

Strengthening Community Health

The Report of the Consultancy and Evaluation Project, Undertaken by the Community Development in Health Project in Collaboration with Five Community Health Centres and with the Support of the Victorian Health Promotion Foundation.

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1. EXECUTIVE SUMMARY

This is the report of the Consultancies Project, undertaken through 1989 by the Community Development in Health Project (CDIH) and funded by the Victorian Health Promotion Foundation.

Context

This Project was premised on the view that, in addition to delivering health care locally, community health has a strategic role to play in health promotion through its community development approach and its potential role in the development of primary health care.

(The strategic context of the project is discussed In Section 2.2.)

The Consultancies Project had two aims.

The first aim was to clarify the kind of strengthening needed by community health (especially in relation to community development) in order for it to play a more strategic role in health promotion. This need was to be assessed through working in depth with a small number of community health centres and in the course of providing one-off workshops.

The second aim was to evaluate the usefulness of the CDIH approach, its acceptability to, and the potential demand from the community health field. This was to be carried out through evaluating the consultancy and support service provided and reviewing the framework with which CDIH works.

(More detail on the background to the consultancies is provided in Section Two.)

Consultancies and Workshops

During the course of the project, CDIH worked closely with five community health services and a regional resource worker, as well as undertaking one-off development and training workshops with 24 community health organisations.

The services provided by the Project included small group discussions, facilitation of workshops and one-to-one support as well as access to other resources.

The consultancies focused mainly on issues associated with planning and evaluation, the

role of committees of management, community health principles, the Ottawa Charter and community development.

(An overview of our general approach to the consultancies is presented in Section Three. A detailed record of each of the five consultancies and the workshops is provided as Appendix One to this report. An analysis of the main themes and issues addressed in the consultancies and the workshops is provided at Section Five.)

Evaluation

An in-depth evaluation of the consultancies project was undertaken. The four main areas to be evaluated were:

- our practice in providing consulting and advisory services and in running workshops (including our material resources),
- the usefulness of our contribution to the work of our partners,
- our understanding of community development in health, and
- prevailing understandings and practice in the community health field.

The evaluation was conducted within an action research framework in four stages:

- documenting our consultancy work and workshops,
- collecting feedback through evaluation and review discussions (facilitated by an independent evaluator) and through on-site evaluations of our workshops,
- identifying the main issues and themes addressed during the consultancies and in the workshops
- reflecting systematically on these main issues and themes in relation to the main areas of the evaluation, listed above.

(A detailed discussion of our evaluation strategy is to be found at Section Four.)

Conclusions

Effectiveness. The CDIH approach to its consulting and advice function has been recognised by our community health partners as strengthening community health practice.

Our consultancies have been associated with improved practice in all of the centres with whom we have worked.

(The usefulness of our contribution to the work of our partners is discussed in Section 6.2; see particularly the discussion of "effectiveness" from page 74.)

Validity. The CDIH Framework for understanding and practising community development in health is affirmed as valid by the practitioners with whom we have worked.

(See the discussion of "validity" from page 77.)

Accessibility. The CDIH approach to community development in health has been found to be accessible and implementable, in large degree, for most practitioners. Some people have had difficulty in getting access to some elements of the framework but for almost all workers there are sufficient accessible entry points to engage the framework at some point and to receive the feedback needed to sustain and further develop their understanding and practice.

(See the discussion of "accessibility" from page 79 and the concept of "developing and sustaining" from page 84.)

Our Practice. The presentation and style of the CDIH staff has proved to be an important asset in working in community health. The fact that CDIH is actually reflecting back to the field the strengths of its own experience facilitates relevance, communication and trust building. For many, the experience of working with CDIH has been energising and revitalising.

We have identified some areas of our practice which need further development. We need to develop more varied presentations and protocols in our consulting and workshops. We need to provide for improved support to our workers.

We have more work to do with respect to being accessible to people who do not have a strong theoretical base or who do not identify with the core values of community development. We need to find different ways of working alongside such people, finding common ground, listening to (and learning from) their perspectives and challenging their assumptions where appropriate.

(Our reflections on "our practice" and "learning how to do it better" are discussed in Section 6.1 from page 69.)

Resources. The Resources Collection has been an important asset in the consultancies. It has been useful, on occasions, for our project workers to be able to refer to individual sections of the Resources Collection. The way in which it has been received by the community health-

field has given us credibility with our partners. It has also given us confidence in our own analysis and in the line of suggestions we are likely to offer with respect to practice.

A range of other resources have also been used in the consultancies and workshops. There is a need to develop this range.

(See discussion of material resources from page 71.)

Community Development in Health. We have reflected on the integrity of the basic CDIH Framework. In particular, we have examined the challenges and resistances which we have experienced during the consultancies, including resistances to the theoretical insights, to the core values and to the suggestions regarding practice that characterise the CDIH approach.

None of these challenges has revealed serious weaknesses with respect in the Framework. Indeed, our experience in the consultancies has helped to clarify the nature of the issues that we are trying to address and has assisted us to develop our ideas further.

There are confusions about community development within the community health field. These are most clearly expressed in relation to terminology, for example, the meaning of the notion of "empowerment". These confusions will need to be addressed through further discussion and reflection in the field.

(Our reflections on community development in health generally are discussed in Section 6.3, from page 90.)

Community Health. There is a clear interest in community health in exploring a more strategic role in health promotion and in primary health care. The ideas and directions suggested by the Alma Ata Declaration and the Ottawa Charter have been part of the CDIH workshops and have been well received.

The kind of developmental health practice which flows from the implementation of the community development in health framework is fully consistent with the strategies and directions sketched by the Ottawa Charter and the Health For All commitment. However, whilst a strengthening of community health in relation to community development is necessary; more than this is needed to realise the strategic role of community health. Stronger community development practice needs to be located more clearly within a primary health care framework.

Whilst there is interest, there needs to be substantial resourcing within the community health field about the implications of Alma Ata and the Ottawa Charter.

A number of issues of community health practice have emerged in the consultancies and workshops. Superficially, these are about basic skills such as strategic planning, community based management, evaluation and accountability, blending health work and community development. However, these are not simply skills issues. Skillful practice in these areas is informed by a broader theoretical framework and derives direction from a set of values. In some degree, weaknesses in these areas reflect a dearth of theory and in some cases a blurring of vision.

However, there are no ready made channels for introducing new ideas into community health; the field is not easily accessed by policy pronouncements or by policy manuals. There is some resistance to abstract ideas. The dispersed and autonomous nature of community health (which is one of its strengths) precludes requiring people to participate in staff development and training sessions. Initiatives aimed at strengthening the understanding of community health must be undertaken developmentally; starting from where people are at and building on that.

The process of documentation and reflection, learning from practice is a key to the strengthening of community health. This is needed in community health settings and at a more general level in relation to the whole field. One-of the main strengths of CDIH is that it has mediated this reflective process, in the development of the Resources Collection and in the consultancies and workshops.

Community health needs additional support in relation to health promotion and primary health care as well as in relation to the skills needed for the practice of community development in health. Such support must be undertaken in a developmental way. Community health also needs clearer leadership in relation to the meaning and content of its work; that leadership must come from within the community health field itself; owned by and accountable to the field.

(Our reflections on the needs of community health are discussed in more detail in Section 5.4, from page 9.9.)

A Resource and Support Unit for Community Health.

We have outlined our conclusions regarding the kind of strengthening that community health would need to enable it to play a more strategic and leading role towards better health.

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Although we have not undertaken any kind of comprehensive review, many of our conclusions correspond to those of previous reviews ¹.

Whilst we have not attempted to put together a comprehensive strategy for change we believe that the results of this project point very *strongly towards the* need for a resource and support unit in community health to continue the kind of work that CDIH has been doing through this project.

The establishment of a resource and support unit could have a major benefit in terms of health promotion and social justice (in particular through addressing the challenge of inequalities in health).

Some of the conditions for success would be that it is accountable to the field; that it respects and builds on the experience and achievements of the field; that it provides skills development in the context of an explicit commitment to Health For All. Promoting the practice of community development in health would be a vital part of its work.

The Community Development in Health Project (CDIH) would provide an ideal foundation upon which to build such a unit.

(We discuss the kind of resource and support unit that we see as needed in Section 6.5 from page 104.)

In summary, community health has a leading strategic role to play in achieving Health For All and reorienting the mainstream health system. The community health sector will need to be strengthened if it is to be capable of realising this potential. The resource and support role which has been played by the CDIH Project has the potential to contribute significantly to the strengthening of community health and primary health care generally in Victoria.

1.1 How This Report is Organised

You may wish to read only part of this report.

Section Two outlines the background to the project, including a discussion of the broader strategic context.

Section Three provides a brief overview of the consultancy and workshop program. A detailed discussion of our evaluation strategy is presented in Section Four.

1. Australian Community Health Association (1986 Review of Community Health Program, ACHA, Strawberry Hills, NSW, 1986.

A general analysis of the main themes of CDIH's work with each community health centre and in the workshops is given in Section Five. More detailed accounts are presented in Appendix One.

Our conclusions and recommendations are developed in Section Six.

1.2 The Victorian Health Promotion Foundation

The Steering Committee of the CDIH Project gratefully acknowledges the support of the Victorian Health Promotion Foundation in the design and funding of this project.

We believe that this report breaks new ground for the community health field. Because of the wealth of information generated in the consultancies and its significance for health promotion and community health the Steering Committee of CDIH mobilised additional resources to undertake a more thorough evaluation than would have been possible within the original VicHealth grant.

The reporting obligations included in our Funding Agreement with VicHealth are met through this report. However, in order to present the transactions and findings of the project in a coherent and accessible format, this report is ordered somewhat differently from the sequence of undertakings documented in the Agreement. The original commitments with respect to the evaluation of the project are listed in Appendix Four, cross referenced against the relevant sections of this report.

1.3 Acknowledgements

The Steering Committee of the CDIH Project acknowledges gratefully the assistance of the following people.

First and foremost, we acknowledge the collaboration of the committees of management and staff of the community health centres with whom we worked. We have referred to them as our "partners" throughout the report to best convey the reciprocal nature of our relations. Our words may not capture the spirit and the drive of the staffs and committees with whom we have worked. We hope they have benefited from our partnerships; we have certainly learned a great deal about community health from them.

Likewise we are grateful to the numerous participants at the various workshops that we have participated in. Their sharing of their experience and concerns, their triumphs and depressions, has been a great source of understanding for us.

We are grateful to the Preston and Northcote District Health Council, Inc who are our host and landlord at 230 High Street. The DHC has always been most cooperative and flexible in accommodating our needs. It would be hard not to be grounded in community development in health living with this district health council.

We are also grateful to the staff of the Community Health Programs Section at the Health Department, Victoria, in particular, Tony Diamond, Maree Martinus and Joanne Gillies for helping out so willingly on so many occasions.

A special thanks to Angela Hill who has provided peer support to Maria and Silvana throughout their period with the Project.

We acknowledge gratefully the assistance of Rick Hudson in relation to the evaluation of the consultancies project. Rick contributed to the evaluation design, he worked with Maria and Silvana in planning and undertaking the evaluation and review discussions, he conducted the interviews and he assisted us in identifying the main themes and issues from each of the consultancies.

Rae Walker also provided valuable advice in relation to the design of the evaluation.

For comments on earlier drafts of this report we are grateful to Yoland Wadsworth, Sally McManamy and Gillian Ednie.

2. INTRODUCTION AND BACKGROUND

2.1 The Consultancy and Evaluation Project

In late 1988 the CDIH Project proposed to the Victorian Health Promotion Foundation the setting up of a consultancy and resourcing capacity focused around the practice of community development in health (including health promotion) and targeted primarily at the community health field in Victoria.

Community health agencies are some of the most significant initiators of health promotion and disease prevention activities'. Further, a number of community health centres have included a strong emphasis on the community development approach to their work over the years; an approach which has been given strong endorsement as a key health promotion strategy,^{2 3}

Funding was sought on the grounds of an identified need for training and development support for community development work. This need had surfaced strongly during our consultations with the field in the preparation of the Resources Collection in 1988.

The Foundation suggested that it would be more appropriate to establish the consultancy and resourcing capacity on a pilot basis; for it to work closely with three community health centres as well as providing one-off workshops and for these to be evaluated to determine whether an on-going service such as CDIH was proposing would be justified.

Negotiating, Recruiting and Accepting Work Partners

It was agreed that the Project would work in a partnership/consultancy role with a small number of community health organisations, evaluating the usefulness of the kind of consultancy service that CDIH was proposing in the context of the specific work programs negotiated.

The notion of working with a small number of specific identified partners was a condition of grant from the Foundation. This meant that the Project had to identify partners and confirm the proposed work programs within a

Ministerial Review of Health Education and Promotion, Victoria, (1986), See especially Chapter 2.

Better Health Commission (1986), "Looking Forward to Better Health", Volume 1.

Health Targets and Implementation Committee (1988), "Health for all Australians", Report to Australian Health Ministers.

short time. CDIH inviting community health centres to join the project was the reverse of what would be a more normal relationship with the community health centres approaching CDIH.

The centres which agreed to become partners for this project were:

Kiewa and ovens Valley Community Health Service,
Broadford *Community Health* Service, and
Box Hill Community Health Centre.

As the project developed, two new partners were added:

King Valley Community Health Service, and
Brunswick Community Health Centre.

The detailed work programs agreed with each of the partners at the commencement of the consultancies are outlined in Appendix One.

The nature of the Broadford Community Health Service's involvement changed during the year and the work with Broadford Community Health Service evolved into a *consultancy with* the North East Regional Community Development officer *and* the Regional Community Health Advisory Group.

The circumstances of the changed involvement of Broadford and the joining of the project by King Valley and Brunswick are outlined in Appendix one.

Workshops and One-Off Consultancies

It was agreed that the Project would reserve a limited amount of time to work with other community health organisations which might from time to time approach us for help. It was agreed that we would be aiming to evaluate the CDIH approach in the context of these one-off activities also.

In fact, during the course of the project we have been approached by a large number of community health organisations and individuals seeking advice or offering possibilities of collaborative work. Where possible we have sought to include them in our program.

A detailed account of the Workshop Program is provided at Appendix 1.6. An analysis of this work is included in Section 5.6.

2.2 The Strategic Context

The CDIH Project has emerged from the experience of the *Victorian community health* field. However, it is also consistent with, and part of, more global policy trends and developments in public health and health promotion.

Some of the key elements of this broader strategic context include:

- the Primary Health Care strategy of the World Health Organisation,
- the Ottawa Charter for Health Promotion,
- the national Health For All commitment, in particular the National Better Health Program, and
- the Continuing Education for Primary Health Care Report.

Primary health Care.

The agencies and services which in Victoria are referred to as "community health" are described in some circles, interstate and overseas, as being part of the "primary health care sector". It is necessary to appreciate this in order to understand what is happening in community health in Victoria in the context of broader debates about primary health care.

"Primary health care" has been the focus of considerable debate. The term has been invested with meaning beyond its face value, in particular by the World Health Organisation. This has created some confusion.

The key to understanding the debate (and the confusions) is to appreciate that the term "primary health care" is used concurrently (or alternatively) in three ways:

- to describe a level of service delivery,
- to characterise an approach to health care generally and
- as a strategy for reorienting the whole health system.

Some definitions⁴ emphasise primary health care as a *level of service delivery* the point of initial and ongoing contact. The characteristic features of primary health care, as a level of service delivery, include: accessibility, a generalist orientation, continuity of care and a recognition of the family and social context of illness.

4. Australian Health Ministers Advisory Council (1989) "Continuing Education in Primary Health Care", Report of a Consultancy, see Appendix One.

The WHO recognises primary health care as a level of service delivery but suggests a broader interpretation; primary health care as an *approach to health care*. The five basic principles underlying primary health care as an approach⁵ include:

- equitable distribution of resources
- community involvement
- focus on prevention
- appropriate technology
- multisectoral approach.

This interpretation is based on the Alma Ata Declaration, endorsed by the World Health Assembly in 1979 as part of the global strategy of Health For All by the Year 2000.

In trying to reconcile the notions of primary health care as both a level of service delivery and as an approach to health care generally it is useful to view it in yet another dimension, namely, as a strategy for change.

Primary health care, as a strategy for change, is aimed at using the primary health care sector as the leading edge in redirecting the development of the whole health system (and the ways in which society conceives health) along the lines suggested by the primary health care approach.

The arguments for harnessing the primary health care sector as part of a strategy for reorienting the whole health care system are several. Firstly, primary health care (as a sector) operates directly with people, in their families, in their communities, in their broader society. If the rest of the system is to be encouraged to give higher priority to whole people and to the social context of health, then it makes sense to strengthen that sector which is most imbued with this perspective.

Whilst primary health care practitioners may have an interest in promoting a social view of health, the communities that they are serving have an even more direct interest. As well as having a direct interest in such a reorientation, as consumers; as members of the broader body politic, they have a capacity to influence the development of health and of health services.

A major strength of the primary health care (sector) is the potential for building greater community involvement in health.

5. World Health Organisation (1986) "Information Package for Health For All Leadership".

The Ottawa Charter .

The Ottawa Charter (1986) picks up the main themes of the primary health care approach, repackaged in terms which have proven more accessible for the developed industrial countries of the West.

The Charter affirms that the preconditions for "health for all" are essentially social: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

It characterises the basic strategies of health promotion as "advocate, enable and mediate".
The *five action slogans* are:

- build healthy public policy,
- create supportive environments, strengthen community
action develop personal skills,
- reorient health services.

Whilst the Ottawa Charter does not have the same emphasis on primary health care as earlier WHO papers, the primary health care sector (or level) remains strategically central to its implementation.

The primary health care level is the level at which advocacy, enabling and mediation are most natural. It is the level at which personal skills and community action can be developed most effectively. It is the level from which community pressure for healthy public policy, more supportive environments and for the reorientation of the whole health system can arise.

The National Better Health Program is Australia's response to the Global Strategy of Health For All.

The Report of the Health Targets and Implementation Committee (1988) reiterates the basic principles of both Alma Ata and Ottawa and again affirms the central and strategic role of the primary health care sector in implementation.

"Primary health care is a vital but neglected locus for illness prevention, health promotion and the reduction of inequalities in health. It is the first point of contact on health matters for the community and involves especially general practitioners, pharmacists, community nurses

and others. Developments to ensure the full use of the potential of primary health care for prevention [are] required."⁶

The Report affirms the potential role of the primary health care sector in health promotion but recognises some of the barriers to that role being fully realised. These include inadequate educational support and disincentives arising in the remuneration structures for general medical practice.

Continuing Education in Primary Health Care

The need for greater educational support for primary health care was addressed in more detail in the 1988 AHMAC consultancy on continuing education in primary health care.

The report of this consultancy reviews the status of primary health care in Australia, its strengths and weaknesses and presents a comprehensive set of recommendations designed to extend and strengthen the educational resources available to primary health care practitioners.

Community Development in Health

The role of community development in health is a complementary theme which has emerged within community health in Australia over the last 15 years⁸

The values, the theoretical framework and the practice of community development are fully compatible with the primary health care approach but are not referenced within the health system particularly. They are more oriented to understanding and addressing the specific circumstances of less powerful and more marginalised groups in society, including their health disadvantage.

Over the last two years the Community Development in Health Project has worked in a close relationship *with the* community health field (nationally as well as in Victoria) to articulate and systematise a framework for understanding the social context of health and illness and for adopting a community development approach in relation to health issues⁹.

Health Targets and Implementation Committee (1988 "Health for all Australians", Report to Australian Health Ministers.

Australian Health Ministers Advisory Council (1989) "Continuing Education in Primary Health Care", Report of a Consultancy.

Community Health Studies (1989) 13 (1).

Community Development in Health Project (1988), "The Resources Collection".

The social context analysis and the practical skills which are highlighted in this work are directly relevant to primary health care¹⁰. However, community development in health is not synonymous with primary health care nor is it entirely contained within primary health care. There are numerous community organisations, working locally for in relation to other communities of interest) who do not identify in relation to health per se nor do they attribute any particular priority to health goals. Nonetheless, within a community development perspective working with such groups may be an essential part of working towards better health. This is fully consistent with the primary health care approach also.

10. Community Development in Health Project (1989), "Community Development and Better Health", Submission to National Management Committee of the National Better Health Program.

2.3 The CDIH Project

The CDIH Project was established in 1987 on an initiative from within the Community Health Section of the Health Department Victoria funded through the Health Advancement Division of the Commonwealth Department of Community Services and Health.

The initial proposal reflected an appreciation of the achievements of the community health field in Victoria, in particular in applying community development principles to health. It is our belief, based on the comments of many overseas visitors and our knowledge of overseas health systems that the community health field in Victoria is one of the world leaders in this field.

Notwithstanding these achievements, it was evident that practice was uneven and there was varying confidence with respect to an understanding of community development in health.

There were frustrations and confusions in the community health field also. Among the confident practitioners there were frustrations at the structural barriers to this kind of practice; among the less confident, confusions about what it is and frustrations at the barriers to finding out.

From the Victorian perspective, it was clearly time to reflect upon and learn from the experience of the last 15 years and to consolidate the understandings and practice of community development and community health.

From the national perspective, a project which would articulate and make more widely available the experience of the community health field in Victoria was most timely. The importance of community development as an approach to health promotion had been highlighted in the report of the Better Health Commission but there were only limited avenues at the federal level through which to advance this approach.

Funding was provided in 1987 by the Commonwealth Department of Community Services and Health for the development of a collection of resources which would support the practice of community development in health.

The Resources Collection was developed (during 1987/88) through an interactive and consultative process with the community health field, listening to people's experiences offering an interpretation, reconsidering, offering a reinterpretation, listening again and so on.

The Resources Collection was published in December 1988. Within the community health field, in Victoria and beyond, there has been a strong and positive response to the Collection

and to the ideas articulated through the work of the CDIH Project. It is a unique resource in the community health field.

During the course of the consultancies project the CDIH has also finalised the publication and distribution of the Resources Collection and has undertaken a major policy project on the role of community development in the National Better Health Program

The CDIH Project operates as an unincorporated body auspiced through the Preston and Northcote District Health Council Inc.

The planning and much of the work of the CDIH Project is undertaken directly through the Steering Committee of the Project as well as by the paid staff, who are also members of the Steering Committee (see Appendix Six.)

The direct consulting function, which is the focus of this report, was undertaken by the two project workers, in consultation with the rest of the Steering Committee.

There was a staffing discontinuity in the middle of this (VHPF-funded) consultancies project. The present staff, Maria Wright and Silvana Scibilia, have been obliged to take over project functions which had been determined and commenced before they started work.

CDIH (1989) "Community development and better health", Submission to National Management Committee of the National Better Health Program.

CDIH (1989) "Community development in Health For All", Proceedings of National Workshop, July 1989, Melbourne.

3.0 THE CDIH CONSULTANCY AND WORKSHOP PROGRAM

The consultancies and workshops have been grounded on the credibility of CDIH within the community health field. This rests on three important factors.

Firstly, CDIH grew out of community health experience in Victoria, and has an existing and developing network of relationships with the field.

Secondly, it has gained significant credibility through the production of Resources Collection (which has now sold over 1200 copies).

Thirdly, it has continued to stimulate and resource the field for example with the National Workshop on the role of community development in the National Better Health Program.

In this Section we present an overview of the consultancy service that the CDIH Project has provided.

A more detailed account of our work with each of the individual centres is presented in Appendix one and an analysis of this work appears in Section Five.

Activities

The work of CDIH has taken its staff all round Victoria during the course of the project. Activities undertaken in the course of the consultancies with the nominated community health centres include:

- centre-based workshops for staff, committee of management members or both

- planning workshops with project subcommittees

- one to one consultancies with managers or individual project workers; providing a sounding board function and questioning and suggesting in relation to projects, or development issues

Activities undertaken beyond the five major consultancies have included:

- one to one consultancies with "clients" from beyond our agreed partners including tertiary programs and other government departments,

- open workshops organised regionally or in relation to particular topics; focusing wholly on community development in health or with CDIH personnel participating in workshops on other areas,

- contributing to tertiary training programs.

A highlight of the year was the July workshop on the role of community development in the National Better Health Program. Quite a few staff from the centres *with whom the Project was working* attended the Workshop.

Our relationship with our partners

Most of the consultancies were initiated by the CDIH Project, seeking nominated partners for the purposes of the funding agreement with the Victorian *Health Promotion* Foundation.

