Tamil and Afghan Community Strengthening Projects 2016-18

FINAL REPORT

enliven

ENHANCING SOCIAL HEALTH

Acknowledgements

The project team at enliven would like to thank the following for the contributions:

- The Afghan and Tamil volunteers for your endless enthusiasm and dedication to making a difference. Thank you for the time and energy you have spent with us throughout the course of these projects – from attending training, to providing cultural advice and guidance, and helping to share our important messages with your communities.
- The Tamil and Afghan Community Leaders Advisory Groups for your commitment to helping us shape and re-shape these projects. Thank you for sharing so bravely and openly and keeping us on track with developing a product your communities need.
- The Community Strengthening Taskgroup for contributing to the design of these projects through sharing experience, knowledge and resources.
- enliven's Management Team and Board for being flexible and encouraging us to be brave and creative to achieve project outcomes.

Thank you all.

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Check out our project video at:

enliven.org.au/enliven-community-strengthening-projects/

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Introduction

The purpose of this report is to provide an overview of the Afghan and Tamil Community Strengthening Projects delivered by enliven between November 2016 and June 2018. It will explore the projects' activities, their outcomes and key lessons learned.

Project aim

The projects aimed to deliver place-based interventions from within the Afghan and Tamil communities in south eastern Melbourne. Activities were designed to strengthen community capacity to live healthy, happy and socially connected lives.

Objectives

1. To improve community health literacy and appropriate access of local health services through the delivery of volunteer-led peer education activities.
2. To enhance connectivity between communities and local service providers through the facilitation of mutually-engaging activities.
3. The above aim and objectives were developed at project conception. However, the projects' agility and responsiveness to community and sector needs also saw the emergence of an additional objective:
4. To build social and economic participation through the coordination of capacity building and development activities for volunteers and community leaders.

In this report, evaluation of project success will be measured against all of the above.

Check out our project video at:

enliven.org.au/enliven-community-strengthening-projects/

Background

The projects built on the foundational work initiated by the South Eastern Melbourne Medicare Local (SEMML) in 2013 – 2015. In the previous lives of the projects, SEMML developed partnerships with both the Afghan and Tamil communities and local service providers with the purpose of gathering insights and advice to inform project design. In particular, the projects sought to focus on migrants from humanitarian (refugee or asylum seeker) backgrounds within the two communities for a number of reasons:

- the sheer volume and demographic footprint of humanitarian migrants arriving from Afghanistan and Sri Lanka, or through transit countries Pakistan and India;
- the complex health and social needs of these migrants resulting from traumatic experiences in countries or origin or in transit, as well as settlement challenges;
- the evident difficulties faced in accessing and navigating services and supports appropriately, made visible by health and social service system data and verified through service sector consultation.

Community leaders and service providers were engaged, initially separately, in a dynamic consultation to:

- identify and prioritise the health and social issues impacting members of the local Tamil and Afghan communities
- co-design and deliver locally-relevant solutions to the identified issues.

The solution

Two peer education projects (one Tamil, one Afghan) whereby trained volunteers from within the community delivered health literacy information sessions to members of their community in language and in local settings.

In this iteration of the project, a similar co-design approach was taken which will be explored in later sections of this report.

The projects were delivered with funding from:

- SEMML (legacy funding)
- The Department of Premier and Cabinet (DPC) through the Victorian Multicultural Commission (VMC)
- South Eastern Melbourne Primary Health Network (SEMPHN)
- SEHCP Inc. t/a Enliven Victoria (enliven)

Our approach: co-designing for success

Forming and storming

Through the work of the Tamil and Afghan bicultural Project Officers, enliven re-engaged the community leaders who participated in the previous iteration of the projects, and with some additional targeted recruitment, formulated two Community Leaders Advisory Groups. Local service providers, particularly those with intimate relationships and/or understanding of the local Afghan and Tamil communities were also engaged. This led to the establishment of an additional advisory group - the Community Strengthening Taskgroup, chaired and convened by enliven.

Afghan Community Leaders	Afghan volunteers
1. Fahima Ashuri	1. Weda Mohseni
2. Farida Bezhan	2. Ghezal Zara
3. Khalil Hamid	3. Ghezal Adam
4. Jaweed Mohammadi	4. Obaid Sadath
5. Fazela Tahery	5. Hamida Zaki
6. Fatima Haidari	6. Shokria Hakimi
7. Ahsanullah Pacha Noori	7. Nilofer Nezami
	8. Monira Tahery
	9. Sahar Batool
	10. Asma Haidari
	11. Elham Kolasinac

Tamil Community Leaders	Tamil volunteers
1. Paramanthan Murugesu	1. Geetha Manickavasagam
2. Ramesh Balakrishnar	2. Kanmani Barthasarathy
3. Malinee Backus	3. Ambika Sivan
4. Muru Murukaverl	4. Steven Shanmuganathan
5. Purushothman	5. Bhagya Etta
6. Parthasarathy	

Community Strengthening Taskgroup

Rob Koch (Monash Health Refugee Health and Wellbeing)	Jemma Clancy (headspace Dandenong and Narre Warren)
Laetitia Encarta (ermha)	Kate Lowsby (Women's Health in the South East)
Myf Evans (Mission Australia)	Lara Ghobrial (Life Without Barriers)
Alaine Prime (Victoria Legal Aid)	Yvette Shaw (Department of Health and Human Services)
Kate Jeffery (Link Health and Community)	Peter O'Hare (Uniting Connections)
Andrea Shepherd (South East Community Links)	Jayne Birkett (City of Greater Dandenong)
Jawid Sayed (Hepatitis Victoria)	Alison Asche (South Eastern Melbourne Primary Health Network)
Emily Harris (South Eastern Melbourne Primary Health Network)	Ali Yaghobi (Southern Migrant and Refugee Centre)
Kalyani Srinivasan (City of Casey)	Glenda George (Cardinia Shire Council)

Through co-design activities, the groups reviewed and refined the list of priority health and social issues afflicting local Afghans and Tamils. They subsequently contributed to the crafting of a suite of health literacy messages to address these priorities that were not only culturally and socially appropriate, but also reflected the language and literacy needs of the communities they were intended for.

