



THE UNIVERSITY OF
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Evaluation of Wise Well Women Community Health Educator Program



Final Report – Phase one

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This evaluation was conducted on the unceded traditional lands of the Yorta Yorta people. We acknowledge the Traditional Owners and Custodians of these lands on which we work and live and pay our respects to Indigenous Elders past, present and emerging.

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Disclaimer

The content of this report has been produced in good faith by the evaluation team. The findings are the result of a systematic and rigorous evaluation process. The views expressed in this report are not necessarily those of Wise Well Women.

Suggested reference

Aberdeen L., Reid, C. & Ibrahimi, H. (2022) Evaluation of Wise Well Women Community Health Educator Program. Culture and Rural Health, Department of Rural Health, The University of Melbourne.

Acronyms & Abbreviations

CHE	Community Health Educator
LGA	Local Government Area
MCWH	Multicultural Centre for Women's Health
UoM	University of Melbourne
WWW	Wise Well Women

Further Information

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Executive summary

The Wise Well Women Community Health Educator (WWW CHE) Program was designed and developed by the WWW convenors, Christine Nunn and Lorna Gillespie, to build the health literacy capacity of refugee and migrant women and a responsive health literacy environment in the Shepparton region. The training component of the program comprised learning modules devised by the convenors. These addressed the Australian health care system, health promotion; intersectionality; legal and welfare issues and facilitating and evaluating health education sessions, all in relation to refugee and migrant women's health and wellbeing. Their content drew on similar resources developed by the Multicultural Centre for Women's Health (MCWH) and Cohealth Community Health Centre; two Melbourne based not-for-profit community health organisations committed to addressing health inequity. The six days of training was delivered to 12 women of migrant and refugee backgrounds in Shepparton, Victoria in April 2021 by 33 presenters recruited by the WWW convenors. Its implementation was evaluated by a team led by Dr Lucinda Aberdeen, Department of Rural Health, The University of Melbourne.

The evaluation research design adopted a mixed methods approach to collect, analyse and interpret a range of quantitative and qualitative data gathered about the implementation of the training. It was undertaken during the months of April to July 2021 and found that the training's implementation was achieved successfully through the combination of three key factors. These were environmental factors which ensured a welcoming and safe learning setting; the content of the training which provided interrelated topics of interest and relevance to the needs of the trainees and their communities and the delivery of the training which enabled ready engagement and dialogue between the convenors, trainees and presenters in a spirit of open and critical inquiry. A program enabler identified in the implementation was the trainee-centred orientation of the training. This not only actively engaged the trainees in topics of interest and relevance to them and their communities' needs, it also enabled their views and concerns to be heard and considered progressively by the presenters during the delivery of the training.

The barriers to implementation identified by the evaluation were time and timing issues for both trainees and presenters challenged by shortage of time to address and fully consider the topics presented. Timing issues were further exacerbated for some trainees by the program's scheduling during school holidays which was the only time when all trainees were available to attend. This also happened to coincide with the commencement of the Muslim holy month of Ramadan when some trainees were particularly busy and committed with religious and social activities. Another associated implementation barrier was the absence of sufficient time allocated for trainees to reflect systematically on the large volume of learning materials delivered intensively throughout the training.

The key changes required during the training, identified by the evaluation, were in regard to scheduling, information technology and co-ordination. On occasions some presentations had to be condensed or altered as the allocated time had expired. At other times, the computer equipment and video teleconferencing failed to work or were slow to engage. In the absence of any on-site technical assistance, this created delays that required just-in-time modifications to the presentations affected. Co-ordination challenges arose when planned on-site visits to health and welfare agencies had to be cancelled owing to COVID public health regulations.

The evaluation identified evidence of growing health literacy capacity amongst the trainees in a wide variety of examples. These included increasing confidence of the trainees to seek more information during the presentations and their expressed curiosity and deep interest to continue learning and self-resource their communities on completion of the training. Most notably, after finishing the training, trainees took on the role of Community Health Educators by networking and contacting presenters to assist families in distress over welfare issues and by organising and presenting community information sessions.

As a result of these findings, the evaluation makes eight recommendations, summarised here, regarding the future implementation of the WWW CHE Program:

1. Develop a pre-training session for trainees
2. Modify the scheduling of the training to reduce its intensity of delivery
3. Expand the content of the training to include basic computer and internet search skills
4. Increase opportunities for trainees to discuss, reflect and consolidate the learning content
5. Increase opportunities to deepen interaction between trainees and presenters
6. Develop a Cloud-based electronic resource that systematically consolidates the program materials for trainees
7. Increase opportunities for trainees to learn how to design, develop and deliver community information sessions
8. Create funded opportunities for trainees, once qualified, to continue learning to keep their knowledge current and assess and discuss community needs.

The subsequent recognised success of the WWW CHE Program during the pandemic has drawn attention to the program's capacity for improvement and sustainability to continue advancing the health outcomes for multicultural communities in northern Victoria. To this end, four recommendations have been developed regarding strategic development, operational resourcing, the ongoing professional development of CHEs and support for regional and rural multicultural communities.

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Background

The Wise Well Women Community Health Educator (WWW CHE) Program aims to build the health literacy capacity of refugee and migrant women and a responsive health literacy environment in the Shepparton region. Its objective is to better support refugee and migrant communities and local health and community service providers in a regional area of northeast Victoria. Like many activities and events during the pandemic, it was subject to unforeseen changes. Originally the program was funded with the intent that it be delivered in 2020 by the Multicultural Centre for Women's Health (MCWH). Issues with COVID and funding arrangements, however, intertwined and halted this development. In response the WWW Co-convenors decided to develop, deliver and co-ordinate the program's training themselves in 2021. During January to March 2021, they designed a training schedule, recruited and briefed presenters, prepared their own presentation materials, enrolled participants, developed WWW branding and sourced uniforms, caterers and childcare professionals. The training was then delivered in Shepparton over six days in April 2021 to twelve women trainees during the first term Victorian state school holidays.

The University of Melbourne, Culture and Rural Health Team was approached in February 2021 to evaluate the WWW CHE Program. Ethical approval to undertake the evaluation was granted by the University's Human Research Ethics Committee in April 2021 (Ethics ID: 2021-21394-15625-2). An evaluation team was formed, led by Dr Lucinda Aberdeen, Senior Research Fellow, Culturally Inclusive Rural Healthcare Department of Rural Health Faculty of Medicine, Dentistry and Health Sciences, The University of Melbourne. The other team members were research assistant, Habiba Ibrahimi, then a Master of Social Work student at La Trobe University Shepparton Campus. Habiba speaks four languages, arrived with her parents to live in Shepparton in 2006 and holds an undergraduate degree in humanities and social sciences. Additional support was provided to the evaluation by Carol Reid who is part of the Rural Health Academic Network (RHAN) co-located at NCN Health in Moira Shire, Victoria. Carol holds a Bachelor of Social Work (Honours) and a Masters in Program Evaluation.

The focus of this report is the evaluation of the implementation of the program's training module designed to build the health literacy capacity of refugee and migrant women in Greater Shepparton. The evaluation aimed to provide real-time feedback to enable adjustments for improvement as the training was being delivered. The significance of this evaluation is its appraisal of a unique initiative designed to address regional refugee and migrant health inequity through building health literacy capacity at both an individual and community level. While the need for such initiatives is well recognised (Garad & Waycott 2015; Henderson & Kendall 2011; Mohamed Shaburidin et al. 2020), few have been implemented and health

literacy research in this area remains undeveloped (Saboga-Nunes et al. 2020). An evaluation study of this program therefore also helps address the gap in the health literacy research in this area.