Following agreement in principle in relation to each consultancy, we have proceeded to more detailed familiarisation discussions and moved from there to negotiate a work program. These work programs have remained open to review during the course of the consultancies.

We have relied heavily on feedback from the centres in the evaluation of the consultancies.

The knowledge and skills content of our work

The general focus, in terms of knowledge and skills, during the course of the consultancies has been around the following areas:

planning and evaluation

team building, organisational development, and conflict resolution,

documentation and reflection,

the role of committee of management members and relations with staff,

understanding community health, including community development in health,

project planning and evaluation in relation to community development work

health promotion project planning and evaluation.

The focus on these areas reflects the identified needs of the partners *with whom we worked*.

Resources

The main resources that the CDIH Project brought to each of the consultancies were as follows:

- the knowledge, experience and skills of the staff involved (see Appendix Six)
- the Resources Collection itself (including two theoretical papers, several practical "how-to" papers, the bibliography and resource directory and the case studies)
- the theoretical analysis and practice suggestions which together constitute the CDIH Framework,
- the support people, experts and consultants whom the staff of the Project have been able to call upon in various roles.

4. EVALUATION METHODOLOGY'

This section has two parts.

The first part is a discussion of the considerations which have set the parameters and constraints of the evaluation.

The second part details the design of the evaluation and outlines how it has been conducted.

4.1 Evaluation Considerations

There are some fairly complex theoretical issues which need to be considered in determining an evaluation strategy for a project such as this one.

Purpose

"Why are we evaluating" is a useful question to start with. There are two main purposes which underlie this evaluation.

The first purpose is to learn how to do it better. This calls for a process-focused evaluation.

The second purpose is to determine how useful the CDIH approach is in the community health context; to assign a "value" to the work of the Project. This purpose calls for evaluation which is focused on the impact of the work undertaken during the course of the project.

These two purposes have somewhat different requirements to be allowed for in planning an evaluation.

Process Evaluation

Process evaluation, aiming to learn how to do it better calls for a process of reflection; documenting what transpired, reflecting on how it could have been done better. This reflection needs to be systematic and disciplined; systematic in that all aspects are included in the review and disciplined in that various sources of bias can be recognised and handled appropriately.

Impact Evaluation

In thinking about impact evaluation (making judgements about the usefulness of the services that the Project has delivered in its consultancy work) it is useful to employ the concepts of dimensions and standards. .

Firstly, what are the dimensions within which we shall judge the usefulness of the Project's work. Secondly, what are the standards against which the work of the Project shall be judged to be useful or otherwise, within each of these dimensions?

The dimensions within which we have sought to evaluate the usefulness of the work of the Project are fourfold. These are

perceived effectiveness: have our consultancies led to better community health practice?

accessibility and implementability: is the CDIH Framework reasonably easy to get into, to find your way through, to apply?

perceived validity: does the CDIH Framework resonate with the experience of the community development in health practitioners with whom we have worked?

developing and sustaining: does the Framework allow and encourage continued learning and the development of expertise and confidence among practitioners?

Within each of these four dimensions, the standards against which the work of the Project has been evaluated are two fold. How does it compare with:

- prevailing understandings and prevailing patterns of practice in community health?
- previously available resources and consultancies?

Focus and Context

What is the focus and what are the boundaries of this evaluation?

Clearly the main focus of the evaluation is the service that the CDIH Project is offering to the community health field. This service can be thought of as a package which incorporates a set of ideas, a set of material resources (including the Resources Collection) and the living practice of the personnel associated with the Project (style approach, techniques).

However, this service is not offered in a vacuum. The rationale for offering the services of the CDIH Project rests upon a judgement that these services correspond to certain needs in the community health field. In evaluating how these services are received it is necessary to have regard to kinds of needs which the CDIH "service" is designed to address.

The focus of the evaluation therefore needs to include a careful consideration of the context in which the work has been undertaken and the ways in which context has influenced process and outcome.

Whose Values?

Evaluation of process and of impact (how to do it better? and how useful is it?) both involve the application of personal and social values. We need to ask, "Whose values?".

Evaluation is about placing values on certain activities or resources. The values that are thus placed are ultimately derived from the value systems and attitudes that are part of our personal stance as members of society. Our values, in turn, are influenced by the cultures and circumstances in which we are socialised.

The dimensions and standards defined above clearly imply the expression of personal values, as in "perceived effectiveness" and "better community health practice".

It is clear that, in the present circumstances, differing personal values could lead to different interpretations and different judgements of value in relation to the impact of the services provided by the Project.

The problem posed by differing value systems is not so acute in circumstances where there is consensus about the meaning of things and *what is good* and what is bad.

The problem is starker in the present case because intrinsic to community development is a challenge to some of the conventional and accepted truths about health and health services.

People who hold to the values being challenged might be expected to come to different conclusions from those arrived at by people who identify with the values and perspectives of community development.

Clearly the values and perspectives of community development (as interpreted by the CDIH Project) are expressed in the design and implementation of the evaluation.

However, it is the values of the community health workers and committee of management members with whom we have worked that we have sought to give most weight to in the present evaluation. The CDIH approach has been developed out of the community health field and has been justified in terms of the need of the community health field for its support. The community health workers and committee of management members with whom we have worked are the reference group for this evaluation¹.

1. We are grateful to Dr Yoland Wadsworth for her advice on the role of the reference group in this kind of evaluation.

Nevertheless, in order to provide access to evaluative judgement *by people who may not* share the values of the Steering Committee or of the partners with whom we have worked, the transactions of the consultancies and the workshops have been fully documented in this Report.

Assumptions and Givens

The CDIH approach pulls together ideas and practices from a range of sources. Some of these ideas and practices have been thoroughly studied and they have strong research validation (for example the statistical relationship between health outcomes and social and economic status). Some of the causal assumptions (for example, involving the concepts of personal control and valued social role) and some of the practice suggestions have not been exhaustively studied or formally "validated". Other aspects of the Framework are intrinsically not "testable". (For example, the "core values", Appendix Three.

The CDIH Project regards the continuing exploration of these causal assumptions and practice suggestions as being a high priority. To undertake this in a comprehensive manner would be a larger enterprise than the scale of our present task. Nevertheless, whilst we have not sought to test these various assumptions and practices formally we have taken the opportunity of learning more about this area of work through reflecting on our experience during the consultancies. (See particularly Section 6.3.)

Outcomes. Does it lead to better health?

Does community development, as promoted through the CDIH Project lead to better health?

We have not sought to answer this question through this project. There has accumulated over the last 20 years a large body of research findings and practical experience clarifying the relations between community development and health². These provide the basic assumptions upon which the work of CDIH is based. The focus of CDIH is the next link in the chain, namely, the implementation of community development in health, in practice.

Aside from this accumulated research and experience relating community development and health, the question "does it lead to better health?" could not be answered in the circumstances of this project. This is for two reasons, firstly, related to research design and secondly, concerned with consistency of argument

2. See Resources Collection.

Research Design. A research program in which this question could be tested would be beyond the scale, timelines and budget within which we are presently working. In the circumstances of this project it would not be possible to control for confounding variables. The cost of measuring appropriate indicators at the required scale and for an adequate length of time would also be out of the reach of this Project at this time.

Consistency of Argument. Two central parts of the CDIH approach are our redefinition of health (in terms which take account of power and social relationships) and our assertion that a more caring and more equal society are legitimate and necessarily independent values. Their acceptance as independent values is a necessary part of the practice of community development in health.

If we were seeking to evaluate the CDIH approach in terms of, "does it improve health?" we would need to determine a set of criteria and definitions regarding "health".

We would face a choice between using definitions and criteria which are part of that which is to be tested or using definitions and criteria which in important respects are being challenged by the ideas and practices to be tested.

We would be pleased to see whether the CDIH approach does improve "health" (conventionally defined and regardless of equity and social justice) but that would be different from evaluating the usefulness of the CDIH Project as we have undertaken to do in this project.

Evaluation constraints stemming from the nature of our partnerships.

The success of our work with our partners depends to an important degree upon the level of trust developed. The underlying principles of community development also require that our relationship with our partners is an open, mutual and sharing relationship.

These considerations would render highly problematic the use of some approaches to evaluation which involve more formal "objective" instruments for measuring various constructs. In designing this evaluation it was seen as essential that our evaluation be not seen as invasive in any way.

4.2 Evaluation Protocol

Parameters of Evaluation

To summarise the parameters and constraints of this evaluation:

We are evaluating the service provided by the CDIH Project (that is the package, comprising the understandings and practical suggestions summarised in Appendix Three, the Resources Collection and our living practice

We are evaluating these services within the institutional and cultural context in which they have been provided.

We are evaluating process, through systematic and disciplined reflection, in order to learn how to do better.

We are also evaluating impact; how useful is the CDIH "service" to the community health field? We are evaluating impact in terms of effectiveness accessibility and implementability, validity and its capacity for developing and sustaining.

Usefulness within these dimensions will be judged in comparison to prevailing understandings and patterns of practice and previously available for (alternative) resources and consultancies.

The critical reference group whose value judgements have precedence in this evaluation are the community health workers and committee of management members with *whom we have worked*.

We are not examining the proposition that the implementation of the community development approach leads to better health.

Our evaluation practice must be consistent with the supportive and respectful relationship that we have sought to build with our partners through the course of the project.

Stages of the Evaluation

Within these parameters and constraints we have mounted an evaluation that has proceeded through four stages:

1. documenting our consultancy work and workshops

collecting feedback through evaluation and review discussions and on site workshop evaluations

identifying the main issues and key themes of the consultancies and from the workshops

reflecting upon each of these main issues and key themes from our work, in order to:

learn how to improve our practice,

make judgements about how useful we may have been in our consultancy work and in the workshop program

improve our understanding of community development in health,

review prevailing understanding and practice within the community health field generally

reassess the strategic usefulness of the kind service that the CDIH Project seeks to offer.

Documenting our Consultancy Work

The general pattern of our consultancy work has been described in Section Three of this report.

The first stage of our evaluation was the full documentation of the work programs undertaken with each of the community health organisations with whom we have worked and of the workshop program. A full account of each consultancy in its historical and local context is provided at Appendix One. An analysis of the main themes addressed in each consultancy is presented in Section Five of this report.

Our documentation of each consultancy was submitted in draft form to our partners for checking accuracy and confidentiality.

Evaluation and Review Discussions

As part of the evaluation design we determined the range of issues upon which we wanted feedback from our community health partners . (*See Appendix Two.*)

Towards the end of each consultancy we organised a series of evaluation and review discussions with each set of people with whom we have worked.

We sought their permission for an independent evaluator to participate and we outlined and sought their agreement with other aspects of the process. Members of the Steering Committee of the Project (other than staff) did not attend these evaluation and review discussions.

The evaluation and review discussions were undertaken in two parts. The first part was facilitated by our project staff and was presented in the following terms:

we seek your help in evaluating the work we have undertaken with you over the course of this consultancy;

you have received our summary record of our work program with your organisation; is this OK?

are there any general issues and questions you would like to raise?

can we now proceed through the Prompt Questions (Appendix Two),

are there any final issues, untouched areas comments?

The independent evaluator (RH) was primarily an observer during this phase of the discussions. Detailed notes were taken.

For the second part of the discussion, our project staff left the room and the independent evaluator (RH) proceeded to interview the group in more depth in relation to the four main dimensions of "usefulness" (namely, effectiveness, accessibility and implementability, validity and its capacity for developing and sustaining). He also probed in more detail the usefulness of the Resources collection.

In addition the independent evaluator (RH) undertook one-to-one interviews with key people in relation to each consultancy.

Detailed notes of these further discussions and interviews were prepared.

The workshops were evaluated through questionnaires distributed and collected immediately following each workshop.

(The full record of the evaluation discussions, interviews and workshop questionnaire summaries is not included in this

3. Dr Richard Hudson, see Appendix Six.

report, partly because length but primarily for reasons of confidentiality.)

Main Issues and Key Themes in the Consultancies and in the Workshops

The next stage was to identify and give a name to) the main issues and key themes which emerged in the context of each of our consultancies and from the program of workshops.

Once we had completed the evaluation and review discussions with our partners, we reviewed our record of work undertaken with each of our partners and of the various "one-off" workshops and also the transcripts of the evaluation and review discussions and interviews.

In relation to each focus or theme we have sought to identify and describe what we believe to have been our main contributions and to recognise the main features of the context in which such contributions have been shaped. The independent evaluator (RH) played a leading role in defining the main themes and issues in each consultancy. Our analysis of main themes and issues was submitted in draft form to our partners for checking accuracy, interpretation and confidentiality.

In Section Five we present our analysis of our contribution in each consultancy.

Reflecting

Our analysis and appraisal of our contribution in relation to the main foci and key themes of our consultancies and workshops have formed the basis for further review and reflection at a more general level:

about our practice,

about the overall usefulness of the contribution we may have made through our consultancies and workshops,

about our approach to community development in health

about the community health field generally, and

about the strategic usefulness of the kind of service that the CDIH Project seeks to offer.

From our reflection in relation to each of these areas we have distilled out our conclusions and where relevant our recommendations. These are presented in Section Six.

About Our Practice (Section

Reflecting upon the consultancies and the workshops, the themes and foci of our work; what were our strengths and what were our weaknesses; what did we do well and where could we have done it better?

We reflected upon the strategies, skills and styles that we brought to our consultancies. We reflected on the usefulness of the Resources Collection in the context of our consultancies and the workshops. We reflected also upon the relationship of the consultancies to the broader work program of CDIH.

About the Usefulness of Our Contribution Generally (Section 6.2)

We reviewed our experience generally, progressing through the themes and foci of our consultancies and workshops.

We evaluated our contribution within each of the evaluation dimensions:

perceived effectiveness: is it perceived as leading to better community health practice?

accessibility and implementability: is it reasonably easy to get into, to find your way through, to apply?

perceived validity: does it resonate with the experience of the community health workers and committee of management people with whom we have worked?

developing and sustaining: does the Framework allow and encourage continued learning and the development of expertise and confidence among practitioners?

Within each dimension we evaluated our contribution against the standards:

prevailing understandings and prevailing patterns of practice (see section 6.4), and previously available or alternative sources of advice and consultancy (see Section 6.5)

About Our Approach to Community Development in Health (Section 6.3)

We developed a check list of the key elements of the CDIH approach or framework; that set of ideas, information and suggestions which together constitute the main features of the CDIH Project's approach to community development in health and

which (as a whole package) is sufficiently different from prevailing practice and understandings to justify describing it as the "CDIH Approach".

A summary of the elements of the CDIH Approach is included at Appendix 3.

We reflected upon our experience in the consultancies and workshops in terms of the key themes and foci. What did our practical experience tell us about the analysis upon which the CDIH approach is based, about the suggestions for practice that it incorporates?

About Community Health In Victoria (Section 6.4)

We reviewed our understanding and experience of the context in which our work partners are working; the context in which community development work is being undertaken.

We reviewed the prevailing understandings and prevailing patterns of practice.

About the Usefulness of the Kind of Service that the CDIH' Project Seeks to Offer (Section 6.5)

We reflected upon the need for the kind of consultancy service we have proposed in the light of:

the broader strategic context (Section 2.2)

prevailing understandings and practice within the community health field (Section 6.4),

our conclusions regarding the usefulness of the service offered by CDIH (Section 6.2) and the scope for improvement in our work (Section 6.1)

our conclusions regarding the CDIH Framework (Section 6.3),

available (and alternative) sources of advice and consultancy.

5. WORKING WITH OUR PARTNERS: MAIN FOCI AND THEMES IN THE CONSULTANCIES

5.1 Kiewa and Ovens Valley Community Health Centres

The Kiewa and Ovens Valley Community Health Service was established in 1975. Its main purpose initially was to supplement the services provided by existing health agencies and professionals. The services were based in the four towns in the Kiewa and Ovens Valleys: Mt. Beauty, Yackandandah, Myrtleford and Bright. The committee of management of twelve has equal representation from each of these towns.-

The localities serviced include: Porepunkah, Sandy Creek, Mt Beauty, Whorouly, Myrtleford, Mudgegonga, Hotham Heights, Harrierville, Bright, Yackandandah, Tawonga, Towanga South, Ovens, Eurobin, Wandiligong. (See Appendix 1.1 for further details.)

The orientation of the Kiewa and Ovens Valley Community Health Centre is toward preventive health care with a family support component. Within the (HDV) Goulburn North East Region the centres are considered to be the leader in developmental work. The position for the grant-in-aid welfare worker at Myrtleford was initiated by the Service. Advocacy and support of adult education, child care and an increase in extended care facilities in the valley are also important facets of their work.

A community development officer in community health was employed on a project basis (supported by the regional office) for a period of 12 weeks in 1986. This worker recommended that a series of workshops be planned for staff and committee of management.

The CDIH consultancy with the Kiewa and Ovens Valley Community Health Service was initiated following a contact with the joint manager of this service and the King Valley Community Health Service. She indicated that she was looking for assistance in strengthening planning and evaluation processes in her centres. She had been referred to CDIH on the occasion of her attending a Women's Health Day (arranged by the Wodonga DHC). CDIH took up the initiative.

The main issues appeared to be staff development around issues of community development in health and its role in community health. Although there is an impressive record of services and programs which are provided by the Kiewa and Ovens Valley Community Health Service, there were no on-going arrangements for the evaluation of the Service's work.

Process

A number of visits were made for discussions with the manager and staff and members of the committee of management to develop a work program around the issues which had been identified. Eight workshops were held with committee of management or staff or jointly. There were also some consultations with individual workers and management.

A more detailed account of our consultancy with the Kiewa and Ovens Valley Community Health Service is included at Appendix 1.1.

The Main Issues and Themes in this Consultancy

The main issues and themes upon which we worked during this consultancy were in relation to:

- consensus building within the organisation,
- planning practice and the development of planning processes
- the development of the Low Income Housing Project
- review and reflection upon the Women's Health Project.

Consensus Building

Reflecting on both the documentation of this consultation and the feedback through the evaluation it emerged that a leading theme of CDIH's work was in contributing to consensus building within the organisation.

Misunderstandings and conflict within community health organisations are not uncommon. In this case, the members of the committee of management represent a very broad range of differing perspectives. The development of trust improved listening, of a sense of common purpose and improved understanding of community health represents a significant step forward, according to our feedback.

CDIH's contribution developed over several workshops, where the roles and responsibility of committee of management, in particular, issues of accountability were dealt with, as well as principles of community health and community development. These workshops were run with staff and with committee members separately (one session each) and with both staff and committee members (two sessions).

CDIH contributed to the development of wider trust across the organisation through the developmental style of the

workshop facilitation, through clarifying the role of committees of management, through clarifying community health principles and community development and hence a more shared view of the common task.

Greater trust has facilitated improved listening and a greater understanding of different points of view and more deliberate and confident planning and progress of the service.

The manager indicated in her interview that she had discerned more substantive communication within the committee of management, "*..they were able to listen...hearing what people are saying ... getting back to them and giving that 'yes', that 's what they meant. ,*

Some of the committee members considered that the CDIH workshops has been more important than committee of management meetings. *It gave us a wider view of community health".* They indicated that there was improved communication between themselves and with staff. They felt that as a result of the workshop session, *"they were encouraged to speak out more - that they were more open "*. One committee of management member stated that *"Individuals know each other better . . are working better together."* Another stated *"this has revitalised our thinking. "*

Members of the committee of management also indicated that as a result of the workshops they had a much better understanding of the role of the committee of management. There was a change in direction from rubber stamping of staff plans and reviewing minor administrative details. They now felt more actively engaged in the planning and development of projects undertaken by staff.

Staff also indicated a positive response to the more active approach of the committee of management. Staff at the final evaluation indicated that the most useful aspect of the consultancy had been the creation of "open discussion".

The attention to team building and discussions of conflict management had helped to create more openness amongst staff. staff indicated that the workshop sessions had allowed staff and committee members to articulate their ideas and understanding of community health, thereby creating a more common understanding. They indicated that they were more comfortable but felt that they still require more skills to work effectively with the committee of management.

.Planning practice and the development of planning processes

During the consultancy a great deal of interest was shown in improving the planning process of the service. A workshop session specifically dealing with planning was run

with the committee of management. Several sessions were run with the community health nurses.

In the session with the committee of management the important focus was on the dynamic nature of planning in community health and the role that the committee of management could play. An important aspect was the development of strategies for the incorporation of planning into their meetings.

With staff, more time was spent on the process of planning, dealing with the community development aspects as well as details of planning such as time plans, action sheets, short and long term goals, objectives and strategies.

Meetings are now being held with members of the committee of management for their particular locality (i.e. Bright, Myrtleford, Yackandandah and Mt Beauty) and their particular staff person in order to plan programs and services.

The independent evaluator reported that members also indicated that whereas they had initially felt intimidated at the prospect of directing the work of health professionals, they were much more confident in questioning and challenging staff 's choice of projects . Staff confirmed this, indicating that the committee of management were now more challenging to work with.

The environmental programme which was initially envisaged as running in the same direction in all four localities, has, as a result of staff and committee working with the different sub-groups, evolved into four quite different projects in each of the localities. There is a firmer understanding of community consultation and its role in the community development process.

In the final evaluation session staff indicated that, as a result of the consultancy, more time was now being spent in planning. Gaps in service planning have been recognised. *"We can now see the trees within the wood's. "* The consultancy had established a model for ongoing work around planning and organisation.

One of the workers indicated that, *" I can see where I'm going. I've always known the goal . . .but into an ad hoc way; this time its been more systematic. "*

The community nursing staff have established a fortnightly meeting, one part of which deals with planning issues.

The nurse coordinator indicated that she had actually turned down additional work so that she could focus more on a planned project to which she was committed. She has also implemented certain disciplines in her daily work routine to protect the time she

needs for her planned work. She has also allocated times for documenting and planning in her weekly timetable. She started to tell the independent evaluator that she was "*less scattered in other activities.*"

The independent evaluator also commented in his report that, "In reviewing the effect of the consultation on day to day practice it seemed that project documentation and planning was the activity that had been most strengthened by the CDIH consultation."

The Low Income Housing Project

This is a project which evolved during the course of the consultancy. One of the community health nurses has taken the lead in researching and planning for the development of a Ministry of Housing homesteading program, aimed at the provision of affordable housing for low income families. This project has involved building networks with local shire members and Ministry of Housing officials and plans to develop links with the local TAFE college home improvement course as well as retired tradesmen.

The project is also pursuing other avenues for low cost and emergency housing.

The community health nurse involved has allocated that the prime contribution the CDIH made to getting this project started was in relation to planning. By encouraging the nurse to give herself permission to plan a long term project, including the development of time lines that recognize her other work, she was able to plan in relation to longer term issues.

Contact has been made with the various departments and key people. There is a small group of families who are interested in participating. The process is being documented and other staff are also developing an interest in this project. The committee of management after initially questioning the involvement of a community health nurse in a housing project, now fully support the project.

Documenting and evaluating the women 's health programme.

The women's health program run in 1988 followed several preventative health programmes run for Warren in 1987. Funding of \$10,000 was provided by HDV North East Goulburn Region and the programme had been completed in June 1988.

CDIH encouraged and supported the worker in preparing and presenting a case study of this project at the CDIH National workshop on the role of community development in Health For All.

The case study has now been documented and evaluated. CDIH supported an emphasis on testing the accessibility of this service to women on low incomes,

The manager has indicated that a funding submission for the development of a women's health service in the area has been reworked (and improved) in the light of what has been learned through documenting and reviewing this case-study.

Use of the Resources Collection

All staff have used the Resources Collection to some extent. It was used particularly by three members of staff, both in relation to project work and day-to-day activities.

Two committee members were familiar with sections of the Resources Collection.

5.2 King Valley Community Health Service

The King Valley Community Health Service is based at two centres, Moyhu and Whitfield, in the Shire of Oxley, in the North East Goulburn Region. It was established twelve years ago.

Because there are no medical services in the Valley, the two centres serve as a first port of call before seeking medical advice 70 km away.

There are few services for youth, young parents or the elderly in the area. The King Valley Community Health Service was in the process of auspicing and establishing an adult day activities service.

Among the health concerns locally two issues have been highlighted. These are the effects of agricultural sprays and chemicals and the lack of public transport.

The service has found it difficult to attract new members to the committee of management. Some members have been on the committee since its inception, twelve years ago.

