CHAPTER 5

DATA ANALYSIS - IMPROVING OUR PRACTICE

Introduction

In this chapter I will look at the data and draw out the issues which came up most frequently and which caused most concern to the Aboriginal Health Promotion Officers. The issues raised most often and which proved to be the most important to the success of the journey we took together were those of support; what is support and what are the features of a 'supportive environment'; clarification of the role called for by the job; team work; and working in partnership. As a Program we are committed to the provision of support to develop skills and understanding. We believe that working within a strong team is essential for the development of creative and thoughtful workers and that working partnerships between Aboriginal and non Aboriginal staff will facilitate our aim to improve the health of Aboriginal people. What the data shows is the difficulty of turning these very noble and easily spoken intentions into reality.

SUPPORT - ONE WORD, MANY MEANINGS

During the many discussions I had with the Aboriginal Health Promotion Officers and general Health Promotion Officers, support was clearly the most important factor affecting how staff felt about their job, their performance, and their relationships in the workplace. When people felt supported they felt

confident, relaxed enough to ask for help and good about the job. When people felt they received an inadequate level of support they were tense, frustrated, less confident and less positive.

Support was the linchpin around which the Health Promotion Program model was constructed. In order to provide support for the health promoting activities undertaken by primary health care providers and communities, we aimed to provide a high level of support for the Health Promotion Officers through the provision of skills development, research and evaluation support. The support team knew that in order to provide effective support to communities we had to ensure our own staff were properly resourced with skills and knowledge. The process used with the Aboriginal Community Health Promotion Project (NBHP) had been refined to develop the present Health Promotion Program model. Shirley Hendy spoke of the importance of the lessons gained from the earlier project:

> We learnt that we need to provide a clear framework for people to work within. We need to provide the support that working as a team requires; people to debrief with, and a process for evaluating performance. Support people are an essential resource; to question, to encourage thinking about alternatives, and to take staff through a clear planning process (Hendy 1993).

It was evident through the course of this process that all people do not naturally offer support to or work in partnership with those around them. Shirley did flag this possibility with me at the beginning when she said that:

> We need to experience that (support) ourselves in order to model it to others. We recognise that such a role is not easy as it is not the way we have previously worked. We are used to providing information rather

than questioning, supporting, challenging and developing (Hendy 1993).

What is support?

With the Health Promotion team situated in the five district centres throughout the Northern Territory, an important method of providing support was to ensure that they received regular visits from the support team. These visits served to provide support in a variety of ways; to discuss issues of importance for the staff in the regions; to provide planning and evaluation assistance; to debrief; and to talk with District Managers and other district staff to validate and support the way the Health Promotion staff were working. Early in my time with the team Carol said to me;

> we need to work together to support the staff. We need time to go and sit down, to talk to those around the workers, to talk to other staff and other organisations, to see how we can support each other (Watson pers.comm. 18/10/93).

During visits to Districts we always discussed support. Discussion included; what support the team needed; how the team could best support activities of other district staff; how best to support communities and Health Workers; and how to build support for our way of working. It was the over-riding concept of all of our work, to assist the team develop the skills to provide a supportive environment and support community action. AHPO's pointed to regular visits as indications that the staff are valued and that Central Office is committed to district staff.

When we looked at what support meant in practice the Nhulunbuy team mentioned;

> Regular visits and contact from support staff and the Director; people making time for us; providing feedback; being focussed on what we are doing; demonstrating unity and showing interest in our work. Regular visits are important to continue to build relationships in the team (Nhulunbuy 1993).

Support was mentioned so often by everyone as an issue needing to be addressed that Gwen and I decided to try out an activity suggested to us as a way to get a clearer picture of what people meant when talking about it. [11] During our next visits to the teams in Nhulunbuy, Katherine, Alice Springs and Tennant Creek, we asked people to identify what support feels like, what it looks like and what it sounds like. The following is a collation of the responses from these teams;

What does support look like?

> Within the team support means working together, being eager to know what each other is doing, looking for ways to work together, sharing information, being professional and unified. Support can be seen by a nod, a smile, focussed attention, and a person being pleased to see you.

What does support sound like?

> It sounds positive; 'mm'; 'right'; 'good one Gary'; ' thanks'. One hears offers of advice and constructive criticism, encouragement, requests for help, and feed back.

When you are supported what does it feel like?

> You feel secure, contented, relaxed, eager to work, enthusiastic, appreciated, pride, confident, acknowledged, and valued. You feel a sense of worth, that you have input, you are sharing information, the workload and ideas. You feel valued and that your needs are being met. (Katherine 1994; Nhulunbuy 1993; Alice Springs; and Barkly 1993)

---

11 The exercise was suggested by Barb Power, a consultant who was working with the Living With Alcohol Program.

This exercise allowed people to really think about what support meant to them and helped them to focus on where they felt that it was missing. If team members were feeling that they were lacking adequate support, we moved on to identify how the team could work towards building a greater level of support within their district.

FEATURES OF A SUPPORTIVE ENVIRONMENT

My notebooks and diaries are dotted with conversations and discussions about how best support could be provided. By pulling out the excerpts mentioning support I found that we can articulate a very clear set of activities which if put into practice would ensure a meaningful level support.

Assistance in the field was requested. Identified mentors need to go on field trips to communities with new AHPO's to work with them clarify their new roles and experiences and to model the best way of working. Gary suggested that:

> the Central Resource Team can provide practical support by coming to communities to go through the experience with us. (We need) peer support from Bernie, Greg and Gary (the local Environmental Health Officer) to see how other people operate (Nhulunbuy 1993).

The team also identified the need for the Aboriginal Coordinator or other support people such as elder Aboriginal Health Promotion Officers with authority and a wealth of experience in working with communities to evaluate how AHPO's and general Health Promotion Officers were actually working in communities. They should "come with us to see how we are going" (ibid.).

Formal skills development was sought, particularly in the areas of planning programs, evaluating, and delivering workshops. This could include regular professional development sessions to plan and review learning needs. It was felt that these sessions could be held during the regular support visits from any of the support team.

Skills development support from peers

The Aboriginal Health Promotion Officers (AHPO's) needed to identify support people within their region with competency in the skills being developed. These support people were key to learning and to the development of effective teams and networks They could assist the AHPO's debrief after field trips and workshops or other activities, and offer support and assistance. During one of our regular discussions on how best to actually work with support people, Carol pointed out:

> As part of the skills development process AHPO's need to identify opportunities for working with others and receiving guidance, support or learning from them.
>
> They need to ask; how can I be supported?
> who can support me?
> what use is that support?
> when will it happen? (Watson 1994)

The skills development process would tie closely into the development of effective and supportive teams and learning would be a two way process. As well as the Aboriginal Health Promotion Officers developing their skills it was expected that people working in the districts would learn a lot from the AHPO's about Health Promotion Strategies and methods, ways to approach and work with communities, good planning techniques, how to document

effectively and how to work well as a team. The desired outcome of such support and teamwork was for non Aboriginal and Aboriginal professionals to work together to build each other's skills and to share their experience.

Support and advocacy by the Program management for the work undertaken by Aboriginal Health Promotion Officers in the Districts was identified as critical. There is the need to ensure that the district managers and staff understand and support the role of the AHPO's. The Aboriginal Health Promotion Officers believed that the Program Director has an important role in ensuring that district mangers were very clear about the directions and goals of the Program. Many districts were not providing support or resources for the AHPO's to do the job effectively.

At times the values, philosophy and priorities of the Program did not fit neatly into the culture and priorities of some of the Districts. AHPO's were encouraged by the Health Promotion Program to spend a good deal of time in communities in order to develop relationships with people in the communities and yet in some places the culture and the hard realities of the district made such flexibility impossible. For example, access to a vehicle is essential to support the ability to travel to communities often and be flexible about the time spent in communities. In Katherine, a limited number of vehicles meant that the AHPO's experienced difficulties accessing vehicles for any more than a few days and often had to share rides with other staff. This meant that they were tied to other people's itineraries and agendas and the team felt that this affected their ability to respond to the needs of the community with whom they were working. At the Mid Year Recall in August 1993 the Nhulunbuy and Alice Springs teams suggested that it was a role for the Health Promotion

Program management to ensure that there are adequate funds available for health promotion work and community visits (Mid Year Recall report, 1993).

The model of working in partnership also fitted uneasily with the management structures in the districts. District managers looking for the ease of clear roles and accountability tended to make the person with the highest salary level the supervisor and manager of the team, enforcing traditional hierarchical structures on the teams. This meant that the non Aboriginal Health Promotion Officer was seen to be the most skilled and authoritative and the skills, leadership ability and experience of the Aboriginal Health Promotion Officers were often not fully acknowledged. It also created difficulties within the team and required skills that the general Health Promotion Officer (HPO) often did not have and which had not been requested when they were recruited. General Health Promotion Officers brought academic skills to the job and very often had far less experience and knowledge than their Aboriginal team mates, particularly with regard to Aboriginal health. General HPO's identified the need for support to undertake the supervisory role expected of them by districts which "work in a hierarchical framework" (Clynes pers. comm. 94).

Support for working in a community development framework

Although in principle, primary health care was believed to be the most effective way of working with Aboriginal communities in the Northern Territory, and community development processes were recognised as complementary to primary health care, in many cases the Aboriginal Health Promotion Officers found that the actual working of community development was neither valued or appreciated. There was considerable pressure from managers and other workers (within the Health Promotion Program as well as from their districts)

to be seen to be producing - to be 'getting runs on the board'. Aboriginal Health Promotion Officers (AHPO's) got the feeling from non Aboriginal staff that it was fine to do community development work if they produced a lot of reports or articles or spoke at conferences. While people said that Aboriginal communication styles were valued, the AHPO's felt that non Aboriginal written skills were required to legitimise the actions. After one of many discussions on this matter I have written in my journal:

> Support for a way of working is important, people need to be validated by those around them to feel confident that they are working well and in the 'right way'. This can be a problem for people working in a community development framework where the process is as important as the result (Harrison journal entry 1993).

