenancy issues, we felt that it would be appropriate to tackle these by initiating a tenants' association. It was thought that a tenants' association would be the medium to both attack and break-down social isolation, as well as improve the physical conditions on the estate.

"TRADITIONAL WAYS OF WORKING WITH THE TENANTS... SEEMED INADEQUATE."

Thus in 1982, all the workers from the FCHC decided that the development of a tenants' association should be given high priority. Each member of staff allocated half-a-day per week to work with tenants. The Committee of Management gave support to the workers for this project.

When the FCHC began this project, it was with the knowledge that there had already been two attempts to set up tenants' associations in the past, both of which had failed. It was for this reason that we decided to proceed slowly; one step at a time. As workers, we were also aware that if this attempt of setting up a tenants' association was going to work, two things had to be built into the process:

a) we had to build links between the people; and

b) the tenants themselves had to own the process.

Our central strategy from the start was to make personal contact with the tenants.

THE NEED FOR A COMMUNITY SPIRIT

In setting about building links between the people, we decided that because of the high level of social isolation which existed, it would be necessary to start small and build links between people on each floor, then move onto building links between each block (or tower), then the whole estate. It was important for people to get to know each other, to become familiar with each other's concerns and issues, so that a cohesive group would form out of each block. It was felt that the alternative strategy of calling a public meeting would not work as people would find that too alienating - few of the tenants identified themselves as part of a community which shared common concerns.

THE NEED FOR TENANT CONTROL

In starting with small groups of people, we felt that it would be easier to develop the tenants' skills, their level of communication and to build on their interests so that they could manage the tenants' association themselves, and become active on tenancy issues. As workers, we all believed in the importance of people taking control of their own lives, and thus saw our role as acting as a catalyst for getting the tenants' association going, but ensuring that the direction and management of the group was firmly in the hands of the tenants. This belief demanded that we work intensively in the earlier stages with a view to gradual withdrawal thereafter. We also felt that our involvement in establishing a tenants' group would influence the community's view of us as health workers, and make us appear more approachable. We hoped that it would make the lines between worker and client less defined as we were working alongside the tenants, not for them.

It was hoped too, that some of the case work needs would diminish by having a tenants' association.

STEPS IN SETTING UP THE TENANTS' GROUP

In August 1982, starting with one block at a time, workers in teams of two started door-knocking the flats, floor by floor. We introduced ourselves to the tenants and told them that we were knocking on everyone's door, asking if people had any problems living on the estate. We then told them that maybe by working together with other tenants we could all address some of the problems. We weren't clear, ourselves, of our 'plan' when we began door-knocking. We made no promises that things were going to change. The tenants themselves felt that the problems were enormous, and that individually, they could not see any way around them. As we were being honest about how we felt, we gained a sort of empathy with them. I think if we had gone in and said:

"... IT WAS EXTREMELY IMPORTANT TO SIT AND LISTEN TO THE TENANTS AS THEY WERE FEELING SO ISOLATED AND POWERLESS."

"We think it's disgusting and we're going to have all the laundries renovated by the end of the year';

then everybody would have walked out on us and told us that we were mad! All we were saying was:

"It's an enormous problem ... it seems like an insurmountable task to even think about how we are going to change people's living conditions here, but we're gonna give it a try."

During the door-knock about seventy-five percent of the tenants invited us into their flats, and we usually stayed for half an hour to one hour, listening. We really wanted to hear what people had to say and we'd try to let them know that we were concerned about what they were saying, that someone cared and that their concerns deserved our attention. We would usually leave with a list of six to seven problems. Although this was very time-consuming, it was extremely important to sit and listen to the tenants as they were feeling so isolated and powerless.

After the initial door-knocks the workers chose a family on each floor, who they felt would be most amenable to having a floor meeting in their flat. Someone on every floor agreed to having a floor meeting. These first meetings (in November 1982) were an incredible success - with about eight of the ten flats on each floor represented! The incentive for people to come to these meetings was the fact that they weren't happy living in their current conditions and we were offering a possible way to change that.

"FOR MANY TENANTS THIS WAS THE FIRST TIME THAT THEY HAD SPOKEN TO EACH OTHER."

With the assistance of non-FCHC staff, such as the legal service staff and the youth worker, we were able to have two to three floor meetings per night. By and large these meetings were like fairly comfortable 'afternoon teas' - with the FCHC providing free tea, coffee and biscuits. The workers' role at these meetings was to act as facilitators, introducing people to each other (with the use of interpreters where necessary). For many tenants this was the first time that they had spoken to each other, even though they lived on the same floor and had passed and perhaps nodded to each other in the corridors regularly. Workers introduced the tenants to each other by saying:

"Do you know this person over here... who lives next door to you and who thinks that they have a problem with the laundry?"

After this prompting to talk to each other about their concerns, everyone soon found that they all had the same problems, such as having to do their washing standing in three inches of water.

TENANT CONCERNS

Although there was the occasional inter-personal conflict between the tenants at the floor meetings, the majority of the complaints that people wanted to address were the appalling conditions of the laundries, their personal safety, the security of their flats and general maintenance issues. Many people had repeatedly asked the MOH to do various repairs, but these had not been done.

By early December, we were ready to have our first block meeting. This meeting was held in the new Youth Drop-in Centre, which the MOH had recently built at the foot of the block. This meeting basically reported back the major concerns from the floor meetings.

"OUR SUCCESS WITH THE FIRST BLOCK SPURRED US ON."

Our success with the first block spurred us on; door-knocks and floor meetings in the second block moved a lot faster as we had the full-time assistance of two students on placement, from the 'Student Initiatives In Community Health' Program.

BECOMING ACTIVE

During 1982, the MOH had begun setting up tenant associations on other estates where they wanted to carry out physical improvements. We had been told that Flemington wasn't on the list for any improvements.

Despite this information, in February 1983, we called a public meeting with the tenants from the two blocks and invited Ian Cathie (then, the Minister of Housing) to the meeting. About two hundred and fifty people attended and they were quite outspoken at this meeting, particularly about the laundries. In fact, one tenant stood up and said:

"Mr Cathie, I don't suppose you do your own washing, but you probably wouldn't want your wife standing in three inches of water like I have to - this is the permanent situation, our laundries are always like this."

After this meeting, there was a vague guarantee given that at some stage the Flemington flats would be placed onto the Estate Improvement Program, but that was to be a long way down the track because there were lots of other estates in front of Flemington.

At this stage, the Flemington Tenants' Association which had emerged from these activities was still a loose, informal body - if you were a tenant, then you were a member. The formal incorporation of this body came at a later stage. The Association held meetings at which issues were raised and decisions made, but the work between meetings was carried out by the FCHC workers. However, the tenants were becoming more and more active. Two sub-committees were set-up: security and maintenance and two FCHC staff members were involved with each.

The maintenance committee was meeting with the MOH staff and talking about the problems that people were having. At the end of 1983, in an attempt to force the MOH into action over promised improvements, this sub-committee arranged for every flat from three blocks to put in an official MOH complaint

Photograph courtesy Flemington Tenants' Association

form for repairs to the laundry - totalling nearly one thousand written complaints! According to the Residential Tenancies law, the MOH had two weeks to complete the repairs. The tenants drew up big charts - one which showed what was wrong; and the other to show which repairs had or had not been carried out and any new repairs to be done. Al the end of two weeks, many repairs had not been done, so we called out the media.

