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COMMUNITY THEATRE:A TOOL FOR HEALTH PROMOTION

by

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Submitted as part of course requirement for

Master of Community Health (by Coursework)

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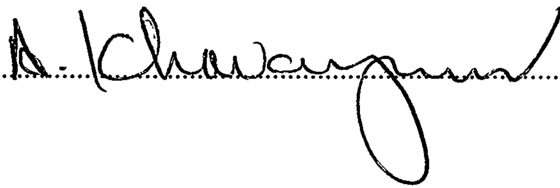
Adviser's Signature...



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Abstract

Community theatre is a means of voicing community concerns, and involves collective analysis of an issue, decision making and action to bring about change. Health promotion through community development involves the community in all facets of priority setting, decision making and implementing actions to alter factors that affect its health. The aim of this study was to match both processes and determine whether community theatre was an effective tool for health promotion, particularly for people of Non English Speaking Background. Four different theatre productions were accessed and the perspectives of the community participants, health educators and artistic directors obtained.

Community theatre was found to be a potentially effective method of health promotion, be it didactic, experiential or through community development. However, its effectiveness could be limited by many cultural, personal and logistical constraints. Therefore it should be applied appropriately. This required much prior planning, greater community participation, adequate resources and realistic expectations. It was thought to be most effective as part of a range of other health promotion programmes.

Greater evaluation and documentation of every such production was required as a guide for future use and support of community theatre for health promotion.

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COMMUNITY THEATRE: A TOOL FOR HEALTH PROMOTION.

Introduction.

Community theatre presents a community's reality as it is affected by social, political and economic influences (O'Neill, 1990). It is created from the community's own situations, language and symbols (Hicks, 1985). It is a means by which the disenfranchised can voice and act on their concerns (Hicks, 1985). A community's health is dependent on its social, economic, political and physical environment (Nutbeam, 1986). Effective health promotion occurs when the community itself is involved and can identify with what is being done and why (National Health Strategy, 1993). Health promotion via community development is a means of reaching the most disadvantaged, empowering them to take control over their own health (Egger, Spark & Lawson, 1990).

From these parallels it was thought community theatre would be a useful means of conducting health promotion. It would enable the community to participate in improving its own health by examining the way it was affected by a broad range of factors. Participation in community theatre would enable a collective raising and discussion of health issues, communal decision making, leading to action that would improve the health of the community.

There is evidence of this having already occurred. Mwansa (1991) describes popular theatre as a contemporary global movement, existing in both developed and developing countries. It is used to communicate, whether as an art form, an educational process or a means of political action. It became increasingly popular around the early 1970s as a result of the Laedza Batanani project. In this project, Byram and Kidd used popular theatre for community development based on the ideas

of Paolo Freire. Through their writings, the work was repeated in Africa, Asia, the Caribbean, and Latin America (Malamah-Thomas, 1987; Kerr, 1989). Although it was later critiqued (Kidd and Byram, 1982; Boeren, 1992), there had been several international workshops and seminars related to the use of popular theatre (Mwansa, 1991).

However, would community theatre work in Australia with people of Non English Speaking Background (NESB)? Is it an appropriate cultural form for the different communities? Is it an effective tool for health promotion? Are there advantages or limitations? The aim of this study is to investigate the use of community theatre as a method of health promotion for NESB people in Australia.

Literature Review.

Community Theatre.

Community theatre was once succinctly described in conversation as theatre for the community, about the community, by the community. More formally, community theatre is an art form used for cultural expression. It presents current and evolving images of an ordinary individual's reality as it is affected by social, political and economic influences (Burville, 1985; O'Neill, 1990).

Culture is the means by which images are made of reality; the way people make sense of themselves, other people and their world (Burville, 1985; Simpson, 1992). It ranges from `high art' in which the images are created through artistic and intellectual activity, to those presented via folk or popular means. Examples of the former include music, literature, painting and sculpture; and of the latter, traditional arts, popular music, film, television and radio. Communities of different cultures vary

in their customs, beliefs, socio-economic backgrounds, ages, gender and class.

Art is used to interpret, rather than reflect, reality (Burville, 1985). It is a selective reworking of information, meanings, ideas and experiences. There are many different art forms. The chosen mode is a stategic decision to ensure a relevant and powerful final product. It is based on what is to be said and the people being addressed. Theatre, as an art form, can affect different facets of consciousness including the rational and sensuous. It challenges the power of mass media on a direct, personal and experiential basis.

Theatre has the potential of bringing about social change (O'Neill, 1990). It can show the true social, political and economic reasons for a given situation, raise consciousness and depict images of future possibilities (Burville, 1985). To bring about change however, requires finding actions, images and words that engage the audience's attention, make it question its accepted image of reality and spur it into action.

Community theatre started in Australia around the 1970s as an artistic means of political activism (Watt, 1992). It was based on the radical left wing theatre practice of the UK and USA. It had a strong political base and was closely allied with the trade union movement and disadvantaged groups. Originally these theatres attempted to work within the forms and styles appropriate to the culture of a specific community. This was to avoid imposing dominant cultural forms on the groups.

Community arts activists advocate that everyone is capable of creativity (Grostal & Harrison, 1994). Participating in cultural activities is an important part of the quality of life of a community, whatever an individual's skill. Using principles of access and equity, the Community Arts Board of the Australia Council pursues

affirmative action in different priority areas such as `Youth and Women', `Art and Working Life', and `Arts for Multicultural Australia'. There is an assumption that community arts is synonymous with multicultural arts (Grostal et al., 1994). However the latter covers a broader range of art fields and expertise; it is more than cultural development for different community groups. This particular study focuses on community theatre within NESB groups rather than on multicultural theatre per se.

The role of the Community Cultural Development Board (CCDB) of the Australia Council is to initiate, fund and evaluate various community arts programmes (Grostal et al., 1994). It provides the resources that enable communities to actively participate in the development of their own culture. It also encourages and supports communities from different cultures to have input into Australia's cultural identity (Watt, 1992).

During the first National Community Theatre Conference, guidelines were set down for the role and assessment of community theatre in Australia (Hughes, 1991). The key elements of community theatre include reaching out to new, non theatre going audiences with suitable, identifiable material; addressing issues of access and participation; the inherent need for diverse methods and venue use; an emphasis on process; and the creation of original Australian theatre.

Health of People of Non-English Speaking Background.

In 1986 the Better Health Commission found NESB migrants had particular health needs (BHC, 1986). Apart from Australian Aborigines, these people are the most disadvantaged in terms of health status and health care (Manderson, 1990). On the one hand, migrants are less susceptible to fatal diseases and have a longer

lifespan. On the other, they have a high incidence of non-fatal illness and disability such as back and overuse injuries (Lin & Pearse, 1990).

Many factors affect people's health and access to adequate health care. In Australia, NESB migrants have the lowest income, the lowest labour force participation rate and the highest level of unemployment of non-indigenous Australians (Foster, Marshall & Williams, 1991). They tend to live in the poorer, less well-serviced areas of a city (Manderson, 1990). Recent migrants are often employed in areas involving few skills, manual labour or factory work (Foster et al., 1991). They are the most at risk of industrial accidents and chronic occupational health disorders (Lin et al., 1990).

Although these socioeconomic factors and gender play an important part in people's health, culture and country of origin can also be influential (Manderson, 1990). Culture infuses people's behaviour, their beliefs, way of thinking and mode of interaction. It forms the basis upon which people create a way of life. Culture can influence people's general health through their lifestyles and occupations, the way they perceive and treat ill health, the way they access health information and services, and their ability to communicate with health professionals.

According to the Better Health Commission (BHC, 1986), primary health care should embrace social, political and ethical considerations as well as clinical ones. However the definition of health is complicated by the different health priorities and perceptions of various cultural and ethnic community groups, and by their particular socioeconomic status in society. Health behaviour and status are the outcome of social and economic forces. Therefore changing the social environment and providing more knowledge, motivation, resources and opportunities enables individuals and

groups to improve their health (BHC, 1986).

Culturally sensitive and successful health promotion depends on the community itself being involved in determining policy and planning programmes (National Health Strategy, 1993). Without community involvement, formal health promotion strategies can lack relevance and be rejected (BHC, 1986). The community is able to address its health problems more effectively than an outside organisation imposing its own solutions.

Health Promotion: The Concept and Strategies.

Health promotion encompasses more than just health education. Health education is any combination of learning activities, either formal or informal, which facilitate voluntary adaptations of behaviour conducive to health in individuals, groups or communities (Fisher, Howat, Binns & Liveris, 1986). It involves communication which improves knowledge, understanding and skills that ensure health (Nutbeam, 1986). It raises awareness about the environmental, economic and social causes of (ill) health.

Health promotion consists of health education as well as related organisational, political and economic interventions designed to facilitate behavioural and environmental changes that improve and protect health (Fisher et al., 1986). It involves the whole population within a context of everyday life. It is most effective if there is community participation in the definition of problems, decision making and action taken to change and improve the determinants of health (Nutbeam, 1986; BHC, 1986).

The 1986 Ottawa Charter by the World Health Organisation (WHO) and the

Canadian Public Health Association set up five health promotion ideals in addressing public health. These were

* developing healthy public policy;
* developing personal skills;
* strengthening community action;
* creating supportive environments; and
* reorienting health services.

One means of conducting health promotion is by developing personal skills. Personal and social development occur through the provision of information, education and enhancing life skills. Hence, people have more options in controlling their own health and the environment, and make choices conducive to health (WHO, 1986). Another means of carrying out health promotion is through community action whereby the community sets health priorities, makes decisions, plans strategies and implements them. This process is based on community empowerment, ownership and control over its own efforts and destiny (WHO, 1986).

There are many different methods of health promotion which can be directed at individuals, groups or communities (Egger, Spark & Lawson, 1990). They all have their strengths and weaknesses. The most appropriate single or combination of methods depends on the particular circumstances ie.the nature and content of message and the target community.

