My story of working with community-based workers

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A trip to India in my final year of university was probably the beginning of my story. I travelled to the remote village of Jamkhed in Maharashtra State with fourteen other students to undertake a three week course in Comprehensive Community Based Primary Health Care. We were the guinea pigs for this program coordinated by the Australian International Health Institute and I really had no idea what I was getting myself in for. I had been planning and saving for a trip to Nepal initially, then I saw this course advertised in India and thought "why not". So before I knew it I was on the plane for my first overseas trip and a life changing experience.

The course was amazing, I learnt so much about true grassroots Primary Health Care (PHC), but also learnt so much about myself and the world around me that I knew my life was going follow a different path from then on.

So, uni finally over I accepted a temporary contract in New South Wales and at the end of the three months I was offered a permanent position with the team. What I had to explain was that in the meantime I had applied for a job in Katherine in the Northern Territory where a PHC focused allied health team were operating, so it was time to make a decision. The decision was made, very carefully, with a pros and cons list, written up at the local brewery on a Friday night and pondered over a few beers. The time had come. I added up the pros and cons… and Katherine was the winner. Better go and get a map and find out where this town is!

The car packed to the last centimetre, I headed up north with my dad, marvelling at the barren yet rich landscape and wondering what awaited me in this town called Katherine. I was feeling a bit hesitant about it all, especially working in Aboriginal communities. The indigenous population in my town seemed to lead a separate existence to the rest of us and only one Aboriginal family attended my school, so I was totally out of my depth.

Finally we arrived in Katherine and had a look around. I'm going to live in this place?? So dad went back down south and it was into work for me. One thing I had in my favour I thought, was the PHC experience, plus I won the Clinical Excellence award at uni so I was confident I could do good work. Yet after a few trips out bush, I began throwing most things out the window. This was hard work and nothing like I had experienced before. In India the village people welcomed us, smiled at us and spoke with us, yet now going to these Aboriginal communities people were pretending they weren't home and didn't want to see us! But we were there to help, didn't they understand?

The first three months went by quickly and slowly I began to feel a bit more comfortable. It was still a great challenge to step into a community with my agenda in hand, knowing how tough it was going to be to tick off the to do list. I remember my first trip to a community by myself and still feel slightly sick at the thought. I just remember thinking "what change can I honestly make here"?

As the months rolled by I began to get the hang of bush work. I started to realise that I needed to earn people's trust and that I certainly didn't gain it automatically by nature of being a health professional. People seemed to value me spending some time talking to them and asking them about their family or their country and for me, well I loved listening to their stories and creating a big family tree in my head between the people and communities I worked in.

It was probably twelve months before I genuinely felt comfortable visiting communities. I had built relationships and thanks to my memory for names, was able to link people quickly and tell them I knew their aunty or their cousin so they knew I was okay. Although I had this new confidence, I still didn't feel like I was making much of an impression with my work and was looking for ways to improve. In India they had spoken in depth about the invaluable role of Village Health Workers, women from each of the small villages in the area who had been chosen to undertake regular health training and provide standard health care to their communities. Many of the Aboriginal Health Workers had been very helpful but they were so busy in the clinic I felt bad about asking them for assistance so frequently. Besides, I was confident with the work that I needed to do, but with seemingly simple things, like good protocol for visiting someone in

their home, I was lost. Of course my colleagues had established their methods and passed these onto me, but I still always had doubt in my mind, wondering if I was offending people.

My colleagues explained that one of our project's objectives had been to employ community-based workers (CBWs) to work with us, but that they had tried to do this in the past and it hadn't worked. We decided it was time to try again with a new strategy. Instead of posters advertising positions, we used word of mouth, telling everybody in the communities that we were looking for people to work with us. We learnt more about the roles CBWs could undertake and how we could support them and we invested a great deal of our energy in trying to make it happen until finally one day we employed a CBW. It had come about from the clinic nurse mentioning the job to a community member who he thought would be good, then advised us to follow up with this man, whose name was Anderson. We talked a lot to Anderson. We explained our work to him and asked him what his interests were. We described what was difficult for us working in communities and he confirmed what we had thought: that people were suspicious. They thought we were Centrelink mob or something!

And so it began. Each time we were visiting Anderson's community we would call him or send a message to him through the clinic to tell him that we were coming. We would pick him up and he would accompany us to visit people. The effect was almost immediate and quite amazing. When we arrived at somebody's house, Anderson would get out, talk to the person, then tell us whether it was okay to come or not. We would get out of the car and sit down together and talk, with Anderson translating when necessary. Previously, my conversations were the 'over the fence' type, brief, to the point and moving along thank you-very-much. Now with Anderson, I was sitting on people's verandahs, in their houses and spending time with them. This was great!! Our referrals increased. People would just see Anderson in the community and tell him to come and visit their uncle with the "Green Shirt Mob" next time. Word was getting around about the work we did and people were seeking our help.

Of course there were difficulties. Sometimes Anderson wasn't in the community or had family commitments. Although I was used to going it alone, once we had him onboard, spending days by myself seemed so hopeless in comparison. We visited the community quite regularly, but Anderson felt that he needed us there more to support him so he could build his confidence and skills more rapidly. Also, he was paid by the hour so the only way he could be paid at that point in time was if one of us were out in the community with him.

