

# WORKSHOP 5

## Building healthy communities in rural and remote Australia

Chair: Di Wyatt

**DI WYATT:** Good afternoon everybody, and welcome to this, the Building Healthy Communities Workshop. We're actually going to start and close the doors because we do indeed have a full house, so thank you for your very positive response to this.

I'd like to introduce myself first. I'm Di Wyatt, Monash University School of Rural Health, and I have my team with me today that are going to tell you about their programs and also work with you, hopefully, to develop some recommendations around the future direction of this program.

So let's start at the end. We have James and Beth, they're from Collie in Western Australia and ran a program that you're going to find most interesting. Next to them is David from Texas in Queensland, and you see they actually talk, the Queenslanders and the Texans. David is the sole representative from Texas. Then next – is somebody else here from Texas, are they?

**MALE SPEAKER:** His wife.

**DI WYATT:** His wife?

**DAVID HAYWARD:** Partner.

**DI WYATT:** So, we really do have the whole of Rural Health from Texas here then. Next to David are Jo and Janine and they are from Kempsey/Taree. The program runs over a couple of sites. .

Next to me – and I don't know really whether I have to introduce him because he does a pretty good job of it himself – but directly on my right is Bernard, and Bernard is now from Mildura, but has worked in Ouyen on the Mallee Track diabetes program which he will talk to you about today. Next to Bernard is Liz Cotton from the Department of Health and Ageing, and we have to thank the department for sponsoring this workshop this afternoon.

Next is my colleague from Monash University School of Rural Health, Marlene Drysdale, and then we have Timmy and Djarti from Galiwin'ku on Elcho Island. So that is the team that will be working with you this afternoon.

The program is actually divided into three specific sections. The first section is introducing you to the Rural Chronic Disease Initiative and what we found through the pilot phase of that, and allowing you to hear from those that participated in that pilot program which was the founding program for the ongoing Building Health Communities Program. They will tell you a little bit about their projects, what they found worked within their communities, what didn't work, what helped them with their projects and the sorts of things that were barriers to them when they were doing their project. And that's a little bit of feedback for you from those that have actually already participated in this Commonwealth program.

We will then have a bit of time for you to talk with a panel and perhaps get a little bit more information of specific areas of interest to you from them before Liz outlines for you where the

program will go over the next two to three years, because I think you will all be aware that there was an announcement in the Budget for ongoing support for programs to address the prevention and management of chronic disease in small, remote communities. Liz will talk to you about that program.

Section 2 of the program is you doing some work, because what we'd like you to do is actually look at the concepts of the program and how they relate to your communities. What in that particular program will help support you and what do you think may act as barriers, because the final section of the day will be some feedback from you to the Commonwealth and potentially some recommendations both to the Commonwealth about the program and its future and, if you wish as a group, a recommendation back to the conference itself, because those of you who have attended conferences before will be aware that the recommendations do go back to the Minister.

So there are those opportunities for you within this workshop. I might need to point out to you that the program actually states that the workshop will go from 4 to 5.30. Given the complexity of the subjects to be covered in this, it will not finish till 6. So just warning people, if you are preparing yourself for 5.30 or have appointments for 5.30, the program will actually run till 6 o'clock.

But let me perhaps start off, before we hear from some of the projects, and talk a little bit about the Rural Chronic Disease Initiative and what we found when we undertook this program last year. If people can find a little bit of floor space, I suggest you do it because we are going to show you a video and then you will have a chance to actually meet with those that appear within the video to ask some questions. So it will take a little while. There is a few chairs so to save you standing for the next half an hour, it might be a good idea to get one.

Now, is everyone settled? Floor space only. I should point out before we start that there is an apology from Thursday Island. Thursday Island were to join us and present their program to you. Unfortunately, you'll be aware that there is a cyclone going through there, and we also have the issue of dengue fever and they're unable to leave the island. But we received a call this morning from the health service manager to ask Liz and I to provide a very brief overview of what they've been doing on Thursday Island. So we will do that on their behalf.

But let's just come back to a bit of history about the Rural Chronic Disease Initiative. As we know, the management and prevention of chronic disease is a major challenge facing rural and remote communities across the world. There is growing awareness of the need to develop innovative approaches to enable and drive change to address the increasing rates at which chronic disease are occurring. By 2020 the World Health Organisation believes that chronic disease will be the leading cause of disability worldwide.

In Australia it is estimated that chronic disease is responsible for around 80 per cent of the total burden of disease, mental problems and injuries and that's from the Australian Institute of Health and Welfare. The Australian Government Regional Health Strategy, More Doctors, Better Services, has provided a policy framework that has enabled the Department of Health and Ageing to establish the Rural Chronic Disease Initiative.

This initiative, which began in 2000 has piloted innovative and flexible community-based models to address the increase in chronic disease in small and isolated communities in Australia. The 30 small communities with populations up to 10 000 people received funding and support under this initiative. Each of this community has had very few resources to address chronic disease issues locally. Each of the projects were developed by the community, in the community, and have targeted the chronic condition identified as a priority for action by

the community in which it was developed. In other words, the responses to date have been community driven.