Process

The consultancy with King Valley Community Health Service was initiated by the joint manager of King Valley Community Health Service and the Kiewa Ovens Valley Community Health Service. As mentioned earlier the manager had attended a function on women's health, organised by the Wodonga DHC where a discussion on planning had emerged. She had expressed the need for more support for her centres in dealing with planning and evaluation. She was referred to CDIH.

After some initial discussion with the manager, a number of workshops were held with the committee of management and also with the staff.

In particular, consultations were held with the co-ordinator of the Adult Day Activities Service.

A more detailed account of our consultancy with the King Valley Community Health Service is included at Appendix 1.2.

Main Issues and Themes in this Consultancy

The main issues and themes upon which we worked during this consultancy were in relation to:

- consensus-building within the committee of management,
- defining the local priorities with the staff and with the committee of management,
- acceptance that more formalised planning processes are needed,
- assisting in the development of planning and evaluation procedures for the Adult Day Activities Service,
- use of Resources Collection.

Consensus-building within the committee of management.

CDIH planned and facilitated several workshops dealing with issues such as:

- roles and responsibilities of committees of management,
- principles of community health and community development.

Although not all committee of management members were able to participate, the opportunity for focused discussions around the principles of community health (beyond the more routine budget and management issues) has contributed to building a common understanding of the task of the centre and a clearer awareness of the differing approaches that different members bring.

The sessions also created interest in the Resources Collection.

A quote from the final evaluation discussion:

"The sessions have increased (my) understanding (of) and insight about the system especially as the system has changed".

Consensus-building Amongst Staff

CDIH developed and facilitated a number of workshops in response to requests from staff. The areas covered were:

- principles of community health,
- community development in health,
- planning,
- team development,
- group dynamics

The CDIH consultancy created the opportunity for brainstorming and focused discussion in a non-threatening and supportive atmosphere.

In the evaluation of each session there were indications that there was greater understanding of the topics covered.

At the final evaluation session it was indicated that the understanding of group dynamics and team building had been a most useful contribution. The administrative staff person had been more integrated into the staff team. She had in fact become involved in a health promotion campaign.

Other comments were that CDIH had "*created a climate*" and "*a +broadening approach to health*" and facilitated "*hearing other staff's point of view*".

At this stage there have been no new initiatives in community development. However, we believe that there is now a basis to build on.

Defining the local issues with the committee of management.

Members of the committee of management made various references in workshops and in discussion about the lack of medical services.

It was evident that committee of management members were disappointed that over twelve years much had been promised by the Health Department Victoria in terms of improved access to medical services but little delivered.

CDIH worked with the committee to develop strategies for overcoming some of the difficulties. A way has been found for employing a woman doctor for one afternoon a week, with the possibility of increasing this time.

This will, in the long run, release the community nurses from having to be in the centre to provide a triage service and enable them to deal with other issues.

New committee members also indicated an interest in looking for other new committee of management members, to increase the level of energy on the committee.

Acceptance that more formalised planning processes are needed

Planning was the subject of a workshop with the committee of management and was also the focus of a workshop with the staff.

With the latter group, we developed a local profile and analysis using local data and experiential knowledge. We explored community health principles highlighting equity of access in deciding priorities. We explored also the practice of planning in the context of discussing the principles, values and implementation of community development programs.

Working with the committee of management we encouraged their acceptance that contributing to planning of services and programs was an appropriate role for them.

We emphasised with both groups the importance of documenting and long term planning.

In our final evaluation with the committee of management it was indicated that some members now felt more comfortable about being involved in planning despite feeling inadequate sometimes on account of their lack of professional experience. One member felt more confident in contributing her experiences to the planning of more appropriate services.

The staff in their final evaluation indicated that the development of a community profile had been useful in broadening their understanding and had “*highlighted the many different aspects to consider when making decisions about service delivery*” “*We are using it in our evaluation of our programme.*” “*It enables us to be pro-active.*” More time is being spent on planning. It was anticipated that the committee of management will become more involved in the planning. It was also felt that there will be more time spent documenting programmes and that this is recognised as a valid activity.

Supporting the Adult Day Activity Support Services co-ordinator in developing planning and evaluation procedures.

King Valley Community Health service is auspicing the establishment and running of the Adult Day Activity support Service. CDIH staff worked with the co-ordinator of this programme in order to develop planning and evaluation processes.

Our key contribution was through discussions focused around her role change from co-worker to co-ordinator and in the developing of short and long term strategies in the three main areas of her role (programme planning and evaluation, staff management and working with her reference committee). We developed with her a six week schedule covering the above three areas. Follow up consultations were held on a two monthly basis, which encouraged her to ensure that time was found for staff meetings and the documentation of the programme.

At the end of the consultancy the co-ordinator indicated that she had found the consultancy enormously useful. She had used the timelines suggested and still referred to them and used the process as a model. She considered that she had changed her style by documenting more information rather than keeping it in her head.

Despite the increasing demand for clinical services, she had instigated weekly early morning staff meetings (partly as a consequence of our emphasizing their importance). She also indicated that she had found the planning section in the Resources Collection very useful and had used the case studies for ideas in program development.

Use of Resources Collection

All staff were aware of the Resources Collection. Two had used it extensively for their written work in their further studies and the co-ordinator of Adult Day Activity Support Service has purchased her own copy.

At the time of the evaluation discussion, the committee of management were not aware of the existence of the Resources Collection in the centre but two of the members indicated that they were looking forward to reading it. Staff had also used a photocopy of the Northcote Hydrotherapy case study in their support of the establishment of a heated pool in Wangaratta.

5.3 Box Hill Community Health Service

The Box Hill Community Health Service was established in 1986 and has established a significant service role within the community (See Appendix 1.3).

Initial contact between the Box Hill Community Health Service and CDIH was made as a consequence of a personal contact between the manager and one of the project officer withy CDIH.

The major focus of CDIH's involvement with the Box Hill Community Health Service was in the development of its health service agreement. There was also some involvement with their secondary schools and minor tranquilliser projects.

CDIH undertook to assist with the evaluation of work to date, the development of planning tools and to facilitate discussion of possible strategies for building on the project work of the centre. CDIH was to assist in relation to the planning and evaluation of community development work undertaken by individual staff and in the development of an integrated approach to planning throughout the Centre. CDIH was also to work with the committee in relation to the principles of community development work in health.

A more detailed account of our consultancy with the Box Hill Community Health Service is included at Appendix 1.3.

Main Issues and Themes in this Consultancy

Over the period of the CDIH consultancy, from October 1988 to October 1989, the main issues and themes upon which we worked were in relation to:

- strengthening of confidence in relation to planning and evaluation within the centre,
- assistance to the manager in developing the health service agreement,
- building consensus between staff and committee of management members about the centre's approach to the health service agreement.
- assistance in the development of project planning for the schools project, and
- using the Resources Collection.

Strengthening of Confidence in relation to Planning and Evaluation

Project planning within the Box Hill CHS had tended to be carried out on an ad hoc basis although they had identified broad priority areas. Staff in the course of their work identified an issue or need and discussed it at staff meetings.

The staff acknowledged the need for a more structured approach and were interested in documenting and reviewing their work. The manager identified the importance of documenting existing projects with a view to staff reflecting on their effectiveness and setting future directions and in introducing a process which involved a review of activities within a community development framework.

A number of workshops dealing with planning and evaluation tools, methods and strategies were run in February followed by participation in specific project sub-committees, attendance at some staff meetings and discussions with individual staff members and the manager to further develop planning and evaluation methods at the centre.

CDIH's contribution through workshops with all staff, participation on specific project sub-committees, and discussion with the manager and other staff members was to develop a better understanding of planning within the priority areas set by the centre with a reorientation from ad hoc, individualist based service programs to issue related project work responsive to the target group's needs. The centre has thereby developed a stronger culture and confidence in planning.

The manager stated in an interview with CDIH's independent evaluator that, *"The way in which staff practice (has) shifted in terms that (they) are targeting better. They're working with communities within communities. They're Prioritizing. They're using time and resources more constructively than they were before."*

At the evaluation workshop held at the end of the consultancy, staff stated that the involvement of CDIH had helped them to focus better on the four priority areas set by the centre and that their planning for 1989 was assisted by CDIH clarifying their purposes and strategies. They also stated that they were encouraged to document their projects.

Assistance to the Manager in Developing the Health Service Agreement

From the initial contact with the health centre, the CDIH project officers were aware that the health service agreement was of concern to the manager as a task which would need to be considered over the next twelve months. While the initial agreement with the centre was for consultancy on planning and evaluation, CDIH saw these as tools to also develop the health service agreement.

The workshops held in February dealt with issues about the centre's programs and how they related to priorities previously set by the centre. These were followed by regular contact and meetings with the manager, during which issues and strategies for planning were further discussed. In April, the manager together with two other staff and two committee members attended a meeting about health service agreements where requirements were specified. It became apparent that the previous work done by the centre with CDIH would provide the foundations upon which it would be written.

Having decided to go ahead and draft a health service agreement the manager continued to receive support from CDIH in April and May 1989.

CDIH contributed by strengthening skills in planning and relating these to the development of the health service agreement.

In developing the four priority areas (elderly, migrants, adolescents and women), here was a step missing....OK women, but what real situations are concerning women out there?....How do (you) translate a global concern for women into a strategic plan? I didn't have skills in strategic planning. CDIH staff gave me the material to work with, they provided the skills....required to actually develop a process"

Building consensus between staff and committee of management members about the centre's approach to the health service agreement.

A joint staff and committee of management workshop was planned to discuss the health service agreement as well as to develop five and ten year objectives and twelve month indicators. Several planning sessions for the joint workshop were held. CDIH facilitated the workshop on health service agreements in June.

Our contribution was primarily in facilitating the group process and in emphasizing the broader context.

A written evaluation of the workshop was completed by all participants. Of the 13 people attending, 11 responses indicated that the workshop had increased their understanding of the content of health service agreements; 10 responded that it had increased their understanding of the process involved. *“It was useful for developing a team approach of committee of management and staff”*.

Assistance in the Development of Project Planning in relation to the Schools Project

The schools project was developed to encourage contact between young people in Box Hill and the community health centre through letting them know about community health. It also aimed to affect school curriculum and activities related to health.

In 1988 the health centre community had worked with two schools. However, in February they had a fairly negative response to the community health centre’s approaches to re-establish the program. CDIH participated on the Schools Project Sub-committee from February to May. In the context of the previous workshops (about strengthening planning and evaluation practice), CDIH assisted in clarifying the centre’s aims and in developing an approach which would meet the aims of the schools and the health centre.

Our contribution was to clarify the analysis on which the program is based and to assist in re-structuring the planning process.

The manager subsequently commented that: *“The involvement of CDIH got (the staff) to re-think the worth of having a schools based program.”*

At the evaluation session held by CDIH at the end of the consultancy, staff commented that the consultancy resulted in:

- helping centre staff to limit their involvement to two schools and eventually to one school and
- expanded their role to working as several levels within the school i.e. students, teachers and principals
- using information including statistical and anecdotal data to plan their programs, and
- to go into schools rather than have the program based at the community health centre.

Resources Collection

Staff were familiar with the Resources Collection.

One member of staff contrasted the Resources Collection to other kits which that person felt were more practically oriented (namely, the Financial Counsellors' and Drug and Alcohol Education kits).

5.4 Broadford Community Health Service and the Goulburn North East Region

The Broadford and District Community Health Service is situated in Broadford and services the Shire of Broadford, the Shire of Kilmore as well as the townships of Pyalong and Glenaroua.

The Shire of Broadford is located some 70 kilometres north of Melbourne and lies within the Goulburn North East HDV Region. The Goulburn North East Region covers 40,280 square kilometres. It is quite sparsely populated. Overall, there are nine community health services in the region. (See Appendix 1.4 for details of staff services offered and particulars of the locality.)

A tension between local and regional priorities set the scene for this consultancy. The consultancy commenced with the Broadford and District Community Health Service but developed into a consultation with the HDV Goulburn North East Regional Directorate. The focus of the consultancy was the development of a regional community health development officer position.

Context

The staff of CDIH established contact with Broadford and District Community Health Service in October 1988. Funding had been allocated, by the Regional Office, for a community development worker. The worker was to be auspiced by the Broadford and District Community Health Service and initially based at Broadford although the plan was for the worker to spend six months at each community health service in the region and also in areas where there was no community health service.

There was some disquiet at Broadford that this position had been created, apparently out of funding which might otherwise have been directed permanently to their service. It was felt by staff and by the committee of management that a community health nurse who could provide direct care services across the very large geographic area serviced by the health centre, would have been more appropriate, particularly as there were community development workers employed at Broadford and Kilmore shire offices. At Broadford and District Community Health Service there was sense of frustration regarding the lack of services in the area and what was seen as a lack of response by HDV to these needs.

Local needs in relation to community health in the region had been documented during 1986 as a result of a community

health research project, funded by the region ("Community Health, A Current Picture Goulburn-North Eastern Region"). The Home and Community Care Local Planning Project for the Shires of Kilmore and Broadford (1986) had recommended that a proposal be developed to increase resource allocation for the Kilmore and Broadford area to the District Nursing Service.

The committee members and staff of the Broadford and District Community Health Service were not comfortable about determining an agreed list of priorities for the proposed community development worker position, because "*there are too many areas to choose from*". There was also confusion and lack of information about what community development is. Consequently, there was no formal plan or time frame, nor were there arrangements planned for the direction of and support for the CD worker.

The committee of management decided that they would accept the CDIH consultancy because they needed assistance with implementing the community development project.

Process

A number of discussions were held with the manager of the centre and the acting community health nurse regarding the proposed appointment. Further discussions were held with regional office staff. Eventually joint discussions were held.

CDIH assisted in developing the job description and participated in the selection process. Once the position was filled the CDIH Project supported the community development worker in his orientation period.

A more detailed account of our consultancy with the Broadford and District CHS is included at Appendix 1.4.

Main Issues and Themes in this Consultancy

During the period of the CDIH consultancy with the Broadford and District Community Health Service, the main foci and themes *upon which we* worked were in relation to:

- the establishment of the community development worker role in the region,
- the development of the regional community health advisory group
- understanding and skills development of local community workers through the use of the Resources Collection, in particular, in planning for the Healthy Localities submission.

The Establishment of the Community' Development Worker Role the Region

The Broadford and District Community Health Service committee accepted the CDIH consultancy at a time when they needed particular help in relation to the proposed community development worker position. They had reservations about the decision to establish the position in the first place. They were not clear about what the purpose of the position would be, what the priorities should be, how to supervise and support such a worker.

The CDIH consultancy commenced with discussions with Broadford and District Community Health Service staff clarifying the role of the worker and planning the project. A job description was developed and worker support structures were designed. The job was advertised in November 1988. Applicants were interviewed but the successful applicant did not accept the position and it was not offered to other applicants. It was decided to review *the position in the new year.*

The continuing controversy over the position was complicated by staff turnover at both the health service and the regional office.

CDIH organised a meeting with the assistant regional director and with the manager and community health nurse from Broadford. At this stage the region was contemplating changing direction again and using the position as a research officer in the regional office. The outcome of this discussion was to reaffirm the potential contribution that a regional community development worker could make and to crystallise out the agreed role of the worker and of the project.

There was agreement that the job description needed to be re-written to take account of regional objectives. (From the regional point of view the primary need was to develop networks and strategies for improving community health program resources, emphasizing the targeting of community health needs.)

It was agreed that a small local steering committee should be established. A job description was developed by the manager of Broadford and District Community Health Service and CDIH. CDIH was involved in the selection process. The position was filled as a regional office position, rather than through Broadford.

What were the key elements of CDIH's contribution during this stage?

The CDIH workers assisted in the clarification of the community development worker role through a number of discussions and through providing support in the interview and selection process.

Whilst assisting in retaining the community development position for the region, the scope of community development was conceived broadly allowing for the worker to play a role in health promotion as well as in the planning and provision of sick care and further research to that end.

CDIH played a mediating role (between the regional office and the Broadford and District Community Health Service) by initiating joint meetings and facilitating the clarifying of their respective points of view. The CDIH project may have been instrumental in retaining this position for the region as a community development worker in health, instead of it becoming a research position.

The manager of Broadford and District Community Health Service has indicated that CDIH was invaluable in clarifying the community development worker's role.

CDIH emphasised the broad role that community health can play in its localities, beyond a sick care role.

The acting community health nurse at that time has stated very strongly that discussion with CDIH staff had clarified community development for her. She was better able to build upon her own practical experience in the process of planning for health promotion.

According to the current community health nurse the committee of management is currently liaising with the local municipal council in order to reestablish the local community development officer position.

The Development of the Regional Community Health Advisory Group

The concepts and strategies of community development in health have generally not attracted a great deal of attention in rural communities. The need for service development, particularly in relation to traditional medical and allied health services is commonly regarded as the main priority. A significant barrier to a more deliberate community development approach within the region is the lack of staff with skills and experience in this approach and the more traditional orientation of staff and members of committees of management.

Staff development and learning opportunities for committee of management members are key strategies in moving towards a community development orientation.

An early initiative from the new regional community development worker was to request CDIH assistance in developing and running a workshop for the Regional Community Health Advisory Committee. This group is open to representatives from each community health centre in the region but was only meeting intermittently (and then at the regions' behest).

It emerged that there was not a clear view of the role of the committee. There was a lack of a shared vision of community health across the region and of community development.

The objectives of the workshops were towards building a shared understanding of community health and of community development. There was discussion around the need to change the direction of the committee and devising strategies for achieving such change. A highlight of the day was the regional director's clarifying his expectations of the committee and his acceptance of its emerging new role.

The committee is now meeting monthly. Regional staff are attending every third meeting only. Various outside resource people have been invited to give presentations to this committee. There are plans to run sessions for committee of management and staff in the region. There are requests from this committee to the regional office for regional community health plans. There are work groups being set up to look at various issues.

The regional community development worker considers that CDIH played a catalysing role in activating this committee. He indicates that ongoing training for staff and committee members is now crucial.

The initial workshop that CDIH ran was a stimulus and in some cases a starting point for individual community health centres as well.

One of the participants on the committee considers that CDIH involvement was timely. Up to that stage the meetings were only information sessions; there was no advisory capacity. The committee is now sending letters to the regional office re policy making and accountability of the region office. It is also hoping to strengthen the commitment within the region towards planning for community health, as this is the only region without a plan for community health.

Another important role that has developed is of mutual support and networking in community health across the region. This is particularly important in situations where a lone worker operates such as in Rutherglen and Benalla.

The clear understanding of the regional community development worker of his role as facilitator of the Regional Advisory Committee and other local community groups makes this regional community development position an exciting opportunity for community development in the community health field.

Understanding and Skills Development of Local Community Workers through the Resources Collection, in particular, its use in Planning for the Healthy Localities Submission

The Resources Collection has been used extensively by the regional community development worker.

The planning and evaluation section have been photocopied by him and distributed to various people, including people working on two Healthy Localities projects in the region, Benalla and Violet Town.

The community development worker found the July 1989 CDIH National workshop a valuable opportunity to further clarify his concepts of community development and to meet with other people with similar interests in community development in rural areas.

The Resources Collection, the national workshop and the consultancy programme, have combined to give this worker, relatively inexperienced in the health field, a good grasp of the concepts and issues of community development in health.

The worker has stated that he has used the Resources Collection extensively. He has resourced other workers with discussions based on material in the Resources Collection. The case studies have provided him with models of working.

The Resources Collection has validated the work of the lone Benalla community health worker. She has worked as a social worker at the Benalla hospital, trying to put local committees in place to deal with various health promotion activities. In particular it has informed her contributions to two Healthy Localities projects originating in Benalla and Violet Town. These have now been combined into one excellent submission. She has used sections of it for resourcing discussions with volunteer committees currently running programs. She also attended the national Community Development workshop.

Several other workers from various other community health centres in the region also attended the National workshop. Those who attended have formed a sub group working on developing resources for staff and committee of management training for community development.

5.5 Brunswick Community Health Service

When the Brunswick Community Health Service started, 13 years ago, ethnic health workers were employed to serve their communities with an emphasis on workers bi-lingual skills and acceptance within their community. Their role consisted largely of case work, especially filling out social security and immigration forms, housing assistance, legal and financial assistance and family issues, and the provision of interpreting and translation services in the Centre and in the community.

The CDIH project staff met with the manager and a committee of management member in March 1989 to discuss the re-orientation of ethnic health workers activities away from solely case work towards incorporating more community development. These positions had not been reviewed since the Centre was established. During this time a range of other services (Central Health Interpreter Service, Department of Social Security interpreters, Ethnic Affairs Commission translating service, etc) had become available. There had also been changes in the make up of the community and new priorities.

The change in the ethnic health worker role followed an almost total change in the committee of management membership in late 1988. During the course of the CDIH consultancy the community health centre moved to new premises and, in late 1989, there was yet another change to the membership of the committee of management.

While the community health centre had started to redraft the job description of the ethnic health workers, it had not yet fully determined their new role. The proposal put to the Brunswick Community Health Service by CDIH was that the Centre would develop a 12 month transition plan for the ethnic health workers which would include staff education *and would* specify changes in work activities expected of the ethnic health workers by the community health centre and timelines for its implementation. This program was to be agreed to by both committee of management and staff.

CDIH's role would be to run some of the educational and information sessions and would comment on the plan if required.

An initial workshop was held in April 1989 with the ethnic health workers. This workshop introduced the Resources Collection and looked at the barriers and difficulties the ethnic health workers faced in their work.

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There was a change in CDIH staff in May 1989 at which time a meeting was held with the manager to review the CDIH role. Following a second workshop with staff and a second meeting with the manager, CDIH undertook to play a more active role in developing the community health centre's timelines for implementing the changed role of the ethnic health workers.

Main Theme

The major theme around which the CDIH consultancy with the Brunswick Community Health service centered was the management of change. The subthemes included:

consensus development within the ethnic health workers group and among all centre staff,

support to the manager and co-ordinator,

support to the committee of management both new and out-going,

planning and prioritizing,

use of Resources Collection.

Consensus Development within the Ethnic Health Worker Group (and among Centre Staff Generally)

At the beginning of CDIH's involvement, the ethnic health workers felt uncertain of how to meet these changing expectations, lacked confidence about their skills and concerned about managing the response they were beginning to get from their communities. They also felt undervalued by the other staff members at the centre.

CDIH served as mediator cum counsellor in this situation. The presence of knowledgeable outsiders provided an opportunity to express the difficulties the ethnic health workers were facing. Their work with CDIH included developing strategies for planning and prioritizing; clarifying their role, developing a policy on their utilisation as interpreters. A consensus developed among the ethnic health workers about their skills and their role.

The role of the ethnic health worker was further clarified with other staff members at a joint staff workshop.

In the evaluation workshop held with the ethnic health workers they commented that the CDIH consultancy had helped them to *"determine their roles, both Inside and outside the centre"* and helped them *"to explain their roles to the community"*. They are now *"working collectively as a team"* and they commented that they *"ere getting confidence and*

doing something about (their) problems". They referred particularly to the development of the interpreting policy.

They added that it had helped their understanding of community development in the context of their evolving role. They were more confident of *"how and when to say no to the client and feel less guilty"* and that while there had been criticism from clients, *"they can do more for themselves now for example ...to fill in their own social security*

The workers felt that they are *"listened to and respected"* by the rest of the staff; that their team meetings were *"given importance" and there were "fewer interruptions"*.

Support to the Manager and Co-Ordinator

At the time of the consultancy the manager was under considerable pressure due to the changes the health centre was going through, in addition to the normal responsibilities of management. The changes taking place included the new committee of management, some resistance to the new community development orientation proposed for the ethnic health workers and moving the centre to a new location. An added pressure was that a health service agreement needed to be developed by 1990.

CDIH was able to provide support to the manager through regular discussions, by phone or at meetings; it provided opportunities to express concerns, and reflect on these issues.

At the evaluation interview the manager commented that *"the most important thing they did for me... was providing me with a bit of support... it comes back to the lonely position of a manager ". "...as neutral outsiders I could talk to them in a way I can 't talk to anyone (inside the centre) "*.

Management responsibility for the ethnic health workers at Brunswick lies with the nursing co-ordinator (a community health nurse). Their change in role demanded leadership and support from him and knowledge of the new directions in which their work was going. He was less certain in facing this challenge than in carrying out his previous responsibilities.

Through regular discussions and meetings, CDIH provided support through listening and reflecting back, generally and specifically; suggesting ways of supporting the ethnic health workers' role change.

