CHAPTER 1

READING THE MAP:
AN INTRODUCTION TO THE PROJECT

This thesis traces the journey I undertook as Professional Development and Training Coordinator within the Health Promotion Program with my Aboriginal and non Aboriginal team mates to develop a an effective training program in the context of our work with the Territory Health Services. We worked in partnership to develop a training program which would assist the Aboriginal Health Promotion Officers to develop the necessary health promotion skills, knowledge and confidence to move towards making real changes in the way health service providers work with Aboriginal people.

This research shows the unfolding of the participatory process. We began the process by developing our relationships within the team and moved on to develop an understanding of how we could work together to build our own skills and facilitate the learning of others.

During the training development process I worked with the other team members to explore the following questions;

- how can we best work in partnership?
- How can we develop a training program which will best provide the necessary skills for the work task?
- How can we best provide the support to develop the skills?

I explored the participatory project undertaken to develop the training program, analysed the key issues resulting from the course development process and extracted from the data a set of principles for providing support and working in partnership.

Aboriginal staff members are potentially the most valuable resource the health service has for working Aboriginal people to improve their health. Aboriginal primary health care workers play an important role in moving people within the health system towards Aboriginal ways of seeing the world and Aboriginal beliefs and priorities. They can teach non Aboriginal primary health care workers about Aboriginal communities, priorities and values. The Aboriginal Health Promotion Officers had the flexibility within their role to work with Aboriginal people to implement their own solutions to health problems. The challenge they faced was to gain acceptance for working within a primary health care and community development model from other health professionals within a system which is hierarchical, has entrenched ways of working and a strong value system of knowing the answers to problems.

Limitations

This study does not provide a comprehensive overview or analysis of the issues pertaining to Aboriginal health, Aboriginal education or working in partnership and it does not seek to reflect the major issues in the field. This is a record of a participatory process undertaken by a team of people over a 16 month period and provides an overview of the activities and a record of the concerns of the team as I have recorded them during that time. The analysis is limited by the scope of the data and does not aim to provide a definitive list of ingredients for working in partnership or providing support.

CHAPTER 2

DESCRIBING THE LANDSCAPE: BACKGROUND TO THE RESEARCH

> Learning involves co-operation...our knowledge needs to be a living thing which we all build on together (Marika-Mununggiritj, 1991:24).

Introduction

The framework within which I chose to research and work encompasses adult education, primary health care and health promotion processes. The research focuses on the practice of adult education in an Aboriginal context, and on ways Aboriginal and non Aboriginal people can work in partnership. The commonalities and intertwining of these processes provided a framework that could provide philosophical and practical consistency to my research methodology and work practice.

Adult education, primary health care and health promotion

Primary health care is an approach which emphasises the use of preventative, community-based care rather than curative, institution based, professionally dominated care, to meet the health care needs of people living in poverty. Primary health care was adopted by the 150 member states of the World Health Organization (WHO) at Alma Ata in Soviet Kazakhstan in 1978 and

has since been known as the Alma Ata Declaration (Johnston and Rifkin 1987:vi-1; Wass 1994:217).

Primary health care is essential health care based upon practical, scientifically sound and socially acceptable methods that are easily accessible to all individuals and families in the community through their full participation, at a cost they can afford to maintain and which promotes self-reliance and self-determination. It brings health care as close as possible to where people live and work and provides the first level of contact with the total health system (WHO 1978).

Primary health care utilises community participation as the most effective way to gain real improvements in health. The key to primary health care is to have many health workers and community members trained in preventative health approaches. It recognises that the work to address health issues is most effective if it is participative and includes individuals and communities in the planning, implementation and evaluation of activities (Johnston and Rifkin 1987:vi-3).

Health promotion is a strategy within primary health care. It is defined as the process of enabling people to increase control over and to improve, their health (Ottawa Charter 1986). Health promotion processes include support for community action, provision of up to date health information, education and resources, strengthening of primary health care delivered through community care centres, and development and implementation of healthy public policies (ibid; Health Promotion Program 1993a).

According to Green and Raeburn (1988), the most important principle in the definition of health promotion is 'enabling'. They point out that as a concept in health promotion it is important because it signifies the trend of:

> people - not just institutions, bureaucrats, professionals and technology - holding power in health matters. A potential battleground takes shape because, although many bureaucrats and professionals in health pay lip service to the concept of passing power to the community, very few can actually bring themselves to do it. "We know best", is the covert if not overt philosophy of most health professionals. The future purpose of the health promotion of the future could be the increasing transfer of the control of important resources in health (notably knowledge, skills, power and money) to the community (1988:155).

Adult education approaches are used widely in primary health care to provide training for health workers and community members. According to Johnston and Rifkin (1987:2-3), the traditional training of health professionals has not provided a framework for shifting control from health professionals to the community. Primary health care requires an approach to education in which the learning is ongoing, and the concepts of listening, having dialogue with and learning from others is essential. This approach to learning draws on the educational philosophy of Paulo Freire (1978) and the articulation of the learning needs of adults by Malcolm Knowles (1973). The skills needed for primary health care are developed through participation and experience. Primary health care and adult education are both approaches which provide the conditions for people to take control of their own lives to improve the social conditions of their community. As Julius Nyerere says, adult education:

> incorporates anything which enlarges (people's) understanding, activates them, helps them to make their own decisions, and to implement these decisions for themselves (1978:30).

Adult education in an Aboriginal context - two way learning

Adult learning theory and practice is guided by a fundamental respect for the knowledge and experience of the learner. Malcolm Knowles (1973:83-5) directed educators to work from the perspective of the learner, and to ensure that the wide life experience of the learner is valued. Aboriginal educators emphasise that education for Aboriginal people must recognise the importance of maintaining the integrity of Aboriginal culture and traditional ways of learning. Grif Foley (1987:5) writes that:

> for Aboriginal people in precolonial times education was part of all social activities and it was lifelong. People learned by participating in community life, education was an active, practical process (Foley 1987:5).

If adult education activities designed for Aboriginal people aim to respect them, they must take into account the collective nature of Aboriginal society and the need for activities to maintain the values and priorities of the group. A number of Aboriginal educators point out that collective learning contributes to common and shared learning experience, increases the interdependence of the learning experience, is an effective way to solve problems and provides support to members of the group (Yavu-Kama 1988:91-92; Tiparui 1993; Sultan 1993). At the first national Aboriginal Adult Education conference, Margaret Valadian called for an education which will build on the strong traditions of the past to rebuild a strong, viable and cohesive community (1988:104).

While Aboriginal people have a rich and varied learning tradition within their own communities, they have rarely felt in control of their own education opportunities. Most Aboriginal people have not enjoyed educational opportunities that are equal to other Australians and Aboriginal people have not been able to fully participate in decisions about education services or in the content of the education offered (Aboriginal Education Policy Task Force 1988: 7-13). Vital services such as education and health provision have failed to bring about any real improvements for Aboriginal people largely because they have almost always been provided by outsiders in response to European priorities and people delivering these services have not sought to work in partnership with Aboriginal people. Decisions about all aspects of Aboriginal life are frequently in the hands of outsiders. Adult education has the potential to assist Aboriginal people make real choices about the future by empowering people to make choices and by enabling people to become actively involved in the structuring and focus of their education (Folds and Marika 1988; Yavu-Kama 1988; Crawford 1988; Valadian 1988).

According to Folds and Marika (1988:140) such empowerment requires a:

> two way education, not a top down one, ... (which) treats Aborigines as equal partners in a common research effort aimed at building a community development framework which starts in communities with community aspirations, not institutional or individual ones.

For adult education and primary health care to be meaningful they must take account of the priorities and aspirations of Aboriginal people. Raymattja Marika-Mununggiritj believes that Balandas[1] have difficulty understanding the

[1] Balanda is the word used to refer to white Australians by Aboriginal people in the top end of the Northern Territory.

Yolngu[2] world view and so fail to take notice of Aboriginal priorities and ways of relating and learning. If Balandas were more receptive they could learn many things from Yolngu, including the social order of Yolgnu life, the way Aboriginal people negotiate between themselves and the importance of the land as the basis for learning; for giving knowledge, meaning and identity (Marika-Munuggiritj 1991:18-22). Kavu-Yama (1988:96) reinforces this when she says that:

> Any learning must be planned through the process of negotiation.... Any learning that will be of significance and value must come from us. We must be the central cog of the enterprise. If we are to be empowered through learning then we must be closer to the central position of the negotiations.

Foley and Flowers (1992) endorse a participatory approach to the development of training programs for Aboriginal people. It involves a long process in which:

- the educator helps people build up their confidence in order to enable them to articulate their needs in their language and as they see them;
- the educator provides information so as to help people make choices among needs and among strategies for meeting needs; and
- the educator helps people examine, reflect on and further articulate their needs in their historical and contemporary social contexts.

> The purpose of doing these things is to support Aboriginal people in making decisions and doing things for themselves....The process outlined above allows community people and educators to set the agenda together (1992:72).

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2 Yolgnu is the word Aboriginal people in the Top End of the Northern Territory use to refer to themselves.

Applying the theory to the project

As a non Aboriginal educator aiming to develop a training program to assist Aboriginal staff develop the necessary skills for their work role, I sought to undertake the task in the most meaningful way possible. By working in partnership with the Aboriginal Health Promotion Officers I could respect and value the way Aboriginal people work and learn. Although the Aboriginal Health Promotion Officers had chosen to work within a bureaucratic system that values the skills, knowledge and activity of the non Aboriginal culture, it was important to value and learn from their priorities and preferences as Aboriginal people; so that while working within the framework of the dominant bureaucratic and educational culture we would do so in a way that respected and drew upon Aboriginal ways of working. My personal challenge was to work with the Aboriginal Health Promotion Officers to develop a training process which would reflect their priorities and needs and which would belong to the team: not be imposed on the team.

Working in Partnership

Processes such as adult education, primary health care, and adult education which aim to empower participants and bring about real improvement in peoples' lives require commitment to working in partnership. Working in partnership within the Health Promotion team meant working collaboratively with others in the planning, delivery and evaluation of projects; seeking advice; sharing skills; mentoring and debriefing. We aimed to work in partnership on projects within the team with the intention of developing our own skills and of modelling partnership to those primary health care providers and communities with whom we worked. In this way we aimed to pass on these skills to others.

Learning together was an important part of working in partnership. The Aboriginal and non Aboriginal team members sharing skills and learning from each other could provide a working partnership strengthened by the values and knowledge of both the Aboriginal and non Aboriginal world views.

An overview of Aboriginal health

The ultimate focus of the work undertaken by the Health Promotion team was to support Aboriginal people in the Northern Territory to improve their health and well being. Aboriginal people have a shorter life expectancy than other Australians; Aboriginal women can expect to live an average of 62 years compared to 81 years for other women, and Aboriginal men can expect to live an average of 57 years compared to 75 years for other Australian men. Aboriginal babies have a lower average birth weight (3140 g compared with an Australian average of 3349g), and Aboriginal maternal and infant mortality rates are much higher than the Australian average. During their lives Aboriginal people are more likely than non Aboriginal people to contract infectious diseases, suffer from diabetes, blindness from trachoma, chronic renal failure and chronic ear disease (National Aboriginal Health Strategy: an Evaluation 1994:6).

In 1994, the evaluation of the National Aboriginal Health Strategy found "minimal gains in the appalling state of Aboriginal health" and called upon the "governments and people of Australia to make a renewed commitment to Aboriginal health and fund bold well managed, community owned programs" (ibid.:2). The evaluation committee found that "not only do Aboriginal and Torres Strait Islander people face the health hazards of a hostile physical environment, but inequity is manifest in their diminished access to health-

promoting knowledge and to the mainstream medical and health-care services" (ibid.:1).

The National Aboriginal Health Strategy recommendations were aimed at improving health services, improving essential services and community infrastructure and improving education, training and employment in Aboriginal health. It strongly reinforced that Aboriginal people hold a holistic view of health incorporating individual physical well-being with the social, emotional and cultural well-being of the whole community. It advocated Aboriginal community control and participation in health services as a means of promoting community responsibility and understanding, and ensuring that the provision of primary health care is socially and culturally appropriate (ibid.:14).

Aboriginal Health in the Northern Territory

In the Northern Territory Aboriginal people make up one quarter of the population and yet account for around 50% of the hospitalisations. A recent morbidity and mortality survey (Plant et al, 1995:x) emphasised that the increasing hospitalisation costs along with the social and cultural costs of illness reinforces the need for primary health care services and preventative measures in order to avert more ill-health. The underlying causes of ill-health in Aboriginal people such as smoking, poor nutrition, alcohol and inadequate sewerage are largely related to social, environmental and economic factors and it is widely recognised that these must be tackled before any real improvements can occur (ibid.:xi).

In the Northern Territory the need for developing effective measures at the community level is paramount, since 70% of all Aboriginal people in the

Northern Territory live outside the main urban population centres where health service delivery is difficult, staff turnover is high, and resources are limited (ibid.:2) (see map in Appendix 1). Health care on remote Aboriginal communities is provided by Aboriginal Health Workers, with one or more registered nurses in larger communities and district based health professionals who visit periodically. Aboriginal Health Workers are members of the local community and play a central role in assisting the community improve its health:

> Historically Aboriginal Health Workers have been chosen by the community to deliver primary health care, for the spiritual, mental and physical well-being of the community.... Aboriginal Health Workers know kinship networks, family obligations, avoidance laws, bush tucker and traditional medicine (Franks and Curr 1992:no page cited).

The NT Government Aboriginal Health Policy commits the NT Government to improve the health and well-being of Aboriginal people so that the gap in health status between Aboriginal and non Aboriginal people is closed. The policy recognises that the primary health care approach is the method of achieving this, and recommends that Aboriginal people should be encouraged and assisted to identify their problems and determine their own solutions; take an active and decisive role in the provision of their health and community services; and have management control of their own health and community services (ibid.).