Volunteers from within the two communities, including some return volunteers from the previous project, were then recruited through the bicultural Project Officers and community leaders. Through a comprehensive training program, these volunteers were equipped with the knowledge and understanding of the health literacy messages, but also with the skills to deliver them within their communities in language and in local settings (Objective 1 and 2).

Building capacity

In addition to the training delivered to build the core competencies of the peer educator role, the volunteers were also offered a range of additional personal and professional development opportunities (Objective 3).

1. Group-based training

A program of group-based training, designed and delivered based on collectively identified areas of interest. External experts and training providers were engaged to ensure training was of the highest quality and of most relevance.

2. Individual learning and development

Each volunteer, as well as two community leaders who expressed interest, were provided the opportunity to write an Individual Learning and Development Plan with the project team. This plan sought to identify both short- and long-term goals, as well as outline any training that participants were interested in for their own personal development and/or career progression, that project funding could be allocated to.

Training session.

Knitting together

All efforts were made to promote social and intercultural connections between and within the two communities, with the global aim of enhancing project sustainability and community ownership in the broadest sense. The primary vehicle for achieving this was through the group-based training program which established a climate for shared learning and positive engagement where both communities participated equally.

However, additional deliberative activities were also facilitated to further reinforce this goal, including:

- Facilitating joint celebration events such as morning teas, dinners and lunches
- Hosting a graduation ceremony to recognise all the volunteers who completed the training program
- Nominating (and winning!) volunteers for awards as a united intercultural group rather than two separate projects and ensuring equal representation from both groups at presentation ceremonies.

VolVic Awards.

Achieving what we set out to

enliven optimised co-design opportunities with community leaders, volunteers and bicultural staff when attempting to envisage what the successful achievement of the project aim looked like. It was determined that the assembly of success against the three agreed objectives would lead to success in achieving the overall aim.

Though there are significant intersections between the objectives and they cannot be appraised independently of each other, it was agreed that means to evaluate each objective separately was required to inform higher level evaluation. The following section includes a report against each of the objectives.

Objective 1

To improve community health literacy and appropriate access of local health services through the delivery of volunteer-led peer education activities.

The mechanism for achieving this objective was through the delivery of information by enliven-trained volunteers. It was evaluated using pre- and post-information session surveys capturing participants' self-reported knowledge. Surveys were administered by volunteers and aimed to identify whether knowledge of health and access to local health care services increased as a result of receiving the information.

A total of 15 community information sessions were delivered by the volunteers across a range of local settings. These were attended by a total of 296 community members, from the following community groups (among others):

refugee clients of AMES (Dandenong)	Afghan seniors group
migrant groups at Southern Migrant and Refugee Centre	Asylum Seeker Resource Centre (Dandenong)
clients (people seeking asylum) of Life Without Barriers (Dandenong)	Hampton Park English Language School
local Women's Friendship Cafes	Dandenong Library
clients of Foundation House (Dandenong)	Cranbourne Dari School
clients of Community Four	Bharathi Academy Tamil School
attendees of City of Greater Dandenong Library	members of Afghan Women's Association

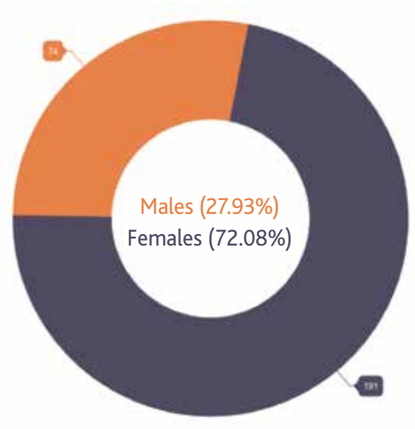
There were noticeable differences in the number of sessions delivered, as well as the number of community members reached when comparing the two projects as depicted in Images 1 and 2. Tamil volunteers delivered a total of five community information sessions, attended by a total of 31 community members. Afghan volunteers delivered a total of ten community information sessions, attended by 265 community members in total. Potential explanations for this will be explored later in this report.

Tamil (left) and Afghan (right) Information Sessions.

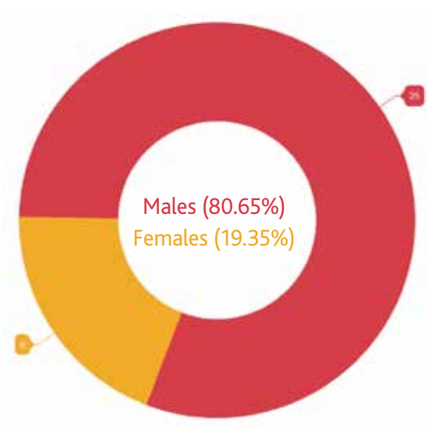
Achieving what we set out to (continued)

Community Information Sessions attendance breakdowns.

Tamil:



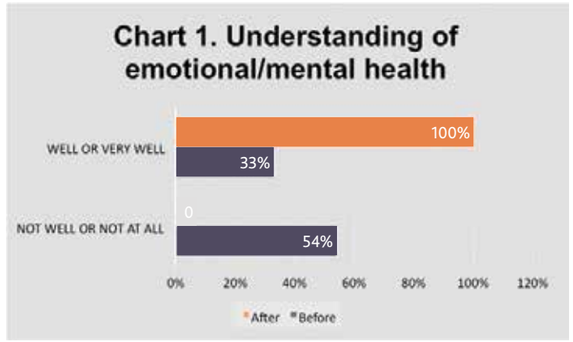
Afghan:



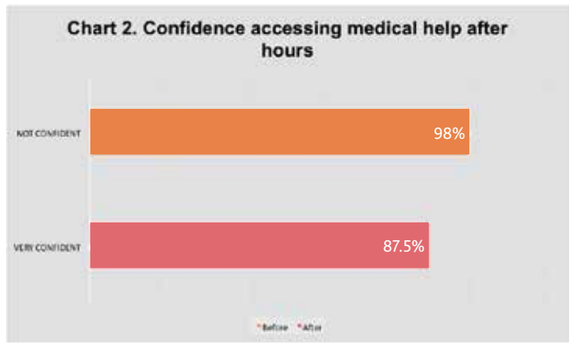
The areas of most significant health literacy improvement were:

- mental health, mental illness and the means of accessing mental health supports. This was expressed in levels of understanding noted prior to, and following receipt of health information
- means of accessing medical help after hours (eg. at nights and on weekends). This was expressed in levels of confidence noted prior to, and following receipt of health information.