"... IN AN ATTEMPT TO FORCE THE MOH INTO ACTION... EVERY FLAT FROM THREE BLOCKS .. PUT IN AN OFFICIAL MOH COMPLAINT FORM... TOTALLING NEARLY ONE THOUSAND WRITTEN COMPLAINTS!"

The tenants took full control: they put both the charts and laundries on display. Tenants who had been injured as a result of the conditions of the laundries were interviewed. They told of broken arms or legs from slipping on wet floors, and of a washing line that had collapsed on the back of a woman's neck. As a result of this tenants' action, the MOH's architects arrived early in 1984 to draw up plans, in consultation with the tenants, for the renovation of the laundries.

The tenants were also concerned that there weren't enough security guards on the estate and that they weren't around at the right sort of hours to protect people. At a meeting with the guards and District Manager, which was called by the security sub-committee, the District Manager stated that it was feasible to change the hours of the guards. Although the hours were not changed a great deal, just an hour each way, the tenants felt a little more comfortable. It was a great 'win' for the tenants - they had spoken out about something, they had been heard and something had changed.

"... MANY REPAIRS HAD NOT BEEN DONE, SO WE CALLED OUT THE MEDIA."

By this time, the MOH and the FCHC had jointly organised funds for a worker to assist the Association. It was then that I was appointed as the worker and my role involved supporting the Association and co-ordinating the Health Centre staff who were working with it. After three months of joint funding, the position was fully funded by the MOH and I became the employee of the FTA.

"THE LOCAL DISTRICT MANAGER... WAS COMMITTED TO THE IDEA OF TENANTS TAKING MORE CONTROL OF THE ESTATES."

The local District Manager of the MOH was committed to the idea of tenants taking more control of the estates. He supported the Association in significant ways. For example, when I approached him for a flat for the group to work from - he was willing to provide one. He also supported tenants being on interview panels for estate office staff.

Perhaps because of the ease with which the flat was obtained, the tenants took a long time to actually feel that they owned it. They seemed to see it as belonging to me - as I was the person who was working there. So for the first six weeks I sat in an empty flat - without furniture - and kept telling the tenants: "It's yours, you'll have to decide what furniture you want." Eventually, people started bringing carpet and furniture that they no longer needed and began using the flat. Initially, the flat was used as a meeting place, then as a workspace for tpe Association and, eventually, it became a very social place - a focus for the estate.

For the tenants, the first priority was achieving physical improvements - and they had demonstrated that by working together they could achieve this. Their second priority was the building of social links and this was, indeed, happening along the way. People looked forward to meeting others and a strong sense of solidarity began to grow with .each new achievement.

THE FLEMINGTON TENANTS' ASSOCIATION TODAY: GAIL PRICE AND BERNADETTE McMENAMIN

The FTA has continued to evolve since its inception in the early 1980's. A lot of change has occurred and these have been due to a number of factors, such as staff changes, the political environment, the changing roles of local agencies and the change in location (from a three bedroom flat to community complex).

Today within the Association there is a 'core group' of active members. These are the tenants who staff the office on a roster system, those who assist in the physical maintenance of the building and committee members. These members are encouraged, 'nurtured' and trained. However, as the achievements of the group have accelerated, members have taken on an increased responsibility for this rather than the tenant workers.

The committee structure, which began with two committees, then developed into five, has now been streamlined into three committees (administrative, estate improvement and security), which meet on a monthly basis. These committees have representation from Vietnamese, Chinese, Spanish-speaking and Arabic-speaking tenants.

The floor representative system has now become unwieldly and thus is not utilised as much as it used to be. If it were run in the same manner as previously, it would mean having one hundred and fifty meetings each year, as well as requiring further maintenance through door-knocking. The floor representative system was an attempt to link tenants by the floor they lived on, rather than by common issues, beliefs or language. The problems which were being brought up were usually ones which could either be more productively handled through existing meetings, or were unable to be solved by the FTA, because they were tenant disputes. Floor meetings had set up the expectation that problems caused by the communal nature of laundries, drying areas, lifts and rubbish chutes could be solved. Some sense of neighbourhood was developed during the first floor meetings and this did resolve some tenants' disputes.

"THE HEALTH CENTRE WORKERS WITHDREW FROM AN ALREADY UNDERRESOURCED COMMUNITY"

Another reason for the relaxing of the floor representative system is because of the increase in numbers of tenants using the FTA, indicating that the FTA is now well-known and that it is no longer necessary to encourage participation floor - by - floor. Instead, participation is encouraged through the three committees; bi-monthly language specific meetings (five languages); an older people's group; social events such as trips, lunches, celebrations, activities and the resourcing of tenants to set up other specific groups, for example, El Salvadorean Club, Vietnamese

Women's Group, Arabic Group, Women's Group, Turkish Prayer Group and so forth. Some of the ways that groups are assisted are by having a regular place to meet, assistance with submission writing, information or assistance in organising activities and events. New tenants are door-knocked and elderly tenants are door-knocked each month by the FTA. All these methods have resulted in a multi-cultural and a multi-aged representative group.

"... THE FTA IS NOW WELL KNOWN AND ... IT IS NO LONGER NECESSARY TO ENCOURAGE PARTICIPATION FLOOR BY FLOOR"

The FTA also manages its own security company which is unique in its nature: 'Highrise Security' employs multi-lingual male and female guards from the estate and an estate-based supervisor. Foyer and patrol duty are included each night.

THE RELATIONSHIP BETWEEN THE FTA AND FCHC TODAY

The first twelve months of the FCHC's involvement with the Flemington tenants saw the establishment of a tenants' association as the top priority. The following twelve months saw a transition from a FCHC focus to one where the onus was on the tenants to take control. That is, four staff members who were putting in time regularly every week, gradually withdrew as time went on.

"... THE FTA ALSO MANAGES ITS OWN SECURITY COMPANY WHICH IS UNIQUE ..."

In retrospect, we now feel that the withdrawal of the FCHC was mis- interpreted. Whilst it was important for tenants to take control of the FTA, this was not to say that the FCHC no longer had a role on the estate. The estate has the greatest population of people within Flemington who are discriminated against or disadvantaged by income, race, gender, various health disabilities and lack of survival skills and education. The Health Centre workers withdrew from an already under-resourced community, leaving tenants with initially only one, and then two, tenant workers to draw on. Certainly the role of the Health Centre needed to change to become one where they resourced and worked with the Association on projects determined by tenants. The Health Centre could have continued, along with the FTA, to work with groups such as women with RSI, unemployed men, young people and isolated elderly - so as to tackle the issues affecting their lives. As with the initial establishment of the tenants' association, it was, and continues to be important for the Centre staff to do outreach work and door-knocking on the estate.

"TODAY, TENSION PREVAILS BETWEEN THE TWO GROUPS..."

The FTA is enabling tenants to take control of their lives and their environment to the extent where the group has some very clear ideas of how agencies should service its members. Tenants have taken steps to have their views heard: by joining the FCHC Committee of Management, offering to have a representative on the Health Centre's interview panels and supporting the Health Centre's campaigns (for example, Dental Health Campaigns). Health Centre staff are invited to elderly lunches and meetings on health issues, and both groups participate in the Flemington Community Network.

"COMMUNITY DEVELOPMENT IS ... AN ONGOING AND COMPLEX PROCESS."

Today, tension prevails between the two groups because the tenants' association believes insufficient developmental work is being done with tenants on the estate.