In a recent review of the roles of Aboriginal Health Workers, Tregenza and Abbott (1995) report that:

> Nearly everyone agrees that Health Workers are the principle and crucial workers in the health system, that potentially they are the health educators and agents of improved health in the community and that they are well placed to implement effective primary health care. However in general, Health Workers are the least prepared educationally, the least supported, the least rewarded, least listened to and least respected of all health professionals ...The Health Workers are thus held responsible for the job but not given the education, resources and control to perform to the level expected of them. Their role in the team is not fully utilised .... Nonetheless, there is regional agreement that the Health Worker role is the most important factor in the struggle for improved health status and that comprehensive primary health care should be principally delivered via these workers with support from nurses, doctors and other health professionals (1995:14-16).

The Health Promotion Program

The people who are the focus of this study are employees of the Health Promotion Program within the Territory Health Services (THS). They are Aboriginal Health Promotion Officers (AHPO's) and their work role is to assist Aboriginal Health Workers, community members and other Primary Health Care providers develop health promotion programs in their work and community. The AHPO's would use adult learning principles and community development processes to work in partnership with health professionals and community members and to provide them with relevant information, skills support and assistance.

The Health Promotion Program aimed to develop a model for working with communities and groups which would enable them to improve their own

health. The model placed teams of Aboriginal Health Promotion Officers in each district to support Aboriginal communities and Aboriginal Health Workers in their primary health care activities. The paper recommending the establishment of ten new Aboriginal Health Promotion Officers positions in 1992 provided the following justification:

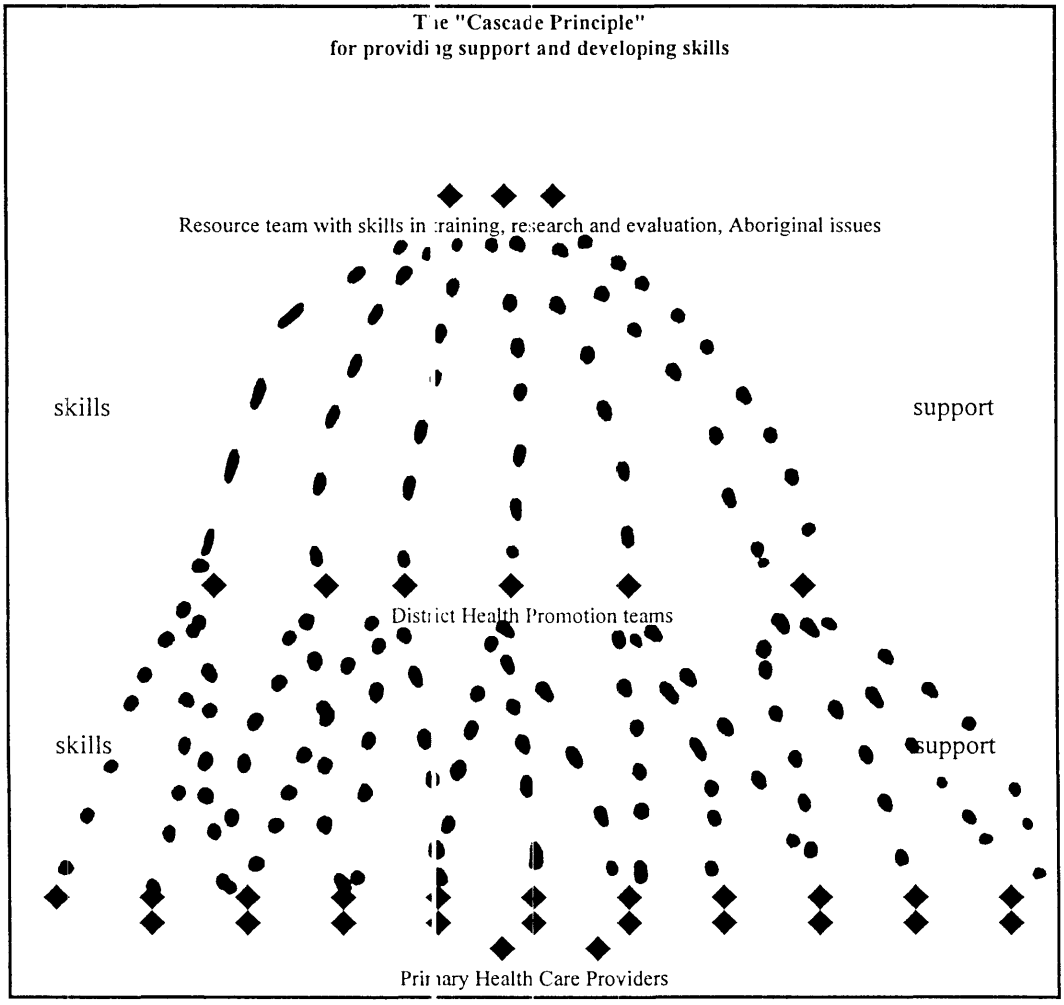
> The current role of community-based Aboriginal Health Workers is centred primarily on clinical work; that is, treating patients who present at clinics, ensuring patients attend clinics, etc. A secondary role has been disease prevention, health education, community development and environmental health. If health promotion is to become a primary focus as specified in a primary health care approach to service delivery, community-based Aboriginal Health Workers will need to be skilled in health promotion strategies including health education and community development. The long-term improvement in Aboriginal community health will only come about when people have the necessary knowledge and skills to make healthy choices within a supportive healthy environment (Briefing paper, 1992).

In order to turn the model into practice, the Health Promotion Program placed teams in each of the five regional centres in the Northern Territory. There are teams in Darwin, Katherine, Nhulunbuy, Tennant Creek and Alice Springs and there is a Central Resource Team based in Darwin to provide support and expertise in research, evaluation, Aboriginal issues, and training. In most districts the teams included two Aboriginal Health Promotion Officers (AHPO's) with community knowledge and understanding and a professional Health Promotion Officer (HPO) with academic training in health promotion who could act as professional support and mentor to the AHPO's. In Tennant Creek and Darwin Rural district the teams were made up solely of AHPO's. The combination of professional and community skills would enable the teams

to provide the support and assistance needed to develop the health promotion skills of primary health care providers and communities.

The Health Promotion Program operated on a "cascade" principle (figure 1) . The Central Resource Team would provide direction, information, training and assistance to the district Health Promotion Officers throughout the Territory,[3] who in turn would resource primary health care providers in health promotion methods and strategies. These primary health care providers would then integrate health promotion into their everyday work with the community.

figure: 1



3 The Territory is an abbreviated form of the Northern Territory.

The ten Aboriginal Health Promotion Officers (AHPO's) were recruited in early 1993. They came with the skills essential for supporting communities to improve their health: good communication skills, proven ability for working well with and motivating others, and a good understanding and respect for Aboriginal culture. Their role would be to train and support Aboriginal community-based health teams in health promotion processes (Briefing paper 1992). They were not expected to have experience and formal training in Health Promotion. In the Northern Territory only 1 per cent of Aboriginal people have tertiary qualifications, compared to 11 per cent of the non Aboriginal population (ABS 1990:70). Formal health promotion skills could be provided on the job, through the proposed (three year) training program. The provision of meaningful professional development and support was seen as the most essential component in the development of a skilled team able to support the health promoting actions of communities.

As Professional Development and Training Coordinator, my brief was to develop a comprehensive training and professional development program to assist in the development of the necessary skills. The training program would be integrated into the work place of the Aboriginal Health Promotion Officer and would exist alongside all of their other work activities. In this research report I will focus on the development of the training program for the Aboriginal staff and trace the changes along the way. Since this program drew heavily on and required the support and involvement of all of the staff in the Health Promotion Program, this report will also frequently refer to the general Health Promotion Officers.

Influences on the Health Promotion Program

The recruitment in 1993 of the Aboriginal Health Promotion Officers was the result of a process happening since 1990 to change the direction of health promotion in the NT. Until 1990 the Health Promotion Program had focused on "healthy lifestyle" activities with Health Promotion staff concentrating on initiating and implementing specific healthy lifestyle and public awareness campaigns, maintaining a healthy lifestyle shopfront service and responding to requests for assistance from other service providers, mainly related to public awareness campaigns and provision of resources (NT HACS Annual Reports 1988-1990). The Health Promotion Program was not attempting to tackle the health problems of Aboriginal people at a time when improving the health of Aboriginal people was a priority at departmental, state and national levels (Health Promotion Service files 1990).

Internationally, health promotion as an area of health activity was changing considerably. The first International Health Promotion Conference held in Ottawa, Canada in 1986 had produced the Ottawa Charter which became the guiding force for health promotion activities. The Ottawa Charter focussed health promotion activities on the whole community and declared the fundamental conditions for health to be peace, shelter, education, food, a stable ecosystem, sustainable resources, social justice and equity and utilised needs assessments, program planning and evaluation techniques. Health promotion practice had moved away from individual interventions to take a broad societal view of health.

Because the Health Promotion team in the NT was small, it was decided that the most effective use of the staff was to work with others in a community development framework (see Glossary). In order to facilitate this change in the direction of the Health Promotion Program, people experienced in primary health care and community development processes were brought in. The AIDS/STD Program within the Territory Health Services had developed a program for educating communities about AIDS/STD's based on community development approaches, which was well received by Aboriginal communities in the Top End of the NT.[4] Steve Hatton, the NT Minister for Health at the time, had recommended that an approach like that developed by the AIDS/STD team be used right across the Health Department and suggested that the Health Promotion Program was the appropriate program to get such a community development approach up and running (Ministerial Statement 1988; pers. comm. Hendy 1994). The Director and the Aboriginal Co-ordinator of the AIDS/STD Program were moved across to the Health Promotion Program to make this happen.

The strategies introduced to the Health Promotion Program from the AIDS / STD Program were based on the high value which Aboriginal people place on relationships and survival of the group; on oral and visual traditions; and interaction between people as the major means of sharing and passing on knowledge, values and heritage. Participation by the community in the activities in order to acquire practical skills was integral to the process (Hendy and Power 1990).

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4 The Top End is the northern region of the Northern Territory. It covers the towns and communities north of Katherine.

The Aboriginal Community Health Promotion Project

In January 1991 the Health Promotion Program employed six Aboriginal Health Promotion Officers (AHPO's) to work on a project called the Aboriginal Community Health Promotion Project. During the project the AHPO's worked in pairs with a selected community on a negotiated community development process. The method for selecting a community to work with was that "both the community and the Aboriginal Health Workers must want their involvement" (Shields pers. comm. 1992). The process recognised that Aboriginal Health Workers are key to the coordination of health promotion activities on their communities.

The project ran for 18 months and was integral to developing the Health Promotion Program vision for improving the health of the community through community development processes. According to the Director, Shirley Hendy; "the National Better Health Program[5] confirmed the legitimacy of the principles that we held dear and we learned a lot from it "(Pers. comm., 1993).

Whereas the AIDS/STD program had been highly structured, the Aboriginal Community Health Promotion project did not focus on any predetermined issue in order to leave the project as free flowing as possible (Watson pers. comm. 1993). Although the community negotiation process was open, the Aboriginal Health Promotion team did develop a set of guidelines for the project which provided structure for the process. The guidelines outlined a process for selecting a community and a set of procedures for developing an understanding of the community. These included what would be documented and how; a minimal set of data to be collected in each community to assist with the process

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5 the Aboriginal Community Health Promotion Project was referred to by participants as the National Better Health Program (NBHP).

of measuring change; and a set of evaluation criteria (National Better Health Program Evaluation Report 1991:15).

The participants who found the process the most rewarding and who were able to point to the establishment of a successful community development process were Gwen Walley and Julie Wright from Alice Springs. They believed this was because; they were rigorous in following the guidelines developed for approaching and involving communities; they supported each other and were conscientious about debriefing during and after community visits; and they made it clear to other Departmental staff that they had a specific project to do and that it was a priority (ibid.:10). The pilot project was valuable in strengthening the participants' knowledge base in working with Aboriginal communities on health programs It also providing insights into working as a productive team:

> 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 our performance (Hency pers. comm. 1993).

The experiences of the AIDS/STD program and the Aboriginal Community Health Promotion Project directed and guided the planning to establish a permanent team of Aboriginal Health Promotion Officers in the Territory Health Services. These projects showed the value of having Aboriginal primary health care workers focussing on prevention, health education, health promotion, environmental health and community development. The most positive outcome from the Aboriginal Community Health Promotion Project was the decision in 1992 to create ten permanent positions for Aboriginal Health Promotion Officers.

Guiding Principles

By 1993 the Health Promotion Program had incorporated a number of principles which had emerged from the Aboriginal Community Health Promotion project and the AIDS/STD Project and which would guide the direction of the Health Promotion Program. These have been articulated as follows:

- **Facilitate people to make their own decisions.** Understand that we as health professionals cannot fix peoples' health, we can be there to support people to do it if they want to and we can provide real support by way of information, assistance and encouragement.

- **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..."

- **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.

- **Working in partnership** is very important. We aim to model Aboriginal and non Aboriginal staff working together appropriately, sharing skills and knowledge and respecting the worth of each other. We place a high importance on modelling how people can work together as colleagues and in the community.

- **It is important to spend time on communities** with people we are working with. We cannot just pop in and out of a community. Everything of value on Aboriginal communities is based on relationships and we have to spend time to continue to build on those relationships. Spending time is our way of saying to people 'this is important'. It reinforces our verbal behaviour with our

actions. It is preferable to work thoroughly in one or two communities, to invest time and be prepared to go slowly. In this way we can meet peoples' needs, by rushing in and out of a number of communities we can meet no one's needs.

