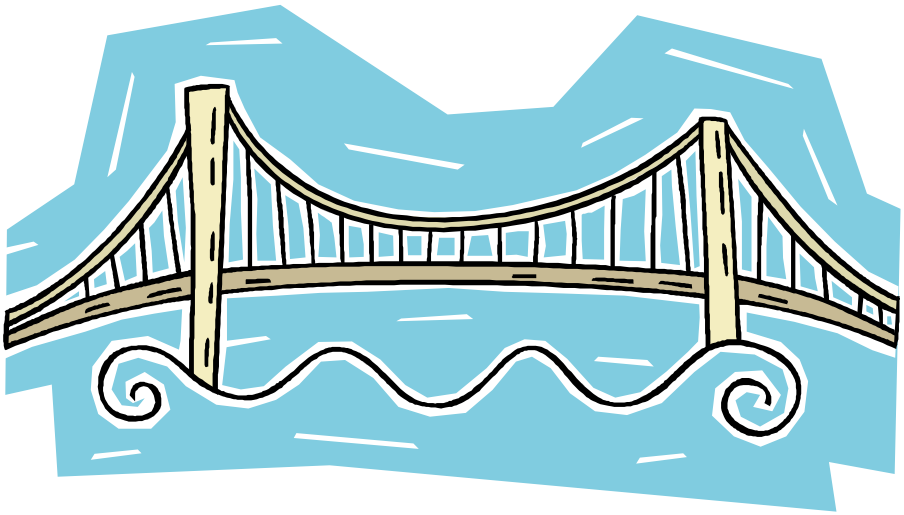
Greater Brisbane Refugee Health Advisory Group

Evaluation Report February 2015



The trees we grow today, I am sure, we will see the fruits of it very soon.
(Refugee Health Development Worker)

Prepared by
Mater UQ Centre for Primary Health Care Innovation

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Acknowledgments

This evaluation of the Greater Brisbane Refugee Health Advisory Group was commissioned by the Project Manager and funded as part of the project costs which received funding from The Mater Foundation, The English Family Foundation and The nib Foundation Contributors to the evaluation include the project manager, the eight Refugee Health Development Workers, and a small group of health service provider stakeholders. Additionally information from refugee community events has been included along with service provider education event feedback provided by Greater Metro South Brisbane Medicare Local.

The evaluator would like to acknowledge and thank all contributors to this evaluation.

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EXECTIVE SUMMARY

Introduction

The Greater Brisbane Refugee Advisory Group project has provided an opportunity for relationships and skills that have been fostered and developed in previous and concurrent projects to be utilised and built upon in a linked capacity. The foundation projects include the Refugee Women as Health Leader's Project (2012-2013), the Refugee Youth Health Leaders Project (2013) and the concurrent project Partners in Recovery: Access to Mental Health Services of people from refugee and CALD backgrounds (2014). All three projects have been led by Paula Peterson the project manager for the Greater Brisbane Refugee Advisory Group. Also of major significance to the project is the work relating to the development of a Refugee Health Model that sits with the Centre and is principally led by the Partnership Advisory Group.

The project aims for the Greater Brisbane Refugee Health Advisory Group were to: (1) Create a mechanism through which health services can have access to the voice of refugee communities as part of a sustainable community engagement framework, (2) Build a bridge between health services, research and communities to facilitate training and education of staff, participate in research projects and contribute to developing resources and documents, and (3) Build the critical health literacy of refugee communities to shape and influence and improve access to health services.

The key element of the project plan was to recruit, train and support eight Refugee Health Development Workers (RHDW's) to assist the project manager in meeting the project aims. Seven of the eight appointed RHDW's had been previously employed on the foundation projects and all contributed to the Partners in Recovery project. This provided consistency to the work delivered by the Centre; an opportunity for the RHDW's to consolidate and build upon their skills and knowledge, and provided the refugee communities and services with a familiar point of contact.

Method

A mixed methods approach was selected for the evaluation of the Greater Brisbane Refugee Advisory Group. Qualitative methods included: interval surveying of the RHWD's, end point surveying of a selection of service and research stakeholders, community event feedback, post education event evaluation surveys and additional feedback from the project manager and RHDW's. Quantitative methods included audit of meeting minutes, project paperwork including funding reports and event attendance. The themes for the evaluation questions were drawn from DR E Jane Davidson's 'Actionable Evaluation Basics' (2013). The five evaluation domains were; (1) project design and delivery, (2) value to stakeholders, (3) value for money, (4) context and (5) need. These domains were felt to provide a practical approach to determining questions that were significant to the evaluation of this project.Stakeholders that provided evaluation feedback included the eight RHDW's and project manager, refugee community and health service event attendees, and service provider stakeholders representing health, research and community sectors.

Findings

Findings relating to how the project responded to the project aims:

Building a mechanism: Project activities and project outputs matched closely with those planned at the outset. These activities form the framework for the mechanism of sustainable community engagement.

Building a bridge: Through the projects activities RHDW's representing Afghan, Burundi, Burmese, Somali, Sudanese and Eritrean communities have been able to build a bridge between these communities, health services and researchers.

Building refugee community capacity: Through planned community education opportunities the health literacy of refugee communities has been positively impacted with observed examples of changes in health seeking behaviour.

Building refugee health provider capacity: Through focused health provider education, there has been self-reported increase in skills and knowledge relating to the needs of refugee communities. Additionally examples of perceived changes in health service delivery have been reported.

Building RHDW capacity: The project has provided multiple opportunities for the RHDW's to facilitate, present, educate, contribute to research and provide input into resources and documents. Feedback from the RHDW's has indicated that significant growth has occurred in their knowledge, skills and confidence relating to health issues and access to services (health literacy) in addition their professionalism and skills in community engagement.

Findings in relation to the five evaluation domains:

Design & delivery: The project benefited from the experience of the project manager and the RHDW's. It was well planned but was also flexible in responding to opportunities and the requests for specific information and training by communities, the RHDW's and service providers. Almost all planned actions occurred within the specified timeframes. The project manager and in her absence her colleague Donata Sackey provided support to the RHDW's regularly and as required. The RHDW's understood their role and responsibilities, responded to the challenges of the project and frequently gave more than was required.

Value to stakeholders: Numerous examples of the value of the project to the three stakeholder groups (refugee communities, service providers and the RHDW's) have been cited. The evidence has been reported by more than one data source adding validity to the case. The long term value to stakeholders has not been the focus of this evaluation, an impact evaluation would be required over a longer period of time to establish this.

Value for money: The project budget and expenditure compared to the number of activities, outputs and outcomes achieved is significant in that a great deal has been achieved to date with limited funding. This as one stakeholder commented has been largely due to careful resource planning and management on the part of the project manager. It is difficult to imagine that more value could have been gained from the $78,000 the project received in funding.

Context: The context in which the project occurred is notable in that the experience, relationships and groundwork that had already been established in previous projects enabled the project to progress at speed and to respond to opportunities that other projects may not have been as fortunate to encounter. Additionally the project being delivered from the Mater UQ Centre for Primary Health Care Innovation alongside other refugee focused initiatives (clinical, research and policy development) was fortuitous.

Need: Expressed ongoing need for the project was unanimous amongst stakeholders. RHDW's and health provider respondents to the evaluation survey alike recognised the value in continuing to build on the achievements the project had made. The method of engaging vulnerable communities was viewed as the right approach to the task in hand.

Conclusion

This report documents the evaluation of the Greater Brisbane Refugee Health Advisory Group Project February 2014 – February 2015. The evaluation has sought to provide an unbiased account of the activities, outputs, outcomes and ultimately the value of this 12 month project to stakeholders. Due to the short time frame of the project its 'impact' cannot be established, for this the project would need to be funded for a minimum of three years but ideally longer.

Whilst the long term impact of this project cannot be established this evaluation indicates that the Greater Brisbane Refugee Health Advisory Group has provided an efficient and effective vehicle for sustainable community engagement, improvement of health service knowledge of refugee community's needs and improvement in the critical health literacy of refugee communities and the RHDW's.

The 12 month project funding ends on the 28th February 2015. The project manager has applied for six months funding to span from this period until the new Primary Health Networks (PHN) have been established (July 1st 2015) after which a longer term funding strategy can be considered. In order to maintain and build upon the group's presence and retain the group's membership an indication of ongoing employment options would be extremely beneficial. This is currently difficult to establish without ongoing secured funding.

This evaluation report is an essential tool in considering ongoing funding for this project. If ongoing funding was to be granted the expertise of the Greater Brisbane Refugee Health Advisory Group is likely to be a sought after commodity by the new Primary Health Networks, Mater Health Services, Local Hospital Networks and the Non for Profit sector.

The Greater Brisbane Refugee Health Advisory Group

QPASTT Leaders Dinner (Mental Health Focus) May 2014

Women's Health Event June 2014Community Leaders

Youth Health Event August 2014

State of the Mater Presentations September 2014

INTRODUCTION

Project Background

The Greater Brisbane Refugee Advisory Group project which came to be termed informally as The Group of Eight (G8) was born out of two significant bodies of work previously undertaken by the Mater UQ Centre for Primary Health Care Innovation (the Centre) led by the project manager Paula Peterson. The first entitled the Refugee Women as Health Leader's Project (2012-2013) was sponsored by the nib Foundation. This project engaged eight women from Afghan, Eritrean, Rwandan, Togolese, Sudanese, Burundi, Burmese, and Congolese communities who undertook community consultations to determine the health needs of each community. Health Action Plans were developed for each refugee community which were well received especially by Greater South Brisbane Medicare Local and West Moreton and Oxley Medicare Local.

The second project was entitled the Refugee Youth Health Leaders Project (2013) funded by the Mater Foundation, the nib Foundation and the English Family Foundation. This project saw the partnering of the Mater UQ Centre for Primary Health Care Innovation partner with QUT and UQ to conduct research into health seeking experience of adolescents and young adults from refugee backgrounds. Four young people were employed (two male and two female) and engaged 31 young people from 21 different communities in peer led interviews. The findings were presented in a report with key themes including: Language issues, accessibility of health services, help seeking practices, strategies for self-management, importance of spirituality, adaptation to food, climate and environment, resourcefulness of this population, paucity of information about particular health issues.

A third short project commenced in early 2014 for three months funded by Greater Metro South Brisbane Medicare Local under the Partners in Recovery (PIR) Innovation Fund. This project employed two part time project officers to determine a draft set of priorities and protocols for system reform for people from refugee and CALD backgrounds requiring mental health services. The resulting report is entitled;

> *'Building the case for reform – The experiences of people from refugee and CALD backgrounds negotiating the mental health system, who are at risk of developing or have severe and persistent mental health conditions.'*
> http://materonline.org.au/services/refugee-services/clinical-resources-and-publications

All members of the G8 team provided input into the PIR project which sought to identify barriers to access mental health services. The G8 members assisted the PIR project by providing community perspectives on mental health issues in their communities and contributed to the design of training and resource development.

Also of major significance to the project is the work relating to the development of a Refugee Health Model that sits with the Centre and is principally led by the Partnership Advisory Group (Terms Of Reference and Membership http://www.materonline.org.au/services/refugee-services/mater-integrated-refugee-health-service-(mirhs)) with the support of key working groups facilitated by Centre Staff including Donata Sackey and Paula Peterson and Medicare Locals, NGOs and a small team of clinicians and researchers.

The Greater Brisbane Refugee Advisory Group project has provided an opportunity for relationships and skills that have been fostered and developed in previous and concurrent projects to be utilised and built upon in a linked capacity.

Project Aims

The project aims for the Greater Brisbane Refugee Health Advisory Group (Table 1) were developed from the experiences and findings of the previous and concurrent projects.

Table 1: Project Aims (November 2013)	
1.	Create, document and evaluate a mechanism through which health services including MHS can have access to the voice of refugee communities as part of a sustainable community engagement framework;
2.	Build a bridge between health service administration, management and research and the communities they seek to serve by being available to facilitate focus groups, deliver training and education to staff, participate in research projects with identified project partners and contribute to development of resources and documents e.g. Mater Health Service community engagement framework, MDA community engagement tool, Medicare Local community consultation plans and other policy documents such as the National Primary Health Care Framework and the work of the Partnership Advisory Group in developing a Queensland refugee health and wellbeing policy.
3.	Build the critical health literacy of refugee communities to shape and influence and improve access to health services

Project Plan

The initial project plan (Table 2) was developed by the project manager prior to obtaining project funding. Refining of the project plan occurred in September 2014 when the project manager and the G8 undertook a process of reflection and re-focusing to determine the priorities for the remainder of the funded project time Appendix 1.