IN SUMMARY

The FCHC was successful in setting up a tenants' association to address the people's social needs, and to give them a feeling of being empowered to do something about their concerns.

The ongoing success and development of the FTA can be attributed to several factors such as:

- the initial approach of the FCHC: the time commitment, working slowly in small groups, building people's skills and a sense of community, listening to the tenants' needs and taking direction from them;

- the commitment of the original tenant worker;

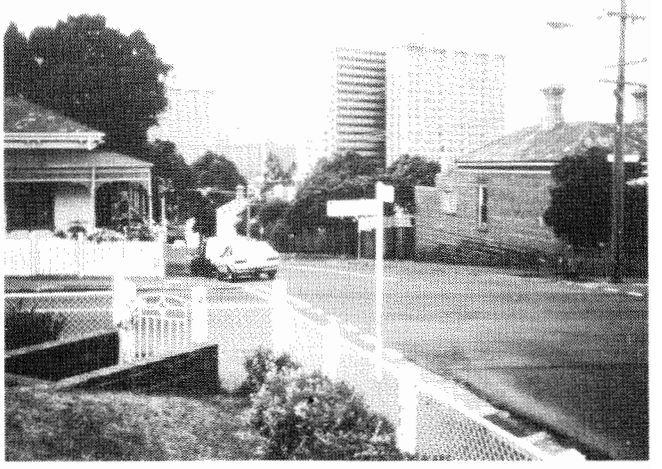
- the initial door-knocking of the estate for a sound beginning;

- the rewarding achievements of the group, for example, estate improvements, better security, the community complex, murals and festivals;

- funding by the Ministry of Housing and Construction for the core functions of the group;

- the political commitment and hard work of the

Photograph courtesy Flemington Tenants Assoc.



tenants and tenant workers for tenant rights, social/ environmental change and empowerment of the group; and

- the support of other organisations and individuals.

Community development is, however, an ongoing and complex process. Once a group is set up, it requires continued support to consolidate and progress, with the supporting organisation being sensitive to the changing role it needs to be playing. The Health Centre withdrew so that the Association would develop its own identity and advocate on behalf of tenants, but without looking to its ongoing role.

The FTA was envisaged as a pressure group to lobby the Ministry Of Housing. This has certainly happened but the group has also taken on a strong representative and advocacy role in areas of tenants' lives outside housing issues. The fact that the FTA has come into its own as an advocacy body can be demonstrated by its willingness to take up contentious issues and challenge the FCHC - the very body which assisted its development!

Sally Mitchell is currently employed at the Fitzroy Community Health Centre and has worked in community settings for the past six years. The focus of Sally's work is skills development with 'disempowered' people.

Gail Price has worked on the Flemington Ministry of Housing and Construction Estate for over five years, first as Co-ordinator of an after-school program and then as a Tenant Worker.

Bernadette McMenarnin has worked in public housing for five years, first in West Heidelberg and then for four years in Flemington.

HEALTH IN A SOCIAL AND CULTURAL CONTEXT

JOAN VICKERY.

This case study follows the development of a series of camps for Koories with diabetes, which addressed the problem of diabetes in a 'caring' framework.

The camps aimed to tackle health in a social and cultural context. They were held in a rural setting and the key features of their success were the involvement of family members as well as those with diabetes; and the emphasis on participation.

Awareness raising, skill development, commitment to diet and lifestyle changes and friendship building were all important outcomes of the camps.

Empowerment was another important aspect of the camps: they were organised and run by Koories; their primary focus was on Koories with diabetes taking control of their condition; and the de-mystification of professional knowledge.

This case study represents a simple strategy reaping multiple outcomes.

INTRODUCTION

The majority of KooriesCl) in Victoria experience the low standards of health associated with other low income groups. Inadequate income results in inferior housing, nutrition and access to health care, amongst other things. Statistics show that among Koories, health is much worse than the average Australian, and diabetes, although rare prior to white settlement, today features high on the list as a cause of early death.

While all the reasons for the high incidence of diabetes are not known and there may be some genetic factors, nevertheless there are contributing factors which can be controlled - like diet, access to information and treatment.

As the Aboriginal Hospital Liaison Officer at St. Vincent's Hospital (Melbourne), I was involved in initiating a program which was designed to tackle some of the problems of educating Koorie diabetics about their disease and its management.

Through my work with Koorie communities throughout Victoria and as a Koorie with diabetes myself, I have gained a good understanding of this wide-spread condition and the special problems associated with it in the Koorie community.

The health system does a lot for diabetics, but medical staff seem to forget just how difficult it is when a diabetic goes home. There is a lack of communication and a lack of knowledge - the family, even my family, do not understand. You're taught, but your family knows nothing, when you go home and need their support and guidance, you don't get it because they don't know what you are on about.

GOVERNMENT RESPONSE

Back in 1980 the Government responded to the health needs of the Koorie community by establishing the Aboriginal Health Resources Consultative Group with a sub-committee focussing on diabetes. This sub-committee confirmed the wide-spread occurrence of diabetes by conducting a sample random survey of a total of fifty Koories in Ballarat and Bairnsdale. Five new diabetics were identified in both groups - that's a total of ten percent increase in two, quite separate communities.

In 1982, I established a diabetic support group at St. Vincent's Hospital, and was approached by a worker from the Lions International Diabetes Institute (Sandy Gifford, a medical anthropologist) who wanted some advice on how to involve Koories in diabetes education programs elsewhere. I explained that with programs run in hospitals along traditional lines, Koories might turn up for one session because their doctors had told them to go to this education program, but many would be unlikely to return. A hospital is like any big institution - Koories feel like strangers in the white person's (gubaa's) bureaucratic system.

"... KOORIES FEEL LIKE STRANGERS IN THE WHITE PERSONS .. BUREAUCRATIC SYSTEM."

ORIGINS OF THE CAMP

It was from this discussion and others with the medical staff at St. Vincent's Hospital that the idea of holding a Koorie diabetic camp arose. The idea for the camp was not just for diabetics, but for the members of their families as well. We decided to specifically target these camps to people who lived in the country, as these people are often the ones who have

least access to information and services. Therefore, we felt that a bush setting would be the best place to hold such a camp as it is more in line with where people live in the country. These camps are more than education camps - they're real 'get togethers'.

The first camp, held in October 1985 at Camp Jungi, Rubicon Lane, Thornton (Victoria}, near the Eildon Weir, was funded by the Lions International Diabetes Institute, but it took twelve months of hard slog beforehand to educate the professionals and the Koorie community. For example, the Dietician needed to know that Victorian Koories are meat eaters. Subsequent camps have been held each year. (In 1988, the State Health Minister, David White, granted ongoing funding for the camps.) The camps are run over five days with participants and organisers 'living-in' at the camp site - sharing accommodation, meals and recreation time. The content of the education programCZ) is similar to standard programs, but care is taken to discuss all issues in the appropriate context of Koorie culture.

THE CAMPS

The idea behind the camps was that they'd be run by Koories, this meant involving Koories from all over Victoria right from the beginning, even before we had the funding for the first camp, and maintaining this involvement before each camp. This emphasis on Koorie management has always been essential for the Koorie community to collectively take control of the problem of diabetes on their own terms.