Monash University School of Rural Health was engaged by the Department of Health and Ageing to write up what had been learnt throughout the pilot phase of the Rural Chronic Disease Initiative. And to analyse those findings to inform future policy direction by the department and to develop a how-to guide, again as an outcome of that. . If you haven't got a copy, there is a postcard on your seat to enable you to get one, it will be provided by the Commonwealth for free. I'll talk a little bit more about what's in it later in the program.

What we were engaged to find out was what had worked; what didn't; what were the enablers; and what were the barriers?

What we did was pull together information on the communities and about the communities, which had been funded. We then went out to visit and talked to the people involved in the project at a local level. We also used post-visit information because we went out to the communities at different times and at different stages of their project.

When we put that information together, what we found was that each of the most successful projects had five things in common and we felt they were essential to any good project in the future, and that was that they were well-planned and well-managed by the community during their lifetime as a project . So, the importance of planning was the very first thing that we found was the key to successfully running a project.

The second key was that they set realistic targets and goals for their project . They didn't try to do things for which they did not have the resources in the community or beyond them. So it's very important to set the realistic goals and targets for yourself when you are developing projects . The third key was that they were supported by the community and I think we're all aware if the communities are aware of things, participate and are active in them, then they're more likely to be successful, particularly, if you're working with a very, very small community. But while the importance of having community support is a key to success; also to have a good team, and people behind the project is essential.

The fifth one is a psychological one, I suppose. Those that actually believe that the program could be achieved, and make a difference within their community, were the ones that were most successful. . So these were the five extremely important components to any successful project.

We also found that it was very important for communities to consider who actually auspice their project.

We found the most successful were those that were within the health services within the community. That they became part of what was happening with health care within that community, and the community understood that. And the least successful were divisions of general practice who were perhaps not identified as clearly within or by the community .

The other very important factor in running a successful project was that a successful program has a project officer with good skills and knowledge base and we can't underestimate the importance of having a very, very good project person active in it.

We also found that there were times when a consultant could be useful in developing your project , and sometimes they weren't.

I think it was the way in which consultants were used, people need to think about using consultants and what you actually want them to do before you employ them to do it, because

they do not come up with the answers. What we found was the opposite. The projects that were developed within the community by the community had the highest level of outcomes as they were then community owned.

What we found on a national level was a key enabler was certainly the partnerships that were developed by projects with other major stakeholders within that community and that they made the linkages within their towns.

Also training, training actually came out as a very important enabler. What the projects needed to be on about was skill transfer, not coming in and doing things, but building the capacity within communities to develop the skills base, how you use training to do that is very important.

Challenges we found were mainly local. A lot of them were actually sorted out, particularly through communication and again linkages and partnerships. But one challenge was engaging the community and those key stakeholders.

A further challenge we found was with projects being run in very, very small communities, was time. Time was an issue for more than just, the running of the project and the tight constraints around how you develop and implement a project of this sort in a 12 months – or two year period.

But also because of limited resources you need to make sure your project activities don't clash with other things going on in the community. For example some things can not be run during the footy season. You need to be aware of what the community is already engaged in and don't put on activities when they're trying to harvest, etcetera. So timing is a very, very important key.

Community capacity and size also made a lot of difference really because very small communities are very under-resourced, so it's how do you maximise the potentials of those very small communities. And is there a level where services or activities become un-viable due to the lack of resources in those communities. Engaging in Indigenous communities is one that I'm sure will be talked about.

We also found that building on and value adding to what's happening within the community supports sustainability of your project. To improve health outcomes in the longer term your project should be integrated into your current community activities and basically builds the capacity of your people. So they were the main things that we found when we went and visited the 29 pilot sites, and there were some very key lessons in that for future programs.

Now, what I mentioned earlier, was we have a wonderful resource kit that has come out of this that has a lot of tools for people to use. One of those tools is a video DVD. So let me put the video on for you now. Sit back and then I'll introduce you to the people that you will see in this.

#### **VIDEO SHOWN:**

**FEMALE SPEAKER:** Throughout Australia, many small rural and remote communities are tackling chronic diseases such as asthma, arthritis, diabetes, respiratory disease and cardiovascular disease. These communities are defined by their geography, history, industry and environment. In tackling chronic disease, community responses need to be innovative and unique to their particular circumstances. Understanding and developing the resourcefulness and capacity of the people within these communities is the key to their success. The Australian government Department of Health and Ageing funded 29 projects across rural and remote Australia.

These projects were funded under the Rural Chronic Disease Initiative. The communities of Texas in Queensland, Galiwin'ku in the Northern Territory and Ouyen in Victoria illustrate how these projects use existing community networks and create new ones in tackling the complex issues of prevention and management of chronic disease. The south-east Queensland country town of Texas tackled the issues of nutrition and physical activity in their "Texas – A Healthy Town" project.