Group Methods.

Health promotion methods for groups can be either didactic or experiential (Egger et al., 1990). Group methods can be used to empower individuals,

organisations and/or communities in a number of ways. These include helping individuals to modify or maintain specific health related behaviour, or to organise community members and enable them to identify and solve their own problems (Egger et al., 1990).

In the `Visual Communications Handbook' the relative merits of the spoken word, visuals and drama as means of effective education are discussed (Saunders, 1974). It is thought people remember 10% of what they hear, 50% of what they hear and see, and 90% of what they hear, see and do (Saunders, 1974, p.15). The author states that drama can be an educational, as well as entertaining, experience for both the audience and the participants. Whether viewing or acting, there is a high degree of involvement as people enter into the experience of the character. Through emotions, the message reaches a deeper part of a person than their intellect.

There are many traditional forms of theatre throughout the world such as mime, dance, tableau, play, pageant, shadowplay, roleplay and others (Saunders, 1974). When working cross-culturally with disadvantaged groups the author suggests looking at the traditional forms first before imposing one's own. The form chosen can be either formal drama with scripts and rehearsals, or impromptu dramatisations made up and performed by participants. These forms can be described as the product or process of theatre respectively.

Drama is versatile (Saunders, 1974). It can be used to tackle many different basic issues such as health, democracy, freedom, forgiveness and reconciliation. It can also be used with people of different ages, education and experience. The author suggests it is a suitable teaching method for people who do not read because he thinks they experience things dramatically.

Didactic.

These methods, such as lectures and seminars, focus on transmitting knowledge through the use of words and visual material (Egger et al., 1990). According to Saunders (1974), words are symbols for ideas or objects. They are understood if the people involved share a culture; if they speak the same language and come from similar backgrounds. The risk of misunderstanding is increased if people come from different cultures. Words for abstract ideas are less easily understood than those for tangible objects because they are difficult to relate to real experience.

Visuals can be structured so they are understood and remembered by people (Saunders, 1974). Memories are made up of mind pictures and people relate to their everyday life in a visual way. Abstract ideas are easier to understand if they are seen rather than described in words. The product of theatre, the performance, can be seen as a form of didactic health promotion. The audience obtains information by passively watching and listening to the performance, without actual physical interaction or participation.

A controlled study was done into the use of theatre (product) in AIDS (Acquired Immunodeficiency Syndrome) education by Elliott, Gruer, Farrow, Henderson and Cowan (1996). In the article they stated that theatre was often used in AIDS education for young people but with conflicting results. Controls, however, were rarely used and it was not possible to tell if any intervention was either more or less effective. They decided to compare the effect of a theatre production on HIV (Human Immunodeficiency Virus) knowledge, attitude and risk behaviour of young people with a standard health education seminar with some group work. They found

there was little difference between the two methods and essentially, theatre made no significant impact in AIDS education. The biggest drawback against theatre was its expense. It was far more economical to run a health education seminar to achieve the same lack of effect.

In the same study (Elliott et al., 1996), focus groups were also held to generate more in depth responses to the use of theatre. Generally, young people found the theatre piece more interesting than the health education seminar. The former was fun and entertaining while the latter was boring and overlong. The language used was more relevant and identifiable than that of the seminar. The views of the young people were echoed by the youth workers. This meant that although theatre was found to be no more effective than a health education seminar, it was better received by its targeted audience.

Another HIV education programme using puppetry and street theatre in South Africa was evaluated (Skinner, Metcalf, Seager, deSwardt & Laubscher, 1991). Part of the evaluation involved a before and after study on audience impact of a series of live shows. The show was found not to be morally or culturally offensive. This meant controversial issues could be handled in a culturally sensitive way using theatre. The authors thought the show made a significant contribution to knowledge and intended behaviour in the short-term. However, they felt it could be made more effective if it was incorporated into existing community based education programmes on HIV infection.

Experiential.

These methods emphasise skills training. They aim at enabling people to modify their behaviour and include role play, improvisation, peer group discussions and others (Egger et al., 1990). Saunders (1974) states that people learn mainly through doing. By being involved, they develop an understanding of the subject and related issues. Drama is thus a creative means of active learning because it requires deeper involvement. Hodgson and Richards (1972) describe improvisation as a spontaneous means of exploring ideas or conditions, both as an individual and as a group. In a group situation, the final understanding reached is the result of communal exploration rather than one person's imagination.

In the study by Elliott and others (1996), both the theatre piece and the health seminar had interactive elements that were well received by the young people. These were in the form of small group workshops and discussions. Although the interactive parts were promising, they were less effective than expected. The authors suggested a number of reasons. These included both methods being too short (1.5 hours) to bring about permanent changes in attitude and behaviour, and each being a one-off event. The authors suggested that more consistent work needed to be done over a longer period of time to bring about a permanent effect.

The youth workers in the above study felt the theatre piece was a good basis for developing further programmes, leading to greater in depth analysis of other issues (Elliott et al., 1996). After both events, more young people requested further information and discussion which was an unusual occurrence. It meant that both methods of health education had been effective in raising sufficient interest in the young people for them to actively request additional information.

Community Approach.

There are also health promotion methods directed at a community or population level such as mass media, community organisation and community development (Egger et al., 1990). Community development comes from within the community while community organisation is the mobilisation of the community as dictated by health authorities. These two methods differ in the level of decision making and control available to the general community. Methods of community organisation include determining the health needs of the community, involving the community in planning, and facilitating action that change health outcomes. Community development is based on the participation of the community itself in all facets of priority setting, decision making and implementation of elected strategies. Empowerment is one of the main principles of the community development process. It involves access to and control over resources, particularly for those currently economically and socially disadvantaged (Egger et al., 1990).

Mass Media.

The media include visual, auditory, print or broadcast components. Successful use of the media depends on selecting the right medium and message, and being aware of individual abilities and limitations (Egger et al., 1990). There is still some controversy over the true effectiveness of the media. Some feel the media are untapped resources, others feel they are ineffective, while a third group feels the media are effective under certain circumstances. Although there have been successful uses of the media for health promotion in the past (BHC, 1986), they have not been supported by ongoing programmes on related subjects using other sources of

information.

Improved media coverage of health promotion depends on the delivery of useful health information. To be accessible to everyone in a target population, this material should be simple in concept and language (BHC, 1986). Communication also depends on specifically identifying the message and the target population. Unsuccessful identification of the target group results in two errors that may alienate an audience. The first is lecturing while the second is saturating people with meaningless information that is soon ignored. The distribution of information by any media outlet is most effective when it is neutral, or friendly and encouraging. Simplicity, encouragement and clarity are essential. These principles are just as applicable to a theatre production for ensuring its effectiveness for health promotion.

Community Development.

Rifkin (1985) describes community development as method, movement, programme and process. As a method, it is similar to the one applied by a social worker working with individuals, but on a community level. It focuses on gaining the community's confidence; determining its `felt' needs and the `real' causes of the problems; encourages it to find its own solution; provides support and resources. As a movement, community development is an ideology based on community members developing their own initiatives. Its ultimate aim is worldwide democracy through people's participation.

Community development programmes are a practical implementation of the ideology (Rifkin, 1985). The programmes vary in content and context but have basic features. These include integrated development of the whole community; planning on

the basis of community `felt' needs; emphasise self help; identify, encourage and train local leadership; and provide resources in the form of personnel, equipment, materials and funds. Programmes and changes are not preset but develop over time as different community members contribute to planning and implementation.

Community development process is an educational approach to development (Rifkin, 1985). The emphasis is not to produce actual community projects but to enable people to learn a way of living and working together that can be applied at any time to any problem which affects community life. It is the means by which people can change themselves, their behaviour and their life situation.

There are problems in applying a community development approach to health planning and community participation. These are mainly due to fallacies and assumptions held by the planners (Rifkin 1985, 1986). Firstly communities are not homogeneous. Socio-economically there are different factions within one community. Each has its own particular interests and differs in the level of power it wields in achieving its needs. The needs articulated and the actions taken to address them do not nescessarily benefit the poor and powerless. Total community involvement requires an overhaul of the current social, economic and political structures. This is difficult for anyone to impose on other people.

Another problem identified is a preference for finite, concrete results rather than an appreciation of the long-term importance of an educational process (Rifkin, 1985). As behavioural and psychological changes are more difficult to see and evaluate, they are often ignored. However without education, participants are left without any understanding or desire to continue or repeat the process.

There is a discrepancy between what health planners and community members

mean by community involvement. It ranges from contributing labour and money, to decision making and resource control (Rifkin, 1985, 1986). It is further complicated if the two groups do not discuss or share expectations of the programmes.

Lastly there are difficulties in actual community participation in health programmes (Rifkin, 1986). Participation is influenced by historical, cultural, social, political and economic factors (Rifkin, 1985, 1986). Communities are made up of people who individually participate in their own way and for their own reasons. Individual motivation is context specific and cannot be universally defined (Rifkin, 1986).

Participation: a Tool for Empowerment.

Community participation in health planning is nescessary to overhaul the social, economic and political structures incompatible with development (Rifkin, 1985). It is a dynamic process reflecting changes in decision making, resource control, and the attitudes of those involved. Participation is a process rather than an end product (Rifkin, 1986).

There are different levels of community participation (Rifkin, 1986). These range from benefiting from the end product of a programme (passive participation) to key members actually planning the programme with the broadest range and depth of involvement (active participation). In between these two extremes, community members participate in activities, implement some of the activities or evaluate the programme. However these intermediate levels of participation fall short of actually developing the programme which remains under the control of others. Often health planners pre-empt full participation because they already have a solution they want

to implement (Rifkin, 1986).

Empowerment is the ability of people to understand and control personal, social, economic and political factors; enabling them to improve their life situation (Israel, Checkoway, Schulz & Zimmerman, 1994). The authors describe three levels of empowerment including individual, organisational and community. The first is an individual's ability to make decisions and have control over her or his personal life. It combines self-esteem, confidence, a sense of control, and being able to influence decisions and institutions.