As I'm pretty well known in the Koorie community (I've been involved with my people in a working capacity for nearly twenty-five years and I've travelled and lived all over the State), I used my contacts with local Koorie Hospital Liaison Officers, Koorie co-operatives and the Koorie medical services around Victoria, and asked them to choose Koories with diabetes and their families to attend meetings with me. At these initial sessions, I explained the idea of the camps to the people:

- that it was a chance for Koorie diabetics to learn about their condition and gain the self-care skills involved;
- that their families were encouraged to come and take part too;
- that it wouldn't just be a lot of boring lectures, but include other activities;
- that we'd discuss the social, economic and political problems associated with being a diabetic; and
- that Koories would be organising and running the camp.

Although I have made it my role to conduct these pre-camp meetings each year, the essential point is that it is a Koorie who is running the meetings. As a result of this approach, the 1985 and 1986 camps both had around thirty people and by 1987, the camps gained much greater acceptance among Koories with sixty-four people attending!

By and large, most people who attend the camps are pensioners or people who are on very low incomes. They come from all over Victoria, including Horsham, Dimboola, Stawell, Portland, Morwell, Bairnsdale, Mildura and so forth. In addition, the 1987 camp had people travelling down from Alice Springs and New South Wales.

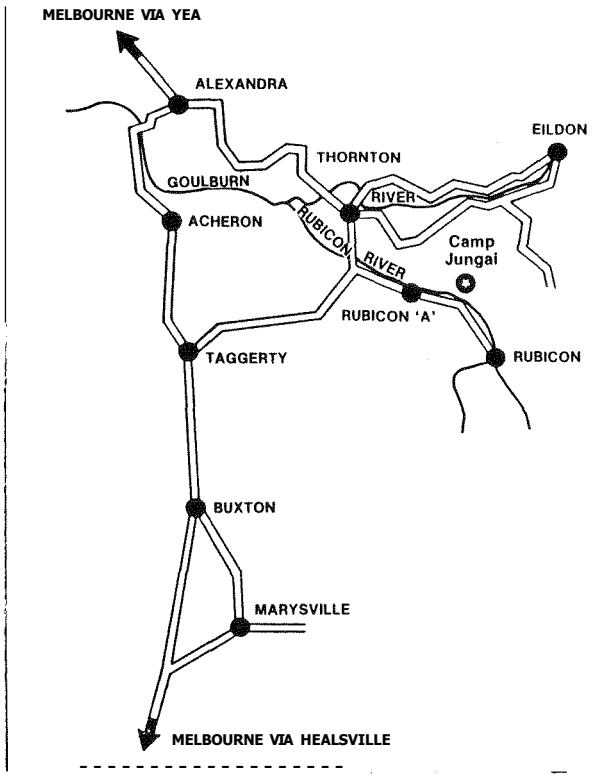
I call these camps 'Togetherness Camps' because they bring people together who don't normally get to see each other - which often happens in our community. A brother or sister live in Bairnsdale and the rest of the family live in Mildura. Diabetes is an inherited disease so the camps have this side benefit of bringing relatives together.

"DIABETES IS AN INHERITED DISEASE SO THE CAMPS HAVE THIS SIDE BENEFIT OF BRINGING RELATIVES TOGETHER"

People come for a variety of reasons, some because they want to be able to help a diabetic father or mother:

"The reason I came here is, I've been associated for over twenty-five years with a chronic diabetic. I came along because I had a compassion but not the understanding of the need for support. " G)

·CAMP· ·JUNGAI·



Photograph courtesy Joan Vickery, Koorie Heallh Unit

"I came (to the camp) to learn about diabetes so I could help my father. It's been good. I learnt a lot about diabetes and health in general. The things I've learnt about eating meat and how the diets changed over the years, I never knew that."

Others attend the camp because they've recently acquired the condition and want more information.

"I've had diabetes for three years... I didn't know anything about diabetes. Nobody had ever sat down and explained it to me".

"I came to the camp cause, well I didn't know I had sugar in my blood till I came to the camp. I knew in my water but not in my blood. Every time I tested it would be negative."

"I've only had diabetes fourteen months. No-one talked to me about diabetes, there were no counsellors at the doctor's surgery. I even went to the library and I couldn't find anything."

The longer term sufferers come to get more information and to meet other diabetics and many come as a direct result of the initial meetings, which precede the camps:

"I've had diabetes fifteen years. I went up to Rumbalara and Joan was there and she said I could come here."

"Being a diabetic for eighteen years, I'm glad I came cause I met a lot of other diabetics. When you don't meet people, you don't know there are so many around... Meeting others with diabetes takes the strain off you."

"Sixteen or seventeen years I've had diabetes. Five out of seven of us in our family had diabetes. I had a brother on insulin and the others on tablets. I came to the camp to find as much info. as I could about it, seeing we were all affected by it."

The camps have a 'holiday' atmosphere and this is an important element in encouraging people to come. Many people have attended several camps and use them as a means of reporting and keeping up their commitment to maintaining changes to diet and lifestyle.

PROGRAM DESIGN

The content of the camps involved contributions from Koories and medicos alike. Prior to the first camp in 1985 a workshop was organised involving key people from throughout the State - Koorics, diabetics, non-diabetics, doctors and health educators. We 'brainstormed' and discussed all sorts of ideas and eventually came up with a five day program which, although it varies a bit from year to year, has been used ever since (sec footnote 2). The program is distributed at each camp and if people want to raise an issue which isn't covered, it immediately gets included in the program. In addition, the participants are involved in an evaluation of each camp. Issues raised in these evaluations are included in subsequent camps.

The emphasis of the program is on participation and practical demonstration. The participation is very important, if the health professionals were doing all

the talking - saying what 'should' or 'should not' be done, people would stop listening, especially Koories. At all times we attempt to link the program to the particular circumstances of people's lives.

SMALL WORKSHOP GROUPS

We spend most of the days in small ·workshop groups which follow the input from the team of doctors, dieticians and diabetes educators. These workshops, through the use of practical exercises, activities and role-plays, allow for real participation and discussion - they give the participants a chance to apply the material to their own lives and circumstances. They also provide the opportunity to share experiences and learn about how each copes with the difficulties created in the lives of Koorie diabetics.

"AT ALL TIMES WE ATTEMPT TO LINK THE PROGRAM TO THE PARTICULAR CIRCUMSTANCES OF PEOPLE'S LIVES."

A further form of participation and empowerment which has been built into the camps is the production, by the participants, of booklets and posters for Victorian and interstate Koorie communities about diabetes and its effects, and about the camps themselves.

The special problems faced by Koories with diabetes go far beyond their lack of knowledge about the condition - they extend right back to the cultural tradition of our people and arise out of the impact of white settlement. During the camps, discussion about these special problems have raised a number of important points.

"... MOST HEALTHY FOOD ITEMS COST MORE THAN JUNK FOOD."

i) **Traditional diet.** Diabetes was rare among Koories prior to white settlement. Now they can't return to their natural high quality diet - few Koories are experienced in obtaining and preparing traditional foods anyway.

ii) **Regulating diet.** Being on low income makes it difficult to buy the right food: "most healthy food items cost more than junk food". "Living in a large family and coping with one diabetic means preparing two sets of meals with two different budgets".

During the c:imp, a day is set aside to look at nutrition and food. In the evening, the meal is designed to follow-up some of the issues which were raised. So for instance, the young men build an underground oven (or 'Hungy') in which the entire meal is cooked - chicken, pork, lamb, pumpkin, potato and cabbage. No fat or oil is used and it demonstrates how delicious a balanced, nutritious meal can be. The same practice is used with fish, where people barbeque their fish in foil, instead of using oil.