· **It is more important to develop and meet a long term strategy rather than respond to acute needs.** Constantly meeting acute needs means the real problems and issues never get addressed.

· **The community has to be the driving force** behind what is done to tackle a health issue.

(pers.comm Hendy; Shields; Laycock; Power; Smith; Walley; Mills; Smith; Sassella; and others in the Health Promotion Program 1993)

Looking ahead

Reorienting the health service and working with Aboriginal communities to identify and work on their own health priorities were all long term goals and would require a Health Promotion team who were constantly developing expertise in adult learning and planning and implementation processes. Our challenge as a team was to develop a training and support process which would assist the Aboriginal Health Promotion Officers develop the skills required and support their efforts. We also needed to develop a group of non Aboriginal Health Promotion Officers who were committed to and practising working in partnership with, and learning from their Aboriginal team mates.

Summary

This chapter provided an overview of the principles which guided the research project and drew attention to the connections between primary health care,

health promotion and adult education principles. It also provided an overview of the health status of Aboriginal people in the Northern Territory; of the changes in the direction of the Health Promotion Program which led to the employment of a team of Aboriginal Health Promotion Officers; and which determined the need for a training program. In chapter three, I will review participatory research as a research method which complements and builds on the principles of primary health care and adult learning; and which enabled the researcher and the Health Promotion Officers to work together in a common research effort.

CHAPTER 3

PARTICIPATORY RESEARCH

Introduction

Participatory research allowed me to combine my role as researcher and as a member of a team exploring ways of working together. Participatory research is a research method which fits closely with the intentions and values of adult education practice and primary health care. It enables the researcher to work in partnership with the participants of the research, and provides an accurate way to generate shared knowledge and to reflect the values and expectations of group. Like primary health care, participatory research includes its participants in the planning, implementation and evaluation of the research activities. It aims to improve the conditions in which its participants live and it emphasises the importance of dialogue and working in partnership. Participatory research offers an alternative approach to knowledge creation and attempts to provide people without the formal title of researcher the opportunity to research and solve their own problems. It demystifies research by taking it out of the hands of the experts and putting it into the hands of ordinary people (Mellor 1988; Ross-Gordon 1991).

Writings in the field have matured over the past twenty years from the initial discussion of the definition of participatory research and debate about its credibility as a research method to a more confident discussion of its forms and the value of working within the tradition. The majority of writings explore

the use of participatory research with people who have traditionally held little power or had no control over the research process. A growing number of writings describe the use of participatory research in organised arenas such as schools and universities (Gitlin 990; Ada et al 1990). It is a useful educative tool for a wide range of sett ngs and a growing number of writers see participatory research as a way to democratise research and to enhance the roles and opportunities of learners.

For the purpose of this thesis many valuable insights were provided by a wide range of researchers reflecting on their own experience, and the writings I have referred to are those which provided guidance to the research activity I have recorded. These writings reinforced my belief in the value of participatory research as an investigative method and provided a set of standards against which to judge my own research activity. The writings from educators in Yirrikala, in North East Arnhem Land were particularly valuable for showing how participatory research could meet Aboriginal peoples' priorities. Marika et al (1992) found participatory research a valuable method for creating an educational framework which can bridge the values and expectations of Aboriginal (Yolgnu) and Non Aboriginal (Balanda) cultures.

The value of participatory research as a research method

Participatory research has developed into a research approach well suited for working on projects where the outcomes include not only expanding the information base of the research topic but expanding the understanding and capacity for change of the people involved in the research. It is described by its practitioners as an activity integrating research, educational work and action in such a way that it contributes to and stimulates the efforts of individuals,

groups and communities to take control of the circumstances within which they live their lives (Mellor 1988; Hall 1981; Hall and Kassam 1989). Marika et al (1992) show how participatory research can serve to reinforce traditional cultural beliefs. It has been seen as an approach that can resolve the continual tension between the process of generating and using knowledge, between the 'academic' and 'real' worlds and between science and life (Vio Grossi 1981:43). Horton and Zacharakis-Jutz quote a Highlander Centre workbook as saying "the more that people see themselves as producers of knowledge, the more they see themselves as producers of change"(1987:1).

According to Hall (1981), participatory research differs significantly from more traditional kinds of research in its commitment to the empowerment of learning for all those engaged in the process. Ross-Gordon believes that "we stand a better chance of producing useful research for the community if research becomes part of the educative process and is linked to action" (1991:11). Participatory research starts with the assumption that in the past, knowledge has been concentrated in the hands of a few and participatory researchers aim to change the power structure of research and make the research capability available to everyone. According to Pagaduan (1988:195), participatory research is a research tool which calls for a "democratic" interaction between the social scientist and the people they claim to study. Marika et al record that the use of participatory research has informed the process of transforming the education process occurring in their community of Yirrikala in North Eastern Arnhem Land in the Northern Territory, so that "the control and responsibility for all things concerning education in the community now resides with community leaders through their school council"(1992:23).

Development of Participatory Research

By the 1970s many professionally trained researchers were searching for alternatives to research paradigms which were unable to provide answers to many of their questions. Failure of aid programs, western education and research to solve the problems of the Third World and the growing visibility of poverty in developed countries all added to the impetus for a new way of researching (Tandon 1981:20). The roots of the participatory research process can be found in the literacy and popular education campaigns in the early post-colonial era in places like Tanzania and India; in adult education movements in North America and Britain: and in the struggles against political and economic dependency in South America (Wright 1992:19).

A growing number of researchers found the classical research paradigm insufficient and oppressive. Its emphasis on value-neutrality and objectivity gave the researcher complete control over the process, treated people as objects and studied them as social phenomena (Tandon 1981:20-21). Gitlin (1990) believes that most traditional research methods establish an alienating relationship which silences those it studies, disregards their personal knowledge and strengthens the assumption that researchers are the producers of knowledge.

For professional researchers who have despaired about the lack of real social value in many other research methods, participatory research has provided an alternative. Merryl Hammond (1989:108) writes, "I have realised that much adult education research is either overly academic, atheoretical, or philosophically inconsistent with adult education principles". Hammond believes that newer approaches to educational research which involve research

participants in the research process, and which respond to the needs and problems of practitioners, are much more likely to result in meaningful and permanent changes in practice (Bennett and Desforges 1985). Ross-Gordon (1991:11) also welcomes participatory research as an alternative approach to knowledge creation and believes we stand a better chance of producing useful research for the community if research becomes part of the educative process and is linked to action.

Characteristics of Participatory Research

Participatory research is a process involving collective definition and investigation of a problem by a group of people struggling to deal with it; group analysis of the underlying causes of the problem; and group action to attempt to solve the problem (Horton and Zacharakis-Jutz 1987:2). It is an approach which aims to improve the lives of those involved by changing both the individuals and the culture of groups, institutions and societies to which they belong (McTaggart 1991:168). It requires participants to engage in the politics of research action by critically analysing the situation in which they work, and thereby strengthens the awareness in people of their own abilities (Hall 1981:7; McTaggart 1991:168).

The research problem originates in the community or workplace itself and the beneficiaries are the workers or community members. Since these people remain in control of the entire process of the research, the term 'researcher' can refer to the workers and community members as well as those with specialised training (Hall 1981:7). Participatory research is a collaborative process and involves action and reflection, a process which unifies the intellectual and practical project - theorising about practices and therefore producing

knowledge (McTaggart 1991). For Tandon (1981:24), the fact that knowing is linked to concrete action enhances the quality of knowledge. However, Gaventa and Horton (1981:37) caution that the requirement that the research problem originate in the community or workplace is overly vague. They feel that there needs to be better elaboration of how such research problems make themselves known through the expressions of oppressed groups, and believe that there is a danger in participatory research of creating the illusion of community spawned research when in fact social activists or activist academics may generate the problem from their own interest.

Although participatory research methodology attempts to reduce or eliminate the limitations of classical research, it does employ data collection prevalent in classical research and emphasises qualitative and phenomenological methods (Hall 1981:7). Researchers such as McTaggart (1991:178) believe that rigorous documentation and careful analysis of the research data is essential. Participatory researchers must create a record of their progress to clearly show how they decided on their research concern, how they shared in the collaboration of the project, the analysis of findings, and the decisions for action. Accurate documentation is a universal goal in research generally. According to Gaventa and Horton (1981:36) it is particularly important in participatory research, for if a project does not produce accurate documentation, it loses all credibility either as a research or action strategy. They caution that the down to earth nature of participatory research should not be mistaken as an invitation to carry out second rate research, in fact the very object of improving the realities of oppressed groups places the responsibility on those involved to be rigorous, critical and thorough. Ross-Gordon (1991:9) concludes that bad research may lead scholars and researchers into work that deepens the inequalities.

Cassara (1988) also urges caution and challenges researchers to take another look at documentation. Although western culture relies heavily on written documentation, many cultures have strong oral traditions where memories are prized and documentation may happen without a graphic process at all, through forms such as oral histories, photographs, popular theatre, and video. It is also important that findings are returned to the communities involved in the project who can then decide how to use the information to develop political strategies, to evaluate the project, and educate the community and necessary authorities on the issue (Gaventa and Horton 1981). Marika et al (1992) draw on the importance of the use of metaphor within their own culture as a tool for bridging the gap between Yolgnu and Balanda educational beliefs. They use the Metaphor Ganma to characterise Yolgnu education. Ganma represents the dynamics of their dual heritage:

> In terms of the Ganma project, ganma is taken as describing the situation where a river of water from the sea (in this case Balanda knowledge) and a river of water from the land (Yolgnu knowledge) mutually engulf each other on flowing into a common lagoon and become one.
>
> In coming together the streams of water mix across the interface of the two currents and foam is created at the surface so that the process of ganma is marked by lines along the interface of the two currents. In terms of the metaphor, then the line of foam that is formed by the interaction of the two currents marks the interface between the current of Yolgnu life and the current of Balanda life. Both Yolgnu and Balanda can benefit from theorising over the interaction between the two streams of life (Marika et al, 1992:31).

Freire (1972; 1978) describes how real respect for another person leads the researcher and participant, through dialogue, to a re-invention of knowledge. Dialogue is a form accessible to all people and a point from which all people can begin to take part in investigation of their world. It requires none of the literacy or numeracy skills so often used to exclude people without the recognised forms of knowledge from participating in the creation of knowledge. It requires only a respect and appreciation for the knowledge all people bring to understanding the circumstances surrounding their own lives.

Marika et al describe the importance of dialogue in examining their own educational practice:

> We can see that it is only through the act of reflection and dialogue that we will be able to bring ourselves to a position where we can step back from our practice and reflect on the things that we do. We do this and still remain a part of our own community as workers and learners / researchers (1992:26).

Popular Knowledge

The development of theory by ordinary people is described by participatory researchers as popular knowledge. It is a process where the 'raw' knowledge of ordinary people is brought into the open and through a process of discussion, reflection and analysis can become new knowledge (Hall 1981). McTaggart calls it "creating the theory of the work"(1991:71). Ada et al (1990:2) write that the difference between participatory research and the many other kinds of research is based on the fundamental belief and trust in the individuals' capacity for knowledge and a great respect for the learner and the participant. Participatory Research attempts to break down the barrier between researcher,

and the participant, between academic and popular knowledge, and to reverse the traditional hierarchy of those relationships (Mellor 1988).

ISSUES IN PARTICIPATORY RESEARCH

A number of issues arise in participatory research methodology which need to be acknowledged and addressed by the researcher. The issues include the concepts of power, participation, the role of the 'outside' researcher, objectivity, and neutrality in the research practice; and will be examined in the next section. The researcher must clarify how the research project relates to these and where they stand in relation to these issues.

Power

According to Tandon (1981:21-24), the traditional research paradigm is linked to exploitation because it implies only those who have been professionally trained can undertake research. As a result of this, ordinary people are not considered knowledgeable or capable of authoritive forms of knowing, and decisions affecting them need to be shown to be based on "expert knowledge". Participatory research aims to provide access to knowledge to ordinary people in order that they may create popular knowledge (McTaggart 1991; Tandon 1981). If ordinary people begin to have influence over the processes of knowledge-generation, utilisation and dissemination, they can use the power of knowledge to counter trends of oppression against them. It may also provide the researcher an opportunity to get authentic information and may help the researcher to generate valid knowledge which represents it correctly (Tandon 1981:24).

Participation

Participation is a frequently discussed concept within the boundaries of participatory research. The Participatory Research Network use the term to cover a range of activities from learning literacy skills, to popular organisation for class struggle at the national level (Hall 1981:11). Authentic participation is considered essential by proponents of participatory research. Tandon believes that participation in research is only authentic when people set the agenda of the inquiry, participate in the data collection and analysis, and have control over the use of outcomes. This means that even the research methodology itself may be reinterpreted and reconstituted by participants (1988:13).

Some proponents of participatory research find that authentic participation is often difficult to achieve in practice. Gitlin (1990) writes about the traps facing the University lecturer when engaging in a participative process with students, and reflects on the ease with which the researcher / lecturer can control the process, by the force of their privileged position. He sees the need to be able to reveal the political nature of the education process and to challenge the privileged position of the university lecturer to produce knowledge by changing the process of research from problem solving to problem posing.

The role of the 'outside' researcher

It is common in participatory research for an outsider with research 'expertise' to be involved in the process. The process however, makes a number of demands on these people. They must be committed participants and learners, they must be committed to seeing the process through to the end, avoid

situations that endanger community members, and see clearly and support, the situation of the subordinate groups within the community (Hall 1981,1988). Above all they must be accountable to the participants (Mellor 1988:74). A number of researchers warn of the inherent dangers of imposing our own values and expectations on those we are seeking to liberate (Willis 1991; Gitlin, 1990; Freire 1978, 1985; Wright 1992).