For example, as shown in ***Chart 1. Understanding of mental health and mental illness***, attendees were asked "How well do you understand emotional health/mental health?" to which over half of all attendees responded either 'Not well' or 'Not at all' prior to the information session. By comparison, 100% of attendees responded either 'Well' or 'Very well' when asked the same question following receipt of information.



Similarly, when asked "How confident do you feel getting medical help after hours?" prior to the information session, almost all attendees (98%) responded 'Not confident'. Contrarily, 87.5% of attendees reported feeling 'Very confident' when asked the same question after the information session as reflected in ***Chart 2. Confidence accessing medical help after hours.***



Achieving what we set out to (continued)

Other areas of notable health literacy improvements were self-reported confidence in accessing medicines (eg. finding and using pharmacy services).

Areas of least health literacy improvement were self-reported confidence in accessing General Practice (GP) services. This is largely attributable to the fact that greater numbers of community members had previously had interactions with GP service, which was reflected in the comparatively high scores noted in pre-information session data.

A key directive from both the Community Leaders Advisory Groups was to explore alternative means of message dissemination, acknowledging the fact that community information sessions may not be accessible to all. Suggestions from these groups included coverage through local press as well as ethnic radio.

As such, enliven sought opportunities to promote project achievements through local press, leading to coverage in the Dandenong Journal[1] and Leader Newspaper South East Melbourne[2]. enliven also arranged for volunteers and community leaders to participate in radio interviews with SBS Tamil[3], SBS Dari[4] and SBS Pashto[5] to perpetuate the spread of key health literacy messages to listeners all over Australia.

Objective 2

To enhance connectivity between communities and local service providers through the facilitation of mutually-engaging activities.

In early project proposal and planning stages, enliven conceptualised sustainability through embedding the project activities within existing community and system infrastructure to enable self-perpetuation beyond the project funding period. The primary strategy for this being the placement of enliven-trained volunteers within key partner organisations known to be supporting Tamil and Afghan community members, formalised through the signing of a Memorandum of Understanding (MOU). The purpose of this was three-fold:

1. *to support host organisations in their engagement and support of clients through the assistance of well-trained bicultural volunteers*
2. *to build community health literacy through the regular delivery of in-situ community information session utilising host organisation resources and supports*
3. *to further promote the expansion of volunteers' professional connections as well as their personal and professional development through exposure to opportunities offered by the host organisation.*

Throughout the projects' duration, a total of four MOUs were signed, including two for the placement of Afghan volunteers and two for the placement of Tamil volunteers. The MOUs have since expired and not been re-signed, however two of the four placements continue outside of the formal agreement.

A number of challenges were encountered in relation to achieving this objective as initially intended, which will be explored in greater detail under 'Challenges.' However, through close consultation with both the Community Leaders Advisory Groups and the Community Strengthening Taskgroup, enliven re-conceptualised sustainability. As a result, a greater emphasis was placed on empowering volunteers and community leaders to be independent self-advocates as opposed to perpetuating any dependence on organisations. This led to the creation of Objective 3.

There were however a number of other unexpected successes seen in relation to Objective 2. As a direct result of the emphasised focus on capacity building and developing volunteers, volunteers were exposed to an array of professionals and local leaders that they otherwise may not have. This included: professional networks and committees, training providers, representatives from the three levels of government, and importantly leaders and members from other communities.

1 Dandenong Journal, August 2017 https://dandenong.starcommunity.com.au/journal/2017-08-31/speaking-the-language-of-health/

2 Leader Newspaper South East, August 2017 https://www.heraldsun.com.au/leader/south-east/migrant-health-champions-show-their-peers-the-ins-and-outs-of-dandenong-health-services/news-story/9f9ade39ec3aba300a609f7613805952

3 SBS Tamil, April 2018 https://www.sbs.com.au/yourlanguage/tamil/en/audiotrack/enliven-victoria-can-guide-you-right-medical-service?language=en

4 SBS Dari, April 2018 https://www.sbs.com.au/yourlanguage/dari/en/audiotrack/about-inliven-1

5 BS Pashto, April 2018 https://www.sbs.com.au/yourlanguage/pashto/en/audiotrack/what-can-enliven-give-afghan-community?language=en

Achieving what we set out to (continued)

Objective 3

To build social and economic participation through the coordination of capacity building and development activities for volunteers and community leaders.

Though not required by project funders, enliven made concerted efforts to empower volunteers/leaders and promote independence through tailored capacity and resilience building initiatives. This objective was conceived in consultation with the various advisory groups, as an alternative to the originally planned mechanism for achieving sustainability (Objective 2). It was determined that the delivery of high quality training programs by industry experts would not only result in enhanced competence in areas such as: civic literacy, leadership and communication, but would also build confidence, resilience and professional networks. The net result being more sustainable promotion of independence and self-advocacy skills.

These relationships now exist independently of enliven and have seen fruitful outcomes such as: the acquisition of employment, successful appointment to advisory committees, engagement in further training and development, and continued personal and professional growth.

As previously discussed, achieving this objective included the delivery of both group-based training and Individual Learning and Development activities.

Group-based training

- A program of group-based training was designed and delivered based on collectively identified areas of interest, including: Mental Health First Aid, Family relationships and family violence, Communication and documenting for professional practice, Volunteers leading teams, Health literacy and Foundations of facilitation, among others. External experts and training providers were engaged to ensure training was of the highest quality and of most relevance.

Individual learning and development

- Each volunteer, as well as two community leaders who expressed interest, were provided the opportunity to write an Individual Learning and Development Plan with the project team. This plan sought to identify both short- and long-term goals, as well as outline any training participants were interested in for their own personal development and/or career progression. These included: Master of Counselling; Certificate IV in Youth Work; Diploma of Community Services and Community Development; private careers coaching; Short Courses in Positive Psychology, Professional Writing, Major Donor Relations, Conflict Resolution; Leadership Programs; Short Course in Conflict Resolution; First Aid; and Yoga Masters.

