

Community action to promote child growth in Gapuwiyak:

Final report on a participatory
action research project



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December 2002



Cooperative Research Centre for
Aboriginal Health



'Let Yo\u do their own sort of affair, you know what I mean? Instead of someone walking on top of it, because it's been too long. This is the time that Yo\u have to stand and talk for their own concerns, their own rights; that's how I see it. Decision-making, decision-making and saying things, that's something Yo\u have to do from here, locally from here. And it won't suit those visitors that are here for a little while, it's going to suit mostly Yo\u who are here for a long time, who live in this land and die in this land.'

(senior male community leader)

First published in 2004 by the Cooperative Research Centre for Aboriginal (CRCAH), this report details research carried out under the Cooperative Research Centre for Aboriginal and Tropical Health which wound up in June 2003.

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Smith, D., 2004, Community action to promote child growth in Gapuwiyak: Final report on a participatory action research project, Cooperative Research Centre for Aboriginal Health, Darwin.

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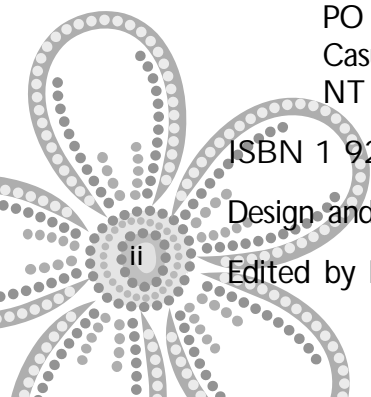
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PO Box 41096
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ISBN 1 920969 01 2

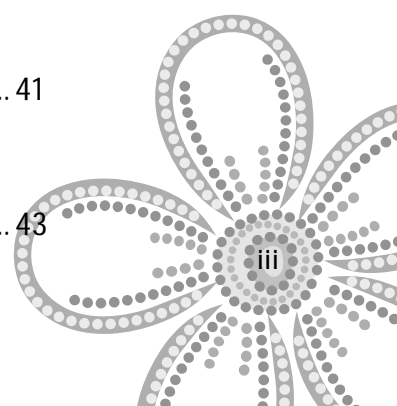
Design and layout by Sarah Walton, CRCAH

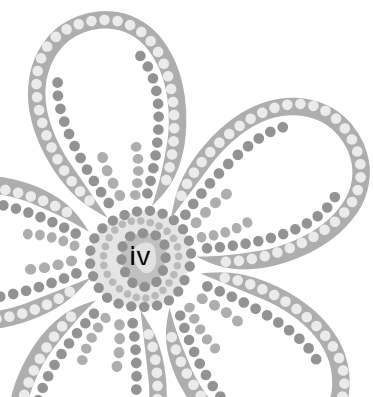
Edited by Michael Duffy, CRCAH



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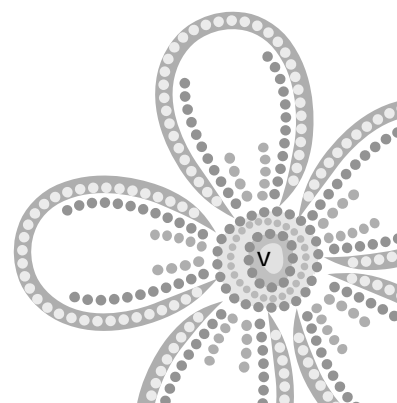
Acknowledgments

The Child Growth Project was made possible through research funding from the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH), a CRCATH scholarship for postgraduate study and in-kind support from the Department of Health and Community Services. Menzies School of Health Research and the Northern Territory University provided further in-kind support and the CRCATH also funded the writing, editing and publication of this document.

Thanks to Gapuwiyak Community Incorporated, Gapuwiyak Yol\u Project Committee, Gapuwiyak Health Centre, Gapuwiyak Women's Centre, Gapuwiyak Community Education Centre and the people of Gapuwiyak who participated in the project. Thanks also to Dr Jeannie Devitt, Dr Colin MacDougall and Professor Fran Baum for their involvement in and support of this research project.

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Implications of this research

The 'Improving Child Growth in the Northern Territory (NT) Project' demonstrates that a community development approach can support Indigenous people in a remote NT community to develop and implement strategies that aim to improve their health. Indigenous community members in Gapuwiyak, a north-east Arnhem Land community, collectively applied their extensive knowledge of their children's development to negotiate a Family Centre strategy. The strengths of their strategy are:

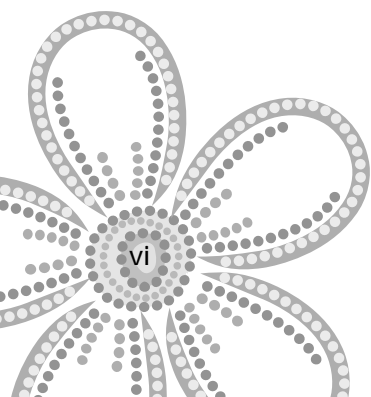
- its basis in Indigenous understandings of poor child development, which are significantly different from those of health professionals; and
- the fact that it takes into account Indigenous social and cultural values and processes.

The Child Growth Project also contributed to individual and community capacity strengthening and empowerment, both of which have the potential to foster improved health.

This research demonstrates that it is vital to address a health issue of concern to Indigenous community members if they are to be involved in promoting their own health. The Department of Health and Community Services' (DHCS) Growth Assessment and Action (GAA) program aimed to involve Indigenous people in improving the physical growth of their children, through growth monitoring and promotion. Gapuwiyak community members, however, had a limited understanding of the program and limited concern about the specific health issue of poor physical growth. The Department and other health agencies may be more successful in engaging Indigenous people in promoting their health if they involve Indigenous peoples in all stages of defining health priorities and then in designing and implementing health programs.

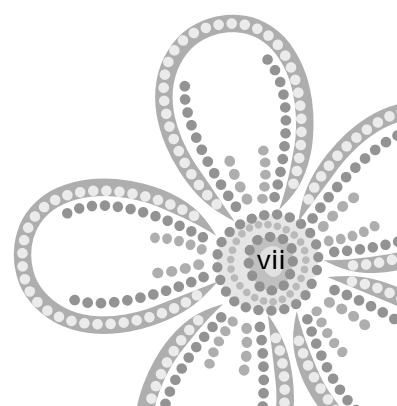
Involving Indigenous people in acting to promote their health is a complex and long-term process, particularly given the pervasive historical and contemporary practice of non-Indigenous people tackling indigenous 'problems'. The Child Growth Project has four key lessons for community development in health in remote Indigenous Australia:

1. Unequal power relations are central to interactions between Indigenous and non-Indigenous participants in community development processes.
2. Indigenous and non-Indigenous participants bring different social and cultural values to the interactions and may have no shared understandings of key constructs, among them appropriate timeframes and decision-making processes.
3. Many remote Indigenous communities are experiencing rapid social and cultural change, which increases the complexity of using a community development approach.
4. The organisation and delivery of health services by a large centralized bureaucracy with a selective primary health care approach undermines the use of a community development approach.



This research also has important implications for increasing the value of a community development approach to improving health in the remote Indigenous Australian setting, which are:

- Comprehensive needs assessment processes would maximize community participation from the outset and promote the likelihood that a comparative community concern is identified.
- The capacity of both Indigenous community members and external agents to facilitate community development processes would be strengthened by appropriate training in community development skills and processes. Critical to successful collaboration between local Indigenous facilitators and people from outside who are non-Indigenous is that they respectfully negotiate their social and cultural differences and that the latter adopt a supporting 'power with' approach.
- Health agencies would enhance the value of the community development approach by adopting and implementing a comprehensive, rather than a selective, primary health care approach.



Executive summary

This report describes the 'Improving Child Growth in the Northern Territory (NT) Project'¹. The Department of Health and Community Services (DHCS) initiated this participatory action research project with funding from the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH). The project was conducted using a community development approach over a two and a half year period, from 2000 to 2002, in the remote north-east Arnhem Land community of Gapuwiyak.

A team consisting of a project leader, a Balanda² or non-Indigenous paediatrician employed by DHCS, a Yol\u project adviser, a Balanda project officer who was a PhD student in public health and several Yol\u community-based researchers facilitated the community development process.³ This report discusses the process used, the outcomes achieved and the lessons learnt about using a community development approach to improve health in a remote Indigenous community setting.

Background

Poor Indigenous child growth is a serious health issue in the NT (Ruben and Walker, 1995; d'Espaignet, Kennedy *et al* 1998; Paterson, Edmond *et al* 2001). In 1998, the then Territory Health Services (THCS - now DHCS) began implementing a new child growth initiative, the Growth Assessment and Action (GAA) program. The program sought to achieve growth monitoring and promotion (GMP), standardise primary health care practices and improve the growth of NT children aged between zero and five years.

The focus of the GAA program is Indigenous children in rural and remote areas of the NT, because of their disproportionately poorer health status (THS 1997, p1). DHCS service providers have subsequently identified four deficiencies in the implementation of the GAA program in the Indigenous context in the Top End⁴:

- insufficient involvement of families and communities;
- poor understanding by service providers of social and cultural issues impacting on Indigenous children's growth;
- inadequate understanding by both families and service providers of growth monitoring and promotion; and
- the lack of guidelines for promoting effective community action.

1. Subsequently referred to as the Child Growth Report.

2. 'Yol\u' is the term used by the people of north-east Arnhem Land to describe themselves and 'Balanda' is the term they use for non-Indigenous people. It is believed to derive from the word for 'Hollander' used by the Macassans, who visited Arnhem Land from the 17th Century. The '\u' symbol signifies a nasal 'ng' sound, such as we find in the English word 'sing'. The languages of the Yol\u clans may be collectively referred to as Yol\u-matha - meaning 'Yol\u tongue'.

3. The original project leader - Karen Edmond - left DHCS in 2001. The role was briefly filled by Barbara Paterson and then by Alan Ruben; both are DHCS paediatricians. Their involvement focused on project administration and neither visited Gapuwiyak or were involved in project implementation. Dr Ruben was, however, centrally involved in analyzing the quantitative data.

4. The 'Top End' includes the NT Government's administrative regions of Darwin Urban, Darwin Rural, Katherine and East Arnhem.

In mid-1998 a group of Yol\u women from Gapuwiyak, expressing concern about poor child growth in their community to the visiting DHCS paediatrician, said they wanted to take some action to deal with the issue. The Department and Gapuwiyak community members subsequently agreed to conduct a project that would investigate both the problem of poor child growth in Gapuwiyak and the identified deficiencies in the GAA program.

The aim of the Child Growth Project was to improve the growth of Indigenous children in the NT, with these specific objectives:

- to increase family and community involvement in child growth promotion;
- to improve the GAA program in Gapuwiyak according to the following indicators:
 - increased understanding by health service providers of specific socio-cultural factors influencing child growth
 - increased understanding by health service providers and families of GMP
 - increased community action to promote growth
- to improve the growth of children in Gapuwiyak;
- to document the community development process, the social and cultural issues affecting child growth and the specific community action strategies; and
- to use this study to improve the GAA program across the NT.

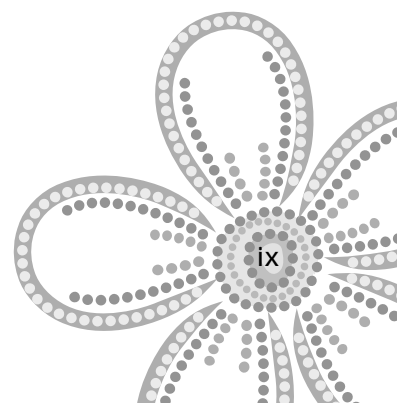
Methods and project process

Based on a review of the relevant literature and recognizing the expressed desire of Yol\u community members to work collaboratively to address the problem of child growth in Gapuwiyak, a community development approach in a participatory action framework was selected as an appropriate method.

Most of the data were collected by qualitative research methods, including semi-structured interviews, group discussions, photographic interpretations (photovoice) and participant observation. Quantitative methods were used to collect children's weights from their medical records at the clinic. The data were analysed and the findings were fed back to community members throughout the project.

The key phases of the Child growth project were:

- mid-1998-Dec 1999: community consultation and project development
- Feb-Apr 2000: informing community about the project
- Apr-Aug 2000: community members and clinic staff assessing 'the problem'
- Sep-Dec 2000: developing and deciding on an action strategy
- Jan-Jun 2001: limited progress
- Jul 2001-Jun 2002: critical reflection and action
- Jun 2002 onwards: continuing work.



Results

Increased family and community involvement in child growth promotion

The project fostered an increase in the quality and extent to which the Yol\u community was involved in child growth promotion. Community members participated in assessing the 'problem' of poor child growth and potential action and then in developing and implementing action strategies, mobilizing resources, forming partnerships and critically reflecting on their actions.

The Yol\u project committee, a community initiative which sustained its activities during and after the project, is further evidence of increased community involvement. This involvement resulted in the development and partial implementation of a health intervention and contributed to individual and community empowerment.

Improved GAA program in Gapuwiyak

This report assesses improvements to the GAA program in Gapuwiyak on three bases:

1. Increased understanding by health service providers of specific socio-cultural factors influencing child growth.
2. Increased understanding by health service providers and families of growth monitoring and promotion (GMP).
3. Increased community action to promote child growth.

Increased understanding by health service providers of specific socio-cultural factors affecting child growth

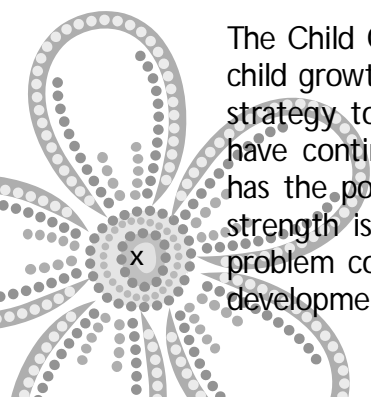
Health service providers in Gapuwiyak engaged with Yol\u community members about the issue of poor child growth through their involvement in the project. Participants from both groups assessed 'the problem' and discussed potential strategies to improve the growth of Gapuwiyak children. This involvement is likely to have increased health service providers' understanding of these factors, but the high turnover of Gapuwiyak clinic staff during the project period may have limited this desirable impact.

Increased understanding by health service providers and families of growth monitoring and promotion (GMP)

This became less of a project focus once it emerged that poor physical child growth was *not* a key concern of either group. Few Yol\u or clinic participants expressed an interest in learning more about either GMP or the GAA program. Yol\u participants, however, expressed significant concern about poor child *development* as a result of inadequate care. The project team responded to this expressed concern with a flexibility that is appropriate to a participatory action research (PAR) approach. The project focus then shifted from physical child growth and GMP to supporting Yol\u to address the problem they had identified with their own solution. The Yol\u action strategy, however, has the potential to increase understanding of GMP once it is fully implemented.