At an organisational level, empowerment occurs through democratic management with shared information and power; cooperative decision making processes; and the design, implementation and control of efforts toward mutually defined goals (Israel et al., 1994). It empowers the individuals within its system and at the same time influences policies and decisions of the larger system of which it is part.

Community empowerment is when individuals and organisations utilise their skills and resources collectively to meet their respective needs (Israel et al., 1994). Participation at this level leads to enhanced support between individuals; conflicts are addressed; and there are increased influence and control over the quality of life within the community. Such a community also influences decisions and changes in a larger social system. Community empowerment relies on collective analysis, action and control. Therefore an important factor is a sense of community within the targeted context which the authors define as an area characterised by membership, mutual influence, common symbols (eg.language), emotional connection, shared values and needs, and a commitment to meeting those needs.

The degree of empowerment achievable varies for different people at different times in different areas (Israel et al., 1994). Meaningful empowerment depends on the social, cultural, historical, political and economic context within which a person lives. Individual empowerment means little if the environment in which a person lives does not allow influence, control and hence improvement in health and quality of life to occur. Therefore, the three levels of empowerment are related through social and political skills, and social support. Also empowerment is not achievable in the short term. It requires commitment to a long-term process (Israel et al., 1994).

Although community empowerment seems to be a worthwhile objective, there are limitations to achieving it. These are related to the community, the health educators, their organisations and external factors (Israel et al., 1994). They include past unsuccessful experiences of trying to influence outside systems; sociocultural differences that inhibit trust and communication; role-related tensions; problem in proving results; difficulty in altering the status quo; a lack of understanding of the process; short time frame expectations; and complex evaluation requirements.

Empowerment education, based on the ideas of Paolo Freire, has been modified and used for health promotion and education (Miner & Ward, 1992; Wallerstein & Bernstein, 1988). It is thought that by developing problem solving programmes based on community empowerment, there will be greater social support and community participation. This increased control in community life will lead to better health, particularly for disadvantaged communities who generally lack control over many areas of their existence (Wallerstein et al., 1988).

Paolo Freire and Augusto Boal are Latin Americans who share similar theoretical and political ideas regarding culture and education (Mwansa, 1991). Their

writings include Freire's `Pedagogy of the Oppressed' (1970) and `Education for Critical Consciousness' (1973), and Boal's `Theatre for the Oppressed' (1979). They provide the theoretical bases, language, modes of analysis and experiential drama methods for exploring local issues within many community based education programmes (Moon).

Freire's theory is based on `conscientisation' which is people learning through dialogue with others to perceive the overall social, historical, political and economic reasons for their current reality. After communal reflection, the people then decide on the best way of changing their particular situation, and take the required action (Freire, 1972, 1973). This concept of conscientisation is used to link the three levels of empowerment previously described (Israel et al., 1994). Through dialogue there can be collective reflection and action as individuals, organisations and the whole community act to effectively bring about social change. Freire (1973) criticises `assistencialism' which is the Latin American term for policies of financial and social assistance. He feels these are paternalistic and attack the symptoms rather than the root causes of social problems. These policies make people dependent on others rather than capable of tackling their own problems.

Boal analyses people's postures in terms of their social or professional roles. Using improvisation, people explore roles outside their own and are empowered. Through this experience they increase their options for taking action to change a particular situation (Moon, 1991).

Theatre: A Tool for Community Development.

In community cultural development, common interests and a shared outlook enable people to work together to influence decisions affecting their lives (Simpson, 1992). Apart from being consulted, the people themselves bring about change through cultural action and art. The participants develop a sense of importance from contributing and hence, become involved in other areas of their lives. As more community development projects are created, more people become involved, leading to greater community control over various influences on community life.

Drama in the form of street theatre or workshops is used effectively to empower communities (Moon, 1992). Overseas organisations have used process oriented drama as a tool for problem solving, raising social awareness and literacy training within a community context. Educational drama methods enable marginalised groups to express themselves and obtain some control over their lives. These activities emphasise increased skills and creative, collaborative problem solving. There is critical analysis of existing events and hypothesizing on the outcomes of various actions on a range of issues (Moon, 1992). These methods help bring to life abstract concepts. Different techniques are used including devising and showcasing images, visualisations and roleplays. Such exercises are not done in isolation but are reinforced by extension activities. These enable the participants to fully reflect on the experience, analyse what happened, and what insights are gained.

In Australia there are numerous examples of the arts and particular disadvantaged groups (Grostal et al., 1994). Langford (1985) singles out youth theatre as an important means of empowering its participants. Based on participation and equity, every young person has an equal opportunity to contribute. The amount

contributed depends on individual factors such as commitment, ability, energy and intelligence. Young people are invested with real artistic decision making power and the contents of the productions are relevant to their lives.

Directors and facilitators have an important role in ensuring the overall philosophy is maintained and the processes are productive (Langford, 1985; Moon, 1992). They have to facilitate the process, provide a framework which enables the participants to turn their ideas into a dramatic form, and ensure that form is effective. A successful process and a high quality product helps educate everyone generally on the validity of both the work and the participants themselves.

Effective community development requires full and continuous access to information, health learning opportunities and funding support (WHO). The use of process oriented drama generally, and community theatre in particular, also requires ongoing support and resourcing (Moon, 1992). The strength of community theatre lies in long-term development work which is only possible through continuity (Hughes, 1990). However, insufficient and unreliable funding means much uncertainty. In some community theatres people are only involved for 6-8 months in a year. Therefore both the relationships amongst the theatre participants, and between the theatre and the community, have to be rebuilt regularly after being repeatedly severed. Issues such as the exact purpose of community theatre, what it entails and hence, appropriate methods of funding, evaluation and accountability need to be further investigated (Hughes, 1990). As theatre ticket sales are inherently limited at a community level, they cannot be used to measure the success or failure of a particular theatre production.

Utilisation of Theatre in Health Promotion for NESB Communities:The Notion of Relevance.

Culture is defined as the range of creative forms used to express the values, beliefs, and ways of life of a particular social group that reflects their distinctiveness (Department of Immigration and Ethnic Affairs [DIEA], 1986). The DIEA suggests public institutions need to support the opportunity for people to maintain, enjoy and develop their cultural heritage and identity. It also believes that cultural activities should be supported on the basis of their intrinsic worth rather than valued against a central standard.

Social, leisure and recreational activities are ways communities maintain their linguistic and cultural links (DIEA, 1986). They also provide an opportunity for the children of a particular community to mix and meet others within an acceptable and supervised environment. Adults are reluctant to participate in activities outside their communities for fear of cultural inappropriateness. They also fear loss of direct control if they allow their children to do so.

NESB people and theatre.

To study the relationship between NESB people and theatre, the audiences at two diffent productions were compared (Shevtsova, 1993). One production was mainstream and conservative while the other was bilingual and experimental. The majority of spectators at both productions were Anglo-Celtic, highly educated and professional people. Those of NESB who were present were of the next generation, born and educated in Australia and more advanced socio-economically than their parents. They formed a slightly larger proportion of the audience at the latter

production. Thus the NESB people who come through choice and accessibility are predominantly from the middle classes. However they still prefer bilingual and relevant productions. This suggests that cultural elements within a production might persuade people to overcome perceived barriers and enter theatres.

Shevtsova (1993) suggests the older generation of NESB people do not attend for a variety of reasons. These include theatre houses being alien to their culture, longstanding class and linguistic barriers, and the location of theatres in supposedly sophisticated inner city business areas which create socio-cultural distance. There are few theatres or performance spaces in areas with high proportions of people of NESB. However, community theatre and bilingual performances are breaking up the isolation of these groups (Shevtsova, 1993). Older NESB people can attend performances depicting immigrant life in spaces within their own communities. They do not have to cross class and cultural barriers that separate them from more mainstream theatre.

The cultural values and purposes of theatre vary depending on the time, place and social stratum of the participants. During a second research study, Shevtsova (1993) found that people at a mainstream production felt the purpose of theatre was mainly for entertainment, and perhaps education. Meanwhile the audience at an experimental, bilingual performance felt the purposes of theatre included cultural development, the presentation of different viewpoints, the communication of ideas as well as entertainment. Many spectators at the theatre productions said they actually preferred the cinema to the theatre (Shevtsova, 1993). The reasons given were cost, convenience of times and locations, and a lack of need for reservations. This means that theatre is not generally the first choice in cultural activity. In spite of this,

audiences feel theatre is more spontaneous and immediate than film. It is possible to discuss and reflect on social issues in a personal and direct way.

As previously defined in community theatre, there is a relationship between the artistic aims of the company, the culture that generates the work and the culture addressed by the work (Shevtsova, 1993). Groups identify their cultures through the activities, attitudes and values important to them. The cultures of different groups contribute to the overall community culture which go into making up the national culture. The culture of a specific class or group does not subsume all others. This means certain art forms have greater relevance to particular individuals, groups or communities than others (DIEA, 1986). Often the artistic work of individuals or groups are misconceived as representing the experiences and concerns of whole cultural or social groups (Grostal et al, 1994). Problems occur when, without community consultation, programmes are set up using artists socially or politically inappropriate for a particular community group. Changes in the funding criteria and focus of the CCDB also occasionally force companies to work with communities that have no inherent interest in theatrical forms at all (Watt, 1992).

The issue of whether universal culture and theatre exist is addressed by Shevtsova (1993). One theory is that as members of the same species, all human beings share a fount of universal meaning. This suggests theatre can be understood and shared by everyone. However words, tones, postures and gestures are all social signs - made and used by individuals in ways related to their gender, family, and profession. They are culturally specific and reflect the different behaviour, attitudes and customs of specific groups of people.