Table 2: Project Plan (November 2013)
1. Form a project reference group with new Terms Of Reference reflecting the new phase of the project
2. Develop a position description for the Great Brisbane Refugee Health Advisory Group Heath Development Workers in consultation with project partners including present and past project workers
3. Recruit 8 Health Development Workers – approximately 4 of whom will be young people
4. Develop Evaluation plan
5. Develop a plan for project activities including a. Greater Brisbane Refugee Health Advisory Group meeting – each month b. Provision of health information to the group – to be determined c. Convening refugee community health information sessions – every quarter d. Provision of training and support to health services – e.g. presentation's at conferences, services Professional Development's, community consultations, practice visits e. Support of existing initiatives such as the Healthy Starts initiative

METHODOLOGY

Evaluation Plan

Project evaluation was seen as an intrinsic part of the project from the outset and was budgeted for within the projects costs ($13, 500). The evaluation plan (Appendix 2) was first scoped in May 2014 with the project manager and evaluator. A draft evaluation plan was discussed with the G8 at a group meeting in the same month. The G8 were invited to ask questions, provide feedback and suggestions. It was felt to be of particular importance to ensure the G8 members felt the evaluation plan would capture the right data to enable a true reflection of the projects activities and outcomes. Periodic evaluation meetings occurred between the project manager and the evaluator particularly at key times when survey data was required. The evaluation plan was revised in July 2014 with minor amendments.

Evaluation approach

A mixed methods approach was selected for the evaluation of the Greater Brisbane Refugee Advisory Group. Qualitative and quantitative methods were employed to produce data that had the potential to provide a more detailed picture of the outcomes and ultimate value of this project. Qualitative methods included: interval surveying of the G8 members, end point surveying of a selection of service and research stakeholders, community event feedback, post education event evaluation surveys and ad hoc feedback from the G8 members. Quantitative methods included audit of meeting minutes, project paperwork including funding reports and event attendance. The themes for the evaluation questions were drawn from DR E Jane Davidson's 'Actionable Evaluation Basics' (2013). The five domains provide a practical approach to determining questions that were felt to be well matched to this project (Table 3).

Table 3: Evaluation domains & questions

Domains	Key question
1. Design & delivery	How well designed and implemented is the program?
2. Value to stakeholders	How valuable are the outcomes for: • Refugee communities • Services & organisations • Health development workers
3. Value for money	Did the project provide good value for money?
4. Context	What works best for whom, under what conditions and why / how?
5. Need	Is the program still needed? How well does it address the most important root causes? Is it still the right solution?

Stakeholders

Stakeholders who provided information that was included in this evaluation are presented in Table 4.

Table 4: Stakeholder groups involved in the Evaluation

Stakeholders	Individuals	Area of Interest	Organisation /Community	Method of data collection
Project Manager (PM)	Paula Peterson	Capacity building / service improvement	Mater Health Services	Survey (Endpoint) Informal feedback
Refugee Health Development Workers (RHDW)	Alie Kenneh	Liberian community	Mater Health Services	Survey (Start & Endpoint) Informal feedback
	Daniel David	Afghan community		
	Elizabeth Niyokushima	Burundi community		
	Evelyn Pe	Burmese community		
	Farhia Haji	Somali community		
	Maria Phaltang	Sudanese community		
	Samira Ali	Eritrean community		
	Utta Lubajo	Sudanese community		
Refugee Communities	Individuals and groups from communities	Health literacy Health improvement Health service delivery	Sudanese Afghan Liberian Eritrean Burmese Somali	Post event feedback Informal feedback to RHDW
Event attendees (services)	Individuals attending	Refugee specific education	Health services	Post event feedback
Service provider stakeholders (SPS)	Angie Kendall	Community Engagement	MHS	End point survey Informal feedback
	Sylvia Penhaligon	Primary Health Care	GMSBML	
	Rebecca Farley	GP MIRS	MHS	
	Margaret Kay	CAG representative & GP	UQ	
	Donata Sackey	PAG refugee health model	MHS	
	Caroline Nicholson	PAG chair & Director CPHCI	MHS	

One of the RHDW's was not able to be contacted towards the end of the project as she had moved interstate to a new position and therefore did not provide a survey response. One RHDW was employed on a contract basis for a short period of time and was not included in this evaluation. Three additional service provider stakeholders were invited to provide feedback, one felt they did not have sufficient knowledge of this project to comment and two were on extended leave at the time of request.

The post educational event surveys were designed, collected and collated by staff from Greater Metro South Brisbane Medicare Local (GMSBML). Summative reports of event feedback were made available to the evaluation office for inclusion in this report. All remaining surveys were devised by the evaluation officer in consultation with the project manager. Returned surveys were reviewed by the evaluation officer and analysed for themes. Quantitative data did not require complex analysis; in the most part it involved determining the sum, averages or percent.

FINDINGS

The finding are presented under the five evaluation domains of (1) Design and delivery, (2) Value to Stakeholders (3) Value for money, (4) Context and (5) Need.

Evaluation Domain 1: Design and delivery

How well designed and implemented was the project?

Community engagement

The project is designed on a community engagement approach, a relatively new concept in Australia which is slowly gaining momentum with vulnerable and hard to reach groups. For the refugee sector this work is ground-breaking and has given rise to the project manager being invited to present at conferences in Cape Town, Third Global Symposium on Health Systems Research Oct 2014 and Melbourne, The Inaugural International Conference on Migration Social Disadvantage and Health Feb 2015. The Greater Brisbane Refugee Health Advisory Group project is the third in a series of projects using this model. Each project has built on the knowledge and experiences of the previous, developing the concept that the Refugee Health Development Worker as the essential bridge connecting their respective communities to the services that seek to deliver health services.

Reference Group

Due to the previous projects and many years of experience working with people from refugee communities, the project manager had developed a significant network, a team of Refugee Health Development Workers and knowledge relating to what was needed next in relation to the delivery of health care to refugee communities. This fast-tracked the initial project scoping phase resulting in a change to the initial project plan. The project manager determined that a reference group was not required for the project however the project manager attended and presented at the quarterly Partnership Advisory Group (PAG) whose focus is '*Building Capacity in Refugee Health in Greater Brisbane'* (Appendix 3 PAG membership) and consulted regularly with members who were more closely involved in the project including representatives from Greater Metro South Brisbane Medicare Local and the University of Queensland. Additionally the project manager held monthly meetings with the G8 members which provided plentiful opportunity to review progress, refocus and reset priorities.

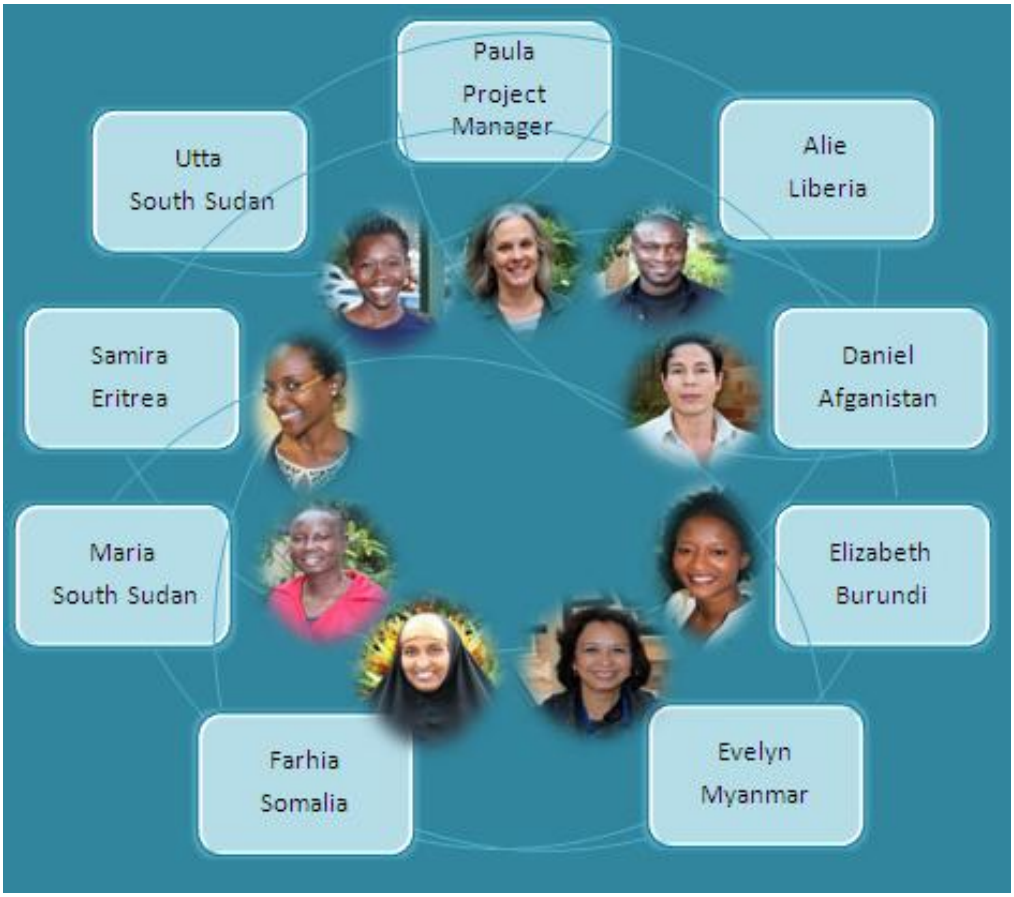
The role of the Refugee Health Development Worker

Of central importance to the success of the project is the Refugee Health Development Worker. How the role was defined, developed, understood, accepted and utilised is a key feature of this project. The following are findings in relation to how this project defined the role and developed the systems to support the individuals who filled these roles.

Position description & recruitment

The Refugee Health Development Worker (RHDW) position description (Appendix 4) was developed in February 2014 followed by advertising of the positions throughout refugee and health networks. Recruitment of the eight RHDW's occurred in March, seven of the eight had held positions on previous projects with the project manager. (Figure 1) An additional ninth person was employed for sessional work for part of the program but due to the short nature of the involvement their feedback was not sort as part of the evaluation.

Figure 1: The Greater Brisbane Refugee Advisory Group



The role of the RHDW's was formerly termed '' Administrative Support Worker – Refugee Projects'' and was positioned on a salary scale of Administrative Officer Level 2. Each RHDW was paid for 4 hours per week for 50 weeks with the understanding that the role might require flexibility in how and when these hours were utilised.

The specific role requirements in addition to standard Mater Health Service accountabilities were:

- Attend, participate and contribute to discussion at the monthly meeting of the Greater Brisbane Refugee Health Advisory Group.
- Participate in the learning and development opportunities provided to the Greater Brisbane Refugee Health Advisory Group. For example health issues to be addressed by the Group.

- Organise the quarterly meeting with refugee communities to assist in the delivery of health literacy information.
- Support existing initiatives that aim to build the health literacy of people from refugee communities – e.g. the Healthy Starts project. This will include organising the venue, catering and contacting key community figures to advise the details
- Participate in other activities relevant to building health capacity of health services and refugee communities as they emerge in discussion with the project manager, including regular participation in the professional training events (three per year) coordinated by the Clinical Advisory Group which reports to PAG and is chaired by the Refugee Health Clinical lead in Greater Metro South Brisbane Medicare Local.