Increased community action to promote child growth

The Child Growth project fostered a significant increase in community action to promote child growth. Yol\u used their knowledge to assess 'the problem' and to develop an action strategy to deal with it. They then worked collectively to implement their strategy and have continued to do so after the project was completed. The Family Centre strategy has the potential to improve the growth and development of children in Gapuwiyak. Its strength is its basis in Yol\u understandings of child growth and it seeks to address the problem community members identified: children being inadequately cared for and their development needs being unmet.



The strategy also aims to improve child development in a way that takes into account the rapid social and cultural change in the community and at the same time incorporates continuing respect for Yol\u values. The decision-making process is another strength of the strategy. Council and clan leader involvement in the process has given the strategy legitimacy as a 'community' intervention. The Family Centre strategy should continue to be evaluated as it is fully implemented to assess whether it is contributing to improved child growth and development.

The physical growth of Gapuwiyak children

Our data suggest a substantial number of Gapuwiyak children remained underweight throughout the project period. We were unable to demonstrate a measurable improvement between February 2000 and December 2001 in the physical growth of children aged less than five years. It is important to note that this was largely due to inadequate timeframes, which meant that we stopped collecting quantitative data at the point at which community action to promote child growth began (December 2001). Nor are our findings consistent with information presented in DHCS' routine GAA reports for Gapuwiyak during this period. Contrary to our data, these show a significant improvement in child growth according to weight between April 2000 and October 2001. It is therefore not possible to be conclusive about the growth patterns of Gapuwiyak children during the project period. Continuing assessment as the Family Centre strategy is fully implemented will be the key to assessing whether it has contributed to improved growth for Gapuwiyak children.

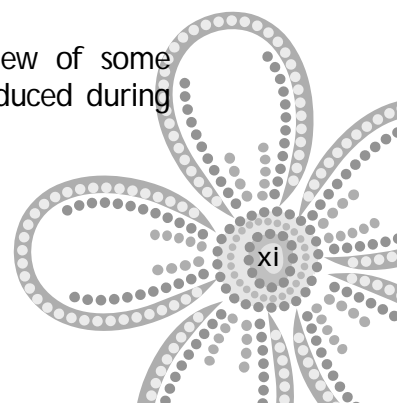
Discussion

This research has identified key factors that affected the value of the Child Growth Project's community development approach. Factors contributing to the project's success included:

- Yol\u community members assessing 'the problem' and applying Yol\u knowledge to address it;
- the Yol\u project committee collectively developing and implementing an action strategy;
- the employment of Yol\u community members to work on the project; and
- Balanda team members adopting a partnership approach and developing trusting relationships.

These factors constrained this approach in achieving its potential:

- limited community involvement in issue selection and project design;
- significantly different understandings between Yol\u and clinic staff of 'the problem' and its 'solution';
- limited sense of 'community' and strong sense of 'family' and 'individual';
- complex and lengthy decision-making process arising from different values and structures; and
- inadequate timeframes for the project, compounded by the view of some health service providers that measurable outcomes *would* be produced during the project period.



The Child Growth Project has four important lessons for community development in health in remote Indigenous Australia:

1. Power inequalities are central to all interactions between Indigenous and non-Indigenous participants in community development processes.
2. Both Indigenous and non-Indigenous participants bring different social and cultural values to the interactions and may have no shared understandings of key constructs such as appropriate timeframes and decision-making processes.
3. Many remote Indigenous communities are experiencing rapid social and cultural change, which increases the complexity of using a community development approach.
4. The organisation and delivery of health services by a large centralized bureaucracy with a selective primary health care approach undermines the use of a community development approach that seeks to increase Indigenous community involvement and empowerment.

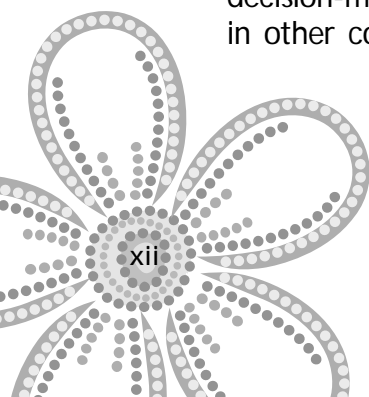
Conclusion and recommendations

The Child Growth Project has important implications for policy and practice. Significant successes have been achieved in Gapuwiyak and DHCS and CRCATH should continue to support community members in working towards the full implementation of their Family Centre strategy. The effects of the project in improving the development of Gapuwiyak children and contributing to community empowerment should be monitored through a continuation of the participatory action research process. This is particularly important as the original project timeline was unrealistic, which meant it was not possible to assess whether the community's action strategy contributed to improved child growth and development.

This research suggests that the GAA program be reviewed in the light of some of its findings, among them that:

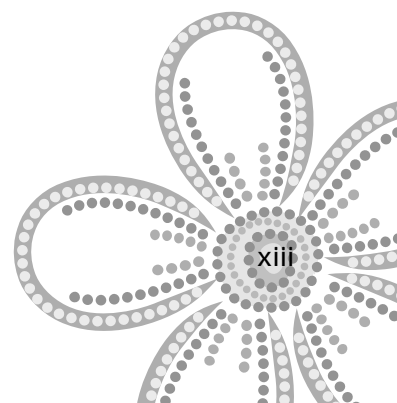
- a broader concept of child growth - beyond the physical growth - may be more useful in Indigenous communities;
- clinic staff and community members need to develop shared understandings of and complementary approaches to child growth and development;
- clinic staff and community members have limited understanding of the GAA program; and
- the GAA program's current focus is on growth *assessment*, rather than on *action*.

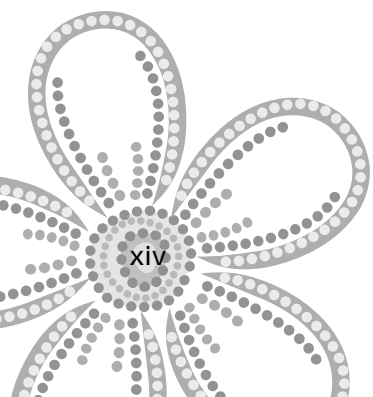
The community development approach used in Gapuwiyak may be applied in the NT's other remote Indigenous communities to address health and other issues. Aspects of the process - among them the employment of a project officer and Indigenous project workers, problem assessment, the formation of an Indigenous committee, community decision-making and critical reflection - should be applied and tested for transferability in other communities.



The value of applying community development approaches in other remote Indigenous communities would be increased by:

- engaging Indigenous community members in determining their health priorities through comprehensive needs assessment processes;
- strengthening the capacity of Indigenous community members in community development skills and processes, so they can support their communities to promote health;
- strengthening the capacity of external community development workers and health professionals to facilitate community development processes in collaboration with local Indigenous workers; and
- health agencies such as DHCS adopting and implementing a comprehensive primary health care approach.





Introduction

Aims and structure

This report documents:

- the methodology and process used to increase family and community involvement in the development and implementation of growth action strategies;
- the outcomes of the Child Growth Project and the factors that affected these outcomes; and
- conclusions of and recommendations from the research.

This report is based on a literature review and on the project team's involvement in implementing and evaluating the Child Growth Project. It is primarily aimed at DHCS health service providers involved in the GAA program, but is also intended for other health service providers, the CRCATH and organizations seeking to foster community involvement in improving Indigenous health. It is hoped this report will be used to inform the GAA program, the development of future program and service delivery and continuing research into the health of Indigenous children. It can also be used more generally to inform community development approaches to improving health in remote Indigenous community settings.

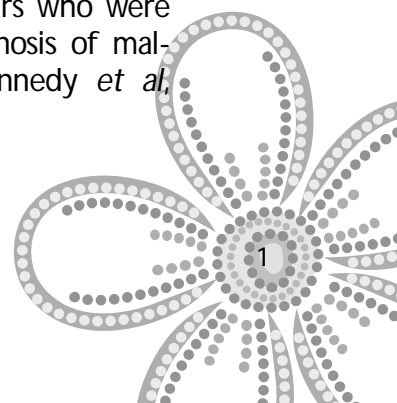
Following this section's description of the research problem, the project aims and the study setting, 'The Community Development Approach' reviews the literature that informed the selection of community development as the project approach and defines 'community development' and its core concepts. A description of the research methodology is followed by a discussion of the project process. The report goes on to examine the results of the project and key factors affecting the community development approach before setting out conclusions and recommendations.

The research problem

Poor growth in Indigenous children is a serious health issue in the Northern Territory (Ruben and Walker, 1995; d'Espaignet, Kennedy *et al*, 1998; Paterson, Edmond *et al*, 2001). Studies in a number of remote NT communities between 1995 and 1998 suggest that:

- between four and eight per cent of Indigenous children under five years of age were wasted (too thin in relation to height);
- between 15 and 17 per cent were stunted (too short in relation to age); and
- between 13 and 22 per cent were underweight (Paterson, Edmond *et al*, 2001).

In comparison, three per cent of all children in Australia are underweight (THS, 2000). Between 1993 and 1997, Indigenous children aged between one and five years who were admitted to hospital in the NT were 120 times more likely to have a diagnosis of malnutrition than non-Indigenous children of the same age (d'Espaignet, Kennedy *et al*, 1998).



The health consequences of under-nutrition in children are an increased susceptibility to infections and delayed physical and intellectual development (d'Espaignet, Kennedy *et al*, 1998; Paterson, Edmond *et al*, 1998). The health and wellbeing of children in the perinatal period and in childhood directly influence health in adulthood (d'Espaignet, Kennedy *et al*, 1998). Evidence has linked low birth weight and poor nutrition in early childhood with chronic diseases, including heart disease, kidney disease and diabetes, in adult life (Paterson, Edmond *et al*, 2001).

Causes of malnutrition described in the health literature include:

- social and economic inequalities;
- cost and availability of food;
- high prevalence of infectious diseases; and
- inadequate access to effective primary health care services (Gracey, 1991; Munoz, Powers *et al*, 1992; Scrimgeour, 1997; d'Espaignet, Kennedy *et al*, 1998; Price and McComb, 1998; NHMRC, 2000).

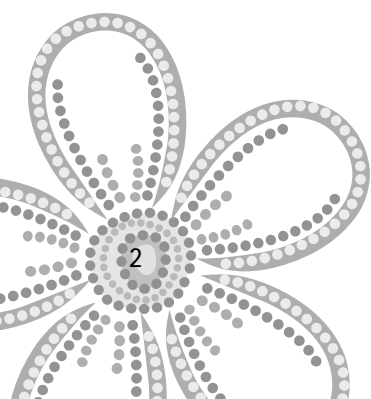
In 1998, DHCS began implementing a new child growth initiative, called the Growth Assessment and Action (GAA) program, which sought to:

- achieve growth monitoring and promotion (GMP);
- standardize primary health care practices; and
- improve the growth of children in the NT aged between zero and five years of age (THS, 1997).

The focus of the GAA program is Aboriginal children in rural and remote areas of the Northern Territory because of their disproportionately poorer health status (THS, 1997). DHCS has, however, subsequently identified four deficiencies in the implementation of the program in the Indigenous context in the Territory's Top End:

1. Insufficient involvement of families and communities.
2. Poor understanding by health service providers of social and cultural issues impacting on Indigenous children's growth.
3. Inadequate understanding by both families and health service providers of growth monitoring and promotion.
4. The lack of guidelines for promoting effective community action (CRCATH Child growth Project proposal 1999).

In mid-1998 a group of Yol\u women from Gapuwiyak, expressing concern about poor child growth in their community to the visiting DHCS paediatrician, said they wanted to take some action to deal with the issue. The Department and Gapuwiyak community members subsequently agreed to conduct a project that would investigate both the problem of poor child growth in Gapuwiyak and the identified deficiencies in the GAA program.



Project aims

The stated aim of the Child growth Project was to improve the growth of Indigenous children in Northern Territory, with these specific objectives:

- to increase family and community involvement in child growth promotion;
- to improve the GAA program in Gapuwiyak according to the following indicators:
 - increased understanding by health service providers of specific socio-cultural factors influencing child growth
 - increased understanding by health service providers and families of GMP
 - increased community action to promote growth
- to improve the growth of children in Gapuwiyak;
- to document the community development process, the social and cultural issues affecting child growth and the specific community action strategies; and
- to use this study to improve the GAA program across the NT⁵.

Gapuwiyak community

Gapuwiyak is a remote community in north-east Arnhem Land, Northern Territory. It was established as a community by Methodist missionaries and Yol\u leaders from the area in 1969 and is also known as Lake Evella. The community has subsequently grown and changed considerably from its beginnings. Around 800 people now live there, several hundred of whom spend [part of the year living on nearby outstations. Yol\u society in Gapuwiyak continues to be organized around patrilineal family descent groups (Toner, 2001). There are currently more than twelve family groups, or clans, represented in significant numbers in Gapuwiyak, although most of the people in the community belong to Marra\u, Guyula, Djambarrpuy\u and Wagilak clans in the Dhuwa moiety⁶ or Dhalwa\u, Ritharr\u, Birrkili, Gupapuy\u and Madarrpa in the Yirritja moiety (Toner, 2001).

Gapuwiyak has a local government council and its infrastructure includes a school, women's centre, health centre, Arnhem Land Progress Association (ALPA) store, Traditional Credit Union agency and workshop. There is also an oval and a basketball court. The council, Gapuwiyak Community Incorporated⁷, receives Government funding to provide a range of services both in the community and to the outstations. It has 12 elected members and employs Yol\u and Balanda staff, working under a Yol\u Town Clerk. DHCS and Miwatj Aboriginal Health Service - the regional Aboriginal community-controlled health service - provide health services. Around 50 Balanda are employed in the community in administrative, managerial, technical and service delivery roles.

In common with other remote Indigenous communities in the NT, Gapuwiyak's population has low levels of income, employment and education. Health is also poor in the community. Poverty, unemployment and rapid social change have contributed to the emergence of social problems, among them gambling and substance abuse.

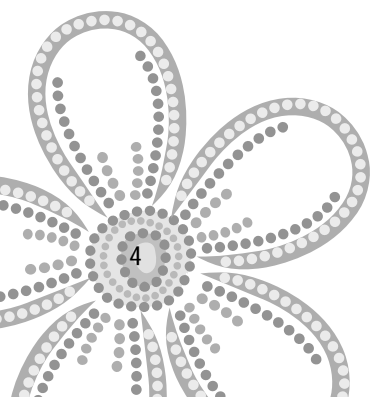
5. These objectives were not changed during the research despite the project evolving during implementation, but they should have been revisited and revised as part of the PAR process.

6. In Yol\u society everything - individuals, groups of people, country, ancestors, species and sacred objects - is categorized as belonging to one of the two complementary moieties (Keen, 1994).