In April 1993, Gwen and I visited Kath and Richard in Katherine and we had a very long discussion on the 'need to produce'. Kath had seen time and time again that:

> AHPO's have to be seen 'producing" or the project may be downgraded. Health staff have been going out to communities for 20 years with no results. Now that Aboriginal people are involved they want instant results....Aboriginal people can see the process working and know that down the track we will get results. We can see it happening. We are seeing results (and) we see changes. Change is a constant and developing process. Non Aboriginal people value a certain way of working and want Aboriginal people to work in the same way. They do not value the way Aboriginal people work (Mills pers. comm. April 1994).

The following extract comes from my diary and was written during the night, after our conversation on the need to produce. I was so angry about the mixed

messages being given to the AHPO's that I had to write it down before I could return to sleep:

> There is effusive praise of Aboriginal staff for their high profile successes such as Elliot on one hand and questioning of the value of work that is not high profile on the other. This leads to a confusing mix of expectations being placed on Aboriginal staff which are both higher and lower that those placed on their non Aboriginal counterparts. Aboriginal staff are more heavily scrutinised, more readily criticised for mistakes and small successes are often built up and praised as if they had exceeded expectations. Similar successes would be expected of non Aboriginal staff. Despite often lofty rhetoric people fall into the trap of having lower expectations of Aboriginal staff; or expectations that are too high. It is a dichotomy which leaves people (both Aboriginal and non Aboriginal) feeling frustrated and unsupported. People also feel frustrated and unsupported when teams are not functioning adequately. If we talk about the existence of a team, the value of a team, but everyone is not sure of the direction (we are heading) and information is not shared, they feel unsupported and confused.
>
> Support is more than just training and skills support. It is support for a persons direction and way of working. A trust that an individual has the necessary expertise to decide the right way to work. Trust that, as Kath said yesterday, Aboriginal people know the best way to work with communities. A way of working that may not be valued by non Aboriginal health professionals is very much valued by Aboriginal people. It is here that the rhetoric of support and the reality of support come into conflict. This is an issue in the Health Promotion Program. In principle everyone expresses support for "Aboriginal ways" but in reality it is European ways and values that take precedence whenever there is any conflict or when work styles come into question. An example is the value placed on the 'planning process' and on skills involved in running workshops, being seen to be working "efficiently", going out bush and being seen to be 'productive'. Such values have lead to the checking of time sheets and talk of 'rorting the system' whenever staff don't fit into these models (Harrison journal extract 1994).

Supporting one another within the team

Support, direction and assistance from other team members was identified as essential and includes making time to meet together to plan and debrief field trips and other activities. Day to day contact between the team members was also identified as a valuable means of support and developing relationships. Many people within the Program did ring each other regularly and found it very useful. More use of the phone was recommended (Mid Year Recall Report 1993).

At the Mid Year Recall the following ways identified for providing support to each other:

> talking ideas over, making time for each other, listening to each other, offering help to other team members who are really busy, feedback diary entries to each other especially if someone away on holidays or sick, ensuring that everyone felt comfortable to seek support, making creative suggestions. Small curtesies such as saying goodbye to each other and being aware of what is happening in each other's life, making coffee for each other, "Sharing and Caring", sending flowers and cards to celebrate successes, or sad times (Mid Year Recall Report, 1993).

The Aboriginal Health Promotion Officers turned to each other for support regularly. During a discussion in Alice Springs in November 1993, Marlene L. spoke of needing more support. At the time, Gwen was regularly away in Darwin and Tennant Creek, acting as Aboriginal Coordinator, and was unable to thoroughly orientate Marlene to the job. As a regional team we discussed how Marlene could best become more familiar with the job and feel more confident to branch out on her own. Marlene decided that she could go out to

Titjikala (a community 3 hours south west of Alice Springs where Gwen had been working for a the past couple of years and where Marlene had been before):

> I can go out to Titjikala, (since) I feel confident to go there and can get to know the women more. I can tie in with activities Ray is doing in Alice Urban, go out with Marlene and Cliff and go out with other staff (Liddle pers. comm. 199[illegible]).

Maintaining support

The Aboriginal Health Promotion Officers identified the need to ensure that they continue to provide ongoing support for each other. After Marlene B and Marlene L joined the Program in mid 1993 we held an orientation workshop in Tennant Creek for the Central Australian AHPO's. At this meeting the Alice and Barkly teams decided to offer support and ideas to each other by send(ing) copies of field trip and workshop reports to other regions each three months. At a later meeting they decided that it was necessary to:

> Meet as a whole team (combined District meetings) twice a year;
> to have Gwen visit Tennant Creek as required but at least 3 to 4 times a year;
> to have visits from the Central Resource Team members at least 3-4 times a year; and to have a meeting with Ray frequently during his regular monthly visit to Tennant Creek (November 1993).

Full complement of staff committed to the process

As a program we always spoke about our commitment to providing support for staff in the field. In a briefing paper in 1993 we wrote:

> we provide a high level of support to our staff; we plan and work collaboratively and they in turn model this way of working in partnership with communities and service providers. (Watson and Harrison 1993)

In light of this often stated commitment the Health Promotion Officers had high expectations of the support they would receive. However, during the period covered by this research project several of the key support positions were not filled for large periods of time which created difficulties actually delivering the promised level of support. When a program aims to support staff it is essential that positions are filled. The amount of time people are not on board impacts strongly on support.

Building support networks in the district

The support team was often unable to provide an adequate level of support. During the course of this project we were never able to visit regularly enough and the key position of Aboriginal Coordinator was vacant for almost 12 months. In response to this and because they needed to develop their networks within their own districts the AHPO's had to create their own opportunities for support. The people they identified as their support network included; the district Health Promotion team; the NT-wide Health Promotion team; the wider district health team, especially other field workers such as Aboriginal Health Workers, Environmental Health Workers and Nutritionists; community members, particularly the council, clinic, shop and school staff; and officers from other Departments.

The Aboriginal Health Promotion Officers proved themselves to be highly self motivated. It became evident that a high level of motivation was essential for

making the best of the job in circumstances that were never ideal. There was not the necessary level of support, the job role was new and it departed from the predominant way of working in the Territory Health Services.

Strategies to improve support for health promotion activities within the Territory Health Services, articulated by the Nhulunbuy team (29/6/93) included running short workshops for other staff to look at what health promotion is, what health promotion means to staff, what the Health Promotion Officers can offer them in the process of building on their role as health promoters.

Providing support to other primary health care workers

As well as identifying opportunities for building their own skills, the Aboriginal Health Promotion Officers had a huge responsibility for providing support to other Aboriginal workers and community people. Often the AHPO's found that it was through assisting Aboriginal Health Workers and other workers build their health promoting skills that they were developing their own skills. The Aboriginal Health Promotion Officers were in a position to provide a great deal of support and encouragement to other Aboriginal workers because of the nature and the flexibility of their job. Bernie spoke of the value of Aboriginal Health Promotion Officers working with communities and running workshops; "Aboriginal people can see our mob getting up and doing things" (Shields 1993).

The Aboriginal Health Promotion Officers consistently showed great commitment to their role as agents of change within the Territory Health Services. Bernie often spoke to the team of the importance of having more

Aboriginal people in the Department to influence planning and delivery, and Kath spoke of the need for Aboriginal people to input into policy:

> It is important to employ more Aboriginal people in the Department to influence the decisions made to reflect Aboriginal ways and priorities. It is crucial to increase the numbers of Aboriginal people involved in both program planning and delivery (Mills 1994).

> Aboriginal people are key to the process, and must be key to all negotiation and education activities involving Aboriginal communities. Aboriginal people can say "we..." (Shields 1993).

Aboriginal staff members are potentially the most valuable resource the health service has for making any real improvement in Aboriginal health. Not only do Aboriginal primary health care workers have the best chance of improving health, they provide a vital opportunity for the health system to become more responsive to the needs of Aboriginal people. Skilled Aboriginal staff can change the way the health system responds to Aboriginal clients and change the way non Aboriginal people work. They can teach non Aboriginal primary health care workers about Aboriginal communities, priorities and values. If non Aboriginal staff cannot work in partnership with Aboriginal co-workers they can never work in partnership with people in communities and can have no positive role to play in working to improve Aboriginal health. The skills needed to work with communities are vitally important and once developed, the Health Promotion teams can become a professional resource for communities. My journal records my personal aim for our program to influence the Health Service to the point where; "service providers ask advice from the AHPO's about how to approach communities before they actually enter and work with communities" (Harrison, 1994).

Supporting communities

Working with communities is the focus of the work of the Aboriginal Health Promotion Officers. The aim of the training and support was to assist them develop the health promotion skills and knowledge to work alongside Aboriginal people in communities to improve their health and quality of life. Developing close working relationships with Aboriginal Health Workers and other community based Aboriginal workers and providing support for them was a major priority for the Aboriginal health Promotion Officers.

Support for community people means being available and skilled to work with communities who have sought assistance on the activities and issues they have determined as priorities. It means respecting the knowledge and priorities of the people in the community; and recognising that the community has to be the driving force behind what is done to tackle a health issue.

At the Tennant Creek orientation in July 93 the teams identified that support for community development could be provided by ensuring community people have:

- control of the programs and responsibility for activities.
- by people working together towards the same goals.
- control of their own social and physical environment.
- by building on and developing skills already in the community.
- working to ensure sustainability - so that a project doesn't rely on the AHPO and doesn't fall apart when you leave.

The Health Promotion Officers adopted a practice called professional loitering which is a way of spending time in a community to build relationships and at the same time having a clear understanding of what their own goals and outcomes are for the visit. Kath spoke of Aboriginal people look for links with

other people; it is an approach that recognises the importance of relationships to Aboriginal people and provides a way for Aboriginal people to begin the process of dialogue with others:

> I use this term to describe the communication procedures vital for good communication on contact between Aboriginal people. These practices recognise Aboriginal etiquette, correct protocol and demonstrates knowledge of cultural law. It incorporates the use of non verbals such as face, hands or body gestures.... Too long Aboriginal people have suffered a history of failure through the lack of cultural understanding. This in turn has produced poor outcomes (Mills 1994).

ROLES AND EXPECTATIONS

The need for ongoing, quality support was tied inextricably to the process each Aboriginal Health Promotion Officer (AHPO) went through of clarifying their roles in relation to the Program the district and the people and communities they worked with. At the beginning of the period covered in this research the focus was on how to begin to develop a role for themselves in their district and with the people they'd be working alongside. As AHPO's became more confident and began to develop relationships with communities and other service providers they looked more at what needed to be done and how they could help. The longer serving AHPO's did provide clear explanations of how they saw their roles as shown by Gwen's attached paper (appendix 7), but it seems this understanding could not easily be passed on. Each AHPO had to develop their own role according to their experiences, priorities and their own confidence level.