In the evaluation interview with the co-ordinator, he commented that the Resources Collection had proved useful and that he'd "*got a lot out of particularly the case studies which depicted situations that you could relate to....*" *The examples were frank about the difficulties*".

Support to Committee of Management (Outgoing and Newly Elected)

During the period of CDIH's consultancy, Brunswick Community Health Centre had a change of committee of management. CDIH ran three workshops with the outgoing committee and one with the new committee.

Sessions with both committees of management covered community development and community health principles and practice. Additional sessions with the outgoing committee included developing a profile of the Brunswick Community; discussing the committee's role and responsibilities in relation to the staff's changing role and looking at the practical implications of the change.

Both the former and the current committees of management have asked CDIH to run additional workshops.

Planning and Prioritising

The need for more formal approaches to planning and prioritizing were recognised in workshops with both the ethnic health workers and with committee of management members. The relevance of these disciplines for the whole staff emerged as an issue for the whole community health centre at a workshop held at the regular staff meeting.

At that meeting the role of the ethnic health workers was discussed in response to a draft policy on interpreting which had been developed by the ethnic health workers. In clarifying the ethnic health workers role as community development workers, staff members raised questions about their role in a community development perspective and the direction the centre should take.

In the evaluation interview the manager commented that before CDIH's consultancy the change in job role "*had been discussed for about twelve months*" and that the then committee of management "*had a very strong feeling that the centre was not nearly involved enough in outreach community development work*". It was at that point that CDIH was approached.

The ethnic health workers, following the consultancy "*did not feel guilty about (looking at issues of) how, what and why plan*". They felt that it "*established (that it's okay*

To) look at work analytically and (that there was acknowledgement of) the importance of setting aside time to plan”.

They were “more confident about how to do community development and how to prioritise” There was an awareness of limitation; that you don’t have to do everything ... change will take time”.

The introduction of annual reviews, focused on what they had done was appreciated.

Use of Resources Collection

The Resources Collection was used extensively by one member of staff. Other staff members were beginning to use it but had found one copy was insufficient to enable easy access to all staff members.

5.6 The workshop Program

A series of workshops has been run with a range of health and education organisations during the course of the consultancies project with the majority taking place between March and September 1989. These workshops were all organised in response to requests from the various organisations. A large number of requests for advice on community development issues were also received by telephone or appointment.

In all, 24 workshops were held with 17 organisations during this period. A number of organisations requested follow-up sessions to deal with issues raised at the workshop.

Workshops ranged in duration from 1 – 4 hours to all-day sessions. A range of topics were covered and issues relevant to the particular organisation were raised by participants. Topics formally addressed included:

- community health and community development,
- planning, evaluation, research and accountability, identification and implementation of community development strategies,
- review and documentation of projects, and
- committee of management – roles and responsibilities.

A more detailed account of our workshop program is provided at Appendix 1.6.

We have reflected systematically upon each workshop on the basis of the staff reports and the post workshop questionnaire summaries. We sought to identify the key themes and topics which the participants had explicitly valued and or responded to.

Community Health Principles

Most workshops have included a review and a discussion of community health principles. A particular emphasis is placed on equity of access and social justice.

This review helps to relate the participants' experiences and understanding of community health to the principles established in the Ministerial Review. This results in a clarification, expansion and shared vision of these principles.

Immediate workshop evaluations have confirmed that most respondents found community health principles a useful point to start with. Whilst almost all had a pre-existing knowledge of community health, the session either “*expanded*”, “*reinforced*” or “*grounded*” their knowledge of the area. One stated (that she/he was) “*more convinced than ever that community health centres should be established in every community*” Another respondent said that “*a useful aspect was clarifying community health.....*”

The Ottawa Charter

Reference was made to the Ottawa Charter in each workshop. However, in half the workshops greater discussion around the concepts and implications for practice in this charger took place.

This provided a broader and deeper understanding of the origins and concepts of community development and health promotion.

The WHO endorsement of primary health care and health promotion was reassuring for many people involved in community health.

Stronger Theoretical Understandings

Theoretical aspects of community development were discussed at each workshop.

Discussion centered around the participants’ prior understanding of community development. The concepts were presented using a range of models and included personal case studies and prepared hypothetical case studies. The case studies and hypotheticals provided a practical context for exploring theoretical issues.

The introduction of theory provided a set of reference points in questioning the basis upon which programs have been (or are being) planned.

For those with a basic understanding, the introduction of theoretical ideas served to affirm and extend their knowledge. It provided an introduction for those participants who had little or no experience.

There is a degree of resistance to theory on the part of some community health workers. Many participants were more interested in issues of practice rather than any kind of theoretical framework for understanding community development in health.

Nevertheless, the diagrams were seen as a useful way of presenting the whole theoretical

framework of CDIH. One respondent said they provided a good framework to analyse case work and hypotheticals; they reinforced his understanding.

Another stated that, in terms of community development, *“it is easy to think of (one’s) own experience as being the definitive experience but other communities (and) people also have ideas”*.

Affirmation of the Validity of People’s Experience and Practice.

The orientation of the workshops was experimental. The sharing of experience and practice in a supportive environment was encouraged. Principles and theory were introduced in the context of discussing practice. The approach helped participants to see their own experience afresh within a more systematic framework.

The emphasis on learning from practice was an affirming experience for many participants.

A respondent said *“it validated the work that was being done by the community health centre”*.

Another indicated that *“it was useful to hear that other workers and organisations had similar experiences, both good and bad.”*

Others found it useful to share their experiences and have others comment in a positive way on those experiences.

Another respondent said that it was good to have reassurance about the direction of the thinking.

The practice of Reflection upon Practice and Experience as Valid Support/Skill/Practice

An important aspect of the workshops was the explicit practice of systematically reflecting on and learning from previous experience.

CDIH encouraged participants and provided an opportunity to look at what they were doing and why they were doing it.

Presenters of case studies were encouraged to reflect upon positive and negative results in order to provide an opportunity for finding out what works best in a particular instance and why. This will in the long run provide further knowledge for the field.

Taking time out to reflect is difficult for many workers because they are pressured by

the unmet needs in their communities. However, reflecting on their work within the context of the framework was often an exciting and useful process for them.

Recognition of Contextual Barriers to the Practice of Community Development in Health

The exercise of working through case studies and hypotheticals and discussing implementing them on a community development model highlighted some common contextual barriers to the practice of community development in health.

Participants shared their experience of barriers they had faced, were facing or thought likely and were able to hear of ways in which other participants had dealt with such barriers. Overall, the process acknowledged that barriers existed and while some solutions to some barriers were put forward, others were recognised as requiring complex structural change. In acknowledging these factors participants were further affirmed.

One respondent said that discussion about the usefulness of community development practice in Australia and the barriers within the intuitional and cultural environment was useful.

Several respondents requested more sessions specifically dealing with the barriers to community development. The sharing of the experiences of barriers was instrumental in participants realising that the barriers were largely structural.

Participants gained more confidence in themselves when they heard that most workers experienced similar barriers.

However, one respondent did state that an awareness of barriers was not useful, only depressing.

Health Planning Skills and Practices

In some cases the reasons for starting particular programs had got lost in time. Other programs had been developed in an adhoc way and didn't necessarily reflect the centre's statement of purpose. Planning processes were considered to be one of the most important areas in which skills development was needed. In most workshops some time was spent considering how to get access to useful planning information.

This process alerted participants to the necessity of having a good knowledge base on which to plan and prioritise and to refer to their organisation's statement of purpose. Where there is no statement of purpose, the importance of developing one was recognised.

Respondents indicated that it was particularly useful to have information about the range, location and access of, information resources.

One respondent said that *“this added to general knowledge of community work and its problems and how to access specific target groups”*>

Another respondent stated that *“using data will help to sort out which programs to initiate in our centre.”*

Another participant observed that the need for a statement of purpose becomes more apparent, particularly in a climate of scarce resources.

Facilitating Project Planning and Strategy Development

In most workshops CDIH provided an overview of the basic elements of project planning, goals, objectives, strategies and tasks including coalition building. These were explored particularly through the case studies and hypotheticals.

Opportunities were created to discuss project planning in community development in health and the issues arising were discussed.

One respondent stated that because case studies were presented by people who knew their area well they could bring that experience to other situation and brainstorm new strategies for different locations.

Another comment was that the concept of coalition building with other agencies in the area was reassuring in the sense that health was now not only the concern of health centres. One participant indicated that this validated her practice of involving a wide spectrum of other agencies in her work.

Another issue was the importance of finding or allowing time for planning.

Reassurance (Community Development is Difficult)

Through exploring the community development framework, and discussing barriers to its practice in an environment which was supportive, participants were able to articulate and hear acknowledged the difficulties that they face as community development workers. This was particularly reassuring for isolated workers.

We provided an opportunity to discuss case studies which reflect community development practice and principles. Presenters were encouraged to share their difficulties.

A respondent said that it was *“very positive to see that community development takes a long time but the results are tangible.”*

Another found that it was good to see successes that it can work well.

A participant found the sharing of things that did and didn't work, being open about the barriers they faced within projects, was reassuring.

One said that *“to see it work is inspirational”*.

Another participant added that they were *“pleased to see that a problem we are experiencing (psychiatric services) has been tackled in a similar manner and been overcome by the others dealing with it”*.

Opportunity to Listen to Each Other, Learning and Networking

Throughout the workshops there were opportunities in small groups or in the large group for participants to hear about other people's perceptions, ideas, experience and visions. For many, they provided an opportunity to meet other community development workers for the first time and for others the possibility to further develop relationships.

The emphasis in the workshop plans was always on the sharing of information. This was facilitated by utilizing small group processes and brainstorming in the larger group.

A respondent said that *“hearing from other health centres was good”* Another said *“it was good to meet other workers and plenty of opportunity to interaction with others”*. Another participant stated that *“it was important to use small groups”*. And another that *“(it was) good ... to share and be with other people”*.

Reworking Community Development Concepts and Introducing the Continuum

CDIH emphasised, in the workshops, that individual case work and community development work are not exclusive concepts but that they are in fact the polarities on a community development continuum.

In analyzing the different aspects of the community development continuum some participants were challenged to question the basis on which they were working.

In the feedback this was appreciated: *“This provided a stimulus to think about community development in a different way while reinforcing knowledge of community development in general”*. Another comment was that, *“the continuum provided ideas on how to include more community development in existing daily work”*.

Value Clarification

The opportunity to discuss practical issues in community development through the case studies or discussing projects currently undertaken, encouraged participants to think about how their practice reflected underlying values of social justice and equity of access.

This often challenged workers to confront their own value system. Some of the issues where this arose were in working with and not for people, considering those people in the community who were most in need and being non-judgemental.

Excitement and Interest

One of the most rewarding outcomes of the workshops was the sense of excitement and interest in the issues which was commonly evident at the end of the workshops (and in the evaluation questionnaires). The workshops provided an environment in which participants were able to share experiences, problems, barriers, skills, strategies and create networks.

Many participants found the workshops useful and asked for further workshops to be able to follow up issues arising from them. Some follow up topics suggested were:

“migrant issues in community health and community development”

“more sharing of case study presentations ... what works, what doesn't”

“setting up community groups”

“ways of approaching community action”

“strategies to tackle the barriers identified”

Others commented that the workshop was helpful in :

”identifying some areas (they) could work on and develop”

“providing an opportunity to work in groups”

One participant commented that *“linking the case studies with the principles provided inspiration, ideas and enthusiasm”*.

6. CONCLUSIONS AND RECOMMENDATIONS

Our conclusions and recommendations are presented in the following five subsections below.

In Section 6.1, (“About Our Practice”) we reflect upon process: learning how to do it better.

In Section 6.2 (“About our Contribution To The Work Of Our Partners”) we reflect upon the usefulness of the contribution that we have made to the work of our partners.

In Section 6.3 (“About Our Approach to Community Development in Health”) we reflect upon what we have learned about community development in health generally from our experience through the course of this project. We reflect particularly about our conceptualisation of community development in health (the CDIH “Framework” – see Attachment Three)

In Section 6.4 (“About Community Health in Victoria”) we reflect upon what we have learned about the context in which we have been working, namely, the community health field in Victoria. We reflect, in particular, about the opportunities and resources for the application of community development principles in community health and also the barriers to this kind of practice.

In Section 6.5 (“A Resource and Support Unit for Community Health”) we return to the proposition with which this project started. We review the evidence and arguments regarding the need within the community health field for more deliberate support in the application of community development principles in community health. We review the evidence regarding the usefulness of the kind of service which the CDIH Project offers.

6.1 About Our Practice – Learning How To Do It Better

In this section we reflect upon process: learning how to do it better.

In coming to the findings detailed below we have reflected upon the consultancies and the workshops, the themes and foci of our work; what were our strengths and what were our weaknesses, what did we do well and where could we have done it better?

We reflected upon the strategies, skills and styles that we brought to our consultancies. We reflected on the usefulness of the Resources Collection in the context of our consultancies and the workshops. We reflected also upon the relationship of the consultancies to the broader work program of the CDIH Project.

The Things That We Did Well

Our consulting style is consistent with the principles of community development, starting from where people are at and building on their skills and knowledge. This makes for better work, contributes to trust building and has an exemplar value in terms of the style of work which we advocate.

We are able to offer people useful insights into their situation because we are familiar with community health and because we have a firm and explicit analysis of the work they are doing and the context in which they are doing it.

Because of the style and strategies of our consultancy practice we are able to facilitate access to ideas and practice suggestions for people who would not be predisposed to using complicated resource material.

We have provided a context in which community health workers and committee of management members can work together, sharing experiences, learning from each others' insights; we have facilitated this process.

Our energy, commitment and challenge has been experienced as revitalising by many of the people we have worked with.

On the basis of the feedback we have received it is clear that trust building (essential for this kind of work) has been facilitated by our organisational independence, our standing in the field (in part a consequence of the success of the resources Collection) and from our commitment to the principles of community health and our respect for their practice.

Areas On Which We Need To Work Further

We need to develop more differentiated presentations (formats, agendas, ideas, resources, strategies, etc) for working with different groups (managers, clinical staff, community development staff, committee of management members etc.) Our presentation would thus be more finely attuned to their needs, where they are at.

We need to explore more the disciplines of adult education (including particularly those of popular learning). This includes improving our group skills.

We have more work to do with respect to being accessible to people who do not have any structural analysis of the social context of health and of developmental health care.

We need to find different forms of working alongside such people in ways that assist them to build a stronger structural analysis from their own experience.

We need to give more thought to how we work with people who do not share our values base, finding common ground, listening to (and learning from) their perspectives and challenging their assumptions where appropriate.

Material Resources

Our project workers have used a range of resource materials during the consultancies, mainly to complement and support their direct personal work.

Many of the resource materials used have been taken from previously existing sources (e.g. the 1985 report of the Ministerial Review, the Ottawa Charter, etc.)

The project workers have also used resources developed the CDIH Project.

Our case studies and our “hypotheticals” (scenarios used as discussion starters) have been particularly useful resources and greatly appreciated by our partners. We need more documented case studies and hypotheticals.

The Resources Collection has been an important resource. The way in which it has been received by the community health field has given us credibility with our partners. It has also given us confidence in our own analysis and in the line of suggestions we are likely to offer with respect of practice. It is often helpful to be able to refer to individual sections of the Resources Collection (in particular in relation to case studies, tools for planning and evaluation, etc.)

Some of the community health workers we have worked with in the consultancies have found the Resources Collection to be a “gold mine”, using the different sections in accordance with their current needs.

A significant number of community health workers have found the Resources Collection intimidating and complex and have not found it easy to get into; not sufficiently to find the sections that would be relevant to them (perhaps the case studies or the story of the peer support group for example).

We are not aware of the reaction of a sufficient number of committee of management members to generalize about its accessibility with this group.

It should be emphasised that, in the context of these consultancies, we were not simply

offering the Resources Collection; we were offering a consultancy service based on the CDIH Framework as presented by our project workers. They were able to use the Resources Collection when appropriate, refer to particular sections and assist people to find the passages which might be relevant to them.

We need to improve the range of resource material we are able to draw upon or offer. The material in the Resources Collection is not equally accessible for people who are coming from different perspectives, or who have different levels of theoretical understanding.

The Broader Work Program of the CDIH Project

The consultancies, which are the subject of this report, and a subset of the broader work program of the CDIH Project.

The broader work program of the Project provides the base from which the consultancies have been undertaken. The status of the Project in the field (arising from the 1988 consultations around the development of the Resources Collection, from the widespread acceptance of the Resources Collection from the strength of the HFA consultation, workshop and report) has given us credibility in the field and strengthened the confidence of our workers. The continuing discussion and debate within and around the Project (e.g. in relation to the HFA Project) has also fed into the consultancies.

On the other hand the consultancies have fed into the broader work program of the Project: the insights derived from the consultancies; the skills acquired by our workers; the stronger relations with the field.

Improving Our Practice as an Organisation

We need clearer guidelines, practices and protocols with respect to commencing consultancies.

We need to give ourselves more time to orient ourselves into the culture and context of differently located consultancies (especially rural consultancies).

We need to develop ways of providing support to our workers (without prejudicing confidentiality in relation to the consultancies in which they are engaged). Reference groups to support our staff may be a way of doing this.

Our staffing arrangements did not allow for adequate administrative and clerical resource; during the second half of the project the only full time worker carried a disproportionate administrative burden.

We need a stronger library resource capacity in our home base.

We need to schedule more time for planning and reflection (practicing what we preach). This is necessary if we are to continue to reflect on community development, to build on that we've learned.

We need to find ways of facilitating the field providing to itself some of (perhaps much of) the support and advice we have provided. This might involve putting more emphasis on building peer support or reference groups to support community development workers in the field (as described in the resources Collection and actually happening in the North East).

This notion of strengthening the self help capacity of the community health field (particularly in relation to community development) should be a leading strategy for the CDIH project.

Our accountability as a service to the community health field needs to be formalised. There are contradictions between our accountability to funding bodies (in relation to grants) and the importance, for community development in health generally, of strengthening our direct accountability to the field. We need to entrench our organisational accountability to the field.

6.2 About Our Contribution To The Work Of Our Partners

In this sub-section we reflect upon the usefulness of the contribution that we have made to the work of our partners.

In coming to the findings detailed below we have reviewed our experience systematically, progressing through all the themes and foci of our consultancies and workshops (as outlined in Section 5, above).

On the basis of this review we have made judgments about the value of our contribution in relation to each of the selected evaluation dimensions:

- perceived effectiveness: have our consultancies led to better community health practice?
- perceived validity: does the CDIH Framework resonate with the experience of the community development in health practitioners with whom we have worked:
- accessibility and implementability: is the CDIH Framework reasonably easy to get into, to find your way through, to apply?
- developing and sustaining: does the Framework allow and encourage continued learning and the development of expertise and confidence among practitioners?

Effectiveness

The general question is about the usefulness of our contribution.

Effectiveness, as one way of thinking about our usefulness focuses on the degree to which the consultancies and the workshops may have led to better community health practice.

In this subsection, we review some leading instances of “improved practice” at each of the centres with whom we have worked. These are instances of improved practice occurring in areas with which we were involved: where the direction of the local partners have expressed the view that our involvement did in fact contribute to this improved practice.

A leading instance of improved practice at the Kiewa and Ovens Valley Community Health Services would be in relation to decision making, project planning and communication within the organisation.

This improved practice has been expressed in the way the environment and health theme has been addressed differently by the four subcommittees of the Service in the four areas in which the Service operates. Staff and committee of management members are working collaboratively to address the different priorities recognised in each area.

Consensus building, planning practice, decision making and roles and relationships were key themes in our consulting work with the Service. They were themes which engaged staff and committee of management members across the Service. (See Section 5.1, pages 34-39, above)

In our evaluation discussions, the people at the Service with whom we worked have expressed the view that the consultancies contributed significantly to improved practice in these and other areas.

The leading instance of improved practice (with which we were associated) at the King Valley Community Health Service was in relation to the Adult Day Activity Support Service. The responsible staff member at King Valley believes that her practice has improved in several respects:

- the more conscious use of timelines in planning,
- documentation of the project (and reflecting whilst documenting),
- the more deliberate use of a developmental model in the program planning, consensus building and organisational development (see section 5.2, page 40)

The worker involved believes that the CDIH consultancy contributed to these improvements.

The leading instance of improved practice at the Box Hill Community Health Service would be in relation to improved project planning and strategic planning. This was a focus of our involvement. The manager of the Service has expressed the view that we contributed to improvement in relation to these areas.

The nature of our contribution was through highlighting issues of planning, encouraging more formal planning practices (less reliance on ad hoc planning), making it legitimate to spend time on planning. We worked with staff and committee and these changes were evident at all levels. (See Section 5.3, pages 45.)

The leading instance of improved practice with which we were associated in our work with Broadford and District Community Health Service and the Regional Community Health Committee in the Goulburn and North East was the improved communication and mutual support between community health centres in the North East. A much stronger network has been developed, building a shared understanding of community

health and community development; institutionalizing at the local level the kind of support that CDIH has been providing statewide. The development of the regional community development position and the regional committee were the main foci of our work. The regional worker has expressed the view that we contributed substantially to the development of the regional network. (See section 5.4, pages 50, above.)

The leading instance of improved practice at Brunswick Community Health Centre would be the steps which have been taken towards more strategically oriented practice by the ethnic health workers. (See section 5.5, pages 57 above.) This was a major focus of our involvement. The ethnic health workers and the manager have testified to our role in supporting this process. The nature of our contribution was in facilitating the management of change, clarifying what community development is, providing a sound board function, and mediating the change process among other staff in the Centre beyond the ethnic health workers.

In relation to the Workshops Program, the question, “Did it lead to better practice?” cannot be answered with any direct references to the day to day work of those who attended. However, it is reasonable to suppose that improved understanding, improved skills, reassurance and affirmation networking and values clarification will lead to improved practice in due course. (See section 5.6 pages 62; see also Appendix 1.6).

In summary, the main thrust of our consultancy work was in relation to planning (organisational development and project planning), on understanding roles and on understanding the principles of community health as well as community development in health. In general this work has been recognised as leading to better community health practice.

Validity

The general question is about the usefulness of our contribution.

Validity, as one way of thinking about our usefulness, focuses on the degree to which the CDIH Framework corresponds to the reality experienced by and practiced by community health workers who are consciously adopting a community development approach to health.

The CDIH Framework (in particular, the Resources Collection) has been developed through a strongly interactive process involving community development practitioners working in community health in Victoria and in other states. These are the people whose insights and experience we tapped in the development of our analysis and the Resources Collection. It is appropriate to reflect upon how the Framework has been received by this group. Did we get it right?

In the circumstances of this consultancies project we have not been able to explore this question systematically and comprehensively. We do not have a list of “recognised” experienced community development in health practitioners who might have responded to a questionnaire about the Framework.

In reflecting on validity we have recalled the responses of the more experienced workers at each of the consultancies and we have recalled the responses of experienced workers with whom we have worked through the workshops program.

Validation of the Framework has sometimes been expressed explicitly; we have also interpreted their expressions of personal affirmation as reciprocal evidence for the validity of the Framework.

There were one or more long standing community health practitioners with experience in community development in health with whom we worked in all our consultancies. Their responses to our contribution was strongly validating for us.

An experienced rural based worker said, *“This validates my experience over a period of 20 years”*.

Another experienced worker said, *“It wasn’t new, it was in black and white and it really validated what had already been done and it actually put it in a systematic way...”*

Among the people attending the workshops there were quite a few community health workers with experience in community development in health. Their response to CDIH

has been strongly validating. There has been a strong sense that their experience and their practice have been affirmed through CDIH. (See section 5.6, page 62.)

Accessibility and Implementability

The general question is about the usefulness of our contribution.

Accessibility and implementability, as one way of thinking about the usefulness of what the CDIH Project offers focuses on the content and presentation of the CDIH Framework. (See Appendix Three.)

The CDIH Framework encompasses:

- an affirmation of the independent legitimacy of the core values of community development
- a set of analytical frameworks for understanding health and illness in a social context and for planning and thinking about community development work in relation to health
- some ways of thinking about practice.

In referring to accessibility and implementability we are referring to this whole package.

Accessibility does not mean that people can absorb the whole package quickly and easily and commence implementing all aspects immediately, no matter where they are starting from.

If the material is accessible and implementable, people would find that they are able to engage the material, start to use it and get into it and build on it as their own work progresses, no matter where they are starting from.