7. Referred to hereafter as 'the Council' or 'Gapuwiyak Council'.

Many Yo\u spend much of their time meeting their basic needs: organizing social security payments and waiting at the Traditional Credit Union to withdraw money for shopping for food at the store, visiting and spending time with the extended family and fulfilling socio-cultural obligations. Many community members spend a great deal of time organizing and attending ceremonies - funerals, men's initiation ceremonies - that occur on a regular basis.

Some community members are engaged in full-time work, although there are few jobs that provide 'proper pay' and the Community Development Employment Program (CDEP) payments do not appear to provide much incentive to work. Some community members spend a great deal of time gambling at cards and drinking kava, which many Yo\u described as significant social problems. So too they described marijuana and alcohol use, which on occasion lead to violence and social disruption.



The community development approach

Rationale for selecting a community development approach

Literature relevant to the research problem and its context informed the selection of a community development approach. The four literature sets reviewed were:

- growth monitoring and promotion (GMP)
- primary health care and public health
- social determinants of health
- Indigenous self-determination.

The importance to improving health of increasing individual and community involvement, control and empowerment are common themes in these literatures.

The growth monitoring and promotion literature

The GMP literature suggested a community development approach had the potential to address the four identified deficiencies in the department's GAA program and to improve child growth in Gapuwiyak. One of the identified deficiencies was insufficient involvement of families and communities in the program. The literature stresses that involvement is central to effective GMP (Drummond, 1975; Latham, 1992; UNICEF, 1990; Cervinkas, Gerein *et al*, 1992; Bravenman and Tarimo, 1994) and that involvement has the potential to reduce power inequalities between health service providers and recipients of those services, as well as contributing to empowerment (Latham, 1992). Community development approaches are centrally concerned with raising the level of involvement.

The second deficiency identified in the GAA program was the poor understanding by health service providers of the social and cultural factors impacting on Indigenous children's growth. Social context provides an important basis for effective cross-cultural growth programs (Pelto, 1987; Cervinkas, Gerein *et al*, 1992; Taylor and Mercer, 1993; Cassidy, 1994) and health professionals require a good understanding of existing child-raising practices and the community's cultural, social and dietary environment (Harrison, 1992; Latham, 1992). As a community development approach involves local people generating knowledge about an issue through the process of problem assessment, it was seen to have the potential to make explicit Yolŋu knowledge about the factors affecting their children's growth.

An inadequate understanding of GMP by both health service providers and families was the third key deficiency in the GAA program. It is central to the effectiveness of GMP as a strategy for improving child growth that both groups understand GMP (Drummond, 1975; Cervinkas, Gerein *et al*, 1992; Hall, 1996). The process of problem assessment associated with the community development approach had the potential to:

- indicate the extent of the two groups' understandings of GMP;
- assist in identifying more appropriate ways of educating people about GMP if those involved considered their understanding to be lacking; and
- increase the knowledge of participants about GMP by discussing poor child growth and possible solutions.

Finally, the GMP literature emphasizes that community action is essential to GMP in improving child growth, because growth monitoring *without* such action does not improve children's nutritional status (UNICEF, 1990; Cervinskas, Gerein et al, 1992; George, Latham et al, 1993; Bravenman and Tarimo, 1994). The GAA program placed increased emphasis on growth promotion action (THS, 1997), but it did *not* include guidelines for supporting communities to develop and implement growth promotion action strategies. Facilitating community action to address problems is central to community development.

Primary health care and public health literature

Community development is an approach that currently has wide appeal in public health, both in Australia and overseas (Petersen, 1994; Baum, 1998). The increasing popularity of the approach in health in Australia reflects the emergence of participation, empowerment and capacity as key concepts in improving health in the international context. The 1978 Alma Ata Declaration articulated the importance of local people participating in the planning and implementation of their own health care. The declaration advocated a primary health care (PHC) strategy, described as:

...essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (WHO, 1978, para 6).

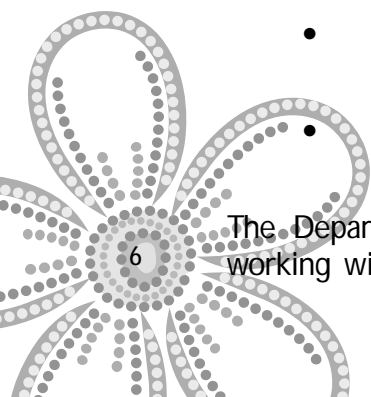
Individual and community participation in the 'planning, organisation, operation and control of primary health care' is one of the key [principles of effective Primary Health Care (WHO, 1978, para 7 part E). The importance of community participation and empowerment was also emphasized in the 1986 Ottawa Charter for Health Promotion. One of the Charter's five strategies - the strategy for strengthening community action - describes 'community development as 'those activities that increase the ability of communities to achieve change in their physical and social environments through collective organizations and taking of action (WHO, 1986)'.

The Ottawa Charter became the foundation of the 'new' public health, which has been embraced in Australia since the mid-1980s (Baum, 1998). The new public health's focus is on health promotion strategies, such as introducing more social interventions, community participation and policy change, rather than on medicine and on behavioural change. The popularity and credibility of community development has continued to grow in recent years and there has been considerable interest in community development strategies (Petersen, 1994; Onyx, 1996; Baum, 1998).

Community development has also been recognised as a potentially useful approach for addressing Indigenous health issues, both in Australia and internationally (Feather, Irvine et al, 1993; Labonte, 1993; Biven, 2000; Ife, 2002). The Commonwealth Department of Health and Ageing's Office of Aboriginal and Torres Strait Islander Health (OATSIH) (2001, p11) and the National Health and Medical Research Council (NHMRC) (2000) support the use of community development approaches to improve health in Indigenous contexts. DHCS also subscribes to the community development principles of:

- increasing participation of Aboriginal people in the decision-making and operational processes of the health system; and
- community control of, and responsibility for, the provision of community-based health care services (THS, 1996).

The Department explicitly describes community development as a useful strategy for working with communities to promote health (THS, 1999, Ch 3, p48).



Recent social determinants of health literature

The growing body of literature on the social and economic determinants of health also informed the selection of a community development approach. It has long been accepted that poverty is powerfully predictive of poor health, as people of low socio-economic status generally lack the finance, knowledge and skills to acquire the prerequisites of good health (Marmot, 2000). Research is increasingly suggesting that psychosocial factors associated with relative disadvantage act in addition to the direct effects of material living standards (Marmot and Wilkinson, 2001).

A 'lack of control', which can occur at the social level, has been shown to contribute to poor health outcomes (Bobak, Pikhart *et al*, 2000; Marmot 2000). This is not 'news' to Indigenous Australians (Devitt, Hall *et al*, 2001) and Indigenous leaders like Professor Lowitja O'Donoghue have argued this point for some years:

The disempowerment of Aboriginal and Torres Strait Islander peoples, as a result of the colonial occupation and the subsequent oppression of Indigenous Australia, is the fundamental root of contemporary Aboriginal and Torres Strait Islander ill-health (O'Donoghue 1997, cited in Scrimgeour, 1997, p79).

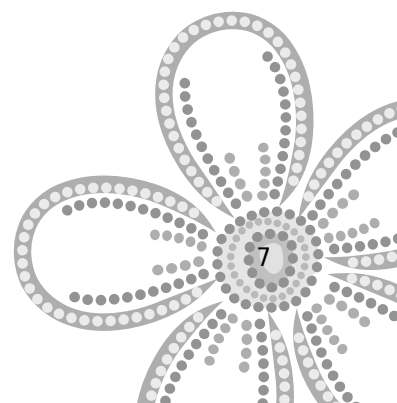
Non-Indigenous activists, medical practitioners and researchers have also identified social inequality and powerlessness as the key issue in Aboriginal wellbeing, which term is taken to include health (Devitt, Hall *et al* 2001). A community development approach seeks to foster individual and community control through increased involvement and empowerment.

Indigenous self-determination literature

The selection of a community development approach was also informed by the Indigenous self-determination movement. Since the 1960s some progress has been made towards 'self-determination', including the establishment of Aboriginal Community Controlled Health Services (ACCHS) (Scrimgeour, 1997). Self-determination is central to Indigenous people seeking to control their own health services, as is evident in the following statement from a leading ACCHS, Central Australian Aboriginal Congress (CAAC):

Our struggle for the control of our organizations is our fundamental human right. The only proper way is the Aboriginal way. Aboriginal control is the most important thing. If that is organized first and we are given resources and freedom to control the services that we supply to our people then the rest will follow naturally (cited in Scrimgeour, 1997, p80).

Indigenous Australians continue to fight for self-determination and demand the right to greater control over, responsibility for and independence in their own lives and communities (Pritchard, 2000). While a one-off research project does not have the same potential to improve Indigenous health as realizing self-determination does, using a community development approach nevertheless supports local people as the primary agents of social change in their communities. Further, the ACCHSs have themselves used community development approaches since the 1970s and continue to advocate their use (Bell, 1996).



Defining a community development approach

Community development concepts

There is a great deal of confusion and contention in the literature about the term 'community development' and its constituent concepts of 'community', 'participation', 'involvement', 'power', 'capacity' and 'empowerment'. Definitions which the Child Growth Project adopted were informed by a review of community development in the health literature.

A community development approach involved the project team in a process that increases community involvement in:

- identifying and defining health needs;
- suggesting new solutions;
- mobilizing local resources;
- developing and implementing community solutions; and
- creating and maintaining local organizations to improve the GAA program and the growth of children, as well as increasing community empowerment (see Labonte, 1993, 1994).

Community was defined in the project proposal as 'all people currently residing in Gapuwiyak community, including service providers'.

Community participation/involvement were taken to have the same meaning: a social process whereby specific groups with shared needs, living in a defined geographical area, actively pursue identification of their needs, take decisions and establish mechanisms to meet those needs (Oakley, 1989; Cornwall and Jukes, 1995).

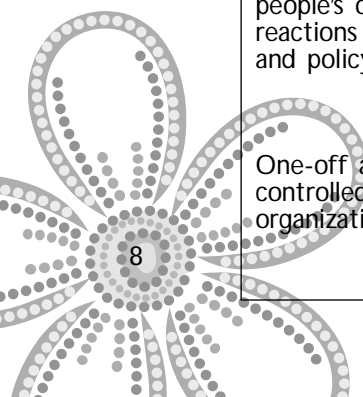
The health development literature describes two types of participation:

- participation as a 'means' - ensuring local people's cooperation/collaboration with externally introduced programs or processes to facilitate the effective implementation of such initiatives and to achieve a set of objectives; and
- participation as an 'end' - the empowerment of people to take greater responsibility for their development through their acquisition of skills, knowledge and experience.

Baum (1998, p326) describes four categories of participation in public health that form a continuum (see Table 2.1).

Table 2.1: A continuum of participation for the new public health

Consultation	Marginal participation	Substantive participation	Structural participation
Organisations outside the community seek people's opinions and reactions to services and policy plans. One-off activity controlled by the organization.	Organisations outside the community seek limited one-off participation to achieve a defined end according to its agenda. May lead to more developmental participation, but not the initial aim.	People actively involved in determining priorities and carrying out activities, but the initiative externally controlled. Usually some shift in power to the community and may lead to structural participation	Community members play an active and direct part in the initiative; community control predominates. Initiative may come from outside but control handed to the community.



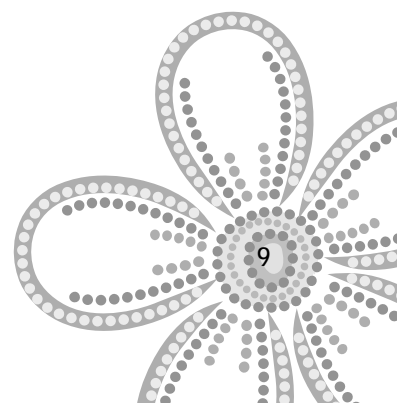
Power refers to 'the ability to affect change, not the power to exploit or dominate others' (Ife, 2002). This research drew on a structural view of power as being influenced by oppression and structural inequality, as well as on a post-structural view of power being influenced by the control of discourses and the construction of knowledge (Baum, 1998; Ife, 2002).

Empowerment and capacity, Labonte (1999, p430) argues, are very similar concepts. Empowerment is 'personal, group and social aspects of power and capacity ranging from leadership, resources and strengthened networks to critical thinking, trusting relationships and increased group participation. Community capacity he defines as 'the set of assets or strengths that residents individually bring to the cause of improving local quality of life...skill and knowledge, leadership, a sense of efficacy, norms of trust and reciprocity, social networks and a culture of openness and learning'.

'Empowerment' was the term primarily used in this research, as it is a cornerstone of public health and represents power as the defining issue. Empowerment can operate at the level of the individual, the organization or the community (Israel, Checkoway *et al*, 1994). Laverack (2001) describes nine 'operational domains' which influence process of community empowerment in a community development program/project context. These are:

- participation
- leadership
- organizational structures
- problem assessment
- resource mobilization
- asking 'why'
- links with other people and organizations
- the role of outside agents
- program management.

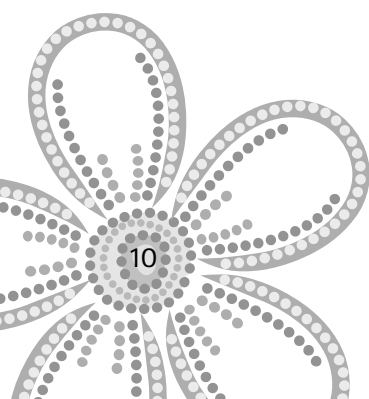
This framework is used later in the discussion on the community development process to unpack the complexities of the process and to identify the factors that affected the use of the approach and its overall value.



Strengths and criticisms of community development approaches

Table 2.2: Strengths and criticisms of community development approaches

Strengths	Criticisms
<p>Increased efficiency as people more likely to be convinced of benefits of initiatives they helped develop and local involvement reduces amount of time needed by paid professional staff.</p> <p>Can make initiatives more effective by allowing people to have a voice in deciding on objectives, supporting project administration and making their local knowledge, skills and resources available.</p> <p>Participating can help break dependency, promote self-awareness and confidence, and teach people how to plan and implement, and increase people's sense of control over issues</p> <p>Offer a way of working with people who are the least healthy.</p> <p>The chances of an initiative being sustainable are increased as local people are the main dynamic (Oakley, 1991).</p>	<p>Lack of accountability for state funding, the potential for social divisiveness in political activism and the apparent waste of resources (Onyx, 1996).</p> <p>Community projects lack continuity and have no assured means of sustaining what they set in motion (Kelly and Sewell, 1988).</p> <p>Emphasising local decision-making diverts attention from the fact that most economic and social policy is national and transnational in nature and does not address the role of the state in creating unhealthy conditions (Labonte, 1994; Petersen, 1994; Baum, 1998).</p> <p>Have been used in health to impose the beliefs of professional groups or politicians, rather than to promote empowerment (Wass, 2000).</p> <p>Have been used in the Indigenous Australian setting to:</p> <ul style="list-style-type: none"> • co-opt Indigenous communities; • save money; • avoid responsibilities to Indigenous people; and • foster economic development. <p>(Wolfe, 1989; Mowbray, 1994; Hollinsworth, 1996; Martin, 2001a)</p>



Research methodology

The participatory action research framework

The Child Growth Project used a participatory action research (PAR) framework because it was compatible with the community development approach. In contrast to conventional research, the emphasis in PAR is on a 'bottom up' approach, with local people:

- defining the research;
- identifying problems;
- analysing potential causes;
- acting to improve the problems;
- then reflecting; and
- implementing further actions (Cornwall and Jewkes, 1995).