Self-definition of role

After the first two team meetings in March and April 2014, the RHDW's were asked in a survey what they saw as their role in the project. The common themes were,

- A bridge, mediator or connector between the refugee communities and services (RHDW 1, 2, 6, 8)
- Conveyor of information (health, health service and health needs) (RHDW 1, 2, 7, 8)
- Advocate (RHDW 4, 5)
- Educator (RHDW 5)
- Health worker (RHDW 1)
- Member of and engager with the community (RHDW 1, 2, 3)

In January 2015 the RHDW's were asked to reflect on what their role had been since the project started and whether there were any differences to what they had first thought. In response very similar roles were described including advocate, educator, information provider, connector, and health worker. One RHDW explained,

> *Because we are from the heart of the community and very aware of the health concerns within the community we functions individuals who let the Health Service Providers know about the emerging issues in the community and work together with the Health Service Providers to find out a solution for the problem of the people (RHDW 2)*

When asked if the RHDW's had experienced any differences in role from five respondents four said there had been no difference with one RHDW explaining,

> *We were very well advised what the role would be at the initial of the Greater Brisbane Refugee Health Community Advisory Group Project. So the path has been smooth…I have not seen anything different that would make me think we are not doing what we were supposed to do, which means we had a very clear map (RHDW 2)*

One respondent who commented that their role had been linked to assisting two different groups of researchers felt that their role had not included any group consultation with the community although the project activity log and other RHDW's feedback suggests elements of community consultation had occurred for some members,

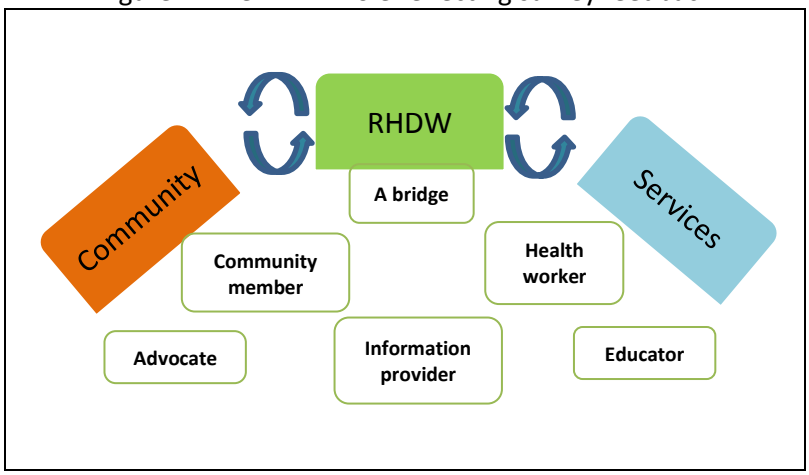
> *On this project we did not have any group consultation with the community members (RHDW 7)*

One RHDW spoke of the challenges of working with youth, this perhaps indicated a change in perception of her role.

> *Yeah, working with youth is challenging especially when you try to explain what is right for their wellbeing as they think what they do is right for them according to their age…for example one boy tried to convince me that this is his time to start drinking and smoking and quit later when he reaches 45yrs of age or more .furthermore he thinks it's right time for him to mix up with the society without thinking what could be the result of smoking and drinking before reaching that age. (RHDW3)*

The close comparison between the G8's initial response to the question of role expectation and the latter response on role reflection after 9 months is an indicator of good project planning and delivery (Figure 2). Although one respondent talked about the challenges of the role it is uncertain as to whether they felt the role was more challenging than they had anticipated.

Figure 2: The RHDW role reflecting survey feedback



Team meetings

The initial project plan stated there would be one team meeting a month for the G8 members and attendance at these meetings was a requirement of the position. As can be seen from table 5, team meetings occurred as stated every month with the final meeting to occur in February (not recorded). Attendance is noted as high with an average attendance for the G8 members of 93%.

Team meetings were opportunities for G8 members to report back findings and progress, reflect on issues, provide suggestions, support each other, receive informal training and plan next steps. Two incidents where informal training was provided included Alie providing training on 'Community Engagement' and Samira providing training on 'Healthy Eating'.

Table 5: Summary of the G8 team meetings

		Alie	Daniel	Elizabeth	Evelyn	Farhia	Maria	Samira	Utta	TOTAL per event
17/03/2014	First	1	1	1	1	1	1	1	1	8
14/04/2014	Second	1	1	1	1	1	1	1	1	8
12/05/2014	Third	1	1	1	1	1	1	1	1	8
16/06/2014	Fourth	1	1	1	1	1	1	1	1	8
21/07/2014	Fifth	1	1				1	1	1	5
18/08/2014	Sixth	1	1	1	1	1	1	1	1	8
1/09/2014	Seventh	1	1	1	1	1	1	1	1	8
13/10/2014	Eighth	1	1	1	1	1	1	1	1	8
10/11/2014	Ninth	1	1	1	1	1	1	1		7
8/12/2014	Tenth	1	1	1	1	1	1	1	1	8
19/01/2015	Eleventh	1	1		1	1	1	1		6
	Total per RHDW	11	11	9	10	10	11	11	9	
	% per RHDW % Average 93%	**100%**	**100%**	**82%**	**91%**	**91%**	**100%**	**100%**	**82%**	**Ave per meeting 7.45 /8**

Possible & experienced difficulties

The manner in which the RHDW's are employed to impact at a community, organisational and systems level is a new concept. Previously roles would have been more closely aligned with working with individuals and families. Enacting change can be difficult especially at the start therefore in May 2014 the G8 members were asked to consider what difficulties they thought might occur with the project. After nine months members were asked to reflect on any difficulties that had occurred. Table 6 provides a summary of the responses.

Table 6: RHDW difficulties

	Possible	Experienced
Communication	Following up on information being circulated between professionals and communities (RHDW 1 & 4) Getting the message of health literacy out to the community. (RHDW 5)	The need to use original community language speaking workers. (RHDW 4)
Engagement	Community members not wanting to participate (RHDW 4 & 8) Keeping regular contact with members of the	Finding enough community participants at times (RHDW4) *I faced some challenges from the boys as they think they know or understand more than*

	community (RHDW 1)	*girls. Boys opposed most of time what I say thinking I am wrong. (RHDW3)*
Time	Having time to meet with the community (RHDW 1)	Give more hours to workers. Give more time to workers to recruit community members. (HDW4)
Clarity	*If the project aims, objectives are not clear from the beginning, there might outcomes similar to other projects in the past where we barely scratch the surface of tackling the problems/issues. (RHDW 8)*	Unclear requirements (RHDW4)
Incentives & Money		Community expectations in relation to being paid for consultations (RHDW1) Give more incentive to participants. (RHDW4) Apply for more money for the project. (RHDW 4)
No problems:	No difficulties perceived (RHDW 2, 3 & 6) Expanding to say: The project was very relevant (HDW6), The expertise of the project manager/s and the experience of the G8 members would overcome any issues (RHDW 2). Community leaders seem very cooperative (RHDW1).	*The project was flexible to me and the topics were straightforward which makes things easier, understandable and ease to explain. No problem or any difficulties at all* (RHDW 3) *I have not encountered any difficulties in this project and the project has also been moving forward very smoothly and successfully. I can promise you will never encounter any difficulties if you work with such great people. (RHDW 2)*

Although the G8 members on the whole felt the project had run well the difficulties that were anticipated and experienced fell into the following categories; community engagement, communication, expectations, clarity of purpose and resources.

Supporting RHDW's

In addition to supporting RHDW's through project difficulties the project manager required great awareness and sensitivity to the ongoing needs of the RHDW's who as individuals continue to experience extreme stress when their families, communities and countries are traumatised by war, disease and famine. Of particular significance to the RHDW's during this project was the Ebola outbreak impacting Liberia amongst other countries, reigniting of conflict in South Sudan and ongoing stress relating to ''not feeling welcome'' particularly experienced by the Afghan community.

A number of the RHDW's noted the skills and support the project manager and close colleague Donata Sackey provided.

> *The PM has a very inclusive approach recognising the contribution everyone in the group makes. (RHDW1)*

> *The brilliant, expert, flexible and joyful professionals both Paula and Donata are, I have really learned very much from these two professionals not only on this project, but since I have started working with them. It has been a very significant part of my life, learning and building myself in order to be doing what we really should be doing as professionals and as individuals in (the) work environment, in the community and in real life to. (RHDW 2)*

Additionally one stakeholder stated

> *With the limited resources and time available for the workers it is remarkable that such a strong and connected team developed. This is a credit to the program manager who was able to maximise resources available, provided solid support and was strategic in developing work plans. Contributions especially to education seminars and facilitation of community health literacy information sessions were a highlight. (SPS 5)*

Planned activities

Project activities were determined in the initial project plan these included; monthly meetings of the advisory group, provision of health information to the group, convening quarterly refugee community health information sessions, provision of training and support to health services and support of existing initiatives. Table 7 on the following page provides a summary of the project activities (not including team meetings which were listed in Table 5. Additional activities such as presentation to sponsors, involvement in strategic planning, research and resource development are also included in Table 7. The table highlights the diverse range of activities undertaken by the G8 members and their representation in each activity.

Table 7: Project activities March 2014-February 2015

Activity Date	Activity Name	Event type	Alie	Daniel	Elizabeth	Evelyn	Farhia	Maria	Samira	Utta	TOTAL per event Ave 4 RHDW
14/06/2014	Women's health information day at MDA	Education Com			1	1	1	1			4
16/08/2014	Healthy starts – refugee youth health	Education Com		1						1	2
18/10/2014	Mental Health Forum	Education Com / HP / RHDW	1	1	1	1	1	1	1	1	8
8/04/2014	GP training - Mental health with refugee communities	Education HP	1	1		1	1	1	1	1	7
11/06/2014	GP and HIV and TB – clinical issues with refugee communities	Education HP		1		1	1		1		4
2/06/2014	QTMHC presentation on Mental health First Aid – at QTMHC	Education RHDW			1			1	1	1	4
22+29/08/14	Mental Health First Aid	Education RHDW		1		1	1	1		1	5
11/06/14	Infectious diseases seminar	Education RHDW		1		1	1		1		4
8/12/2014	Health eating	Education RHDW	1	1	1	1	1	1	1	1	8
19/1/2015	Community engagement	Education RHDW	1	1		1	1	1	1		6
25/09/2014	Incidental counselling QPASTT	Education RHDW		1		1		1	1	1	5
25/08/2014	Meeting with researcher - Infant feeding practices	Research			1	1	1	1	1		5
25/08/2014	Meeting with PHD student re Infant feeding practices	Research			1	1	1	1	1		5
1/12/2014	Input to CALD Pharmacy access research	Research	1		1		1	1	1		5
21/10/2014	Community Leaders meeting – resource development	Resource			1	1	1		1		4
9/12/2014	AOD Refugee Tool Kit Roundtable – resource development	Resource								1	1
17/09/2014	State of the Mater presentation	Sponsors	1				1		1	1	4
11/04/2014	Meeting with English Family Foundation	Sponsors	1	1							2
25/08/2014	Presentation to Mater Foundation	Sponsors						1			1
16/05/2014	Adolescence and Young Adult service plan - GMSBML	Strategic	1	1						1	3
27/05/2015	Community Health Forum - GMSBML	Strategic				1					1
29/05/2014	QPASTT Leaders dinner – focus mental health	Strategic	1	1	1	1	1	1	1		7
6/08/2014	MAYAC Consumer Reference Group	Strategic	1							1	2
24/10/2014	MAYAC Consumer Reference Group	Strategic								1	1
24 activities	**Total per RHDW**		**10**	**12**	**9**	**14**	**14**	**13**	**14**	**12**	**Average 12**
24 activities	**% per RHDW**		**42%**	**50%**	**38%**	**58%**	**58%**	**54%**	**58%**	**50%**	**Average 50%**

Evaluation Domain 2: Value to stakeholders

How valuable are the outcomes for:

Refugee communities

Services & organisations

Refugee Health Development Workers

The concept of 'Building Capacity' has been a central theme of this project with three specific groups and associated methods identified as:

- Refugee communities through health literacy
- Health service workers and organisations through refugee specific information exchange
- Refugee Health Development Workers through provision of training and opportunities to present and lead.

Therefore with respect to determining the value of the project to the three stakeholder groups each group will be discussed in turn.

Building capacity: Refugee Communities

At the time of writing three community education events had occurred (Table 8). The Mental Health Forum was a joint community and service provider education event.

Table 8: Community events

Activity Date	Community Activity Name	Alie	Daniel	Elizabeth	Evelyn	Farhia	Maria	Samira	Utta	TOTAL per event
14/06/2014	Women's health information			1	1	1	1			4
16/08/2014	Healthy starts – refugee youth health -		1						1	2
18/10/2014	Mental Health Forum	1	1	1	1	1	1	1	1	8

Women's Health

The first planned community education event occurred in June 2014 held at the Multicultural Development Agency (MDA) in Woolloongabba and had a women's health focus (Figure 3). Elizabeth, Evelyn, Farhia, Maria and Esperance participated (Esperance was involved in a contracted capacity at the early stages of the project).

Attendance was approximately 40 women and their children representing Burundi, Somalia, South Sudan, Myanmar and the Congo.