In this subsection we reflect upon our consultancies and workshops in relation to the main elements of the CDIH package:

- affirmation of values,
- social context analysis,
- suggestions for practice.

To what extent did our partners take up the different elements of the package?

Why did they find some aspects accessible and/or implementable but not others?

Affirmation of Core Values

We have argued that community development practice involves an affirmation that the core values of equity, participation and social justice are independent guiding values alongside the commitment to health. They are not subordinate to health values, justified only because of their relevance to health.

The degree to which our partners have taken up this notion varies considerably.

The support that the Committee of Management at the Kiewa and Ovens Valley Community Health Service has shown for the low income housing project (see Section 5.1, page 38) suggests that, at least in some degree, they have accepted values of equity and social justice as a reference point in community health. There may be further implications associated with *affirming social justice values* which will be further worked through by the staff and committee in due course.

At Box Hill Community Health Service there has been an affirmation of social justice with an explicit social justice orientation in the health service agreement (e.g. focusing its work with ethnic communities in relation to recently arrived groups) and in improved targeting of the womens' health program.

Brunswick Community Health Service is an interesting case because the centre has had a strong rhetorical commitment to social justice values for many years. The ethnic health workers have shown themselves to be keen to apply such values more consciously in reshaping their jobs. This is expressed in their recognition of the legitimacy of going beyond "own ethnic group" sometimes, e.g. working with disadvantaged Australians of English-speaking background also.

In the Workshops also the concept of core values as part of community development was well received.

The CDIH Approach to Practice

We have suggested that the practice of community development can be thought about at three levels: activities, projects and developmental principles. At its most basic level community development is about the everyday, commonplace activities of being with people; doing things with people. It is useful, particularly to facilitate planning, to think of these commonplace activities as contributing to discrete projects. At a more basic level, the principles of empowerment and building community guide daily work style and inform project planning.

We have explored in more detail the application of community development principles to issues of practice. The "continuum" model highlights the range of contexts in which developmental practice can be undertaken. We have also

explored the implications for planning, evaluation and accountability of the community development framework.

The CDIH approach to practice is outlined in more detail in Appendix Three.

The degree to which our consultancy partners and workshop attendees have taken up the CDIH approach to practice varies considerably.

The leading instance at the Kiewa and Ovens Valley Community Health Service might be the increased attention to the notion of local (downwards) accountability reflected in the establishment of the local subcommittees including locally based staff and local resident members of the committee of management.

A leading instance in the Goulburn North East would be the use that has been made of the Planning Evaluation Research and Accountability paper¹. The Regional Committee (see Section 5.4, page 50) has also taken up the peer support model².

At the Box Hill Community Health Service the leading instance might be the more deliberate approach to the practice of longer term strategic planning.

A leading instance of taking up suggestions with respect to practice at the Brunswick Community Health Service might be in relation to the reorientation of the focus of the ethnic health worker role. There have been deliberate steps taken towards reducing the individual focus, addressing the client dependency issue, and thinking about one's practice in terms of empowerment and personal development.

In the context of the workshops program, the practice suggestions which participants found most accessible were in relation to the continuum principle (see Section 5.6, page 67) and the emphasis on learning from practice through peer support and reflection (see page 64).

Analytical Frameworks

The CDIH Framework incorporates a structuralist approach to understanding health and illness in a social context. It *draws strongly on* feminist thinking in understanding the relation between the personal and collective action at the local and community level and the broader structural determinants of health.

1. CDIH (1988) Resources Collection.

2. CDIH (1988) "Peer Support in Community Development", in Resources Collection.

It is not easy to cite instances from consultancies or workshops which might illustrate the accessibility of these ideas or otherwise.

In general, the number of local partners and workshop participants who were drawn to the theoretical side were in a minority.

From this minority, one workshop participant said, "*This was the most stimulating and challenging staff development session in the seven years I have worked at this centre*". (See also Section 5.6, page 64.)

The most common response to issues of theory was one of passivity, there was some active avoidance and some overt resistance.

In general, we conclude that the theoretical resources of the CDIH Framework have not been widely accessed.

Aids and Barriers to Access

In general, it is our impression that our consultancy partners and workshop participants have taken from the CDIH Framework that which was relevant to their current tasks and challenges, within limits which reflected the cultural and institutional context in which they are presently working.

However, it is evident that the degree to which the CDIH Framework as a coherent body of ideas has been accessed is quite variable.

The core values concept has been found useful in some situations but probably not widely implemented. The theoretical resources have not shown mass appeal. The CDIH approach to practice has been accessed and implemented most widely, particularly in relation to planning. The CDIH approach to accountability has also shown some influence.

The factors which may facilitate or prevent people from accessing the CDIH Framework may be considered in terms of:

Presentation. The way in which the package is presented, including the practice style of our project workers and the material resources used will clearly influence accessibility.

Context. The context in which people are working can impose limits on their taking up new or different ideas; the current tasks and challenges which they are facing may determine what they are able to implement.

Personal engagement. Differences in people's background, their values, skills and knowledge, make it easier or more difficult to access and implement the ideas which make up the CDIH Package.

It seems likely that the variable access which we have commented on reflects all of these different kinds of factors .

We have commented on some aspects of our practice which might have improved our presentation of the CDIH Framework {see Section 6.1 above. We discuss our use of material resources in Section 6.1 also.

Limits which stem from the context in which people are working are discussed in more detail in Section . below

Access barriers identified in the context of persona engagement are discussed in more detail below in relation to *Developing and Sustaining*.

Developing and Sustaining

The general question is about the usefulness of our contribution.

Does the Framework allow and encourage continued learning; the continuing growth and development of expertise and confidence among practitioners? Are people empowered to continue to build their understanding and practice through their use of the CDIH Framework? Are we “useful” in the sense that developments that we have facilitated continue to evolve and develop?

The construct of developing and sustaining as one dimension of usefulness focuses attention on the process of engagement as people implement the CDIH Framework in their work over a period of time.

It is evident that the duration of the present project has been too short to accumulate a great deal of empirical experience about the developing and sustaining qualities of the CDIH Framework. However, there are some early indications. This is a complex issue and we need to tease out the issues a little more before reflecting on our experience in the field.

In the preceding sub-section we have discussed factors which facilitate or hamper the accessing and implementing of the CDIH Framework.

Access barriers identified in relation to the process of personal engagement included.

- non-congruent values,
- lack of theoretical skills and abstract thinking, limited inter-personal skills.

Clearly the CDIH Framework has a value position. People who are not comfortable with the value assumptions of the CDIH Framework may find it difficult to access much of the analytical framework and will probably find it hard to implement the suggestions with respect to practice.

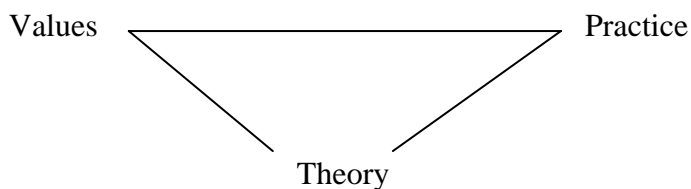
The CDIH Framework also has a strong theoretical base. People who do not have experience or confidence in handling abstract ideas are likely to have difficulty accessing the package as a whole, understanding the emphasis on care values and taking on board the principles underlying our practice suggestions.

The CDIH Framework arises from, and feeds rote practice. Whether in the provision of services or in providing support to a committee the practice of community development is basically about "being with people". The developmental principles of empowerment,

building community and personal growth are fundamentally about people and personal relationships. People who do not have well developed “people skills” (active listening, connected knowing³, constructively handling conflict, etc) may find it difficult to identify with the practice, access the theory and understand the practical relevance of the affirmation of the core values.

These three barriers to access also provide a useful framework for reflecting upon the developing and sustaining usefulness of the Framework. Does the CDIH Framework have the resources and the potential to enable people to work through and transcend such barriers?

Is it possible to gain access to part of the Framework and start implementing on that basis? Does the Framework provide the opportunities and conditions for reorienting one's values and/or developing theoretical skills and/or people skills



There are a number of features of the CDIH Framework which should contribute to its developing and sustaining usefulness.

For people who are resistant to theory (perhaps the commonest access barrier) the following features may facilitate access

The emphasis on reflecting from practice, e.g. scheduling time for reflective discussion and documenting case studies, may assist in the development of theoretical skills and the demystification of them

The emphasis on longer term strategic planning throws up questions which require the development of some theoretical skills to address.

The emphasis on peer support should provide non threatening opportunities to come to grips with theoretical issues.

Belenky MF, BM Clinchy, NR Goldberger and JM Tarule (1986) "Womens' ways of knowing", Basic Books, New York

The continuum concept offers an image of developmental practice without heavy theoretical overhanging. However, seeking to practise in this way will raise questions which will call for some exploration of theoretical issues.

The demystifying of theory may have been advanced by the work of CDIH in this area and the sense that CDIH belongs to the community health field.

For people who feel uncomfortable with the explicit affirmation of social justice values as having independent legitimacy the following features may facilitate access.

The emphasis on community accountability (exposing one's self to direct feedback from the people whose health and development one is supposed to be working for may lead to a rethinking of one's value assumptions.

Exposure to information and debates about inequalities in health may also lead people to rethink their previous value assumptions.

Peer support groups will also provide opportunities to rethink different aspects of one's professional socialisation.

For people whose limited interpersonal skills make it more difficult to identify with the principles and values of community development in health the following features may facilitate access.

Emphasising the importance of personal development and the strengthening of personal relations as central developmental principles affirms the importance of personal style in day to day practice, real talk and connected knowing⁴. Giving a higher priority to interpersonal skills should encourage more deliberate steps to improve one's skills in this area.

The establishment of peer support opportunities should provide opportunities for skills development.

To what extent have our clients and partners picked up these access features of the CDIH Framework?

Do they in fact facilitate developing and sustaining usefulness?

4. Belenky MF, BM Clinchy, NR Goldberger and JM Tarule (1986) "Women's ways of knowing", Basic Books, New York.

We believe that the North East Regional Community Health Committee and the Kiewa and Ovens Valley Community Health Service both illustrate groups who may not have a strong tradition in theoretical work but, having come to grips with the values and practice of community development are moving towards a more confident approach to the theoretical side

another instance of a group which was not fully comfortable with the value stance of CDIH we have observed as they get involved in strategy planning and confront information about inequalities in health, a gradual rethinking of some value assumptions.

These examples are essentially straws in the wind. They demonstrate that knowledge and skills development and the reorientation of values are possible through the use of the Framework but they do not give any indication of the extent to which it might be taking place. The time spanned by our consultancies has been very short in relation to the kind of personal and skills development involved in this concept of developing and sustaining usefulness. Perhaps these questions will form the basis for the next evaluation and research project.

Summary - The Dimensions of Usefulness

We have explored four dimensions of usefulness .

In relation to “effectiveness” (does it lead to better practice?) we cited leading examples of improved community health practice from each of our consultancies. These were in areas of practice with which we had been involved; the directions of change were consistent with our suggestions and feedback from our partners suggests that we did in fact contribute to the improved practice.

We concluded that, in the context of these consultancies, the service offered by CDIH has been effective.

The second dimension of usefulness which we have used is “validity” which refers to the CDIH Framework as a package. We have reflected particularly on the response of experienced community development practitioners to the framework; both their explicit reactions and whether it was regarded as affirming their practice.

We have concluded that, in these terms, the Framework is valid.

In relation to “accessibility and implementability” we reflected on the three main elements of the CDIH framework, practice, theory and values. We reflected on instances where our partners had taken up in some degree these elements or had found some difficulty in doing so.

The practice elements of the Framework have been accessed most easily. Some people have accessed the theory with enthusiasm but they are in a minority. The affirmation of the independent legitimacy of the core values, as a key element of community development, is consistent with the practice of many of the people we worked with but it was not overtly taken up widely.

We have identified three sets of factors which may have made accessing the Framework easier or more difficult. These relate to presentation (discussed in Section 6.1), context (discussed in Section 6.4) and the process of personal engagement (with the Framework).

This process of personal engagement is the focus of the *developing and sustaining usefulness* concept, the final dimension in which we are evaluation the usefulness of the CDIH Framework. This concept starts with the premise that many potential users will have difficulties in engaging one or more components of the Framework. The question we asked here was whether the Framework has the resources to sustain such incomplete engagement

and to provide opportunities for the individual to gradually develop an understanding or ownership of the other, initially more difficult aspects

We have noted some early findings which suggest that the Framework y have this quality of developing and sustaining usefulness.

We conclude that the consulting practice of CDIH and the Framework on which it is based are effective and valid accessible and implementable in some degree for most of the people we have worked with.

In short, we conclude that it is useful

Our conclusions correspond to the feedback that we've received from cur partners

One manager has commented , "*It 's a pity that words that can't capture the spirit and motivation with which our staff and committee are now facing the development of our health service agreement and the other the tasks of community health*".

A regional director said, "*The community development approach is an unknown quantity in the delivery of health services in rural area. CDIH have provided a lot of assistance in helping us to understand the community development approach and its benefits*".

The next question is, "*How Useful?*" These are the *dimensions* of usefulness which we have employed in this evaluation. The question of how useful, is to be answered with reference to the *standards* that we proposed should be used within the dimensions of usefulness, namely:

- how useful, in relation to prevailing understandings and prevailing practices?
And
- how useful, in comparison to previously available or alternative sources of consultancy support and resourcing?

We discuss *prevailing understandings* and practices in Sections 6.3 and 6.4 below, against the strategic policy context set out in Section 2.2, above.

We consider *previously available and alternative sources of consultancy support and resourcing* in Sections 6.5 , below.

6.3 About Our Approach to Community Development in Health

In this sub-section we reflect upon what we have learned about community development in health from our experience through the course of this project. We reflect particularly about our conceptualisation of community development in health.

For the purposes of the evaluation we developed a check list of the key elements of the CDIH Framework; that set of ideas, information and suggestions which together constitute the main features of the CDIH Project's approach to community development in health and which (as a whole package) is sufficiently different from prevailing practice and understandings to justify describing it as the "CDIH Framework".

A summary of the elements of the CDIH Framework is included at Appendix 3.

In coming to the findings detailed below we have reflected upon our experience in the consultancies and workshops in terms of the key themes and foci. What did our practical experience tell us about the analysis upon which the CDIH approach is based and about the suggestions for practice that it incorporates?

In essence, our experience in these consultancies has been broadly consistent with the CDIH Framework.

In testing our own ideas against our experience of the consultancies and workshops we have looked particularly for instances where there was opposition or resistance to our approach. However, it is necessary to make a judgment in each case as to whether such resistance would be interpreted as reflecting intrinsic weaknesses in the CDIH approach or, on the other hand, whether it reflects practices and understandings in the field which are inconsistent with community development in health.

Testing the Integrity of the CDIH Framework

Core Values

We have emphasised the concept of "core values" as integral to the definition of community development and have affirmed social justice values as independently legitimate reference points.

This affirmation of core values has generally been strongly accepted. However, while

there has been no clearly articulated challenge to this approach, there has been some occasional grumbling.

There are some who hold that social justice has nothing to do with health. There are others who hold that health workers should not recognise social justice issues unless clearly and causally related to health.

We do not interpret such resistance as challenging the integrity of the CDIH Framework.

Rather, we recognise the influence of different streams of thinking which contend within the broader cultural and ideological areas of society.

We also recognise the influence of significant currents of thought within the mainstream health system. We discuss some of these in more detail in a later section

Theory

We have identified four key insights which we regard as integral to the CDIH Framework (see Appendix Three).

We are conscious that our experience in the consultancies and in workshops has helped us to articulate these insights more clearly.

We have experienced occasional passive resistance to discussions of theory. There have been few actively articulated challenges.

We have sought to understand such resistance as we have experienced

In large degree we attribute it to a general underdevelopment of theoretical discourse in community health.

There is another pattern of tentative resistance which we believe can be traced to some of the difficulties in actually implementing community development in health. All workers experience frustration from time to time at the contextual barriers to implementing a community development approach in their health work. Sometimes in such situations one wonders whether the theoretical tools one is working with are at fault. We have reflected on the occasional instances of this response. It is usually clear that there are other reasons for these frustrations. We are also conscious of other comparable instances where other approaches, consistent with community development theory have been more successful.

Finally, we are also conscious of the continuing influence of schools of thought which seek to understand inequalities in health and the differential prevalence of risk factors in terms of:

- free choice (and hence not to be addressed), or
- moral weakness (and hence unable to be addressed) or
- behavioural weakness (and hence to be addressed primarily through behavioural strategies).

Practice

The practice of community development in health (within the CDIH Framework) is conceived in terms of three levels of practice: activities, projects and developmental principles/strategies. The continuum concept and our approach to the interrelationships between planning, evaluation, research and accountability are also important parts of the CDIH approach to practice. These are discussed in more detail in Appendix Three.

We have not presented these ideas as a single formal package. Our general practice has been to offer ideas and suggestions which are related to the concerns and context of the people with whom we are working.

Our ideas in relation to planning were actively taken up in most of our consultancies. Once people have started to consider the application of developmental principles in project planning, it is our experience that they move more comfortably to adopting a developmental approach in their activities of daily practice.

Whilst we have not been confronted with any formal challenges to our approach to the practice of community development in health we are of course aware that a great many practitioners continue to practice in more traditional patterns and styles.

There have been challenges to some particular elements of our practice.

There is patchy resistance to the notion of responding to the priorities of the people for whom, with whom you are working. Presumably, the expert knows best.

There is a significant stream of opinion that is skeptical, if not cynical about community-based management.

The concepts of empowerment and community-building are sometimes challenged as “jargon”.

For every critic such as these we are aware of several other practitioners who are practising in accordance with the CDIH Framework and we see others who are gradually reshaping their practice in this direction. we do not interpret these criticisms therefore as pinpointing fundamental weaknesses in the Framework

We do attribute some of these challenges to the continuing influence of the disease-centered paradigm and traditional professional values. We are also aware of significant contextual barriers to the practice of community development in health.

Part of the CDIH approach to practice is the emphasis on community accountability and some related ideas about the interrelations between accountability and evaluation, planning and evaluation, and evaluation and action research.

These ideas were not widely accessed during the consultancies. However, our observations of the ways in which these functions are undertaken within the field generally strongly supports the priority we have previously given to these issues.

There is a common confusion around the proper relations of accountability and evaluation. There is uncertainty about reasonable and unreasonable accountability obligations. The practice of action research as a routine part of practice is too often consigned, with theory, to the "academic" basket.

Nonetheless we are aware of a number of practitioners who are rethinking these issues in different to s as a consequence of our consultancies and workshops

Our specific suggestions in relation to the interrelations of planning evaluation and accountability have not really been tested extensively.

The continuum concept is an important part of the CDIH Framework

The problems in practice which lead to its original formulation are still evident, in particular, the tendency to marginalise community development as something that the "community development worker" does, rather than understand the more general applicability of the developmental principles.

The continuum concept has been well received. It is explicitly about the interface of health work and community development; it is about practice (and doesn't involve any

theory); it is reassuring for practitioners to realise that developmental practice is consistent with continuing one to one clinical work. It has proved an accessible entry point.

The Standing of Community Development

We have reviewed our experience with the CDIH Framework focusing particularly on instances where we could see it being taken up or instances of resistance to it.

We have reflected on these instances have confirmed the basic robustness of the Framework.

We now come to reflect on the meaning of the resistances that we have experienced. We have recognised two sets of attitudes in relation to community development in health which we believe underlie the resistances we have experienced.

The first set is characterised simply by confusion. We discuss some general issues of terminology below and some specific confusions.

The second set of attitudes are more explicitly oppositional. Community development in health aims to improve health whilst and by addressing the structural causes of ill-health. It is to be expected that a reformist approach to health promotion will illicit a conservative reaction. We discuss below two specific sources of opposition.

Terminology

Perhaps the most salient findings in relation to the status of community development in the community health field arise in the diversity of meaning attributed to the term.

This was well illustrated in the papers presented to the national workshop on the role of community development in the National Better Health Program, in particular, the different meanings evident in the papers given by Galbally, Leeder, Furler and Legge¹

There is a common tendency in the community sector generally to use the term "community development" simply to mean service development, without significant weight being placed on parallel developments in social relations such as are expressed in the notions of empowerment and building community.

CDIH (1989) "Community development in Health For All" , Proceedings of National workshop, July 1989, Melbourne

It is apparent that Rothman's categorization of community organisation² (locality development, social planning and social action) still exercises a significant influence on local discussion of community development. Rothman's categories are primarily descriptive, describing different patterns of community work which can be observed. The continuing influence of Rothman's analysis may contribute to some of the segmented thinking which is evident.

We have followed Benn's "developmental model"³ rather than Rothman. By focusing attention on underlying social process and societal dynamics Benn's thinking encourages the use of categories which are more consistent because they are derived from a more coherent theoretical framework.

Key elements in our formulation (Appendix Three) are the developmental principles (empowerment can community- building) and the continuum principle (the concept that these developmental principles can be expressed in a wide range of contexts.

We are here considering the application of community development principles in health. our analysis, in relation to health, commences with what could be regarded as the leading public health issue of the day, the existence of stark inequalities in health, across social and economic status.

Our understanding of the underlying dynamics of social inequalities in health attributes key significance to the concepts of powerlessness (as compared to exercising reasonable degree of control over one's destiny) and alienation (as compared to filling a valued social role in your community)⁴.

Benn's developmental approach integrates well with this analysis of health differentials and in a way which can be usefully applied in the community health context

The continuing diversity with respect to the meanings given to the term "community development" has contributed to a degree of confusion which is evident in the field in Victoria.

2. Rothamn J (1979), "Three models of community organisation practice" in Cox FM et al (Eds) "Strategies of community organisation: a book of readings", FE Peacock, Illinois.

3. Benn C (1981) "The developmental approach: demonstration programs in the Brotherhood of St Lawrence", Social Research Centre, University of New South Wales, Kensington.

4. CDIH (1988), "Health and illness in a social context and the role of community development", Overview paper in the Resources Collection

Some people's thinking is still bounded by Rothman's categories; others have taken the opportunity of the unsettled nature of the issue to interpret the term on the basis of strategic convenience rather than in terms of any coherent model of health and social process.

Different uses of the term sometimes obscure different theoretical or value positions. They are commonly a barrier to communicating in relation to these more fundamental issues.

One of the most common expressions of unclear thinking in relation to community development is when it is used as a transitive verb; something one person or group does to another.

It is useful to keep in mind the literal meaning of the term "community development", in effect a social and historical phenomenon; communities develop. Community development is not something that one person or group "does" to another person or group⁵.

The "discipline" of "community development" is about locating one's practice within a social context (See Appendix Three for a more detailed account of our understanding of community development in relation to health).

Empowerment

This confusion in relation to the meaning of community development and its theoretical underpinnings is commonly expressed in the use of the term "empowerment".

Because of the importance of the concept in our Framework the confusion warrants some discussion here.

We have observed a common tendency, in discussions of community development to refer to "empowerment" as a transitive verb (e.g. "we empower them"). In our view the concept of "empowerment" as part of community development theory must be expressed as an intransitive verb; a developmental process which people may go through, perhaps as a consequence of certain experiences but not the consequence of a direct "handing over of power". This latter use of the term is inconsistent with the

5. See particularly the comments of Leeder in CDIH {1989 "Community development in Health For All", Proceedings of National Workshop, July 1989, Melbourne

Developmental approach of Benn and is inconsistent with our CDIH Framework⁶.

The Challenge of a New Paradigm

It is evident that there is some resistance to community development ideas within the culture of the health system. This may be partly attributable to terminological confusions but there are other sources of resistance also.

A significant source of resistance to the application of community development in health arises from the explicit challenge of the pathology or disease-centred model of health which informs a great deal of policy and planning as well as clinical practice.

Our insistence on understanding health and illness in a social context has not been overtly challenged during our consultancies but hesitation around the notion of "health and illness in a social context" has permeated our reception in many respects.

In brief, the issue is whether the prevention and treatment of disease (defined as the presence of pathology) should be regarded as the primary purpose of the health system (institutions and professionals) or whether health should be regarded more overtly as a means to an end, in which case how should that end be conceived?

In some formulations the purpose of health care is expressed in terms such as "more effective social functioning:". This essentially begs the question by not specifying the meaning of "effective social functioning".

In our formulation "effective social functioning" is defined in relation to two conditions: firstly, a reasonable (and equitable) degree of personal and community autonomy and secondly, opportunities to play a valued social role in one's community and society.