Community development involves a similar process, the key difference being that PAR involves systematic investigation for the specific purpose of generating knowledge (George, Green *et al*, 1996). PAR has been described as being appropriate for use in the public health context (George, Green *et al*, 1996; George, Daniel *et al*, 1998-99; Minkler, 2000) and particularly in the area of Indigenous health research, both internationally (Herbert, 1996; Davis and Reid, 1999) and in Australia (Hecker, 1997; Baum 1998).

PAR seeks to achieve two main objectives by encouraging the full and active participation of local people in research:

1. to produce knowledge and action that is directly useful to communities; and
2. to facilitate the empowerment of people through the process of constructing and using their own knowledge (George, Daniel *et al*, 1998-99).

These objectives reflect community development's objectives of increasing participation as a 'means' and an 'end'.

Research methods

The majority of data were collected by the research team using qualitative research methods, including:

- semi-structured interviews;
- group discussions;
- photographic interpretations (*photovoice* - people taking photographs of things they considered 'good' and 'bad' in the community and commenting on the photographs during interviews); and
- participant observation.

Qualitative research methods were used to collect children's weights from their medical records at the clinic. Table 3.1 summarises the methods used and data collected.

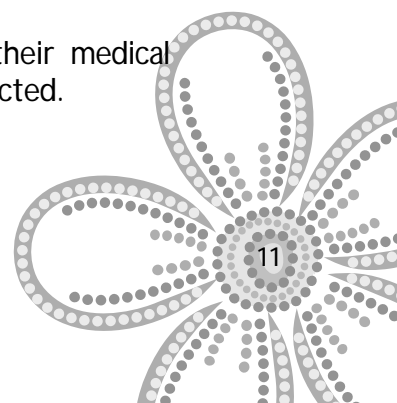
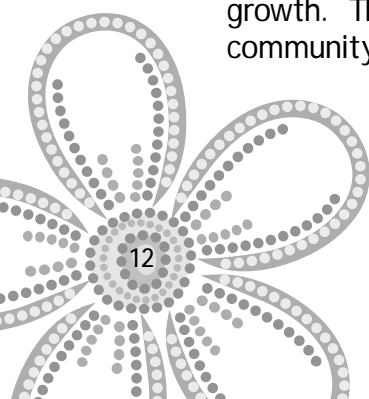


Table 3.1: Methods used and data collected

Method	Project phase used	Data collected	Subject of data
Semi-structured interviews and group discussions	April-August 2000 (Months 3-7)	Taped interviews; transcriptions and translations of interviews. Notes on interview context, process and content	Community and clinic staff perceptions of child growth; Knowledge of other group's understanding; and ideas for growth promotion action
	July 2001 (Month 18)		Community and clinic staff perceptions of: Issues of concern; responsibility and capacity for addressing such issues; the action strategy developed; and the value of the project. Project team member views on the value of the project and the community development approach
Photovoice	July 2001 (Month 18)	Photos. Taped interviews; interview transcriptions and translations. Notes on interviews	Community perceptions of community strengths and weaknesses; responsibility and capacity for addressing problems; the action strategy; and the value of the project.
Participant observation	April 1999 - December 2002	Notes recorded in journal. Committee meeting Minutes	Child-rearing practices; food consumption; decision-making; community concerns; and interactions between community members and clinic staff and between Yol\u and Balanda.
Quantitative analysis of weights	February 2000-December 2001 (Months 1-23)	Weights recorded in an Excel spreadsheet	Monthly weights of resident children aged 0-5 years

Sample selection and data collection

Gapuwiyak was selected as the study community because community members expressed interest in being involved in a research project that looked at how to improve child growth. The entire population of about 800 Yol\u and Balanda formed the overall community sample.



Qualitative data

A sample of 'community' and 'clinic' participants were recruited for the interviews, group discussion and photovoice at two distinct stages of data collection during the project/. The first stage data collection (April-August 2000) aimed to explore perceptions of 'the problem' of poor child growth, the extent of knowledge each group had of the other group's understanding and possible actions to improve child growth. The interview themes were:

- the reasons children grow well;
- food;
- caring for children;
- ways of knowing whether a child is growing well;
- knowledge of the GAA program;
- knowledge of the other group's understanding; and
- ideas for growth promotion action.

A representative sampling strategy was used to recruit 43 Yol\u to the 'community' group for individual and group interviews (see table 3.2).

Table 3.2: Community members interviewed in 2000 by parenting category

Parenting category	F	M	Total
Young people with no children	2	7	9
New parents	4	3	7
Parents with two or more children	7	6	13
Grandparents	10	4	14
Total	23	20	43

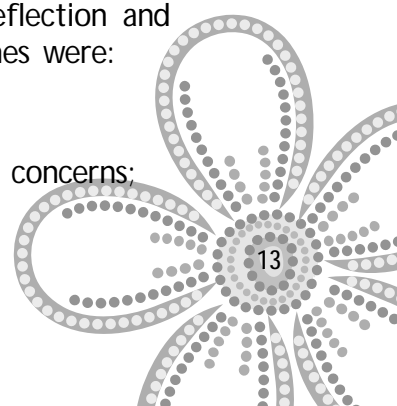
All 13 health service providers at the Gapuwiyak clinic were recruited to the 'clinic' group (see Table 3.3).

Table 3.3: Clinic staff interviewed in 2000 by occupation

Occupation	F	M	Total
Community Medical Officer (doctor)	-	1	1
Nurse	5	-	5
Aboriginal Health Worker (AHW)	4	2	6
Visiting paediatrician	-	1	1
Total	9	4	13

The second stage data collection (July 2001) aimed to facilitate critical reflection and action and to gather information for project evaluation. The interview themes were:

- community strengths and concerns;
- responsibility and capacity for decision-making and action to address concerns;
- extent of concern about child growth;
- reasons for good and bad child growth;



- knowledge of the project;
- knowledge of the selected growth promotion strategy; and
- value of the project and suggestions for its improvement.

The project team sought to recruit Yol\u participants for photovoice from the first stage interviews, but this proved difficult because of the high mobility of community members. Seventeen Yol\u were recruited to participate in the photovoice exercise, in which they took photos of what they perceived to be strengths and concerns in Gapuwiyak and discussed them in interviews. Twelve participants were interviewed about the photos they had taken (see Table 3.4); the remaining five were not in Gapuwiyak at the time of interviewing.

Table 3.4: Community members interviewed as part of photovoice in 2001 by parenting category

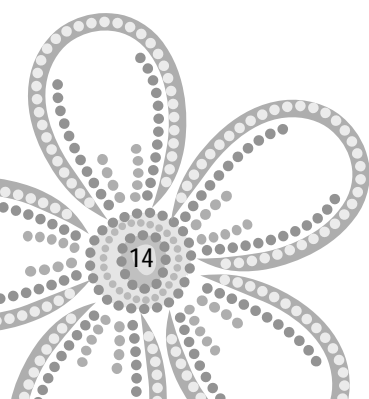
Parenting category	F	M	Total
Young people with no children	1	2	3
New parents	-	-	0
Parents with two or more children	2	2	4
Grandparents	2	3	5
Total	5	7	12

The team had hoped to recruit all clinic staff who had been involved in the first stage data collection or further interviews, but only three were interviewed again: the doctor and a male and female Aboriginal Health Worker. Six of the original participants were no longer working in the clinic and one AHW had passed away. Two nurses declined to be interviewed again and the Darwin-based paediatrician was only prepared to be interviewed in a group with other staff, which was not possible.

Methodological issues:

Sampling

- Yol\u researchers preferred to recruit close family members, which may have biased the community sample
- It was difficult to recruit young people, particularly young men, who were 'too shy' to be interviewed
- High mobility of Yol\u community members and high turnover of clinic staff meant only 10 out of 56 participants in the 2000 interviews were interviewed again in 2001
- Two clinic staff declined to be interviewed again, partly because they were upset by the project team's analysis of the 2000 interview data



Interviewing

- Young people were 'too shy' to be interviewed individually, but were also reluctant to give their views in a group discussion involving older family members
- There was limited interaction in group interviews as Yol\u respondents considered they all had 'the same story'
- Yol\u in both the 'community' and 'clinic' groups were generally uncomfortable with direct questioning and this was only partially alleviated by using semi-structured interviews because of Yol\u researchers use of interview themes as fixed questions in the initial interviews
- It was difficult for the project officer to establish a 'conversational' style because of her limited Yol\u-matha and the limited English of many respondents
- The interview process of recruiting, interviewing and translating/transcribing took longer than anticipated and limited the number of interviews that could be conducted
- Some Yol\u respondents were reluctant to give written informed consent; this ethical requirement appeared to cause stress for some.

Quantitative data

All children under five years of age identified in Royal Darwin Hospital records as residing in Gapuwiyak at the project outset were recruited to the study. Children born between February 2000 and December 2000 and who had a medical record at the community clinic were added to the study sample. Altogether the project team collected weight data for 159 children, which may, however, not be a fully representative sample.

The project team visited the clinic every few months between February 2000 and December 2001⁸ to collect monthly weights from the children's medical records. Although the GAA guidelines stipulate that children under three should be weighed monthly, this did not occur in Gapuwiyak during the study period and coverage was poor, ranging from between 40 per cent and 80 per cent of eligible children (Fig 3.1).

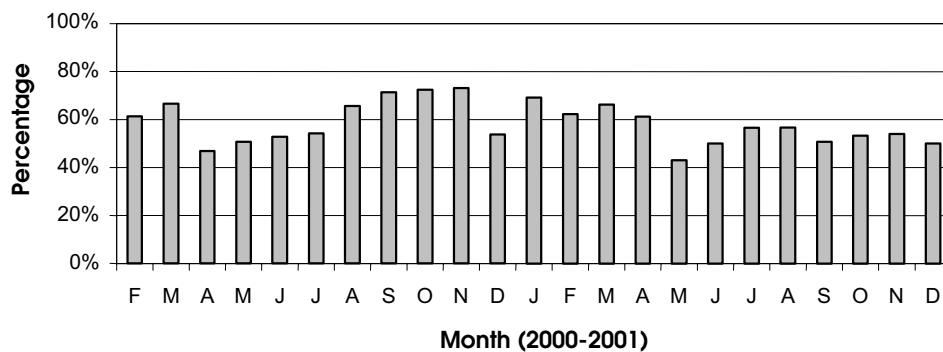


Figure 3.1: Percentage of Gapuwiyak children under three years of age who had a weight recorded each month 2000-2001.

8. The team did not collect children's weights during the six-month period for which the project was extended.

The poor coverage of children aged less than three is likely to be partly due to children not being brought to the clinic for weighing, which is understandable in the context of Yol\u being not particularly concerned about physical child growth and having a limited understanding of GMP. At the same time, there was also evidence in the medical records of some children not being weighed when they attended the clinic.

As coverage was so poor, we sought to establish whether the weights we collected were for the same group of children aged less than three. Assuming that each child should have been weighed monthly, according to GAA guidelines, Fig 3.2 shows the percentage of months a weight was recorded in the clinic notes for each child.

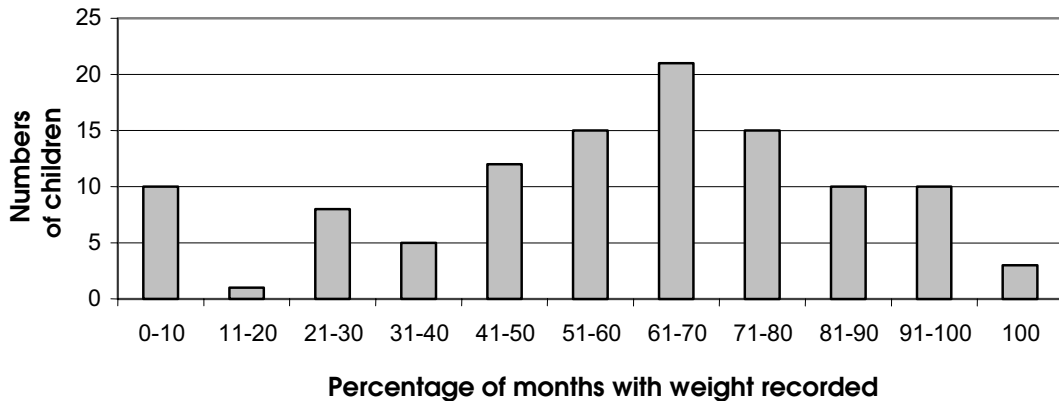


Fig 3.2: Numbers of Gapuwiyak children under three years of age by percentage of months with weight recorded 2000-2001.

Less than five eligible children had a weight recorded in their file every month from February 2000 to December 2001. Attendance was between 61 per cent and 70 per cent of the recommended frequency; the majority of children attended between 40 per cent and 80 per cent of possible times. Only ten children attended less than 10 per cent of the times. Among the reasons for this, it may be that some were not in fact resident in Gapuwiyak.

Coverage of children aged between three and five was greater - between 60 per cent and 80 per cent - and this is likely to be due to weights for these children being taken only on a six-monthly basis.