"THESE ROLE·PLAYS ALSO EDUCATE THE MEDICAL TEAM AS THEY SEE HOW KOORIES SEE THEM."

iii) **Side-effects.** For diabetics: "Other illnesses are more likely - so it's hard to adjust". These side-effects include weakness in legs; sores on legs and feet; poor eyesight; sleepiness; absent-mindness; unbalanced

Photograph courtesy Joan Vickery, Koorie Health Unit

gait (which can be mistaken for drunkenness and sometimes results in arrests).

iv) **Understanding.** "I don't understand why my diet has to change"; "there's not enough education and information provided".

In addressing these issues, we use practical exercises, such as, blood sugar level tests and role-plays, where we set up a situation representing the roles of doctor and patient. In this way participants learn about their right to ask questions of doctors and to demand a doctor's full attention. These role-plays also educate the medical team as they see how Koories see them. On the day we're discussing hypoglycaemia we take the participants on a walk for exercise.

"..,, WE USE THE EVENINGS AS RECREATION TIME SO THAT PEOPLE CAN SOCIALISE AND GET TO KNOW OTHER PEOPLE..."

Other issues are harder to address, such as:

v) **Medication.** "Most Koorie diabetics live in town camps and have no fridge, that means they have trouble stocking foods and diabetic medicines".

vi) **Isolation.** Their lack of access to medical services creates further problems: "Living in remote areas with no transport means having to rely on health workers".

(These comments were about Aboriginals who live in the centre of Australia.)

Of course the camps are not all work, we use the evenings as recreation time so that people can socialise and get to know other people, including the medical team and organisers. We have darts, hockey competitions, lawn bowls and bingo.

DE-MYSTIFYING PROFESSIONALS

Whilst the camps, themselves, are run by Koories, the education team - which includes doctors, dieticians and diabetic educators - is made up of white professionals, for example, one doctor from St. Vincent's Hospital, one doctor from the Aboriginal Medical Service (Melbourne) and a nurse educator from the Lions International Diabetes Institute. We've been lucky to have had very sensitive professionals who are prepared to listen, rather than taking the standard approach of professionals of just going off and doing what they usually do in a hospital or medical centre situation. Our team members have always been prepared to adjust their approach and follow my advice: before talking to a group, we'd sit down and go through it together - in this way we could fine-tune the content for example, type of terminology used, so as to make it relevant to Koories and acceptable to communities from different parts of the State.

"DEVELOPMENTAL PROGRAMS LIKE THE CAMPS ARE ALWAYS HARD TO EVALUATE IN TERMS OF CONCRETE OUTCOMES."

This sensitivity of the professional is all important, as one participant put it:

"The dietician, the doctors and the nurse, who ever picked them out, well, they were spot on! Especially bow they communicated to the Koories. They were easily understood. It took a couple of days to work out who the doctor was! He blended in so well!"

A big function of the camps is breaking down the suspicion which surrounds medical professionals. Role-plays, involvement by the professional team in all the social and practical activities and the live-in nature of the camps, all help in making the professionals more 'human' in the participants' eyes. At the start of each camp every member of the team introduce themselves - who they are, where they work, whether they are married, how many kids they have and so forth. The general Koorie attitude is: "if you're going to be working with me, I want to know a little bit about you".

OUTCOMES

Developmental programs like the camps are always hard to evaluate in terms of concrete outcomes. The fact that we have had such a huge attendance and interest shown at the camps signifies that the camps are important to the people. It's clear that participants gain a great deal of information and leave with a much clearer understanding of their condition. The following comments were recorded at the evaluation of the 1985 camp:

"I found out a lot I didn't know. I found out about not eating too much meat and eating bread and potatoes and plenty of vegetables and fruit. I met peopie and got to talking."

"...THE CAMPS HELP TO STRENGTHEN THE PARTICIPANTS' WILL TO CHANGE..."

"It was very interesting. Communicating with other diabetics was good and I learned a lot more from them. I learned a lot about smoking and what it does to your feet and legs. I knew what it did to the lungs but not the feet and legs. I liked the discussions. That was good the discussions different people had."

"I've accompanied Ruth over the years to doctors that were dictatorial. I wasn't interested. But here, the collective interest is good. You become involved yourself. Otherwise you're just sitting on the outside. Here this can't happen. It's the result of the discussion groups. The relaxing atmosphere was beneficial to everyone and I'm looking forward to any further involvement in discussion: groups for diabetics."

Whilst responses like these are rewarding for the organisers and show that we have achieved what we

set out to do, they are not the hard, concrete outcomes which the Health Department requires.

"MORE MEASURABLE OUTCOMES HAVE EMERGED IN THE FORM OF INDIVIDUALS SEEKING MORE APPROPRIATE MEDICAL SERVICES."

We certainly can't claim that the camps have permanently changed the participants' lifestyles. It's clear that education alone is not enough - the camps help to strengthen the participants' will to change but circumstances remain the same. Low income make it extremely difficult to stick to the right diet; Victorian Koories are meat eaters so the transition to more vegetables in the diet is hard; and fast food is such a temptation. Nonetheless, small, long lasting diet and lifestyle changes are achieved by some participants, as shown by the following comments:

"The special thing learned was about my diet. I didn't know I could eat bread and potatoes."

"I learned a lot... about this here new diet. If I hadn't a come, I'd still be on that old diet I reckon. And the bread and the spuds are more filling than the meat."

"I learned about the new diet. I was educated in the old way. The new diet isn't so hard!"

More measurable outcomes have emerged in the form of individuals seeking more appropriate medical services. This comes about because the camps help them break through some of the fear and suspicion with which they view white professionals and institutions. For example, one participant who was on medication, but who obviously needed stabilisation, took action following the camp. She came to Melbourne and chose to go to hospital where she received the treatment that she needed. She realised during the camp that her eyesight was being affected by her condition and proceeded to undergo laser treatment and to wear glasses. Her own self-care has also improved. This example is typical and many participants who attend the camps seek out and become more receptive to medical assistance.

"KOORIES ARE ABLE TO RELATE TO THEIR PROBLEM IN THEIR OWN TERMS."

CONCLUSION

It has now been three years since our first camp and each year since we have been attracting greater numbers. People are interested in the camps because of the way they are structured. The emphasis on participation provides the opportunity for Koories to take control of the problem of diabetes, both individually and collectively. The fact that the program looks at diabetes in the context of the particular circumstances and culture of Koories means that Koories are able to relate to their problem in their own terms. The camps have provided people with many benefits: the opportunity to gain greater information on diabetes; to share experiences and other issues of common inter-

Photograph courtesy Joan Vickery, Koorie Health Unit

ests; to strengthen links and for many, to reinforce the commitment they made to life-style and diet changes. We also hope that Koories leave the camps with less suspicion and fear of the medical profession and that the health professionals realise the need for change to the traditional manner in which Koorie diabetics are treated.

FOOTNOTES

(1) Koorie is the term that Victorian Aboriginals prefer to be known by. It is a traditional language term which means:"One of Us".

(2) THE PROGRAM:

Monday

What do you think causes diabetes?

How did you feel when the doctor told you that you had diabetes?

How does it feel being a Koorie and having diabetes?

Is it harder for Koories to follow diabetes treatment? and why?

How does having diabetes affect your life?

Tuesday

Developing lists of food groups:
- Starch (low and high fibre)
- Sugars
- Fat foods (pure and high).

Listing good diet.