Figure 3: Women's health invitation

The following is an excerpt from a report by the project manager on the day:

> *One 14 June 2014 a group of 50 women and 20 children gathered at the Brisbane Multicultural Centre to hear information about women's health – especially cancer screening and prevention. The day was established in response to the expressed needs for information from women who had been consulted as part of the refugee Women as Health Leaders project in 2013. These women were from 4 communities – South Sudan, Congo, Burundi, and Myanmar. Somali women were also invited as Farhia had since joined the project. (PM)*

Additionally one of the presenters gave the following feedback to the Project Manager and her colleague Donata Sackey,

> *The event on Saturday was amazing! – Well done – very impressive engagement. The health leaders were simply great. Thanks for organising this – you did a great job and it seemed to be very positively received by the communities. (SPS 4)*

The event provided not only an opportunity to inform attendees from refugee communities about women's health issues but also to take the opportunity to learn what was important to these women in relation to their families and communities wellbeing. The project manager explained that whilst waiting for the women's health presentations – women who had gathered in groups from their own community brainstormed the question *'If you had one wish for the health system what would it be?'* The answers to this question from the women in the different communities helped the health development workers and project manager consider the priories for the ongoing project as well as provide grass roots information that could be shared with health service providers.

Youth Health

The Healthy Start workshop which focused on Youth Health was organised by the Multicultural Development Association in association with the Healthy Start Program (Figure 4). The Healthy start program describes itself as;

> *We are a preventative health education project run by HOPE4HEALTH, M.A.D. and TIME who work with newly arrived refugees in order to increase their health literacy…. Students educate refugees to improve their health literacy and settlement outcomes in Australia.*

Figure 4: Youth health invitation

The topics included:

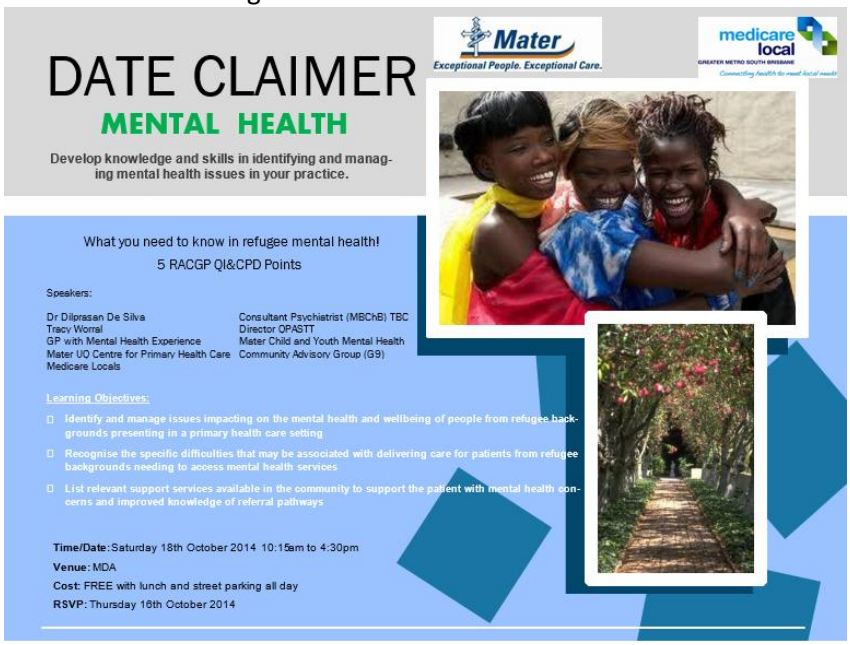
- GP and Hospital Emergency - covering responsibilities about accessing GP and hospital services and detailed information about hospitals and emergency services.
- General medical - maintaining a healthy lifestyle and accessing health care appropriately - ill health prevention.
- Dental health and hygiene
- Nutrition - understanding nutritional information on the back of food packaging and what a balanced diet looks like by Australian standards
- Medications - which medications require prescriptions and how to read and understand packaging, side effects, and mixing meds
- Women's Health - specialised information about menstruation and products to use, understanding female bodies and preventative procedures expected of women in Australia
- Men's health - specialised information about sexual protection (STDs etc.), use of condoms, male health prevention procedures
- Drugs and alcohol- use and effects

The youth RHDW's worked to encourage attendance form their communities in addition to Utta and Daniel attended to support the program and absorb the information provided for the attendees so that this could be relayed back to other community members who could not attend. A formal evaluation for this event was not available to the evaluator however informal feedback from the attendees and the medical students delivering the health information suggested that this was an excellent strategy for delivering targeted health information that is sensitive to the cultural and developmental issues of a cohort.

Mental Health

The third event was a mental health forum (Figure 5) open to primary care, community and hospital based professionals and to refugee community leaders and members. Held on Saturday 18th October at MDA, the forum saw approximately 70 people in attendance with 41 completing a post event evaluation mostly comprising of primary care professionals.

Figure 5: Mental health invitation



The forum hosted a panel of specialists including: Dr Dilprasan De Silva (Consultant Psychiatrist), Tracy Worrall (Director QPASTT), Fernanda Torresi (Training Coordinator QPASTT), Karen Grimley (Multicultural Mental Health Coordinator, MSMH Metro South Mental Health), Andres Otero Forero (Clinical Educator, Queensland Transcultural Mental Health). Evaluation of this event was compiled by GMSBML of which a section is featured in Figure 6 and 7 in the following section.

The impact of community education

The project manager indicated the project had made good headway in meeting its original objectives of an increase in the critical health literacy of refugee communities by undertaking the three education events,

The value for the refugee communities came through the information session being provided to the community on mental health, youth health and women's' health…..Refugee communities reported increased levels of information and appreciation for health sessions provided by Margaret Kay (women's health) and the Healthy Starts project. (PM)

This was supported by other stakeholder feedback,

Health literacy information session well received. Good to have own community members as role models and employed by the Mater. (SPS 5)

I am always excited to hear that a patient of mine has been involved in an activity involving one of the group's members. They sometimes come back to me with a much greater understanding of some of the health beliefs and systems we have here in Australia and it provides an opportunity for more effective communication between me and my patient. (SPS 3)

Building capacity: Health Services

Three events were scheduled in collaboration with Greater Metro South Brisbane Medicare Local (sponsor), the Clinical Advisory Group and the Mater UQ Centre for Primary Health Care Innovation to promote clinical knowledge and information exchange for health workers in relation to refugee communities (Table 9).

Table 9: Health Service Education Events

Date	Event	Code	Attendance
08/04/14	Mental Health - What you need to know in Refugee Mental Health	MH1	40 attendees (7GP's, 19 Practice Nurses, 14 Other)
11/06/14	Infectious Diseases: Managing infectious diseases in refugee populations in primary care	ID	*Approximately 50 people attend this event (41 from primary care settings.) PM* 28 evaluations of attendees received (5 GP's, 1 Practice Nurse, 22 Other)
18/10/14	Refugee Mental Health Forum	MH2	*Approximately 70 people attend this event (41 from primary care settings.)PM* (41 attendees completed an evaluation 11 GP's, 15 practice Nurses, 15 Other)

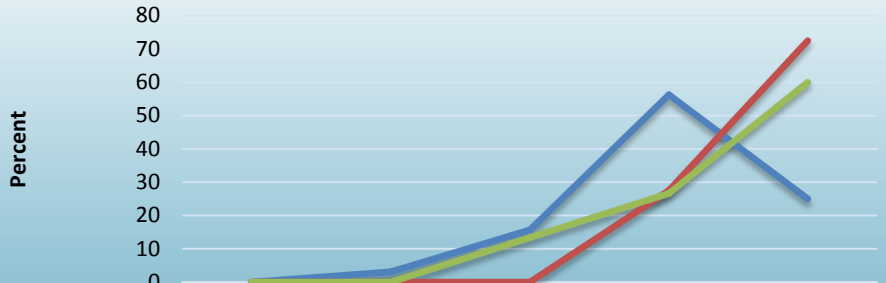
The term 'other' generally reflected other nurses, other medical staff, allied health professionals, community leaders and members, and non-clinical health related staff.

Event attendee self-reported knowledge and skills pre (Figure 6) and post (Figure 7) event for the three events indicates a notable increase reported post event. This would suggest overall the events had a positive impact on perceived knowledge and skills relating to refugee specific information.

Figure 6: Health Service Education: Pre-event knowledge & skills self score

	Very poor	Poor	Average	Good	Very good
MH1 Pre	3.13	25	53.13	12.5	6.25
ID Pre	0	5	47.5	35	12.5
MH2 Pre	0	19.57	30.43	28.26	21.74

Figure 7: Health Service Education: Post-event knowledge & skills self score



	Very poor	Poor	Average	Good	Very good
MH1 Post	0	3.13	15.63	56.25	25
ID Post	0	0	0	27.5	72.5
MH2 Post	0	0	13.33	26.67	60

Feedback from the Mental Health Forum

Each of the RHDW's were asked to provide their reflections on the impact of the mental health workshop on the 18th October 2014. Some responses have been included to illustrate the benefits of such events,

Challenging assumptions about mental illness,

> *In most countries mental illness is for a "crazy person" and the community say "let's avoid him". Feeling that he is "contagious" and we don't want to be like him. It pushes him to be more depressed. What I find beautiful in this country is that there is training for everything. We got to know places we can refer people – it is beneficial for them. (RHDW 2)*

An example from our community – I heard about a person (very traumatised) who complains all the time. Another community worker said "Our people are so unsatisfied and not thankful. " I believe she is not unsatisfied she is unwell. The community worker gave an unsympathetic response. People are expected to be happy and thankful but sometimes are not well enough. (RHDW 7)

Expanding knowledge of services;

There was a lot of information about how to access mental health services. I only knew about QTMHC before. Now I know about how to access QPASTT, Harmony Place…It was very educational. (RHDW 5)

Immediate application of knowledge;

After I attended this day I took my blind friend to Harmony Place. I connected her with them. Through their PIR work, she now does dancing, women's group. I could use the information from the day immediately. It was life changing for my friend. They take her to the doctor, help her pay her bills, read the papers to her (all things that I used to have to do.) (RHDW 6)

I found out a lot more information. I gave this information to one lady – I know she is really depressed – she tried to suicide. I am not sure whether she will use it……I also talked to Dr Da Saliva about what family members can do to help… (RHDW 6)

General Comments relating to health provider events

In addition to comments made by RHDW's relating to observed changes in health service delivery 9Table 13, p34), the following comments were made in direct reference to the health provider training events.

As a health care provider it has provided me with a much greater understanding of some of the feelings, beliefs and experiences of my patients. (SPS 3)

Particularly in the area of mental health – the community has helped general practice understand cultural nuances…I think that requests for cultural education in primary care ranked very high. We as a ML (Medicare Local) have now implemented continuous cultural awareness training for primary care every six months. (SPS 2)

RHDW contribution to events

The survey of stakeholders found that the impact of RHDW's at training events had a positive impact,

Feedback from health providers attending education sessions that involved the health leaders was very positive. The voice of the health leaders was very powerful for education of health workers (SPS 4)

Health professionals commented repeatedly at the value of having the health development workers involved in training and information sessions. It complimented the clinical information and provided depth of understanding which would not have been possible without the workers being directly involved in the delivery of the education sessions. (SPS 5)

Clinical services and organizations reported significant levels of benefit from having input from the health development workers into training particularly as they were able to bring to life the patients perspective in clinical settings. (PM)

(I) have welcomed the involvement of members of the group at education sessions for health care providers that I have been involved in. The insight they offer to healthcare providers is invaluable. (SPS 3)

Additional RHDW contributions to health service capacity building

Health service capacity has been further enhanced through the Health Development Workers contributions to the Mater Adolescent and Young Adult Centre (MAYAC) Reference Group (2 RHDW Youth Leaders), Greater Metro South Brisbane Medicare local youth stakeholder planning meeting (3 RHDW Youth Leaders), Partners in Recovery Barriers to access mental health services for refugees research study (8 RHDW's) and to the development of a health information website launched by West Moreton and Oxley Medicare Local www.communityhealthhub.com.au.

An example of the value of the RHDW's contribution to these additional pieces of work is demonstrated in the following message sent to the project manager,

A big thank you for helping us get refugee communities represented at the youth advisory group last Wednesday- their contribution was so valuable…. Both Alie and Utta have been invited (if they would like to continue) to be part of the group on a regular basis to add further input and decisions into the MAYAC service. (SPS 1)

Building capacity: The Refugee Health Development Workers

Personal Contribution

In May 2014 early in the project the group of 8 RHDW's were asked to consider what they were hoping their own personal contribution to the project would be. The inclusion of excerpts of each RHDW's response provides information in relation to the aspirations of each member of the Group of 8 indicating the group's common and individual nature. Providing a link from the community to inform health services of its needs and making information available to communities from health services featured in a number of responses as RHDW 4 describes the *'bridge'*. Another theme that was present was that of the value of the RHDW's coming from a refugee background enabling an understanding of the community that otherwise would not be possible and additionally in having that shared experience being able to gain the community's trust.