Participatory research demands that the researcher become a learner along with the community. The outside researcher should be involved in building the skills of the community and helping them to analyse their situation and build new knowledge. If the initial impetus for a project comes from an outside researcher they must ensure that the decision making processes shift over to the people (Tandon 1981; Hall 1981). Tandon (1981:27) believes that outside researchers can have a valuable role by translating ordinary peoples store of knowledge into a form that planners and decision makers understand and accept. However, the ultimate aim for those involved in participatory research should be for the community people to become accepted as experts in their own right.

Brant Castellano believes that nothing precludes scientific researchers from participating as peers in a community's participatory research, "but they must be willing to submit their experience to the collective process of deciding what is valid and useful as the basis for action" (1986:53). She adds that "with the proviso that the community which creates the knowledge has a right to prevent dissemination of information they feel are contrary to their interests, participatory researchers can and do draw inferences, postulate theories, publish reports of their activities and engage in scholarly exchange that may be quite separate from the development goals of the host community" (ibid.).

Ross-Gordon advises researchers to be aware of the epistemological framework underlying our work, the cultural biases in our research tradition and the ethics of our research tradition:

> Traditional research tradition is one way of knowing. We must listen to the people we are working with to discover other ways of knowing and be aware of the potential conflicts between the two (1991:10).

Objectivity and neutrality in Research

> If you act to achieve change some people say that you are no longer educators, no longer scientists. but ideologists. For me I think that position is itself an ideology. By saying that education is neutral they are ideologists. When they deny the very process of ideology they are making ideology (Paulo Freire in Hall and Kidd 1978:274).

Participatory research advocates defend the method against criticism for being subjective and reject the notions of objectivity and neutrality in research as myths. Gaventa and Horton argue that by clinging to the notion of value neutrality in research, the social scientist is able to ignore the mechanisms of control and domination while at the same time participating in them and enjoying their rewards. In fact the myth of neutrality serves primarily to obscure partisanship:

> The requirement that analysis be objective or scientific is often little more than another means of social control. It not only controls knowledge, but also the definition of acceptable knowledge (1981:40).

Hammond points out how researchers and evaluators often justify an inherently conservative approach by hiding behind the desire to "remain neutral" or be "objective" as researchers (1989:109). Kassam writes that the very methodology chosen is a political act because it defines how the research investigation is carried out, what instruments are used, which issues are to be investigated, the questions posed, and how findings are interpreted (1982:35).

PARTICIPATORY RESEARCH IN AN ABORIGINAL CONTEXT

The principles outlined for participatory research are illustrated by the research practice undertaken by Yolgnu educators in Yirrikala over the past ten years. This research practice has been carried out by Yolgnu educators who have used participatory research to explore appropriate strategies and approaches to transform the education and schooling in their community. They seek to develop a unique Aboriginal pedagogy and an educational framework which will recognise Aboriginal authority (Marika et al 1992:23-4). Their research seeks to "decolonise" schooling; to produce new understandings for contemporary Yolgnu, to overturn their "oppressive history", and to lay down strong foundations for the education of Yolgnu children which encompasses a "greater appreciation of the standing and legitimate status of Yolgnu world view and heritage" (Marika et al 1992:25).

> This process requires the participants to set the directions of their endeavour, and it requires everyone in the process to accept the role of "learner" and to involve themselves in acquiring new skills and knowledge so that they contribute to their community's development through developing their skills as Yolgnu educators. In doing these things properly, we see that new Yolngu knowledge

> will be produced and used as we apply the findings of our research (Marika et al 1992:24-5).

For Marika et al, participatory research operates in an environment where there is collective responsibility and where the cooperative working community has got "ownership" and control of the work (1992:25-6). The participatory research builds upon Yolgnu values, attitudes and knowledge by building on their law - Yolgnu rom.[6] Negotiation plays an important role in the research process and a vital role in the Yolngu rom:

> Our research requires negotiation between the respective groups. The negotiation is between the Nalapal[7] as our teachers and the Yuta Yolgnu[8] (us and our children) as the learners.... Knowledge is not owned by individuals for their own selfish purposes, it belongs to everyone (ibid.:26).

The Yirrikala educators have found that participatory research establishes common objectives and allows participants to negotiate the right place to begin the research process. It also influences the power relations between Yolgnu and Balanda researchers since the reassertion of Yolgnu ownership of educational research in their community ensures that the Yolgnu control the process, decide the questions to research and decide how the information from the research should be recorded (1992:27-36).

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6 Yolgnu rom means Yolgnu law and the things it requires Yolgnu to know about (Marika et al 1992).

7 Nalapal is a Yolnu Matha word meaning thinking people, intellectuals who guide Yolgnu life according to Yolgnu law (Marika et al 1992).

8 Yuta Yolgnu is a Yolnu Matha word for learners who are still learning the law and how they should live according to the law (Marika et al 1992).

Bridging the literature and the research project

The participatory research process undertaken in Yirrikala shows how well the research methodology can mirror the priorities and values of the community and provide a framework for using traditional law to negotiate modern relationships. The Yirrikala educators describe how participatory research requires everyone in the process to accept the role of learner and to engage in ongoing negotiation and renegotiation of the participatory project. They describe how participatory research is built on understandings of reciprocity; this means giving and then getting something back and is termed "bala lili" (1992:26-7).

Throughout the participatory process described in this thesis, our developing roles and relationships and the ongoing negotiation of our direction led us to an understanding of the complexities involved in developing a training process which would meet the range of expectations within the team. The collective definition of the research problem led us to look at how best to develop a training process which would provide support to the participants. As the research process progressed it became evident that a range of other issues needed to be addressed before a useful training process could be attempted. Relationships needed to be developed, job roles needed to be clarified and people needed ongoing, practical support in their workplace. We also had to determine how to provide people with the skills to work in partnership. A good deal of dialogue and reflection led to the analysis of the data which is recorded in the contents of this thesis. The next step in the participatory research project will be for the participants in the process to decide how to use the findings to improve our practice.

Gaventa (1981:40) sums up the writings on participatory research well when he says that "while (the) approach has some weaknesses and occasionally falls victim to its own illusions, it nevertheless provides us with one example of an attempt to integrate theory and practice, (and) for that reason alone it deserves our serious attention." In the situation described in this thesis participatory research is clearly the most appropriate in terms of sharing control of the research process, the most accurate in terms of generating shared knowledge and the most useful for achieving outcomes acceptable to everyone.

The next chapter describes the methodology used in the participatory research process. Just as the research process took direction from the priorities of the participants, the data results from our everyday activities and efforts to develop a training process which would meet the professional development and support needs of the Aboriginal Health Promotion Officers.

CHAPTER 4

METHODOLOGY: TRAVELLING AND TALKING

Conceptual Framework

This thesis explores the participatory research process undertaken by the Health Promotion team to develop a training process and to develop a framework for working in partnership and providing a meaningful level of support for staff in the program. The ideal training program would combine the essential elements of skills development, working in partnership and support.

I worked with the other team members to explore the following questions:

- How can we best work in partnership.
- How can we develop a training program which will best provide the necessary skills for the work task.
- How can we best provide the support to develop the skills.

As Researcher I have sought to explore the participatory project undertaken to develop the training program and to:

- analyse the key issues resulting from the course development process; and
- extract from the data a set of principles for providing support and working in partnership.

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. During that time I had noted everything which might prove useful for understanding the needs and expectations of the team.

In line with the principles of adult education, primary health care, and participatory research it was essential to choose a way of working which would involve everyone in the team; since the training was for them, the direction needed to come from them. I was guided by team members who had already been through a similar process of developing and undertaking on-the-job training with the Aboriginal Community Health Promotion Project. Their experience in the Aboriginal Community Health Promotion Project had shown that those participants who closely participated in the job as designers, evaluators, learners and researchers gained the most out of it (Walley and Wright in NBHP Evaluation Report 1991; Walley and Watson pers. comm. 1993).

The seriousness with which the team members who had participated in a similar process in the Aboriginal Community Health Promotion Project took the process of being participatory learners and researchers proved a strong influence on the Health Promotion team and guided the development of the training process. They saw training as a very important matter and the job as a very important matter and made it clear that a second rate process would never have done. All participants had a wide range of varied skills to draw upon and the program would be the richest it could possibly be by using the ideas and skills of everyone in the team

My role within the team as Professional Development and Training Coordinator was to provide direction and guidance for the development of the training process and to document and collate the process. In order to do this I took my lead from the needs and responses of the team. As researcher I have sought to explore the process, and to pull out and analyse the key issues.

The purpose of the research

The purpose of this research is to improve the educational and professional practice of the researcher and the Health Promotion team. The research method allowed me to reflect on the everyday activities and interactions I shared as participant researcher with the rest of the team to build a picture of what we were doing. The data provided me with a rich and complex picture of interactions and activities to analyse and draw understanding from. The research process has provided a valuable opportunity to look at our activities in a searching way with more thought and clarity than I could do in my everyday work. The research methodology has allowed me to record and analyse the public and private interactions in order to draw out clear principles and activities which if seriously implemented will improve our educational and health promotion practice in the future.

Ethical considerations

As an exercise in participatory research, the project to develop the training set out clearly to meet the personal and skills development needs of the Health Promotion team. Given that involvement in the training program was not voluntary there was a good chance that commitment to the process would be variable. A participatory design process was the best way to ensure

commitment and maintain relevance as well as provide an opportunity for the whole team to develop a wide range of research and analytical skills. It also reflected the way we sought to work. Working in partnership and making team decisions was clearly articulated in our discussions and formalised in our workshops

Outcomes for the training design process were clearly articulated and agreed upon by the team at the beginning of the process and provided for a great deal of freedom within the process to develop along with the needs and priorities of the team. Involvement in the process varied among team members, with people who saw the most relevance for themselves and the team taking the most active roles. If the process was to be a useful and empowering process it was important to provide opportunities for everyone to be involved in each step but to accept each person's decision about the level of the involvement they had. We believed that the process was as important for providing skills and developing relationships as the final product.

The outcome of the participatory project belonged to the team and my role was clearly defined. The research project specified for this thesis is my analysis and work as participant researcher. I sought permission from each person within the team to use material owned by them, to include their comments, or to use their activities to illustrate a point (appendix 2).

INTRODUCING THE PARTICIPANTS

The participants in this project fall into three groups which I have called the support team, the Aboriginal Health Promotion Officers and the (general) Health Promotion Officers. The general Health Promotion Officers feature as an integral part of the team and participated in many of the activities, but the central roles in this research project are played by the Aboriginal Health Promotion Officers and the support team.

The support team

I shared the training and support role with Bernie, the Aboriginal Coordinator; Gwen, and Greg, the Senior AHPO's; Carol, the Evaluation and Research Coordinator; and Ray, the Health Promotion Unit Manager in Alice Springs. Together we made up the support team.

As members of the support team we saw our role as providing on-the-job support and training support to Health Promotion Program staff. Apart from me who was brought in (late in 1992) to facilitate the training process, the other members of the support team had been working together for some time and had been closely involved in setting the philosophical approach and direction taken by the Program.

Bernie was the Aboriginal Coordinator and was committed to ensuring the Aboriginal and non Aboriginal teams developed their skills and modelled working in partnership. She was a visionary for the team and had a particular gift for inspiring those around her. She had a strong belief in the necessity for Aboriginal people to take a guiding role within the health sector and was

instrumental in the development of the philosophical and developmental approach taken with the Aboriginal team. Her excellent people skills meant that she inspired and motivated people and therefore gained support and enthusiasm for the project, and the model of working in partnership with the community; from the Departmental heads, the program staff, and community members.

Bernie had a strong background in the task we were undertaking and worked naturally in a participative style. She had a gift of passing on skills to those she worked with in a gentle, guiding way. She never worked alone and always acted as mentor for those she worked with; taking the lead yet ensuring that the work was seen as a double or a group act. She allowed her co-workers to take as much responsibility as they felt comfortable with, worked beside them, and always debriefed after an activity with her co-workers.

Carol was the team's evaluator. She had the dual role of being the Research and Evaluation Coordinator and the Program Director for the first six months of the research process. Alongside Bernie, Carol led the larger process of developing the team. She had been part of the development team and had led the evaluation process for both the AIDS/STD and the Aboriginal Community Health Promotion Project. Carol's experience in working with Aboriginal people to evaluate their programs was a long way from her Ph D in anatomy, but her down to earth style meant that she was able to enthuse others in the activity of evaluation. She encouraged members of the Health Promotion team to reflect thoughtfully on our work and to build evaluation into all of our activities. She encouraged us to document our work activities in a non cumbersome way and so build up a useful data base from which to make assumptions and decisions. The decisions about what to document and how,

were decided by the team in a number of workshops, and resulted in each person having a process to work with, which had been chosen by the group, but was flexible enough for each person to adapt to suit themselves.

Carol showed by example, the value of working collaboratively; of debriefing as an important evaluative and learning technique; and reinforced the importance of reflecting and learning from every activity. More importantly she showed how the skills of effective evaluation and research are available to everyone. Carol's accessibility as a team leader and collaborative working style provided the team with an important role model to follow long after she had gone. An illustration of her ongoing influence was given by Gary several months after Carol had left the Program:

> When he attended a seminar on evaluation in Nhulunbuy, where the expert talked of the difficulty and complexity of collecting evaluative data, Gary said that he wanted to stand up and say "no it isn't! it's easy and it's essential". He felt that a little further down the track in his development as an Aboriginal Health Promotion Officer he would have felt confident to do so, but not just then (Janke pers.comm. 1994).

Gwen was the senior Aboriginal Health Promotion Officer based in Alice Springs. She had been part of the Aboriginal Community Health Promotion Project and as a participant in that process had rigorously adhered to the working protocols decided on by the team. She believed that her serious application of the principles of developing community relationships, documenting, evaluating and debriefing was the reason for her success in her work and for the skills and knowledge she developed on the job.