How can you reduce your fat intake and still enjoy eating meat?

How can you eat and drink when out, without upsetting your diabetes?

Food for diabetics - our thoughts.

Quick alternative meals at home.
Alternative meals to suit the whole family.
Recipes and Menus.
What are the best kinds of take-away foods?
Group ideas for a leaflet about food for diabetics.

Wednesday

Role-plays by doctors, nurse and diabetic educator.
How do you choose your doctor?
Your rights as a person and so forth.

Thursday

Blood sugar - causes
- how do you feel when you have it?
- what can you do about it?

Friday

Changes needed in this program.
What would you like to learn about?
What was good about this camp?

'Fun' Activities During The Camp:

Boat cruise, Bingo, Bike riding, Dart competition, Hockey

(3) This quote and all others that appear are taken from:Victorian Aboriginal Sugar Diabetes Camp, October 1985. This booklet was produced from comments by the participants of the 1985 camp.

Joan Vickery is a member of the Gundijmara tribe in the Western District of Victoria. Joan has worked extensively with Koorie people across Victoria in legal, welfare and educational areas. For the -past twelve years, she has worked in the health area and is currently a Koorie Diabetes Health Educator at the Koorie Health Unit, Victorian Ministry of Health.

OLDER, HEALTHY AND MOBILE

Joyce Spokes Helen Lewis Estelle Cother Eileen Larkin Beryl Grover Kathy Rush
Marjorie Oke Iris Wileman Ann Graham Lina Cintino Ida Dolinko Elsie Warren Cathy Tibbett
Del Brown Lois Shugg Sam Watchorn Sheila Baldwin Ada Handyside Ethel Butcher Val Goad Reg Warren Cliff Dodd
Shirley Wilson Rosei Visione William Atkin Doug Butler Peggy Stenberg

This case study focusses on the evolution of a health centre run hydrotherapy group into an independently run self-help group.

The group, largely composed of older women who are on full pensions, has since expanded its activities to include bus trips, newsletter production, massage and the publication of a book. The self-help group fulfils the physical, emotional and social needs of the group.

The group has taken the concept of self-determination further by lobbying for funds to ensure the provision of appropriate resources.

People in the group have shown remarkable improvement of health. The undeniable changes in physical health is a result of hydrotherapy and massage. The improvement in mobility, the companionship and friendship of others has enhanced their sense of empowerment and purpose to lead a full and active life for as long as possible.

BACKGROUND

In the early 1980's, the physiotherapist from the Northcote Community Health Centre (NCHC) in Melbourne was treating people for a variety of health concerns - Repetitive Strain Injuries (RSI), arthritis-related pain, injuries related to car accidents and incomplete movement ability. The physiotherapist found that some of her patients were not responding to the treatment which she was giving them, so she decided to try hydrotherapy, that is, gentle exercises in warm water. This proved to have beneficial results and soon the physiotherapist was taking two groups of women to hydrotherapy at the YWCA pool.

"MANY••• GDING TO HYDROTHERAPY ••• HAD DIFFICULTY GETTING ON AND OFF TRAMS AMO BUSES, AND MANY COULD NOT WALK VERY FAR..."

The two groups were quite mixed - there were a variety of new and older migrants, as well as Australian-born women, between the ages of thirty to eighty-four. Our group consisted of mostly older women on pensions, who lived in the northern suburbs - Northcote, Thornbury, Fairfield. Many of those going to hydrotherapy at this time had difficulty getting on and off trams and buses, and many could not walk very far - so the physiotherapist had to pick them up and take them home again.

It wasn't long before the physiotherapist's faith in hydrotherapy started proving its value. Recently when we met to talk about our involvement, one person summed it up when she said:

"We all feel that the exercises have been wonderful, not only the exercises, but also being at the pool with people means a lot."

'Health wise' we are all much better, everyone is 'swinging' more freely from the hips, much pain has disappeared or lessened and people are saying how 'young' we are all looking. In fact, many who came to the sessions with walking sticks, back braces and such, and those whom we had to push and pull onto and off the bus are, after regular hydrotherapy sessions, able to walk to the trams or bus stops; once again use public transport; do their own shopping and some have even put away their walking sticks!

The following comments are typical of what hydrotherapy and being together has done for us:

"I have four of my disks in my lower spine worn out with arthritis, and my knee as well. So a Jew years ago, my doctor suggested hydrotherapy. up till that time, my life was miserable because I had to wear a metal brace to be able to walk... my life and health since then has changed for the better. It keeps me going... we became like a 'close family'... I don't know what would I do without my friends... "

"...THERE'S A YOUTHFUL ENERGY IN OUR GROUP••• THAT GIVES PEOPLE THE WILL TO CARRY ON.'

"I suppose God gave us water for many purposes, healing and faith, pleasure and business, a power of strength in its own right, so why not? To bring better health and happiness to sufferers of arthritis, disabled people, and a lot of social happiness to many lonely, forgotten and sick people. "

"... the group in the baths, even doing our exercises in the baths is much more Jun than standing there doing them on your own... "

Photograph courtesy Jan McDonald

We ail feel that we have really proved something, not only to ourselves, but to our doctors. A common experience amongst members of our group has been going to doctors with a complaint, and being told: "Oh it's just old age". Well, we're tired of being told that and now we have found something that we can do for ourselves. Everyone tells us how much better we look, there's a youthful enerb'Y in our group; an enthusiasm, goodwill, good spiritedness and friendship that gives people the will to carry on.

Some members of our group have been told by their doctors that hydrotherapy is a waste of time and doesn't do any good anyway. Now members can go and show their doctors that it didn't waste their time and that it was worthwhile. Doctors need re-educating on a whole lot of things and our group is doing that.

ON OUR OWN

We had been going to the pool with the physiotherapist for about eighteen months or so, when she told us that the doctors were referring so many new people to hydrotherapy that she couldn't cope with all the numbers. She then suggested that we organise ourselves.

We were happy to do this, but it meant that we had to hunt around for another pool because up until then the Health Centre had been subsidising us at the YWCA. As we were all pensioners, we felt we couldn't afford the three dollars a week that the YWCA charges. Therefore, we looked around at various pools and found that we were either, unable to get a convenient time or had to go in with the school kids, and one pool was designed in such a way that we basically had to be contortionists to get in and out of the water. The Melbourne City Baths, however, had just been renovated and were beautiful: nice, airy and sunny. We found that we could get in at the time we wanted at a pensioner concession rate. As one group member had a swimming qualification, the City Baths were willing to accept her as the leader; she was responsible for the group and led us through the series of exercises that the physiotherapist had shown us. The physiotherapist advised her on what exercises to do with people who had particular problems. Now, another member takes turns leading the group in exercises and when these two members are away, the group does exercises without a leader! Every now and then various members introduce new exercises that they have heard of, such as exercises for incontinence or for the