Process information from communities to health services and visa versa….comparing that information, assessing it as a refugee and employee and seeking to understand the reason behind decisions that are made. (RHDW1)

I will try my level best to be the in the heart of the community and present the community and it's need to the project. Moreover, I will also be finding out the health needs and health issues of the community and let the Medicare Local, Health Service Providers and all the responsible bodies recognise the issues, the community is suffering from. (RHDW 2)

Sharing experiences with others, bring feedback from community and see how we can improve any unclear situation by asking other and reflect on other group members' experiences. (RHDW3)

A bridge between community and health authority and health professionals. (RHDW4)

To enlighten the group and the sponsors of the project on the plight of the people in my community in terms of mental health and other health issues…Be able to represent my community. (RHDW5)

By using my own experience and all that I have seen other people go through can be used in the project (to) help refugee background women, if needed in terms of health. Being one who is well involved in the community activities is a good chance to find information out as I am not a stranger to them and (they) would trust me. (RHDW6)

I am hoping to contribute to this project by bringing thoughts/assumptions/ mind set of the refugee towards the health system and what the community consider as a barrier to trust and access the health care facilities. (RHDW7)

I am hoping to be a voice for those young people who don't have one and to help with health information through referring them to the correct source or making recommendations not as a health professional but as a mentor/role model. To achieve this, I hope to take every opportunity to receive the appropriate training to increase my level of expertise as a potential leader within the community. (RHDW8)

Personal and professional development

In January the group of 8 were reminded of their initial response to the question of their contribution to the project and asked to reflect on what they had gained professionally or personally from being involved in the project. Understanding the value of being involved in this project comes from reading the responses of the RHDW's. Common themes include gaining better communication and engagement skills, health care and health system knowledge, gaining the communities trust, personal confidence and a greater sense of professionalism.

I have learnt confidence, better communications approach, understanding the inclusive model of practice and social justice. Learnt where to access information and how to convey it better. (RHDW1)

Professionally, I have gained effective communication and good community engagement strategies and how to address some health issues. (RHDW3)

I have gained professionally more knowledge about public health and community care from being involved in this project. Also I have gained more involvement with my community and more trust from my community too. (RHDW4)

Working in this project has really been a very huge contribution to my professionalism, experience, understanding, flexibility and knowledge. (RHDW 2)

(I) have learnt a lot especially about the health system around mental health and referrals to mental health. (RHDW5)

I have learnt so much from the project through the training from different health professionals. I know now (health wise) things I had no idea about before the project. (RHDW6)

I have learned a bit on how research (is) done by individuals. I have broadened my network I had the chance to be in a panel and talk. I took part of in putting ideas together for "the mental health brochure" made by Ally. I was able to take part of the "state of the Mater" for the second time. This time I talked about understanding the person(s) background for the current health care approach. I have learn(ed) about community engagement from Alie presentation (RHDW7)

One of the RHDW's working with youth provided an example of how they had put this knowledge into practice.

For instance talking or explaining (things to) young people what is right requires to be patient and understand their age, respect, listen to what they say and convince them to what is good or bad by using examples, it was one way that I have found to be effective. (RHDW3)

Additionally one RHDW spoke passionately of the gains not only to their professional life but also their personal life.

I do really thank God, and I think I was very much lucky to be able to have a significant part in this amazing project. I have gained more than I could ever think of or mention about…it has been a very significant part of my life, learning and building myself in order to be doing what we really should be doing as professionals and as individuals in (the) work environment, in the community and in real life to. (RHDW 2)

Education opportunities

Improving the health literacy of the RHDW's occurred through formal education made available to the RHDW's on the topics of mental health, incidental counselling, infectious diseases and hepatitis. Informal education was provided by two of the RHDW's to the group on the subjects of community engagement (Alie) and healthy eating (Samira) as this was an area they had previously obtained skills and knowledge in. Table 10 summarises these educational activities.

Table 10: Training made available to the G8

		Alie	Daniel	Elizabeth	Evelyn	Farhia	Maria	Samira	Utta	Total
11/04/14	Mental Health seminar	1	1		1	1	1	1	1	7
2/06/2014	QTMHC presentation on Mental Health			1			1	1	1	4
11/06/14	Infectious diseases seminar		1		1	1		1		4
22+29/08/14	Mental Health First Aid		1		1	1	1		1	5
25/09/2014	Incidental counselling QPASTT		1		1		1	1	1	5
18/10/2014	Mental Health Workshop	1	1	1	1	1	1	1	1	8
8/12/2014	Healthy eating (Samira)	1	1	1	1	1	1	1	1	8
19/01/2015	Community engagement (Alie)	1	1		1	1	1	1		6
8 activities	**Total per RHDW**	4	7	3	7	6	7	7	6	Ave 6
	% per RHDW	50%	86%	38%	86%	75%	86%	86%	75%	Ave 75%

Feedback from the RHDW's was positive in relation to the education and information they had been exposed to as part of the project,

> *I have learnt a lot with training and consultation about health issues in Australia, I am better equipped now than before. (RHDW1)*

> *My understand(ing) of health especially primary health is broadened by this project. (RHDW 6)*

With specific reference to the Mental Health First Aid training one RHDW forwarded this response to the project manager.

> *In our country…they think Mental Health is to talk about crazy people, or people who need to be put in a locked room. People think people with Mental Health should be considered different from other human beings or be chained in order not to be a threat to other people. But while attending a Mental Health training with the professionals change the whole idea of an individual about Mental Health (problems). It really does bring a significant change in thinking about people who have Mental Health issues. Moreover, it does really give you a very great understanding of the Mental Health causes, consequences and for sure the ways that people can get help from and be mentally healthy once again…I personally really thank Mater Hospital for granting me the great opportunity to attend the Mental Health training, which was really very helpful. (RHDW 2)*

Utilised Skills & Knowledge

In January 2015 the group of 8 were asked to consider if there were any aspects of their skills and knowledge that were not utilised. Three of the 4 RHDW's that responded to this question did not think their skills or knowledge was underutilised of which two elaborated by stating,

> *I think I did have the opportunity to utilise my full potential skills and knowledge wherever and whenever required. (RHDW 2)*

> *No, I used everything I know in discussing with the youths…(RHDW3)*

One RHDW answered 'yes' to this question explaining,

> *I like to (be) involve more projects so I can use my knowledge and my skills more. Also I like to attend more training or seminars. For example: more health information workshops for women; group activity (RHDW4)*

The following two quotes reflect on the value of being involved in the project to the career path of the RHDW's.

> *For the workers it has built knowledge and confidence with some undertaking other pieces of work. (SPS5)*

> *The greatest value was for the health development workers and all were able to translate the experience and the skills gained in this work to build their respective work and careers. (PM)*

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Evaluation Domain 3: Value to for money

Did the project provide good value for money?

The project received in total $78,000 funding from three philanthropic funding sources.

Table 11: Project income	
Grant funding	
• Mater Foundation	30,000
• English Family Foundation	20,000
• NIB Foundation	28,000
Total Income	78,000

A budget was determined and managed by the project manager with Table 12 representing the breakdown of expenses that were budgeted and the actual spend to the point of January 2015.

Table 12: Project expenses	Actual expenditure to February 2015.
Staffing costs	
Evaluation	13,200
RHDW	54,293
Goods & services	
Stationery, printing, photocopying, medical graphics, postage	
Telecommunications	1,600
Information systems support	
IT	1,200
internet	
Travel	
Taxi, parking, mileage	1,800
Administration costs	
Insurance	1,200
Corporate Mx	1,200
Sundries	
Meeting costs	
Catering	3,640
Total expense	78,133

Value for money

Stakeholders commented on the cost of the project compared to what it managed to achieve.

> *Very little money with huge benefit for so many people!! (SPS 4)*

The exposure and impact of the program for both communities and service providers was extremely cost effective. It would be a shame for the investment in the workers to be truncated prematurely because of lack of resources. (SPS 5)

In my experience this has been a highly valuable project that has fostered greater communication between health care providers and the communities they are working with. (SPS 3)

One stakeholder commented that good project management had played a significant part in the success of this project which had limited resources.

With the limited resources and time available for the workers it is remarkable that such a strong and connected team developed. This is a credit to the program manager who was able to maximise resources available, provided solid support and was strategic in developing work plans. (SPS 5)

The project manager in reflecting on this question highlighting some of the challenges of being funded for one day per week,

The dollar investment is really very small. The Mater Health Services provided the salary of one day of coordination time – an essential part of the project which brings together 8 different people from different backgrounds and abilities and competing schedules. Timetabling was an issue from time to time…. (PM)

Is there a better way?

Two stakeholders commented that they did not feel there was a better way to obtain greater value for money

Better ways – no. (SPS 6)

Can't imagine any better way to do this (SPS 4)

The project manager suggested a new method of remuneration which she proposed would provide a fairer way of compensating RHDW's for the actual time they worked for the project reflecting on how some group members had given above and beyond expectation which was not common to all.

In future it would be good to experiment with a different formula for remuneration – i.e. on submission of an invoice for work completed rather than the 4 hours per week part time…. In future I would like to experiment with a "fairer" system. (PM)

Best value for money?

A question which was not directly answered by many stakeholders was that of which aspects of the project provided the best value for money. Comments in previous sections had indicated the value of the RHDW's in relation to engaging with their communities, informing services of their community's needs, providing education, contributing to service design, research and tool development. These achievements should be considered with respect to being employed for four hours paid work per week. Additionally the project manager's skills, knowledge and approach was reflected on by stakeholders as being of value to the project.

Evaluation Domain: Context

What works best for whom, under what conditions and why?

This evaluation domain seeks to understand what contextual elements were unique or important to the project, what was learnt with regard to what works best for whom and under what circumstances and determining if there any variation in outcomes for specific stakeholder groups.

Project context

This project being the third in a series focusing on refugee community health, being coordinated by the same project manager and re-employing seven out of eight RHDW's from previous projects is of contextual significance. This building of knowledge, skills, networks and trust has been a crucial part of this project. Additionally this project benefited from the Centre having established relationships with a number of Medicare Locals and being the coordination point for the Partnership Advisory Group and the related working groups, ,

> *The MLs were also keen to work with the team to engage communities in planning. This worked well when the MLs could provide extra funding to make this happen. The fact the program sat within the Centre and could feed into existing mechanisms e.g. PAG and CAG increased its impact. (SPS 5)*

Similarly the ground breaking role the project played for Mater Health Service was significant in relation to tangible efforts to engage with its community, a requirement of the Australian Council on Healthcare Standards (ACHS),

> *There was also value for the Mater in being able to demonstrate a commitment to community engagement. (SPS 5)*

What works best?

From responses to this and other questions asked as part of the evaluation and from conversations with the project manager the following provides a summary of findings relating to what works best for whom, under what circumstances in relation to this project;

- A group of funders who recognise the need to develop a program for vulnerable communities which operates at a systems as well as individual level.
- A RHDW who is immersed in their community, who speaks the community's language, understands the community's cultural norms, who understands what it is to be a refugee and who can legitimately gain the communities trust.
- A skilled project manager who has strategic vision, who remains flexible, consistent, inclusive and supportive in approach.
- A project team who listen, relate, respect and trust each other.
- A peer led approach to engaging with refugee communities and recognition of the unique insight the RHDW's can provide in community and health professional education.

- A health system that is ready to listen, learn, and adapt to the changing needs of the communities it serves.
- A policy structure that encourages innovation, funds appropriate resources and can see the big picture.

Variation in outcomes

In relation to variation in outcomes two stakeholders directly commented on this aspect,

> *I am sure there was variation in outcomes but the future is very likely to see further outcomes e.g. the refugee youth are likely to have more significant roles in their communities over time and this will be very valuable but as yet unrealised outcome – difficult to measure such potential (SPS 4)*

> *The demand for the workers increased throughout the life of the project as they gained greater exposure e.g. at the State of the Mater. However with limited resources and time it was not always possible to engage at all levels. (SPS 5)*

Additionally from a comment made by one of the RHDW's a variation in outcomes could have occurred with some male youth who may have found it difficult to take on board information from female RHDW's.