Different sectors of a society vary in their degree of appreciation of the socio-

cultural meanings of a performance (Shevtsova, 1993). This is even more so if the production is performed and viewed by different cultures. Cross-cultural interactions have to be assessed from the point of view of the audience and not of the performers. Performances have to be in a context accessible to the audience. Without relevant reference points the audience can be unmoved or totally confused. Shevtsova (1993) questions whether culture in a theatre production should be affirmed and presented socio-historically, or taken out of context altogether in pursuit of universalism. She suggests cultural markers are nescessary to both base a production as a piece of art, and to communicate emotion and meaning through a social and cultural framework.

The capacity of theatre to communicate universally also depends on whether a theatre culture has been acquired or is accessible by the audience. Referring to art and theatre culture respectively, Vaughan (1986) and Shevtsova (1993) both say some education is nescessary. People require knowledge and exposure so they understand the different forms used, the ideas and values behind the execution and therefore be able to critically appraise the final product. Vaughan (1986) feels involvement in community arts enables the artistic and cultural development of the broader community.

Evaluation.

Evaluation is a process of systematically determining the efficiency, effectiveness and appropriateness of a programme against some predetermined yardstick (BHC, 1986). It is important to evaluate health programmes, the processes used and the infrastructures that delivered them so as to guide the allocation of resources in current and future programmes.

Evaluation in any field is difficult (BHC, 1986). It is particularly so for health work as it is not easy to measure the activities carried out. Qualitative judgement is nescessary, supported wherever possible by quantitative data. It is important to avoid unrealistic expectations in health promotion initiatives (BHC, 1986). There are long lead times before the outcome objectives of certain programmes are realised, and often it is difficult to separate the effect of a particular programme from other concurrent and influential environmental factors.

This point about further evaluation was brought up in the study by Skinner and his co-authors (1991). They felt their show needed to be compared with other health education strategies to assess whether it was the most efficient way to allocate resources. A follow-up of the programme needed to be done to determine long-term effects of the show especially in combination with other educational programmes.

It is also important to determine and measure outcomes of community cultural development (Simpson, 1992). Community access and diversity are addressed through participation, which have economic and cultural industry outcomes. More research data on the economic benefits and influences of market forces on community cultural development are important as they provide a greater basis for funding on economic outcomes.

Several issues regarding community empowerment evaluation are raised by Israel and her co-authors (1994). Although the process of empowerment is important, do people actually acquire skills that can be used in future situations? The authors feel both process and outcome are important. This means different data collection methods are required to assess both the process of collective action, and the resulting empowerment of the people involved. Related to this issue is whether empowerment

is perceived or actual. The former is important but less useful if the latter is not also true. This means self-reported measures of empowerment may be insufficient if trying to determine objective reality. To overcome these problems, the authors suggest a participatory action research approach to designing, implementing and evaluating an empowerment intervention (Israel et al., 1994). This involves practitioners, researchers and community members in a joint problem solving process, based on a cycle of diagnosis, action planning, action taking, evaluation, and redirected learning. Hence a health educator can identify appropriate process and outcome objectives for achieving community empowerment.

A review of the literature reveals many issues related to the use of community theatre as a tool for health promotion amongst people of NESB. These issues cover the theoretical bases of both community theatre and health promotion, particularly from the point of view of community development, participation and empowerment. Possible advantages and limitations are identified. However, the effectiveness of any method of health promotion can only be assessed through formal evaluation. This in turn has its inherent difficulties.

Methodology.

This study involved a review of relevant literature for theory and experiences related to the use of theatre as a tool for health promotion. Four local community theatre groups that had created productions based on health issues and Non English Speaking Background (NESB) communities were visited and representatives interviewed. This was to determine the effectiveness of the productions in terms of health promotion. The four theatre groups were Death Defying Theatre, People in Theatre, Unus Terra and Shopfront Theatre for Young People.

Literature Search.

An initial search of the literature was made for any examples of community theatre used for health promotion. Further searches were done to obtain specific Australian examples but there were few. There was a lack of formal documentation that could be accessed generally for public study. The NSW Community Arts Association's Resource Library was one of the centralised sources perceived to have ample information. Several projects were sourced but few were formally documented. Of the four projects looked at, there was an artistic report for Za Dusa and an evaluation report of Blood Orange.

Accessing the theatre productions.

Telephone calls were made to representatives from different types of organisations to obtain names of theatrical productions that had addressed health issues and involved people of NESB as their target group. The types of organisations contacted ranged from theatrical, arts, ethnic/multicultural to health promotion. Four

productions that differed in their structure, method of working and approach to community participation were eventually found. They were accessed through word of mouth and included

* Blood Orange - Death Defying Theatre.
* Circus of Life (Sida Noda) - People in Theatre.
* Yann Zone - Unus Terra.
* ZaDusa - Shopfront Theatre for Young People.

There may have been many other projects occurring at a community level but they were not widely known or accessible in time available. The word `health' was quite restrictive. Although this study was based on the wider definition of health, most people thought of disease.

Data Collection.

Sampling.

The people interviewed were chosen for their perspectives and experiences on the use of community theatre as a tool for health promotion. They included artistic directors, health educators and community participants. There were eleven interviewees altogether.

For three productions (Sida Noda, Yann Zone and Za Dusa) both the artistic directors and health educators were interviewed. In Sida Noda the director and educator also performed in the production. Hence they doubled as participants. For the other two productions (Yann Zone and Za Dusa) two participants each were interviewed. In Yann Zone they were both Indochinese while in Za Dusa one was Macedonian and the other Anglo-Celtic. Interviews with people involved in Yann

Zone suggested the use of community theatre, in this instance, had been markedly affected by the role of the main sponsor regarding funding and content. A representative of the funding organisation was also interviewed. It was thought an additional perspective might clarify what had occurred.

Most people approached directly were willing to be interviewed. A few had to be approached via a third party. One such person contacted the researcher but the others did not. The ones who did not were all community members who had participated in the productions. Amongst the non-responders was a male participant who was specifically approached for his perspective. Possible reasons for people not responding might have included being uninterested in the study, being too busy or perhaps being unable to contact the researcher. One participant initially agreed but did not turn up at the appointed time. She was uninterested in making alternative arrangements.

With Blood Orange no one directly involved in the production was available to be interviewed. Most had dispersed within the last three to four years, in particular the young participants. It was suggested the evaluation report and a video recording of the performance might be adequate data sources for this show. The evaluation report was comprehensive and contained comments made by the participants and others at the time.

Interviews and Other Data Sources.

The interviews were all semi-structured and took place at a time and place that was mutually agreed upon. Some took place in people's homes, others in workplaces or cafes. The interviews took around one to two hours and were not

always continuous. Occasionally they were postponed to another time, or interrupted and continued at a later date. Most took place face to face, one was over the telephone and two were a mixture of both. The interviews were recorded using field notes and later transcribed and analysed.

Other resources included videotaped performances, interview segments made for community television and evaluation reports.

Issues.

The interviews revolved around people's experiences of the productions, their own backgrounds, how they became involved and in what capacity. They were asked what they felt they had gained from and contributed to the experience; if community theatre had been an effective and appropriate tool for health promotion, both generally and for the targeted community; if there had been any problems or if anything could be improved upon. An important area was the level of community participation possible within each production.

Due to time constraints, the literature review was incomplete when the interviews were conducted. This meant the interviews were not as focused as they should have been, even taking into consideration they were meant to be semi-structured.

Community theatre as a tool for health promotion could be studied from the point of view of either process or product. In this particular study the emphasis was more on process than product. It looked at what the people who had been directly involved had got out of the process.

Ethical Considerations and Bias.

It was not always possible to approach people as independent individuals. Often there was reliance on referrals from other people. This may have slightly biased some accounts if interviewees were conscious other people they knew had either spoken to the researcher or were likely to be interviewed later. Some people asked directly who had given out their names and who else had been approached.

Although confidentiality was mentioned in the information sheet this was not practical within the context of a particular production. The study involved interviewing people based on their particular roles. It was therefore obvious who some of the interviewees were. Under these circumstances it was not possible to maintain confidentiality amongst those involved.

Most interviewees were female. This reflected the fact few males were involved in these productions, particularly as participants. One potential male participant could not be contacted directly and never replied to the request for an interview.

Blood Orange by Death Defying Theatre (DDT) differed markedly from the other three productions in terms of subject matter and data sources. A decision had to be made about whether or not to retain it in the study. It was a name offered repeatedly by different people during enquiries about suitable productions. DDT was renowned for such types of productions. To have left it out would weakened the credibility of the study.

The validity and reliability of the results have to be assessed in the context of the resources available to the researcher. There was the researcher's own interpretation of written, verbal and visual information. There was also the interaction

between the interviewer and informant during the interview process. The possibility of bias in the information revealed was discussed previously.

Limitations.

There were some allusions to what an audience might have got out of the production as a product of health promotion. However many of the performances had taken place some time ago and any audience members would have been difficult to trace unless they knew people who had participated. And if so, their views might not have been impartial. A proper study of the `product' of community theatre as a tool for health promotion would have required interviewing people in the audience just before and after a performance. They would also have had to be reinterviewed at a specified time later to see if there had been any long term response or behavioural change as a result of the show. Even in this present study there was a time lag between people being involved in the show and being interviewed about their experience.

To more accurately assess the `process' of community theatre as a tool for health promotion, a future study could focus on the processes involved throughout a single production. People could be interviewed periodically throughout the process and observed to see whether what was revealed in an interview matched what actually took place. It would be a more appropriate way of determining the exact level and tone of community participation. This method was not possible for the current study as there were no such productions underway.

It would have been interesting to study the long term effect of a community theatre production for health promotion either as a process or as a product on all the

people involved. It would also have been interesting to study the eventual effectiveness of different types of productions eg.a short-term, one off project or a long-term one that built on preceeding work.

Results.

The Productions.

The following section will be a description of the different examples of community theatre productions done that addressed health issues and a section of the NESB community. In particular there will be reference to the role of community participation within the processes involved in putting together these productions eg.how and why the shows were initiated; by whom; who from the community was involved; how were they recruited; and the overall level of community participation in the process.