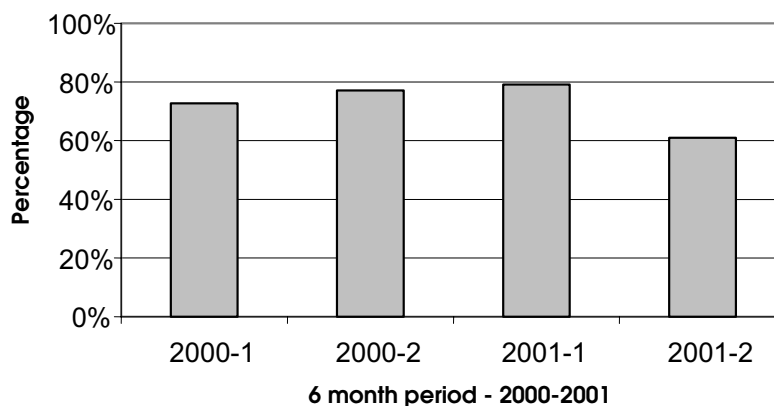
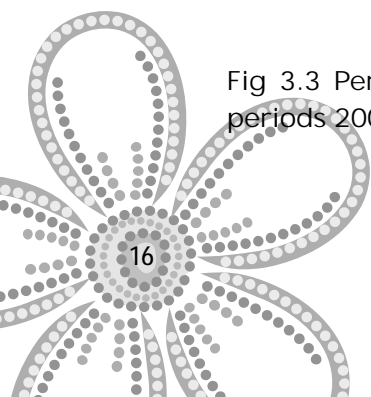


Fig 3.3 Percentage of Gapuwiyak children aged 3-5 with weight recorded by six-month periods 2000-2001



It was not possible to follow the stated aim of the project proposal that the project team would collect *monthly* weights from medical records of children aged between three and five and this highlights a weakness in the study design. Overall coverage was fairly poor for children in both age groups and remained so over the study period.

Methodological issues

Sampling:

- Our sampling may have included children who were not resident in the community, or who were away for extended periods.
- Children who were residing in the community, but who were listed as being resident elsewhere, may not have been included.
- The data may be biased by the greater likelihood of sick children attending the clinic and clinic staff then being more likely to weigh sick children.
- Children who were well 'cared for' may have been more likely to attend the clinic for a routine check-up than those whose parents were said not to 'look after' them well.

Data collection

- Data coverage was poor in both age groups (0-3 and 3-5).
- The project team stopped collecting quantitative data when the first growth promotion action strategy was implemented in December 2001.

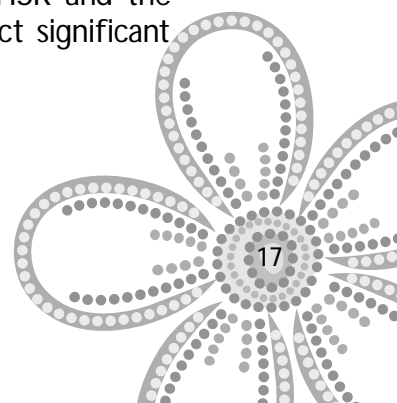
Data analysis and feedback

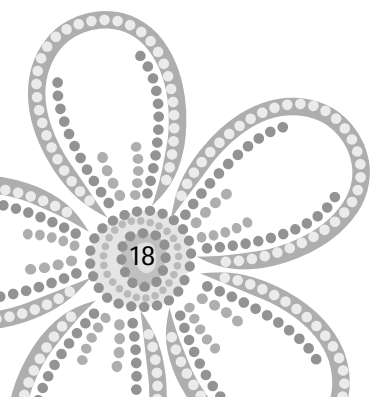
Yol\u and Balanda team members analysed the interview and photo data throughout the research. The project leader and project officer analysed the quantitative data and the project officer also conducted an in-depth analysis of the interview, photo and observational data as part of her PhD research.

Findings were fed back to community members throughout the project period using various feedback techniques: one-page handouts, reports, community meetings, talks on the local radio station and a video. Feedback reports were most effective when project team members explained them in detail in Yol\u-matha. On occasions when it was not possible to deliver explanations in language, the reports created confusion about the project and were generally viewed as 'educational tools' developed by the research team to teach Yol\u how to care for their children. Committee members identified a video as an appropriate feedback medium and this was produced with additional financial and technical support from the CRCATH. It is not yet possible to comment on its effectiveness as it had only recently been completed at the time of writing.

Limitations of the research

Parts of the project as described in the project proposal were developed with only limited community input, because the project team was reluctant to initiate a PAR project without approval from the Joint Institutional Ethics Committee of RDH, MHSR and the CRCATH. Furthermore, the study may not have lasted long enough to detect significant differences in impact measures.





The child growth project

DHCS implemented the Child Growth Project in partnership with Gapuwiyak Council. The team - a project leader, a Yol\u project adviser, a Balanda project officer and Yol\u community-based researchers - facilitated a community development approach through a PAR framework In Gapuwiyak between February 2000 and June 2002⁹.

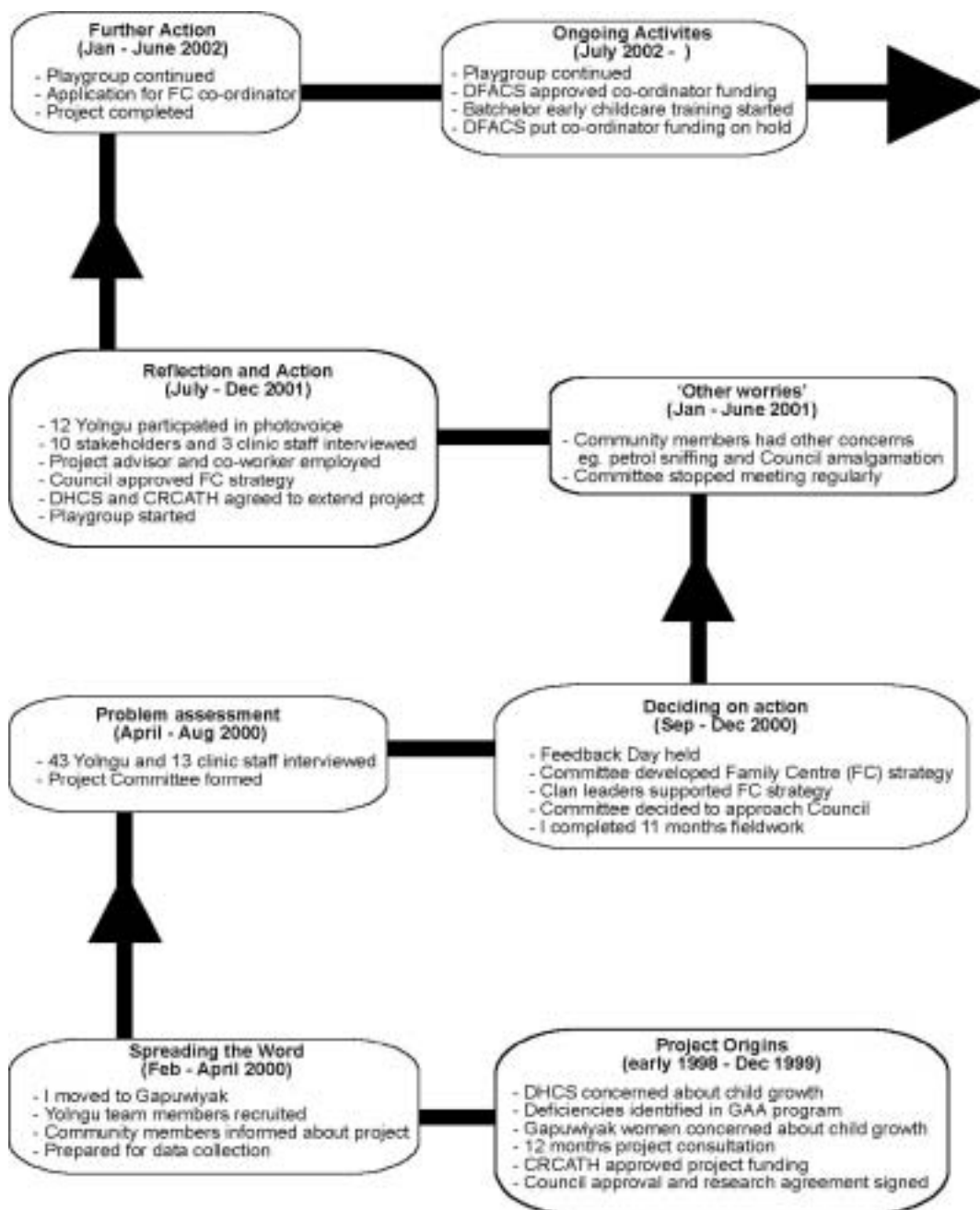


Fig 4.1: The phases of the Child Growth project

9. The original project leader, Karen Edmond, left DHCS in April 2001. The project role was briefly filled by Barbara Paterson and then by Alan Ruben, both of whom were DHCS paediatricians and both of whom focused on project administration. Neither of the two subsequent project leaders visited Gapuwiyak or were directly involved in project implementation, although Dr Ruben was centrally involved in analyzing the qualitative data.

Project origins and development

As discussed earlier, there are two key elements in the origins of the Child Growth Project:

- a recognition by Top End health professionals that there were deficiencies in the GAA program; and
- Yol\u¹⁰ women in Gapuwiyak expressing a desire to 'do something' to improve their children's growth following a presentation on the GAA program in mid-1998.

A project proposal was then developed and submitted to the CRCATH in August 1999. During the proposal's development, the project leader made six trips to Gapuwiyak to consult the interested women, the Health Committee¹¹, the clinic and the Council. The project team considered that there was only limited community involvement in developing the proposal and acknowledged this as a limitation in the proposal.

After the proposal was submitted, an externally-based health educator who had interpreted for the project leader on one occasion during consultation informed the project team that community members:

- may not have wanted to be involved in the project;
- did not understand what the project was about; and
- had not said 'no' to the project because this was not culturally appropriate and they were 'fearful of the dominant culture'.

The project team had already recognized that there had not been enough community involvement in developing then project proposal, which was primarily due to a lack of funds for comprehensive consultation. They had not understood, however, that Yol\u might not want the project to go ahead. The project leader subsequently visited Gapuwiyak again specifically to discuss this and to assure Yol\u that there would be no repercussions if they decided against the project. The project team recognized that power relations and cultural mores may have meant that community members had been reluctant to say 'no' to the Balanda project leader, but had been unable to identify strategies to overcome this possibility. The Yol\u women involved maintained that they *did* want the project to go ahead, subject to meeting the project officer, who was the principal author of this report. The project officer then visited Gapuwiyak for the first time¹² and, following this meeting, the women agreed to be involved in the research project.

10. Among them workers with the DHCS 'Strong Women, Strong Babies, Strong Culture' program (the 'Strong Women workers'), which employs senior Indigenous women to work with pregnant women and young mothers to improve birthweights and child growth; and women employed by the Home and Community Care Program (HACC) to deliver 'Meals on Wheels' to the elderly. The Balanda coordinator of the Women's Centre and a resident Balanda who was a volunteer with the Strong Women also attended.

11. The Health Committee was no longer functioning when the project got under way in February 2000.

12. The project team had decided that the project officer would not visit Gapuwiyak until the project had been given formal CRCATH approval, as the team was aware that its majority Indigenous Board did not want researchers visiting communities to talk about research that had yet to be approved. The project leader was able to visit, however, in her capacity as community paediatrician.

The CRCATH approved the project in September 1999 and the Balanda members of the team then visited in November seeking formal Council approval for the project and again in December to sign a research agreement with the Council. This agreement was considered an important mechanism for promoting Yol\u control over all aspects of the research process, including ownership of data and dissemination of research findings. The team also collaboratively developed job descriptions for the project adviser and other team members.

February-April 2000(Months 1-2): Spreading the word

The project started in February 2000, when the project officer and primary author of this report moved to Gapuwiyak to begin 11 months of field work. Gapuwiyak Council employed a senior woman as project adviser and two young women to work on the team with funds from the project. The Yol\u team members and the project officer were all put on a three month trial by the Council; one of the workers stopped work at the end of this trial period. A senior man joined the team during this period as a CDEP-funded worker, but stopped work several months later when he went to live at his outstation.

The focus of activity in months one to three was informing community members about the project. The project team visited every house in the community and played a tape recording in Yol\u-matha that followed the content of the project information sheet. The team also held public meetings, put up posters around the community and discussed the project in the community radio broadcasts. During this period the project officer also began to develop relationships with Yol\u, both with team members and other people in the community, an essential element in collecting quality data.

The project team also prepared for the first stage data collection, by:

- talking about research previously conducted in the community;
- discussing how best to get information from Yol\u;
- developing and translating the project information and informed consent sheets;
- developing a list of themes for semi-structured interviews; and
- practice interviews.

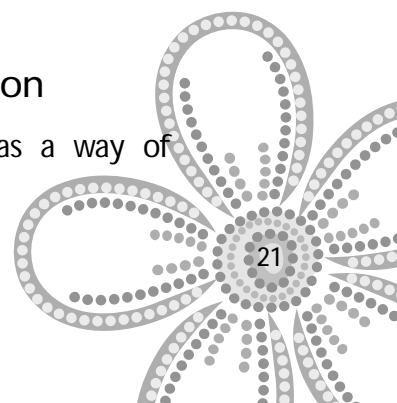
This phase ended when the project officer considered that most people in Gapuwiyak had heard about the project.

April-August 2000(Months 3-7): Problem assessment

From April to August 2000 the project team conducted interviews and group discussions to facilitate assessment of the 'problem' of poor child growth and possible solutions, recruiting respondents from both the 'Yol\u' or 'community' group and the 'clinic' group. This data collection took significantly longer than had been anticipated and allowed for in the study design. The team had originally considered that a growth promotion action would be in place by July 2000 (Month 6), but did not complete the interviews until August (Month 7). At this point the team commenced the decision-making and action phase of the project.

September-December 2000(Months 8-11): deciding on action

In month 8 the project team completed a partial analysis of the data as a way of stimulating community-decision-making and growth promotion action.



The data were coded for three themes:

- reasons for good growth
- reasons for bad growth
- ideas for action.

This preliminary analysis demonstrated that there was a significant gap between Yol\u and clinic understandings of poor child growth. The main theme in the Yol\u interviews was concern about the way inadequate care adversely affected the growth of children in Gapuwiyak. Clinic staff, on the other hand, focused on the impact of illness on children's physical growth¹³.

This information was given to community members on a 'Feedback Day', organized in September by the Committee and the project team and held on the Council lawns. There was an open invitation to all community members, Council members, clinic staff, school staff and students. The project team explained key findings from the first stage interviews in English and Yol\u-matha and distributed A4 copies of the 'community' and 'clinic' stories. These were later delivered to every house in the community. Among other 'Feedback Day' activities, clinic staff presented the latest GAA report for Gapuwiyak, there was a drawing competition for schoolchildren and there was a barbecue,

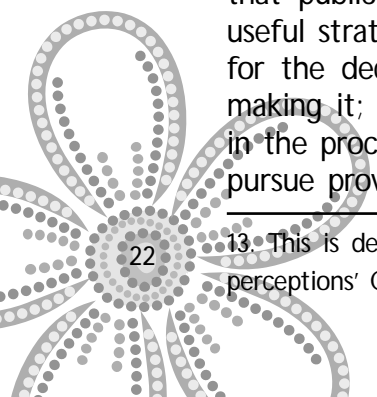
Between months 9 and 11 the project team analysed the interview data in more detail and facilitated the decision-making process, which was lengthy and complex. The project team and Committee held a series of public meetings so that all community members had the opportunity to become involved in the process. Because of poor attendance at these meetings, the project team then focused on supporting the Committee to reach a decision about action.