At the Orientation workshop in February 1993, Bernie told the group:

> The resources we are interested in are people.
> Health promotion is about process - we work in the area of promoting health. We work in a community development style - working to the needs of the people and involving them along the way (Shields 1993).

The uncertainty caused from the lack of a clearly defined role created a great deal of anxiety for some of the team. Cheryl for example, came to the job from being an Aboriginal Health Worker in a clinic where her role was clearly defined with a set of tasks to do each day. The loose structure of the Health Promotion job could be very stressful at times and she often wished she could return to the security of a tightly structured job. Although Gary constantly reassured Cheryl that she was doing a good job, it wasn't until we began to work on developing the orientation module for the training program that she could see that she had been working the right way' after all.

The AHPO's had been given an overview of the type of activities they would be involved in during their orientation in February 1993; the challenge for them was to determine how to go about it. A thorough orientation and a defined implementation process in the training program was identified as a way to make the way easier for staff in the future.

Clarifying the role of an Aboriginal Health Promotion Officer

The mid year recall in August 1993 provided an opportunity for everyone to share their experiences and activities. This helped people see how others had found their way and provided the opportunity to reflect on their own experience.

At the mid year recall we conducted an exercise to assist the AHPO's clarify their roles. Following is the list they developed of the activities they undertook in their work. This exercise shows the wide range of activities the team were involved in and also shows a range of ways different people undertook particular activities. Tension between assisting and skilling other groups to plan and implement programs, and undertaking programs themselves would be a continual grey area for many of the team. Although our charter was to assist other service providers and community members to develop the skills to promote health there was considerable pressure on team members from district management and from the new Health Promotion Director to be seen to be 'doing' health promotion activities.

What does it mean to be an Aboriginal Health Promotion Officer?

Community needs assessments
Talking to people to find out what they want
Read other people's departments needs assessments - and check with the community to see if they are correct
Survey people in the community
develop a community profile - for background information
Community and Social Development
Giving people control - making own decisions
Sharing information
Working together
Getting to know people
Supporting, following up on programs
Helping to evaluate programs
Program Evaluation
See how things are going
Make changes, decide what needs to be done next
To see where our strengths and weaknesses lie
Establish guidelines
Design Programs
Communicate with community to see what they want
Goal - What do you hope to achieve?
Objectives - how you are going to achieve your goal.
- are they achievable?
Research to see if the program has been attempted before
Help identify what resources are available within and outside the community
Implement / Deliver programs
- work with community to begin program
- Monitor and evaluate program

Share information
- communicating - talking to people
- pooling of knowledge and ideas
- resources - when and how to develop or access
- health promotion strategies
- up to date information

Health issues
- read and keep up to date
- attend seminars/workshops on health issues/priority areas

Health promotion strategies
- professional loitering (spending time in communities to develop relationships)
- community development
- primary health care
- workshops
- communicating /sharing information
- making information available/accessible ie library
- providing assistance

Liaising/working with other Government /non-Government Departments
- identifying resources and building on relationships
- networking
- find out about program
- meetings
- travel
- working on programs
- workshop together
- creating supportive environments

Workshop facilitation
- know your topic
- develop good presentation skills
- process-small group work
- planning
- evaluation
- flexibility
- people skills (Mid Year Recall Report August 1993)

Playing a multitude of roles

The need is so great for skilled Aboriginal people who can work within the bureaucracy that the Aboriginal Health Promotion Officers tended to be called on to play a multitude of roles. Unlike their non Aboriginal team mates Aboriginal Health Promotion Officers were not able to concentrate solely on their identified tasks. The more experienced an Aboriginal person is the more they are required to undertake a variety of roles not required of non Aboriginal people. They were asked to input into policy; advise on protocol; coordinate and lecture in training courses at the Certificate, Associate Diploma and Degree levels; sit on selection interviews; input to national enquiries on all matters of

Aboriginal health, education and justice issues; advocate for Aboriginal empowerment; negotiate; mediate; and always be available (Walley; Smith; Mills; 1994).

Building an understanding in others of the Health Promotion Role

The data shows quite clearly that much of the difficulty the Health Promotion team experienced clarifying their roles was bound up with the expectations many of the other people in the Territory Health Services had about their roles. The Health Promotion Officers were charged with the responsibility of changing the way people worked with Aboriginal communities by assisting them to develop the skills to take on primary health care and health promotion practices. The AHPO's had to find ways to reorient the health service, and to assist people in Aboriginal communities to identify and work on their own health priorities (Health Promotion Program goal 1993-6). For a Department which was not working in this way, and for health professionals who are used to fixing problems and finding solutions, the Health Promotion Program and its officers seemed to be offering very little. The AHPO's and the HPO's were constantly having to justify the legitimacy of their way of working. Even the new Program Director was not overly confident and kept saying that "we have to sell our successes" in order to show we were doing something valuable (Lindsay 1994).

At our direction setting workshop in February 1993, Shirley Hendy had posed the question "are we changing the organisation or just doing it ourselves?" (Workshop Report February 1993) and it is clear from the reactions of many people we worked with that they wanted us to 'do it ourselves'. In Katherine, Richard and Kath came across a view from district staff that Aboriginal staff

spending time in communities were "rorting the system" (April 1993). Many people within the Territory Health Service had clearly not taken on the spirit or practice of primary health care.

When we looked at the programs people were involved with at the Mid Year Recall it was clear that the Aboriginal Health Promotion Officers were working in an effective way. Their activities included developing a strong role for themselves in the areas of Aboriginal health and community health issues and being seen by the District health workers as people who could provide skills and assistance in planning community health programs (Mid Year Recall workshop report 1993).

Gary and Richard both developed posters to take to communities to introduce themselves. Gary even left posters behind on notice boards in the clinic and council office after he had visited a community so that people would become familiar with him and his role. The following extract from my journal records a discussion between Greg, Gwen and I and shows the concern they felt about helping the team describe their role more clearly to others:

> The AHPO role is difficult to define, we need to develop a way to clearly describe what we do and how we do it. Health Promotion does not have a concrete package or task to take into a community. Greg suggested developing something to take in which in an hour session could show what we do;
>
> Health promotion is... examples, photos. It would pose the questions;
> How do you feel about promoting health?
> Do you see a role for health promotion in your community?
> Do you have a health committee?

> We could provide a list of communities with health committees, and suggest that they contact them to see how they work. If you want to set one up we can help you (Harrison journal June 1993).

We also discussed developing a health promotion manual which would serve as an AHPO handbook and include definitions of health promotion, provide examples of health promotion activities, and list what the Health Promotion team can do to assist community based projects (Harrison Journal June 1993).

PARTNERSHIP

Defining teamwork

For the purposes of this process, teamwork included working together in the range of teams we belonged to; the Health Promotion Program team, our smaller Health Promotion unit teams in the districts, the Aboriginal Health Promotion Officers Territory wide saw themselves as part of a team, and in the districts we belonged to various rural health or allied health professional teams. Teamwork means people working together to share ideas, develop each others skills and knowledge, and to ease the burden. In such an environment the skills of the group becomes the resource rather than a collection of individual skills.

Defining partnership

Working in Partnership is used by the Health Promotion Program to describe the activity of Aboriginal and non Aboriginal people working together. We sought to develop working partnerships within the team, to share activities, and to model how to work in partnership to other people in the health service in the

belief that working in partnership is the key to making any real progress towards improving health. We also aimed to develop working partnerships with people in communities and other primary health providers.

The creation of teams in each district working in partnership to assist other service providers and communities become agents of change is the embodiment of the goal of the Health Promotion Program. The process of developing skills and consolidating a clear role for each person within the job necessitates a strong team working together. Within Health Promotion Program skills are predominantly developed in the field, and the majority of skills development will come from working within the team and from the Aboriginal and general Health Promotion Officers reflecting on the way they work and seeking out ways to learn from each other and the people around them. Partnership uses the skills of teamwork to share information, pass on skills, debrief after activities and field trips and discuss progress to evaluate the way each member of the team is working.

The partnership model

Partnership is embodied in the model adopted by the Health Promotion Program with each district team comprising two Aboriginal AHPO's working alongside a general Health Promotion Officer, as Carol said:

> Working in partnership is very important. We aim to model Aboriginal and non Aboriginal staff working together, sharing skills and knowledge and respecting the worth of each other (Watson 1993).

The model for working in partnership necessitated employing Aboriginal Health Promotion Officers with good communication skills and the ability to

work in partnership with a range of people from health professionals to people living on remote communities. It was crucial to have at least two Aboriginal staff in a team to provide support for each other and to provide a team to work in partnership with other primary health care providers and Aboriginal communities. We wanted to show communities that we were serious about working to help them and that we recognised the importance of support from the team, the district and the Program. The model also meant employing general Health Promotion Officers who would bring with them the formal, academic knowledge of health promotion processes and theories, and who must have the ability to work in partnership with their Aboriginal colleagues:

> We place a high importance on modelling how people can work together as colleagues, in the community and as individuals. (Watson 1993)

Conditions for Partnership

Conditions for partnership involve understanding the value of difference, mutual respect, developing relationships and trust, and sharing responsibility for decisions. During the mid year recall in August 1993, we sought to tackle the issue of developing effective working partnerships as a whole team. Activities identified as building partnerships and ensuring effective working relationships between Aboriginal Health Promotion Officers and general Health Promotion Officers included :

> sharing the administration load;
> trying to ensure regular get togethers especially when teams are often out working in the field; This requires creating an atmosphere where you can take time to be together;
> using each other as mutual support;

Clearly defining the administration and managerial role;
"we don't feel the difference in levels we all work as a team".