Blood Orange.

Blood Orange comprised the stories of young NESB women, in particular Arabic, Italian, Vietnamese and Cambodian. It depicted the split between their public and private identities within a very broad health and wellbeing context. There were two versions of the production. The first involved young women from the community and was performed for a short season of three, three-day weekends at the Fairfield School of Arts in 1992. The second show was modified to be performed by three professional actors and toured various communities in the Sydney metropolitan area. These included several inner Sydney high schools and community organisations over a period of about three months. There was also a performance at the Fringe Festival.

Video recordings were made of both productions and an evaluation report written.

The production was put together by Death Defying Theatre (DDT). Watt (1992) wrote that DDT had changed its work methods to those of community development. Facilitators had replaced actors. DDT's most important skills were now organising individual projects and making theatre with communities appropriate to their particular contexts. There was emphasis on inventiveness and adaptability.

Blood Orange was initiated by DDT as a follow on from a 1991 project called Cafe Hakawati. DDT decided to do another community participation project but focussing on young NESB women. It was an opportunity for the young women to learn theatre and design skills; express their stories and aspirations; challenge stereotypes; be validated to their peers, families, communities and the media; access those who did not use existing services; explore health issues and share information between themselves and audiences; and to form networks between various community development agencies. Funding and support came from the Community Cultural Development Unit (CCDU) of the Australia Council and several local organisations.

Initial talks to determine overall focus and content of the production involved community members and representatives of various relevant organisations. A steering committee to discuss, clarify and plan ways of achieving objectives was composed of women who had participated in the original project, who worked in a broad range of areas and members of the artistic team. There appeared to be few representatives of the actual targeted group ie.young NESB women. These women only really became involved at the research/interview phase. Some came from two different suburban high schools, others had been out of school for a year or were young mothers.

Recruitment was via multilingual leaflets, 2EA radio, local community language newspapers, and talking to local high schools and community organisations. There was a launch to raise publicity for the project and encourage participation.

Workshops were planned and facilitated by the artistic team. The participants contributed ideas, stories and experiences which formed the script and performance. They also helped with the design. They contributed time and energy, and performed in the local production. The final cast comprised of around 20 young women of a broad range of ages, cultural backgrounds and experiences.

Community members came to view the show. There was indirect community participation in relatives allowing the participants to be involved. Participants required transport to and from the workshops and rehearsals at night. Participants suggested women only performances.

Although there was much community input and involvement, the artistic team had overall control of the production.

Sida Noda.

Sida Noda was a street theatre production to provide basic information on HIV/AIDS discrimination, transmission, prevention and bisexuality without alienating the Spanish speaking community. Performances were followed by simple question and answer card games with the audience to gauge if the messages had been understood. There was opportunity for discussion and further dissemination of information if people were interested.

The project was initiated by the health educator who was a member of the community. She felt theatre would be a more effective, innovative and entertaining

way of reaching people with health information without being too moralistic or judgemental. The project was supported by the Liverpool HIV Area Health Service.

Two performances at the Fairfield Showground were planned for the Independence Days of Uruguay and Chile in 1995. The show was very popular and further performances were requested. After around eight months and many performances in various venues to different spectators, a final bilingual version was performed for a mainstream audience at the Kaleidoscope Festival held at the Australian Museum.

In Sida Noda, general community members were not involved in performance. The show's four participants were all members of the community but were also either skilled and/or experienced in theatre. They included the health educator, the artistic director, a drama teacher and a member of a community theatre group. Some community participation initially took place as consultation with respect to the level of knowledge of and attitude to the issues being addressed. The people consulted included community members, health educators, people with the virus or the disease, and theatre people. Once the show was put together there were further discussions and people were asked their opinion of the show in terms of content and delivery.

Much more community participation occured once the show had been created. This took the form of being an audience at the various performances and responding to the information being delivered. Occasionally suggestions were made by the audience which were incorporated into later performances.

Yann Zone.

Some prior community development work had been done on a community art

project called `In the Closet' involving HIV/AIDS issues and Indochinese youth. Yann Zone, a theatrical production, was initiated by the health educator to expand on the issues covered and build on the rapport established with Indochinese youth. Both projects were a response to research done showing there were significant cultural barriers to HIV/AIDS information and education in Chinese and Vietnamese communities. Yann Zone was a means of using visual fantasy to pass on a range of information related to HIV and AIDS. An artistic director was hired to create the show. Initial funding was provided by the Multicultural HIV/AIDS Education and Support Service and the Drug and Alcohol Unit of the South Western Sydney Area Health Service. The latter withdrew during the production of Yann Zone.

Over 20 people were involved in Yann Zone. They came from south western Sydney but ranged broadly in age, socio-economic and cultural background. Recruitment was via prior involvement in `In the Closet', advertisements placed in schools and word of mouth. The last method was said to be the most effective.

Community participation involved the participants contributing their ideas on how the information given them should be passed on in a non-threatening way and used to create a theatrical production. They devised and wrote the piece based on their cultural experiences and backgrounds. They contributed commitment, time and energy. Some performed while others preferred to help out behind the scenes. There was some peer education. The artistic director worked with the participants to mould their ideas into a performable piece.

There was indirect community participation in parents allowing their children to be involved in such a sensitive project. Much commitment was required from everyone because the project took almost a year. Participants had to turn up regularly

to take part in various workshops, make their masks, and rehearse. Some relied on others to transport them. There was support from schools as well. Towards the end some participants had to take time off from study so they could rehearse. Some members of the community came to watch the single performance held at the Fairfield School of Arts on 11th December, 1995.

Za Dusa.

Shopfront Theatre for Young People was a community youth theatre company. Young people owned shares in the company and had a voice in decision making and the running of the theatre. There was a director, an administrator and some support staff.

Za Dusa was initiated by the health educator as a result of a needs assessment done of all youth in the St.George area. One finding was young Macedonians lacked HIV/AIDS knowledge and a perception of risk. The community suggested a creative method would be an appropriate way to address the problem. The theatre was approached by the South Eastern Sydney Area Health Service (later the HIV/AIDS Education Unit) on the basis of its reputation. Funding was provided by the CCDU of the Australia Council.

Apart from dealing with issues surrounding HIV/AIDS, the show was an opportunity for the theatre to further open up and maintain access to the community. It was also a means of getting across the participants' own views and stories.

The participants were upper youth, aged in their early 20s and educated. Their backgrounds included Greek, Anglo-Celtic, Spanish as well as Macedonian. They were recruited via various community organisations, school adverts or were

already involved with the theatre.

In Za Dusa community participation was on a number of levels. The community was consulted during the needs assessment phase and as to the best means of tackling the problem. Some members participated as actors while others were part of the artistic team. All participants contributed and helped put together their ideas and experiences. They also helped design and perform the piece but under the guidance of the artistic director and health educator. Macedonian participants were specifically asked for cultural background material to be incorporated into the content and design of the production. A variety of activities and processes were used by the artistic director and the health educator to generate ideas and increase the knowledge of the participants. For a return season a Macedonian participant was asked to generate publicity and specifically access the target community. Members of the community watched the performance either directly at the theatre or via segments made for community television.

Next the views of artistic directors, health educators and participants will be given on issues related to their experiences in the use of community theatre as a health promotion tool for people of non English speaking background.

Why Theatre?

Creative versus Didactic.

Apart from Blood Orange, all the productions were initiated by the health educators. Their reasons for using theatre revolved around using a creative rather than didactic approach to educating people. Their views were supported by the artistic directors. In one case a creative method was the community's suggestion.

Traditional methods such as seminars and reading material were felt to be less than effective. Many people were thought not to be very receptive to either the spoken or written word. People switched off because they found the usual health promotion methods boring, negative and irrelevant. One health educator said a successful educational method should encourage people to want to know more, not turn them away. One director described traditional health promotion as being two dimensional.

Increasing Audience Receptivity.

It was generally thought by most interviewees that people would be more receptive to information from a medium that was visual, entertaining, positive and culturally appropriate. One participant mentioned the possibility of artistic licence in handling certain issues while another commented it helped the community see itself in relation to the broader population. The participants also felt people would not be alienated if the show included humour and was non-confrontational. This was supported by one director who felt health promotional messages were better received and more effective if humour rather than drama was used. This was particularly important if the topic was threatening.

Visual.

The directors felt theatre being visual had greater effect than something based on sounds or words. One director placed greater emphasis on action than dialogue. Another felt theatre gave an additional dimension to health promotion by making the messages more tangible. People responded to its visual and narrative aspects. Theatre

was also involving and intimate.

Involvement.

One director compared the mass media and theatre as means of reaching people. With mass media, people could ignore them totally, switch them on and off, or do something else at the same time. As tools of health promotion the mass media were less intimate and involving. Hence their abilities to influence people were reduced. Being live, theatre required direct involvement of everyone present. People had to respond to what was going on or being said. Therefore they were more likely to be influenced by such a medium.

However in Australia, the director felt theatre was an unfamiliar experience for the wider population. The mass media were cheaper, more common and accessible. The director felt although a theatrical experience was more influential, television and radio were more likely to be effective mediums of health promotion because of their reach and familiarity.

Culturally Sensitive.

It was generally felt by most respondents that theatre was a means of incorporating cultural markers such as symbols, stories, music and language. As such it could be a means of dealing with any cultural barriers that might exist to some of the issues being addressed.

The participants commented on having cultural input into theatre in terms of music, dance, design and symbolism. This was supported by one director who felt even young people responded to the symbols as evidence of an identity that was

generally missing from the mass media.

Prior Experience and Versatility.

Two of the artistic directors and a health educator came from countries where theatre had been used to deal with various issues including politics. The health educator also believed in the ideas of Paolo Freire.

Theatre was described by the directors as versatile. Done properly it could address any topic, in any circumstance, to widely different audiences in accordance with the resources available. One director felt some health promotion issues were universal and therefore could be handled effectively for different groups of people using community theatre.