The adoption of this more specific concept of social functioning has crucial consequences in relation to health practice; indeed the concept of applying "developmental principles" in sick care or health promotion turns upon the notion of addressing objectives which are defined in terms of disease and pathology and in terms personal and community autonomy and valued social role.

One illustration of the far reaching implications of this developmental orientation in health practice is the phenomenon of dependency creation in clinical practice, a

6. Leeder's comments are particularly relevant here also. (in CDIH (1989) "Community development in Health For All", Proceedings of National Workshop, July 1989, Melbourne.)

side effect of much that is respected and effective within the narrower disease-centred paradigm and yet an approach to practice which is actively eschewed where developmental principles influence health practice.

It is apparent that the continued dominance of the disease and pathology centred view of health is a major barrier to the application of community development principles in health on a wider canvas. We need to continue to rework our ideas in order to produce a more accessible presentation of the social context paradigm.

A challenge to Professional Values

In reflecting on our experience over the last twelve months, another source of resistance to community development ideas in health is discernible, namely the challenge that the CDIH Framework represents for some of the more reassuring tenets of professional value systems.

The clash arises particularly from the implication that values of equity, autonomy and participation must be regarded as legitimate independent goals; not simply as instrumental conditions for achieving health. Health *and* social justice; not social justice *in order* to achieve health.

This notion does not sit easily with the concept of the professional as an expert in relation to certain defined territory; someone whose status is tied to a field of practice defined within the terms of those professional boundaries. The application of community development in health involves moving beyond the safety of conventional professional boundaries; taking a position in relation to values of equity, autonomy and participation; key conditions for addressing inequalities in health but not argued from within health.

There is some resistance to community development ideas as arising from this clash of values. It doesn't represent any kind of direct challenge to the intellectual integrity of the CDIH Framework but must be accommodated in the presentation of community development in health.

6.4 About Community Health in Victoria

In this section we reflect upon the kinds of strengthening that community health needs if it is to realise the strategic role towards better health, envisioned by the Alma Ata Declaration and the Ottawa Charter (discussed in Section 2.2).

We reflect upon our experience in the five consultancies and through the workshops program. Our conclusions are of course also strongly influenced by our wider knowledge of the field.

Community Health and Primary Health Care

First and foremost, we affirm the potential of community health to serve as the leading edge of a strategy for better health, as envisioned in Alma Ata and Ottawa.

On the basis of our experience through this project we confirm that the resources (people, organisations, ideas and skills) are there; there are no insuperable barriers.

Community Development Essential In Primary Health Care

Secondly, we affirm that the discipline of community development (the Framework, as set out in Appendix Three) is entirely consistent with the primary health care strategy; indeed it brings together a set of ideas, and practice suggestions which are essential for the implementation of the primary health care strategy.

The concern for inequalities in health which underpins Alma Ata and Ottawa is also one of the starting points in our analysis of community development in health and is fully recognised in the core values.

The need for a structural understanding of health and illness in their social context is clearly a prerequisite for advancing the primary health care strategy. The elements of such an analysis are part of the CDIH Framework.

The Ottawa Charter calls for a health practice which is "enabling, mediating and advocating" and which addresses structural causes of ill-health at the same time as addressing immediate health needs. The practical skills and strategies needed for this kind of practice correspond entirely to the elements of practice outlined in the CDIH Framework, including the notion of developmental health care practice.

We acknowledge that questions have been asked about the degree to which community development in health (as promoted through CDIH) has been contextualised within the primary health care strategy¹.

In fact, our presentation of community development in health during the consultancies and in the workshops has at all times strongly referenced community development in health to the primary health care strategy and the relevant policy references.

The Need For Strengthening

It against the background of these conclusions that we have reflected upon the community health field as we know it (including our experience of the consultancies project).

Practice

The most obvious need areas are in relation to issues of practice.

There is a widespread recognition of the need for assistance with planning (organisational development and project planning) but planning which is sympathetic to community health.

Uncertainty about the role of committees of management is common. There is a need for clearer understanding about why committee of managements are important; the strategic significance of community based management.

Closely related to questions about the role of committee of management are uncertainties around a range of issues associated with accountability. Clearer and more sophisticated understandings of accountability are needed; integrating concepts of community accountability with the obligations of bureaucratic and professional accountability.

There is a widespread commitment to the concept of a multidisciplinary style of practice; there is no clearly articulated rationale attracting a consensus across the field as to why multidisciplinary teams are a good idea. Working in a multidisciplinary way is difficult in the absence of any clear account of why this is a good way to work.

These are not simply skills issues. Skillful practice in these areas is informed by a broader theoretical framework and derives direction from a set of values. In some degree

1. See especially Furler and also the report of the final plenary in Proceedings

the weaknesses in community health reflect a dearth of theory and a blurring of vision.

Theory

The prevailing level of discussion and debate about the principles of community health (including community development) and the broader strategic context represented by Alma Ata and Ottawa is not intense within the community health field. Nor is it sufficiently wide reaching to throw a sharp light on many of the grumbling issues in community health.

There is a significant number of workers in community health who do not have a clear understanding of a structural analysis of health, illness and health care. In addressing issues of community development, such people are commonly frustrated by references to theory; they would prefer a cookbook approach to community development.

One of the preconditions for a more vigorous culture of reflection and discussion is a stronger sense of being part of the same movement, a sense of greater coherence and self-consciousness as part of the community health movement.

There is a need for a stronger common understanding about what community health is on about; there is also perhaps a need for clearer leadership. Such leadership should be consistent with the dispersedness and local autonomy which are part of the strength of community health. It needs to be seen to be arising from and accountable to the field.

How To Strengthen Community Health

These observations set the context for a discussion of strategies for strengthening community health so as to enable it to realise its strategic potential in the terms of the primary health care strategy.

The conditions for community health to realise this potential appear to us to fall into three groups.

Firstly, it is clear that there needs to be a continuing support and resourcing in relation to the ideas and practice suggestions gathered together in the CDIH Framework. This would include building a culture of reflection and developing a stronger theoretical capacity on that basis. It would include affirming the independent legitimacy of the core values. It would include the strengthening of practice in its theory and values context.

Secondly, there needs to be continuing discussion around the ideas, background and accumulated experience which have fed into the primary health care strategy and the role of

primary health care in the implementation of the Ottawa Charter.

Thirdly, there is a need for a clearer sense of leadership in community health, a clearer collective vision and the development of a more conscious sense of being part of a broader movement.

The development of leadership, of a collective vision and a stronger self-consciousness depend primarily on the people and organisations who are part of the community health movement.

Any initiative aimed at promoting community development in health and or the ideas of primary health care in community health should be undertaken in such a way as to also promote the development of clearer leadership, a clearer collective vision and a stronger sense of self-consciousness as part of a movement.

Historical Aspects

It may be useful to recognise where community health in Victoria is today within an historical perspective.

Community health commenced in 1973. The early to mid 1970s was a period of great activism. Among staff and committees there were a high proportion of activists who had a strong commitment to community controlled health care.

The activism was rekindled during the late 1970s as Commonwealth funding was reduced but, over the years, as community health settled down, the activists (amongst the staff of community health centres) were in some degree replaced by recruits from the hospital system. Among this group were people who knew what kind of health care they didn't like but who had not had any training or opportunities to explore the principles underlying community health.

During the 1980s some of the earlier intensity and urgency in community health has subsided. A new generation of staff has been recruited who have not been stimulated or encouraged to challenge and criticise and rework the way things have always been done.

Among committees of management the experience of working with governments which are supportive of community health has quenched some of the urgency and questioning of the early years. During the 1980s the questioning subsided; the activists became fewer and more marginal.

We have a sense that the wheel has turned full circle; that community health is ready for an explosion of reflection and research, criticism and creative thinking.

The reception that the CDIH Project received from the field during the development of the Resources Collection and the reception of the Resources Collection itself prefigure a renaissance in community health in Victoria.

The energy and questioning which we have experienced during the four consultancies suggest that this renaissance has commenced.

6.5 A Resource and Support Unit for Community Health

In this section we address directly the need for a resource unit to support the practice of community development in health within a primary health care framework.

Community health has a strategic and leading role to play in health promotion, in the delivery of health care and in the reorientation of the whole primary health care sector, the whole health system. This notion (developed first in Section 2.2) is confirmed by our experience through the consultancies project (discussed in more detail in Section 6.4, above).

Community health will need some strengthening if it is to fully realise its potential as the leading edge of a primary health care strategy towards better health. The kind of strengthening needed is discussed in Section 6.4 above.

Our evaluation of the consultancies project confirms the value of the CDIH Project, as a resource and support unit to the community health field. (Our conclusions regarding the usefulness of our contribution in the consultancies are discussed in Section 6.2.) We have noted some aspects of our own practice where there may be scope for some improvement (see Section 6.1).

As part of this evaluation we have reviewed the package of ideas which the CDIH Project has gathered together; the theoretical frameworks, the ways of understanding practice and the core values concept. In so far as this package of ideas (the CDIH Framework, see Appendix Three) has been tested in the circumstances of this project it has proven to be robust. (See Section 6.3.)

The strong response from the field to the Resources Collection and to our workshops suggests that CDIH is regarded by the field as having an important and continuing role to play as a support and resource unit to community health.

The range of educational and support resources available to the community health field has been reviewed as part of the AHMAC Continuing Education in Primary Health Care report. It is clear that there are no resource units comparable to CDIH in Victoria, or elsewhere in Australia. The community health field in Victoria has been chronically underresourced

1. Australian Health Ministers' Advisory Council (1989) The Report of the Consultancy on Continuing Education in Primary Health Care.

in terms of central support. The community health research units in South Australia have not been replicated elsewhere.

We believe that an essential strength of CDIH is the appreciation that it has grown out of the community health field and that in a real sense belongs to the community health field.

Some of the conditions for success for any future unit would be that it is accountable to the field; that it respects and builds on the experience and achievements of the field; that it provides skills development in the context of an explicit commitment to Health For All.

Promoting the practice of

community development in health would be a vital part of its work.

The Community Development in Health Project (CDIH) would provide an ideal foundation upon which to build such a unit.

In summary, community health has a leading strategic role to play in achieving Health For All and reorienting the mainstream health system. The community health sector will need to be strengthened if it is to be capable of realising this potential. The resource and support role which has been played by the CDIH Project has the potential to contribute significantly to the strengthening of community health and primary health care generally in Victoria.

1. RECORD OF OUR FIELD WORK

In this Appendix we provide a description of the "partners" with whom we have worked and a summary account of our "field work" program with each of the partners.

Confidentiality. The sharing of uncertainties has been an integral part of our work with the various community health organisations with whom we have worked over the last ten months. The confidentiality of these discussions has been regarded as an important condition of our partnerships. The staff of the Project who have undertaken all of this consultancy work have not shared the details of this work even with the Steering Committee of the Project. It would not be appropriate to provide more than a summary description of work undertaken here.

1.1 Kiewa and Ovens Valley Community Health Service

Kiewa and Ovens Valley Community Health Services was established in 1975. The services are based in the four main towns in the Kiewa Ovens Valley Beauty Yackandandah Myrtleford and Bright.

There are the equivalent of six full time staff: .5 manager

- 2.7 community health nurses
- 1 administrative officer
- 1 welfare officer
- 1 ethnic worker (grant-in-aid)
- .2 administrative assistant.

Services offered include: blood pressure checks; bowel cancer screening for men and women; exercise for older adults; arthritis programme; hydro-therapy; parenting classes; the women's sharing and support group.

Among the health education programs offered are: diabetes activities; self-help education and support; breast self-examination; health and well-being, activities for persons of non-English speaking backgrounds; middle years education; living skills for women with English as a second language; education about sexually transmissible diseases.

Other programs offered are: counselling; emergency relief (finance); financial counselling; resource information and referral work; health/welfare group meetings; group work; advocacy; social security workshops; case conferences; adoption counselling; housing; social security work, family therapy.

The Environment

The Kiewa and Ovens Valley Community Health Services covers and services an area of approximately 5000 square kilometres, covering three shires: Bright, Myrtleford and Yackandandah. The population of the three shires is approximately 13,800 people (1981 Census Statistics).

A natural geographic division of the area is provided by a mountainous ridge which separates the two major river valleys - the Ovens and the Kiewa Valleys. While both Valleys and the towns situated in them, are very different in many ways they share several similar characteristics.

Both, at their Northern ends, are influenced by an alpine region, with its associated ski and tourist industry. There is restructuring underway in the agricultural sector in both areas.

Both contain at their Southern ends, much larger rural centres (out of the Kiewa and Ovens Valley Community Health Services area) to which the valley populations largely relate, and which provide services to that area. Regionalisation of government departments has for the most part ignored these natural relationships and linked the valleys for service provision. Other services provided by these large centres may not be restricted by valley or shire boundary, but distance often serves that purpose.

There are four major towns - two to each Valley - in the Kiewa and Ovens Valley Community Health Services area: Bright and Myrtleford (Ovens Valley) and Mt. Beauty and Yackandandah (Kiewa Valley).

Kiewa and Ovens Valley Community Health Services maintains or shares an office in each of these towns. The Upper Murray Regional Socio-Demographic Profile (1984) describes the region as a whole as a "region under transition" and this is particularly true for the Kiewa and Ovens Valley Community Health Services area. Many of the changes that the document outlines can be found in the different Kiewa and Ovens Valley Community Health Services areas:

- Increased population (Shires of Bright and Yackandandah),
- The decline of agriculture as an employer of labour (all rural areas but particularly Myrtleford),
- The growth of the Tourist and Service industry (Shire of Bright),
- The lack of public housing stock (particularly Myrtleford),
- The attraction of particular municipalities as retirement centres (Shire of Bright)

Perhaps the most important socio-demographic data for the purposes of the Kiewa and Ovens Valley Community Health Services relates to its population projections. These suggest that the Shire of Bright can expect a growth rate of more than double the Victorian average by the year 2001 with the Shire of Yackandandah not far behind, while the Shire of Myrtleford is expected to decline and tend towards the upper age groups. Both the shires of Myrtleford and Bright show a higher proportion of overseas born residents than country Victoria, and all three shires of Myrtleford and Yackandandah have a substantially larger proportion of families of the nuclear family' type (head, spouse and children) than the Victorian average.

Not only do the three shires within the Kiewa and Ovens Valley Community Health Services area show considerable socio-demographic differences, but the towns within the shires also have different influences.

Mt. Beauty township, while attracting a growing tourist industry, like the rest of the Shire of Bright, also has the largest proportion of its population employed by the State Electricity Commission. They work on the maintenance and operations of the Kiewa Hydro Electricity Commission, maintaining and operating the Kiewa Hydro Electric Scheme and bringing a suburban type of lifestyle and suburban needs to an otherwise rural area. The proximity of this town also to both the ski industry and a still significant tobacco industry has meant relatively large numbers of itinerant workers pass through the town all year round.

Yackandandah township is the centre of a largely ageing rural district, yet shows an increasing number of young families. This appears to be due to the growing numbers of professional people and families moving to the township to live, while continuing to work in the larger centres of Albury/Wodonga - a dormitory suburb in the making!

Most of the Kiewa and Ovens Valley Community Health Centres' area is well resourced in the everyday health and human services (doctors, hospitals, day care centres, district nursing services, ambulance services, infant welfare, pre-schools, schools (primary and secondary) and senior citizens clubs). Nursing home facilities have been scarce in some localities but this situation is changing with the building of new facilities in two towns. Infant welfare and pre-school needs are growing, particularly in Bright and Yackandandah but this is recognised by the responsible departments.

Other more specialized services are not so available locally, particularly those provided by government departments. Field workers are generally sent to the outlying areas but as their visits are likely to be on a monthly basis or at worst, irregular, these services are not always satisfactory.

The CDIH Consultancy

In October 1988 discussions were held with the manager regarding a possible consultancy with CDIH.

In November 1988 the committee of management endorsed the consultancy with CDIH.

In January 1989 there was a meeting with manager to discuss the consultancy and for the Project staff to be briefed in relation to background issues.

The following areas of work were identified as activities that were to be undertaken in the next ten months.

review the cycle of accountability, planning and evaluation in place at the service;

conduct workshops for the staff and committee of management at the service, including an introduction to community development issues and a discussion of future directions for the service;

introduce and trial the Resources Collection in the operations of the service.

(These were the draft consultancy objectives which were forwarded to VicHealth.)

During February there were visits to each of the four centres and discussions held with community health nurses and committee members.

A number of more specific areas emerged during these discussions. These were:

time management and priority setting by staff and committee

developing strategies for volunteers to become more involved in the work of the Kiewa and Ovens Valley Community Health Service

how to raise the profile and influence of community health in the region.

In April there was a joint meeting with Committee of Management from Kiewa and Ovens Valley and King Valley CHCs. The workshop was planned as an introduction to community health and community development. One of the main values of the meeting appeared to be the interchange of ideas from the two different centres. Some of the issues that emerged were

the relationship between doctors and community health the role of primary care in community health,

the role of committee of management members in setting priorities at the HDV regional level

how to build political support for community health.

A useful discussion was held with the community health nurse and the welfare worker at Myrtleford regarding services for people requiring financial relief. There was

interest in targeting groups of people who frequently utilize the Kiewa and Ovens valley Community Health service who are in receipt of pensions or benefits. Possible strategies discussed included: food co-operatives, credit union and housing cooperatives. It was agreed that more information about these strategies was needed.

In May there were discussions with the manager regarding the possibility of her publishing and presenting the Well Women's Project at the July 1989 National Workshop on Community Development in Health For All.

There was also a workshop held for committee of management members and staff around concepts of primary health care. This session was well received. The importance of networking with other welfare and health agencies in the localities and of improving co-ordination and cooperation between the services emerged.

Further discussions were held with the community health nurse at Myrtleford regarding services and possible project initiatives for low income people in the area. It was determined that a food co-operative was not feasible at this stage. It was decided that the welfare worker should concentrate on the family violence project at this time.

It was decided that the community health nurse should proceed to explore possible initiatives in relation to low cost housing. Issues discussed in this context included: defining target groups, type of housing required, availability of housing in the area, goals and objectives and time lines within the context of her existing work load.

During July the workshop on the Role and Responsibilities of Committee of Management Members was held.

One of the issues that emerged during the workshop was the variation in understanding and acceptance of the role and responsibilities of the committee of management. There was not unanimity around the general area of accountability to the local community. The need for greater communication among committee of management members and also between committee of management and staff was highlighted. The need for improved planning and reporting structures were also identified.

During August there were continuing discussions with the community health nurses in relation to planning work loads forward planning of programs, targetting particular groups and reporting mechanisms.

There was further discussion in Myrtleford regarding the Housing Project. Contact had been made with the Ministry of

Housing and Construction regarding urban homesteading. The project is to be documented in diary form and photo album.

There was a discussion with the nurse co-ordinator regarding the Feldenkrais exercise programme for chronic pain sufferers, in particular planning the programme and planning the evaluation.

There was a discussion with the nurse co-ordinator regarding the nurse co-ordination role:

prioritising

timelines

clarification of the role and its responsibilities.

In September there was a workshop for the committee of management on planning, communication and structure in the Committee of Management and conflict resolution.

The most important issue that emerged for committee of management members was that they have the power to use their own experience and perception of needs in their localities for suggestions in the planning of programs.

Another issue that emerged was around lay representatives dealing as management with professional staff, particularly where there was conflict. The issue of distance was recognised as a real barrier to better communication between meetings.

A recurring theme was the tension between spending time on service delivery versus finding time for planning.

Amongst the action steps agreed upon were the formalisation of a planning structure, the establishment of a sub-committee to consider the conflict resolution process and the exploration of the "pink planners" process.

There was also a workshop run for staff, around team building and conflict resolution. Issues that emerged included the following.

The majority of staff are women and community health nurses; therefore other staff can sometimes feel marginalised.

It is difficult to function as a team working in dispersed locations, let alone provide effective peer support.

It is important to build a sense of team culture, common goals and norms.

It is important to deal with conflict rather than stepping around it.

There is a need for improved communication channels with the Committee of Management.

Tensions were recognised between individual professional skills and expectations and the community health philosophy and goals.

A planning session was held with the community health nurses regarding environmental programs. Issues which emerged included:

importance of local alliance building

importance of delegating activities

recognition of differences in the various localities utilisation of data and people

not being reactive to other peoples issues

creating time lines.

In October there was a workshop on evaluation for the Committee of Management. Issues which emerged included the following.

Experience with evaluation had not been positive after a threatening experience.
Standards must have relevance to the community.

The rural experience is often not recognised.

There was firm acknowledgement of the need to work towards a better evaluation system.

A workshop on planning was held with the community health nurses around the Environmental Health Project.

Drastic changes were made to the initial plan. It was agreed that each locality should devise their own plan. The community health nurse and members of the Committee of Management had met in three localities and defined the areas they wanted to develop. These included:

recycling

chemicals in the home,

use of chemicals in farming.

1.2 King Valley Community Health Service

The King Valley Community Health Service was established twelve years ago. It is based at two centres Moyhu and Whitfield and is located in the Shire of Oxley.

It has a total staff resource equivalent to 6.5 full time staff. Staff directly employed include:

- manager
- secretary,
- five community health nurses,
- Adult Day Activity and Support Service co-ordinator
- activities officer
- driver

In addition the are visiting staff who work from the centre include:

- doctor (one session per week)
- maternal and child health nurse
- district nurse,
- podiatrist
- masseur,
- naturopath,
- learning exchange coordinator
- occasional child care staff,
- mobile preschool staff,

Staff who are available for consultations on an as required basis include:

- dietician, and
- occupational therapist.

The localities served by the service include:

Greta, Hansonville, Oxley, Docker, King Valley, Carboor, Cheshunt Moyhu, Myrhee Whitfield Whourouly, Bobinawarra.

The Shire of Oxley extends across an area of 2,792 square kms. It is a large rural municipality characterised by a large number of small hamlets. The major centres Whitfield Moyhu and Whorouly are isolated from each other.

Its main industries include tobacco, hops and horticultural production in addition to beef and dairy farming.

The population is widely dispersed across the Shire. The estimated number of residents is 5,630. There were no medical services in the whole of the King Valley. As of November 1989, a doctor will be providing a medical service

on two afternoon sessions per week at the Moyhu Community Health Centre.

There is no hospital in the area.

The residents of Oxley Shire generally relate to the City of Wangaratta for services. The Shire Office is in Wangaratta

Programs and services offered at the King Valley Community Health Service include:

- home visiting and assessment
- district nursing care,
- maternal and child health assessment,
- antenatal classes
- Mammacheck,
- blood sugar screening
- women's health workshop,
- blood pressure screenings,
- stress and relaxation management,
- minor illness and infections management,
- first aid,
- Fresh Start campaign,
- Sun Smart, personal safety and human development program in all schools in the Valley
- other programs on request.

The CDIH Consultancy with the King Valley Community Health Service was initiated by CDIH staff who contacted the co-ordinator of both the King Valley Community Health Service (one day a week), and Kiewa and Ovens Valley Community Health Service (two days a week).

She believed that in terms of community development a review of activities and directions was timely. Important issues identified by her were the effects of agricultural sprays and chemicals and the total absence of public transport.

Another area in which the King Valley Community Health Service was involved was the establishing of an adult day care program. In 1988 the Departments of CSV and Health had conducted a needs study in the Shire and recommended that funds be made available for a HACC/Department of Health day care programme but the Shire was not willing to take it up. The King Valley Community Health Service after lobbying, got the commitment for the service, which is to be auspiced by King Valley Community Health Service and not the Shire.

The Wangaratta Base Hospital will be shortly taking over the auspicings of the district nursing service from the Wangaratta Base Hospital. The service will be increased from 18 hours per week to full time, thereby freeing up community health nursing time, possibly allowing for more community development oriented programs and services.

Process of Consultancy

In January the first meeting was held with the manager. She emphasised that it will be important to work with each service separately.

In February there was a meeting with the committee of management, regarding the proposed CDIH consultancy. Issues which could be addressed in the course of the consultancy:

- assistance in planning funding submissions,
- the development of ongoing evaluation system for the Adult Day care Service
- developing a plan of operation for the first 6 weeks of service.