Future needs

Comments were made in relation to what stakeholders were hoping for in the future, these comments included,

> *More resources to enable longer follow up so the health leaders can continue to meet as they develop their roles in the community, more resources for more training so more health leaders from different communities can be trained (and) more resources to enable health leaders to be engaged with more education of health providers….(SPS 4)*

> *Extend this program to other areas of the state (SPS 4)*

In responding to the expressed needs of the community the project has provided education relating to mental health, women's health and youth health. Continuing to understand the changing needs of refugee communities will be an ongoing challenge which the Greater Brisbane Refugee Health Advisory Group are best placed to respond to. These changing needs may translate into a need to adjust the group's membership to reflect the community's needs. Additionally continuing to grow the skill base of the RHDW's in order that they can provide ongoing education to refugee communities and also continue to impact service delivery and research will also be an ongoing need.

Increasing visibility of the Greater Brisbane Refugee Health Advisory Group, maintaining relationships with refugee and generic service providers and developing new collaborations particularly with the new Primary Health Networks has been identified by the project manager as important in the future.

Evaluation Domain: Need

How well does the project address the most important root causes or needs?

Is the project still needed?

Is it still the right solution?

How well does the project address the most important root causes?

Table 13 provides a summary of two questions asked of the RHDW's the first in May 2014 *'What difference are you hoping the project will make?'* asked to determine the need for the project and the second in January 2015 *'Can you describe any positives or benefits you have seen or heard that are a result of the project?*' asked to determine outcomes from the point of view of the RHDW's.

Table 13: Project outcomes (RHDW feedback)

RHDW identified area of need	What difference are you hoping the project will make? (RHDW May 2014)	Can you describe any positive changes or benefits you have seen or heard that are a result of the project…? (RHDW January 2015)
To improve refugee communities awareness of health and health services	*I am hoping this project will make any community people find out about health services and can get link with the services (RHDW 4)* *This project will help community members to learn how to access health, learn where to go for and support and be able to know how to manage minor health issues (RHDW 5)*	*…they were provided enough necessary education and information in different areas of their day to day health concerns, including: comprehending Health Services in Queensland Australia, the right to ask for interpreters, the importance of a healthy diet, drug and alcohol harms for health, sexual health and diseases that can be caused because of it, and numerous more…(RHDW 2)* *Women members of my community called me and asked me for invitation to attend next community workshop because the one who attended last year told to other community members how benefits for that information session. (RHDW 4)*
To build confidence and reduce stress	*To build confidence in finding their way around the health care systems in Brisbane. (RHDW 1)* *To reduce feelings of stress related to medical appointments for service*	*They showed not to have any problem in accessing health services but fear questions they may face when they get to the Doctors and financial issues or supports as many young people do not work. (RHDW3)*

	provider & community members linked to feeling misunderstood or ignored(RHDW 1) *It will let the voice of the vulnerable ones be heard and give them an opportunity to be looked after, and provided the support needed, and waited for…. The ones who are really waiting for someone to come to them, to speak their own language, from his own background. (RHDW 2)*	
To provide youth with confidence, knowledge and skills	*I believe through this project many younger people from community will be able to express their feelings and be able to be directed to relevant people who may help them with their concerns. This project will give youth an opportunity to collaborate effectively with others and know where they should get help when is needed. (RHDW 3)*	*Personally I have been told by many young people I consulted during youth projects, their new and positive ways of visiting their GP and specialist appointments. (RHDW1)* *From this project youth have changed a lot as they become well organised in their health and communicate their views with other community members….. This project also helped some youth in the community to understand themselves and other people better. As it addresses the importance of accessing health services, and how and where they can get some help. (RHDW3)* *They talked openly what they think to me and ready to participate in any project to improve their understanding of health issues (RHDW3)*
To help improve refugee community's health	*The difference I am REALLY HOPPING is that after this project at least some but will understand some important health issues and those they were aware of before project and take control of their own health and the health of their family leading to a healthy community. (RHDW 6)* *I hope that this project take us steps further towards the improvement of refugee health. (RHDW 7)*	*Many of my community members now visit and do follow medical appointment. (RHDW1)* *Particular some women in my community benefited from the project. They can now visit their GP's regularly to check their health which the opposite before this project. (RHDW 6)*
To improve provision of health	*I hope this project will move a step further in making health information*	*Health service delivery is better than before. For example: using professional interpreters*

information to refugee communities	*available and more accessible to communities that are still trying to navigate their way through the health system. (RHDW 8)*	*instead of family members and follow up call as well; send reminder text message for hospital appointment the day before. (RHDW 4)*
To improve health services knowledge of refugee communities health needs	*Let the Service Providers know about their health needs, about the gaps that is available between the communities and the GPS. (RHDW 2)*	*(Relating to Health service workers…)Well knowledgeable, well organised, good listener and very patient when discussing some important issues (RHDW 3)*
To reduce barriers to accessing health services	*I also do hope this project will be a core/significant body in working with health professionals to make them aware of what the community needs are and how we can better work together to identify the underlying issues/barriers (RHDW 8)*	*Many of community members also not complain any more about their children not being looked after. (RHDW1)*
To provide a seamless service	*The health system could provide care with little gap/no gap (RHDW 7)*	*The capacity of health care workers are still not enough but more health care workers are working among the community these days especially post baby delivery and nursing areas. But difficult to find community health care worker. (RHDW4)*

As can be seen from the above table, RHDW's have been able to identify observable positive change in the refugee communities and in health service delivery which they can relate to this project. Examples of community increased confidence, motivation, awareness and behaviour change have been observed by the G8 members.

The stakeholder group were asked to consider how well the project addressed the most important root causes or needs relating to the project, two stakeholder comments have been selected to illustrate the general feedback received.

> *It has provided an avenue for the voices of the community to be heard - for health providers to hear first-hand the issues impacting on refugee background communities. It has also built the health literacy of the communities targeted. This has been achieved through investing in building the capacity of "community health leaders" who are trusted and have existing relationships with their communities. (SPS 5)*

> *The program was designed to enable better engagement with refugee communities to enable and improve health service delivery, especially in the primary health care sector and to enhance the health literacy within refugee communities and to facilitate the design and enable the capacity for research with refugee communities. It was great in addressing this with dedicated people engaging flexible and innovative ways with multiple organisations with definitive outcomes throughout the breadth of the sector. (SPS 4)*

Is the project still needed?

All seven respondents said clearly the project was still needed. The project manager's categorically stated,

> *I think the program is still needed and I don't envisage a time anytime soon when it won't be needed. (PM)*

The remaining respondents highlighted there reasons for the project needing to continue.

Because needs continue to change…

> *The need still exists in this changing environment and with the continual arrival of people from a refugee background. Inclusion, diversity and understanding are high priorities in this area….. The need is to continue this work and not let it decrease in any way (SPS 2)*

> *Yes, it is ongoing, needs change, the more you are informed you understand its ongoing (SPS 6)*

> *The need continues to exist. The overarching need is the same though the specific response required varies over time. The plan was always to continue to engage with new people and organisations as different situations arise. (SPS 4)*

Because it addresses a gap…

> *The program is still very much needed and addresses the gap between community and health service providers. (SPS 5)*

Because we need to provide efficient services…

> *Now more than ever with increasing diversity, major health reform and the push to reduce care costs, consulting with consumers from diverse cultures provides an opportunity to deliver services in the most cost effective and efficient way. (SPS 1)*

Because we need to build on achievements…

> *While the gains that have been made through the work of the group have been great, there is still much to be done and I feel there is still an ongoing need for the program. We are in a wonderful place to build on the greater understanding that has been achieved to date. (SPS 3)*

Is it the right approach?

Three respondents spoke of the projects engagement approach being the right approach,

> *Based on findings of previous work by Paula and Donata which identified a need (to find a) way of engaging with communities around health needs and messages….Yes I believe it is a very good way of engagement (SPS 6)*

> *Engaging with diverse cultures in the community is an essential project to ensure Mater provides equitable care, access to services and ongoing quality improvement and support. (SPS 1)…Exploring*

appropriate measures to consult with the rising refugee population is a solution to better care and long term health outcomes for the individual and the health organisation. (SPS 1)

The third comment was provided by the project manager who although agreeing that the approach was effective also highlighted the need for a much broader approach which included the support of the 'system',

I think the program addresses the root causes of engagement with 'hard to reach' and 'vulnerable' communities…It is not the only way nor can it effectively address the issue on its own. It needs responsiveness on the part of the system as well. (PM)

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CONCLUSION

Summary of findings

The original project aims were to:

1. **Create, document and evaluate a mechanism** through which health services including MHS can have access to the voice of refugee communities as part of a sustainable community engagement framework;

2. **Build a bridge** between health service administration, management and research and the communities they seek to serve by being available to facilitate focus groups, deliver training and education to staff, participate in research projects with identified project partners and contribute to development of resources and documents

3. **Build the critical health literacy** of refugee communities to shape and influence and improve access to health services

The following is a summary of findings relating to how the project responded to these aims:

Building a mechanism: Evidence gathered as part of this evaluation indicates that project activities and project outputs match closely with those planned at the outset (Table 17 appendix 5). These activities form the framework for the mechanism of sustainable community engagement, an example of how this has been presented to project funders can be viewed in appendix 6 (Presentation to the Mater Foundation).

Building a bridge: Evidence also suggests that through the projects activities RHDW's have been able to build a bridge between refugee communities, health services and research.

Building refugee community capacity: Through planned community education opportunities the health literacy of refugee communities has been positively impacted with observed examples of changes in health seeking behaviour.

Building refugee health provider capacity: Through focused health provider education, there has been a reported increase in skills and knowledge relating to the needs of refugee communities. Additionally early examples of perceived changes in health service delivery have been reported.

Building RHDW capacity: The project has provided multiple opportunities for the RHDW's to facilitate, present, educate, contribute to research and provide input into resources and documents. Evidence from the RHDW's has indicated that significant increase in knowledge, skills and confidence relating to health issues, access to services, community engagement and professionalism.

The following is a summary findings in relation to the five evaluation domains:

Design & delivery: The project benefited from the experience of the project manager and the RHDW's. It was well planned but was also flexible in responding to opportunities and the requests for specific information and training by communities, the RHDW's and service providers. Almost all planned actions occurred within the

specified timeframes. The project manager and in her absence her colleague Donata Sackey provided support to the RHDW's regularly and as required. The RHDW's understood their role and responsibilities, responded to the challenges of the project and frequently gave more than was required.

Value to stakeholders: Numerous examples of the value of the project to the three stakeholder groups (refugee communities, service providers and the RHDW's) have been cited. The evidence has been reported by more than one data source adding validity to the case. The long term value to stakeholders has not been the focus of this evaluation, for the purposes of establishing sustained value an impact evaluation would be required over a much longer period of time.

Value for money: The project budget and expenditure compared to the number of activities, outputs and outcomes achieved is significant in that a great deal has been achieved to date with limited funding. This as one stakeholder commented has been largely due to careful resource planning and management on the part of the project manager. It is difficult to imagine that more value could have been gained from the $78,000 the project received in funding.

Context: The context in which the project occurred is notable in that the experience, relationships and groundwork that had already been established in previous projects enabled the project to progress at a speed and to respond to opportunities that other projects may not have been as fortunate to encounter. Additionally the project being delivered from the Mater UQ Centre for Primary Health Care Innovation which through Donata Sackey and colleagues work was developing the Refugee Health Model was fortuitous.

Need: Expressed ongoing need for the project was unanimous amongst stakeholders. RHDW's and health provider respondents to the evaluation survey alike recognised the value in continuing to build on the achievements the project had made. The method of engaging vulnerable communities was viewed as the right approach to the task in hand.

Limitations

The evaluation whilst gathering and reviewing data from a number of sources did not attempt to obtain independent feedback from refugee community members. Information representing the views of refugee communities was obtained indirectly from event participation feedback and through feedback from the RHDW's. This information could therefore be subject to bias as a project of this unique nature is hoped to succeed and show significant impact. In order to respond to this potential issue the evaluator has sought to obtain data from more than one source to validate a point.

A significant period of time would need to pass to determine the 'impact' of any project. Therefore it is recommended that should the project continue to be funded that an impact evaluation be considered which could take a longitudinal approach to gathering and analysing data relating to sustained health literacy of refugee communities, health service utilisation by people from refugee communities, sustained skills and knowledge of health service providers, changes to health service delivery, policy development and other system changes that require significantly longer than 12 months to evaluate.

Implications

This report documents the evaluation of the Greater Brisbane Refugee Health Advisory Group Project February 2014 – February 2015. The evaluation has sought to provide an unbiased account of the activities, outputs, outcomes and ultimately the value of this 12 month project to stakeholders. Due to the short time frame of the project its 'impact' cannot be established, for this the project would need to be funded for a minimum of three years but ideally longer.