Throughout this period the Committee was developing an action strategy. It began as a feeding program, but rapidly evolved, firstly into a child care centre and then into the broader concept of a 'Family Centre'. The Family Centre is a multi-faceted strategy which aims to ensure that the developmental needs of *all* children in Gapuwiyak are met and they are well cared for. Its key programs are:

- a play group;
- early childhood education, including teaching children Yol\u law and culture;
- healthy food for all children who attend;
- education for parents in Yol\u and Balanda stories about 'looking after' children;
- sport and after hours programs for teenage children; and
- bush trips.

While the Committee was prepared to develop this strategy, it did not consider it had the authority to pursue it. Committee members maintained that 'the community', not the Committee, should make the decision on the action strategy. Despite recognition that public meetings were generally poorly attended, they were suggested again as a useful strategy. At this point the process appeared to have reached an impasse: in order for the decision to have legitimacy, more community members had to be involved in making it; but only a limited number of people were interested in involving themselves in the process. Trying in this way to reach a 'community' decision about which action to pursue proved to be ineffective.

¹³. This is detailed in the interim project report 'How Children Grow: Indigenous and health professional perceptions' CRCATH 2002)



The Committee then agreed that a 'family' or 'clan-based' decision-making approach be adopted, but rejected the project team's suggestions that each family pursue its own action. The subsequent support of several clan leaders for the Family Centre gave the Committee the legitimacy to describe the decision on the action strategy as a 'community' decision. In December 2000 (Month 11), however, the Committee decided the strategy also needed support and formal approval from the Gapuwiyak Council. At this time the project officer completed fieldwork and returned to Darwin; the project adviser had stopped work several months earlier to care for her young son. This meant that in December 2000 there was only one team member based in Gapuwiyak.

January-June 2001 (Months 12-17): 'Other worries'

In January, the remaining Yol\u worker stopped work and went to live at a nearby community. From January to June 2001 there were no project team members based in Gapuwiyak and working on the project, which significantly affected what was achieved.

The Committee only met on the project officer's visits to Gapuwiyak and had not approached the Council for approval of the Family Centre strategy. The Council itself was preoccupied with amalgamating the outstation and community councils. Petrol sniffing was also a key concern during this period; the number of children sniffing allegedly increasing from two to around 20.

The project officer, working in Darwin, completed a full thematic analysis of the first stage data and a draft interim project report. She also visited Gapuwiyak three times to support the community development process and to discuss the draft report with the Council, the Committee, community members and clinic staff. While no Yol\u stakeholders expressed concerns about the draft, several Balanda clinic staff said they were upset by the project team's analysis. They questioned it and said they considered it reflected badly on them and did not highlight all the hard work they did with limited resources.¹⁴ Following the release of this draft, there appeared to be a reduced involvement in the community development process by some Balanda clinic staff.

July-December 2001 (Months 18-23): Reflection and action

The project team collected the second stage data over a three-week period in July 2001. Three community members were employed to work with the project officer during this period (the man who had briefly worked with the team at the outset, the grandmother who established the Committee and another woman from the community). Photovoice and interviews were used to explore the extent of concern about physical child growth and to facilitate critical reflection on both the community development process to date and the reasons no action had been taken to implement the Family Centre Strategy.

The key themes in the photovoice and interview data were:

- Yol\u concern about inadequate care leading to poor child development;
- a decreased level of clinic and Yol\u concern about poor physical growth over the project to date; and
- Yol\u community members' range of concerns changing over time.

Yol\u stakeholders also said that it was 'too hard' to work without the support of Gapuwiyak-based project team members. This led to the man being employed as the project adviser and the younger woman joining the team as a worker. Yol\u respondents also said the project was 'too short' and subsequently DHCS and CRCATH agreed to extend it by six months, to June 2002.

14. These concerns are elaborated in the interim project report 'How Children Grow'.

The project team also used interviews to discuss the community development approach with Yol\u respondents. While some had not understood that the project was about the team supporting Yol\u to make decisions and act, respondents strongly supported this approach to their health problems.

The two Yolngu project team members then worked with the Committee to secure funds to implement the Family Centre strategy. In December 2001 a playgroup - a component of the strategy - began, with the Commonwealth Department of Family and Community Services (FACS) providing funds to employ two Yol\u playgroup workers and for fruit and drinks for the children. The Yol\u project workers also negotiated with the Women's Centre to run the playgroup on the verandah of the Centre during this period and established a partnership with the Strong Women workers, who lent the playgroup toys from their program.

January-June 2002 (Months 24-28): Further action

The Yol\u project workers and the Committee established a partnership with the school and ran the playgroup jointly with the pre-school class during this period. The project adviser and the Committee also identified interested people from the community to undertake childcare training through Batchelor Institute of Indigenous Tertiary Education (BIITE), which was the second component of the Family Centre strategy.

The Yol\u workers and the Committee also met with FACS staff to discuss funding for a Family Centre building. FACS initially over funds for extensions to an existing community building, but the Council could not reach a decision quickly enough on using the funds and they were subsequently unavailable. The Yol\u team members and Council also applied for FACS funding to employ a Family Centre Coordinator (possibly the project adviser) to continue working towards the full implementation of the strategy after the project finished in June 2002. Other funding bodies were also approached.

July 2002 and beyond: Continuing activities

The playgroup and the Committee continued to function after the project ended in June 2002. In August 2002 the project team made a 'feedback' video with financial and technical support from the CRCATH. In the same month BIITE started delivering childcare training in Gapuwiyak to 15 women and FACS offered funding to employ a Family Centre coordinator. At the time of writing, however, it was unclear whether the funds would be paid to the Gapuwiyak Council. In September 2002, two FACS project officers visited Gapuwiyak for a day and subsequently recommended that the grant be put on hold. The project officers had not been able to let anyone in Gapuwiyak know in advance that they were coming and met no Committee members or the former Yol\u project team.¹⁵ Nevertheless, after speaking to some Yol\u community members and two Balanda Council employees, they formed the view that people in Gapuwiyak did not want the Family Centre to go ahead at that time.

15. The man who had been the project adviser and who had helped finalise the application for the funding was particularly upset by the conduct of the project officers. He considered that they should have informed him they were coming and sought him out on arrival in Gapuwiyak before speaking to anyone else.

Results

This section presents results against the three project objectives and meets the fourth objective by documenting the community development process and the action strategies developed. The interim report documented social and cultural issues influencing child growth. It is hoped that this final report on the project will contribute to improving the GAA program, which as the fifth objective of the project.

Increased family and community involvement in child growth promotion

The project fostered an increase in the extent and quality of Yol\u community involvement in child growth promotion in Gapuwiyak. Community participation was marginal at the outset; exploring Indigenous perceptions of child growth was largely viewed by DHCS as a *means* for improving the GAA program. As the project progressed, however, people recognized the potential health benefits of capacity strengthening and empowerment and sought involvement as an *end* in itself. While ultimate control remained with DHCS, substantive participation was fostered as Yol\u gained more control of determining priorities and project activities.

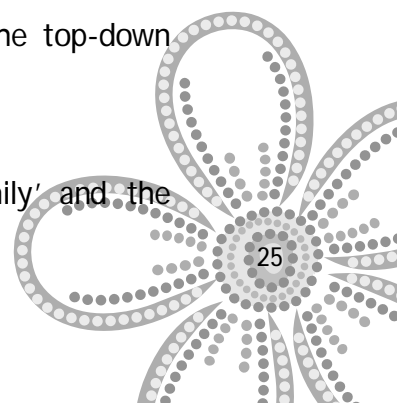
Community members were involved in assessing 'the problem' of poor child growth and then in defining priorities, developing and implementing action strategies, mobilising resources, forming partnerships and critically reflecting on their actions - all of which are important factors contributing towards community empowerment (see Laverack, 2001). The self-formed Yol\u Project Committee, which managed the partial implementation of the Family Centre strategy and sustained its activities during and after the project period, is further evidence of increased community involvement. Moreover community members' active involvement in these processes resulted in the development and partial implementation of a Family Centre strategy that has the potential to improve the development of Gapuwiyak children.

While some community members had extensive involvement in the project, there were others who had either limited involvement or none at all. Yol\u who were most involved were generally more powerful and were those who had a greater capacity to interact with Balanda and 'Balanda processes'. The most involved participants generally:

- spoke good English, had reasonable levels of English literacy and some formal education;
- had been involved in the Council and other community committees;
- had worked closely with Balanda in the past and has some experience of dealing with funding bodies; and
- were employed.

A number of barriers limited the involvement of other community members in this community development process, among them:

- confusion about the community development approach, given the top-down selection of the issue by DHCS;
- limited concern about either poor child growth or development;
- limited sense of 'community' and a strong sense of the 'family' and the 'individual';
- lack of power and limited capacity to participate;



- lack of incentive to become involved;
- fear of upsetting the clinic or DHCS by appearing to be 'stealing their work'; and
- confusion generated by the project being conducted within a research framework.

Balanda clinic staff also had limited involvement in the development and implementation of the Family Centre strategy. The problem assessment process highlighted the difference between Yol\u and clinic understandings of 'the problem' of child growth, which in itself contributed to a lack of agreement about a 'solution'. Consequently the involvement of Balanda clinic staff was largely limited to their raising concerns about the strategy. At the same time, a man who was an Aboriginal Health Worker (AHW) at the clinic was a key Committee member and was centrally involved in developing and implementing the Family Centre strategy.

Improved GAA program in Gapuwiyak according to:

Increased understanding of specific socio-cultural factors influencing child growth for health service providers

Through their involvement in the project, health service providers in Gapuwiyak engaged with Yol\u community members about poor child growth. Members of both groups assessed 'the problem' and discussed potential action strategies. Clinic staff attended the Feedback Day and a Committee meeting to discuss their concerns about the Family Centre. Clinic staff also received copies of the draft interim report, 'How Children Grow: Indigenous and health professional perceptions', which set out the differing perceptions in some detail. This involvement is likely to have increased their understanding of the socio-cultural factors influencing child growth in Gapuwiyak.

Several Balanda clinic staff commented that, while they felt the research was confronting, they also recognized it was useful in highlighting the significant gap between Yol\u and clinic understandings of child growth. They also said the information that was generated by the first stage interviews gave them useful insights into Yol\u perceptions of the factors affecting child growth. Unfortunately, this increased understanding was constrained by the high turnover of clinic staff during the project period. Only three Balanda were on the clinic staff for the length of the project; many relief staff came and went over the period and had no involvement in the project. Of the three who stayed, only one was interviewed again in July 2001. It is therefore not possible to evaluate formally any increase in health service provider understanding.

The researchers also presented on the socio-cultural factor affecting child growth at a number of DHCS workshops in practical paediatrics and nutrition in both Darwin and Nhulunbuy. Health service providers working outside Gapuwiyak are therefore likely to have a greater understanding of the influence these factors have on child growth.

Increased understanding of child growth monitoring and promotion by service providers and families

Data from the 2000 interviews show that most Yol\u and some clinic staff had a limited understanding of GMP, Yol\u generally knowing little about the GAA program but 'the line has to go up' on the growth chart and some clinic staff describing it as being only about growth monitoring without adding '...and promotion'. There was also little evidence of feedback to community members of the information in the GAA reports. Increasing understandings of GMP became less of a focus during project implementation,

however, and this objective should have been amended to reflect this. At the same time, some Yol\u expressed a desire to learn more about growth charts and some clinic staff suggested providing carers with copies of children's growth charts as a way of increasing Yol\u involvement in GMP.

It became clear during the first year of the project that poor physical growth was not a key concern of either Yol\u community members or the Balanda health service providers at the Gapuwiyak clinic. Rather, Yol\u participants expressed significant concern about poor child *development* as a result of inadequate care and the project team then responded to this in way that was consistent with the flexibility required of a PAR approach. The project focus then shifted from physical child growth and GMP to supporting Yol\u to develop and implement an action strategy to address their concern.

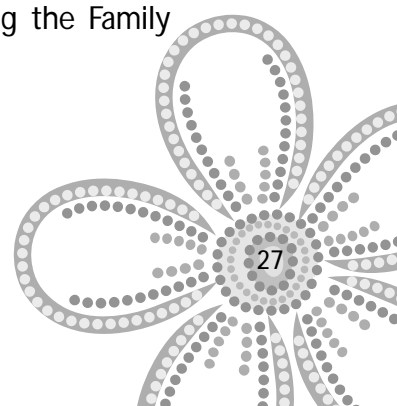
The Family Centre has the capacity, however, to increase understanding of GMP in the future. One of the components of the Family Centre strategy - and it is one some Yol\u said they wanted to learn more about - is to educate Yol\u parents in 'clinic' understanding of child growth. If clinic staff are involved in talking about GMP, this may also contribute to understanding.

Increased community action to promote child growth

The Child Growth Project fostered a significantly greater community action to promote child growth Yol\u used their knowledge of child growth to assess 'the problem' and develop an action strategy to address it. The Committee developed the Family Centre strategy and sought approval from clan leaders and the Gapuwiyak Council. Members of the Committee then worked collectively to implement their action strategy and have continued to do so after the end of the project. All the community members involved in the project strongly supported the idea of Yol\u working on their own health problems.

The Family Centre strategy has the potential to improve child growth and development in the community. Its strength lies in its basis in the Yol\u understanding of child growth and in that it seeks to deal with the problem identified by Yol\u themselves: that children are inadequately cared for and their development needs remain unmet. The strategy also aims to improve child development in a way that takes into account the rapid social and cultural change Gapuwiyak is experiencing. It takes account of the continuing value placed on aspects of Yol\u society and culture by most community members, such as respect for individual autonomy. It also recognizes the need for young people to learn the clinic understanding of child growth and care, as well as the need to provide institutional care for children who may continue to be neglected.

The strategy constitutes a positive approach to ensuring children develop well that does not seek to lay blame for the current lack of care many children may be receiving. It respects the right of individuals to determine their behaviour and aims to encourage parents to take more responsibility by teaching them how to look after their children. Its strength is also founded on the lengthy decision-making process that led to the agreement to adopt and implement it. The Committee was not prepared to make the decision on its own and sought the involvement of others from the community, particularly the clan leaders and the Council. As Yol\u decision-making is generally consensus-based, this process took much longer than the project team had anticipated. The involvement of the Committee, clan leaders and the Council, however, means that implementing the Family Centre strategy is viewed as a legitimate 'community' decision.