In addition to these formal activities, enliven also sought to provide informal mentoring and support where required. Through preserving close contact and clear lines of open communication with volunteers throughout the projects, the Project Team developed a clear sense of each volunteers' personal goals. This led to many additional development activities such as: assisting with completion of application forms and enrolment papers, preparing letters of support, providing references and assisting volunteers' to understand complex organisational and navigational processes.

Volunteers and community leaders were surveyed at various intervals throughout the projects to ascertain levels of satisfaction. This included: one external process evaluation (qualitative) and two internal evaluations (1 during, 1 at conclusion).

Chart 1. Satisfaction with capacity building programs. An initial evaluation survey was administered to volunteers in May 2017. 75%

Achieving what we set out to (continued)

of respondents rated the group-based training program as 'Excellent' with the remaining 25% rating it as 'Good.' The exact same results were recorded for the Individual Learning and Development program.

These results increased at the conclusion of the training program, evidenced in the results of the concluding evaluation survey administered to volunteers in July 2018. 85.7% of volunteers gave an overall rating of 'Excellent' for the group-based training program, with the remaining 14.3% rating it as 'Good.' Again, the exact same results were recorded for the Individual Learning and Development program.

In August 2017, Monash University were engaged to conduct qualitative evaluation with volunteers. This was seen as an important step in obtaining unbiased data on project satisfaction, given the person completing data-collection was not a member of the Project Team and could guarantee confidentiality. This evaluation indicated that the volunteers found the training invaluable and wanted to commend enliven's decision to pay for it. Many also found the training timely and relevant to the needs of their community and spoke about the strategies they had used for sharing their learnings with the community. Most importantly, volunteers reported feeling supported, and were satisfied with the varying aspects of mentorship provided by enliven.

"I love the team work they have there (enliven), especially the way they care about us volunteers."

Afghan volunteer

"I think I gained more confidence at enliven. So like I am a little bit shy type. When I used to receive information I never used to stand in front of all others and talk about it. Now actually got the guts to express because I feel more confident about the topics they covered in the training and I feel I can go for more independently."

Tamil volunteer

"Everything that they do, they ask us and they make sure it is based on our needs and I am very happy with all the training they provide."

Afghan volunteer

Sustainability

A key aim that transcends the three objectives was the intent to establish outcomes that were sustainable beyond the cessation of intervention from enliven.

In the unpredictable and uncertain environment of grant-funded project delivery, enliven acknowledged the importance of, as discussed in 'Objective 2,' embedding the project activities within existing community and system infrastructure to enable self-perpetuation beyond the project funding period.

As part of the evaluation framework established to measure the success of these projects, enliven created a sustainability self-assessment matrix which included measurement against all of the sustainability related activities. Self-assessments were completed by the Project Team twice to establish baseline and comparison data (See Appendix A).

As previously mentioned, the Project Team were presented with a number of challenges which were resolved by slight deviations in project design. However, to preserve data integrity and allow for true comparison against baseline, the sustainability self-assessment matrix was not altered. As such, it should be acknowledged that the final sustainability scores shown in Table 1. Sustainability self-assessments of 50% sustainability for the Tamil project and 53.75% for the Afghan project, are not a true reflection of the overall sustainability of the projects. Rather, the scores depict the projects' sustainability in comparison to original, unrevised conceptualisations of the idea.

Table 1. Sustainability self-assessments

Audience	Baseline	Comparison
Tamil	27/80 or 33.75%	40/80 or 50%
Afghan	35/80 or 43.75%	43/80 or 53.75%

Challenges

A number of challenges were experienced throughout the lives of the projects that had direct impacts on the project design and therefore the outcomes. Some of the key challenges are discussed below.

Shifting winds of change

Perhaps the greatest challenge related to Objective 2 – the placement of enliven-trained volunteers within key partner organisations. Whilst four MOUs were signed, there remained a number of volunteers who were unable to be placed, at least in an official capacity, formalised by an MOU. This was attributed to a number of factors:

- The significant changes to the humanitarian/settlement sector as a result of Government policy changes. This sector comprises a large portion of potential partners whom were required to prioritise other organisational changes and client-related concerns above negotiating volunteer placements.
- The significant degree of effort expended on capacity building and upskilling volunteers which resulted in a large portion becoming engaged in part- or full-time employment or enrolled in study. In effect, whilst they were available to run community information sessions on a semi-regular basis, their availability to sign up as an official volunteer to another organisation was reduced.

However, a bi-product of the extensive training calendar and plethora of professional development initiatives was the strong connections developed between most (84%) volunteers and between 1 and 3 local service providers. These include:

- Red Cross – Forced Marriage Prevention project (n = 6 x casual employment)
- Uniting Connections (n = 1 part time employment)
- Wellsprings for Women (n = 1 volunteer)
- Women's Health in the South East (n = 2 volunteers – one with signed MOU, one without)
- Save the Children (n = 1 full time employment)
- City of Greater Dandenong (n = 1 full time employment)

Sustainability (continued)

These relationships and other connections that now existing independent of enliven, mirrored what was initially intended, however have not been formalised by the signing of an MOU at the preference of the organisations.

Recruiting the right mix

In previous iterations of the projects, the demographic profile of the volunteer base was significantly different. There existed a balance of volunteers from ethnic groups (sub-cultures) within each culture, a spread of volunteers from across age groups, and relatively even numbers of males and females. Whilst many of the volunteers who participated previously were interested in again taking part, they were only able to do so at a reduced capacity due to education, work, or family commitments as well as geographic barriers. Additionally, there were a small number who were no longer interested or able to make any commitment.

At the time when recruitment efforts ceased, the volunteer base was largely comprised of females, aged between 27 and 50 leaving a number of notable gaps. These included:

- Gender
  A deficit in male volunteers. With only two male volunteers (one Afghan and one Tamil) capacity to connect with males in the community was limited.
- Ethnicity
  The majority (80%) of the Tamil volunteers were Indian-born Tamils. As such, these volunteers did not have the degree of connection with the Sri Lankan Tamil community, particularly the significant numbers refugees and people seeking asylum from Sri Lanka whom the project aimed to reach.

  Similarly, 60% of the Afghan volunteers were Tajik (one of the three primary Afghan ethnicities), resulting in small numbers of Pashtun and Hazara volunteers. When overlayed with the gap in gender, this left no Hazara male volunteers which restricted ability to connect with another key target group of refugees and people seeking asylum.