A workshop on community development in health was mounted for the staff of the centres. Issues that emerged in relation to community health and community development include:

- difficulties experienced by people in rural areas
- lack of health resources no doctor in the valley
- long distance which people have to travel to providers
- contribution of community health empowering people to take control making people aware of self and environment
- developing knowledge skills and self confidence enabling elderly people to stay at home longer helping others to help themselves
- support to carers in the home

A discussion with the community health nurse at the Whitfield centre brought up a series of issues:

- lack of funding for programs
- limited time for program planning and delivering due to expectations for service delivery and seasonal factors in relation to crops - grape picking, hay making
- small population in a large geographic area

identification by hamlets rather than King Valley

limited catchment groups for identifying with particular issues

need to work with existing groups

difficulty of developing rapport with isolated people cultural of independence,
therefore we don't need help time spent

lack of planning by staff as a result of the above factors and the fact that most are part
time

In April a workshop for committee of management members was held, designed as an
introduction to community health and community development.

This was a good workshop with committee of management members from Kiewa
and Ovens valley and King valley Community Health Services. Issues raised
included:

the relationship between doctor and community health

co-ordination of health services and role of community health at committee
meetings.

A discussion with the Co-ordinator of the Adult Day Care Services about different types
of evaluation staff performance (including self assessment) was held. Further issues in
relation to older people which were discussed were:

responding to the different needs of the elderly and developing appropriate
services

socialisation opportunities to counteract rural isolation

overcoming loss of skills after illness,

family relief - dealing with the difficulties of living with children.

A discussion with the Nurse Co-ordinator regarding health education resources was held. This
clarified that there are two different sets of resource needs, those for staff and those for the
community. The possibility of using the DHC's information was also discussed.

In May the workshop for committee of management members on roles and responsibilities of committees of management was held.

There was a discussion about why people are on committees of management. Among the reasons these committee members articulated were:

to develop better services for the older people, responsibility to the Community,

contribute local knowledge for particular issues control over service delivery

function as a sounding board and support for staff

Among the key issues that emerged in the discussion accountability were:

difficulties with the increased demands from HDV regional office

a clear sense of being accountable to local community

the crucial role of the manager as being the main channel for communication between committee of management and staff was recognized

the implications of the manager being employed only one day per week in terms of communication and therefore the role of the nurse co-ordinator.

Among the barriers to community development that were identified were:

time for dealing with service providers and HDV political agendas in the

community, lack of resources - money, time and skill

A discussion was held with the nurse co-ordinator supervising the Adult Day Activities Centre focussing around developing strategies for the planning of the program. The importance of creating timelines and short and long term goals was recognised.

A discussion was held with the manager and other staff regarding the Protective Behaviours Program and other local issues.

In July a workshop for staff on planning was held. Issues which emerged included the following.

Needs of isolated elderly:

- transport
- home visiting
- support for keeping elderly at home home handy service
- lawn mowing.

Issues in relation to youth:

- entertainment
- under age drinking
- transport
- schooling outside the valley
- time on buses

Issues for young parents included child care and parenting skills.

Other needs included support groups for sufferers of cancer arthritis and chronic pain, nutrition and womens health issues.

In September there was a session for staff around team building and conflict resolution.

Issues arising included:

Team are important in community health:

- because they expand skills and knowledge based community health
- changes are dynamic
- greater ability to respond to wider needs in community
- they create more continuity and support for workers and the community

Factors important for successful teams include: honesty

- each team member pulling their weight good
- communication planning
- sharing of information

Barriers to team development include:

- lack of resources and planning
- sharing information

not acknowledging problems

community's expectations

marginalizing of some staff

lack of conflict resolution strategies no orientation
for new staff

A workshop for committee of management members on planning and conflict resolution was held. Issues that emerged included:

Barriers to Planning:

lack of resources, time

distance skills vision

an increased sense of disempowerment of committee of management
members versus professionals

lack of support for community health; therefore some people on committee of
management for ten years

community's expectations

lack of services - forward planning structure

no procedures for decision-making

The most important aspects of community health were: community

participation and support,

community needs, particularly outreach to the isolated members of the
community, especially the elderly and young mums

providing an alternative broader view of health encompassing
housing etc.

1.3 Box Hill Community Health Centre

Box Hill Community Health Centre, established in 1986 covers the municipality of Box Hill and a small area representing 1000 residents, not covered by the Waverly Community Health Centre and the Chadstone Para-medical Centre. It is located in the main shopping centre in Carrington Road.

There is an effective full-time staff of 11.6 at the centre. These include:

- manager,
- podiatrist,
- social worker
- ethnic health worker
- health educator (0.8),
- community health nurses (2),
- administrative officer
- receptionist (0.2)
- physiotherapist,
- occupational therapist
- dental officer (0.8)
- dental nurse (0.8).

Among the direct care services offered by the centre are:

- podiatry,
- physiotherapy
- counselling
- individual assessment
- dental.

Group work undertaken includes:

- stress management,
- men's communication group,
- agoraphobia support group,
- minor tranquillizer support group
- health and human relations (in schools)
- stroke group
- hydrotherapy,
- back pain management,
- Cambodian elderly group,
- primary health fair,
- ethnic health fair (Spring Fiesta)
- women's day
- Mama check
- family camping,
- youth health festival
- community work.

Other organisations based at the centre include:

Box Hill Family Planning Clinic Victorian
Deafness Foundation
Lao Women's Association,
Chinese Association of Older Persons
Box Hill Scrabble Group,
Outer East Ethnic Communities Council
National Campaign Against Alcohol and Drug Abuse
Community Resource Workers
Financial Advisory Service.

Box Hill is a predominantly middle-class area bound by mainly affluent suburbs. It covers approximately 27 square kms. Together with its largely residential area there are small pockets of industry, a large central business district and several major education and service centres.

Box Hill's population is ageing with associated health problems. There is significant increase in the age group 65 years onwards. While the population has a large proportion of elderly people, more recently young families have moved into Box Hill. Fifteen of the twenty three percent of people born overseas living in Box Hill have been in Australia for less than five years.

With the introduction of a "Dual Dwelling Code" there has been an increase in the number of one bedroom flats being built. In South Box Hill a number of small Ministry of Housing estates have been built in the last five years.

There are a range of community, health and educational services in Box Hill including:

Box Hill College of Technical and Further Education
Victoria College (Burwood Campus)
Office of Intellectual Disability Services,
Royal Victorian Institute for the Blind,
Adult Migrant Education Centre;
Box Hill City Council,
Department of Social Security and
Box Hill Hospital.

There is a wide range of government and non-government services to migrants in the area including:

Department of Immigration Local Government and Ethnic Affairs;
Cambodian Community Welfare Centre;
Laotian Women's Association;
Federation of Chinese Association;
Senior Citizen Centre groups for Greek, Italian and Chinese people.

CDIH was involved with the centre from October 1988 to October 1989.

In October and November 1988 initial discussions were held with the manager regarding a CDIH consultancy. It was conceived that the main focus of the consultancy would be in relation to planning and evaluation.

The tentative work program developed at this time included:

- document two projects completed or currently conducted by the Service:
 - minor tranquilizers group
 - secondary schools project
- assess evaluation processes for these projects including advise on appropriate evaluation tools
- develop techniques to review strategies at the Service for implementing and delivering services.

(These were the draft consultancy objectives which were forwarded to VicHealth.)

During February 1989 there were two staff sessions. The first was a general session on community development; what does it mean, what are the issues where community development might have a role to play. The second session was a more focused review of past activities and areas of concern in relation to services presently provided.

There was also a session with the manager, reviewing the draft adolescent health policy and there was a session with the Schools Program Sub-committee looking at the aims of the Program.

In March 1989 there was a further session with staff generally looking at the role of community development and looking at evaluation and program planning using a case-study approach.

There was a session with the minor tranquillizers project sub-committee discussing plans for 1989 and possible involvement of CDIH.

During April there was another session with the minor tranquillizers sub-committee, discussing a program-of "community talks" and which groups to target.

There was a further meeting with the schools project sub-committee reviewing of recent progress planning next steps.

There was a further session with staff looking at the community profile, reflecting on the needs of various target groups in terms of access to services and priority in health terms.

In May there was meeting with the manager finalising plans for a joint planning day for staff and committee of management members service agreements. Plans were also discussed for a workshop with committee of management members on principles of community health and the role of the committee of management.

During June there was a meeting with staff to discuss CDIH's on-going involvement.

The joint committee of management and staff workshop was facilitated by CDIH on the role of health service agreements and developing a health service agreement for the centre.

During July there was further discussion about the follow up to the health service agreements workshop. There was discussion regarding the evaluating of the one year operating plan.

There was further discussion regarding community development in health and the practical implications.

In August there was a session with the schools project sub-committee around issues associated with documentation and evaluation.

In September there was discussion around the minor tranquillizer program and the women's health program.

In October the main event was the evaluation discussion review the work of the Community Development in Health Project with the centre over the last twelve months.

1.4 Broadford and District Community Health Centre

The Broadford and District Community Health Centre (BDCHC) was established in 1978 and serves the Shires of Broadford and Kilmore as well as other localities such as Seymour, Glenrowan, Puckapunyal, Tallorook, Pyalong. The CHC is situated in the Goulburn North Eastern Region of Victoria.

Staff based at the centre include:

- Community Health Nurse Co-ordinator
- District nurse,
- Physiotherapist, part time,
- Occupational therapist, part time,
- Manager, part time (based at Seymour Hospital)
- Administrative officer, secretary
- Typist/stenographer,
- Gardener/cleaner/handyman, part time,
- Hospital orderly/allied health assistant, part time,
- Driver, part time.

Visiting staff include:

- Medical
- Dental,
- Optical,
- Allied health services
- Pathology,
- Family Day Care,
- Welfare Officer.

Services offered include:

- Health screening and health talks,
- Nursing Care in the Home
- Rehabilitation and Self Care
- Assessment Treatment & Prevention of disorders of Human Movement
- Counselling
- Family Day Care
- Pathology
- Anti Natal Classes
- Activities Program
- Day Care Program

Broadford Shire, with a population of 3,230, is located in the south of the Goulburn Region, closer in distance to the service centres of outer Melbourne than to Shepparton, the major service centre in the Goulburn Region.

Fifty per cent for the Broadford Shire is under age 30, and almost 30% under age 14. Twelve per cent of the population

is over the age of 65 (by way of comparison, the national figure is 9.1%). The Shire's population characteristics indicate a need for a well balanced service system that meets the needs of families with dependent children as well as aged people.

The projected population trend for Broadford is 2.7% growth per annum, which amounts to an additional 1,500 persons by 2000. It is expected that Broadford and its surrounding areas will continue to grow as a commuter district for Melbourne suburbs. It is likely that a relatively young age structure will be maintained.

The Shire's economy in 1981 was based on manufacturing (27.8%), community services (12.7%), agriculture (10.1%), construction (7.2%), wholesale/retail (12.9%) and finance (3.8%). Broadford's occupations ranged across all categories with no single occupation predominating.

Broadford's major employers are:

- APM - employing around 150
- Allens Sweets - Proposed 150 -300
- Dunlop - 100
- Wool Scourers - 40
- Nightingales - 50 (female workforce)
- Wiring Assemblies - 40 (female workforce)

Broadford residents also commute to Melbourne by train and car for employment. There are three train services daily to Melbourne. There is a train service to Seymour, but no bus service. Community transport is a major issue in the Shire.

The Goulburn-North Eastern Region covers 40,280 square kilometres or approximately eighteen per cent of the total Victorian land mass. However, the total resident population is only 229,800 or five and a half per cent of the State total.

Most of this population is fairly evenly distributed, although there are three relatively large population centres in the provincial cities of Shepparton, Wangaratta and Wodonga and some scattered isolated communities in mountainous areas to the east of the Region.

The Goulburn-North Eastern Region is experiencing a faster average annual growth in population than the State as a whole, 1.8% compared with 1.1%.

The municipalities with high average annual growth rates are Kilmore Shire, 5.4%, Broadford Shire, 4.7%, and the Rural City of Wodonga, 4.3%. At the same time, there are certain areas experiencing a decline in population, namely Tungamah

Shire with 0.5% average loss also, and Myrtleford with 0.04% loss per annum.

There are seven community health services operating in the Goulburn-North Eastern Region. Three are located in the Goulburn Sub-Region (at Broadford, Marysville and Stanhope) and there are four in the North Eastern Sub-Region located in the Kiewa and Ovens Valley (at four locations), King Valley (two locations) Woods Point and Yarrawonga.

All community health centres are located away from the major population centres. Only one centre, Yarrawonga and District, serves a sizeable yet relatively compact population. The combined catchment populations of all community health centres in the Region total only 35,780 persons or 15.6 per cent of the population. The major population centres of Shepparton, Wodonga and Wangaratta and the medium-sized yet growing centres of Moroopna, Seymour Benalla and Kilmore have no community health centres.

Of the existing community health centres, one of the most notable features of their operations is the variation in type of service offered, reflecting both the availability of primary medical care services in the catchment areas and the health education and promotion needs and priorities of the communities served. The Kiewa and Ovens Valley Community Health Service, for example, is the only one offering specific health promotion activities for non-English speaking persons. Marysville and District Community Health Centre, whose catchment has no resident general medical practitioner, tends to emphasise nursing and allied health services and emergency care for its very large tourist population. Allied health services available in all centres in the Region are greatly restricted by lack of certain professional personnel, particularly podiatrists, physiotherapists and occupational therapists, who, in recent years, have proved difficult to attract to country regions.

CDIH's involvement in the Goulburn North East commenced with the Broadford and District Community Health Centre and concluded as a regional consultancy.

A six month community development project was offered by HDV Goulburn North East Region to Broadford and District CHC with the possibility of transferring that position to other community health centres in the region after that period.

CDIH became involved in the initial period, developing a job description and an interview process. No-one was employed after interviews for the job in November 1988.

This was followed by a period where the proposed community development project workers role was clarified and developed. There were three quite different expectations

for the role. These expectations fluctuated and changed over time.

From the regional office point of view, the community development officer was to look regionally at what services existed; who they serviced and how they could best be run *and what sort of new* services were needed. The Broadford and District CHC would be funded for the position which was likely to shift to another area in the region after six months.

From the point of view of at least some of the Broadford staff the project worker ought to facilitate the community in expanding health promotion and health care in addition to looking at the co-ordination issues. Action research appeared to be an attractive possibility for further use in other rural communities.

The Broadford and District CHC committee of management raised the issue that a community health nurse was needed in the Seymour area, not a community development worker. The short term nature of project was very like a previous PIT study which had no follow up services. Overall they were prepared to run with the project only if regional office staff were directly involved in the interviewing process and further support of the project.

It must be recognised that as the profile indicates access to professional services is very difficult in these rural areas, the committee's response is understandable.

The CDIH consultancy commenced in mid October 1988.

CDIH was involved in initial discussions with the community health nurse/co-ordinator and with the part time manager based at Kilmore hospital.

In November there was a session with the committee of management and staff regarding the CDIH consultancy. The tentative work program developed at this time included:

- assistance with the establishment of the community development officer position and subsequent project planning, implementation and documentation;
- consultancy sessions and educational support visits to be held with staff and committee members to facilitate decision making in areas such as:
 - staff role
 - strategy planning,
 - community participation and accountability
 - research methodology, and
 - utilisation of resources.

(These were the draft consultancy objectives which were forwarded to VicHealth.)

In December 1988, there were further meetings to clarify the expectations of the community development project held by the regional office staff and at Broadford.

In January 1989, a joint meeting between CDIH,, the Regional Office (of HDV) and Broadford and District Community Health Service was held. Discussions as to what community development is and the role of community health were an important part of meeting.

Frustrations were voiced by Broadford related to staff turnover at the regional level and the fact that the nurse co-ordinator was returning from 12 months maternity leave (the staff member with whom CDIH had been working was a locum).

A decision was made to make the position a permanent position for the region, to be auspiced by Broadford and District Community Health service.

A Steering Committee was to be established with involvement with key groups.

In February the role description was finalised and the position advertised.

In March CDIH participated in the interview process.

In April the position was offered to and accepted by the present incumbent.

In May there were discussions with the worker. Issues covered included defining his role, clarifying accountability, the establishment of a local task force and use of the Regional Advisory Committee.

Possible strategies for the Regional Advisory Committee in auspicing workshops for committee of management members and staff about community development were discussed. Other strategies for providing an in-service resource for community health centre staff across the region were discussed.

In June there were further discussions with the community development worker, clarifying the contradictions between local versus regional needs, defining local issues and possible action, defining regional issues and possible actions.

In July there were further discussions with the community development worker regarding the proposed workshop for the Regional Community Health Advisory Committee.

There were discussions with the manager regarding the proposed committee workshop.

The workshop at Benalla was run.

In August there was discussion regarding a workshop for an advisory committee on the development of community health services in the local government areas of Broadford and Kilmore.

The workshop at Kilmore was run.

In October 1989, the evaluation discussions were held.

1.5 Brunswick Community Health Centre

The Brunswick Community Health Centre was established 13 years ago in response to a strong political campaign by local residents.

The Brunswick community has a large percentage of people born overseas.

In 1988 there was an almost total change in committee of management membership. Many of the original activists who first established the centre retired.

Another change of committee of management membership took place in late 1989.

The centre also moved to new premises at this time.

There are seven ethnic health workers at the Centre. The hours are equivalent to 5.4 full-time positions. The languages covered are Greek (2), Italian (2), Arabic Vietnamese and Turkish. They are directly responsible the community health nurse. The centre's staff also includes two other nurses, two physiotherapists, an RSI support worker, a podiatrist, four doctors, a dentist, a dental nurse administrative and clerical staff.

When the Brunswick CHC started 13 years ago, ethnic health workers were employed to "service their communities" with an emphasis on the workers' bi-lingual skills and acceptance within their community. Their role consisted largely of case work, especially filling out social security and immigration forms, housing assistance, legal and financial assistance and family issues and the provision of interpreting and translating services in the Centre and in the community.

CDIH commenced its consultancy with the centre in March 1989. The centre has expressed an interest in CDIH continuing to work with them in 1990 to develop a health service agreement.

In March an initial meeting was held with the manager and a committee of management member to discuss the reorientation of ethnic health worker activities towards a community development orientation. These positions had not been reviewed since the Centre was established. During this time a range of other services (Central Health Interpreter Service, Department of Social Security interpreters, Ethnic Affairs Commission translating service, etc) had become available. There had also been changes in the make up of the community and new priorities identified. CDIH put a

proposal to the committee of management that it plan for a 12 month transition which included a timeline with specific targets regarding worker's duties e.g. case work; community development and changes to be made. CDIH's role would be to run educational and information sessions on agreed topics and to comment on the draft plan (if required).

In April the first session was run. This session consisted of an introduction to CDIH; the role of the ethnic health workers; the Resources Collection; a definition of community development and a profile of the community.

In May discussions were held with the manager to clarify and confirm CDIH's involvement with the centre.

During this discussion, it became apparent that a number of issues remained unresolved. There had been no development of a plan to implement the proposed change in the role of the ethnic health workers and there continued to be a lack of understanding among the ethnic health workers about the change of role to community development.

However, some further work had been done on job description and duties.

It was agreed that CDIH would run a session with the ethnic health workers regarding their role as community development workers and priority setting, working through issues related to the camps program they run each January. CDIH would discuss further involvement with the centre following that session.

The ethnic health workers workshop session on Community Needs and Worker's role: the Camps Program was run..

In June there was a regular consultation with the manager and the nurse coordinator.

There was a follow-up workshop with ethnic health workers (outside regular meeting time). It addressed the following questions:

- What are the support structures needed
- What support structures will be put in place
- Plans for role change
- Job description/duties

An outline was presented of what CDIH could offer, for example taking a more active role in planning for change, process, timelines, support structures etc. with staff and committee of management.

A further consultation with manager and nurse coordinator regarding the job description (and also the supervisory role of the community health nurse co-ordinator).

A proposal was forwarded to the committee of management for three sessions to deal with:

committee of management's roles and response to staff's changing role

practical implication of change in the context of the health service agreement (with the committee of management) and

develop a more structured plan & timeline for implementing change (a joint staff committee of management members workshop).

In July there was a brief workshop with the committee of management discussing community health and community development. The session was briefer than planned due to problems with having moved into a new premises that day.

In August the workshop on committee of management roles responsibilities was held.

There was a staff session for the ethnic health workers. This explored the implications of saying "no" about having been presented with a new role and responsibilities without support.

In a session with the nurse coordinator there was discussion around the process to be put in place in relation to the health needs of ethnic communities.

In September there was a workshop with the ethnic health workers regarding interpreting policy.

In October CDIH made a presentation to the new committee of management

There was a session with the whole staff session to discuss the proposed new interpreting policy in relation to the new role of ethnic community development worker.

A session with the ethnic community development workers and the nurse coordinator was held.

In November the evaluation session and interviews with the ethnic community development workers, the manager and the nurse co-ordinator were held.

1.6 Workshops and Other Consultancies

October 1988

Ethnic Health Services

Community development principles and practice

November 1988

East Preston Community Health Centre

*Discussion worker re domestic violence project. Staff development workshop
Introduction to community development*

Monash University, Department of Social and Preventative Medicine. Master of Public Health.

Community development

February 1989

District Health Councils Executive Officers' Conference

*Community development principles and case study discussion
Resources Collection*

March 1989

Springvale Community Health Centre Staff Workshop

Community development principles and practice

District Health Councils Executive Officers' Workshop

*Introduction to community development In health,
The Resources Collection
Community development principles
Hypotheticals*

April 1989

Western Region Workshop

*Community development values
Case Study discussion and
The continuum.*

Flemington Community Health Centre

Community development and planning

Victoria College, Rusden Campus, Health Studies Students

Introduction to Community Development

Western Metropolitan Regional workshop for Committee of Management members

Roles and responsibilities of committee of management

Ballarat Regional workshop

*Introduction to community development and community health principles
community profiles planning, research*

North East Ethnic Issues Network

Discussion about Network s issues

June 1989

North East Ethnic Issues Network

Meeting to discuss August workshop

August 1989

North East Ethnic Issues Network

Introduction to community development principles

North Richmond Community Health Centre

Community development principles and practice

Joint MAV CDIH Workshop

Analysing broad health issues, hypotheticals

North East Ethnic Issues Network

*Extending and strengthening the Network
Planning for Action.*

September 1989

Victoria College, Burwood Campus

Community development principles and practice

November 1989

Victorian Community Health Association

*Community development
Community health principles and practice
Hypotheticals and case studies*

East Preston Community Health Centre

Community development principles and practice

Health Sharing Women

*Community development Community health principles and practice,
Hypotheticals*

In addition to these organised workshops, there were a number of requests for advice or discussion by telephone or appointment. These included:

Swan Hill District Hospital

Hobart Women's Centre

Ministry of Education Curriculum Branch

Department of Youth, Sport and Recreation

Students and lecturers from a range of tertiary institutions (Monash Department of Social Work, Lincoln School at Latrobe etc.)

South Port Community Health Service

Carlton Community Health Centre

Springvale Community Health Centre

2. THE EVALUATION AND REVIEW DISCUSSIONS

The following questions were prepared a framework and guide for the evaluation and review discussions and associated interviews.

Review of work undertaken

How would you describe the role of CDIH staff in working with your organisation over the last few months?

What were the main aspects of the work which has been undertaken with the CDIH staff?

Questions About the CDIH Framework

Were we of any help, and if so how, in relation to the ideas on which community development in health is based?

Were we of any help in relation to the practice of community development in health, issues associated with

- Day to day activities
- Project work
- Developmental principles?
-

Were we of any help, and if so how, in coming to grips with the core values on which community development in health is based?

Were we of any help, and if so how, in relation to the planning in and for community development in health?

Were we of any help, and if so how, in relation to the practice of evaluation in and for community development in health?

Were we of any help, and if so how, in relation to the practice of action research in and for community development in health?

Were we of any help, and if so how, in relation to understanding and dealing with the accountability requirements associated with community development in health?

Some General Comments on our Contribution

Perceived effectiveness has our contribution contributed to the development of better practice?

Accessibility and implementability - is reasonably easy to get into, to start to use, to apply and then absorb more through practice?

Perceived validity does it resonate with the experience of the community health workers and committee of management people with whom we have worked?

How does our contribution to your work compare with

prevailing patterns of practice and

prevailing understandings

previously available resources and consultancies

3. THE KEY ELEMENTS OF THE CDIH FRAMEWORK

(For the purposes of this evaluation (see Section Four) we developed a check-list of the key elements of the CDIH approach. We included that set of ideas, information and suggestions which together constitute the main features of the CDIH Project's approach to community development in health and which, as a whole package, is sufficiently different from prevailing practice and understandings to justify describing it as the "CDIH Framework".)