Gwen had received strong support from her mentors, and she in turn provided strong support for those around her. She kept the project on line and insisted

on our remaining rigorous with the process. She believed that staff should be assisted at all times and that they should be serious enough to put a good deal of effort into the process. Gwen nurtured and supported the members of her team in Alice Springs and Tennant Creek and spent a lot of time working alongside them showing by example. The people who worked with Gwen felt valued, supported and keen to give their best to the job at hand.

Ray was Gwen's co-worker and manager. His gentle manner and team skills encouraged and nurtured the teams in the Alice Springs and Tennant Creek area. Ray and Gwen set a standard for working in partnership which stood as a benchmark for the rest of the teams within the program.

Greg was the senior AHPO based in Darwin. He had previously been an AIDS/STD educator and had been mentored by Bernie in the AIDS/STD Program. Greg was very thoughtful about his work and is an excellent facilitator. He has strong skills in explaining things clearly and in facilitating others learning and in bringing people into a process as willing participants. At the time of this research process. Greg did not direct his energies into training the other Health Promotion staff, although he did provide a great deal of personal support to the AHPO's. A lot of his energy was directed to changing the way the Rural Services section of the Department worked with Aboriginal communities; and working to move health service providers towards a more coordinated way of working in line with primary health care principles. He was also developing and facilitating health promotion workshops for Senior Aboriginal Health Workers based in remote communities.

The Aboriginal Health Promotion Officers (AHPO's)

The participants in the project were the Aboriginal Health Promotion Officers (AHPO's), who were situated in teams in each regional centre in the NT. The team of AHPO's consisted of people with vastly different expectations, backgrounds and skills. There were twelve AHPO's in the program over the period of the project. The full complement of AHPO's in the NT was eleven but full staffing was never achieved. At the beginning of the project the participants included the two senior AHPO's, Gwen and Greg; and six AHPO's; Jacqui, Kevin, Kath, Richard, Gary and Darrin. Jackie and Kevin had been part of the Aboriginal Community Health Promotion Project and the other four had been newly recruited. During the fist twelve months Jacqui and Kevin left the program and four new AHPO's were recruited; Lyn, Marlene L, Marlene B, and Cheryl. The team came from diverse backgrounds and brought a wealth of knowledge and experience to the job. Kath was a grandmother with a long involvement in the health sector and had particular interests in land rights, juvenile justice and community matters. She was a women of the highest standing in the Aboriginal Community in the NT as well as a sought after adviser to government and industry. She was also a poet, and writer. Her advice, questioning, suggestions and mentoring were very important to the learning process.

Richard had been a carpenter before moving into the Health Promotion Program and was very keen to make the shift from a highly focussed job to one which involved working with people. Gary a was a labourer who had returned to education and had recently graduated from a community worker course at the Northern Territory University. Gary had come to the NT from Far North Queensland, and like Richard was entering a new field of work and was greatly looking forward to it. Marlene L and Marlene B had both been welfare

workers with considerable experience with the bureaucracy and with Aboriginal communities. Marlene B had a key role outside work as a member of her local Aboriginal community organisations. Lyn had an administrative and community organisation background, and was excited at moving into a role in which she could use and develop her excellent communication skills. Kevin had been a Field Officer with another Government Department, and Jacqui had a background in personnel. Darrin had been an Enrolled Nurse and Cheryl, like Gwen and Bernie was a qualified Health Worker of many years experience. What all of the AHPO's had in common were excellent people skills, and an openness to a new way of working. The challenge for the support team and me in particular was to develop and implement a training process which could accommodate the differing needs and expectations of the team.

DATA COLLECTION

The scope of this research project will cover the 16 months from the orientation of the Aboriginal Health Promotion Officers in February 1993 to the completion of the draft accreditation document in June 1994. This represents the developmental period.

What data was collected

The data collected included everything relating to the central focus of developing the capacity of the team for working in partnership within the program, the district and with communities; developing the skills of the team; and ensuring a working environment which could support the development of the members of the team.

How Data Was Collected

Workshops

During this developmental period we ran four workshops; an orientation and a workshop to set directions for the Program in February 1993; a recall in August 1993 to review the first six months, to ensure that people were clear on their roles as Health Promotion Officers, and to provide feedback and to determine support and training needs; and the annual workshop to build on the team development and direction in February 1994. From these workshops came group discussions and decisions on the direction of the team and ways to develop training; consensus on ways of working with communities; and documentation of activities in the field. Issues needing attention such as working in partnership and ways to improve cultural understanding also came out of these sessions.

Workplace meetings and visits

Regular visits to team members in their workplace for purposes of support, assessment of skills and to determine training needs provided opportunities for collecting data. Sometimes data came out of formal training and planning sessions and sometimes out of our many and varied discussions. I kept a journal in which I recorded everything relevant to training or support needs of the team. During conversations, planning meetings or work discussions I would jot down anything which I saw as useful or important to guide the direction and method of the training.

The journal was my personal document and in it I recorded personal perceptions, comments by team members, and any things which were not for public record. Although these diary notes were not for general viewing, I used them extensively during the development process to guide discussions with team members and later in the analysis of key issues.

Formal records were kept in the form of field trip and workshop reports and I kept more general notes and appointments in a work diary. Notes from formal and informal meetings in the workplace which influenced the direction of the program have been used. Key points of telephone conversations have been recorded in my diary.

Other written sources used include archival material such as workshop reports from the Aboriginal Community Health Promotion Project; reports; articles and briefing papers written by team members and past staff members; old Program files and reports.

How I dealt with the information collected

The training development process was guided by the team and was constantly evolving from formal and informal conversations, team meetings, field visits, and training sessions. As program developers, initiators, and participants we all had a wealth of ideas to inform the process. The most powerful part of the process was the chance to pull together all of the many things the team members saw as being essential in a training program. The close working relationship and the constant dialogue meant that the team developed a consensus on the needs the training program should address. The numerous discussions about how to develop a supportive framework, how to ensure

people worked better in partnership, and issues of respect all informed the development of the training process. I have collated those issues raised most frequently through the course development and analysed these.

Structured course development sessions were held from February to June 1994. during this time I met with the Darwin and Katherine teams and I travelled to Nhulunbuy and Alice Springs to work with the staff there to determine priorities as a team. In small groups we worked on identifying the skills needed in the job and the best ways of gaining these skills and developing knowledge. These sessions were recorded on an electronic whiteboard and typed up after the session. Once I had worked with each group of people identifying skills, I consolidated these into one list. This list was the basis for writing the curriculum. The curriculum development work was done primarily in Alice Springs and was a collaboration between myself, Carol, Gwen and Ray. We worked in workshop style using a whiteboard and printed copies of the skills development work as our reference material.

Analysing the data for key issues

Throughout the course of the research project a number of themes occurred frequently in our discussions and activities. The most frequent of these were the issues of support, clarification of roles and working in partnership. I pulled out of the data the issues most frequently referred to and collated these into major thematic areas. I examined these themes and provided an overview of the key issues arising from the data.

Examination of the data in order to extract set of principles for providing support and working in partnership

The detailed examination of the major themes, discussions and written data has enabled me to pull out some principles for providing support and working in partnership which can guide our practice in the future. The themes and issues which arose from the data will be discussed and analysed by the Health Promotion team in the next stage of the process.

TIMELINE OF THE TRAINING DEVELOPMENT PROCESS

First Stage:	**Settling in and Clarifying Roles**
February 1993	Orientation Workshop in Darwin for AHPO's and those HPO's working with them. Direction setting workshop for everyone in the Health Promotion Program. Teams return to their districts. New teams begin to establish a role for themselves.
March - July	Support team visits district staff to assist planning and direction. Develop and trial skills assessment with AHPO's in Nhulunbuy, Darwin and Katherine. Orientation and planning meeting in Tennant Creek . New Program Director arrives in May.
Second Stage:	**Consolidating our gains**
August	Mid Year Recall Workshop in Darwin; to assist staff clarify roles, and provide support and guidance. Introduce AHPO's to the plan for the training program.
September-November	Visits to support team in field. Skills assessment is refined and adapted. Works well in some districts and not so well in others. Strains begin to show in teams because of differing expectations by Program and district management. Visit to Alice Springs to work with Alice and Barkly teams on skills assessment and training. AHPO's insist we ensure training is well assessed and recognised.
Third Stage:	**The Way Ahead**
February 1994	Annual workshop for Health Promotion Program. Decision by AHPO's to develop an accredited training program and to be fully involved in the process.
March - May	Ongoing support visits to districts during which we develop a list of skills which will form the basis of the training program. Katherine team come to Darwin to help with the process. Workshop in Alice Springs to pull together the skills lists and turn them into curriculum.
June	Develop a Draft Curriculum document. This is sent out to AHPO's to review and adapt to their needs.

CHAPTER 4

THE JOURNEY - TOWARDS THE PARTICIPATORY PROCESS

Prologue

My own introduction to working in partnership within the Health Promotion team began in November 1992 with a workshop at Mataranka, situated about an hour drive south of Katherine. Mataranka is home to the Mataranka Hot Springs and the "We of the Never Never" homestead. Bernie, Greg, Jackie and Kevin were facilitating a five day workshop on health promotion for Aboriginal Health Workers (AHW's) enrolled in the Batchelor College Certificate in Health Science Course. AHW's must complete this course to gain Health Worker registration in the NT.

Bernie asked me to come along to evaluate the workshop and to provide feedback to the facilitating team, but I believe that she actually intended it to be my orientation into the way the team worked. She also intended this to be a way for me to begin to build my relationship with the Aboriginal Health Promotion Officers (AHPO's).

The Aboriginal Health Promotion Team had taken on the responsibility of delivering the health promotion module of the Batchelor College course some years earlier to help the College out when they were low on staff, and they had

designed and delivered it ever since. It was an ideal way to pass on health promoting skills and to build the working links between the AHPO's and the Aboriginal Health Workers (AHW's). The AHPO's took the responsibility very seriously and saw it as an opportunity to model the 'Health Promotion way' of working and as an opportunity to mentor and encourage the AHW's. As Bernie said to the AHW's during the workshop; "it is essential for us to be teaching our people, Aboriginal people can say we". The AHPO team used every opportunity for modelling the behaviour and skills they were passing on; by showing how well a team can work in partnership; by taking the lead in all aspects of planning and delivery; and by modelling responsible behaviour in the evenings at the bar. In fact they took the matter of passing on skills to their people so seriously that some conflict arose with the Batchelor College staff when the team refused to accept less than perfect conditions in the learning environment. It was late November, stiflingly hot and humid and arrangements had been made for the workshop to be held in an outdoor Bistro. In her workshop report Jacqui wrote:

> We had to use the venue at the Bistro. This included putting up with noises from the juke box, peacocks and tourists wandering around (Garling, Nov 1992).

The team insisted on finding another venue and we moved to a large shed owned by the Mataranka Council, no cooler but it was quiet and private; and later in the week the team refused to compromise on the learning opportunity presented by leaving out material which they considered essential in order to finish the workshop half a day early (in order to travel back to Batchelor). In the team's feedback to Batchelor College after the workshop they wrote:

> We want to use 5 days for the workshop. Cramping the program into 4 days meant the days were long and heavy and there was no time for a bush trip (Health Promotion Unit Feedback to Batchelor College, 1992).

The team also asked for there to be greater collaboration between themselves and Batchelor College. At the time the team was responsible for course delivery and Batchelor College staff were assessing the students without the two groups planning the process together.

The situation of four people facilitating a workshop was unusual for me, but I was soon to learn that this was the preferred way for the Aboriginal Health Promotion team to work, with more experienced people mentoring and training the less experienced. Bernie was the main facilitator and had taken the leading role in the planning. Greg had worked with Bernie before, and as Senior Health Promotion Officer took the role of co-facilitator. The workshop was a learning experience for Jackie, Kevin and me. Bernie directed the learning activities but shared the process with the rest of the team. She allowed everyone to take as much responsibility as they chose, while ensuring that no one was left out of the process. So while Bernie and Greg shared the facilitation of the sessions, Jackie and Kevin moved among the students providing assistance and guidance.

The process worked to support and skill both the facilitators and the student group. Bernie took care to ensure that I had a clear role within the workshop by regularly drawing me into the process as a partner and by having me provide feedback on the facilitation. The student group were motivated and encouraged by the presence of a team of Aboriginal 'teachers' and excited about the possibility that each of the facilitators were learning and developing along with

them. Bernie encouraged even the shyest students to speak in front of the group by the end of workshop and had a strong impact when she told them that not so long before "like you I was too shamed to get up and talk in front of a group".

This Mataranka experience introduced me to the ingredients which we would include in all of our health promotion activities and which guided my own work with the team to develop the training process. These included working in partnership in all activities with the more experienced person mentoring and supporting the less experienced person. This meant that as the more experienced people left the program others were confident to step into their shoes. There was a dedication to ensuring the process empowered and drew and built on the skills of everyone involved in it. During this Mataranka workshop I was aware that I was receiving support and direction to guide the way I would work with the team. There was no assumption that I was the 'training expert' there to pass on skills; I was regarded as a team member with skills to share and much to learn.

Every evening after the workshop the team would meet in Bernie's and my room to debrief and evaluate the day's activities. We would examine the evaluations completed by the students and use these to guide us in planning our tasks and roles for the following day. The emphasis in these sessions was to strengthen our skills and build our confidence as facilitators. We would then go and meet the students and spend social time with them. At the end of a week at Mataranka I left feeling very excited, knowing that I would be given the opportunity to learn a great deal from and share real learning opportunities with my team mates.