Targeted efforts to recruit were largely unsuccessful in addressing the identified gaps, though they did see the recruitment of a number of incredibly enthusiastic and motivated volunteers.

Maintaining relevance

It was acknowledged at project commencement that the health and social priorities, as well as the key health literacy messages crafted to address them in the previous iterations of the projects may no longer meet the communities' changing needs. However, due to budget restrictions enliven was not able to undertake a dynamic and in-depth consultation and co-design process as conducted previously. Whilst every attempt was made, in close consultation with the three advisory groups, to revise and refine the priorities and messages, it was determined that building on the success of an existing model was preferable to re-commencing the entire process.

This lead to variable outcomes:

- The Tamil Community Leaders Advisory Group advised that health literacy levels had indeed changed in the preceding two years within their community, and whilst there were sects within the community (namely people seeking asylum), that still required basic health literacy messages, the majority of the community would require more sophisticated information about the intricate workings of the health system in order to benefit from the intervention. A co-designed process of revising priorities, re-drafting key messages, updating teaching resources, and re-training return volunteers ensued, leading to an estimated 50% of the overall content being changed. However, the Project Team and volunteers still reported regular difficulties in attracting attendees for community information sessions. It was deduced that this was a result of either unappealing and inappropriate content, or the lack of connection to the sects of the community requiring the level of information on offer, or a combination of both.
- Contrarily, the Afghan Community Leaders Advisory Group identified that their community was still in need of basic health literacy information about health system access and navigation. As such, the existing suite of health literacy messages and accompanying resources were used by volunteers when delivering community information sessions. Subsequently, volunteers had a much easier time recruiting attendees for community information sessions than their Tamil counterparts.

To address this challenge and ensure equity of outcomes across the two community groups, it would have been preferable to conduct an in-depth consultation and co-design process with both community groups at the outset rather than utilising existing models. However, due to the aforementioned budget restrictions and funding timelines, this was not within scope of these projects.

Key learnings and recommendations

The projects produced many interesting and important learnings, with high levels of relevance for others currently work with or planning to work with communities in a similar way.

1. Developing volunteers

Purposefully seeking volunteers from within communities is an effective means of ensuring the right people with the right intentions (eg. those driven by the desire to support their community as opposed to remuneration) are recruited. Similarly, it also has positive impacts on sustainability as engagement is not dependent on continued funding. However, it is essential that efforts are made to ensure volunteers feel personally valued and supported, and that they are adequately rewarded beyond simply compensating participation through small payments or vouchers.

In these projects, significant investment was made in the volunteers' personal and professional development. This included taking the time to understand each volunteers' interests. Funding volunteers to undertake development opportunities that linked to their interests regardless of how closely they aligned with project objectives, ensured they felt truly supported and valued by the organisation. It also produced additional unintended outcomes such as:

- propelling budding community members into competent and thriving leaders
- enhancing volunteer social and emotional wellbeing through intercultural connectivity and by providing a platform for "giving back"
- promoting volunteer educational progression, employment readiness and professional networks.

2. Maintaining engagement

Projects that depend on volunteers, are only as successful as the degree to which those volunteers remain engaged and active. As such, it is important to recognise that volunteers have lives, responsibilities and people depending on them outside of the project. Projects that have a long lifespan (eg. greater than six months) will therefore experience peaks and troughs in volunteers' levels of engagement. Variability in volunteer engagement is likely to increase as the number of volunteers expands, due to the distribution of responsibility across a greater number of shoulders.

It is critical to think creatively about means of keeping volunteers engaged over a long period of time, particularly as dips in engagement levels are noted. In these projects, the most successful strategies for preserving engagement of long-standing volunteers were:

- Actively seeking opportunities to celebrate individual and group achievements such as hosting celebration events, and nominating volunteers for awards
- Offering formalised opportunities for mentoring and leadership. This included backfill arrangements for Bicultural Project Officers; utilising experienced volunteers to deliver training to newer ones; and providing select volunteers with the opportunity to participate in consultations with Community Leaders Advisory Groups. Volunteers were appropriately remunerated for participation in these opportunities in acknowledgement of the fact that it sat outside of the what was expected of them as volunteer peer educators.

3. Having the right team

Bicultural Project Officers were key to the successes seen by the projects. They were critical to ensuring:

- that the right volunteers were recruited and equipped with a sound understanding of what was expected of them and what they could expect
- that the issues identified by the Community Leaders Advisory Groups were matched with well-crafted, sensitive messages that the volunteers could be trained to deliver
- that the strategies for disseminating key health literacy messages were appropriate and acknowledged any cultural nuances
- that opportunities arising within the community eg. cultural events, festivals etc were harnessed as opportunities for message dissemination.

There were also a number of challenges experienced in relation to this:

- Limited funding resulted in a restricted budget for part-time Bicultural Project Officer roles (0.2 EFT - 0.5 EFT). This created a number of challenges, particularly in terms of ensuring expectations of staff were managed, and boundaries were preserved so that their time was not exploited by the community or organisation

Key learnings and recommendations (continued)

- Bicultural Project Officers' have a finite supply of personal and social capital, meaning:
  - They do not, nor should they be expected to, have connections into ever sect of their community. As such, additional innovative solutions were trialled, albeit with limited success, (eg. consultancy arrangements with volunteers who have complementary socio-demographic and ethnic profiles), to achieve equitable distribution of project outcomes for community members who are not directly connected with the team
  - They also must continue to exist and operate within their community outside the formal project confines and timelines. As such, it is critical that their personal and social capital is not exploited, and that their reputation within the community is not impacted in any way by the project. Strategies to address this included ensuring Bicultural Project Officers had work email addresses, and that personal mobile use was limited, opting to give out office or Project Manager phone numbers instead.

4. Bringing together, separately

As mentioned in 'Knitting together,' where appropriate every attempt was made to promote social and intercultural connections between and within the two communities, by delivering many project activities simultaneously. Knitting communities together through shared experiences, as opposed to shared cultural background produced a great number of unintended and unexpected positive impacts on project sustainability.