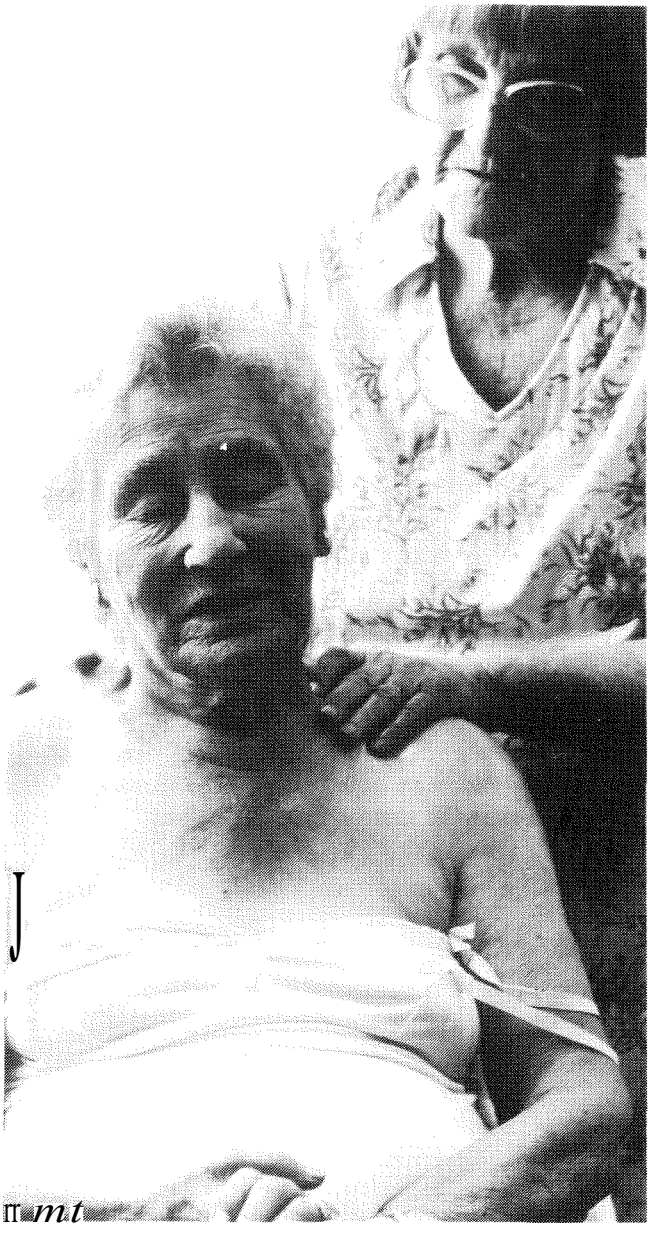
"As ONE[IROUI' MUUIBEII HADA SWIMMING QUAUFICATIIIi, THE CITY BATHS WERE WILLINGTO ACCEPTIIER AS THE LEADER; SHE••• ml us THROUGHTHE SERIES OF EXERCISES THATTHE PHYSIOTHERAPIST IIAll slowll us."

eyes; we just learn different things as we go along.

The City Baths provided a good environment, but we did have a few problems getting the water to be the right temperature. We lobbied and carried on a two year campaign with letter writing to the manager and the Melbourne City Councillors, but they said they couldn't do anything because the other people who practiced swimming in the big pool needed it cooler than we did for hydrotherapy. We then found out that the Box Hill Baths had three different temperatures, so we dug the manager out and asked him to find out how they do it. With this information the Melbourne City Council was able to finance the desired changes in their next budget. They eventually got it right, but if we hadn't kept up our moaning and groaning, it wouldn't have happened.

'WITH THIS INFORMATION THE MELBOURNE CITY COUNCIL WAS ABLE TO FINANCE THE DESIRED CHANGES BUT IF WE HADN'T KEPT UP OUR MOANING AND GROANING IT WOULDN'T HAVE HAPPENED.'

Photograph courtesy Jan McDonald



INTRODUCTION OF MASSAGE

Recently we've introduced massage into our activities. This came about because one of our members had been having face massages and had found it to be beneficial. So we applied to the Women's Trust Fund for funding to learn massage and were successful in receiving a small grant. The Health Centre made a room available for us to use for massage and a masseuse came there to teach and massage us. We soon realised that the amount of funding which we received was not enough, so with the assistance of the Local Council and Community Health Centre, we obtained more funding which lasted until Christmas. In 1986, we gained a self-help health grant from the Ministry of Health to further our activities.

When we are massaging each other, if we have any doubts about what to do, we ask the masseuse: "What about this or that?", and she'll come over and check something out. She keeps her eye on us, and new members are treated by her before we get to work on them. She advises us what to do.

Most people who have the massages find that they are very good for pain and tension as the following demonstrates:

"... since we've introduced massage into our group, my neck gets done every week, my face gets done every week, my sides are better, I don't get the aches and pain anymore..."

One person in our group, who is in her eighties, lives in a very stressful home situation and comes every week to have the tension massaged from her neck and shoulders. Someone suggested that she should sort out her problems and not depend on massage. However, her situation is very difficult - looking

after her husband who suffers with emphysema; so she has her massage and finds that it helps her to cope for another week.

"MOST PEOPLE WHO HAVE THE MASSAGES FIND THAT THEY ARE VERY GOOD FOR PAIN AND TENSION."

Everybody involved in the massage works together, the Health Centre's physiotherapist and our group are very thorough about the medical side of what we are doing.

Since we started the massage, five men have been referred to the group, although they are not doing hydrotherapy - only massage. One of the men used to have very swollen ankles: the flesh just stood out around them but with massage the swelling went down. One of the others has spondylitis, a condition in the spine which results in pins and needles in the feet - this is what he has to say about massage:

"THE COMBINATION OF THE HYDROTHERAPY, MASSAGE AND THE COMPANY HAS GIVEN US ALL A SENSE OF 'YOUTHFUL' ENERGY."

"... my feet, although still with pins and needles are only about a quarter as painful as they were. One time I couldn't bear to stand up, on account of the loss of blood in my feet, they were more or less dead. They're not now..."

The combination of the hydrotherapy, massage and the company has given us all a sense of 'youthful' energy.

THE EARLY DEVELOPMENT OF OUR SELF-HELP GROUP

In the early days when we started going to hydrotherapy, we were simply an informal group of women. However, in 1984, whilst on the way to the baths with the physiotherapist, one of our members said:

"Oh, I haven't seen this part of Melbourne for so long - it's lovely to go here."

A few of us felt it would be great if we could take trips together and get out more, especially those who have great difficulty with mobility. We knew that we could get the Council bus on the weekend - but we needed to pay for a driver. We all thought that having each other's company would be good. As one of our members said:

"You go up shopping, you never meet anybody you know... that's the point - loneliness..."

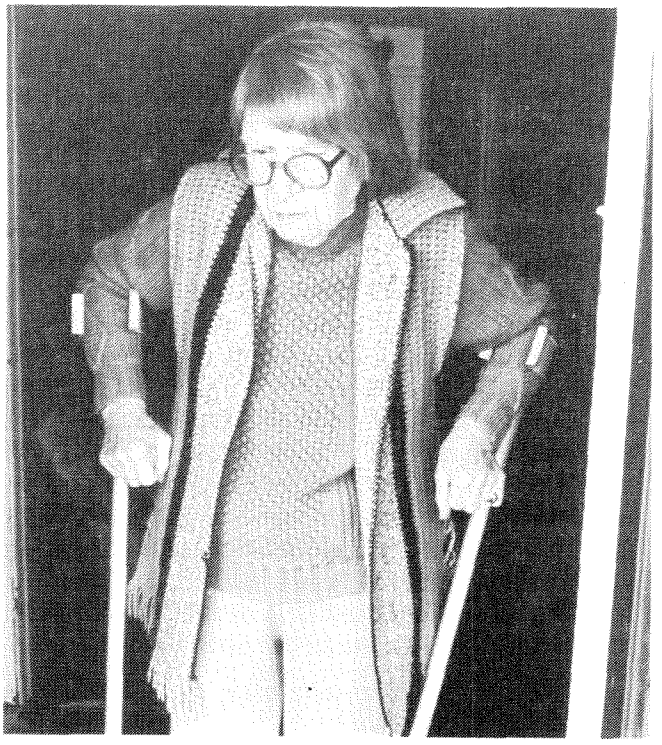
We spoke to the physiotherapist about the idea of bus trips and she agreed. One of our members went to see the Council's Recreation Officer, who gave us a form to apply to the Department of Sport and Recreation for funds for a driver. At first people in the group did not have very high expectations or enthusiasm about getting the funds - they were not accustomed to asking the Government for money, usually they were the ones paying out. The physiotherapist helped us with the submission and the Health Centre offered to receive the funds on our behalf (as they are an incorporated body) and provide us with the services of their treasurer and auditor. We were successful in this submission - we got $1000! It was at this time that we came to call ourselves the 'Northcote Hydrotherapy Self-Help Group'.