INTRODUCTION - THE JOURNEY BEGINS

> We are like the thunderstorm in the desert before the flowers bloom (Smith, pers comm., 1984).

The data takes us on a journey and shows the unfolding of the process to become participatory. Through the data we can see how the participatory process came about. We didn't sit down as a group and say 'lets develop a training program in a participatory way'; it was part of a long process of refining a way of working with people to facilitate their learning and professional development. Looking back on the process described by the data I can see that we were learning together and developing the skills and understanding we needed to work in partnership and to facilitate the learning of others. First we built our relationships within the team, and clarified our roles in relation to our interaction with those around us. An important feature of this process was its long gestation period. The data shows that in order to develop a meaningful participatory process the participants needed to reach a point from where we could move on together.

The essential ingredients for ensuring the development of a team process; working in partnership and providing support for people to develop skills, were already deeply enmeshed in the program's philosophical framework before I came into it. These were seen as crucial to working successfully with Aboriginal people in a primary health care framework. What we had to do was to work out exactly how these key ingredients could best be achieved.

We found that people needed to develop a very good understanding of their own role in the job, and to develop their skills and confidence to a level where

they could look thoughtfully at what needed to be done and what skills they needed to develop to do it. We also needed to have developed strong relationships to be able to move on to work together. It was a journey of discovery and by no means a smooth one, nor did the processes of developing our relationships and clarifying our roles happen in distinct stages. Our relationships influenced the roles we took within the various teams and our roles influenced our relationships. My own role was strongly influenced and guided by my developing relationship with Bernie, Gwen and Carol and the AHPO's in particular, and our roles and relationships continued to change and develop. By revisiting the data found that I was able to look closely at what we did and trace the journey towards the participatory process.

FIRST STAGE: SETTLING IN AND CLARIFYING ROLES - FEBRUARY TO AUGUST 1993

The Orientation and Goal Setting workshops

The journey described in this research began with the Orientation Workshop for the newly recruited Aboriginal Health Promotion Officers (AHPO's) in February 1993. This meeting was seen by Bernie, Greg and Gwen as key to introducing the new team members into the culture and philosophical framework of the program. The Health Promotion Officers who were working in teams with the AHPO's were also included so the 'teams' could work together and develop their partnerships from day one. The Orientation concentrated on building the team as a whole, and looking at how the district teams would work together back in their communities. The week was lively and positive and at the end of five days the AHPO's felt part of the wider team and were ready to work as such. The Health Promotion and Aboriginal Health

Promotion Officers were keen to work in partnership and model this to the others (Workshop Evaluation Feb 1993). Following is a poem written by one of the team during the orientation :

HEALTH PROMOTION OFFICER - WEEK 1

I'm at a workshop here in Darwin
10 past 11 and I'm starvin
Carol's talking about evaluation
I'm sitting here interested and patient
I'm learning a lot and its all sinking in
Greg is just recovering from a night full of sin
Kevin's colouring his first day faces
and Dianne keeps on changing places
Gary is writing everything down
while Ray is listening and sitting aroun
Kathy thinks this is really great
because this is our job and we're all team mates.
Nea and Karyn are both sitting there
writing things down in their nice little chairs
Bernie and Gwen who share running the show
sitting there worried about how things will go.
Esther and Margaret both from Tennant Creek
Hope they enjoy this workshop week.
Tracy who joined us a little bit late
To have her here with us is really great.
Sue and Richard are the only ones left
To find something to say has left my mind blank
Overall we make a good team
its great to find out what HPO means.
Its good to see which directions to take
and to work as one and all be mates.
30 min to write this poem.
Roll on 4.30 so we can all go home
to wait to Monday to get on with the
show. (Darrin)

The following week, the rest of the staff of the Health Promotion Program joined the team from the orientation for a workshop to establish the Program values, objectives and directions for the next three years. There were 20 staff in the program as a whole. In contrast to the orientation workshop which was planned and facilitated by the Aboriginal staff and placed its main emphasis on building relationships; the second week was heavily focussed on the important

and difficult tasks of providing direction to the Program. As a consequence there was little time for team building activities and the process proved to be very stressful and tensions were often extreme. These two workshops illustrate the tension members of the Aboriginal Health Promotion would encounter in their work with communities; the emphasis on building relationship would often come into conflict with the bureaucratic expectations that something is produced.

Both of these workshops were planned as all processes within the Health Promotion Program would aim to be; to model adult learning principles, and to use workshop facilitation, decision making and evaluation techniques. We used a set workshop process which was applied to each activity in the workshop. The steps encouraged the participants to share information; contribute ideas; to reflect upon, clarify and analyse these; and to explore options and plan actions.[9]

As well as developing values to guide the team and key objectives for the program to work towards (appendix 3), each district group developed action plans to guide their work when they returned to their districts. This gave participants the opportunity to gain an understanding of how their own work activities would fit in with the team as a whole.

Settling in

Back in the workplace in Darwin, Katherine, Nhulunbuy, Tennant Creek and Alice Springs, the new Health Promotion teams were settling into new jobs and for some, new towns. Armed with little more than a set of objectives and a list of values the Aboriginal and general Health Promotion Officers had to develop

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9 This workshop process is adapted from Alan Randall in Bourke, A et al. 1990.

a role for themselves within the health care system. In order to do this they first had to develop a clear understanding of what health promotion was and how it could help the rest of the staff in the Health Service and the communities they served. Next they had to develop a clear picture of their own role as Health Promotion Officers. This was not an easy task, at this time I was searching to clarify my role as well. Although I had a clear idea of the role a training coordinator could play, and a wealth of experience with adult education and community development processes, I was grappling with how exactly I could best provide support and assistance to the team, and I was far from clear about what health promotion actually meant.

Clarifying their role provided challenges for all members of the Health Promotion Program. Half of the staff in the Program in February 1993 had come from outside the Service and (like me) one third had come from outside the health system. Since the Health Promotion Program aimed to work with communities in a collaborative way, most of the recruits from outside the Health Service were employed for their experience in community development processes. The challenge they faced was to work effectively within a health service which was focussed on the medical model of 'experts' going in to communities to administer health solutions. The most pressing need identified in our discussions was for members of the support team to visit each district and work with staff to clarify their roles and determine where and how they could begin to work.

Providing Support and Developing Relationships

Carol, Bernie and I visited each of the teams in their districts to provide planning support, discuss their projects, and to meet with their district

managers to discuss how the Health Promotion team could best work with other district health teams. These visits served to support the Health Promotion teams by helping them to plan as a team, provide the opportunity to discuss issues, and to reinforce their way of working to the district managers and staff. We visited as a team or in pairs whenever possible to model working and planning as a team.

The following extract is from my report on my first trip to visit the team in Katherine at the end of March 1993, and it shows how my visit provided the opportunity to develop my relationship with the team and to assist them gain a clearer idea of how they could develop a role for themselves within the Program and their district:

> Kath, Sue and Richard each talked about what they have been doing and what they plan to do for the rest of the year. We discussed these and listed them. We then went through the list and discussed which of the Program goals and key objectives they addressed. By the end of the day we had a clear picture of how the Katherine team's objectives fitted into the overall Health Promotion Program's objectives (29/3/93).

On 30/3/94 I had written:

> Back in the conference room we began to take the objectives recorded on Monday and put them into the set format. A great deal of discussion took place around each one; on personal and community priorities how to achieve the objective; what was already being done; difficulties; how to record and report activities. After lunch we went out to Katherine Gorge and continued the planning process under a big shady tree. On the way back to Katherine we stopped to collect some bush currents and had a bush tucker lesson with Kath (Harrison Field Trip Report 1993).

Guided by the planning activities from the February workshop, the teams had to find their own way of working in their Districts. Aboriginal Health Promotion Officers (AHPO's) were seeking ways to work with other service providers and with the remote and urban Aboriginal communities in their Districts. Following from the precedent set by the Aboriginal Community Health Promotion Project (NBHP) they planned to visit communities in their District and target one or two communities to work with. They were guided by the protocols for selecting and working with communities set by the Aboriginal Community Health Promotion Project (appendix 4).

Trial and Error: Seeking a training framework

At this early stage in the process I was focussed primarily on providing support and direction for the staff. I believed that an effective training program had to come out of the needs of the participants and in order to have any chance of being meaningful would have to gain its momentum from them. Because the program staff were all based in Districts and the distances between them were great (appendix 1), it was clear that training could not be a matter of simply providing workshops on issues. There were a number of very complex skills the Health Promotion Officers had to master which could not be left to chance and needed to be covered in a thorough way. These included specific strategies and processes used in the field of health promotion such as workshop facilitation, program planning, research and evaluation processes, community development processes, and effective communication skills. Developing such skills would take time and yet the AHPO's needed to begin to develop them as soon as possible to begin to meet the expectations placed on them from people they worked with in their Districts. Having chosen not to provide a

comprehensive training program before the Aboriginal Health Promotion Officers began work we now faced the challenge to integrate such training into their work life.

It became clear to me that until I had developed strong relationships with the Aboriginal Health Promotion Officers I could not begin to develop a 'training program'. Some training had been occurring from the beginning with the orientation and planning workshops, and continued with every visit the support staff made to the districts. This was not enough however, and people still felt unconfident, so a more formal training process had to be developed. Working with Gary and Dianne in Nhulunbuy, helped me identify the need for a training process which would assist the AHPO's and HPO's clarify their roles and responsibilities and which would allow each person to control their own learning activities. Gary and I spent a great deal of time during my visit to Nhulunbuy in March 1993 looking at the activities he was involved in and asking the question "Is this what I should be doing as an AHPO?" Gary was receiving a lot of requests for information sessions on smoking and scabies; in fact in Gapuwiyak he was known as 'the scabies man'. We discussed strategies for ensuring that he was passing on the skills to the Aboriginal Health Worker in Gapuwiyak and the teachers at Yirrikala school in a way that they could run these activities themselves in future with support and resource help from Gary if necessary.

In a memo to Carol on 4 April 1993, I proposed developing a training needs assessment for each staff member, which would involve looking closely at the job and listing all of the tasks and activities involved in it. I would then work with each AHPO to determine the skills necessary for each of these tasks, to

assess the level of skill the worker already had, and to develop a training plan to address the gaps.

> The training plan will include set activities such as the Certificate in Health Promotion and any relevant training courses available through Staff Development Services. It will also identify a range of skills which can be developed in regular workshops and tutorial sessions (Harrison 1993).

Finding Direction

By June the teams felt that they had a clear idea of where they were going but were still experiencing some difficulty in how to get there. During a visit to Nhulunbuy in June 1993 Gary and Dianne identified their main tasks as:

> 1. to become a fully functioning team. To get our third person on as soon as possible. preferably a woman, (Nhulunbuy hadn't recruited their second AHPO at this stage and Gary was keen to find someone to look after women's business);
> 2. to visit all communities in the region and prioritise which community we will meet with; and
> 3. to build up relationships in communities and to develop community participation.

They planned to do this by following up requests by Yirrikala school to work with the teachers on developing lessons on smoking and petrol sniffing, and by tapping into the community networks to assist with women's health issues. Their long term goals for two years down the track were to have selected;

> communities know who I am and what health promotion is, for people to know what we really can do, to have the groundwork done and see the community running health promotion programs

and we are just a resource (G. Janke); and to work in an integrated way with other health workers (field notes from visit to Nhulunbuy 29/6/93).

Each team varied in experience and took quite different ways to find communities and groups to work with. One team wrote letters of introduction to every Aboriginal community in their district offering assistance with a "health promoting" activity and were disappointed when they only received one reply. This led to discussions about the most effective way to communicate with communities and the appropriateness of such activities. When the Aboriginal Health Promotion Officers discussed this as a group in August 1993 they agreed that teams would choose communities to work with where they had already developed relationships or where key people such as an Aboriginal Health Worker or a council member was keen to receive assistance on a particular project. With new teams struggling to develop their role in such a vast, unstructured area we felt that it was important for the AHPO's to undertake small defined projects where they could meet with success and develop both their confidence in themselves, in this way of working and gain the confidence of those around them (Mid Year Recall workshop discussion).

During the first six months the importance of ensuring each person had a mentor to guide them and ease their way was reinforced. The Senior AHPO's, the support team and the general HPO's (in areas they had expertise) had a role to play in acting as mentors to the AHPO's. Effective mentoring involved introducing their team mate to key people in the district and in communities, and accompanying the AHPO's on field trips to communities to assist them develop the right protocols for working with communities. It also involved sitting down together to debrief after every field trip or activity, to discuss how they went about their work, and to look at the variety of ways a given situation

may be approached. Debriefing provides a valuable opportunity for members of the team to reflect on each activity and interaction, and to evaluate and learn from it.

Despite our commitment to providing mentors for all staff, in reality we were not able to. Bernie, Gwen and Greg planned to work with the AHPO's to orientate them into the communities they would be working with, but due to other pressures on their time this did not happen as it should have. Bernie was committed to a range of other activities and was unable to make the time to visit the communities with the AHPO's. She moved on to another job six months after the program began and the position was vacant for almost twelve months. This was a great blow, given the importance of the Aboriginal Coordinator for providing support to the team.

In August 1993 the main leadership and mentoring responsibility lay with Gwen and Greg. Greg as the Senior Aboriginal Health Promotion Officer in the 'Top End' was heavily committed to activities in Darwin Rural region and was not able to provide the necessary level of support to the teams in Nhulunbuy and Katherine. He was also constrained by the district structure which did not enable him to easily work out of the Darwin Rural district. As the Senior AHPO in Central Australia, Gwen was able to put all of her energy into training and support and as a consequence her team felt confident and supported. In a discussion Greg, Gwen and I had in August about their roles as Senior AHPO's, we looked at the increasing responsibility placed on them to fulfil the roles of mentor, change agents and in Greg's case; as a member of the management team in Darwin Rural district. There was often tension between Program and district responsibilities.