The participants thought theatre was generally useful because it was visual and accessible to people, whatever their age or background. Also some of the issues tackled transcended cultures.

Other Reasons.

One health educator was a firm believer in the principles of community development.

Community Theatre Effective as a Tool For Health Promotion:Problems and Improvements.

Most interviewees, but particularly the artistic directors, distinguished between process and product when assessing community theatre as a tool for health promotion. Most health educators had a mixed response to its effectiveness. The

participants felt the effectiveness of the show depended on the group targeted. A single show was not relevant to the entire community.

Process.

The process of community theatre for health promotion was thought by the three groups of informants to be more effective because people were actually involved and learnt through doing. One health educator said the participants increased their knowledge and skills, developed confidence and there was scope for peer education.

It had been thought that through working with a small group of participants, information would pass out into the wider community. This was not supported by some of the health educators or participants. The participants said there had been some transfer of knowledge from them to their friends and siblings, but little to their parents and the broader community. They said this was due to poor family interaction and communication, language barriers and sensitivity on the issues.

Health educators also doubted there were any permanent changes. They felt theatre should not be used in isolation but be backed up by other activities.

The participants and an artistic director said the main problem with process was that not enough people from the community actually participated. The various reasons cited were dealt with below.

Product.

It was generally felt the products of the various theatre productions were good and culturally appropriate. Artistic directors felt the product was still important as a

focus for the processes used. The product could then be used to reach more people. Also the productions had been designed specifically for particular communities to ensure there was identification with the projects.

One participant said theatre as a product could be effective for health promotion because it was make-believe and hence less threatening. However she followed that by saying it might also be difficult to bring about change because it was only pretense. She thought there needed to be reinforcement.

Two of the productions toured and were seen by large numbers of people. The people involved in these shows felt the products had been received well and were successful. In both cases only a small number of experienced performers were involved.

Most of the interviewees from the other two productions said their products were of limited effectiveness because they were seen by a relatively small proportion of the community. Many in the audience were either already aware of the issues or if not, they were more interested in seeing the participants than in absorbing the health promotional content.

Reasons given by participants for the poor community turnout were dealt with below.

Cultural Constraints.

According to all three groups of informants there were cultural constraints against community participation. The participants felt these needed to be considered when using community theatre for health promotion. Firstly there were problems over the issues being addressed. In some communities certain subjects were never

discussed generally eg.sex. For others, the issues were too confronting and they preferred not to acknowledge them eg.promiscuity, unsafe sex and death. It was through fear of such controversy that one group was refused permission to perform where it could be seen by the greatest number of people. Other groups felt the issues were totally irrelevant because their community did not have homosexuality and hence could not possibly be at risk of HIV or AIDS.

Another problem voiced by participants and directors was that not all communities actually identified with the theatre. It was not in their experience to go and watch a performance in a formal theatre space. A couple of participants felt some community members thought there might be intellectual or language barriers, or were intimidated by the idea that theatre was `art'.

Some participants, a health educator and two of the directors said there was a poor perception of any community activity, and community theatre in particular. It was felt if something entailed voluntary involvement and little cost, then it was amateurish and worth little. One participant felt this attitude was reinforced when community theatre received scant official support.

Other cultural constraints identified by participants included time and location of activities, reliance on others for transport and permission from families to actually be involved.

Personal Constraints.

Generally speaking there were many more female than male participants and many of both sexes dropped out during the process. Several reasons for this were given by the artistic directors and health educators. These included personal barriers

to being involved, no interest or identification with the issues of activities, and other commitments. Males particularly were thought to be uncomfortable with the processes involved, or found the issues too relevant and confronting.

For some participants it was unimportant if males were involved or not. They felt it was more important that those taking part were interested and committed rather than present simply to make up the gender balance.

Another participant felt the male presence ensured the final form of the product was still accessible to the wider audience. She felt part of the audience would have been alienated if it had been predominantly female as the final show would have been too emotional and overwrought.

One health educator said the participants' own attitudes and ideas had to be dealt with before they could put together a show that addressed the attitudes of the wider community.

An artistic director spoke of the problems of working with voluntary participants. Some were unreliable while others were enthusiastic but lacked ability and/or experience. There was felt to be a significant difference between the motivations and goals of voluntary community participants and professional artists.

Logistical constraints.

Several of the informants felt community theatre lacked full support and sufficient resources. Some directors thought funding bodies perceived community theatre as being easy and cheap to do. There was little appreciation of the skills, time and money involved in working with voluntary, inexperienced people to produce a powerful effective product. This was even more so when trying to access difficult to

reach NESB communities. Planning was often short-term and goal based, with little consideration of the long term, intensive nature of the work involved. The people involved in the productions were expected to take on many different roles in addition to their main one. They were also expected to generate their own publicity.

This issue was particularly pertinent to one production where the problems encountered were described as a conflict between community development principles and bureaucratic politics. A health educator felt there had been no recognition of the importance of the principles and processes of community development work. She felt the participants'contributions had been devalued, reducing their ownership of the project. The director said the participants lost enthusiasm when the content was changed as the new focus of the piece lacked relevance for them. She said reworking the piece in the time left affected the final product and reduced its effectiveness.

Neither the participants nor the health educator felt there was any incentive for people to be or remain involved, or for other organisations to be supportive. The educator and director found resources difficult to access and insufficient. No allowances had been made to maximise the full potential of the project in terms of both process and product.

The sponsor's representative felt the production lacked strict guidelines, control and accountability over content, rehearsals and participant commitment. As there had been no preplanned allocation of resources, there was nothing, in terms of time, personel or money, available for further work on the project after the single performance. The withdrawal of a co-sponsoring organisation was blamed on political conflict between professional organisations. The sole remaining sponsor then exerted its rights for recognition and control over the production.

Increasing community involvement.

When targeting a particular community for health promotion an artistic director said it was important to involve actual members of that community to ensure its trust and identification. One participant concurred. She felt the community would know best what would be most effective and appropriate for its people.

Both participants and artistic directors felt the main way of improving the effectiveness of community theatre for health promotion was to increase its access to the community. There were several suggestions about how this could be achieved.

Firstly the participants and an artistic director suggested a member of the community should be involved in specifically accessing and recruiting community participants to be involved in the process of community theatre. A community member should also carry out the publicity for the performance in order to maximise audience attendance.

Several participants said the product should be taken to the community rather than the reverse. The participants and art directors suggested touring to schools or community venues; videotaping the product and showing that at suitable venues; or showing the product on television which may have greater recognition and reach within particular communities.

Resources.

An artistic director said a different approach was required when trying to access a NESB community. In order to increase community participation in and access to community theatre, more was required in terms of time, resources, personnel, publicity and long-range planning. One participant said more support and

incentives were needed to get people involved and stop them dropping out. She felt there should be greater value and official recognition of the work done.

Proper Planning.

The health educators stressed that much thought had to be given to the ultimate objective of the production and the best means of achieving it. More time and thought had to be given to recruitment of community members, content and presentation of the production. The theatrical work needed to be appropriately designed and applied with respect to its content and the target audience. It was difficult to address different levels of the community at the same time.

Another health educator said not all members of the community identified with her and what she had to say. She also said groups within a community had different cultural tastes. Not everyone responded to a particular show. She felt it was important to use a format popular or identifiable to a particular group to ensure receptivity to the messages contained.

One health educator thought it was important to know when to finish one project and then move to something else, building on what had been achieved initially. Another said it had not been possible to determine if the process had been effective as no follow-up had occurred. Nor had there been any building onto the work done.

Improvements.

One health educator suggested community development would be a better means of doing health promotion. This would enable greater involvement of the

community and its leaders, providing skills, addressing relevant problems and engendering a sense of ownership. He felt it was still useful to use a method with a creative focus, that was fun, that built on existing knowledge and had scope for peer education.

Another health educator felt that for community development to work, the coordinator should be accountable but still have full control over the resources. This would enable ease and flexibility in responding to the participants' needs. She felt the participants were entitled to recognition, ownership and responsibility of their work with the aim of empowering them. She felt that where people had more confidence, there was greater willingness to learn. This health educator emphasised rapport, incentive and respect when working with the participants.

In contrast, the sponsor's representative felt a strict protocol should be drawn up at the start. There should be greater organisational control over the entire process covering bureaucratic procedure, resource allocation, financial accountability and content. The coordinator should be free to concentrate on interacting with the participants and the community.

Most of the artistic directors felt community theatre and crosscultural work should be seen as a challenge. To use the talent and resources available, working within particular cultural constraints and a sensitive issue to produce something effective. They felt there should be greater recognition of the importance and difficulties of producing community theatre.

<u>Overall Experience</u>.

<u>Sense of Contribution/Participation</u>.

Everyone felt they had contributed something useful to the experience of creating a piece of community theatre. The participants said they contributed their own ideas, experiences and cultural backgrounds which formed the basis of the script and design of the productions. They felt involved intellectually, physically and emotionally. Even if they participated indirectly, they still affected both the process and product of community theatre.

Artistic directors generally felt they contributed their professional skills and experiences. These could be divided into those applied to working with people, and those directed to producing an effective piece of theatre. The former included being a facilitator - getting people to interact, contribute their ideas and discuss issues from various perspectives in order to break down barriers and misconceptions.

The latter skills affected the actual structure of the theatre piece eg script format, design, performance direction and imparting the required skills. Two directors specifically mentioned teaching and guiding participants in the performance skills required. They spoke of working around the participants' abilities, their strengths and weaknesses. Another spoke of specifically accessing relevant cultural elements and presenting issues in a way the targetted community could identify with.

The health educators said they provided and maintained the primary focus of each project. The ultimate purpose of the theatre piece was to be a means of health education/promotion. Although the participants contributed material and delivery suggestions, the health educators had final control over health content.