The physical growth of Gapuwiyak children

Our data suggest that a substantial number of Gapuwiyak children remained underweight throughout the project period. We were unable to demonstrate a measurable improvement in the physical growth of children aged less than five years between February 2000 and December 2001. This was partly due to poor coverage in the quantitative data. Inadequate timeframes mean that the team stopped collecting quantitative data at the point at which the first community action to promote child growth began (December 2001). Figure 5.1 presents all the weights-for-age recorded between February 2000 and December 2001 for children aged less than five.

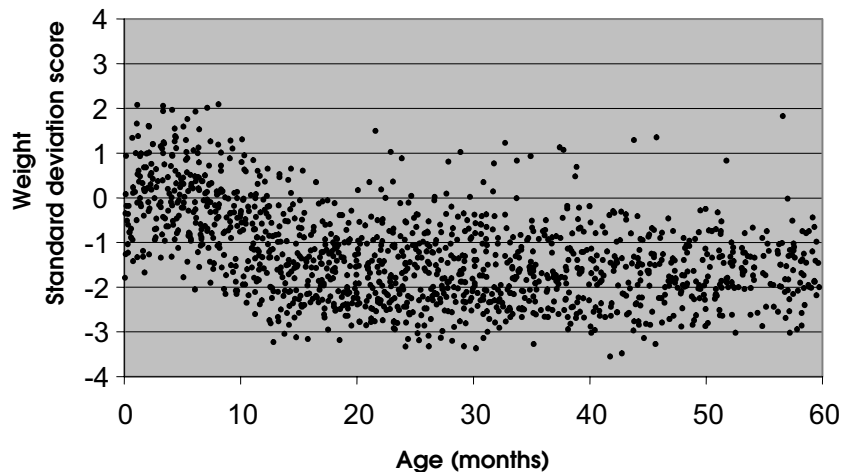


Fig 5.1: Weight-for-age scores for Gapuwiyak children aged 0-60 months, 2000-2001

There should be an equal number of recordings above and below the zero (average) line, but the team's data show that, as Gapuwiyak children got older, their weights fell further behind what is expected for their age. This pattern is consistent with children's nutritional status worsening as they are weaned from breast-feeding and adequate additional foods are not introduced into their diet.

To assess whether there was any change in physical growth during this period, the team explored what happened to the weights of children who had an average weight, and those who were underweight, at the beginning of the study (Figure 5.2). We defined 'entry to the study' as referring both to those children who were resident in Gapuwiyak in February 2000 and to the date a child was born and added to the study.

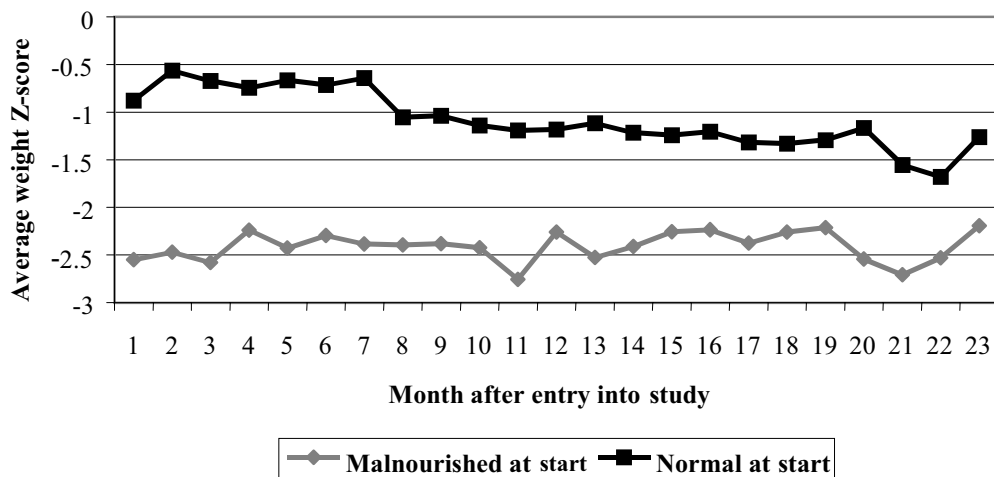


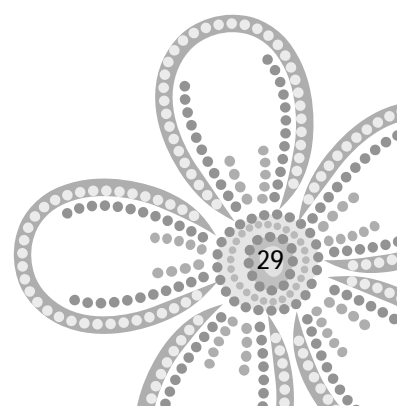
Fig 5.2 Progressive average weight (Z score) over period of children who entered study with normal weight and underweight.

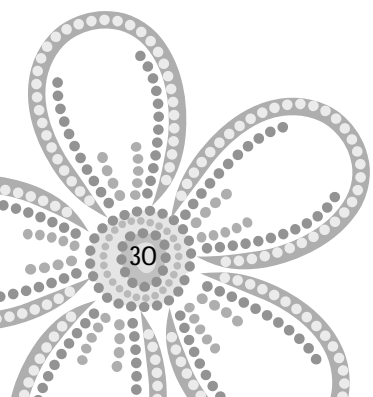
Fig. 5.2 demonstrates that children who were underweight on entering the study remained so, while the nutritional status of children who entered the study with better nutrition (average weight) worsened over the period. This appears to be related to the age of children on entry to the study. The average age of children with a normal weight on entry was 22 months, while the average age of children who entered underweight was 31 months. This confirms the information in Fig. 5.5, which shows an age-related drop-off in weight that is suggestive of weaning malnutrition.

The team's finding that there was no improvement in the physical growth of children according to weight is inconsistent with information in DHCS' routine GAA reports over this period. Contrary to project data, these reports show that the percentage of Gapuwiyak children who were underweight improved significantly from 38 per cent in April 2000 to 23 per cent in October 2001 (THS, 2001).

The project team identified two possible explanations for the difference in findings. There is a substantial difference between the number of children included in the project study and the number described as Gapuwiyak residents in the GAA reports. In April 2000, for example, the team included 140 children in its sample, compared to 88 in the GAA sample. Conversely, the coverage in the GAA reports is significantly higher, with more than 90 per cent of available children reported as being measured in all reports, except for October 2001, where coverage was around 77 per cent. Although the project study suggests that the GAA report is missing many resident children, the reports have many more measurements than the project team was able to collect from medical records at the clinic. This may indicate that information collected as part of the six-monthly GAA data collection is not being recorded in the children's medical records, which suggests that using data collected by the GAA program for planning and service delivery could be problematic.

Given the uncertainties in the data, it is not possible to be conclusive about whether there were or were not changes in the growth patterns of Gapuwiyak children between February 2000 and December 2001. Regardless of whether or not there was an improvement over the period, however, both data sets show that the number of children who were underweight at the end of 2001 remained high at more than *seven times greater* than the expected number.





Discussion

Key factors affecting the community development approach

The Child Growth Project demonstrates that a community development approach is an effective way of involving Indigenous people in developing and implementing interventions to improve their health. Laverack's (2000) empowerment framework has been used to identify specific factors that limited or promoted the value of the approach (see Appendix 1).

Factors central to the success of the Child Growth Project:

Problem assessment

Community participation in defining child growth, identifying a solution and acting on it was central to the development of a health initiative and to fostering community development. The process enabled people to articulate both the issue and their concerns. It revealed that, while they had limited concern about *physical* growth, they were greatly concerned about the overall growth of children, and about their development needs being unmet because of inadequate care. The project consequently changed its focus, the project team supporting Yo\u in working out how they wanted to deal with the problem they had identified.

The problem assessment process also meant that Yo\u knowledge about child growth was framed and given a voice alongside biomedical knowledge. Despite their perceptions of continuing opposition to their strategy from some clinic staff, Yo\u were able to apply this knowledge to their own 'problem'. This suggests changed power relationships within the community (see Cheek *et al*, 1996).

The Yo\u Committee

The self-formed Committee played a key role in the development of the health intervention and in fostering individual and community empowerment. Working collectively Committee members applied Yo\u knowledge to develop a strategy, mobilize resources and finally to develop partnerships with the Council, the school and the Strong Women workers to move their strategy forward. Consequently Committee members identified as a 'community', strengthened their sense of 'community' and increased their leadership skills - all aspects of community development and all of which has the potential to foster better community health in the longer term.

The employment of Yo\u to work on the project

Employing a Yo\u project adviser and Yo\u workers on the research team was central to the project's success. Their knowledge of local languages, and social and cultural values and processes, together with their established relationships and capacity as Gapuwiyak residents to take a long-term approach, were critical elements in making the community development approach work. The successive project advisers guided the research and both mentored and supported the project officer so that she was able to work effectively in the community. They also played an important leadership role by encouraging Yo\u involvement in the project and supporting the development and implementation of the Family Centre strategy. All Yo\u team members were involved in data collection, analysis and feedback and they developed research skills through their involvement in the project.

Balanda team members adopting a partnership approach and developing trusting relationships

The capacity of the non-Indigenous researchers was initially constrained by:

- limited collective experience in putting community development into practice in Indigenous settings;
- initial lack of knowledge of Yol\u languages, social and cultural values and practices; and
- recently-established relationships.

The deeply embedded nature of unequal personal and institutional power relations between Yol\u and Balanda also made it difficult for the researchers to facilitate the community development approach.

Over time, as knowledge increased and relationships developed, the Balanda researchers were able to use the community development approach more effectively. Valuing and respecting Yol\u knowledge and ideas helped make it work: the project officer began learning Yol\u-matha and adopted a 'power with' approach, for instance. Yol\u described this as working 'in the good way', 'side by side', 'sharing ideas back and forth' and 'training each other'. The Balanda researchers brought knowledge of spoken and written English, community development and PAR approaches, and the bureaucratic systems and processes of agencies outside Gapuwiyak. The partnership between Yol\u and the Balanda researchers, with their respective capacities, was consistent with the strong Yol\u desire for Balanda to support them in dealing with their own problems.

The Participatory Action Research framework

The PAR framework both constrained and promoted the community development approach in different phases of the project. To secure available research funding, the Balanda researchers had to articulate a detailed research process in the project proposal that was submitted to the implementing body (DHCS) and the funding body (CRCATH). This meant that, despite limited community input, the team committed itself to certain 'objectives', 'processes', 'methods', 'outcomes' and 'evaluation strategies' from the outset. Moreover, in order to generate knowledge that would be acceptable to DHCS and the research community, the team used standard research methods, which are unfamiliar to most Yol\u. The use of instruments such as informed consent forms, data coding systems and feedback reports created some confusion about the project. The research process itself reinforced the idea that the project was a 'Balanda exercise' being carried out by Balanda 'experts' with their particular research skills and in accordance with their agenda.

On the other hand, the critical reflection phase that occurred as part of the PAR process was crucial to the project's success. Extensive reflection on the project was part of the second state data collection. The interviews provided the opportunity to reflect on:

- why no action had yet been taken to implement the Family Centre strategy;
- perceptions of whose role it was to address problems in Gapuwiyak; and
- the community development approach and the relative merits of Yol\u, rather than Balanda, making decisions and taking action.

This process of reflecting critically stimulated the Committee to begin implementing their strategy.

Factors limiting the achievement of project outcomes:

Limited community involvement in issue selection and project design

The choice of poor physical child growth as the project focus was the result of:

- DHCS' selective primary health care approach;
- power inequalities between Indigenous and non-Indigenous participants; and
- the inexperience in assessing community needs among the health professionals associated with the project.

Non-Indigenous health service providers drove the selection of the issue to be examined by the project and that issue was not of broad comparative concern to Yol\u.

The lack of community involvement in identifying the issue was:

- a barrier to participation;
- created confusion about the community development approach'; and
- reinforced power inequalities between Indigenous and non-Indigenous participants.¹⁶

The limited involvement of Yol\u from Gapuwiyak in project design adversely affected their participation in the project's later stages. The research finding process required the researchers to articulate a detailed research process, but there were no funds for engaging community members in developing the proposal. The fact that Yol\u were only marginally involved at this stage contributed to confusion about the community development approach because it contradicted the approach's 'bottom-up' emphasis. Language barriers and the lack of any widespread understanding of the community development approach exacerbated this.

Overall, there was the perception that the project was being done for the benefit of DHCS. With time, however, the perception changed and some Yol\u developed ownership of the project. This highlights the fact that, while community development projects should ideally start 'where the people are', it is possible to foster increased involvement in the later stages of a project *even when the agenda is externally set*.

Different understandings of 'the problem' and its solution between Yol\u and clinic staff

There was significant gap between Yol\u and Balanda clinic staff understandings of 'the problem'. Yol\u were concerned about the overall development of children, while clinic staff generally focused on the narrower issue of physical growth and neither could develop shared understandings.

16. The Yol\u women employed in DHCS' Strong Women Strong Babies Strong Culture Program were similarly confused by the project despite being one of the key stakeholder groups involved in the consultation process. The researchers intended to work on child growth closely with the Strong Women workers; there is some evidence, however, that the Strong Women saw the project as taking over their work. Over time, the involvement of the Strong Women in the project grew and they formed a partnership with the Committee.

The same gulf was evident in approaches to the solution. Several Balanda clinic staff repeatedly questioned the value of the Yol\u Family Centre strategy. They were doubtful that it would contribute to improved physical growth and were concerned that children attending the Family Centre would suffer an increased incidence of illness. They also felt that the Family Centre could contribute to parents taking less responsibility for their children and that they should care for their children at home. Finally, they argued that the practice of older Yol\u women teaching young mothers in the home could be further eroded.

Yol\u participants perceived this repeated questioning of their strategy by the Balanda clinic staff as Balanda 'trying to tell them what to do'. This view appears to be informed by frustration with historical and contemporary power inequalities between Yol\u and Balanda, as well as at the pervasive practice of Balanda setting the agenda. Yol\u resisted what they considered was clinic opposition and there was no partnership with Balanda clinic staff. Although Yol\u were able to implement their strategy in part, more may have been achieved through a partnership.

Limited sense of 'community' and a strong sense of 'family' and 'individual'

Rapid social and cultural change has contributed to the emergence of different views among Yol\u about the roles and responsibilities of 'community', 'family' and 'individual' in ensuring children develop well. Many Yol\u did not see child development as an issue that could or should be addressed by Gapuwiyak 'community'. Others saw value in a community level action, but did not view themselves as having a role to play as 'members' of the 'community'. The emphasis in Yol\u society on family and individual autonomy therefore limited participation in collective efforts to address the problem.

Committee members, on the other hand, identified the importance of a 'community, rather than a 'family' level, response and were strongly motivated towards collective action on poor child development. Committee members developed their sense of community through the project, while designing the Family Centre strategy to take account of the high value placed on autonomy.