Gwen managed well because the Alice Springs team actually comprised the ideal partnership between HPO's and AHPO's, and Ray took on the management role leaving Gwen to concentrate on providing support to the Central Australian Aboriginal Health Promotion team. As manager of his team, and as one of the key Aboriginal staff in Darwin Rural District, Greg was given increasing district responsibilities. The Health Promotion Program needed Greg to provide training and support for the AHPO's in Nhulunbuy and Katherine, but his district role made no provision for him to move outside the district to work. Greg felt ;

> bad about not being able to give enough support to Gary and Cheryl in Nhulunbuy and Richard and Kathy in Katherine but I know I am changing Rural Health (pers. comm. 26/8/93).[10]

Assessing skills as a first step towards developing a training framework

Using the Aboriginal Health Promotion Officer duty statement as a guide I developed a skills assessment tool in which each area of experience, knowledge and understanding was listed separately (appendix 5). I hoped that the skills assessment would enable me to sit down with each AHPO to look closely at the job and would provide a way for us to work together. I trialed it with Gary in Nhulunbuy in July 1993.

> The process was extremely demanding. It took us three days to work through each skill, dissecting it for meaning, turning it into more understandable language, deciding what it meant for Gary and his work situation, what skills he had, what he needed to develop and how this could be done. Although the process was difficult it was valuable for several reasons; it provided a detailed breakdown

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10 Rural Health is the district section which oversees health service provision to the remote Aboriginal communities in the Darwin district.

> of the skills needed and required us to look at what the job actually entailed, what skills were necessary to competently carry the job out, what skills Gary already had and how skills could be gained. The process helped us look at what the job was and led to a lot of discussion about what the job role was and how things could be done (Harrison, Journal: April 1993).

Because the Aboriginal Health Promotion Officer job was new and there were few precedents to follow within the Territory Health Services, the AHPO's and I often found the job difficult to conceptualise. It was essential to understand it clearly ourselves before we could begin to explain it to others. Working through the job in such detail was valuable as a clarification process and for providing the chance to discuss just what was acceptable and desirable within the role of AHPO. Giving time to carefully dissect and discuss the work role was important and we found that the process was most valuable and useful where we gave enough time to it as we did in Nhulunbuy with Gary, in Alice Springs with Gwen and Marlene L. and in Tennant Creek with Marlene B. and Darrin.

For the other regions where we never had the necessary time, or where the team members did not see the value of the process, it was not as useful. I found that the perception of the value of the process was closely tied to the relationships within a given team, and the commitment of the team to work together. Where the person in the team designated as mentor or support person was not closely involved in the process it was not as successful as where the support person was. I found that I was not able to engage the members of those teams which were not working in partnership and who did not at this stage, see the real value of the training program. The widely varied commitment to the training process drove the search for a more effective way to assess the skills of

staff, orientate them into the requirements and needs of the job and another way to gain the support and involvement of all the teams.

In order to develop a program which would give back to the Aboriginal Health Promotion Officers as much as it would demand from them, I sought to make the training as meaningful and as valuable as possible. In my search for other skills development and training activities available in Health Promotion Programs around Australia, I found that there were no formal training courses offered and no national competency standards in the field of health promotion. The most useful guidelines for competency in the field was a list of core skills and knowledge in the publication Pathways to Better Health (1993).

I compared these to the list of skills and knowledge I had developed from the AHPO duty statement and was delighted to find that all the key skills and knowledge listed in Pathways to Better Health (1993:54-5) were well covered by the AHPO duty statement. By combining these two documents I was able to refine our skills assessment and develop a training guide which I believed would be both responsive to the needs of the Aboriginal Health Promotion Officers and keep us in step with national developments (appendix 6). I felt that the key to developing a successful training program was to tie it in closely to everyday activities and to use the documentation processes already agreed upon by the team for recording skills development. The aim was to enhance the work being undertaken rather than add on another layer called training.

Clarifying roles

The most difficult part of the job according to most new Aboriginal Health Promotion Officers was to clarify their role. Unlike other staff in the Department they did not have something concrete to offer. They could not say I am the Doctor, Physiotherapist, or Nurse come to look at your illness, or the Environmental Health Officer come to look at your drains (in fact their role was the very antithesis of the entrenched medical model of fixing illness). They had no money to offer and often felt that they had no specific skills. They would soon develop specific skills in planning, evaluation, and health promotion strategies but at this stage the AHPO's were trainees and believed they needed something to offer. They felt that saying "I am here to assist you with any health promoting projects you wish to do" was too vague especially when the assistance most people expected was funding, solutions or resources (pers. comm. Smith, Janke 1993). In many ways the Health Promotion Program was swimming against the tide of established practice and that in itself placed great pressures on the small number of people in the Program. Gary and Dianne addressed this by making up a poster with their photographs on it which said 'if you wish to run a program to improve health on your community we can help you' and which gave concrete examples of the assistance they could provide. Examples included assisting the community plan activities such as community clean up days, workshops and meetings to discuss health issues of concern to the community; anti- natal get togethers for expectant mothers; working with teachers to plan lessons on smoking.

Specific roles had been established by the AHPO's in Darwin and Alice Springs who had joined the Program during the Aboriginal Community Health Promotion Project. They had established roles facilitating modules for Aboriginal Health Workers (AHW's) studying through Batchelor College and

had developed a Health Promotion workshop for Senior Aboriginal Health Workers. Senior Aboriginal Health Workers were trained as health workers under the old work based training scheme and were not graduates of the Batchelor College Certificate course. They were generally older and had more cultural authority than the Batchelor College Graduates. The 1995 review into Aboriginal Health Worker roles in Central Australia recommended that these Senior AHW's take responsibility for local health centre management and that they take responsibility for development and delivery of health education and promotion in their community (Tregenza and Abbott 1995:31-34). The Aboriginal Health Promotion Officers designed the Senior Aboriginal Health Worker workshops to provide professional development opportunities in health promotion. The workshops involved the AHPO's working alongside the senior AHW's to plan and implement projects in their community and provided a very practical ongoing advisory and support service for the Senior Aboriginal Health Workers. Some of the district Health Promotion teams were also were running workshops in health promotion for Health Service staff which focussed on defining health promotion and or looking at ways primary health care workers could be more health promoting in their own work.

During the visits other members of the support staff and I made to the districts during the first six months we encountered a good deal of confusion amongst both the Aboriginal and non Aboriginal Health Promotion Officers about their roles. Staff were unsure of how well they were beginning to work in communities, how the teams should be relating to each other, what supervision role the general Health Promotion Officer had, if any, and whether they were working in the right way. It became clear that staff had been sent out to communities without sufficient orientation. Although the work the staff were doing was well received in their districts and the officers appeared to be

working well, there was enough uncertainty and enough variation in the way staff were working to concern us. The principles of community consultation and teamwork processes had been discussed in the orientation and planning workshops but we had not covered them in depth. There had been no agreed protocols for how to work in communities or in the district and there had been no detailed focus on how to consult with a community or facilitate community action.

The lack of this training for work in the field led to a great deal of uncertainty and a wide variety of ways of working in the field. Had there been sufficient support from the identified mentors; the Aboriginal Coordinator, senior AHPO's, the HPO's and Central Resource Team, some of these problems may have been prevented. The mentors should have accompanied the AHPO's on their first few field trips, or we at least should have had very clear agreed upon protocols for approaching and engaging community support for our activities. These procedures would have made the role of the Officers and the Program much clearer.

The support team believed that it was important to tackle these difficulties early in order to ensure that all staff were heading in the same direction. If any staff were floundering in the job it was important to provide support and direction as soon as possible. As part of their training program we decided to bring the Aboriginal Health Promotion Officers together at the end of their first six months to review their progress, provide support and professional development, develop the protocols for working' and discuss how to best implement the training program (discussions between Nea, Gwen, Greg and Carol 1993). The general Health Promotion Officers also felt that they needed

guidance and the opportunity to discuss issues and concerns, so the whole team planned to come together in September 1993.

By this stage it was also becoming clear that some teams were having difficulties finding a way of working in partnership. We wanted to work on this issue and we particularly wanted to build on the recognition that "the strength of the Health Promotion Program lies in the combined skill of the whole team" (Smith 1993).

During a planning meeting Greg, Gwen and I discussed the importance of ensuring that the workshop was positive and enabled issues to be brought out in a positive way. We decided that the workshop theme be: "our strength is in the way that we work together. Our strength is what we bring to the job and our ability to do the job well depends on how we work together" (25/8/93). We decided that focussing on positive activities and modelling good teamwork and support was the most effective way to build team morale and show how teams should work together. We also discussed the importance of looking at the issues which had arisen over the past six months, and decided that a good way to draw out the variety of inspiring projects people were involved with, was for each AHPO to document and present a major project they had been working on. We also needed to look at how to measure change; who can provide support and how; the AHPO role; and participation in and evaluation of the training program.

Seeking commitment to the skills development process

Gwen and I planned a workshop session during the August Recall to identify how best to take the training process forward. We were looking for commitment from the AHPO's to the training process. "We can provide support and assistance but they are the people to make it work" (Walley 10/8/93). We wanted the teams to go away from the workshop with a clear plan of action for their skills development, to consider how to learn from each other, how to develop clear work and training practices, and for each person to identify someone with good understanding of health promotion and partnership with whom they could debrief as part of the learning process. We wanted the AHPO's to look at the training process and ask:

> is it working?
> what are the gaps in the program?
> what are our expectations of the program?
> how do we work with a mentor?
> how to make the relationship work well?
> how to make it easy; judgement needs to be made about what a mentor does and what advice to they give.
> We need discussion in the workshop, who can be a mentor? what do they do? what skills they should have?
> As a group we need to come to agreement on what to document and the procedure for documentation and on the way to organise the folder and documentation (Planning session with Carol and Gwen 11/8/93).

SECOND STAGE: CONSOLIDATING OUR GAINS

AUGUST 1993 TO FEBRUARY 1994

The mid year recall workshop - August 1993

The Program team came to Darwin in late August for the recall. The AHPO's met on Monday and Tuesday, the HPO's met on Tuesday and the whole group met together on Wednesday and Thursday. The need for the two groups to meet separately to discuss issues reflected the separate needs of each group and also the fact that there was not a close working relationship between the two groups. For a program advocating and modelling partnership there were a number of issues to resolve, relating to partnership, expectations and respect.

The workshop was successful. The focus was on information sharing and these sessions showed how much the teams had achieved over the past six months. The list of projects and activities was long and exciting and the group found a confidence and enthusiasm for each others achievements. The list included:

- reorienting Aboriginal Health Workers and community people through Primary Health Care Workshops;

- working with communities such as Oenpelli and Belyuen on community concerns such as nutrition and alcohol;

- facilitating mens' health workshops on communities;

- working with the Gurungu Council in Elliott to run a survey which resulted in the successful application to the liquor commission to limit take-away grog sales, to ban children from public bars and to cease take aways on Sunday;

- presenting a paper at the national speech and hearing program;

- involvement in juvenile justice workshops;

- working with nutrition program and store staff in communities on projects to get good food into the stores.

Also refer to (Appendix 9).

In the workshop evaluation people "liked getting together and sharing positives", "enjoyed hearing how other people work", and felt that they were "learning from each other" and 'extending ideas" (Mid Year Recall workshop report September 1993). We did however still have a lot of work to do as a Program to assist district teams develop stronger partnerships. At the workshop the AHPO's expressed a commitment to the training process and were keen to have the opportunity to develop skills, although there was some uncertainty about how the process would actually work and concern that participants receive adequate recognition for their effort. We decided to evaluate the process further at the February 1994 workshop, which would give staff time to trial the process.

Visiting each district to work on individual training plans

After the workshop I visited each district in order to complete the skills assessment and to plan training activities for the rest of the year. In October 1993, Jacqui and I spent a day discussing her work. We covered a range of areas including how she was working, how she felt about it, what assistance she needed to improve these activities and her aspirations for the future. Jacqui identified gaps through this process and we had a very thorough discussion

covering the work she was doing. The session was so enjoyable and positive that I decided to focus in future on the actual work each person was doing and then fit these into the training needs rather than focussing on the skills listed in the assessment.

During my next visit to Nhulunbuy we built on Jacqui's activity by listing all of the activities Gary and Cheryl were involved in and then referring to the competency list (appendix 6) to record which competencies each activity required. This proved to be an effective way to see the relationship between each job and skills development. It was also an empowering process since it highlighted how many skills each activity or program entailed and showed how many skills the AHPO's actually had. For example supporting the Aboriginal Health Worker and Council representatives at Gapuwiyak to design and implement a scabies program, which included a research process to collect baseline data on the prevalence of scabies, a community education program, a community clean up day, and an ongoing evaluation process necessitated the following skills:

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
1.6 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 synthesise 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, inc uding goals, objectives, strategies, evaluation, performance indicators etc.

3.2 health promotion strategies a id 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 he alth promotion programs

4. IMPLEMENTING STRATEGIES

Ability to:

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

5. INITIATING AND MAINTAINING PROGRAMS

Ability to:

5.4 assist the community identify and obtain resources

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

IMPLEMENTING PROGRAMS

Ability to:

6.1 oversee/manage implementa ion, including problem solving, negotiation, report writing, public communicati on etc.

6.2 develop contingency plans a s project develops and needs change

6.3 manage people, money and time

6.4 implement strategies

7. GENERIC SKILLS

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

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

7.3 teaching skills-including cor flict 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-inclu ding critical appraisal of the literature on health and determinants

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

7.9 Cultural awareness-includin g 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 P omotion Officers' AO4 and AO5 Duty Statements.)