The health educator who believed in community development saw her role as

providing the resources the participants felt they required. She provided them with information, support, access and incentive. She then left them to do what they thought was best, with guidance from the artistic director.

Learning.

Almost everyone mentioned learning from the experience. The participants felt they had gained more knowledge on the issues addressed and theatrical skills. They had a greater appreciation of their own creativity and imagination. They also mentioned learning about other people from different cultures.

The artistic directors too learnt more about the issues being addressed. One spoke of being exposed to and gaining insight into different people's perspectives. There was also an appreciation amongst some of the directors and educators of the capabilities of the participants.

Both a director and a health educator spoke of acquiring personal and professional skills, knowledge and experience that could be used in the future. For the latter it was a new experience in the use of theatre, cultural issues and working with a NESB community.

Connection.

For many participants it was a revelation they could identify and share with others despite the diversity in age and backgrounds. It was a positive emotional experience. The health educators and a director agreed there was great cohesion and few barriers. The participants developed an appreciation of, and respect for, people's differences and similarities. Many said they had formed friendships and continued to

see the people they had met.

Different reasons were given for this rapport. In one production the participants credited the artistic director with working hard to engender interaction and rapport. In another the educator felt the similarities of various cultures outweighed their individual differences.

The interaction between the participants and the directors and educators was also generally good. However in one production the participants agreed rapport was greater with one than the other. They ascribed this to their different roles in the project. The artistic director had to put a workable show together despite a lot of restrictions while the health educator worked to keep the participants motivated and committed to the project.

The participants felt the greater rapport with the health educator was due to her similar cultural background and her ability to relate well to young people. They found her more accessible. The health educator thought her rapport was due more to her ability to respect and treat them as equals than to her own cultural background. She admitted providing incentives to keep the participants involved.

The director was less positive. She had encountered a lot of problems which resulted in a loss of support from the participants, their parents and the health educator. The director persevered for a small core of highly committed participants.

In another production the interaction was described as generally good. However there were a few arguments when participants disagreed over the purpose of the production ie. educational versus artistic.

A third director normally did not encourage much community input into her work although she created works for her community. She felt it was too difficult to

reach a consensus and was not ultimately useful. In this particular production there was some community input but she did not comment on the experience.

Overall Rewards.

After contributing and being involved, the participants felt a sense of ownership over the final product. It was important to them that their languages were recognised. In addition to the knowledge and skills they gained, they mentioned self acceptance, self expression, self esteem and confidence. In this sense the participants were empowered.

The main thing the artistic directors gained from the experience was satisfaction in reaching people, whether they were participants or audiences. One director also emphasised the professional benefits to the company as a result of their production.

All the health educators expressed pride and satisfaction in what was achieved.

Discussion.

Review of the results suggested there was a lack of distinction between health education and health promotion. If one took the notion that health promotion was organisational, political and economic interventions that supported health, as well as health education, then community theatre in this study was probably used more as a tool for health education than health promotion. One production delivered health information in a culturally sensitive way for its community, using a small group of people experienced in theatre. Two of the productions also delivered health

information in a culturally sensitive way but with community participants. One of these was explicitly based on community development principles. The last production was based on community cultural development which touched on certain health issues but health was not the main focus. The latter two productions might more accurately fit into health promotion as they tried to address `organisational intervention' as well.

The main results of using community theatre, either as a process or a product, were an increase in knowledge about the issues, the acquisition of new and appropriate skills, and personal development. However there was a marked difference in who from the community benefitted most and in what way.

For members of the community who watched the performance, community theatre could be likened to a form of didactic health education. However instead of being delivered in the traditional verbal way, information on health issues, attitudes, behaviour and skills were provided in a visual, dramatic and culturally sensitive way. It was argued by the interviewees and Saunders (1974) that information presented in this way would be better received by the audience, particularly if it was kept simple and positive.

Watching a community theatre performance may have raised consciousness about certain health issues. However there was nothing to suggest that this led to any permanent changes in attitude or behaviour, or that anyone acquired useful skills. This was consistent with the study findings of Elliott and his co-authors (1996). Related points brought up by two studies (Elliott et al., 1996; Skinner et al., 1991) were that theatre was useful either as a starting base for further health promotional work in related areas using other methods, or as part of a range of associated health promotion programmes. The product of community theatre was probably an excellent

means of raising awareness about particular issues but additional measures were required to reinforce any message, develop effective skills, or permanently alter attitudes and behaviour patterns.

The methodology of the present study was limited in addressing the perspectives of a community audience. In one production there was some clarification and reinforcement of the information contained in the show ie. via question and answer card games and discussion. There seemed to be some effect as people (children, people in the street) who had seen the show commented some time later on what they had learnt. This suggested that members of the community who actually went, might have benefited from watching the productions. The main problem however, was that not many members of the targetted community came to watch the performance.

This then was a discrepancy between reality and the theoretical universal accessibility and flexibility of theatre. According to Saunders (1974) and some of the informants, the visual, active nature of theatre was supposed to overcome cultural, social and educational barriers. Also theatre was supposed to be flexible enough to handle any subject matter for any audience. However in the present study, the effectiveness of theatre was tempered by cultural and personal barriers. It was thought the targeted communities did not identify with either going to the theatre, learning from a performance, or the issues themselves. These findings supported some of those of Shevtsova (1993), and Grostal and Harrison (1994). For example, some cultures lacked exposure to theatre and hence found theatre houses alien. One could conclude then that a theatrical artform was not always appropriate to particular communities, to particular factions within a community, or to individual community

members themselves. There were suggestions that members of a community might relate better to other forms entertainment such as television or films. These then might be more appropriate vehicles for information transfer.

Generally speaking however, social, cultural or economic barriers did not apply to attending community theatre. This was because it usually occurred within the community's local area and was not as costly as mainstream theatre. The content was specifically culturally relevant, sensitive, bilingual and often performed by members of the community themselves. This was to ensure the community identified with the production. There were suggestions that some of the performance seasons were either too short or not appropriately publicised. This meant members of the community who might have come did not because they were unaware or unable to come in the time available to see the performance.

To remedy the problems identified above, several solutions were suggested. Rather than expecting a community to come to a performance, the performance should be taken to the community. This could be accomplished by touring the production to schools and suitable community venues, videotaping the performance and showing that at appropriate places, or televising the show on community television. If the production was going to be shown at a particular space, then more appropriate publicity was needed to access the community and longer seasons planned for. This allowed time for word of mouth to be effective. Consideration should also be given to counteracting certain constraints against attending eg. women only performances at a suitable time with child care available.

In terms of effectively imparting skills, altering people's attitudes and behaviour, and personal development, the actual process of community theatre was

more successful than the product. This could be the equivalent of an experiential method of health education whereby people learnt through being involved physically, intellectually and emotionally, as advocated by Saunders (1974) and Hodgson and Richards (1972). Some of the techniques used in exploring issues in a group situation were loosely based on Freire's idea of empowerment education (1970). Participants collectively explored and analysed an issue as it was influenced by a range of factors. Through this understanding they developed the skills to deal with the issue effectively in real life.

The process of community theatre took place over a longer period of time than a single performance of the product. For example, weeks and months compared to only an hour or two. This was important if any permanent changes in an individual's knowledge, attitude or behaviour were to occur. The potential for a single performance of deeply and permanently affecting a spectator was limited. This point was brought up in the study by Elliott and his co-authors (1996). Also any changes needed to be supported by the individual's wider social, cultural and economic environment. Otherwise, even if there were any intended changes of attitude and behaviour shortly after watching a performance, they were unlikely to be sufficiently entrenched after such a short time to be able to withstand external influences. This was related to the South African study (Skinner et al., 1991) where the authors suggested that although there was a short-term influence on the audience, follow-up was needed to see if the benefits were long-term.

Personal development included greater self esteem, capability, confidence, and a sense of validation. The participants felt empowered from their experience of being involved in the process of community theatre. They also developed a greater

appreciation of, respect for and identification with others despite the range in cultures, ages and socio-economic backgrounds. Thus, the process of community theatre was an opportunity for a diverse group of people to overcome any perceived social and cultural barriers, and enjoy interacting. From this interaction they could then work collectively and effectively together in pursuit of some objective. This was the precise aim of community cultural development (Simpson, 1992). From personal empowerment there was then the possibility of organisational empowerment, and perhaps eventually community empowerment (Israel et al., 1994).

The community members who benefitted most from this experiential method of health education were those who actually participated in the production. However they represented a minute proportion of the targeted community. This low level of community participation will be further discussed below. There was little evidence the information and skills these participants acquired eventually passed out into the general community. The main reasons for this were probably the sensitivity of many of the issues and the general dynamics of the community. It would have been difficult and inappropriate for young people, for example, to discuss certain topics with older people or people they did not know well. One advantage however was that there was some transfer of knowledge sideways and/or downwards to people their own age or younger than themselves. Hence there may be a positive effect in the long-term.

Two of the productions were specifically based on community development which was thought to be an important way of conducting health promotion, particularly if trying to access difficult to reach communities (Egger at al., 1990). Apart from providing health information and suitable skills, there was an attempt to

enable the community to fully participate and have some control over the process. This was in order to realise both individual and community empowerment. It was infered that the general physical, emotional and mental empowerment of the participants enabled them to have greater control over other aspects of their lives, including their health. This idea was carried through to a certain extent but perhaps not to the utmost degree.

In the two productions based on community development there was a great deal of involvement and contribution from the community participants. However it was debatable how much power the community was allowed to wield over the entire process. In both cases the participants were reasonably young and inexperienced. Overall there seemed to be some tension between allowing community participants to have greater control over what was being done and yet still create a professional effective piece of theatre. In one case this conflict was compounded by a lesser appreciation of the principles of community development by the sponsor. This created problems between all parties (the sponsor, the health educator, the artistic director and the participants) and the full effectiveness of both the process and the product were not realised.