Understanding the value of difference

During the course of this development process we often discussed the special qualifications AHPO's and HPO's brought to the job and found that for partnership to occur people needed to value and appreciate the different skills each person brought to a job. The following list was developed by the team during a discussion on the equivalence of different qualifications brought to the partnership by Aboriginal and non Aboriginal people. It shows how the roles and skills brought to the team by the two groups are different but complementary. These are listed in order of importance as seen by the group. The combination of these skills and qualifications would ensure that team as a whole had the range of skills its needs to achieve its aims:

AHPO	**HPO**
Aboriginality	Professional qualifications
Communication skills	Communication skills
cultural knowledge	knowledge of bureaucracy
(community) networks	(professional) networks
(planning session 27/8/93)	

Respect

We found during the course of this training development process that respect between the team members was the most important condition partnership. Unless the team developed respect for each other and each others ways of working, partnership did not appear to happen; the team was not happy and did not function well. Even where respect was present, the differing expectations

of the district and the Program could create tension and lead to different role expectations from members within a team. In Nhulunbuy for example, Dianne struggled with the notion of the shared team responsibility on one hand, and the expectations from the district that she be a supervisor on the other. During a discussion to resolve these issues the Nhulunbuy team decided that:

> Dianne as supervisor should provide guidance yet still work as a team (member). The AHPO's are to be seen as professionals who set their own agenda. The supervisors job is to provide guidance and attend the managers meetings (April 1994)

They also decided to discuss the issue more and to:

> come up with a framework for how the team should work and give it to the Central Resource Team (ibid.).

In this way they believed they could influence the direction the team took and set their own priorities, rather than being caught up in fulfilling the expectations others had for how they should work.

Decision making is a shared responsibility

From the Health Promotion Program perspective we believed that it was important for each member in a team to have equal say in decision-making regardless of their level. In reality however different levels created different expectations - and we knew that we needed to be aware of this and to support the team approach clearly, particularly during our interactions with districts (Mid Year Recall Report 1993). Shared decision making meant that each member of the team needed to have a clear idea of the roles and responsibilities

of all of their workmates, and to have access to all of the information needed to make decisions.

Developing relationships and developing trust between team members were important aspects of the way we were working. We found that the development of strong and trusting relationships in the work field was significant for the development of skills, job development and feeling supported. We also needed to acknowledge that strong working relationships and trust take a long time to develop (Discussion with Ray and Carol). It was clear from discussions and from our visits to Districts that there was the need for relationships to be established before the training program could be effective. During one of our discussions Carol asked:

> How do you know when someone trusts you or that you have built up trust? They come to you and ask questions (personal communication. Watson 1994).

Development of trust needed people to take the time to build their relationships, and an appreciation of different ways of working.

Teamwork difficulties - barriers to working in partnership

Despite a clear and often expressed view that teamwork and partnership are the cornerstones of the way we worked together in the Program, and one that was enthusiastically embraced by the staff in the first workshop, working in partnership was not easy. Six months into the process we found ourselves discussing the need to develop some clear and detailed protocols on partnership.

Where there were teamwork difficulties other problems arose such as unhappiness about salary differences between team members, especially when the AHPO was involved with a high level of policy and planning work requiring a higher level of responsibility than base AO4 level positions normally do. In cases where teams where not working in partnership comments like the following arose:

> - personality problems are par for the course but there is no recognition for the work;
> - Work practices are questioned and described as scams and rorts;
> - Travel allowance and time sheets are questioned;
> - I feel like I am being kept an eye on;
> - I need to justify where I am going and what I am doing;
> - there seems to be a way of looking at how Aboriginal staff are working;
> - We need to talk about treating Aboriginal people equally. We are made to feel that we are out to rort the system (Harrison Journal entries:1993-4).

The health system places a high value on professional qualifications and the Aboriginal Health Promotion Officers certainly felt that they were performing at level equivalent to many staff with professional qualifications. Being Aboriginal also placed much greater demands on them in the workplace than their non Aboriginal colleagues. The after hours work, the policy advice, the counselling, and the huge personal commitment was all mostly unrecognised. The process of accrediting the training program would enable the AHPO's to be able to quantify their skills in health promotion and would ensure that they received recognition for their skills and their experience. The Recognition of Prior Learning process was seen as very important by the Aboriginal Health Promotion Officers as an activity which could provide recognition for the large number of unrewarded skills and knowledge they held.

Summary

Throughout the sixteen months the training process was being developed, the issues of support, developing working partnerships and clarifying roles were feeding into and guiding the process. We took steps to address these issues by ensuring that the training process involved everyone in the teams in working together and by writing the concrete aspects of teamwork and partnership; mentoring, debriefing, working on projects together, and joint decision making into the training program. In the final chapter I review the training process and identify the key processes which will enable us to move to the next stage in the process.

CHAPTER 7

REVIEWING THE JOURNEY AND LOOKING AHEAD

REVIEWING THE JOURNEY

Looking back on the process it is possible to see three distinct stages in the journey we made. The first stage was the team building stage and involved building our relationships with the people we would be working with and clarifying our roles in relation to those around us. The second stage was the analytical stage. Having developed an understanding of what the task at hand required we were able to look critically at what skills we needed to develop, make decisions about what direction the training process should take, and identify what steps needed to be taken to develop working partnerships. The third stage involved looking further afield to see how the training process could fit into the wider professional community and meet recognised academic requirements.

The first stage - building relationships

The first stage began with the first orientation meeting in February 1993. The united and inspiring vision for working in partnership within the Health Promotion team, and with other health workers and communities provided by the established team members set the scene for a strong team focus in our health promotion activities. This start united the team and led to team

members regularly seeking out assistance from others in the NT wide Health Promotion team.

During the first six months team members were involved in discovering how to work together in the Health Promotion team, building relationships with people in their districts and clarifying their roles in relation to the people with whom they were working. The early skills assessment activities provided me with an opportunity to build my own relationship with each person in the Program by providing the opportunity to spend time together, to discuss concerns, plans, to clarify ways of working, and to build our understanding of the job at hand.

The negotiation process involved in the identification of training needs can only occur in an environment in which there is a high level of respect and support. Within a supportive environment, people felt comfortable to look critically at their own activities and identify which skills they needed to develop in order to confidently guide and support the people in their own region. Once the team building elements were set in place people could look at the support mechanisms around them and made decisions about what level of support they needed from their team mates, the support team, and the district.

The second stage - the analytical phase

By the second stage people had reached a point where they felt comfortable about their role and had begun to establish relationships within the Health Promotion Program and their district. This realisation often comes like a bolt of lightening, 'of course, that's how I can go about my work', or 'now I know what I am doing'. I was hit by such a realisation six months into the job, when suddenly my role became very clear and I felt comfortable with my direction.

My role as Professional De'elopment and Training Coordinator was strengthened when the people in he Health Promotion team clarified their own roles and identified how I coulc help them move forward. Having become aware of what needed to be done within the job, people could look analytically at their activities and identify what they skills they needed to develop to enhance these activities. The skills assessment process became far more meaningful for people six to eig it months after they had been working, when the skills and knowledge listed on the page could be related to specific activities. This was a time of co nsolidating our gains.

The third stage - formal recognition

The third stage in the process involved moving on together to formally recognise the skills and know edge of each member of the team. The Aboriginal Health Promotion team as a whole had very seriously taken on the task of developing their skills in order to provide a high quality of support to health professionals and members of the Aboriginal community. In return they sought a quality evaluation and assessment process from the training program. Formally accrediting the training course was important for providing recognition of the effort put in by the Aboriginal Health Promotion Officers and for ensuring that their existing skills and knowledge were recognised. Recognition of Prior Learning principles within the accreditation process enables Aboriginal people to gain due recognition and credit for the skills and knowledge developed over many years.

LOOKING AHEAD: PRINCIPLES FOR PROVIDING SUPPORT AND WORKING IN PARTNERSHIP

The process of recording the journey undertaken by the Health Promotion team provided a valuable opportunity to review our practice and our interactions, and to draw from the record some principles to guide our practice in the future.

A number of these principles were articulated by the members of the Aboriginal Community Health Promotion Project and reconfirmed by the present Health Promotion team.

Take time to build relationships

The skills development process reinforced the importance of building relationships as a first step. A team can not move on to work in partnership or identify their own skill development needs until they have developed good relationships with those around them. Developing relationships within the team, within the health sector, and with Aboriginal people on communities is essential before any meaningful work can occur. Taking time to build relationships indicates an appreciation of the importance of relationships within Aboriginal society. Spending time on communities developing relationships is important and recognises that everything of value on Aboriginal communities is based on relationships. Spending time is our way of saying to people 'this is important'. It reinforces our verbal behaviour with our actions.

Build on Aboriginal knowledge

It is important to employ more Aboriginal people in the Department in both program planning and delivery positions. Aboriginal staff members can influence the decisions made to ensure these reflect Aboriginal ways and

priorities. We also need to support Aboriginal staff and recognise that they know the best way to work with communities. Aboriginal people must be key to all negotiation and education activities involving Aboriginal communities.

Provide a clear framework for people to work within.

Determine what skills and knowledge each team member brings to the team and articulate and value both Aboriginal and non Aboriginal knowledge and skills. The skills a team member has should determine what activities they place their emphasis on at the beginning and they can build on other skills they need during the skills development process. Clarify roles of members within the teams; clarify supervision roles and articulate expectations in terms of mentoring. Clearly articulate the expectation for working in partnership within the team and community, and identify opportunities for gaining support within the team and the workplace.

Building the skills of the team

The combination of the skills of the team members provides a whole and the team needs all of these skills to operate well. Recognise that Aboriginal cultural knowledge and community skills and knowledge are equivalent but different to professional skills. Form an agreement for sharing skills and knowledge and document the responsibilities each member has for passing on their particular skill to the other team members. Identify skills the team does not contain and decide how best the team can develop these. It may mean forming partnerships with other people and groups who can bring these skills.

Looking at the data a number of checklists can be drawn up to guide our practice and These are shown below:

A supportive team includes:

- people to debrief with; to question, challenge, support, develop...not provide answers;
- people who encourage thinking about alternatives.

Support involves;

- knowing what each other is doing;
- sharing information and ideas;
- offering encouragement;
- presenting a united front;
- asking for assistance
- providing feedback;
- planning together; and
- building reflection into the everyday activities of the team.