We wasted no time. Our first trip was to the Begonia Festival in Ballarat; since then we have had trips to Point Leo, Phillip Island, Lorne, Hanging Rock and other areas. One of the members has taken on the job of tour organiser; she arranges the bus, maps and program for the day. These outings have been successful in getting people out of their homes and encouraging people to be active in the company of others, as demonstrated by the following quote:

"... we had our lunch at Stevenson's Falls. Before that we went for a walk, to see the water falling down. I shall never forget that view. Some of the very 'brave girls' climbed to the top."

Recenlly *we* learnt that Arts *Access* has 'Ease Tickets' which help groups on low income and people with disabilities to have cheaper admission to entertainment. This is really wonderful for us as we can now, individually or as a group, enjoy theatre, which was once beyond our means. The play: "Seven Little Australians" was our first outing. We are happily looking forward to many more such pleasurable times.

"... WE WERE ONCE ISOLATED AND IN SOME CASES LIVING ALONE, WE NOW HAVE EACH OTHER'S SUPPORT."



Great friendships have developed amongst us all; where we were once isolated and in some cases living alone, we now have each other's support. In particular those who have come from overseas, places like the British Isles, Poland and Italy feel warmly accepted and part of the group. They talk of Northcote as their home.

OUR COMMITTEE

We have what, technically, can be described as a 'committee meeting'; once a month we get to the baths an hour earlier and talk about how things are going and what we've arranged. For example, our 'tour leader' asks us to suggest where we would like to go; or our 'submission writer' reads what she has written. If there is anything contentious, we sort it out at these meetings and get a majority decision on it. No-one goes off and makes decisions on behalf of the group, everything comes back to the group - it's a democratic process.

We also meet to plan our newsletter and from time to time everyone contributes things that interest them. We use the Health Centre's photocopier for the newsletter, but pay for our own paper. Our editor, who is eighty-four, was once a journalist, poet and cartoonist.

EDUCATING THE COMMUNITY

In October 1987, the Director of Wyuna Nursing Home asked if some of their clients could attend our hydrotherapy classes. Those that came had severe disabilities: they came in wheelchairs, were lifted into the pool by nurses and held all the time they were exercising.

They joined in our 'hokey-pokey' exercise and one woman, who had very little use of her arms, amazed the nurses by being able to get her hands under her chin. The nurses could also faintly hear her singing 'hokey- pokey', whereas they had previously thought that she had lost her speech ability.

"...WE ARE IN THE FORTUNATE POSITION TO PASS ON OUR EXPERIENCES TO THE COMMUNITY IN THE FORM OF A BOOK."

It's important to us that people in nursing homes be integrated into activities like ours, as we feel that this would improve their lifestyle.

All our members feel that we have gained great benefits from being involved in hydrotherapy, massage and self-help. Now we are in the fortunate position to pass on our experiences to the community in the form of a book. We were inspired by the work of a photography student from the Australian College of Photography, who approached us at the baths and asked if she could take photos for her assignment, entitled: "From Dark To Light". This title was symbolic of her change of attitude to being old. When she met us she was afraid of old age:

"... but since meeting you all, I have grown from a dark attitude to a light attitude to old age; I am not afraid anymore."

We decided that it would be wonderful if that theme could go everywhere and so we applied to the Consumer Health Forum for some funding to establish our own book, entitled: "Growing Older Is A Lifelong Process. Enjoy It!". We were successful and are currently working on the book. The same photography student (who has now completed her course) is helping us put the book together - she is doing some taped interviews and we are using her photos.

THE FUTURE

For the past three years we have been talking to the Northcote Councillors about a pool for hydrotherapy. There have been some discussions between the City Engineer, the Town Planner and the Health Centre. Plans have been drawn up and leaving nothing to chance (or the experts) we made it our business to see the plans and suggested changes, so as to ensure that the need5 of older people arc taken into account. Unfortunately, at this time the Council do not have the funds for their plan, but we keep our fingers crossed and hope that we might one day, have a hydrotherapy pool in Northcote.

IN SUMMARY

Our group is probably successful because of the support from the Northcote Community Health Centre - Committee and staff - who were and are happy to help us. Our physiotherapist who took us to hydrotherapy was certain that we would be able to develop as a self-help group. We could ask her for advice, as well as other staff members, who were prepared to give their time when we called. We have

always felt that they loved us and were happy to see us developing and carrying out new ideas.

We knew we had good medical care and advice when we did think up new ideas. We have never been a sub- committee of the Health Centre, we have always made our own decisions; we talk things out and have become more articulate. We are pleased to be independent and not waiting for someone else to organise us. In our group, people are willing to do the jobs which need to be done, like writing the newsletter, being the tour leader and sending 'get well' cards.

"... WE HAVE ALWAYS MADE OUR OWN DECISIONS... WE ARE PLEASED TO BE INDEPENDENT AND NOT WAITING FOR SOMEONE ELSE TO ORGANISE US."

Being independent is very important to us, we are all determined to die in our own beds and not go into nursing homes. There are only two of us who have home help and with the future development of the Home and Community Care Program and the extension of the Domiciliary Care Program, we should be able to have our wishes fulfilled.

Perhaps, indicative of what this group has done for its members is the example of an eighty-seven year old member who recently took a trip to China with her son, and then went onto Queensland on her own. She has no help at home, and can still find the energy to look after her great grandchildren - even more remarkable considering that when she joined the group she had two walking sticks, calipers on her knees and a brace on her back, all of which in her own words she:

"... hung them on the wall and said: you bloody stay there'."

You could question whether it's the company and outings, or the massage or hydrotherapy which has had such beneficial results, but really it's a combination of all of these. As one member said:

'You get in there and you forget everything, whereas when you're home, you sit around and you're thinking everything and you make yourself ill."

"... AN EIGHTY-SEVEN YEAR OLD MEMBER... RECENTLY TOOK A TRIP TO CHINA WITH HER SON... WHEN SHE JOINED... SHE HAD TWO WALKING STICKS, CALIPERS ON HER KNEES AND A BRACE ON HER BACK...'

Sometimes it can get very lonely in Northcote, even though some of us have lived here for over sixty years, when we go up the street we might not meet anyone we know.

Our group will continue going probably until we drop dead, or as long as we can get onto a bus or tram. Our ambition is to spread this message of self-help, dignity and independence to senior citizen groups, health centres and such places around the country. Our work should help to do that.

OTHER CASE STUDY REFERENCES