Introduction

There is a wealth of research demonstrating that regional and rural Australia-wide have poorer health outcomes; health services are less available and harder to access, such services are chronically under-utilised by diverse populations in regional Victoria and the cultural diversity is not well reflected in the composition of the rural health workforce (Bourke et al. 2019; Huff et al. 2014).

Furthermore, a characteristic of this health disadvantage is low levels of health literacy amongst migrant and refugee communities in Victoria (Health Issue Centre, 2017), exacerbated by language and literacy barriers, culturally unresponsive services, lifestyle upheavals that accompany migration and settlement and differing cultural perceptions of health (Garad & Waycott, 2015). Increasingly, therefore, health literacy is being recognised as a social determinant of health (Nutbeam & Lloyd 2021) which needs to be embedded at both an individual and institutional level to improve health outcomes (Batterham et al. 2016).

To this end in Australia, the Commission on Safety and Quality in Health Care adopted a national health literacy strategy in 2014 to enable 'healthcare organisations to improve their local health literacy environment' (ACSQHC 2014, p.3). Then in 2016 the Shanghai Declaration, arising from the 9th WHO Global Conference on Health Promotion, identified health literacy as one of three pillars essential for achieving the 2030 Agenda for Sustainable Development (Saboga-Nunes et al. 2020, p.1).

Despite these developments, research in health literacy has been criticised for its continued focus on individuals and its failure to engage at a community and organisational level (Kendir & Breton 2020), overlooking the effects of health literacy on health equity (Nutbeam & Lloyd 2021) and its transformative potential for social justice (Pithara 2020). It has also been criticised for being Western-centred (Saboga-Nunes et al. 2020) and for neglecting how skills in health literacy are developed and practised (Guo et al. 2020). Against this background, this research project aims to evaluate an initiative in health literacy in regional Victoria which by its aims and objectives aims to counter the limitations characterised above.

Wise Well Women Program Context

The Wise Well Women Community Health Educator Program aims to improve:

1. the health literacy and capacity of the refugee and migrant communities; and
2. the health literacy environment in Shepparton including infrastructure, people, policies and relationships

The Program objectives are:

- To develop an understanding of how health promotion and education that attends to sex and gender influences stands to produce more effective health promotion overall, and better health promotion for women specifically
- To develop an understanding of the wide range of intersectional factors that impact upon refugee and migrant women's health and wellbeing
- To develop the knowledge, skills and confidence necessary to prepare, facilitate and evaluate health education sessions with refugee and migrant women and their families
- To establish an excellent knowledge base about refugee and migrant women's health and the Australian health care system including consideration of health promotion and education, prevention, primary and tertiary care, across key women's health topics such as: Sexual and Reproductive Health, Mental Health, Safety and Wellbeing, Prevention of Violence Against Women and Making Healthy Choices and health impacts.

The program was developed by Lorna Gillespie and Christine Nunn. A range of program funders and supporters provided different levels of assistance for the training. These included financial, staff release, auspice and resources such as photocopying, reduced cost venue hire, program materials and professional support (see Appendix 1).

Evaluation design

Aim

This project aimed to evaluate the Wise Well Women Community Health Educator (WWW CHE) Program in Shepparton, Victoria.

Objectives

The objective of the evaluation was to identify the strengths and weaknesses of the program's design and delivery and identify features to improve it for future replication.

Key evaluation questions

1. How was the implementation of the training achieved?
2. What enablers and barriers were identified in the implementation of the training?
3. What changes were required during its implementation?
4. In what ways did the training increase the health literacy capacity of the trainees?
5. What modifications to the training were identified as necessary for the program's future replication?

Method

The evaluative research design involved a mixed methods approach to collect, analyse and interpret a range of quantitative and qualitative data. The evaluation for the Wise Well Women Community Health Educator Program was undertaken during April through to July 2021.

Data collection

The evaluation data involved the collection of several sources of evidence:

- Observational data
- Documentary data
- Trainee and presenter program feedback forms
- Trainee and presenter focus group interviews

Observational data

The observational data consisted of the evaluators' systematic handwritten observations of the program participants in the training environment. Between them, the three researchers attended all training sessions and took handwritten notes during each of them. Their notes were then compared and cross-referenced to inform the interpretation of the other evaluation data collected.

Documentary data

The documentary data consisted of all the materials provided to trainees, such as learning materials in the form of printed handouts to trainees, presenter PowerPoint slides and service information flyers.

Trainee and presenter program feedback forms

Daily training feedback forms for trainees and presenters were developed in conjunction with the WWW CHE convenors, prior to the commencement of the training. The purpose of these forms was to capture feedback on each of the presentations delivered during each training day. An end of session survey form was also developed for the trainees to complete.

Trainee and presenter small group and individual interviews

After the training was delivered, trainees and presenters were invited to participate in a group or individual interview. The purpose of these interviews was to gain more in-depth views and about the training from the participants' perspectives. This resulted in 11 of the 12 trainees and 7 of the 33 presenters being interviewed either individually or in small groups (see Table 1), using one of two sets of questions. Two group interviews were held in-person at locations convenient to the participants. Owing to the introduction of COVID-19 public health restrictions, all 7 individual interviews and the third group interview were conducted virtually via video teleconferencing. All the group and individual interviews were recorded. The recordings were then transcribed, coded and examined for themes by members of the evaluation team.

Table 1: Interview type, participant type and numbers

Interview Type	Participant Type	No. of participants
Small group 1	Trainees	4
Small group 2	Trainees	4
Small group 3	Presenters	3
Individual	Trainees	3
Individual	Presenters	4

Ethical considerations

Ethical approval for the evaluation was granted by the University of Melbourne's Human Ethics Research Committee (ID: 2021-21394-15625-2). Informed consent ensured that all participants had the choice to take part in the study and fully understood its risk and benefits and what would be asked of them. All potential participants (trainees and presenters) were provided with a plain language statement and an opportunity to ask questions for further explanation about the evaluation. Signed consent forms were required prior to evaluation activities commencing.

Results

Environment

The training took place over six days in April 2021 and was held at St Paul's African House in Shepparton. This venue comprises a Lutheran Church and community facilities which were purpose built in 2014 for the Greater Shepparton African community. The facility is regularly used for cultural and capacity building activities by migrant and refugee communities and was selected by the Program convenors as a culturally inclusive and safe environment. To facilitate access to the CHE training program, childcare for trainees was provided at the venue. Three children of the trainees were supervised by qualified multicultural childcare workers over each training day. Lunch and healthy snacks which accommodated dietary needs, such as halal requirements, were provided for the trainees.

Evaluators' observations

On each day of the training an evaluator observed and took notes. These were used to cross check and verify the data gathered by the feedback forms and interviews and assist with the overall evaluation of the training.