Support for the health promotion activities of the team from the Central Resource Team involves:

- advocacy for Health Promotion Officers' work with managers and staff in districts to ensure roles and expectations are consistent between the program and the district;
- providing a thorough orientation process;
- validating the Health Promotion Officers' way of working;
- regular visits to staff in the field;
- providing feedback on activities;
- taking an interest in Health Promotion Officers' work;
- accompanying team members on field trips and providing feedback;

- providing formal skills development in the areas of planning, evaluation, workshop delivery;
- ensuring there is a full complement of staff.

Providing support fo· Primary health care providers and Aboriginal community ɪ eople by practices that;

- enable Aboriginal Health Promotion Officers to work in a community development way;
- recognise the worth of Aboriginal elders both in the community and in the Department. They can provice guidance for the best way to work to improve Aboriginal Health;
- pass on health promotion skills and knowledge to enable people in communities take control of their own health promotion activities;
- model working in partnership;
- Appreciate Aboriginal ways of knowing and finding solutions to issues;
- recognise Aboriginal priorities for developing relationships.

Moving on to the next stage

This research process provided the opportunity to reflect on the journey we took as a team to develop the training process and to analyse our interactions. the findings from the research process reinforce the importance of taking time to build relationships within the workplace and the community. They also reinforce the importance of ongoing support for the skills development process. The principles embedded within adult education, primary health care and health promotion such as respect, dialogue, and ongoing learning, provided guidance and support to our practice. The participatory process was collaborative and involved reflection and analysis, which as Hall (1981) says

creates new knowledge. This new knowledge will provide guidance for our future activities.

This thesis marked the point within the journey where I paused for reflection. The principles articulated in the analysis for providing support and building strong partnerships will be taken back to the Health Promotion team to discuss, debate, add to, adapt and finally be integrated into our work to improve our practice. In the next stage of the process we need to give serious thought to developing a meaningful mode for working in partnership. This research process has shown that within the Health Promotion Program the Aboriginal staff do most of the adapting, most of the giving, and most of the reflecting on their work practice. There is a great deal of work to be done to bring about profound changes in the way people within the health system work to improve the health of Aboriginal people. There is no doubt that for any real changes to occur, Aboriginal people and Aboriginal knowledge must take centre stage. Aboriginal people must guide the way the bureaucracy works with Aboriginal communities and the Aboriginal community has to be the driving force behind what is done to tackle a health issue.

BIBLIOGRAPHY

Aboriginal Education Policy Task Force (1988), *Report to the Ministers for Employment, Education and Training and Aboriginal Affairs*, Canberra.

Ada, A. F. et al. (1990), 'The Educator as Researcher: Principles and practice of participatory research', *National Association of Bilingual Education International Bilingual/Bicultural Education Conference (19th annual)*, Tucson, Arizona.

Allen, R. E. (ed) (1991), *The Concise Oxford Dictionary of Current English*, Oxford University Press.

Australian Bureau of Statistics (1990), *Aboriginal People in the Northern Territory*, Government Printer of the Northern Territory.

Bailey, D. M. 1991, *Research for the Health Professional: A Practical Guide*, F. A. Davis Company, Philadelphia.

Bennett, N. and Desforges, C. (1985), *Ensuring practical outcomes from educational research*, in Shipman, M. (ed), Educational Research: Principles, policies and practices. The Falmer Press, London. (Hammond, 1989:109).

Bilbil, M. 1993, 'You are Talking To The Wrong Person', *Kularlaga: Journal of Aboriginal Adult Education*. vol. 5, pp. 13-14.

Boeren, A. (1992), 'Getting Involved: Communication for participatory development', *Community Development Journal*, vol. 27(3), pp. 259-271.

Bourke, E. et al. (1990), *Towards Better Management: Trainers manual*, DEET, Adelaide.

Brant Castellano, M. (1986), 'Collective Wisdom: Participatory Research and Canada's Native People', *IDRC Reports* (3), pp. 50-53.

Cassara, B. B. (1988), 'Participatory Research for Primary Health Care'. *Women's Conference*, East Lansing, MI, USA,

Commonwealth Of Australia (1994), *National Aboriginal Health Strategy: an Evaluation*, AGPS, Canberra.

Conchelos, G. and Yusuf, K. (1981), 'a Brief Review of Critical Opinions and Responses on Issues Facing Participatory Research', *Convergence*, 14(3) pp. 53-63.

Crawford, F. (1988), 'Aboriginal Knowledge: Does it Count?' in Harvey, B. and McGinty, S. *Learning My Way*, pp. 49-56.

Feuerstein, M. T. (1986), *Partners in Evaluation: Evaluating Development and Community Programmes with Participants,* London, Macmillan Education Ltd. in conjunction with Teaching Aids at Low Cost (TALC).

Folds, R. and Marika, D. (1988), 'Aboriginal Education and Training at the Cross Roads Reproducing the Present or Choosing the Future?', in Harvey, B and McGinty, S. (eds) *Learning My Way*, pp. 135-140.

Foley, Griff. (1987), 'Aboriginal Adult Education'. *Interlink* pp. 4-7

Foley, G, and Flowers, R. (1992), 'Knowledge and Power on Aboriginal Adult Education', *Convergence*, 15(1) pp. 61-73

Franks, C. and Curr, B. (1992), *Aboriginal Health Worker Project: Why don't they stay,* NT Dept of Health and Community Services.

Freire, P. (1973), *Education for Critical Consciousness,* New York, The Seabury Press.

Freire, P. (1978), '"As Educators we are Politicians and also Artists": An interview with Paulo Freire', in *Adult Learning : A Design for Action,* (eds) Hall, B. L. and Kidd, R. J., New York, Pergamon, pp. 272-280.

Garling, J. (1992), unpublished Field Trip Report.

Gaventa, J. and Horton, B. (1981), 'A Citizens' Research Project in Appalachia, USA', *Convergence*, 14(3), pp. 30-41.

Gitlin, A. D. (1990), 'Educative Research, voice, and School Change', *Harvard Educational Review,* 60(4), pp. 443-466.

Green, L. W. and Raeburn, J. M. (1988), 'Health Promotion, What is it? What will it become?' *Health Promotion* 4(2), pp. 151-59, Oxford University Press.

Hall, B. L. (1981), 'Participatory Research, Popular Knowledge and Power: A personal reflection', *Convergence* 14(3), pp. 7-17.

Hall, B. L. and Kidd, R. J. (ed.) (1987), *Adult Learning: A Design for Action,* Oxford, Pergamon Press.

Hall, B. L. and Kassam, Y. 1989 *Participatory Research. Lifelong Education for Adults: An International Handbook,* Oxford, Pergamon Press.

Hammond, M. (1989), 'Issues for Adult Educators to Consider Before Beginning a Research or Evaluation Project', *Adult Education Quarterly* 39(2), pp. 108-119.

Harrison, N. 1992-4, Journals: in possession of the author, Darwin.

Harvey, B. and McGinty, S. (eds), (1988), *"Learning My Way"*, Papers from the National Conference on Adult Aboriginal Learning, Institute of Applied Aboriginal Studies, WACAE, Mt Lawley.

Hatton, S. (1988), Ministerial Statement on health in the NT, Darwin. Health Promotion Service 1990, Territory Health Services Departmental files.

Health Promotion Program (1993a), *Workshop Report: 8-12 February 199,3* NT Dept of Health and Community Services, Darwin.

Health Promotion Program (1993b), *Mid Year Recall: Workshop Report: 30 August-3 September*, NT Dept of Health and Community Services, Darwin.

Health Promotion Program (1994), *Certificate level 4: Health Promotion Principles and Practice, Draft Accreditation Document*, Darwin

Hendy, S. and Power, B. (1990), *Aids - a story in our hands to Share.* Northern Territory Department of Health and Community Services, Darwin.

Horton, A. I. and Zacharakis-Jutz, J. (1987), 'Empowering the Poor: Participatory Research as an Educational Tool'. *Annual Meeting of the American Association for Adult and Continuing Education*, Washington D.C., Lindeman Centre, Northern Illinois University.

Howitt, R., Crough, G. and Pritchard W. (1990), 'Declaration of Ethical Requirements for Aboriginal People'. *Central Australian Aboriginal Congress*, Alice Springs.

Hughes, B. (ed) (1993), *The Penguin Working Words: An Australian Guide to Modern English Usage,* Penguin Books Australia.

Johnston, Mary. P. and Rifkin, Susan B. (eds.) (1987), *Health Care Together: Training Exercises for Health Workers in Community Based Programmes,* Macmillan London.

Jurmo, P. (1985), "'Dialogue Is Not a Chaste Event.'" Comments by Paulo Freire on Issues in Participatory Research. *Centre for International Education*, University of Massachusetts USA.

Kassam, Y. and M., Kassam. (eds.) (1982), *Participatory Research : An Emerging Alternative Methodology in Social Science Research,* New Delhi, Society for Participatory Research in Asia.

Knowles, M. (1973), *The Adult Learner. A Neglected Species,* Gulf Publishing Company, Houston (3rd edition)

Lipps, G. and Grant, P. (1990), A Participatory Method of assessing Program Implementation.' *Evaluation Review* 14(4), pp. 427-434.

Marika, R, Ngurruwutthun, D, White, L. (1992), 'Always together, Yaka Gana: Participatory research at Yirrikala as part of the development of a Yolngu education', *Convergence* 25(1), pp. 23-39

Marika-Mununggiritj, R. (1991), 'How Can Balanda (White Australians) Learn About the Aboriginal World?' *Ngoonjook, Batchelor Journal of Aboriginal Education*, No. 5, July, pp. 17-25

McTaggart, R. (1991), 'Principles for Participatory Research', *Adult Education Quarterly* 41(3), pp. 168-187.

Mellor, M. (1988), 'Ethics and Accountability: Participatory research in a worker co-operative', *Convergence* 21(2/3), pp. 73-84.

Mtonga, H. L. (1986), 'The Concept and Development of Participatory Research in Adult Education', *Australian Journal of Adult Education* 26(2), pp. 19-25.

National Better Health Program (1991), *Evaluation workshop Report, Aboriginal community Health Promotion Project in the Northern Territory*, 19-21 August. Northern Territory Department of Health and Community Services, Darwin.

National Health Strategy (1993), *Pathways to Better Health*, Issues Paper No.7, March.

National Health and Medical Council (1991), *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health Research,* iith Session of the NH&MRC Ouncil, Brisbane, June, interim format pending publication.