We have found it useful to understand community development as an approach to health practice which refers to a "cluster" of practice, values and theory.

Key Elements of Practice

The practice of community development in health is informed by theory and energised by values but there are also skills information, techniques, and strategies which are intrinsically part of practice.

These elements of practice need to be named, thought about and evaluated if practitioners are to improve their practice and share their accumulated experience.

We have found it useful to think about community development practice at three levels: the activities of daily practice identified projects and developmental principles.

Activities

The basic units of community development practice are the day by day activities which occupy the worker's time.

These may include: talking to people, providing specific health services, *giving support, arranging* meetings, facilitating discussions, getting the newsletter out, arranging for an article to go into the local paper, arranging a deputation, writing up the minutes and much more.

There is nothing specific to community development about this list of, activities. They are specific to community development where they are conducted in a developmental style and where they are directed (amongst other objectives) towards implementing the developmental principles (discussed below).

A developmental style of practice is characterised by the following features:

- respect for and recognition of the strengths and priorities of the people with whom you are working;
- respect for the personal development and relationships development which are at the heart of community development; allowing time for personal growth; it can't be rushed!
- understanding one's own relationship with people as *an important* instrument of change, connected knowing, real talk¹;
- risking personal exposure and experiencing the support of the people you are working with and for;
- coping with the contradictions between the special strengths associated with the position of community worker (information, links to who-you-know, salary etc) and the concept of being accountable to the people you are working with:
 - recognising the contradictions; articulating the mutual obligations, the elements of the contractual relationship;
 - building on the commonalities: common purpose common opportunities for personal growth, common exposures to risks and hazards;
 - (for the workers) seeking personal support from peers;
 - recognising that the contradictions sometimes run over you and you just have to get out;
- coping with similar contradictions when your community is your employer, including in addition:
 - issues and traps in community based management;
 - supporting the development of less experienced, less confident members of committee of management;
- confidence arising from proper process; if the process is right the outcome will follow;
- making allowances for uncertainty.

The daily activities of community development are also characterised by an underlying sense of purpose. From this stems the appraisal of need, the planning, the drive towards longer term goals which are part of daily practice. The direction of this underlying purpose is informed by the *developmental principles*.

Projects

Projects are the basic unit of planned work; projects are bite-sized chunks of work. In the real world, different activities blend into each other, projects arise before they are named, projects change unrecognisably and sometimes

1. Belenky MF, BM Clinchy, Goldberger and JM Tarule (1986) "Womens' ways of knowing", Basic Books New York.

evaporate. Nevertheless if community development work is to have a forward view which is shared among all those involved, some form of explicit planning is necessary. The identification of projects is a useful aid to planning so long as it is kept in mind that these are arbitrary boundaries within a continuous endeavour.

Project planning is informed by the key elements of theory and by the developmental principles (outlined below). The projects themselves are undertaken in a developmental style.

What are the key aspects of community development which determine our approach to project work?

The daily activities of the community development workers are infinite and concrete and it is easy to get absorbed in the urgency of the *daily rush*. The concept of the project and the process of planning and evaluation gives one an occasion and an opportunity for reflecting on the broader context in which you are working.

Community development is a collective process. Project planning is an opportunity for developing a shared understanding of the issues, the strategies and the work plan.

Health issues and health objectives need to be integrated with developmental objectives. Both need to be planned for; an integrated work plan addresses both of these aspects together.

Planning is necessary also for some of the preconditions for effectiveness, e.g. planning for personal support and for learning; planning for planning.

Community development requires a special need for knowledge about society and social change, as an input to project work; knowing where you are trying to go, being able to locate oneself at all times, knowing how to navigate the currents and winds of the area in which one is working.

Developmental Principles

We see *the main* developmental principles in community development in terms of *empowerment* and community-building. These stem from the theoretical framework and the core values described below.

These two principles are the community development response to powerlessness and alienation which are seen as key

influences on health (discussed below under theoretical framework).

These principles are expressed in a day to day manner in the activities of community development practice and inform project planning and evaluation.

It is useful to think about empowerment as taking place through:

- gaining access to information,
- building stronger relationships,
- gaining in understandings and insights,
- exercising control over resources.

This understanding of empowerment is expressed in the style of daily community development practice. It also feeds into project work in community development. Projects which achieve increased access to information; which strengthen people's relationships; which enable people's to increase their understanding and which increase their control over resources; these reflect empowering strategies.

It needs to be emphasised that information and understanding, stronger relationships and control over resources are not passive commodities to be transferred to empty vessels. The conditions for empowerment involve action: questioning, working together, sharing visions. If people are not actively asking questions they will not acquire the answers; if people are not working together on shared priorities, they will not forge stronger relations; if people do not have a vision of what they want to do with the resources, the concept of "control" is meaningless.

This is not a "chicken and the egg" closed loop. It is about spiralling upwards. It is about community and personal development. The role of the community development "practitioner" is to facilitate (and take part in) but not to mediate the "empowerment".

The community-building concept corresponds to alienation (as one of the key factors mediating social influences on health). If we conceive alienation having an opposite, it might be expressed as "willing appreciated neededness". It follows that the conditions for addressing alienation include:

- the collective addressing of shared needs
- the building of communication and trust,
- the building of mutual caring and support.

Community-building strategies are about building the conditions for trust, communication and identification within the group or network. They are about people

being affirmed through contributing within their communities (celebrating the "gift" relationship²).

These strategies inform project planning and are expressed in the style of daily work.

Community-building is not "done to" a passive subject group; it is not to be conceived as akin to "social engineering". The development of trust is an active learning process; it cannot be created artificially. The experience of contributing follows an act of free choice; it cannot be contrived.

The role of the community development "practitioner" is to take part in and to facilitate the conditions for community-building not to undertake it.

Development is personal as well as community

In fact, these two "developmental principles" are actually two different perspectives on the same developmental process; one described in terms of empowering "us" in relation to the outside world and the second, focusing inwardly on building "us" as a group. Experiences which are community-building must also be empowering and vice versa.

Neither empowerment nor community-building can be commodified nor engineered. At their core these principles involve a process of personal and cultural growth. It cannot be prescribed; it cannot be determined.

The Core Values

If inequalities in health are due to inequities in access to resources and power and in opportunities for exercising a valued social role then it is clear that equity and social justice are conditions for better health. This is the utilitarian argument for social justice, social justice as a strategy for health.

This argument is common ground.

However, the conditions for collaborative action between workers and the communities involved are that the professionals accept and respect the priorities of the people involved. The priorities of the people involved are generally more likely to see social justice as a prior value. "Community development" initiatives which recognise social justice only as in terms of its contribution to health do not establish the conditions for partnership.

2. Titmus RM (1971) "The gift relationship", Pantheon, New York.

The affirmation of the independent legitimacy of social justice and equity, of striving for a contributory and supportive society is intrinsic to community development: the goal is health and social justice, not social justice in order to achieve health.

Key Elements of Theory

Community development practice needs applicable theory; frameworks which illuminate understanding and which can inform planning and practice. The concern for theory is not an expression of academic curiosity; it is a necessary resource for practice.

There are four key theoretical insights which we regard as critical for understanding community development in health. These concern:

- personal control and valued social role
- getting a handle on social structures
- personal action can lead to change
- development: personal and community

Personal Control and Valued Social Role

A central concern of community development in health is the health gap; different health outcomes associated with class race, other socio-economic variables and national wealth.

How shall we understand the linkage between broader social structures and the health experience of different groups?

We have focused on two central constructs in setting a framework for understanding health and illness in a social context.

The first is about control and power: the degree of control that we exercise over our destiny, collectively as well as personally, counterposed against powerlessness (that members of some groups experience more than others).

People and social groups who are relatively powerless generally have poorer health experiences. We regard powerlessness as being causally related to ill-health; not as a secondary phenomenon.

The second construct centres on the degree to which we play a valued social role in our community and society (willing appreciated neediness versus alienation). People and groups who are socially alienated tend to have poorer health experiences. Conversely, people who exercise a valued social role in their community are more likely to experience better health. We regard alienation as being causally related to ill-health not as a secondary phenomenon.

These ideas are developed further in the Resources Collection³.

Getting a handle on Social Structures

An important aspect of community development in health involves consciously thinking in terms of the structural determinants of health at the same time as working with people on their personal and local concerns.

How shall we understand the broader structures of society within which personal control and valued social role are determined?

We have found it helpful to use three interdependent frames of reference in trying to understand the impact of society on our personal and collective resources for health. These three frames of reference are:

- institutional structures
- culture and ideology, and
- social relations (of class, gender, race, etc).

These three frames of reference provide particular insights into understanding how society works. They are essentially just different ways of looking at the same "real world". They can be used interchangeably if it is understood that the salient features within each frame of reference expresses influences which would sometimes be better understood if described in the terms of the other frames of reference. The flexible use of these three frames of reference is discussed in more detail elsewhere⁴.

Personal Action Can Lead To Change

Intrinsic to community development practice is the notion that action which is undertaken at the local, personal or community level also has significance in terms of the broader social influences on one's health.

This principle can be seen as being inconsistent with the broader structural understanding of the determinants of health; the structuralist understanding becomes a determinist scenario which restates and reinforces the reality of personal powerlessness.

1. See especially "Health and Illness in a Social Context and the Role of Community Development", Overview Paper in Resources Collection.
2. Legge DG et al (1988) "Community development in health: the Victoria experience", pp 25-42, in Douglas RM (Ed), "Health Development; whose baby?", proceedings of a seminar published by the National Centre for Epidemiology and Population Health, Australian National University, Canberra.

Community development workers need a clear theoretical framework in which to understand the ways in which personal and collective action, especially when it is part of broader movements, can effect changes in the broader structures and reverse the determinism.

The developmental principles of empowerment and building community (corresponding to control / powerlessness and valued social role / alienation) provide mediating constructs between the immediate circumstances of our lives and broader patterns of institutional structures, ideological currents and the alliances and tensions within the social relations matrix of class, race, gender, etc.

If powerlessness reflects broader structures is not possible to experience "empowerment" without, in some small degree shifting those broader structures. Likewise, if alienation reflects broader societal influences, it is not possible to strengthen networks and communities (so that people are more valued) without, in some small degree reshaping the broader social influences.

These ideas have been discussed in more detail elsewhere⁵.

Development: Personal and Community

Community health workers spend most of their time working with people, with individuals. Some spend most of their time delivering services to people or supporting people in their personal tasks in community activities and facilitating the development of local/community relationships.

Even the concepts of "empowerment" and "building community" can seem a bit unreal in the context of the day to day hurly burly.

And they are. These developmental principles serve to articulate the two faces of community development; our growth in power vis a vis outside forces which also exert control over us, and secondly, our growth together, as a group, building bridges of communication and trust between people, working together to address shared needs.

For understanding purposes, it is valuable to distinguish between the outward looking concept of empowerment from the inwards (our group) focused concept of building community. However, in the daily activities of community health, the experiences and relationships which carry these two faces of development are not so easily classified. Indeed they are the same experiences and relationships.

5. Legge DG et al (1989) in CDIH (1989) "Community development in Health For All", Proceedings of National Workshop July 1989, Melbourne.

For the individual, growing strength vis a vis the outside world and stronger relationships with family, friends and colleagues, are part of the same developmental process.

This insight, that personal growth and stronger interpersonal relationships are at the core of community development links the more abstract theory back to the reality of the day by day work experience of the community development practitioner.

An appreciation of the linkages between personal development, community development and structural change at a societal level establishes a theoretical framework which illuminates the broader meaning of the day to day activities of the community development worker⁶

6. Legge DG et al (1989) in CDIH (1989) "Community development in Health For All", Proceedings of National Workshop, July 1989, Melbourne.

Applying These Key Elements

There are numerous ways in which these core elements might be put together as resources for community development in health.

In two important areas we have explored the application of community development principles in health in more detail.

The first is the "Continuum" concept.

The second concerns the linkages between planning, evaluation, action research and accountability in community health.

The Community Development Continuum

The continuum concept arose out of the experience of workers at the Fitzroy Community Health Centre

The continuum referred to extends across a range of contexts within which community development work may be undertaken. The continuum ranges through:

- developmental casework
- mutual support,
- issue identification and campaigns,
- participation and control of services
- social movements.

The notion that community development principles can be expressed in a wide range of contexts is contrary to some versions of community development which would define all forms of casework as "bandaiding".

In our experience however, the concept of developmental casework, the possibility of applying developmental principles in the clinic, has proved quite liberating for many community health workers.

There are several important consequences of the continuum concept.

- all of the workers in an agency can apply developmental principles in their work;
- within any particular program (e.g. domestic violence services for the elderly, dental care) the central issue is construed differently for different clients/patients. For some it will be intensely personal or therapeutic; others will be looking to be involved in more organisational ways.

7. Jackson T, Wright and S Mitchell (1989) "The community development continuum", *Community Health Studies* 1), 66-73. NB. This paper was also reprinted with permission in the Resources Collection.

- the most appropriate ways of working in a developmental way with different individuals will vary according to their health problems and where they are at personally.

Planning, Evaluation, Research and Accountability

This is the title of one of the resource papers on the Resources Collection. It was developed in response to the common experience of frustrations and uncertainties in relation to planning, evaluation, action research and accountability in community health.

At heart the issue was that conflicting and incompatible accounts of these functions were (and still are) contending within the community development and community health fields.

Some presentations of evaluation and accountability are essentially about creating the conditions for bureaucratic control and divert community health workers from the developmental opportunities of creative evaluation and action research and building community accountability.

Some presentations of planning are dominated by the accountability rationale and obscure the liberating and empowering possibilities of relevant planning.

Some presentations of research are elitist and mystifying and convey messages about the control of knowledge and the exclusion of "practical" workers from knowing things independently, from developing new understandings.

The planning, evaluation, research and accountability paper presents an integrated account of these functions embedded within the theoretical framework of community development in health.

4. REPORT IN ACCORDANCE WITH FUNDING AGREEMENT

Evaluation and reporting obligations were specified in the Funding Agreement with the Victorian Health Promotion Foundation. The CDIH Project believes that these obligations are met with the submission of this Report.

However, the format and presentation of this Report do not coincide entirely with the form and sequence of the reporting obligations specified in the Funding Agreement. Accordingly, this appendix has been prepared to provide a cross reference between the agreed reporting obligations and the relevant sections of this Report.

The sections of the Funding Agreement in which reporting obligations are specified are Sections 3, 4, 5, 6 and 7.

3.0 OBJECTIVES/SERVICE GOALS

The objectives for this project .. are:

To test the community development framework through working with three nominated community health centres and to provide a related advisory service to community health organisations on an as requested basis.

The number of community health centre partners was expanded to five during the course of project.

The initial three consultancy partners were to be Kiewa and Ovens Valley Community y Health Service, Box Hill Community Health Service and Broadford Community Health Service.

The Kiewa and Ovens Valley Community Health Service has an association with the King Valley Community Health Service and I t was felt reasonable, upon request, to extend our consultancy to that service also.

The evolution of our consultancy with Broadford Into a consultancy with the Regional Community Health Committee Is described a t Appendix 1.4 and discussed In more detail Section 5.4.

Our consultancy with the Brunswick Community Health Centre developed out of an initial one-off workshop session. The detailed circumstances are outlined In Appendix 1.5.

The manner In which the CDIH Framework has been tested through the consultancies and workshops is outlined in

Section Four, on Evaluation. The detailed results of this evaluation are provided at Section 6.3 of the Report.

The related advisory service" provided to other community health organisations is documented at Appendix 1.6 and analysed at Section 5.6.

To make available to a range of community health centres consultancies on:

- a) how to apply a community development approach health;
- b) planning, evaluation, research and accountability tools and methods in community health;
- c) identification and implementation of community development strategies for centres;
- d) review and documentation of existing and proposed community health projects.

The details of the services provided to the community health centres are documented in Appendix 1.6 and analysed in Section 5 of the Report.

4. AREAS OF WORK

(This section of the Funding Agreement outlines the initially proposed work programs with three centres: Kiewa and Ovens Valley Community Health Service, Box Hill Community Health Service and Broadford Community Health Service.)

The development of our work programs with each of the community health centres is described in Appendix 1.

In no case did the work program evolve exactly accordance with the initially proposed program. Circumstances of these developments are outline Appendix 1.

There were some variations with respect to the main consultancy partners as noted above.

5. BUDGET

(This section of the Funding Agreement outlines the budget approved by the Foundation.)

An extract of our detailed budget report is included at Appendix five.

6. PERFORMANCE INDICATORS

The achievement of the objectives will be measured by:

- a) Documentation of the projects conducted at each community health service.

This has been done. See Appendix 1 and Section 5 of the Report.

- b) Documented assessment by staff and committees of management of the CDIH Resource collection and the outcome of the consultancies.

This has been carried out in full

See Section 4 for a discussion of our evaluation approach.

See Section 5 for feedback from individual consultancies

In relation to the Resources Collection, see Section 6.1 in particular, from page 71) for a discussion of the resources we have used in our consultancies and workshops.

In relation to the outcome of the consultancies see Section 6.2. This is a review of the “usefulness” of our contribution to the work of our consultancy partners. See especially the discussion under the heading of “Effectiveness” (from page xx) where we review the impact of the consultancies on community health practice at each of the centres.

- c) Documented changes to programs and management arrangements at each of the services following the consultancies.

Changes have been documented. See Section 6.2, in particular the discussion (from page 74) of improvements to community health practice flowing from the consultancies.

- d) Production of an overview paper reviewing (the) CDIH framework for community development.

In a general sense this full report fulfils this commitment but in particular see Section 6.3.

- e) Listing of advisory services provided to community health services.

See listing at Appendix 1.6 and discussion on at Section 5.6.

5. EXPENDITURE REPORT

**Extract of audited report, submitted in accordance with
Funding Agreement between Victorian Health Promotion Foundation and
Community Development in Health Project.**

**STATEMENT OF INCOME & EXPENDITURE
FOR THE PERIOD 1/11/88 TO 31/10/89**

INCOME	\$	\$
GRANT – VICTORIAN HEALTH PROMOTION FOUNDATION		100,000
<u>LESS EXPENDITURE: - (NOTE 1)</u>		
Salaries	79,582	
Workcare Levies	1,145	
Office Rental, Rates, Light, Power	4,007	
Office Requisites & Equipment	3,726	
Office Supplies & Postage	2,058	
Office Cleaning	550	
Photocopying	550	
Books & Publications	165	
Staff Advertising	855	
Audit Fees	680	
Travelling Expenses	2,784	
Personnel Expenses	2,206	
Telephone	1,692	100,000
SURPLUS/DEFICIT		NIL

NOTE 1.

EXPENDITURE INCLUDES ACCRUALS AE .AT 31ST OCTOBER 1989

Salaries (November 1989)	1,540
Holiday Pay	2,702
Workcare Levies	282
Photocopying	275
Audit Fees	210
Personnel Expenses	1,916
Telephone	166
	<u>7,091</u>

6. PERSONNEL

Project Staff

During the course of this Consultancies Project the project staff have been as follows:

Gina Fiske (to April 1989)
Angela Hill (to May 1989)

Maria Wright (from May 19 8 1989)
Silvana Scibilia (from May 1989)

Gina Fiske

Gina worker with CDIH as project officer from November 1987 to April 1989. She played a major role in the development of the Resources Collection and was closely involved in the planning and development of the Consultancies Project.

Gina's original training was in youth work and she has extensive experience as a field worker and as a consultant in planning and evaluation.

She has undertaken further studies in political science, anthropology and program evaluation.

Gina is presently working in staff development with Co unity Services Victoria.

Angela Hill

Angela worked as a project officer with CDIH from June 1988 to May 1989. During this time she assisted with the compilation of the Resources Collection and establishing the consultancy role for CDIH

From January 198 to June 1988 .Angela worked as executive officer at the Dandenong and Springvale District Health Council. As well as establishing the council, the major health issues she worked on there included environmental health, dental health and the development of community health services in Dandenong.

She is presently working on a local environment plan for Brunswick and Northcote City Councils.

Maria Wright

Maria has worked full time with CDIH since May 1989. Prior to that she worked at Fitzroy Community Health Centre for

five years as community health worker and acting manager Maria trained originally as a nurse; she has undertaken further studies in sociology and small group work.

Maria is a past president of the Victorian Community Health Association and was the convener of the 1988 Australian Community Health Conference

Maria has been interested in health promotion in its widest interpretation for many years. Maria attributes the two years that she spent with the Royal District Nursing Service as a key influence in developing her understanding of the social context of health and the potential for community development work. Prior to joining CDIH, Maria had written about community development in health, in particular in relation to the Continuum concept.

Silvana Scibilia

Silvana has worked three days per week with DI since May 1989. She has had extensive experience in the human services area. with a focus on rights issues She also has experience in teaching. She is currently a member of the Social Security Appeals Tribunal and the Intellectual Disability Review Panel.

Her training is in political science, Indian studies, sociology and public policy.

From 1983 – 1988 she was the Director of Action on Disability within Ethnic Communities. ADEC is a community based organisation which services people with disabilities from non-English speaking backgrounds and their families. It's focus is on advocacy and consumer rights. ADEC's program consists of advocacy, case-work, community development and education, policy development and research.

From 1983 – 1985 she was the co-ordinator of the PACT Project (Parents And Community Together) a three year project funded through Commonwealth Schools' Commission funded and managed by STAR: Victorian Action on Intellectual Disability. The aim of the project was to develop information and resource materials for parents and to raise awareness in the professional and broader community to parents' needs.

She has also published on disability issues

Richard Hudson

Rick Hudson acted as independent evaluator during the evaluation and review sessions and associated interviews.

Dr Hudson has worked in community health since 1978 at the James Bay Community Project in Victoria, British Columbia. This is an innovative project in the community management of primary care. During this time he worked with community groups to develop a peer counseling project for elderly residents of the neighbourhood. He is currently working towards a Masters Degree in Public Health.

Clerical Administrative Support

During the period of this *project* the project workers have been ably supported by the following administrative staff persons.

Narelle Stavrou	Nov 1988 – May 1989
Beverley Grimes	Nov 1989 – Dec 1989
Mary Karavarsamis	Nov 1989 – the present
Fiona Maclaine, Finance	Nov 1988 – Nov 1989
Amata Hall - Preston & Northcote DHC	Nov 1989 – the present

The Steering Committee

The Steering Committee of the Project {at the time of this Report} consists of the project staff {listed above plus the following: Shirley Freeman, Demos Krouskos, Terri Jackson {on extended leave, David Legge Tony McBride, Sally Mitchell, Onella Stagoll.

Shirley Freeman was president of the Flemington Community Health Centre when she joined the Steering Committee of CDIH. She is the current president of the Victorian Community Health Association and is vice-president of the Australian Community Health Association. She works part time for the Community Health Unit of the Health Department in the Self-help Funding Program and in the regional committee of management education program. Her training is in social work.

Demos Krouskos is the executive officer of the Preston Northcote District Health Council. He has been in this position since April 1986. Prior to that he worked in health promotion. He is an historian by trade and has lived in Collingwood for 30 years.

Terri Jackson joined the Steering Committee of the CDIH Project while she was manager of the Fitzroy Community Health Centre. Terri has been involved in health promotion and community health for many years, particularly in women's health. She was a founding board member of the Victorian Health Promotion Foundation. Terri is presently undertaking completing a doctorate in health policy and health economics at Brandeis University in Boston.

David Legge was Co-ordinator of the District Health Councils Program and Manager of Community Health Programs during his five years with the Victorian Health Department. Prior to that he worked as a physician. He is presently working at the National Centre for Epidemiology and Population Health at the Australian National University

Tony McBride has been a community worker since his or under the Australian Assistance Plan from 1975. He has worked mainly in the community health field, both in England and here and' recently worked at the Kensington Community Health Centre for four years. He is currently a project officer with the Healthy Localities Project

Sally Mitchell is an experienced community development worker in health. At the time she joined the Steering Committee of CDIH she was working as community health worker at the Fitzroy Community Health Centre. Prior to that she worked with the Flemington Tenants Association. She is presently a research fellow with the Lincoln School of Health Sciences at La Trobe University.

Onella Stagoll has a long and varied experience in community development in health. She is presently manager of the Women's Health Programs Unit with the Health Department, Victoria. Prior to that she worked with the District Health Councils Program