Complex and lengthy decision-making processes arising from different values and structures

Yol\u and Balanda participants had different views of how the decision about action would be reached. The Balanda researchers sought to 'give a voice' to all community members, but this proved ineffective and the decision was eventually made by the more powerful community members, in accordance with Yol\u hierarchical power structures. This is likely to have reinforced power inequalities among community members.

The rapid social and cultural change Gapuwiyak is experiencing also meant that there was a lack of consensus as to whether the Council (formal leadership of the 'community'), the Committee (informal leadership) or the clan leaders (culturally appropriate authority) had the authority to decide which growth promotion action to pursue. This made it difficult for all of the three groups to be authoritative and take a strong leadership role in the project. Again, the capacity to lead was tempered by the high social value Yol\u place on individual and family autonomy.

Finally, reaching a decision was a lengthy process because Yol\u decision-making is generally consensus-based. The opposition of one clan leader to the Family Centre strategy meant it took a long time to reach a decision to pursue it. Even now the decision is not considered to be final and continues to be discussed.

Inadequate timeframes and different views of time

Inadequate timeframes limited what the project could achieve and most project phases took twice as long as the Balanda researchers had allowed. The shortage of time affected the development of a partnership between the Committee and the Balanda clinic staff limited the capacity of the project officer to support the implementation of the family Centre strategy after the first year of the project.

The action orientation of the project meant the project team's focus was on facilitating a decision about a strategy and there was insufficient time to work towards a shared understanding of 'the problem'. Inappropriately short timeframes also meant it was not possible to measure any improvement in physical child growth as the team stopped collecting weights when the first intervention (the playgroup) began. These factors highlight the limitations of trying to measure health outcomes in the short term when a community development approach is being used.

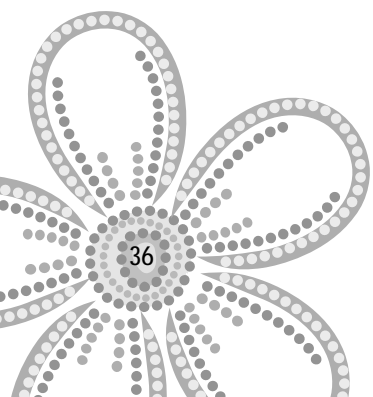
The shortage of time was partly addressed by extending the project by six months. The project team and DHCS responded to Yol\u complaints in the second stage interviews that the project was 'too short' and this made a significant difference to what was achieved. Yol\u, however, continued to argue the project was 'too short' and expressed frustration at the inadequate timelines often developed by government departments.

Conversely, some DHCS staff considered that the project team should have achieved *more* from the project. Some of them appeared to consider the process of systematically involving Yol\u in defining and then addressing their issues to be of little value; their interest lay in whether there had or had not been a demonstrable increase in child growth. The value placed on process as opposed to outcomes highlights the different social and cultural values of Yol\u and Balanda participants in the project.

Lessons for community development in health in remote Indigenous Australia

The Child Growth project has four key lessons for community development in health in the remote Indigenous Australia context:

1. Power relationships are central to interactions between Indigenous and non-Indigenous participants in community development processes. Non-Indigenous community development facilitators must therefore have a detailed understanding of power relationships, must be prepared to adopt a 'power with' approach and should work in partnership with trained Indigenous community development facilitators.
2. Indigenous and non-Indigenous participants, with their different social and cultural values, do not necessarily share understandings of key constructs, such as appropriate timeframes and decision-making processes. Both must respectfully negotiate their differences in order to agree on how to implement community development approaches to maximize empowerment and health outcomes.
3. The rapid social and cultural change many remote communities are experiencing increases the complexity of a community development approach, but equally highlights the need for it.
4. The organization and delivery of health services by a large centralized health bureaucracy with a selective primary health care approach undermines community development approaches that seek to empower Indigenous people and increase Indigenous community involvement. Community development approaches would be of far greater value if health agencies adopted comprehensive primary health care (CPHC).



Conclusions

The Child Growth Project has important implications for policy and practice. There have been significant successes in Gapuwiyak, where Yol\u have laid the foundations for better health by developing and partially implementing a strategy to promote the development of their children. Their involvement in acting collectively to address child health problems has also fostered individual and community empowerment, which itself has the potential to promote better community health in the long term. DHCS should continue to support the community members to work towards the full adoption of their action strategy. The effects of the project in improving the development of children in Gapuwiyak and in contributing to community empowerment should be monitored by maintaining the participatory action research process.

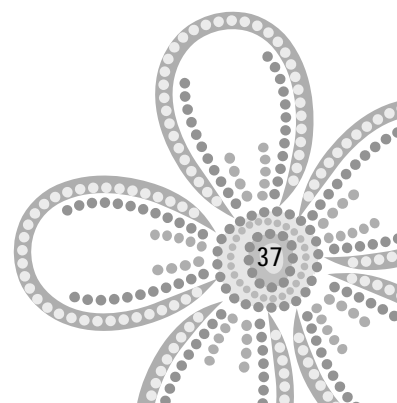
The focus of the GAA program in Indigenous communities should be broadened to cover promoting general child health and development. There should be an increased emphasis on growth promotion and people in the community should be supported to develop and implement growth promotion strategies. Clinic staff should spend more time educating and involving Indigenous carers in growth monitoring.

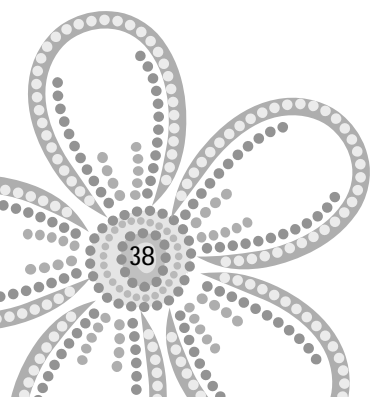
The community development approach used in Gapuwiyak may be applied to health and other issues in other remote Indigenous communities in the Northern Territory. Aspects of the process should be applied and tested for transferability, including:

- employing a project officer and Indigenous project workers;
- problem assessment;
- forming an Indigenous committee;
- community decision-making; and
- critical reflection.

The value of applying community development approaches in other remote Indigenous communities would be enhanced by:

- engaging Indigenous people in remote NT communities in determining their health priorities through comprehensive needs assessment processes;
- strengthening the capacity of Indigenous people in community development skills and processes so they can support their communities to promote health;
- strengthening the capacity of external community development agents and health professionals to facilitate community development processes in collaboration with local Indigenous agents; and
- health service agencies, including DHCS, adopting a comprehensive primary health care (CPHC) approach.





Recommendations

These recommendations were developed at a workshop involving the researchers, DHCS policy staff and health professionals and CRCATH research transfer and knowledge brokering consultants. The research team had developed a set of draft recommendations and these were discussed and further developed at the workshop.

At the Gapuwiyak community level

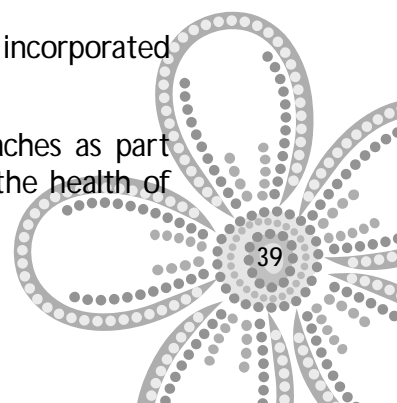
1. That DHCS and CRCATH support the continuing implementation and evaluation of the Family Centre strategy.
2. That the evaluation of the Family Centre strategy be informed by this project, particularly by maintaining the PAR approach and pursuing the qualitative and quantitative data issues raised in this report.
3. That DHCS encourage clinic staff to work with community members to develop a shared understanding of, and complementary approaches to, child growth and development. This could be done through measures identified below at the GAA program and policy level.

At the GAA program level

1. That the GAA program be reviewed, taking into account:
 - the need for a broader concept of growth than physical child growth alone;
 - the need for clinic staff and Indigenous community members to develop shared understandings of and complementary approaches to child growth and development;
 - the need for clinic staff to develop a comprehensive understanding of growth monitoring and promotion, as well as using tools such as growth charts and action plans;
 - the likelihood that monthly weighing of 0-3 year olds may not be realistic;
 - the need for greater attention to growth action strategies involving community members; and
 - the need for GAA data to be disseminated to families eg by providing carers with children's growth charts and giving feedback on community GAA reports.

At the policy and agency level

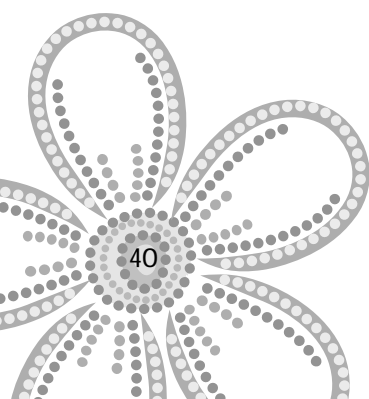
1. That DHCS adopt and promote a broad concept of child growth and development.
2. That the findings of this report and the interim, project report be incorporated into staff orientations and in-services.
3. That DHCS routinely implement community development approaches as part of a Comprehensive Primary Health Care approach to improving the health of Indigenous Territorians by, for example:



- establishing regular forums where community members and clinic staff discuss health issues and strategies;
- strengthening the capacity of DHCS staff in remote communities to work within a community development framework, by strategies including orientation and training for health centre staff and visiting staff and by employing specialist community development staff;
- taking steps to reduce the impact of high clinic staff turnover, recognizing that establishing trusting relationships is central to community development;
- recognizing that community development takes time and that measurable health outcomes cannot be expected in the short term; and
- building flexibility into program development and implementation.

Recommendations to the CRCATH

1. That the CRCATH continue to support:
 - participatory action research and research with a community development focus;
 - the use of appropriate research methods, including, for example, photo-voice; and
 - community members identifying appropriate feedback techniques, including, for example, videos.
2. That Research Agreements be developed and signed by CRCATH researchers and community councils.
3. That Indigenous project advisers be employed to mentor and guide researchers working with Indigenous people.
4. That the CRCAH monitor project management to ensure continuing stakeholder involvement.

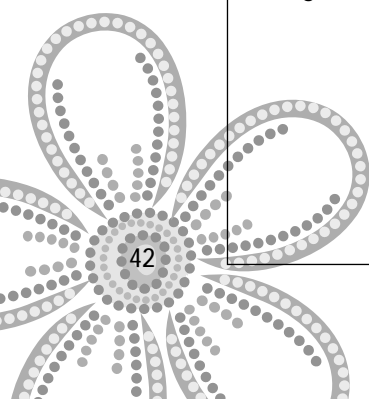


Appendix 1

Factors that affected the project's community development approach

Domain	Influence on project outcome
Participation	<ul style="list-style-type: none"> • Limited community participation at outset resulted in selection of 'wrong' issue and adversely affected participation in later stages • Participation increased over time in quantity and quality as project changed focus to address poor child development and inadequate care • The engagement of a group of community members in acting collectively to address the issue they had identified resulted in the implementation of an action strategy and is evidence of empowerment. • A range of barriers limited the involvement of many Yol\u
Leaders	<ul style="list-style-type: none"> • The existence of three types of leaders and the lack of whether formal, informal or clan leaders had power/authority to decide on action strategy • Over time, through reflection on community decision-making, Yol\u resolved that they needed the support of all three types of leaders, which gave their strategy legitimacy as a 'community decision', although their capacity to lead was tempered by the high value Yol\u place on family and individual autonomy. • Several informal leaders played a key role in implementing the strategy.
Organizational structures	<ul style="list-style-type: none"> • Yol\u Project Committee central to the success of the project, as by acting collectively they partially implemented a strategy that ahs the potential to improve child development. • Through the collective application of their skills and resources to meet a community need, they contributed to a process of community empowerment. • The lack of a 'sense of community' in Gapuwiyak constrained the Committee's ability to mobilize action to address child development at the 'community' level.
Problem assessment	<ul style="list-style-type: none"> • Yol\u defining child growth, identifying solutions and taking action a strong aspect of project. • Family Centre strategy informed by Yol\u knowledge and values, which should promote its effectiveness, and Yol\u knowledge about child growth framed and given a voice alongside biomedical knowledge. • Yol\u participants resisted the Balanda clinic staff's opposition to their strategy and utilised their own knowledge.

Resource mobilisation	<ul style="list-style-type: none"> • Committee and Yol\u team members secured funds to employ two playgroup workers and to employ a Family Centre coordinator to facilitate full implementation of their strategy. • Internal resources were mobilized from the Council, the school and the Strong Women program.
Asking 'why'	<ul style="list-style-type: none"> • Respondents reflected on the causes of poor child development in the first stage interviews. • Committee members engaged in some reflection on the pros and cons of the Family Centre strategy, but were reluctant to reflect further in response to the clinic's concerns. • Extensive reflection seen as part of the second stage data collection on the Family Centre strategy, the reasons it had not been implemented and the value of the project and the community development approach. • The process of critical reflection stimulated the Committee to act on its strategy.
Links with others	<ul style="list-style-type: none"> • Links formed with Council, school, Strong Women program to partially implement the Family Centre strategy. • No partnership with Balanda staff because of: • Different views of 'the problem' and its solution; and • Yol\u resistance to perceived Balanda attempts to influence their decision.
Role of outside agents	<ul style="list-style-type: none"> • Capacity of Balanda project team members initially constrained by: • limited collective experience in community development approach in remote Indigenous community setting; • limited skills in community consultation; • limited Yol\u-<i>matha</i>, limited knowledge of Yol\u social and cultural practices and limited relationships with community members; • deeply embedded power inequalities between Yol\u and Balanda; • capacity constrained by shortage of time, but increased over time as trusting relationships established, by working in supportive partnerships with Yol\u and by learning language.
Project management	<ul style="list-style-type: none"> • Limited initial community involvement in managing project as DHCS shaped it. • Signing a research agreement with the Council did little to increase their role in managing project and key decisions about funding and timelines continued to be made by DHCS. • The second project adviser (a man) and the Committee increasingly made decisions about project implementation.

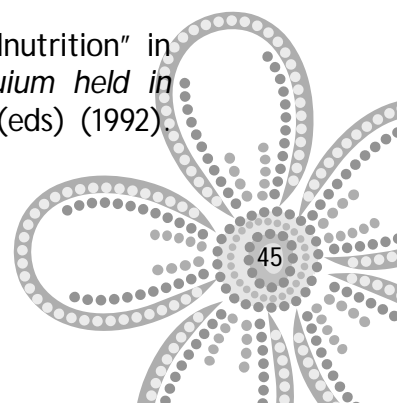


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