Northern Territory Department of Health and Community Services (1988-1990) *Annual Reports*. Darwin

Nyerere, J. K. (1978), '"Development is for Man, by Man, and of Man" : The Declaration of Dar es Salaam.' in Hall, B. L. and Kidd, JR. eds *Adult Learning: A Design for Action*, Pergamon Press Ltd Oxford.

Ormeno, E. L. (1991), *Adult Education Research: Latin America. Lifelong Education for Adults: An International Handbook,* Oxford, Pergamon Press. pp. 514-517.

Pagaduan, M. C. (1988), 'Mindanao peasant Women: A Participatory Research Investigation of their Realities and Potentials.' *Community Development Journal* 23(3), pp. 195-201.

Plant A. J., Condon J. R. and Durling G (1995), *Northern Territory Health Outcomes, Morbidity and Mortality 1979-1991*, Northern Territory Department of Health and Community Services, Darwin.

Ross-Gordon, J. M. (1991), 'Needed: A Multicultural Perspective for Adult Education Research', *Adult Education Quarterly* 42(1), pp. 1-16.

Sultan, M. (1993), 'Working Together in Groups, Pushes Us All Through', *Kularlaga: Journal of Aboriginal Adult Education* No. 5, pp. 21.

Tandon, R. (1981), 'Participatory Research in the Empowerment of People', *Convergence,* 14(3), pp. 20-29.

Tandon, R. (1988), 'Social transformation and participatory research', *Convergence,* 21(2/3), pp. 5-14.

Tiparui, J. (1993), 'This Has Always Been Our Way: Group Learning in Aboriginal Adult Education', *Kularlaga: Journal of Aboriginal Adult Education,* No.5, pp. 21.

Tregenza, J. and Abbott, K. (1995), *Rhetoric and Reality: Perceptions of the roles of Aboriginal Health Workers in Central Australia,* Central Australian Aboriginal Congress.

Uphoff, N. (1991), 'A Field Methodology for Participatory Self-Evaluation', *Community Development Journal* 26(4), pp. 271-285.

Valadian, M. (1988), Aboriginal Adult Education', in Harvey, B. and McGinty, S. (eds.) *Learning My Way,* pp. 101-105.

Vio Grossi, F. (1981), 'Socio Political Implications of Participatory Research', *Convergence*, 14(3), pp. 43-51.

Wass, A. (1994), *Promoting Health: the Primary Health Care Approach,* Harcourt Brace and Company. Australia. pp. 217-219.

Willis, P. (1991), 'Education for Life Transition: Recollections for Practice', *Studies in continuing Education,* 13(2), pp. 101-113.

World Health Organization (1976), 'Ottawa Charter for Health Promotion', *International Conference on Health Promotion*, November 17-21, Ottawa.

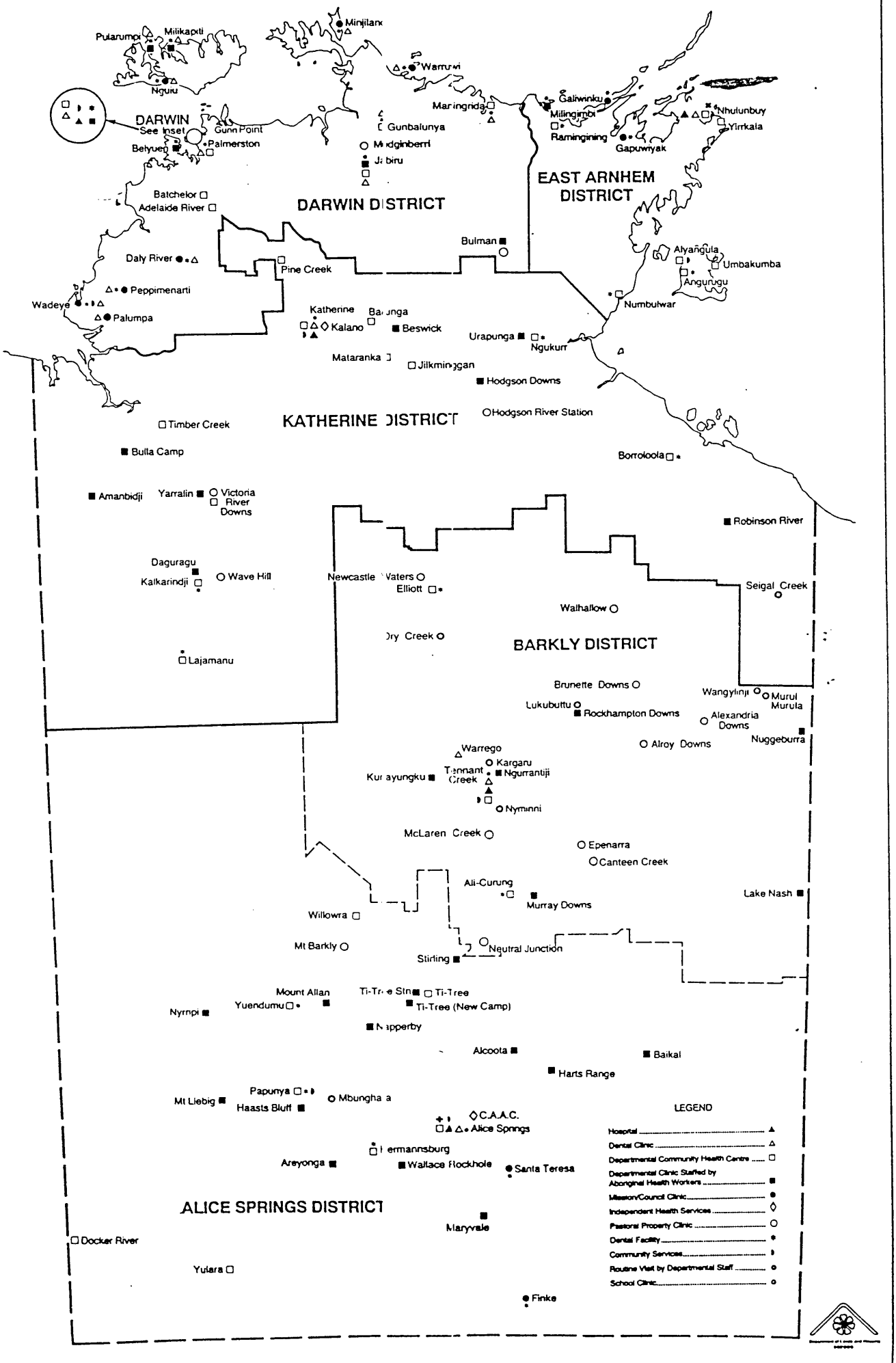
World Health Organization (1978), *Declaration of Alma-Ata.* Alma-Ata 1978, pp. 2-6.

Wright, S. (1992), 'Rural Community Development: What sort of social change?', *Journal of Rural Studies,* 8(1), pp. 15-28.

Yavu-Kama, C. (1988), 'Empowerment Through Learning from a Black Australian Perspective', in Harvey, B and McGinty, S. (eds.) *Learning My Way,* pp. 91-97.

APPENDIX I

HEALTH AND COMMUNITY SERVICES OUTLETS IN THE NORTHERN TERRITORY



APPENDIX 2 Permission Letter

11 Mary Street
Stuart Park NT 0820
12 February 1996

Dear Bernie,

As part of my Masters in Education (Hons), I have been writing a thesis on the development of the training program for AHPO's. The thesis looks at the process we went through as a team to develop the training program and to develop a framework for working in partnership and providing a meaningful level of support for staff in the program

The research project aims to;
1. explore the participatory project undertaken to develop the training program and to;
2. analyse the key issues resulting from the course development process; and
3. extract from the data a set of principles to guide our practice.

I have looked at the following questions as the key ones we have sought to answer:
1. How can we best work in partnership.
2. How can we develop a training program which will best provide the necessary skills for the work task.
3 How can we best provide the support to develop the skills.

In order to carry out this exploration of the process and analysis of the key issues I revisited the data I collected as part of the course development process from February 1993 to May 1994. During that time I had noted everything which might prove useful for understanding the needs and expectations of the team. I have used my diary notes, field trip reports, workshop reports, reports articles and briefing papers written by team members, file notes etc.

I have found this process of looking carefully at what we did together and what our concerns were, very useful for identifying what support and commitment is necessary to really support our team in the field and what barriers held us back (such as never having all of our support positions filled). I will give you a copy of the findings very soon.

The thesis includes notes of our work together and I have used your comments, insights and suggestions often. Please have a look at the draft paper (I have not written the final chapter yet which will be a list of principles and a summary) particularly the chapters talking about the team; chapters 1,3,4,& 5. If you are not happy to be quoted directly by name you could choose a pseudonym or an initial.

I am seeking your permission to use this information and will respect your wishes with regard to it.

Yours sincerely,

Nea Harrison

APPENDIX 3

Outcome:

HEALTH PROMOTION PROGRAM KEY OBJECTIVES FOR 1993-1995

- TO IMPROVE THE SUPPORT FOR HEALTH PROMOTION WITHIN THE DEPARTMENT AND THE COMMUNITY
- TO INCREASE THE ACCEPTANCE OF HEALTH PROMOTION AS AN ONGOING PART OF EVERYDAY SERVICE DELIVERY
- FOR ALL HEALTH PROMOTION OFFICERS TO BE PART OF A SUCCESSFUL COMMUNITY DEVELOPMENT PROCESS
- TO DEVELOP AND IMPLEMENT A COMMUNICATION STRATEGY FOR THE HEALTH PROMOTION NETWORK
- TO DEVELOP A CONCISE "LIST " OF RESOURCE MATERIALS FOR USE BY THE COMMUNITY AND HACS STAFF
- TO DEVELOP AND IMPLEMENT A PROFESSIONAL DEVELOPMENT PROGRAM FOR HEALTH PROMOTION STAFF
- TO PROMOTE AND PARTICIPATE IN CROSS CULTURAL PROGRAMS
- TO CONTRIBUTE TO THE DEVELOPMENT AND IMPLEMENTATION OF THE NT YOUTH POLICY
- TO REDUCE THE EXPOSURE TO PASSIVE SMOKING
- TO ENSURE THERE IS A GREATER UNDERSTANDING OF SMOKING ISSUES IN ABORIGINAL COMMUNITIES
- TO ESTABLISH LIVING WITH ALCOHOL PROGRAMS IN THE WORKPLACE, FOR YOUTH AND THE ALCOHOL INDUSTRY

RECORD OF THE OBJECTIVES WHICH WENT INTO THE KEY OBJECTIVES

TO IMPROVE THE SUPPORT FOR HEALTH PROMOTION WITHIN THE DEPARTMENT AND THE COMMUNITY.