Five days of the six-day program were delivered in the large foyer at African House, while the sixth day compromised site visits to health and welfare agencies in the Shepparton CBD. The foyer was a space well-lit with natural light and an attractive outlook onto the facility's gardens and car park. During the presentation sessions at African House, the trainees were seated in groups of three around four circular tables. These seating arrangements were observed to enable the trainees to get to know and assist each another. A welcoming touch was added to the ambience of the learning space by the convenors who covered the tables with bright tablecloths and decorated them daily with fresh flowers. Each trainee was provided with a laptop for use in class and their own folder in which to store all hard copies of the learning materials. Further, a photo ID and biography of all the trainees and the presenters were displayed openly at the foyer entrance for all the program participants to view.

Most learning modules were delivered in-person by the presenters using audio-visual aids, such as PowerPoint slides and video clips, and printed materials including flyers and brochures which they distributed to the trainees. Occasionally presenters circulated objects such as contraceptive devices for trainees to handle. Many of the presenters were observed to make very effective use of humour and share their own experiences to encourage the trainees to talk and reflect about their own experiences. The success of this approach was apparent in the confidence trainees increasingly displayed in their class participation through sharing examples and questioning. Several presentations were delivered remotely from presenters unable to

attend in-person (days 3, 4 and 6). On several occasions, these were not successful owing to a break in transmission which proved difficult to resolve in the absence of any on-site technical back-up. In addition, viewing videos and PowerPoint slides shown on the single small wall mounted screen in the foyer was observed to be difficult for trainees.

The convenors undertook very active 'hands on' roles throughout the training to establish and maintain a safe, well organised and positive learning environment. This involved their welcoming and introducing presenters to the trainees as well as delivering several learning modules themselves. In addition, the convenors openly prompted and encouraged trainees to participate and question (including during service site visits); addressed intermittent AV failures; compiled a cumulative handwritten glossary on butcher's paper and oversaw the catering. The convenors also assisted the trainees who were tasked to thank the presenters and give them gifts and to undertake an Acknowledgment of Country in pairs on each day of the program. At the start of the second week, the convenors employed an assistant to support them organise the training materials for trainees to keep these systematically in the folders supplied to them. The assistant also provided support with technology, running occasional errands and packing up at the end of each day.

At times during the presentations, the learning space was observed to be noisy and busy as people not associated with the program moved in and out of the venue to attend to unrelated matters. This did not appear to bother or disrupt the trainees and their eagerness to learn despite their physical and mental tiredness apparent at the end of each day's training. They were observed to establish collaborative and supportive inter-group relations taking turns, for example, in assisting with the care of one trainee's newborn baby who was present throughout most of the training. Further, in the second week, the emergence of a group identity amongst the trainees was apparent with each of them wearing their WWW CHE uniforms in an individually styled manner. The uniforms were presented by the convenors to the trainees at a family lunch for trainees and their families held in African House at the end of the first week. They consisted of large colourful scarves, long sleeved long white shirts and name tags.

The consensus of the evaluators' observations was there was systematic attention by the convenors to the social and emotional wellbeing and safety of the trainees and their learning needs, as exemplified by the setting described above.

Participants

Trainee recruitment into the program was undertaken during 2020. It involved approaching community-based organisations within Shepparton whose staff members represented different ethnic and language groups, were recognised as such and enjoyed the support of their

communities to identify potential trainees. In addition, such individuals needed to be fluent in both English as well as their first language. Once it was established that the individuals identified wanted to undertake the WWW CHE Program training, a process of negotiation with their employer to secure their work release for six days training was undertaken by one of the program convenors.

By this process, 12 multicultural local women with a range of technical and post-secondary qualifications and employment and volunteering experiences in the health, welfare and education sectors were recruited as trainees by the end of 2020. They represented eight multicultural communities across Shepparton including Afghan, Burundian, Filipino, Kenyan, Iraqi, Sri-Lankan, South Sudanese and Sudanese. Amongst this group over 12 languages (including dialects) were spoken. Although trainees were not paid to participate by WWW CHE Program funding, those employed in agencies were paid by their employers for the days they normally worked and trainees who were not employed at the time were paid an honorarium.

Sourcing appropriate local presenters to deliver the training sessions was undertaken by the convenors throughout January to March in 2021. This was reported by the convenors to be particularly challenging given the timing coincided with COVID public health restrictions and associated workplace restrictions. Despite this, individuals from local health, welfare and community organisations and several private providers, numbering 33 presenters, were recruited to deliver the training (see Appendix 2). To enable consistency of approach in the depth of coverage of the topics, the presenters were provided in advance with briefings and preparatory materials by the convenors. These included a proposed format to cover the topic along with a photograph and biography of each of the trainees, prepared and circulated with their permission.

Program training content

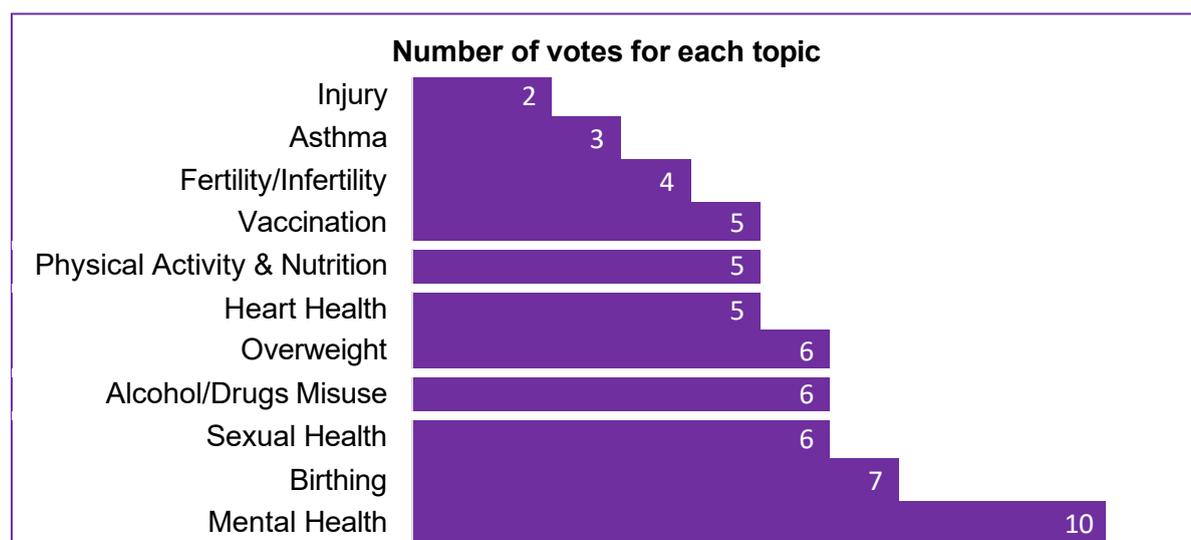
The training was devised and developed by the WWW convenors to address the program's four objectives (see p.10 above). Specifically, it comprised learning modules addressing health promotion; intersectionality; facilitating and evaluating health education sessions and the Australian health care system, legal and welfare issues, all in relation to refugee and migrant women's health and wellbeing. Each of the learning modules delivered was purposively arranged to have a central theme and associated topics. For example, day five of the program focused on the subject of family safety and included topics on family violence, sexual assault and the Australian family court system. This was not always achieved as the training delivered was somewhat different from planned for a range of reasons: timing, presenters needing to change time of delivery. It also meant that some components of the training, such as the

trainees learning how to keep reflective journals (day 1) and sharing their content with the class (day 2), were not fully realised. A copy of the full training program is attached in Appendix 2.