However, it is critical that this approach is not viewed purely as a pragmatic cost-saving solution. It was not a one-size-fits-all strategy! Some evidence of this includes:

- Co-design processes and consultations specific to each community, were conducted completely independently of each other at all stages to ensure the highest level of customisation and relevance
- Community engagement and intel gathering strategies were targeted and specific for each community and sub-community, to ensure opportunities such as cultural events and festivals could be capitalised
- All evaluation activities were conducted separately or included the capacity to stratify results for each community. This was integral to ensuring grant-related reporting could be executed with the highest level of accuracy and validity, but also because the strategies and resources available for project implementation differed and therefore produced differing results that warranted acknowledgement.

None of the above could be executed by viewing the project participants (eg. community leaders, volunteers and community members) as a homogeneous group. Having quality checkpoints and mechanisms for cultural customisation was essential to enabling the highest level of success.

5. Shaping and re-shaping

Setting realistic and achievable aims and objectives is vital to successfully delivering on similar projects, particularly when doing so with external funding. This requires a sound understanding of the complex systems and structures in which communities and the organisations working with them operate within. With such a large number of extraneous variables and competing demands having the capacity to influence engagement and outcomes, it is critical not to over-promise from the outset.

These projects, whilst ambitious, proposed the delivery of quite realistic outcomes based on political and social climates at the time of conception, as well as the existing capacities within the organisation and community. However, following the approval of reduced funding, negotiations were critical to re-assessing and shaping achievable outcomes. Similar negotiations with funding bodies were also required at various other stages throughout project delivery to respond to the changes in the political and social climate discussed in 'Challenges.'

This agility and capacity for re-shaping calls for mechanisms that facilitate reflective practice. It is imperative to recognise when things are not working as early as possible so that creative problem solving can take place and amendments can be made. Depending on the challenges being experienced, it may also call for bravery – to follow where the momentum is organically leading rather than attempting to rigidly adhere to what was proposed. For these projects, achieving this required clear and considered articulation to funding bodies how alternative approaches would produce outcomes of equal or greater desirability. In doing this, it was important to emphasise the project teams' accountabilities to communities and local stakeholders, and the importance of balancing these with those to funding bodies.

Conclusion

The Tamil and Afghan Community Strengthening Projects aimed to deliver place-based interventions focussing on strengthening community capacity to live healthy, happy and socially connected lives. These interventions were co-designed in partnership with leaders of the communities as well as representatives from local stakeholder organisations. The primary aim of the projects was to improve community health literacy and in turn health outcomes through volunteer-led health information sessions. However, in response to a series of community and sector changes that occurred amidst implementation, additional aims were conceived, and in many ways took precedence. At project conclusion, the overall reported benefits were relatively comparable to those originally intended. However, the journey to achieve those benefits also produced a large number of unintended yet immeasurably meaningful outcomes. The success of these projects is a testament to the agility, responsivity and dedication of the Tamil and Afghan community leaders and members, local partner organisations, and the bravery of the project team.

"It is good to have an end to journey toward; but it is the journey that matters most in the end."

Ernest Hemingway

Afghan Rahimi Dinner.

Tamil Information Session.

APPENDIX A

Sustainability self-assessments

Appendix A: Sustainability self-assessments

Friday 21 April, 2017 • Tamil Community Strengthening Project sustainability self-assessment

Sustainability scores				Total
Systemic ownership	1	Professional development	9	27/80
Health literacy and health service access	5	Community engagement	12	

APPENDIX A	**Excellent** (each tick = 5)	**Good** (each tick = 4)	**Average** (each tick = 3)	**Poor** (each tick = 2)	**Very poor**(each tick = 1)
Systemic ownership (maximum score = 20)	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation ☐ Volunteers feel a sense of belonging and connection to their host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **bi-monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver **occasional** information sessions	☐ Between 50% and 80% of volunteers placed in local community organisations ☐ Volunteers required to independently plan and deliver information sessions	☑ Below 50% of volunteers placed in local community organisations ☐ Volunteers experience barriers or objection to the delivery of information sessions
Professional development (maximum score = 20)	☐ All volunteers have an Individual Learning and Development Plan and are implementing them according to proposed timelines ☐ All volunteers have completed all professional development opportunities arranged by **enliven** ☐ Volunteers have actively contributed to the professional development calendar by suggesting appropriate group and/or individual training opportunities ☐ Volunteers are **extremely** satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan and are implementing them **almost** according to proposed timeline ☐ Over 80% of volunteers have completed the professional development opportunities arranged by **enliven** ☑ Volunteers are mostly satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan but they **are not** being implementing according to proposed timeline ☑ Over 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☑ Between 50% and 80% of volunteers have an Individual Learning and Development Plan ☐ Less than 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☐ Below 50% of volunteers have an Individual Learning and Development Plan ☐ Volunteers have completed less than 50% professional development opportunities offered by **enliven**
Health literacy and health service access (maximum score = 15)	☐ Community understands and shares key health messages within their communities ☐ Community members access available health care services appropriately ☐ Opportunities for volunteers to continue delivering key health messages are scheduled for dates beyond project completion	☐ Community understands key health messages and how to use these to improve their/their family's health ☐ Community members access available health care services appropriately	☑ Community understands key health messages but does not always use these to improve their/their family's health ☐ Community does not always access health care services, and at times accesses them inappropriately	☐ Community understanding of health is poor ☑ Community access some but not all health care services, and at times access them inappropriately	☐ Community understanding of health is poor ☐ Community do not access health care services or access them inappropriately
Community engagement (maximum score = 25)	☐ Community advisory groups, volunteers and other community leaders and networks take ownership over the projects ☑ Community advisory groups and other community leaders and networks are willing to provide support and advocacy for project continuity ☐ Community members and host organisations share additional resources and ideas for further relevant key messages via the volunteers to ensure continuous quality improvement ☑ Community Strengthening Taskgroup continue to meet **monthly** and collaborate on locally relevant issues ☐ Community Strengthening Taskgroup is integrated with other community advisory groups, community leaders and networks	☐ Community advisory groups, volunteers and other community leaders and networks are engaged and feel that project ownership is shared between organisations and the community ☐ Community Strengthening Taskgroup continue to meet and collaborate on locally relevant issues ☐ Some collaboration between Community Strengthening Taskgroup and other community advisory groups, community leaders and networks	☐ Community advisory groups, volunteers and other community leaders and networks are engaged but feel that project ownership sits with organisations ☐ Community Strengthening Taskgroup continue to meet but ownership is not shared, and collaboration is minimal	☑ Community advisory groups, volunteers and other community leaders and networks attend meetings and events but do not wish to take ownership over the projects ☐ Community Strengthening Taskgroup meets infrequently and membership fluctuates	☐ Community advisory groups, volunteers and other community leadersandnetworksare not engaged ☐ Community Strengthening Taskgroup ceases to meet