BY 1995 the Health Promotion Program will be seen as a vital and excellent resource by HACS and community people.
- selling ourselves
- creating awareness of what is being achieved
- spreading the word about the value of health promotion.

TO INCREASE THE ACCEPTANCE OF HEALTH PROMOTION AS AN ONGOING PART OF EVERYDAY SERVICE.

By 1995:

There will be in place a program or process for incorporating environmental issues into health promotion which acknowledges a social / holistic view of health.

There will be improved practice of health promotion amongst all health professionals in the NT. This will be achieved through training, workshops, evaluation and planning.

Both Non Government and Government organisations will have the opportunity to participate in health promotion strategies and methods workshops and gain an understanding of the principles of Primary Health Care.

TO DEVELOP AND IMPLEMENT A COMMUNICATION STRATEGY FOR THE HEALTH PROMOTION NETWORK

A range of regular, ongoing strategies will be in place to ensure regular contact between the Territory-wide Health Promotion team.

TO DEVELOP A CONCISE "LIST" OF RESOURCE MATERIALS FOR USE BY THE COMMUNITIES AND HACS STAFF

TO DEVELOP AND IMPLEMENT A PROFESSIONAL DEVELOPMENT PROGRAM FOR HEALTH PROMOTION STAFF

By 1995:
All Aboriginal Health Promotion staff will have completed their Certificate in Health Promotion.

There will be a continuing professional development program in place for all Health Promotion staff including community development processes and workshop facilitation.

All members of Health Promotion will have developed new skills and be motivated to learn more.

There will be the opportunity for Aboriginal Health Promotion Officers to complete a degree and be eligible for a P2 position.

The Health Promotion Program will work in a coordinated manner and will have developed good working practices and relationships within communities and with other service providers.

TO PROMOTE AND PARTICIPATE IN CROSS CULTURAL PROGRAMS.

By 1995 :
Health professionals will understand and respect traditional culture.

Health professionals will have knowledge of and respect for bush medicine.

There will be a reorientation of health services to offer culturally appropriate choices to clients.

TO CONTRIBUTE TO THE DEVELOPMENT AND IMPLEMENTATION OF THE NT YOUTH POLICY

By 1995:
The young people's community will be
- recognised as important
- will have better developed interpersonal skills.
- will run alcohol free activities.
- will access health services.
- will participate in drug education
- every young person in the NT will have been given the oportunity to state what their major worry in life is.

TO REDUCE THE EXPOSURE TO PASSIVE SMOKING

TO ENSURE THERE IS A GREATER UNDERSTANDING OF SMOKING ISSUES IN ABORIGINAL COMMUNITIES.

TO ESTABLISH LIVING WITH ALCOHOL PROGRAMS IN THE WORKPLACE, FOR YOUTH AND THE ALCOHOL INDUSTRY.

VALUES

as to how it will
assist us
a framework for

ling
owa Charter).

oard.

ive. The whole

ehaviours and

the next couple
g list of key

nportant and

The Outcome

HEALTH PROMOTION VALUES

Health Promotion believes people are the solution.

Health Promotion is committed to a multicultural approach.

Health Promotion acknowledges the cultural diversity of Aboriginal people.

Health Promotion is committed to the Ottawa Charter Framework.

Health Promotion is committed to quality work practices.

Health Promotion is committed to ongoing personal development.

Health Promotion supports individuals, groups and communities to take responsibility for their choices.

Health Promotion encourages service providers to build on their existing Health Promotion skills.

APPENDIX 4

PART 4: CRITERIA FOR SELECTING AND INVOLVING COMMUNITIES IN THE PROGRAM

Contributing our ideas:

Aboriginal health promotion officer must be able to feel comfortable with people in that community.

It should be a community with few barriers to success - there is not long to achieve the goals of this program and early acceptance by community influencers and controllers is important.

Only two communities per region.

In Alice Springs and Barkly region:
1 x Alice Springs region
1 x Barkly region

The Darwin region team:
1 x Darwin region
1 x East Arnhem region

Community must want us:
- active and responsive
- supportive
- make a commitment

Can we identify a local contact person (maybe CDEP)

AHWs must want us

What is already happening in the community? (Should not be too many other programs on the go)

Accommodation for us to stay for up to two weeks.

Distance form town - is this a consideration?

Where relationships already exist.

General decision = We will work closely with a small number of communities. (= basic to a community development approach).

Following analysis and clarification of our ideas about community selection criteria, we decided on the following procedure:

PROCEDURE FOR SEEKING COMMUNITY INVOLVEMENT IN THE NATIONAL BETTER HEALTH PROGRAM

CRITERIA FOR SHORTLISTING COMMUNITIES (4 - 6)

- The community has been consulted before, and has expressed need for this type of program.
- We feel comfortable with the people/groups in that community.
- Relationships already exist with people there (and we don't have long to get this program established).
- The community is "stable", with not much "to and fro".
- Not too much happens there with programs from the Department or other Departments.
- There is potential for accommodation (up to two weeks at a time).
- The AHWs would, as far as you know, be keen to be involved.

PROCEDURE FOR RANKING THESE COMMUNITIES

1. Discuss these selection criteria with the Regional Director and significant others ("controllers" and "influencers") in the Department to seek support and to gain ideas about other selection criteria we may not have thought about.

2. Gather preliminary information to build a general community profile. Get hold of relevant reports written within the Department. Use networks to get information from other Departments and organisations (eg. NADU). Does the community have a history of involvement and active participation? What is your "gut feeling" about it?

3. Seek advice of local "controllers" and "influencers" in the region. (Regional Director, Rural Director, Program managers - AHW Manager)

4. Apply the seven criteria above (and possibly new ones according to advice received) and:

RANK COMMUNITIES

in order from 1 to 6, depending on how many of the criteria they meet, then:

5. Feedback to Regional Director, etc. regarding consultation and travel plans, and dates. Take "movement requisitions" and seek approval.

6. Approach communities in rank order.

FINAL SELECTION CRITERIA:

- Community must want our involvement and offer to make a commitment, respond actively and provide support, so that we have a good chance of success.

- AHWs in the community must want our involvement.

WHAT INFORMATION DO WE NEED TO COLLECT FOR COMMUNITY PROFILES?

Suggestions from the group, information should include:

- demographic profile of community
- population (male/female/age distribution...)
- clan members/skin groups
- council members
- funding of community
- money coming in (amount and from where?)
- health status
- resources
- essential services
- schools
- outstations

APPENDIX 5

1/7/93

ABORIGINAL HEALTH PROMOTION OFFICERS - AO4
SKILLS ASSESSMENT

	SKILLS REQUIRED	EXISTING SKILLS	SKILLS DEVELOPMENT	how
1.	Work with groups to clarify health issues. - communication skills - Listen + talk clearly - understand - understand health issues - know where to go for more info - have a broad idea of issues - don't have to have expert knowledge	1 - listening/communicating - negotiating - bringing people in - good skills at finding info from range of people in Dept + community - approachable - good at sitting down + listening	1. - more about health issues + 2. - what diff health professionals do 3. Develop a really good understanding of issues + what others do 4. Develop ability to use other resources/people better.	1 work with other health professionals - go out with them + learn about role + health issues 2 Read Pamphlets, books 3. learn from people around me.
2.	Work with groups to support community based health promotion programs. 1. · communication skills broad knowledge of health 2. - understand + work within cultural of the people 3. - not impose your ideas + ways on them	- Confident with communicating - 2 - continually learning 3. Don't impose your ideas + values on People	Get to know Community can sit down + work easier 1. know people + needs of community 2. learn about culture East Arnhem area 3. Dev some lang skills (not priority) 4. Build up rapport trust 5.	visits work on small, concrete projects to get to know community - develop community profile
3.	Work with groups to share health information - communication - sit down + talk - formal talks / class / workshops on health issues - understand health issues	see 1	1.	1.

	SKILLS REQUIRED	EXISTING SKILLS	SKILLS DEVELOPMENT	How
4.	Work with groups to prioritise health promotion activities. - be able to work out/identify priorities working with - ~~help~~ group to identify priorities - community Devt skills - without imposing own ideas	- some techniques - finding out what community wants through listening	- know more about different strategies to prioritise programs - have skills to prioritise issues - developing skills in needs assessment, prioritising techniques, - techniques for working groups through process of prioritising	- workshop - HP Certi - planning module
5.	Work with groups to develop community development plans - getting to know the community - ~~&~~ 2.2 - 2.3 - how to develop a community development plan	- listening - communicating - not impose ideas - some skills in how to get to know community -	- how to get to know community - how other people people work in communities - learn about other ways in order to compare my ways to - give me more options	- workshop Go and with other staff a see how they operate - evaluate that has happe
6.	Develop skills in workshop facilitation. - communication skills - clear explanations - know your topic/issues - draw out info from audience - get audience involved - diff activities - how to break up/ change activities - understand audience ie. read body lang - how to control group - evaluation techniques - group work	- confident - write smoking Diagram -	- speaking - clearer/slower - practice + confidence in front of audience - develop all of listed skills	- Train the trainer - practice to develop confidence - co facilitate other wshop - observing workshops critically - workshop

AHPO TRAINING PLAN

Name:

TIME FRAME	CORE SKILLS PROCESS	CERTIF IN HP	HP RUN W'SHOPS	OTHER	W'SHOP EXP	SUPPORT	ON THE JOB EXPERIENCE
Aug 93 **Sept 93** **Oct 93** **Nov 93** **Dec 93** **Jan94** **Feb 94** **Mar 94** **May 94** **June 94** **July 94**	AHPO's work through the core skills and knowledge assessment. (Prepared from the outline of the National core skills and knowledge for HP workers and the AHPO 4 Duty Statement.) A self assessment will highlight areas you wish to develop individually and priority areas for the whole group.	The work-shops making up the Certificate in Health Promotion	work-shops developed by the HP Program to meet the needs of the training program.	Work-shops , courses and activities you attend to enhance your skills devt. Training not provided by the HP Program. ie. use of visual aids, public speaking, w'shop facilitatio n, The reading program	Work-shops facilitated by AHPO's. These will be used as opportuni ties for training, by develop-ing your w'shop facilitatio n skills. W'shop process - *planning, *contrib-uting and sharing. *reflecting ,analysing and sharing *exploring options *planning action	Identified opportunities for working with others and receiving guidance, support, or learning from them. You will need to ask; how (can I be supported)? who (can support me)? What use (is that support)? when (will it happen)? ie. debrief field trips with mentor on return. Discuss options for action with support person.	A community development project identified. Planning. Working with other staff on projects. Issue based projects. Ongoing review and documentation of activities. Liaising with other Govt and non Govt groups.