Trainee feedback

The Wise Well Women Program undertook paper-based pre and post program surveys with the trainees as a collaborative undertaking with the evaluator. Overall, eleven pre-surveys and seven post-surveys were completed by trainees. The pre-surveys explored women’s health issues in which the trainees were most interested, with sexual health and mental health indicated as areas of high interest (see Graph 1).

Graph 1: Trainee votes on health issues they were interested in learning about



Post-survey, the trainees indicated the health topics important for their community, these can be grouped into three key areas (see Table 2). Responses suggested learning about community needs had been triggered by the program for trainees.

Table 2: Health topics trainees indicated as important for their communities

Key topic	Sub-categories
Women and family health	Family planning (avoiding and controlling pregnancy, contraception), family violence, children’s health, mental health
Chronic health	Cancer (bowel cancer and sun cancer), heart disease, diabetes
Service system	Organisation available and services offered

Pre-and post-surveys were compared for change under the broad domains of trainee's self and learning confidence and health topic confidence. A selection of these results is summarised in Table 3, reported by percentage ratings of agreement.

Table 3: Comparison of pre and post trainee feedback

Domain	Question	Pre-training rating	Post-training rating
Self and learning confidence	Speaking in front of people	91% agreed	100% agreed
	Using email	91% agreed	100% agreed
	Using the internet	91% agreed	100% agreed
	Trying new things on a computer	91% agreed	100% agreed
	Keeping a record of discussions	91% agreed	100% agreed
Health topic confidence	Talking to healthcare workers about my/my family's health	82% agreed	100% agreed
	Asking healthcare workers questions	91% agreed	100% agreed
	Getting agreement with my community about health needs and issues	90% agreed	100% agreed

Post-survey written comments showed that the trainees enjoyed making connections and the engagement with the presentations, for example:

I enjoyed every day. Each day was educational, addressing a different health topic. The program was really beneficial for me and our community.

Trainees also commented on challenges and areas of improvement for example:

The short time for each guest speaker, we need deep sessions and on some of the important topics, such as mental health, avoiding pregnancy for women.

Trainee interviews

Group and individual interviews with the trainees were conducted to provide further understanding of their experiences in undertaking the training. Interview questions were similar to those on the feedback form, asking about successful and challenging factors, keys areas of learning and desired further learning, additional learning support, improvements for the program, impact on health literacy and concerns about working as a community health educator. A total of eleven of the twelve trainees agreed to be interviewed.

Program enablers

The enablers were identified by asking trainees: What did you think was the most successful aspect of participating in the program? Their responses were grouped under the broad sub-theme of program content. This revealed that it was the depth, range and usefulness of the information presented about refugee and migrant women's health and wellbeing which the trainees saw as the most successful aspect of the program. For example, one participant commented,

I liked the program from day one to the end ... I learnt a lot for my community, we like to share with them (Participant 4)

Topics noted as being particularly useful included *family violence and women's health* (Participant 2), *Centrelink* (Participants 6 and 7), *the Australian health system* (Participant 9) and *contraception... mental health [and] nutrition* (Participant 11). Specific attributes of the presenters were noted as enhancing the delivery of the program's content. These included the presenters' skills in establishing good rapport with the trainees,

There was good communication between us and them (Participant 1)

Having only female presenters deliver information about women's health issues with whom 'you can tell everything' (Participant 2), was viewed as important in enabling open communication. One trainee also commented that the cultural diversity of the trainees itself enhanced co-learning opportunities in the program.

Program barriers

Program barriers experienced by the trainees were explored by asking them the question: What do you think was the most challenging aspects about participating in the program? Their responses indicated that key barriers were the volume of content and pace of its delivery. Typically, the trainees remarked as follows,

We have got like four or five guest speakers in one day. It was too much.
(Participant 2)

It was lots of information in a very short time ... I find that it was rushed.
(Participant 12)

For a number of trainees this intensive learning situation was exacerbated by the fact the program's delivery occurred during the commencement of Ramadan. In addition to fasting throughout the day for the month, it meant additional activity in gathering nightly with family and friends for a meal to break their fast. One trainee commented that it was 'too much' (Participant 5). Another explained,

It was hard... from the morning we started fasting and we came there [to the program] from nine to four (Participant 8)

Several trainees were of the view that ICT used for the delivery was challenging, either because it failed or because of their dislike or unfamiliarity with online learning via video conferencing.

Building health literacy and capacity of the refugee and migrant communities

Building the health literacy and capacity of the refugee and migrant communities is a key aim of the WWW CHE Program. The evaluation sought evidence of this outcome by asking trainees interview questions such as: What were the key areas of learning for you from the program? In what ways do you think your knowledge about health literacy from the program will help your community? and Do you have any concerns or fears about working as a community health?

The trainees' responses indicate that the program enabled them to learn about refugee and migrant women's health and wellbeing in Australia in a number of domains. These included learning in specific areas such as family planning (days 1 and 3), mental health (day 4), family violence (day 5), health and welfare services information (days 3, 5 and 6), nutrition (day 1) and women's health issues (days 2 and 3). A number of trainees commented on the relevance of these areas to their communities. For example,

Most of the people have gone through mental health issues, but they don't want to talk about it, because maybe they think the community might judge them (Participant 11)

In addition, a number indicated awareness of the intersectional nature of these areas, such as the overlap between the Australian 'health system with the legal system' ((Participant 1), particularly in regard to migrants and refugees securing permanent residential status in Australia.

Knowledge about health literacy gained from the program was seen by the trainees as enabling them to help their communities. Comments included,

It really helped with the health literacy, actually. For example, when we go to the specialist from here in Shepparton to Melbourne, we didn't know actually, there is a thing we can claim transport [and that] you can write applications and things. Those things, so many things we learn [for example] with family violence where to go to - counselling, or support people, no jobs, what to do, how to get Centrelink and things, how to apply (Participant 9)

Yes, it will help them especially ours from Africa. They don't have that much knowledge, especially those who are from the camps.... I think it will help them so much (Participant 11)

At least four of the trainees reported using the knowledge gained from the program subsequently to assist community members by referring them to health and welfare services to address issues of concern. One remarked,

I liked the health part, which is the family planning and those things, which helped me to pass information around the community and refer them to GV hospital, so they can get an idea [about] how they can bring [have] more children, or they can have a plan before they get pregnant (Participant 2)

Another trainee reported that the program had given her confidence to organise a community meeting in a local mosque to discuss mental health, a topic which community members had previously been reluctant to consider. She commented on the meeting's success,

We did not expect [but] a 100 people came in the mosque. So, it was really good (Participant 8)

The concerns or fears about working as a community health educator, which the trainees voiced, pertained to feeling the need for 'more information' (Participant 4), that is, more training on how to organise and conduct community meetings and information session. Many of the post training activities planned were disrupted and stalled, however, by the stay-at-home public health COVID-19 directives. As one trainee stated,

because of the COVID, we're stuck, we can't do anything much (Participant 2)

Several trainees were concerned about their capacity as CHEs to balance the demands of the role with their private lives. One stated,

You're having this role between you and the community and you don't allow them or give yourself the whole time for them ... during the night or whatever they want (Participant 1)

To this end, learning about self-care through setting professional boundaries and time management on day 6 of the program was seen 'really useful' (Participant 2).