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FINAL REPORT

Appendix A: Sustainability self-assessments

Monday 26 June, 2017 • Tamil Community Strengthening Project sustainability self-assessment

Sustainability scores				Total
Systemic ownership	2	Professional development	13	40/80
Health literacy and health service access	12	Community engagement	13	

APPENDIX A	**Excellent** (each tick = 5)	**Good** (each tick = 4)	**Average** (each tick = 3)	**Poor** (each tick = 2)	**Very poor**(each tick = 1)
Systemic ownership (maximum score = 20)	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation ☐ Volunteers feel a sense of belonging and connection to their host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **bi-monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver **occasional** information sessions	☑ Between 50% and 80% of volunteers placed in local community organisations ☐ Volunteers required to independently plan and deliver information sessions	☐ Below 50% of volunteers placed in local community organisations ☐ Volunteers experience barriers or objection to the delivery of information sessions
Professional development (maximum score = 20)	☐ All volunteers have an Individual Learning and Development Plan and are implementing them according to proposed timelines ☐ All volunteers have completed all professional development opportunities arranged by **enliven** ☐ Volunteers have actively contributed to the professional development calendar by suggesting appropriate group and/ or individual training opportunities ☑ Volunteers are **extremely** satisfied with professional development calendar and session content	☑ All volunteers have an Individual Learning and Development Plan and are implementing them **almost** according to proposed timeline ☑ Over 80% of volunteers have completed the professional development opportunities arranged by **enliven** ☐ Volunteers are mostly satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan but they **are not** being implementing according to proposed timeline ☐ Over 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☐ Between 50% and 80% of volunteers have an Individual Learning and Development Plan ☐ Less than 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☐ Below 50% of volunteers have an Individual Learning and Development Plan ☐ Volunteers have completed less than 50% professional development opportunities offered by **enliven**
Health literacy and health service access (maximum score = 15)	☐ Community understands and shares key health messages within their communities ☐ Community members access available health care services appropriately ☑ Opportunities for volunteers to continue delivering key health messages are scheduled for dates beyond project completion	☑ Community understands key health messages and how to use these to improve their/their family's health ☐ Community members access available health care services appropriately	☐ Community understands key health messages but does not always use these to improve their/their family's health ☑ Community does not always access health care services, and at times accesses them inappropriately	☐ Community understanding of health is poor ☐ Community access some but not all health care services, and at times access them inappropriately	☐ Community understanding of health is poor ☐ Community do not access health care services or access them inappropriately
Community engagement (maximum score = 25)	☐ Community advisory groups, volunteers and other community leaders and networks take ownership over the projects ☑ Community advisory groups and other community leaders and networks are willing to provide support and advocacy for project continuity ☐ Community members and host organisations share additional resources and ideas for further relevant key messages via the volunteers to ensure continuous quality improvement ☑ Community Strengthening Taskgroup continue to meet **monthly** and collaborate on locally relevant issues ☐ Community Strengthening Taskgroup is integrated with other community advisory groups, community leaders and networks	☐ Community advisory groups, volunteers and other community leaders and networks are engaged and feel that project ownership is shared between organisations and the community ☐ Community Strengthening Taskgroup continue to meet and collaborate on locally relevant issues ☐ Some collaboration between Community Strengthening Taskgroup and other community advisory groups, community leaders and networks	☑ Community advisory groups, volunteers and other community leaders and networks are engaged but feel that project ownership sits with organisations ☐ Community Strengthening Taskgroup continue to meet but ownership is not shared, and collaboration is minimal	☐ Community advisory groups, volunteers and other community leaders and networks attend meetings and events but do not wish to take ownership over the projects ☐ Community Strengthening Taskgroup meets infrequently and membership fluctuates	☐ Community advisory groups, volunteers and other community leaders and networks are not engaged ☐ Community Strengthening Taskgroup ceases to meet

Appendix A: Sustainability self-assessments

Monday 24 April, 2017 • Afghan Community Strengthening Project sustainability self-assessment

Sustainability scores				Total
Systemic ownership	1	Professional development	14	35/80
Health literacy and health service access	4	Community engagement	16	