This process of focussing on t ıe activities each AHPO was involved with provided an excellent opportunity for discussing each persons work in detail and for providing a focussed, non judgemental look at where each person was. I found that I needed to spend at least a day with each person for the process to be useful.

In November Gwen and I met with the Alice Springs and Barkly teams. We worked through the skills asses sment activity and discussed how to evaluate the training program and ourselves. The Alice / Barkly team decided that we needed to come up with a good assessment procedure. They wanted to be able to develop a process to show:

> How do we know what we have learnt?
> How do we know what skills we have developed?
> What skills do I need most to work well in my job?
> How will we evaluate -
> the program?
> ourselves?
> How can we best use the skills assessment? (Alice Springs 16/11/93)

Marlene B suggested that we develop a check list of skills:

> Then for any given project we can go through the list of skills needed for the project and compare it with our check list. This would give us an idea of which skills we need to concentrate on most for the project (Bennett, 93).

We agreed to take one day in the February Workshop to decide how we would assess participants and evaluate the training program and the teams decided to document their skills development activities for the next 6 months. The following list records their agreed outcomes:

HOW DO WE MAP OUR PROGRESS AND OUR SKILLS DEVELOPMENT?

1. For the next six months we will record our activities by putting records of all of our activities in our folders. Records will include:
Plans and reports of visits and activities
Community profiles;
Letters from communities and groups;
Notes from workshops we attended or were involved in facilitating;
Articles in journals and newspapers;
Photos;
Journal reports of activities, including recording how you felt about an activity you were involved in;
Copies of evaluations and debriefing sessions;
At our next meeting we will review the documentation and discuss the value of the activity and decide whether to continue such documentation or change it;

2. Redo the skills assessment in June 1994. This will provide another way of mapping skills development. We can compare the second assessment with the first.

3. All AHPO's complete a St Johns Ambulance Course.

4. Nea will produce a skills checklist and distribute it. This will enable us to check off skills as we have developed them. It will have 4-6 columns so we can make comments of progress along the way.

5. Include a day long session on evaluating the training program in the February Workshop. As a group we need to decide on clear guidelines for assessing skills, evaluating the training program, mapping progress, and criteria for completion of the program.

6. In order to review the process of working in a community that Gwen, Nea and Marlene go out and record the health promotion way (Alice Springs, Nov 1993).

The Team takes charge

The meeting in Alice Springs marked the point where the journey became participatory. It is at this point that members of the team picked up the training program and said if we are going to do it lets do it together and let's do it well.

The Alice Springs and Barkly teams built upon the development work laid down in Nhulunbuy and led us to look closely at how we could evaluate the program, evaluate the progress of the participants and how we would know when someone had fulfilled the requirements of the program (Harrison, journal 94).

After the meeting in Alice Springs, Gwen and I discussed a range of options for assessment with the rest of the teams ; including how they could demonstrate when they had completed the training program; when will assessment take place and what criteria would we use. We planned a session on assessment in the February workshop to get agreement on how the group would like to be assessed and in the meantime I planned to look at the assessment procedures of the Living with Alcohol Program and the Batchelor College Remote Area Teacher Education (RATE) Program.

Seeking recognition for undertaking the training

In many of the discussions we had during the year, concerns were raised about the recognition of the training. The AHPO's in Darwin, Katherine and Tennant Creek all expressed concerns about the outcome of the training and posed questions such as:

> What recognition would the AHPO's get for doing the health promotion training? Will we get higher pay after the training? Will we receive recognition from other study we may be doing or decide to do in the future?

It was clear from these concerns that the training had to have a more concrete outcome than merely being skilled for the job. While it can be argued that skilling to improve performance is important it is not enough to sustain the

commitment of a group of people through three years of training. The possibilities we discussed during the August 1993 Recall included:

- a certificate of completion from the Territory Health Services
- recognition for prior learning (RPL). We agreed on the importance of documenting all skills development in order for the AHPO's to be able to show proof of their skills development in the future.
- accredit the program in order to formally recognise the skills and work done by Aboriginal people.

THIRD STAGE: MOVING ON TOGETHER

FEBRUARY TO JUNE 1994

The way ahead

At the Health Promotion Program workshop in February 1994, we continued the discussion on how best to assess the training with the whole AHPO team and agreed on the need for a formal and rigorous assessment process and for the preference to gain formal recognition for the training. The assessment session during the workshop showed that the Aboriginal Health Promotion Officers were committed to the training as a way to develop skills and enhance their work but expected recognition and reward for their efforts. They clearly wanted skills development to be a team effort and wanted the general Health Promotion Officers to commit themselves to full involvement and support for the AHPO's and training. Recorded here are the comments made by the team during the session:

HOW TO ASSESS THE TRAININ(PROGRAM SESSION 10/2/94

1. WHAT IS USEFUL ABOU' THE TRAINING PROGRAM?

Provides you with skills, and to identify your skills.
Assist to build on these skills.
Enhances upon your development (co fidence).
Sharing information.
Enables you to put these skills into work practice and enables you to be assessed on skills attained.
If it enhances your work.
Helps you understand better what the job is about.
Increase understanding of Health Pron otion.
Increase skills in: partnerships
consultation
evaluation
program planning
communica ion skills
Improve on Aboriginal health with lea ned skills.
Professional standing recognition.
Understanding of Community Develo ment.
Increase understanding of what health promotion is.
Professional standing - recognition.
Transferring skills - workshops.
Understanding of community develop ent.
To improve Aboriginal health with lea ned skills.
Keeps track of program.
Maybe used for prior standing accredi ation.
Good as a measure/gauge.
Great for self analysis.
Highlights trouble areas/identify need .

2. WHAT IS NOT USEFUL?

Not enough follow up.
Not enough HPO's working on Progra n with AHPO's. Whole team not being involved.
To be developing the course in isolatic n to the rest of the AHPO.
Doesn't get us more money.
No certificate for completion.
Not quite clear.

3. WHAT WOULD YOU LIKE TO SEE COME OUT OF THE TRAINING PROGRAM?

A certificate in recognition of training
To be enabled to go on to professional development.
To have confidence in developing pro rams and action plans.
To be fully conversant with computer applications.
An accredited certificate - Training re ognition
Everyone skilled
Professional acknowledgment
Better team work.
Computer training.
Recognition for AHPO Certificate.
Better programs (Community involvement).
Culturally appropriate programs using trained AHPO.

As a bridging gap to further professional development.
Equality in the pay scales of Aboriginal and non-Aboriginal (Remuneration).
Accredited point to courses in the future.
Recognition at the vital part of AHPO's play to the overall success at the HP Program.
A realisation that change in a learning experience and for AHPO's to facilitate change they must be trained or be receiving training in a wide variety of fields.

4. HOW WOULD YOU LIKE THE TRAINING PROGRAM TO WORK.

To work together with the support of Nea.
Whole team involved and it be seen as a way to develop whole team.
Like to see program for all HP staff.
Everyone clear about objectives and way it works.
I would like the program looked at in depth on a regular basis in the work place.
I would like to see support from within the HP management structure and a true commitment to professional development.

HOW CAN WE ASSESS THE TRAINING PROGRAM?

To be assessed by Nea (CRT Team).
Sending work in.
Formal type assessment including:
self assessment
peer assessment
theoretical documentation - a set standard of work is required.
practical assessment/application for workshop skills and community development work.
Projects can be sent to Training Officer for assessment and accreditation , the work then will be put into suggested folder with objective then being struck from the list.
The piece of work could overlap into other objectives this could also be struck from the list.
The programs could either be projects or hypothetical situations if a program can't be used.

The meeting in February 1994 launched the training program in the direction we felt that we had needed to go all along. It was the logical progression of where all of our talks and had been leading. It was so logical that I wondered why it hadn't happened six months before, but have concluded that the decision was part of the participatory process and had to be arrived at by the group. Formalising the course would tie up all of the ends of the training program which had never been clear. These included the issue of recognition for the hard work put in by participants; the confusion expressed by some participants about how it could enhance their work; it would clarify assessment and evaluation procedures; and we would be able to tie in the values of support, teamwork and partnership we believed were essential for skills development

and team development. Formalising the course would also assist to clarify the roles of all of the people involved in the training process, including the general Health Promotion Officers and support staff. We could articulate these clearly in an implementation manual we would design for participants in the training program.

After the meeting I took the ideas of the group to The Northern Territory Employment and Training Authority (NTETA) to discuss accredited training provider status for the Department and the possibility of making the training program an accredited training course. We found out that we had the ideal course for accreditation and that we were already well advanced in developing the curriculum. My diary records:

> The next step as support staff will be to visit each of the districts to work on assessing the training program and developing a formal training procedure for the whole team. This may include support, assessment, documentation, debriefing, feedback on ideas of other districts, development of team work protocols, recognition of differing roles team members play and a way to articulate this in a formal way (Harrison Journal 94).

In order to ensure that we would have a truly participatory process we planned to meet with the whole team and work through the requirements for accreditation and together develop a document / plan for action including ways to ensure whole team planning and assessment, reviewing, debriefing. Such joint negotiation should ensure everyone was clear about the process, everyone had input and everyone was committed to it.

> A very clear role would then be spelt out for each member of the team - AHPO's, HPO's, CRT, Senior AHPO's, district staff and the

resulting course document would ensure all stakeholders are clear of the program, expectations and their role in it (ibid).

Developing the course

I began the process of applying to develop a nationally accredited course in February 1994 and Gwen and I made plans to visit all of the districts to begin the course development process.

The course development process began with the Nhulunbuy team. Gary, Cheryl, Dianne, the Aboriginal Health Worker Manager, and I sat around the whiteboard in Gary's office and wrote up all of the key things Health Promotion Officers need to be able to do. We began by identifying the key areas Health Promotion Officers needed to develop skills in and then discussed the level of skills necessary for each of these areas (appendix 8).

The activity in Nhulunbuy was so useful in developing a list of skills and knowledge necessary that we used the same process with all teams. The process was expanded to include the assessment criteria we would use. The workshop process with all teams was not rigid or restricted and each group took different tacks depending on their interests. Some groups produced lengthy lists of skills while others concentrated on specific areas. When Kath and Richard came up from Katherine to work with me, we concentrated on the areas of communication and Aboriginal culture. The sessions were all enjoyable and energetic and we used electronic whiteboards where ever possible to save having to rewrite lengthy notes.

We became very enthusiastic about the course development process and everyone was keen to be involved. The AHPO's took hold of the process and the course developed from the ideas and needs of the team. Had the decision to develop an accredited course been made by the Program management, I am sure that it would have been no more a part of the team than the initial planned training program was.

During this time Lyn, Marlene, Gary and Cheryl, all commented how going through this process as a team in March made the process of skills development much clearer. The core skills and knowledge assessment process had not been at all meaningful to them at the beginning because of unfamiliarity with the job and the difficult concepts involved; as one team member remarked "it all goes over the head" (Nhulunbuy, 1994). In my journal I noted that the knowledge and skills list developed by the team was very similar to the 'core knowledge and skills list from the publication Pathways to Better Health, although "it was far more detailed and more useful. It was more meaningful because it came out of their own experience" (Harrison 1994).

Turning the teams' efforts into curriculum

The district workshops resulted in the clarification and documentation of key knowledge and skills and provided a beginning for developing competencies and assessment criteria. I took the lists developed by the team, produced two draft modules from them and submitted these to the Northern Territory Employment and Training Authority (NTETA) to ensure we were on the right track.

In May the support team met in Alice Springs and over the period of five days we turned the skills lists into draft curriculum. We were careful to build in the important foundations of teamwork and partnership into the curriculum as we wanted to ensure that the course would formalise the processes of working together in partnership and providing support to develop skills. This was done by requiring that participants discuss projects with their team members; demonstrate planning, working and making decisions as a team; and show evidence of sitting down together and debriefing after field trips (Draft Accreditation Document 1994). In June I sent the draft curriculum out to each of the program participants for them to assess and further develop. Following is an extract from the covering letter to the District teams:

> It is amazing what we can do when the whole team is involved. This is the result of the sessions I had with the AHPO's and some of the HPO's deciding what skills and knowledge we should have at the end of a training program. Then I sat down with Gwen, Ray and Carol and we took the list of skills and knowledge, and put them into some sort of order and wrote them up in the format required by the Accreditation Board who are part of the Northern Territory Employmen and Training Authority. Once finalised and accredited the course will be equivalent to any (Advanced Certificate level) course offered at the TAFE level by NTU, or Batchelor College....
>
> Accreditation documents such as this are usually written for lecturers who use them to guide workshops. This one is different. It has to be understood by you as participants so that you can work from it and know what skills to develop, what documentation to collect and what assessment is required.
>
> **Now its your turn....**
>
> Please have a look at these draft modules and see if they;
>
> 1. are understandable: could you work from them?

2. represent what you want in the course?

Please suggest changes and additions. The format is set and so we will have to keep to this, but we can make it as 'user friendly' as possible.

The next step is for my replacement to come out ASAP and go through this document with you, to explain it and make sure it is clear and to work through any changes, additions you think need to be made. Then to begin to work with you on a plan to implement the program. You can begin to collect your documentation for assessment as well, since most of you have already completed projects which will cover many of the modules.

So far this has been a great team effort and I think we have done a wonderful job together, we have to ensure that the process continues to belong to the whole team. If you need any guidance or have any questions in the next few weeks ring Gwen, Ray or Carol (Harrison May 1994).

The process continues

The story ends here for the purposes of this research project. At this point, having sent the draft curriculum document out to each participant I went on maternity leave. The process continued on with the rest of the team firmly in control. I continued to talk to the team on the phone and provide tea and cakes whenever they came together in Darwin, and I attended some of the meetings held to continue to adapt and refine the curriculum. The pleasure of seeing the process become participatory is that it becomes part of the team and its life becomes what ever the needs of the team require.