Whilst the long term impact of this project cannot be established this evaluation indicates that the Greater Brisbane Refugee Health Advisory Group has provided an efficient and effective vehicle for sustainable community engagement, improvement of health service knowledge of refugee community's needs and improvement in the critical health literacy of refugee communities and RHDW's.

The group's 12 months project funding ends on the 28th February 2015. The project manager has applied for six months funding to span this period until the new Primary Health Networks (PHN) have been established (July 1st 2015) after which a longer term funding strategy can be considered (Appendix 7). In order to maintain and build upon the group's presence and retain the group's membership an indication of ongoing employment options would be extremely beneficial. This is currently difficult to establish without ongoing secured funding.

The Greater Brisbane Refugee Health Advisory Group meets a need highlighted by one of the stakeholders,

> *With a National focus on poor health literacy as a barrier to receiving care, and increasing health care costs (with readmission rates and poor adherence to treatments) due to lack of understanding and trust- exploring appropriate measures to consult with the rising refugee population is a solution to better care and long term health outcomes for the individual and the health organisation. (SPS 1)*

This evaluation report is an essential tool in considering ongoing funding for this project. If ongoing funding was to be granted the expertise of the Greater Brisbane Refugee Health Advisory Group is likely to be a sought after commodity by the new Primary Health Networks, Mater Health Services, Local Hospital Networks and the Non for Profit sector.

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Appendix 1: Table 14: Project Plan (September 2014) GREATER BRISBANE REFUGEE HEALTH ADVISORY GROUP – PLANNING AND REVIEW GOAL: To be an effective mechanism for building connection between the health system and the needs of the community it serves.				
Objectives	**Strategies**	**Possible actions**	**Immediate action/when**	**Who**
Build skill and capacity in ourselves	Seek training – critical health literacy	Presentation skills Public speaking Leadership Management skills Community engagement Communication skills Community consultation (how to)	Community engagement	Alie to deliver a session to team??
	Seek training – functional health literacy	Healthy diet Sexual health Chronic disease Skin disease Hygiene Disability Stress Management Incidental counselling	Family Planning Qd re sexual health Healthy Diet QPASTT Incidental counselling – 25/8/2014	Paula to follow up Samira to deliver a session to team?? Samira, Evelyn, Samira, Utta
Build skill and capacity in the community	Coordinate community workshops	Contribution to Healthy Starts	20th September 2014 – General health Starts at MDA October 2014 – (still to be finalised) women's health focused healthy Starts in Goodna area	All team to publicise event in your own community Esperance, Elizabeth, Maria Samira and Farhia to be involved in publicising, supporting women and attending.
Build skill and capacity in the health system	Contribute to delivery of training	Contribution to ML locals training events Contribution to PIR and Mental Health sub Group training	Mental health training day on 18th October 2014	All team
	Give input to policy	Representation on ML consumer advisory committee	Elizabeth represented ongoingly on WMOML Consumer E Advice Committee	Elizabeth

	Give input to service development	Representation on MAYAC	First meeting attended. Ongoing invitation to represent the views of CALD on the MAYAC Advisory group.	Alie and Utta
	Contribute to development of resources	Develop resources for the community in relation to stress management and mental health Review "Tip Sheet" for primary care.	Ally and Narelle working on this in October. The team to help with advice and review resources before they go out to the communities.	All team
Build sustainability	Improve visibility	Photos of what we have done Brochures Website More presentations Networking M newsletter Presentations at Conferences and workshops Seek further partnerships with mater Consumer Engagement Unit	State of the Mater presentation on 17th September 2014 Paula to seek opportunities for presentations Paula to keep in contact with development in the Consumer Engagement Unit	Farhia, Alie, Utta, Samira Paula Paula
Maintain momentum - Be ready to partner with PHN	Review and renew	Consolidate our work through renewed funding Continue to meet monthly , but can meet more often if necessary	Application to Mater Foundation (due 15/9/2014) Next team meeting 13/10/2014	Paula All team

Appendix 2 Table 15: Evaluation Plan: The Greater Brisbane Refugee Health Advisory Group (G8)				
Resources / Inputs ***Resources required to operate the intervention***	**Activities** ***The planned activities that we can accomplished within the resources available***	**Outputs** ***The amount of the service or product that we intend to deliver through our activities***	**Outcomes** ***The benefits to participants if we accomplish our planned activities to the extent we intend (health workers, health providers & community)***	**Impacts** ***The changes that we expect to see in organisations or systems as a result of these benefits to participants***
<u>Grant Funding:</u> Mater Foundation $30,000 English Family Foundation $20,000 Nib $28,000 <u>Funded Resources:</u> 8 RHDW's 4 hrs per week for 50 wks. PM 0.2FTE Evaluator	1. Inform and seek feedback from existing reference groups with an interest in the health of refugee communities (Partnership Advisory Group, Mater Consumer Advisory Group)	(a) Presentation of the projects work at meetings (b) Preparation and presentation of a mid-point progress report.	The project through the activities of the health care workers will 'build a bridge' between: • The Communities they serve • Health service administration • Health services management • Research institute By: • Facilitate focus groups	Increased critical health literacy of refugee communities. Through the bridging activities, the health workers representing their communities shape and influence and improve access to health services. This could be seen in examples of development of or changes to:
	2. Develop a position description (PD)	(a) PD produced (b) PD circulated (timeliness, breadth, response rate) (c) PD is accurate reflection of the position as the project was delivered (d) Changes required to the PD required if replicating the project?		

<u>In-kind Resources:</u> (Networks) ○ PAG ○ MCAG ○ GMSBML ○ QPASTT ○ ECCQ ○ MDA ○ UQ	3. Recruit 8 health worker	(a) Number of HW's recruited and communities represented (b) Number of HW's retained (c) HW's pre & post reflection on role	• Deliver training & education to staff • Participate in research projects with identified partners • Contribute to the development of resources and documents. In order to: • Increase critical health literacy of refugee communities. • Promote the health development workers as a resource for the health system to draw on. • Increase confidence of health service workers to provide services to people from refugee backgrounds. • To shape health service policy, planning and research.	resources products staffing mix education opportunities organisational practices
	4. Develop a project plan (PP)	(a) PP produced (b) PP circulated (timeliness & breadth) (c) PP is accurate reflection of how the project was delivered (d) Number and reason for changes required to the PP during project delivery (changes in focus and their rationale)		
	5. Develop an evaluation plan (EP)	(a) EP developed (b) EP signed off (c) Data collected as per evaluation plan (d) Data analysed using appropriate methods (e) Evaluation report produced & circulated in a timely manner		
	6. Participate in Greater Brisbane Refugee Advisory Group Meeting monthly	(a) Attendance (b) Contributions (c) Satisfaction with involvement		
	7. Provision of health information to the group	(a) Range of health education provided (b) Number of sessions (c) Attendance at sessions (d) Satisfaction with sessions		
	8. Convene refugee community health information sessions	(a) Number of sessions (b) Attendance at sessions		

	quarterly	(c) Range of topics (d) Satisfaction with sessions (participant & presenter feedback)		
	9. Provision of training and support to health services	Number and range of: (a) Presentations at conferences (b) Service prof development (c) Community consultations (d) Practice visits		
	10. Support of existing initiatives such as the Healthy Start Program	(a) Range of support and number of occasions support provided		
	11. Document detailing a mechanism through which health services can have access to a voice in the community as part of a sustainable community engagement framework	Document (a) Produced (date) (b) Content (relevance) (c) Circulation (d) Acceptance		

Appendix 3:

Table 16: Partnership Advisory Group (PAG) Membership List - January 2014 ***Building Capacity in Refugee Health in "Greater Brisbane"***
Access Community Services
Australian Red Cross
CHQ (Children Health Queensland)/SEQ Medicare Collaborative/Zillmere Refugee Health Service
DoH (Department of Health) Public Health South
DoH (Department of Health) Public Health North
DoH Strategic Policy Unit
GP representative/Clinical Lead/Discipline of General Practice, School of Medicine The University of Queensland
GMSBML (Greater Metro south Brisbane Medicare Local)
IHMS
Mater Refugee Health Service
Mater Extended Care
Mater Health Service – Clinical Support Services
Mater UQ Centre for Primary Health Care Innovation
Metro South HSS- Logan Refugee Health Service
Metro South Addiction and Mental Health Services
MNBML (Metro North Brisbane Medicare Local)
MDA (Multicultural Development Association)
QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)
QTCMH (Qld Transcultural Mental Health)
UQ Health Care
WMOML (West Moreton Oxley Medicare Local)
WWG (World Wellness Group)

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Appendix 4 Position Description RHDW

Role Title:	Administration Support Worker – Refugee Projects
Agreement Classification Level:	AO2
Division/Hospital:	Mater UQ Centre for Primary Health Care and Innovation
Department/Unit:	Clinical Support Services
Date Created/Reviewed:	20th January 2014
Reports To:	Director - Mater UQ Centre for Primary Health Innovation
Level of Accountability:	Team Member

Role Purpose

Assist Mater Health Services engage successfully with refugee communities to build high quality sustainable health services to refugee communities.

Behavioural Standards

This role requires the incumbent to adhere to the Mater behavioural standards including the Values, Code of Conduct, Credo and any other relevant behavioural standards.

Role Level Accountabilities

This role is responsible for fulfilling the following accountabilities:

Self Accountabilities: For all Mater people

My Behaviour	➢ I role-model the values in the way I behave towards others and adhere to organisational behavioural standards at all time ➢ I translate mission into practice in my behaviour and actions
My Role	I am accountable for ensuring that: ➢ I am clear on the tasks and accountabilities that are associated with my role ➢ I fulfil any mandatory/professional competency requirements ➢ I contribute to, and sign off on, my performance objectives and development plan ➢ I request regular feedback from my manager in order to meet target performance expectations throughout the year ➢ I carry out my development plan ➢ I make an active contribution in my role as a team member
Safety and Quality	I am accountable for: ➢ contributing to safe and quality patient care and employee safety on every occasion by adhering to the relevant legislation, standards, policies and procedures ➢ contributing my part to 'zero harm' for staff, and 'zero preventable harm' for patients
Patient Experience	I am accountable for: ➢ contributing to the positive experience of patients and visitors to MHS in everything that I do ➢ providing information to patients, carers and consumers that is evidence based, useful and meaningful to them

Continuous Improvement	➢ I am accountable for recognising inefficiencies in my role and raising them with my Manager
Reputation	➢ I am accountable for representing MHS and being a champion of all that is great about working at Mater

Role Specific Tasks

- Attend, participate and contribute to discussion at the monthly meeting of the Greater Brisbane Refugee Health Advisory Group.
- Participate in the learning and development opportunities provided to the Greater Brisbane Refugee Health Advisory Group. For example health issues to be addressed by the Group.
- Organise the quarterly meeting with refugee communities to assist in the delivery of health literacy information.
- Support existing initiatives that aim to build the health literacy of people from refugee communities – e.g. the Healthy Starts project. This will include organising the venue, catering and contacting key community figures to advise the details
- Participate in other activities relevant to building health capacity of health services and refugee communities as they emerge in discussion with the project manager

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Qualifications

Essential

- No formal qualification is essential.

Desirable

- Qualification in health service, community development, human services.

Experience

Essential

- Proven experience in working with communities from refugee backgrounds
- Proven experience in community leadership (or the potential to become a community leader).

Technical Competencies

- Ability to speak and write English
- Well-developed communication skills with all project stakeholders – refugee community, project reference group and health services
- Capacity to listen to community feedback, synthesize content, and write a report (in English) results from consultations
- Capacity to organize community events and consultations
- Problem solving skills – capacity to identify problems and propose solutions

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Behavioural Capabilities

Patient/Client Centred: Ensures that the needs of patients, family members, students, and internal and external customers (collectively referred to as clients) are taken into account when problem solving and decision making, involving them in their own care or service wherever possible. Involves "putting the patient first" by anticipating and responding to the needs of the patient.

- A Foundation level of this capability is required for this role

Results Focus: Organised and able to effectively plan for the completion of tasks that contribute to the strategic direction of the organisation. Strives to set and achieve challenging goals, and applies and builds upon own expertise in order to achieve outcomes. Holds self and others accountable for the successful attainment of goals.

- A Foundation level of this capability is required for this role

Developing Self and Others: Mobilising, empowering, and developing self and others to meet current and future business needs. Able to create a culture of continuous feedback and collaboration where people strive for common goals and care about each other. Comfortable with complexity, examines problems carefully, is inquisitive, and can make fresh connections between different concepts.