One resounding finding from these theatre productions was if something was being done with a particular community, then people from that community needed to have greater involvement in the various aspects. These ranged from general consultation, accessing others in the community, participation in the process to viewing of the product of community theatre. This correlated with Rifkin's discussion of the various forms of participation possible and what they meant in terms of overall control (1986). In reality the scope of participation was limited by the fact there was

a health agenda to be implemented. The difficulty was finding a suitable compromise between allowing the community full participation and control, and achieving a specific objective.

Within this study there had been community consultation and input. However, not as many community members as were hoped for either participated in the process or came to watch the product. The many reasons given for low community participation and a significant number of dropouts were classed as cultural, personal and logistical constraints in the results section. Some of the possible cultural and personal barriers included sensitivity or non-identification with the issues being addressed, uninterested in theatre itself or uncomfortable the processes involved. It was also difficult for some people to participate without parental permission or a means of transportation.

Of the community members who did participate, many were young, female and of NESB. There might have been social, cultural and gender restrictions on their participation that kept their numbers low. There were even fewer male participants. They, too, would have been affected by both personal and cultural constraints but in different ways to the females. The final gender balance might have affected the content, structure, design and performance of the final production. This could then have influenced the identification and accessibility of a production to a wider audience. Spectators might not attend a performance they felt would not appeal to them or that they did not identify with. Although community theatre was supposed to be about the community, a predominantly young female production was not going to appeal to the entire community. The same applied to different productions aimed at other community sections based on various socio-economic, political and cultural

factors. This point was emphasised by the DIEA (1986), Grostal and Harrison (1994) and Shevtsova (1993). Any section of the community that did not identify with a production would be less receptive to the message it contained.

Rifkin (1985, 1986) outlined some possible problems with participation and community development which could be applied to the current study. Firstly, as previously discussed, communities were not homogeneous. Therefore the ideas and contributions of those who participated did not nescessarily represent those of everyone else in the same community. In one particular production greater value was conferred on the absolute product than on the educational process, eventhough the former was more expensive and less effective in the long term. Community involvement meant different things to the various groups of people involved such as participants, artistic directors, health educators and sponsors. There needed to be more discussions involving all people so everyone knew what was the ultimate objective of the exercise. Lastly, participation was determined by multiple social and individual factors. It was hard to generalise and get everyone from all communities to participate in the same way.

Three linked levels of empowerment were identified by Israel and her co-authors (1994); that of the individual, the organisation and the community. In the present study, participants were empowered to varying degrees within the different productions. Overall there appeared to be much perceived individual empowerment which was still present when they were interviewed. For example, the participants felt they had gained in knowledge, confidence, a sense of responsibility and ownership over the projects. However there did not appear to be any peceived sense of community empowerment. Then again, empowerment of individual participants at a

community level would have been difficult for social and cultural reasons. Many of the participants were young, and/or female, and from communities that might not have supported such empowerment. In two of the productions there might have been a degree of perceived organisational empowerment where the participants felt they had some input and control over organisational decisions. Community development principles were explicit in one of these productions and implicit in the other. In the latter case, eventhough community development was never mentioned, the theatre was based on devolving much decision making and running of the theatre to the community shareholders.

Israel and her co-authors also stated that perceived empowerment may be different to actual empowerment (1994). The researcher thought there was more perceived than actual empowerment of the participants. They contributed a great deal and had some control over the process of community theatre, but perhaps not as much, or over as broad an area, as might have been possible. The participants were not always involved in the discussion and planning stages of either the production or workshops. In one production larger roles were given to a few, more experienced older participants. In another production, community participation was limited to consultation while a few experienced individuals actually performed. These occurrences were related to the need to balance the ideal with the practical. They were similar to those for limited participation which included there being a health agenda to be implemented, and artistic control to ensure the final product was theatrically effective.

Some problems which might occur when engendering community empowerment were described by Israel and her co-authors (1994). The one most apt

to the use of community theatre for health promotion was role related tension. This affected the dynamics between community members, health educators, artistic directors and sponsors. This had been quite marked in the project that was explicitly based on community development principles. Various representatives had different aims for the project. In the end most people involved expressed some dissatisfaction, and the full effectiveness of neither the process nor the product of community theatre were realised. Other problems also experienced by the project included a lack of trust and positive communication; a lack of full understanding of the process; limited time frame and insufficient resources. There was also general difficulty proving empowerment had occurred as complicated methods were required to collect the relevant evidence for evaluation.

Future studies researching the effectiveness of community theatre as a means of empowerment would benefit from a multifaceted way of measuring both perceived and actual empowerment. The methodology used in the present study would not have been appropriate. The suggestions made previously under the methodology section still assessed perceived empowerment and hence would be limited. A method based on participatory action research (PAR) was suggested (Israel et al., 1994). PAR involved all representatives of a project in a joint problem solving process based on a cycle of diagnosis, action planning, action taking, evaluation, and redirected learning. Within this process a health educator, in conjunction with the others, would be able to identify and evaluate suitable process and outcome objectives for community empowerment.

Creating theatre as an effective medium for delivering specific messages required skill and experience. It required even greater skills and realistic amounts of

time and money if it was to be achieved through empowering voluntary untrained and inexperienced community members. Time was nescessary to properly access the community for consultation and participants, build up trust, obtain the participants' contributions, provide them with the nescessary skills and eventually create something effective to take to the rest of the community. Money was nescessary to cover the time, skills and people involved. Theatre productions also had their own costs such as rehearsal space and equipment for lighting, sound and recording. Theatre projects were expensive if they focused on a single, short performance. However the cost could be mitigated by thinking of the long-term benefit. The maximum potential of every production should be fully explored in terms of touring, recording and reasonable seasons. Also the benefits to the participants of simply being involved in the process should be given greater value.

There needed to be increased documentation and evaluation of the projects. Documention was required as a record of the projects. Evaluation determined the efficiency, effectiveness and appropriateness of what had been done, identifying weaknesses and strengths (BHC, 1986). During evaluation, full consideration should be given to all aspects (indirect/direct, short/long-term, individual/community) of the process and end product so they contributed to the overall worth of the exercise. Depending on what was being measured, appropriate data should be collected. There should also be greater follow-up of projects to see if they resulted in any long-term effects. Balanced evidence should generate greater support by funders for this form of work. It was hard to change people's general perceptions of the value of community theatre; however it was even harder if there was little tangible support for it.

Conclusion.

Overall community theatre had the potential to be an effective tool for health promotion for NESB people. This effectiveness applied to its use either as a product or a process, which may be seen respectively as didactic and experiential methods of health promotion. Community theatre could also be effective as a community development approach to health promotion. The main results of the use of community theatre included increased knowledge, acquisition of new and appropriate skills, and personal development. However, depending on the way community theatre was used, there was a marked difference in who from the community benefited most and in what way. There were also many cultural, personal and logistical constraints to it being used most effectively.

Community theatre was an intensive method of health promotion with respect to time, labour and money. It should be used judiciously. A lot of planning had to be done beforehand to determine its appropriateness in terms of the community being targeted, the message being delivered, method of delivery, design of the product, level of participation and so forth. The people who could best advise were members of the community who were actually being targeted, not simply community leaders.

The potential of each production should be fully explored so as to maximise benefit from the outlay of resources. Also, as a method of health promotion, community theatre should not be used in isolation but as part of a range of interventions. This would increase cost efficiency and any benefit from participating in community theatre could be supported and reinforced from a number of different sources. In addition, a community theatre project was a useful starting point for building a long-term relationship with a particular community. This relationship could

then be employed in addressing other issues that affected the life of a community.

There was potential for empowering disadvantaged community members through participation in community theatre. Theoretically in community theatre, members of the community would be able to voice their concerns by collectively analysing an issue, making decisions, planning a production and performing it. They could then take action that would alter the situation. However this objective of empowerment had to be realistic, taking into consideration the various constraints possible and a full appreciation of what exactly was entailed. The principles of community development process had to be understood and valued by all involved.

Lastly, there should be greater evaluation and documentation of the different ways of using community theatre for health promotion amongst people of NESB. Evaluation determined the ultimate effectiveness, weaknesses and strengths, of community theatre while documentation provided a record. The conclusions drawn from this study might not apply to other productions based on different organisational structures, different communities, different factions within a particular community or different health topics. With more evidence of the degree of usefulness of this method of health promotion, there might be greater incentive for realistic support by funding bodies.

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Appendix.

Information Sheet.

The University of Sydney
Faculty of Health Sciences
School of Community Health

INFORMATION SHEET

COMMUNITY THEATRE: A TOOL FOR HEALTH PROMOTION

Dear Participant,

You are invited to participate in a study which will be investigating the usefulness of community theatre as a means of health promotion, particularly amongst people of non-English speaking background. This project is part of the requirement of a Post Graduate Course in Community Health in the Faculty of Health Sciences, the University of Sydney, being undertaken by researcher Rogayah Shahariman whose supervisor is Dr. Freidoon Khavarpour (Phone: 9351 9127).

If you agree to participate in the project you will be involved in a semi-structured interview which will last no more than one hour at a time and location that is convenient for you. Participation in this project is entirely voluntary and you may withdraw at any time during the interview or study process.

The questions asked will be related to your ideas and perceptions on the potential of community theatre for health promotion. This project has been approved by the University of Sydney and meets the guidelines for ethical research which requires full disclosure to participants of the purpose of the research, and guaranteed confidentiality to all participants.

The information you give in the interview will be confidential and your identity will not be disclosed to any other person. The interview will be recorded using fieldnotes but your name, personal details and name of the organisation will not be used in the final report unless you give permission. During the interview you will have the opportunity to raise any questions you may have. You may contact Rogayah Shahariman on 9649 3302 (h) or 9858 1033 (w) if you wish to participate in this study or if you wish to discuss any aspect of the interview or other matters related to this research.

Your contribution to this project would be greatly appreciated.

Yours sincerely,

[Dr] Rod Rothwell.
Head of the School of Community Health.

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