APPENDIX 6

SKILLS REQUIRED	EXISTING SKILLS	SKILLS DEVELOPMENT	HOW TO DEVELOP SKILLS
1. BACKGROUND **Knowledge of:** 1.1 Aboriginal Health Issues 1.2 population health issues in Australia and their determinants			

APPENDIX 6

CORE KNOWLEDGE AND SKILLS FOR HEALTH PROMOTION PROFESSIONALS

1. BACKGROUND

Knowledge of:

1.1 population health issues in Australia and their determinants
1.2 Aboriginal health issues
1.3 Aboriginal communication styles and networks
1.4 national goals and targets and priorities for health promotion
1.5 scientific and theoretical bases for health promotion
1.6 social change and advocacy processes and methods, especially community

Ability to:

1.7 share information which assists communities clarify their own health issues
1.8 communicate with decision makers and communities

2. ASSESSING NEEDS

Knowledge of:

2.1 quantitative and qualitative research methods, particularly participatory research

Ability to:

2.2 assist community members and health teams conduct needs assessment
2.3 analyse synthesize data to describe the state of health of a population and the determinants of health

3. PLANNING PROGRAMS

Knowledge of:

3.1 program planning stages, including goals, objectives, strategies, evaluation, performance indicators etc.
3.2 health promotion strategies and their application

Ability to:

3.3 write goals and objectives, identify appropriate strategies and appropriate levels of evaluation in collaboration with the community and other sectors
3.4 support community based health promotion programs

4. IMPLEMENTING STRATEGIES

Ability to:

4.1 implement health promotion strategies (for example, conduct small group education, work with primary care providers to design, develop and deliver health promotion programs)

5. INITIATING AND MAINTAINING PROGRAMS

Knowledge of:

5.1 how organisations and bureaucracies work

5.2 funding sources and criteria

Ability to:

5.3 obtain resources (space, money, staff)

5.4 assist the community identify and obtain resources

5.5 communicate effectively with decision-makers, communities and staff about progress, roles and future action

6. IMPLEMENTING PROGRAMS

Ability to:

6.1 oversee/manage implementation, including problem solving, negotiation, report writing, public communication etc.

6.2 develop contingency plans as project develops and needs change

6.3 manage people, money and time

6.4 implement strategies

7. GENERIC SKILLS

The following core competencies are considered to be prerequisite skills for all health promotion practitioners (Public Health Association of Australia, 1990)

7.1 writing skills-for planning, grant submissions, research proposals, reports, position papers, and journal articles

7.2 interpersonal skills-including conflict resolution, problem solving, negotiation and counselling

7.3 teaching skills-including conflict resolution, problem solving, negotiation and counselling

7.4 group skills-including group leadership, group maintenance, focus group discussion and facilitating workshops, being an effective team member

7.5 advocacy and public presentation skills-including public speaking, use of visual aids, presentation of papers at professional meetings and for some, use of the media

7.6 research skills-including the ability to develop a research proposal and conduct small-scale research projects

7.7 critical appraisal skills-including critical appraisal of the literature on health and determinants

7.8 personal skills-including flexibility, ability to motivate others, ability to meet deadlines

7.9 Cultural awareness-including understanding and respect for Aboriginal culture

(Based on the Core Knowledge and Skills identified in *Pathways to Better Health* 1993, Chapter 5 and The Aboriginal Health Promotion Officers' AO4 and AO5 Duty Statements.)

APPENDIX 7

HOW THE OTTAWA CHARTER IMPACTS ON MY OWN WORK.

Gwen Walley

Building healthy policy.

A.T.S.I.C are funding a Council admin officer position until the people in the community hold elections and have an operating council in place.

O.L.G will then take over the funding role.

The policy building will then actually take place.

In the meantime we have created an awareness of how important their decisions are :

* in policy making

* in effects on their health and lifestyle issues.

* in the actual control they have over their lives.

They are becoming more involved and taking more responsibility for their own , for their families and their communities health and well being.

Create supportive environments

We have created a supportive environment with our community

* by forming close relationships with the people.

based on honesty and trust, taking the time to sit ,talk with , listen and to learn from them , by sharing our feelings and concerns with them.

* We were able to liaise with people from within the Dept and tell them what we were all about .

During our networking we came up against a few challenges but we feel we have established a good working relationship with our colleagues.

* Our work site/area is a supportive one and I think we are all quite happy with it except when we go visiting our neighbours and see what they have.

We each have a great respect for each other , acknowledge that we have different skills and use those differences to compliment each other.

Our respect for each other includes an understanding that we each need our own space from time to time.

* in our community we have also been able to bring the health staff into closer contact with the people outside of the clinic.

Strengthen community action

* the whole process of community development is an action that has to strengthen communities as it depends on the involvement , support and participation of the majority of the community.

Titjikala is an example of community action.

The community

* got together
* identified the issues that concerned them
* set the priorities
* planned the strategies
* implemented them

Develop personal skills

* workshops with HP team
* workshops with health workers
* workshops with community people
* having access to information
* having access to further and ongoing education

learning can happen anywhere, anytime , every contact with people can and should be used as a teaching/learning opportunity.

Reorient health services

* workshops with other health professionals
* meetings " " " "
* contact " " " "
* changes in attitudes
* changes in professional education and training
* changes in organisations, policy and planning etc.

Appendix O

Core Skills and Knowledge for Health Promotion Officers

Following is the list put together from the sessions held with all AHPO's and some HPO's to determine what should be in the training program.

From this list Gwen, Nea, Carol and Ray worked to develop the Draft of the (Advanced) Certificate in Health Promotion Practice course.

Communication Skills
with;
allied health staff
community people
council

listening - good
ability to be receptive to what others are saying
With communities need both way communication,
ability to listen and share information.
Ability to deliver information to the level of the people you are working with, the target group.
Understanding of communication styles and networks in the community
Knowledge of how to develop networks.
Ability to develop networks
Knowledge of the role of the council and key decision makers in the community.
writing
negotiating
compromise - meet half way
working with others toward a common goal
good telephone manner
respect the culture of others
networking
assertiveness
cross cultural learning
listening and hearing / understanding
Ability to be able to remove all ideas - previous preconceptions
to be open to learning in all situations
Be willing to accept differences
Be willing to accept changes
be able to recognise the importance of old methods
the ability to interpret information so that people can understand

Ability to give information in the right way
We see our role as passing / interpreting information two ways
A - 1 - B
AHPO
Have empathy with all people you are working with
knowledge of history
real recognition of the area (place)
- owners and language

Cross Culture
Need a sound knowledge of both worlds
- European and Aboriginal
Ability to translate information from one to the other.
an understanding of Aboriginal English
Understanding of Aboriginal ways, networks, communication
- skin and kin
- relate in own community
Knowledge of history - pre and post contact in the NT and the influences of contact on Aboriginal people. An understanding of the time line; for many groups in the NT contact has only been a matter of a few years.

Government policies in the NT - assimilation, self management, self determination, Mabo, ATSIC,
Knowledge of Aboriginal protocol - how to begin to work in the community.
Knowledge of Aboriginal politics including who are the
Owners of country
Movement of people so that they may not belong to that country.

<u>Level of skills/knowledge</u>
Active listening - the ability to
- listen
- learn
- feedback / check
- make a joint assessment of meaning with the other person.

to be able to make an appropriate assessment of what the information means.
ability to be an open listener
Ability to apply Aboriginal methods of listening;
- identify yourself
- wait to be asked

Ability to apply Aboriginal methods of listening
Ability to acknowledge Aboriginal methods of listening
(ie. Aboriginal people are actively listening without necessarily having input.)
Ability to understand the concept of one law, one rule.
Allow people to offer you information and rights.

NB.
- We will need to have explanation papers / resources to explain this properly.
- We need funding to put together a plan to really implement this program well.
- It is important to work with communities on assessment of these skills etc.
- We should be involving the community in the planning of the program.
- it will be useful to put this information together for non Aboriginal staff.

Respect
for individuals
for culture
understand traditional culture
understand the organisation /the bureaucracy - systems and protocols
Respect and understand traditional culture and law
Show evidence of respect and understanding of traditional culture and law.
Ability to develop guidelines for new workers in communities.
Attend cultural awareness course.
Understanding and respect for Aboriginal Culture
knowledge of the community
who's who - key people
how to approach
where things are - clinic, council
key health issues in the community
what has happened before - ie programs /why they did or didn't work
work with the wishes of the community
relate well to people in communities
to encourage community/HW to be involved in professional development ie Cert.

Background knowledge

Primary Health Care
Knowledge of what PHC is. A good understanding is essential.
Knowledge of how it relates to health promotion.
Knowledge of how it fits into a community.

Health Promotion
Knowledge of the theory of health promotion - what it is.
Knowledge of the history of health promotion.
Knowledge of the Ottawa Charter.
A good understanding is essential so that HPO's can easily explain it to a community or a workshop.
ability to explain health promotion clearly to other people
A good knowledge of key literature
ie. Ottawa charter
Pathways to Better health
Partners in Evaluation
knowledge of key people in HACS
the communities
Ability to develop a community profile on community visits, including information gained on the community visits, letters, information

Health Knowledge
good general knowledge of health issues across a broad range
knowledge of specific issues such as;
alcohol
nutrition
women's and men's health
hygiene
everyone concentrate on 1 or 2 pet projects or areas

knowledge of what is happening in communities
knowledge of what is happening in HACS
knowledge of who the key people are in
HACS staff
school
community leaders
council

Resources