Program change and improvement

Perspectives on improving the program were a further element of the evaluation. To examine modification or change for the training the evaluators sought evidence about achievement of the WWW program objectives and critical sustainability factors. To explore these areas the questions incorporated into the interviews were broadly: What topics would you like to have learnt more about? What if any additional support would have assisted you? and Do you think there are any ways in which the training program could be improved?

Mental health, addressed in day 4 of the program, was most frequently mentioned as the topic about which the trainees would like to have learned more. The prevalence of mental health illness in their communities and stigma and reluctance to acknowledge this were seen as requiring additional knowledge and skills to address. For example, one trainee commented,

We need more support on it, because everybody has a mental problem
(Participant 4)

Another commented,

... it's a hard topic because ... most people don't accept it. Most of the people have gone through mental health issues, but they don't want to talk about it, because maybe they think the community might judge them (Participant 11)

Other topics about which the trainees would like to have learned more were education to encourage regular health checks, community organising for health education, '*how to bring them [the community] together*' (Participant 5) and trauma training. In this aspect, one trainee stated,

... we want some exercise or some techniques that we can actually use that teach the parents and the young kids that come from trauma backgrounds to make them to feel them that it's okay, you're now ... not in prison (Participant 6)

One additional support which trainees identified would have assisted them in participating in the program was a centralised, preferably electronic, resource where the learning materials were collated and stored and available to access for review and revision in their own time. This was seen as a means to overcome difficulties in note taking and writing in English as a second, third or fourth language,

... you cannot take down notes, you know, with them, while somebody is presenting there. You have to listen (Participant 7)

I am not really fast [at] writing (Participant 8)

Regular opportunities during the training for small group work where trainees could discuss and review the learning materials amongst themselves in a more informal manner were identified as another means to assist participation.

I think would be nice if they let us like, discuss it just together, like as a group, or just discuss it among us, instead of putting us on the spot ... I feel like I'd have a lot more to say and just be more relaxed in sharing my thoughts (Participant 2)

The inclusion of small group work was also suggested by trainees as a means to deepen the learning experience from the program. Typical comments included,

We need to have like a review after each session... [to] comment or review about topics and discuss more deeply (Participant 1)

...more group activities, like smaller groups, do stuff and then present it (Participant 3)

Reducing the content covered each day by the program was also identified by trainees as another way to enhance deeper learning and improve the program.

Maybe we could have fewer speakers per day..... So that we can get to understand much better (Participant 11)

Another improvement suggested by the trainees was to slow the pace of the program's delivery by holding it over a longer period and for shorter days and not during Ramadan.

... not during the Ramadan ... a shorter day, perhaps from 9-2, not to 1 [pm], they can do it instead of six, day seven- or eight-days training in a shorter way, and then we can learn more much better in that way (Participant 2)

Several trainees were of the view that the program would be improved by incorporating ongoing education through the formation of a group of CHEs who met regularly,

... working as a community health educator day by day, things [are] changing like, like global pandemic and things, day by day, vaccination problems, government rules and regulations. Those kinds of things. How about [meeting] once a month or something, we can refresh our knowledge? (Participant 9)

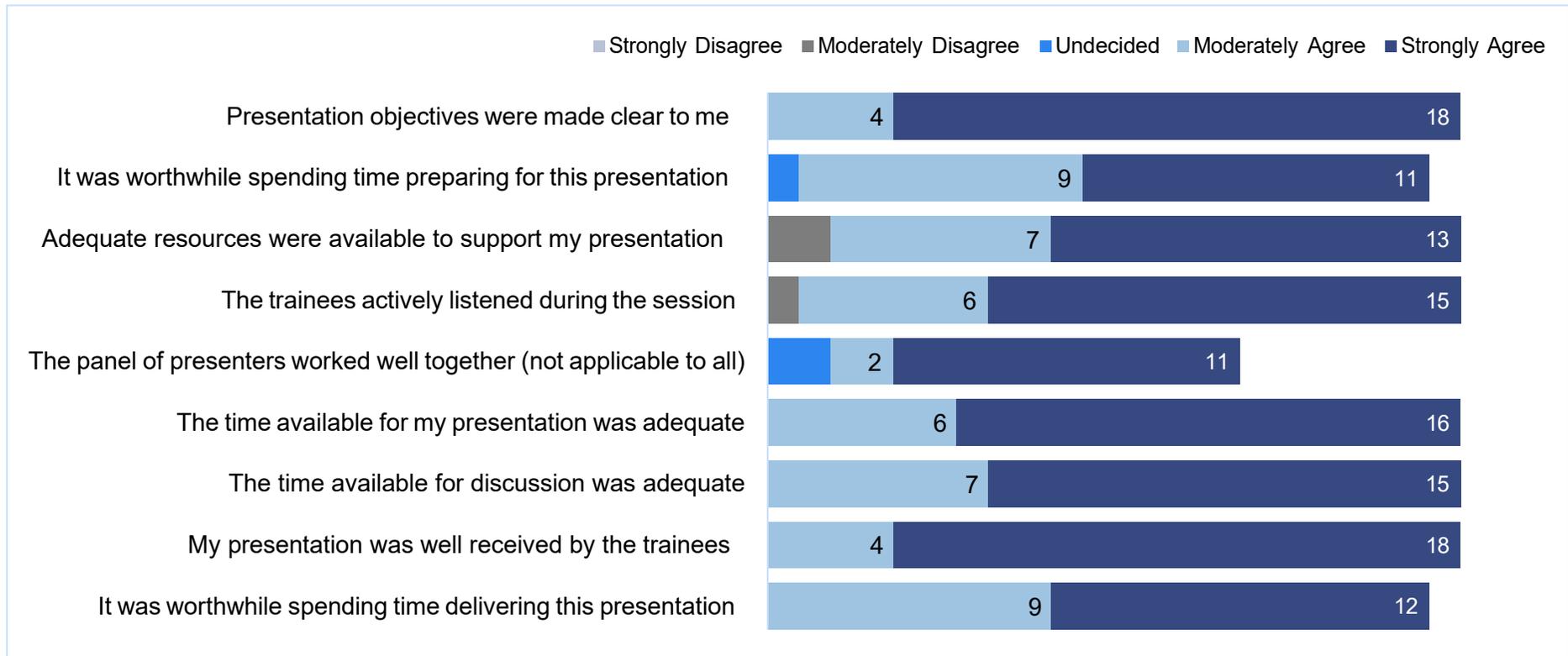
Presenter feedback

Overall, 33 presenters provided information to trainees over six days. Twenty-two presenters returned feedback back forms, a return rate of 66 per cent. Levels of agreement on nine broad areas indicated presenters mainly 'moderately agreed' or 'strongly agreed' when rating the statements. A summary of key results is provided in Graph 2. Written comments elaborate this feedback shown in Table 4.