- A Foundation level of this capability is required for this role

Relationship Building: The ability to work in a co-operative and helpful way with colleagues, whilst dealing with interpersonal difficulties in a manner that ensures objectives are met. This high interpersonal effectiveness includes active listening, negotiation and influencing.

- A Foundation level of this capability is required for this role

Critical Thinking and Problem Solving: The ability to effectively deal with complexity and ambiguity. Requires the ability to analyse data, seek and draw linkages between key sources of information, and show initiative in developing innovative solutions. Applying these skills on daily basis will assist in ensuring that a continuous improvement focus is maintained.

- A Foundation level of this capability is required for this role

Commercial Acumen: The ability to understand the key business drivers within MHS, the health industry and the environment in which we operate in. Applies key financial concepts and analysis to decision making. Supports strategic direction, is politically astute and engages in information seeking/networking and exploration of external benchmarks.

- A Foundation level of this capability is required for this role

Change Agility: Maximises opportunity that change offers and brings people along to understand and embrace change. Able to be visionary in the face of change and to adjust own behaviour to facilitate the change.

- A Foundation level of this capability is required for this role

Self Management: Incorporates the ability to have a high level of self awareness, the ability to manage ones emotions, whilst also exhibiting self belief and self care.

- A Foundation level of this capability is required for this role

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Appendix 5:

Table 17: Summary of project activities and outputs with corresponding evidence

Activities	Outputs	Evidence
1. Inform and seek feedback from existing reference groups with an interest in the health of refugee communities (Partnership Advisory Group, Mater Consumer Advisory Group)	(a) Presentation of the projects work at meetings (b) Preparation and presentation of a mid-point progress report.	(a) 3 PAG group meetings State of the Mater presentation Member of Mater Consumer Advisory Group (b) Funding body midpoint progress report cited
2. Develop a position description (PD)	(a) PD produced (b) PD circulated (timeliness, breadth, response rate) (c) PD is accurate reflection of the position as the project was delivered (d) Changes required to the PD required if replicating the project?	(a) PD cited (b) PD circulated via email to all RHDW's and related networks (c) Pre-post role reflection suggests an accurate PD (d) Plan to change method of remuneration being proposed
3. Recruit 8 health worker	(a) Number of HW's recruited and communities represented (b) Number of HW's retained (c) HW's pre & post reflection on role	(a) 8 RHDW's (+1 consultant) recruited (b) 7 retained to project completion (c) Pre-post role reflection indicates some difficulties but mostly satisfaction with the role
4. Develop a project plan (PP)	(a) PP produced (b) PP circulated (timeliness & breadth) (c) PP is accurate reflection of how the project was delivered (d) Number and reason for changes required to the PP during project delivery (changes in focus and their rationale)	(a) PP produced Nov 13 amended RHDW's Sept 2014 (b) PP is an accurate reflection of activities that occurred (c) Project responded to opportunities especially re: mental health and youth work. (number of changes not recorded)
5. Develop an evaluation plan (EP)	(a) EP developed (b) EP signed off (c) Data collected as per evaluation plan (d) Data analysed using appropriate methods (e) Evaluation report produced & circulated in a timely manner	(a) EP developed with PM (b) Circulated and agreed to (c) Survey timing and circulation was modified. Time did not permit interviews with RHDW's by evaluator. (d) EP completion delayed by 2-3 weeks.
6. Participate in Greater Brisbane Refugee Advisory Group Meeting monthly	(a) Attendance (b) Contributions (c) Satisfaction with involvement	(a) Attendance logged as high (b) Contributions noted in agendas / minutes (c) Levels of satisfaction with meeting

		indirectly receiving positive feedback by a number of RHDW's and PM
7. Provision of health information to the group	(a) Range of health education provided (b) Number of sessions (c) Attendance at sessions (d) Satisfaction with sessions	(a)& (b)Training record cited (c) Attendance logged (d) Survey feedback indicated value of training
8. Convene refugee community health information sessions quarterly	(a) Number of sessions (b) Attendance at sessions (c) Range of topics (d) Satisfaction with sessions	(a) Advertising material (x3 events) (b) Approximate attendance recorded (c) Topic selection met communities expressed needs form earlier projects (d) Informal feedback suggested the events met community needs.
9. Provision of training and support to health services	Number and range of: (a) Presentations at conferences (b) Service prof development (c) Community consultations (d) Practice visits	(a) Presentations to stakeholders by RHDW's recorded / presentations at conference by PM Cape Town, Melbourne (b) 3 Service provider education sessions (c) Not evidenced (d) Not evidenced
10. Support of existing initiatives such as the Healthy Start Program	(a) Range of support and number of occasions support provided	(a) Youth community event was a healthy start initiated event
11. Document detailing a mechanism through which health services can have access to a voice in the community as part of a sustainable community engagement framework	Document (a) Produced (date) (b) Content (relevance) (c) Circulation (d) Acceptance	(a) Presentation to the Mater Foundation which articulated the Concept of the Greater Brisbane Refugee Health Advisory Group as being a "bridge between the health system and the community. (appendix 6)

Appendix 6 Presentation to the Mater Foundation August 2014

What came first

Refugee Women as Health Leader's Project

2 year project funded by *nib* Foundation

- 2012 – 4 women engaged
- Consultations with Afghan, Eritrean, Rwandan and Togolese communities
- Health Action Plans for each community
- M'Locals respond to recommendations

1

The team 2012

2

What came next

Refugee Women as Health Leader's Project (cont)

- 2013 – another 4 women engaged
- Consultations with Sudanese, Burundian, Burmese, Congolese communities
- Health Action Plans for each community
- M'Locals respond to in recommendations

Refugee Youth Health Leader's Project

Replication of the Refugee Women as Health Leader's Project with young people: Funding from Mater Foundation

- 2013 – 3 young people engaged
- Formal research with Sudanese, Liberian and Afghan young people

3

The team 2013

4

The lessons

- 11 people had worked on the projects
- Significant positive professional and personal impacts for those people
- Health services "thirsty" for "the lived experience" to inform policy and skills development
- ML's responsive and keen for more!
- Need to formalize the consultancy and advisory potential

5

And so…

2014 -Combines the two elements

Greater Brisbane Refugee Health Advisory Group

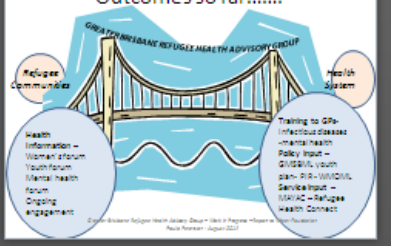
- Women – extension of the Refugee Women as Health Leaders project *(funded by MF)* – 4 women – Sudanese, Burmese, Somali, Eritrean (a 5th engaged later)
- Young people – (*funded by nib Foundation and English Family Foundation*)– 4 young people - Sudanese, Afghan, Liberian and Burundian
- G9 formed

6

The team 2014

7

Outcomes so far……



8

Foundations

Building engagement with "vulnerable and hard to reach communities"

- Building a sense of team
- Training around cross cultural work
- Developing critical and functional health literacy
- Providing personal support
- Providing ongoing mentoring
- Building skill base and capacity - individuals and their communities
- Building skill base and capacity in the health system

9

Maintaining the bridge

What we are doing now

10

Maintaining the bridge

What we need to do next

11

Intentionally blank

Appendix 7:

GREATER BRISBANE REFUGEE HEALTH ADVISORY GROUP (Beyond February 2015)

Background

The Greater Brisbane Refugee Health Advisory Group grew out of an amalgamation of two previous projects – the Refugee Women as Health Leaders project (which commenced in 2012) and the Refugee Youth Health Leaders Project (which commenced in 2013). In 2014, the two projects combined to form the Great Brisbane Refugee Health Advisory group.

During 2014, 8 Health Development Workers were employed for 4 hours per week (casual rate of $32.95 per hour). Each person was employed against a job description and employed by Mater Health Services as an Administrative Worker level 2 from March 2014 until 28th February 2015.

The team met once per month and in the intervening times, the team attended training, attended consultations and reference group meetings, gave input to research and policy development, and assisted in the delivery of training to primary care clinicians and support staff. A summary of achievements in 2014 is below:

• Improved health literacy of Health Development Workers through participation in formal and informal learning opportunities	➢ **Health literacy has been improved through participation in the following** • Mental health seminar on April 11th • Mental health workshop for communities October 2014 • Presentation by Queensland Transcultural mental Health centre on June 2nd, 2014 • Incidental Counselling Course at QPASTT • Formal certificate course in Mental Health First Aid. • Hepatitis Seminar September 2014 • Infectious Diseases seminar on 11th June. • Health eating session delivered by Samira Ali • Community engagement session delivered by Alie Kenneh
• Improved health literacy in the broader community	➢ **Convened and/or contributed to the following** • Women's health workshop on 14 June 2014 • Youth healthy starts in August 2014 • Mental health workshop in October 2014
• Articulation of health needs	• In the early part of the project, Health Action Plans were developed after consultation with the women from 8 communities. These plans were delivered to the Medicare Local who acted on many of the recommendations contained in the documents in 2014. Plans were created for the following communities: Eritrean, Afghan, Rwanda, Togolese, Congolese, Burundian, South Sudanese, Burmese

	• HDWs conducted in depth interviews with 31 young people from refugee backgrounds in 2013. • The findings of this research were analysed in 2014 and will be published in 2015.
• Improvement in health service capacity to provide services to people from refugee backgrounds	➢ **Health service capacity has been enhanced through contributions to the following training** On April 8th a training seminar on the delivery of mental health support for people of refugee backgrounds in the primary care setting was held. • On June 11th a training seminar on the delivery of health support for people of refugee backgrounds with infectious diseases in the primary care setting was held. Approximately 50 people attend this event (41 from primary care settings.) Evaluation of the training revealed that 61% of respondents improved skills, knowledge and confidence. • On October 18th a second training seminar on the delivery of mental health support for people of refugee backgrounds in the primary care setting was held. Approximately 70 people attend this event (41 from primary care settings.) Evaluation of the training revealed that 60% of respondents improved skills and knowledge and confidence. ➢ **Health service capacity has been further enhanced through the Health Development Workers contributions to the following opportunities to develop service capacity** • 2 of the Youth Leaders have joined the Reference Group for the newly formed Mater Adolescent and Young Adult Centre • 3 of the Youth Leaders gave input to the Greater Metro South Brisbane Medicare local youth stakeholder planning meeting • All members of the team have given extensive input into the PIR project conducted in 2014 which sought to identify barriers to access mental health services. Input ranged from giving community perspectives to the PIR project team, contributing community perspectives to training, and giving input and comment on resources that were developed as an outcome of that project.

Funding for all this work has come from three separate sources of philanthropic funding:

- Nib Foundation
- English Family Foundation
- Mater Foundation

An application was submitted to the Mater Foundation in late 2014 to continue funding the work of the Great Brisbane Refugee Health Advisory Group for another 12 months to enable it to reach a level of stability until the Primary Health Networks (due to commence on 1st July 2015) are fully established. It is assumed the PHN's will be committed to engage with the group, as were the Medicare Locals, as it has been widely recognised that this group is an effective mechanism to engage with a significant part of the community.
The current project is only funded until the 28th February 2015.

The future

The project has demonstrated that the Greater Brisbane Refugee Health Advisory Group is becoming an important feature on the health landscape. Therefore the Mater UQ Centre for Primary Care is committed to providing some support for it to continue for a few more months while sustained funding can be sought. The following will apply for the period 1/3/2015 – 30/6/2015.

The objectives of the next 4 months remain as before; that is to

1. Improve the health literacy skills of the HDWs who form the Greater Brisbane Refugee Health Advisory Group
2. Improve the health literacy amongst the broader communities of people from refugee backgrounds
3. Contribute to opportunities to articulate the health needs of people from refugee backgrounds
4. Improve health service capacity to provide services to people from refugee backgrounds

The engagement of the Health Development Workers will change from 1/3/2015. It is proposed that the workers' pay rate will increase to the rate of Administrative Worker level 4 (casual rate of $45.52 per hour). The following changes will apply

- HDW will be engaged as consultant staff – i.e. they will submit an invoice for hours of work completed at the end of each month.
- Each HDW will need to acquire an ABN if they do not already have one.
- Hours will be capped as follows
    - Two hours per month to attend monthly team meetings
    - Six hours per month to conduct work in the community – this to be negotiated with project manager but could be delivering information to community members, sitting on a reference group, assisting in the delivery of training to health care providers etc.