APPENDIX A	Excellent (each tick = 5)	Good (each tick = 4)	Average (each tick = 3)	Poor (each tick = 2)	Very poor(each tick = 1)
Systemic ownership (maximum score = 20)	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation ☐ Volunteers feel a sense of belonging and connection to their host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **bi-monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver **occasional** information sessions	☐ Between 50% and 80% of volunteers placed in local community organisations ☐ Volunteers required to independently plan and deliver information sessions	☑ Below 50% of volunteers placed in local community organisations ☐ Volunteers experience barriers or objection to the delivery of information sessions
Professional development (maximum score = 20)	☐ All volunteers have an Individual Learning and Development Plan and are implementing them according to proposed timelines ☐ All volunteers have completed all professional development opportunities arranged by **enliven** ☑ Volunteers have actively contributed to the professional development calendar by suggesting appropriate group and/or individual training opportunities ☐ Volunteers are **extremely** satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan and are implementing them **almost** according to proposed timeline ☑ Over 80% of volunteers have completed the professional development opportunities arranged by **enliven** ☑ Volunteers are mostly satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan but they **are not** being implementing according to proposed timeline ☐ Over 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☐ Between 50% and 80% of volunteers have an Individual Learning and Development Plan ☐ Less than 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☑ Below 50% of volunteers have an Individual Learning and Development Plan ☐ Volunteers have completed less than 50% professional development opportunities offered by **enliven**
Health literacy and health service access (maximum score = 15)	☐ Community understands and shares key health messages within their communities ☐ Community members access available health care services appropriately ☐ Opportunities for volunteers to continue delivering key health messages are scheduled for dates beyond project completion	☐ Community understands key health messages and how to use these to improve their/their family's health ☐ Community members access available health care services appropriately	☐ Community understands key health messages but does not always use these to improve their/their family's health ☐ Community does not always access health care services, and at times accesses them inappropriately	☑ Community understanding of health is poor ☑ Community access some but not all health care services, and at times access them inappropriately	☐ Community understanding of health is poor ☐ Community do not access health care services or access them inappropriately
Community engagement (maximum score = 25)	☐ Community advisory groups, volunteers and other community leaders and networks take ownership over the projects ☑ Community advisory groups and other community leaders and networks are willing to provide support and advocacy for project continuity ☐ Community members and host organisations share additional resources and ideas for further relevant key messages via the volunteers to ensure continuous quality improvement ☑ Community Strengthening Taskgroup continue to meet **monthly** and collaborate on locally relevant issues ☐ Community Strengthening Taskgroup is integrated with other community advisory groups, community leaders and networks	☐ Community advisory groups, volunteers and other community leaders and networks are engaged and feel that project ownership is shared between organisations and the community ☐ Community Strengthening Taskgroup continue to meet and collaborate on locally relevant issues ☐ Some collaboration between Community Strengthening Taskgroup and other community advisory groups, community leaders and networks	☑ Community advisory groups, volunteers and other community leaders and networks are engaged but feel that project ownership sits with organisations ☑ Community Strengthening Taskgroup continue to meet but ownership is not shared, and collaboration is minimal	☐ Community advisory groups, volunteers and other community leaders and networks attend meetings and events but do not wish to take ownership over the projects ☐ Community Strengthening Taskgroup meets infrequently and membership fluctuates	☐ Community advisory groups, volunteers and other community leaders and networks are not engaged ☐ Community Strengthening Taskgroup ceases to meet

Appendix A: Sustainability self-assessments

Tuesday 10 July, 2017 • Afghan Community Strengthening Project sustainability self-assessment

Sustainability scores				Total
Systemic ownership	3	Professional development	15	43/80
Health literacy and health service access	7	Community engagement	18	

APPENDIX A	Excellent (each tick = 5)	Good (each tick = 4)	Average (each tick = 3)	Poor (each tick = 2)	Very poor(each tick = 1)
Systemic ownership (maximum score = 20)	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation ☐ Volunteers feel a sense of belonging and connection to their host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver information sessions at least **bi-monthly** ☐ Volunteers provided opportunities for future learning and development by host organisation	☐ All volunteers placed in local community organisations ☐ Volunteers supported by host organisation to deliver **occasional** information sessions	☐ Between 50% and 80% of volunteers placed in local community organisations ☑ Volunteers required to independently plan and deliver information sessions	☐ Below 50% of volunteers placed in local community organisations ☐ Volunteers experience barriers or objection to the delivery of information sessions
Professional development (maximum score = 20)	☐ All volunteers have an Individual Learning and Development Plan and are implementing them according to proposed timelines ☐ All volunteers have completed all professional development opportunities arranged by **enliven** ☑ Volunteers have actively contributed to the professional development calendar by suggesting appropriate group and/or individual training opportunities ☑ Volunteers are **extremely** satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan and are implementing them **almost** according to proposed timeline ☐ Over 80% of volunteers have completed the professional development opportunities arranged by **enliven** ☐ Volunteers are mostly satisfied with professional development calendar and session content	☐ All volunteers have an Individual Learning and Development Plan but they **are not** being implementing according to proposed timeline ☑ Over 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☑ Between 50% and 80% of volunteers have an Individual Learning and Development Plan ☐ Less than 50% of volunteers have completed the professional development opportunities arranged by **enliven**	☐ Below 50% of volunteers have an Individual Learning and Development Plan ☐ Volunteers have completed less than 50% professional development opportunities offered by **enliven**
Health literacy and health service access (maximum score = 15)	☐ Community understands and shares key health messages within their communities ☐ Community members access available health care services appropriately ☐ Opportunities for volunteers to continue delivering key health messages are scheduled for dates beyond project completion	☑ Community understands key health messages and how to use these to improve their/their family's health ☐ Community members access available health care services appropriately	☐ Community understands key health messages but does not always use these to improve their/their family's health ☑ Community does not always access health care services, and at times accesses them inappropriately	☐ Community understanding of health is poor ☐ Community access some but not all health care services, and at times access them inappropriately	☐ Community understanding of health is poor ☐ Community do not access health care services or access them inappropriately
Community engagement (maximum score = 25)	☐ Community advisory groups, volunteers and other community leaders and networks take ownership over the projects ☑ Community advisory groups and other community leaders and networks are willing to provide support and advocacy for project continuity ☐ Community members and host organisations share additional resources and ideas for further relevant key messages via the volunteers to ensure continuous quality improvement ☑ Community Strengthening Taskgroup continue to meet **monthly** and collaborate on locally relevant issues ☐ Community Strengthening Taskgroup is integrated with other community advisory groups, community leaders and networks	☑ Community advisory groups, volunteers and other community leaders and networks are engaged and feel that project ownership is shared between organisations and the community ☐ Community Strengthening Taskgroup continue to meet and collaborate on locally relevant issues ☑ Some collaboration between Community Strengthening Taskgroup and other community advisory groups, community leaders and networks	☐ Community advisory groups, volunteers and other community leaders and networks are engaged but feel that project ownership sits with organisations ☐ Community Strengthening Taskgroup continue to meet but ownership is not shared, and collaboration is minimal	☐ Community advisory groups, volunteers and other community leaders and networks attend meetings and events but do not wish to take ownership over the projects ☐ Community Strengthening Taskgroup meets infrequently and membership fluctuates	☐ Community advisory groups, volunteers and other community leaders and networks are not engaged ☐ Community Strengthening Taskgroup ceases to meet

APPENDIX B

Volunteer health literacy teaching resources

Appendix B: Volunteer health literacy teaching resources

Resources to support volunteers

A number of easy-English and translated resources were developed in partnership with Community Leaders Advisory Groups and volunteers. The purpose of these resources was to support the volunteers to communicate key messages as well as to provide take-home resources to community members for reinforcement and retention of information.

Afghan Community Engagement supporting materials

Storyboards

Postcards

DVD

Ghezal Adam delivering key messages to a group of women in Dandenong.

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