Table 4: Presenter written feedback

Feedback question	Response summary	Example written comment
What was the most <u>successful</u> part of your presentation?	Written comments were mainly about the interest, engagement and questions from the trainees.	<i>“There was engagement from the trainees, with strong interest to learn more.”</i>
What did you find <u>challenging</u> about delivering your presentation?	Comments acknowledged the difficulties in providing broad information concisely to meet the needs of the trainees.	<i>“This is a huge topic, and it would be better to break it down, I felt I tried to give too much information.”</i>
In what ways could the training be <u>improved</u> ?	Most comments were about needing more time.	<i>“More time for more group discussion would be great.”</i>
Other comments	Presenters wrote they were appreciative of the opportunity to present and connect with the trainees.	<i>“Loved meeting the women. Hope to connect with them in future.”</i>

Graph 2: Presenter feedback



Presenter interviews

Group and individual interviews with presenters provided an opportunity for in-depth understanding of their experiences with the training. Interview questions were similar to those on the feedback form, asking about successful and challenging factors, learning and change (professionally and organisationally) and improvement for the program. A total of seven presenters agreed to be interviewed.

Program enablers

The enablers were identified by asking presenters: What was the most successful aspects of the program? Their responses were grouped under the broad sub-theme of:

Trainee centred approaches and adult learning principles

This theme included the strong enabler of the opportunity to involve diverse presenters. It was thought to assist with demonstrating potential success to encourage the trainees. This feedback demonstrated the contribution toward the WWW objective for CHE's to develop the necessary knowledge, skills and confidence to prepare, facilitate and evaluate health education sessions. The following presenter interview quotes provide examples:

I think one of the things that is really, really important is, when you're delivering to a multicultural group, that there is representation, at least from some aspects of that group.

It's very important as individuals to be able to identify with someone when they're [referring to the CHE's] learning new experiences. ... It was just so relatable for the participants to see what they can achieve.

Another key program enabler evident in this theme was engagement and interaction and the intimate nature of the small group format. This facilitated interconnectedness, as illustrated by the following quotes:

I think that engagement was the most successful aspect and the opportunity to address all the questions individually, ... [to] make them feel heard, and to tailor and address their questions

One of the great things was it was a more intimate group. So, there wasn't a large number of people. So automatically, that rapport was there and they were really eager to learn.

Program barriers

Program barriers experienced by the presenter were explored through the question: What do you think was the most challenging aspects about presenting in the program? A broad sub-theme to program barriers was highlighted as:

Presenting a general view within time constraints versus specific needs

Generic and general overviews of topics were a barrier against usefulness to the trainees. More tailored presentations would have addressed the trainees' backgrounds and their needs. However, time constraints prevented this as illustrated by the following quotes:

[Topic name] is a huge topic. So it was keeping to a time frame and, I guess, trying to build in some activities that could have got people interacting more, when trying to fit content in such a short time frame.

Not to be drawn into specific cases, for single questions. Keeping to the general side of things, what [name] program, what services we offer, from a more general view.

I kept it very broad and just assumed very little understanding, but I suspect that across that group, there was quite a broad level, due to broad backgrounds.

Building the health literacy environment

Building the health literacy environment is a key objective of the WWW Program. The evaluation sought evidence of this by asking presenters interview questions which included: What do you think you learned professionally from presenting? and, In what ways could your learning assist you to improve the service you or that of your organization deliver?

Two sub-themes relevant to professional learning and service improvement were apparent. Firstly, aspects of building capacity through workforce diversity:

Workforce diversity builds capacity for community-based solutions

Reinforce things more than learning ... the importance of working together, getting people together, so they can problem solve together.

Delivering in a group environment with different backgrounds does come with a lot of benefits.

I would definitely, if that opportunity come up again, to source someone to come, student ambassadors, reflecting on their experiences is way more powerful.

The second sub-theme was relevant to building service capacity:

Advocacy and role models to increase inclusive, effective & efficient service

It just really brought home to me how difficult it is for our non-English speaking background community. I can still see there's major gaps from our service perspective of how we reach out to people.

Communities of education and working in a small, rural areas. I think we need to be out there talking more.

Seeing that people can succeed, for example, graduate nurses, could talk to their local communities about their journey

Program change and improvement

Perspectives on improving the program were a further element of the evaluation. To identify modifications or change for the training the evaluators sought evidence about achievement of the WWW program objectives and critical sustainability factors. To explore these areas the interview questions asked of presenters included: Is there any additional support that would have looking back, you think might have helped? Do you think there are any ways the training program as such, could be improved? What opportunities there might be to utilize a community health educator in your role? and How will you encourage others in your organization to utilize the skills of a community health educator in their health promotion activities?

Three sub-themes important to evaluate opportunities for change and improvement emerged:

More time to be social

More time, to be more relaxed, more informal time.

I felt it was a big subject. And I just thought, it probably would have been an opportunity to come, have morning tea, socialise a little bit with the women and then engage in the topic.

Reflective group work

Probably some interactive kind of things, where some small group work would be useful, and getting people to talk a bit amongst themselves.

I would like to come back to do some more specific work on different things.

Opportunity realised and future potential

The program was valuable because of the contact we made on that day. We created that network. It facilitated working together to get a payment sorted for family and to run COVID information sessions and Family Violence sessions.

Certainly, having continual engagement is really good on both sides. Also emphasising the point that it's really important to have robust conversations where there's shortfalls or where we need to pick up on things, like if there's a referral pathway that didn't go so smoothly.

Review of the Findings and Recommendations

This section of the report returns to the key evaluation questions and summarises the findings relevant to each question.

1. How was the implementation of the training achieved?

Implementation of the training was facilitated mainly through:

- environmental factors such as the safe venue, attractive and welcoming setting, on-site childcare and provision of refreshments and healthy food options
- program content factors including the selection of interconnected topics of interest and relevance to the needs of the CHE trainees and their communities
- program delivery factors of relationship and engagement such as the high levels of trust between the co-conveners as program developers and the interactive dialogue between trainees and presenters.

2. What enablers and barriers were identified in the implementation of the training?

The enablers identified were:

- the trainees felt highly engaged and well heard
- the range of interconnected topics presented which were of interest and relevance to the trainees
- provision of wide-ranging and useful health and services access information and resources which were highly relevant to their communities' needs
- the use of tactile teaching aids disseminated during presentations

The barriers identified were:

- time and timing issues where trainees and presenters experienced a shortage of time as a challenge which was exacerbated for some trainees by the program being conducted during Ramadan
- the absence of allocated time needed by the trainees to reflect systematically on the large volume of learning materials delivered intensively throughout the program

3. What changes were required during its implementation?

Changes to the program related to:

- time, there were occasions where the program had to be condensed or altered due to the allocated time expiring
- technology issues when video conferencing did not operate and sound had to be accessed through a mobile phone

- co-ordination challenges with unexpected cancellations of on-site visits to health and welfare agencies

4. In what ways did the training increase the health literacy capacity of the trainees?

There is a wide variety of examples of increased capacity in trainees:

- the emerging confidence of trainees to ask question during the presentations
- feeling empowered to act, shown subsequently by trainees as CHEs in their networking and contacting presenters to assist families in distress with welfare issues and to present community information sessions
- curiosity and passion to continue learning and self-resource communities as CHEs

5. What modifications to the training were identified as necessary for the program's future replication?

The responses to this key question inform the eight recommendations of the evaluation that align with the objectives of the WWW CHE Program:

1. Develop a pre-training orientation session for trainees which explains how the training will proceed and what to expect from it and which identifies and addresses concerns of trainees in advance
2. Modify the duration of the training to incorporate shorter learning modules (e.g. four to five hour time periods) delivered over three or four weeks
3. Expand the content of the training to include an optional learning module addressing basic computer and internet search skills
4. Introduce opportunities, such as small group activities, for trainees to systematically discuss, reflect and consolidate the learning content throughout the program
5. Introduce opportunities, such as ice-breaker activities, to deepen interaction between trainees and presenters by knowing more about each other
6. Develop a Cloud-based electronic resource that consolidates the program materials for trainees to review and revise during and after the program
7. Increased opportunities for trainees to learn how to design, develop, deliver and review community information sessions

8. Create opportunities for trainees to continue learning through regular catch-up meetings, similar to a Community of Practice, to keep their knowledge current and assess and discuss community needs.