Honesty was essential for this partnership to work. If I had to visit someone who Anderson couldn't see for cultural reasons he would tell me. We developed a strategy for these situations whereby if we approached somebody's house and Anderson saw someone he shouldn't talk to he would say "I'm going to stay in the car here". Later he would explain. We were also flexible with what Anderson did. He enjoyed working with the old people and so we supported him to learn more in that area. He wanted to do a First Aid course, so we arranged for him to do one. He wanted to do interpreting training so we supported him to do that. His confidence grew and grew. Eventually he got to a point where he would visit the old people when we weren't in the community and call us if there were any problems. "Hey Claire when you come out you need to bring some of those rubber things for that old lady's walking stick", "Claire I think that blind man needs some help from you mob, we'll visit him when you come next"…this was what we had needed all along! We became so much more efficient simply because we were given the heads up on our clients before we even got to the community.

While all this great work was happening in Anderson's community we also employed some CBWs, which we renamed Community Co-Workers, in other communities. Again we were flexible with their interests so one CCW spent a lot of time with the women and the women's centre and another assisted a boy with muscular dystrophy with his personal care every morning before taking him to school. Some CCWs were just brilliant referrers. One old lady would sit me down and say "Now Claire, have you seen that little girl in that house over there? She's not talking you know and she's three now. I reckon you should see her." We were finding people who had slipped through the cracks of the clinics and other services and finally we were able to offer some assistance.

Having supportive clinic staff made such a difference. Mostly the clinics would help our CCWs with their timesheets and give them access to the fax and phone as necessary. They could obviously see the importance of supporting these people because essentially they were keeping a lot of community people

out of the clinic. We were very fortunate and I was glad I had invested energy into nurturing all of these partnerships.

There were some things I battled with during this time. Although we paid our CCWs a reasonable rate of $20 per hour, I felt that it wasn't fully acknowledging our partnership. As allied health professionals we were being paid more, yet our CCWs were helping to make the team so much more effective. There were also difficulties when our payments impacted on some CCWs Centrelink payments, yet we were unable to offer them full time positions. Once Anderson had been on board for a number of months, or maybe over a year, we began to pay him for 10 hours per week without us needing to be in the community with him, as he was visiting the old people each day and helping some with exercises or taking them for walks. I felt that by not employing CCWs under the same conditions as ourselves, we were undervaluing their contribution. Did my degree really make me more worthy of full time, well-paid employment than a local Indigenous person with a whole set of valuable skills?

I think maybe people would argue that yes, university graduates **are** more deserving of these employment conditions and perhaps this is one reason why courses for CBWs and allied health therapy assistants have been developed. This can provide employers with a clear idea of what the CBWs have learnt and also place them on a tangible pay scale. Yet I would still argue that it is not necessary to formally train every CBW and I actually believe that if we had made this compulsory a number of people would have withdrawn their interest. That old lady I mentioned before who was always referring people to us, didn't need to go and do a course to learn things she didn't want to do. Her contribution was so valuable, and it was her own observation and acquired understanding of what our team members did, which made her such a great referral source.

This isn't to say that we didn't provide our CCWs with any training. Usually when we were at the beginning of the employment process with a CCW we would explain what each AHP did. Then most of the other training was on the job. The occupational therapist taught Anderson some basic wheelchair maintenance for one of the old men in the community; the physiotherapist trained another CCW in car and hoist transfers for the young boy with muscular dystrophy; I worked with another CCW doing some assessments with children. When we had two students come to Katherine we used the opportunity and they were required to develop a one day training course and deliver it to the CCWs about different aspects of their respective professions. I know that the CBW courses are full of useful content, but when our CCWs were working in such specific areas of interest, I don't know that a generalist course would have assisted them more than our training. I think we need to carefully consider and consult with our CBWs before we send them off to acquire qualifications. Some people **do** want to do formal study but I really believe it should be up to the individual.

I remember that there have being lengthy discussions around the fact that the lack of a defined career path for CBWs could be a disincentive, and for some this may be the case. Yet my experience was that our CCWs were so happy to be able to help their own communities, that this is what gave them true satisfaction. And in some ways, there was a potential for progression. Our next step with Anderson was going to be for him to become a CBW trainer and select some younger people in his community to do a kind of apprenticeship with him. Unfortunately the project funding ended before this could become a reality.

Funding is another factor I battled with. The project in India had been running for thirty years when I went there. Thirty years of consultation, evaluation and modification, mistakes, lessons and reflection had contributed to the gradual, sustained health gains of this remote area. Our project was funded for three years and we were expected to find, employ, train, establish and sustain an Indigenous workforce in six remote communities. That doesn't allow much time for anything! There seems to be more talk of CBWs these days, with many programs looking to employ local people as part of their teams. Yet I would argue that before this can happen there needs to be longer-term funding agreements so that truly sustainable models can be established.

One of my dreams for our communities was for them to rally like the communities in the NPY lands and stipulate that no health professional (or any visitor for that matter) can enter the community without the company of a CCW. I had a vision of a whole team of CCWs in each community, each with their own specialty area, training young people to also become CCWs. For them to have their own building separate

to the clinic and the resources to do core health care like taking old people out bush for fishing, hunting or collecting pandanus, or running their own training programs. I dreamt of the day when I would become redundant and out of a job. I keep hoping for those days to come. And really if we don't have the dreams, how can it ever become a reality?

Presenter

Claire Salter is a speech pathologist who worked with the KRAHRS Allied Health Team during the initial three year pilot project and after an 18 month sojourn in Spain, returned to the refunded team for a further 6 months. She now works as a Project Officer for NT Hearing Services, though maintaining her interest in community-based rehabilitation and primary health care. Anderson George: has lived in Wugularr community for many years but comes from the Lake Evella region. He has worked with the KRAHRS Allied Health Team in varying capacities, but mainly as a valued Community Co-Worker. He has recently worked with Sunrise Health Service and Wugularr School, but has been kept busy with his newborn son Jacob and his interpreting studies.