Limitations of the evaluation

The evaluation of the training was conducted when intermittent COVID -19 public health restrictions were in force. These restrictions impacted on both the training and its evaluation in number of ways. Firstly, they meant that the delivery of the WWW CHE Program overall was subject to last minute changes and periodic delays. This resulted in the evaluation addressing the first aim of the program to build the health literacy capacity of refugee and migrant women, but left it unable to assess its second aim to build a responsive health literacy environment in the Shepparton region after the training was delivered.

Secondly, working remotely in a pandemic environment created additional demands in the lives of the presenters who delivered the training sessions. Despite most agreeing to take part in either group or individual interviews, many found themselves unavailable to do so. This resulted in a lower than anticipated participation rate (22%) in these evaluation activities.

Postscript

The pandemic saw unexpected and funded opportunities arise for the newly trained CHEs to assist in public health education and the vaccine roll out for multicultural communities in the Shepparton region leading to increased vaccination rates and alleviated fear within their communities. Their emergence and acknowledged success indicate that the health literacy capacity they acquired from the training has been put to use by them as CHEs to help build a responsive health literacy environment in the Shepparton region. This success of the WWW CHE Program has drawn attention to consideration of the program's capacity for improvement and sustainability to continue the advancement of health outcomes for multicultural communities in northern Victoria. To this end, four recommendations have been developed by the evaluation team in consultation with the program convenors. These address strategic development, operational resourcing, ongoing professional development of CHEs and support for regional and rural multicultural communities as set out below.

Recommendations for WWW CHE Program improvement and sustainability

Strategic development

It is recommended that a sustainable governance structure (e.g., auspice arrangement, consortia model or stand-alone not-for-profit organisation) be adopted to assist with securing recurrent funding and that sustainable contractual arrangements be established for the ongoing engagement of the CHEs, partners, health and community service providers.

Operational resourcing

It is recommended that CHE training be further supported through policy and procedure development; documentation and communication management; administrative and office support and delivery logistics (e.g., organisation and costs of venue hire, catering and childcare). In addition, such resourcing should also include training for the development and writing of manuals, capturing and monitoring evaluation data (e.g., all types of feedback from various stakeholders) and funding for ongoing professional development, effective use of technology and expenses allowances (e.g., telephone, data, travel and stationery).

Professional development

It is recommended that the ongoing professional development of trained CHEs be supported through the establishment an overall annual training plan and individual professional development plans that encourage CHEs to build their own capacity (e.g., via access to free on-line education) and a community of practice to discuss common work and enable regular networking, planning and debriefing meetings (e.g., monthly/bi-monthly and guest speaker events).

Regional and Rural Multicultural Communities

It is recommended that multicultural community members as health consumers and health service providers be supported further by recognising their needs through developing an annual/bi-annual context relevant health literacy plan (considering mutual needs and challenges) and through planned sessions and multiple ways of providing two-way engagement (e.g., formal and informal sessions, mix of in-person events and information sharing via social media and video conferencing).

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Appendix 1



Wise Well Women: A Community Health Educator Program

Organisation	Financial	Auspice	Staff Release to Participate in Training	Professional Advice and Support	Other Resources e.g., photocopying, reduced cost venue hire, program materials
Ethnic Council of Shepparton and District					
Greater Shepparton Foundation					
Upotipotpon Foundation					
Women’s Health Goulburn North East					
St Paul’s African House					
Uniting Goulburn North East					
Save The Children					
FamilyCare					
Connect GV					
Greater Shepparton Lighthouse Project					
Caroline Chisholm					
Greater Shepparton City Council					
Multicultural Centre for Women’s Health					
Cohealth					
The University of Melbourne					

Legend

The WWW CHE program commenced with a six-day training program (CHE TP), computers were required for a number of the women, this is acknowledged as Computer Purchase (CP).

Not all the agencies which provided speakers for the CHE Training Program are included. For this information, see Appendix 2.

Appendix 2



Wise Well Women: A Community Health Educator Program



	9.15 am – 10.15 am	10.15 am – 12.25 pm	1.00 pm – 3.20 pm	3.20 pm – 4.00 pm
<p>Day 1</p> <p>Wed 7 April</p>	<p>Presenter(s): Lorna and Chris</p> <p>9.30am – 9.50am Introduction and Welcome to Country Chanoa Cooper A little local history Chanoa's connection to country Welcome to Country and what it is about</p> <p>9.50 am – 10.15 am Icebreaker: Introductions and sharing knowledge of myths in relation to Women's Health (1 per participant)</p>	<p>Facilitators: Lorna and Chris 10.15 am – 11.00 am Overview of the project Health educators': introduction to roles, responsibilities, purpose, benefits for communities and service Introduce Lucinda re: Evaluation Read Plain Language Statement Complete Consent Form Complete Pre-training Survey</p> <p>Break 11.00am – 11.10am</p> <p>Making Healthy Choices 11.10 am – 12 noon</p> <p>Presenter: Varin Eddy Addictions: Alcohol, Drugs, Smoking and Gambling</p> <p>12 noon – 12.25pm Overview of Australian Health System Day 1 Session 1 Handout (01) Factors Influencing Health Literacy Day 1 Session 1 Handout (02) Australia's Health Landscape Print as A3</p> <p>Importance of focussing on refugee and migrant women's health</p>	<p>Facilitators: Lorna and Chris 1.00 pm – Presenter 2.20pm: Suzanne Wallis Reproductive Health Family planning including Natural Methods Infertility Pregnancy Choices Effects of Alcohol and Drugs Health consequences related to Female Genital Mutilation/Cutting (FGM/C)</p> <p>Break 2.20pm – 2.30pm</p> <p>2.30 pm – 3.00 pm Presenter: Chris Biesiekierski Hepatitis</p> <p>Making Healthy Choices 3.00 pm – 3.20 pm am Presenter: Izzy Gribben PCC and Simple & Whole Nutrition Nutrition: healthy eating, 5x food groups, portion size, occasional foods, food labelling, food safety and storage impact e.g., Dental, Diabetes Exercise: Benefits of physical activity, recommended amount for ages and stages of life, ways to increase physical activity</p>	<p>Presenter(s): Lorna and Chris</p> <p>Making Healthy Choices cont.... 3.20pm – 3.50pm Presenter: Izzy Gribben PCC and Simple & Whole Nutrition</p> <p>3.50 pm – 4.00pm Start Reflective Journal Reflect on the day including feedback survey</p>
<p>Day 2</p> <p>Thurs 8 April</p>	<p>Presenter(s): Lorna and Chris</p> <p>9.15 am – 9.20 am Welcome to Country: Muzhgan</p> <p>Group asked to share something from their Reflective Journal</p> <p>9.45 am – 10.15 am</p>	<p>Facilitators: Lorna and Chris 10.15 am – 11.00am Presenter: Katie Emanuelli GV Health Bowel Cancer</p> <ul style="list-style-type: none"> Family history Environmental causes Screening 	<p>Facilitators: Lorna and Chris Women's Health 1.00 pm – 1.30 pm Presenter: Michelle Parish Women's body Breast Health: (Breast Screen, Breast Awareness, Breast Cancer) Cervical Health: Pap smears, Abnormal Pap Tests, HPV, Cervical Cancer, Ovarian Cancer</p>	<p>Presenter(s): Lorna and Chris</p> <p>3.20 pm – 3.30 pm Celeste Holden M&CH Nurse Support after birth: role M&CH, services and programs for mother and baby etc, Mother & Baby Unit (Familycare), Healthy Mothers/Healthy Babies (GV Health), Playgroups etc</p>

Training Plan (V24) April 2021 How it happened (1)

1



Wise Well Women: A Community Health Educator Program



	9.15 am – 10.15 am	10.15 am – 12.25 pm	1.00 pm – 3.20 pm	3.20 pm – 4.00 pm
	<p>History of women’s movement</p> <ul style="list-style-type: none"> Aboriginal women Australian – suffrage movement video Each country <p>Make reference to Brazen Hussies (ABC TV) Provide handouts</p>	<p>11.00 am – 11.05 Break</p> <p>11.05 am – 12.25 Presenter: Suzanne Wallis, Sexual Health Safer Sex Sexually Transmitted Infections Vaginal Health and Hygiene Sexuality and Gender including sexual identity Healthy Relationships (Negotiating sex)</p>	<p>Presenters: GV Health</p> <p>1.30 pm – 3.00 pm Bridget Hurley Antenatal Clinic Coordinator Sandy Winter-Irving Associate NUM Birthing Suite Linda Gladman Extended Postnatal Service (Domiciliary midwifery care) Pregnancy and Birth: Birthing approaches and interventions: antenatal and postnatal care, consequences of birthing e.g., incontinence Osteoporosis, Pelvic Floor, Polycystic Ovarian Syndrome (PCOS)</p> <p>Break 2.45pm – 2.50pm</p> <p>2.50 pm – 3.00 pm Celeste Holden M&CH Nurse Support after birth: role M&CH, services and programs for mother and baby etc, Mother & Baby Unit (Familycare), Healthy Mothers/Healthy Babies (GV Health), Playgroups etc</p>	<p>3.30 pm – 3.45 pm Why Women’s Health completed</p> <p>3.50 pm – 4.00 pm Women’s Movement and Aboriginal Movement</p> <p>Reflect on the day including feedback survey Reminder regarding Reflective Journal</p>
<p>Day 3 Fri 9 April</p>	<p>Facilitators: Lorna and Chris</p> <p>9.15 am – 9.20 am Welcome to Country: Participant/s Eman Handout Welcome to Country and Acknowledgement of Country</p> <p>Introduce Habiba Evaluation Research Assistant to the group</p> <p>9.25 am – 10.15 am Via Zoom Presenter: Caz Butler NB: technical issues delayed start Reproductive Health (cont.) Endometriosis Chronic fatigue syndrome</p>	<p>Presenter(s): Lorna and Chris</p> <p>Reproductive Health (cont.) 10.15 am – 10.30 am Via Zoom Presenter: Caz Butler</p> <p>10.30 am – 11.15 am Lia Standard Julie Brisbane & Christian Santana?????</p> <p>11.15 am – 11.20 am Break</p> <p>11.20 am – 12.25 pm Community Health Educators detailed: role, responsibilities, purpose and benefits for community and service providers</p>	<p>Facilitators: Lorna and Chris</p> <p>1.00 pm – 2.15 pm Via Zoom Presenter: Lynette Squires Using medicines safely and impact of work on health Drugs-Prescription: Non-prescription: Alternative Therapies Varicose Veins, Stress Arthritis Menstruation, PMT Menopause, HRT Alzheimer’s and dementia Lung disease</p> <p>Break 2.15 – 2.25pm</p>	<p>Presenter(s): Lorna and Chris</p> <p>Navigating the health system (detail) Roles of different health workers and how to access: GPs, specialists and specialist services, allied health workers, Social workers, dental etc Accreditation of health professionals Health insurance, bulk billing, gap fees Health Rights: Australian Charter of Healthcare Rights, Health Standards, Organ donation, Transplants Asked to consider the 2x handout on the Australian Health System</p>



Wise Well Women: A Community Health Educator Program

	9.15 am – 10.15 am	10.15 am – 12.25 pm	1.00 pm – 3.20 pm	3.20 pm – 4.00 pm
	Fertility Pain Management Alternative Therapies TCM Acupuncture	including working in a team with a health expert (NB we would develop proforma to help this, along the lines of the questions in the session plan and Co-health work) PD – 1x page Where to find resources Identifying the right people in organisations Working with statewide organisations, local organisations and local communities: helping to link, build relationships etc Making sure orgs and community understand your role Determining if community will accept and utilise information and implement changes for self or families Keeping a record of what is happening Following up H&C orgs with issues and how to solve them Confidentiality Managing disclosures during sessions Responsibilities/duty of care etc Discuss Homework to be completed in the break	2.25pm – 3.20pm Presenter: Allison Harris Family counselling: behaviour change, trauma, stress management	Reflect on the day including feedback survey Remind Trainees about the Family Day on Saturday
Sat 10 April		Family Lunch: African House 11.30 am – 1.30 pm <ul style="list-style-type: none"> • Welcome to Country (we missed this!) • presentation about the program • information about the Evaluation and introduce Carol • present “Uniform” • asked to wear uniform on Day 4 and Day 6 		
Day 4 Wed 14 April	Start 9.00 am – 9.05 am Acknowledgment of Country Participant/s: Shakilla and Susan Shakilla – inform group about Ramadaan 9.05 am – 9.25 am Feedback on week 1 and adoption of changes as necessary	Facilitators: Lorna and Chris Presenters: 10.15 am – 11.15 am Sonali Jayasundera & Ethan Chan, Declo Bisimwa Workshop	Facilitators: Lorna and Chris Cancer: prevention, screening, treatment, services. 1.00 pm – 2.00 pm Presenter: Natalie Areyanda Cancer Council <ul style="list-style-type: none"> • Family history • Environmental causes 	Facilitators: Lorna and Chris Presenter: Jennifer Collier GV Cardiologist 3.20 pm – 3.30 pm cont... Healthy Heart, Cardiovascular Disease Diabetes, Cholesterol Support Groups

Training Plan (V24) April 2021 How it happened (1)



Wise Well Women: A Community Health Educator Program

9.15 am – 10.15 am	10.15 am – 12.25 pm	1.00 pm – 3.20 pm	3.20 pm – 4.00 pm
		<ul style="list-style-type: none"> • What advice can be shared about working with agencies and working with community? • What could/should be changed? • How a role in Community Services, Project Management has assisted being a Bilingual Health Educator <p>2.00 pm – 2.45 pm Ildy Kerry GOTAFE Career Development and Training</p> <p>2.45 pm – 2.50 pm Break</p> <p>2.50 pm – 3.20 pm Review of the whole training program</p>	



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