**MALE SPEAKER:** The Texas community has embraced the Rural Chronic Diseases program to promote health across all ages of the community to participate in sports, walking, in general activities, and healthy eating. It's a self-help program where we hope that people, through their own endeavours, will be able to ward off the effects of diseases and sicknesses, particularly, in later life.

**MALE SPEAKER:** When we first started out, our objectives were really to look at active lifestyles, increasing the level of activity within our community, so educating people like, you know, that, you don't have to be out there in your leotards and doing aerobics. A half hour of brisk walking each day is what is required.

**FEMALE SPEAKER:** One of the reasons I do walk of a morning is because of my blood pressure. And the doctor told me if I walked four or five times a week or, say, four, that I would get my blood pressure down and that has happened.

**MALE SPEAKER:** Rather than look at some of the symptoms and try and treat those. What we're looking at is saying, "What really causes this? What are the main tie ins?" And our project has said, "Well, we think that the two main self-modified causes that you can find that relate to most chronic conditions are the levels of physical activity and the eating habits of people."

**MALE SPEAKER:** I've been involved in the Healthy Towns project and on the lean meat side of it, changed a lot of recipes and it's mainly healthy living in Texas.

**MALE SPEAKER:** One of the things which is ironical about this program, there is a swimming pool built at the hospital for the nurses, and it sat there for many, many years, this pool, and I don't think it's ever been swam in very much until they converted it to a therapeutic pool and it's heated in winter and a lot of the elderly people who are suffering from either broken bones or arthritis are using it much more than the nurses, that it was put in for, I never dreamed that they would get the use of it.

**MALE SPEAKER:** We've got to travel about 100 kilometres to the nearest pool, the nearest hot pool, and half of that road is dirt, and with a sore back, I can't sit for any more than about an hour when I go travelling any distance. I've got to stop, get out, walk around. Whereas, we're 15 minutes out of town, I can drive in, have this, go home.

**MALE SPEAKER:** One of the best examples, I think, of something that has come out of the Rural Chronic Disease Initiative directly is the Little Athletics group.

**FEMALE SPEAKER:** We've formed a partnership with the school. They've got the facilities that we need to run the centre, and they've said that, we can use the centre. And we will be buying equipment with funds which have become available through the Healthy Towns project as well.

**MALE SPEAKER:** Partnerships is obviously something that we're really focused on. And we've been lucky that previous work we'd done in projects, we'd actually developed some networking and some partnerships, to a certain extent. And we also thought, well, with the prevention side of chronic disease, what better place to start than the children at school.

**FEMALE SPEAKER:** We've got a structure across the school where all the kids study in the areas of maths, literacy, physical education being an active program. And the other significant one is what we call, integrated studies. What it means, in terms of the Healthy Towns project is at least, probably, once a year the kids in this school, in every year level, are doing a term that's really focused on health.

**MALE SPEAKER:** We've had a win there because, obviously, we got more time in activity and we're also getting stronger health messages across into the curriculum as well.

**FEMALE SPEAKER:** All these projects have actually linked in together and long term, we expect to see the outcomes. But we're certainly seeing that people are actually taking ownership of their health now.

**MALE SPEAKER:** If you can get key people in the community enthusiastic about doing these sorts of things, they tend to bring a lot of other people on board because it's the social aspect of going out and having a walk with their friends. And also they can be very powerful messengers for you.

**MALE SPEAKER:** If I can give any advice to any other community about this program, I would say that if you get the opportunity to run the program in your community embrace it. It is not difficult. It requires dedication by a team of people to supervise it, and organise it. I feel so strongly about the program that I'd like to see it expanded across the whole state, not only the two towns in our shire. The program embraces so many people to encourage people to help themselves.

**FEMALE SPEAKER:** It's just opened people's eyes to the fact that we can do a lot to help ourselves.

**FEMALE SPEAKER:** In north-east Arnhem Land in the Northern Territory, the Indigenous community of Galiwin'ku has been addressing healthy food and community activity through the Home Gardens project.

**TIMMY GALALINGU:** Hello. My name is Timmy Galalingu Gunnenburrah and I'm on this island called Galiwin'ku and I am doing this program in the Home Garden."

**MALE SPEAKER:** The Home Gardens Initiative was a result of a study. What we were trying to identify was a benchmark of the existing level of diabetes and blood pressure and those diseases that are commonly referred to within Aboriginal communities. One of the key elements of the report is the capacity building area so that the community itself can address some of the issues that need to be addressed. Low levels of consumption of vegetables, fruits, and things like that, were one of the things that was identified as being a critical factor.

**MALE SPEAKER:** Now, this boy has just got this from our takeaway and our program, The Healthy Home Gardening, is trying to replace it.

**FEMALE SPEAKER:** We're nurturing the kids and the older kids or elders of the community, you know, people, you know, Yurimu people. We're mainly looking at exploring the connection on health and education because a lot of you will find out that they have diabetes or, you know, kidney problem, heart problem and Yurimu decided, "Yes, that's right because we are more depending on shop." So they thought that we could have our own garden.

**MALE SPEAKER:** This is the soil that we picked it up from other areas. To use it to plant some garden because it's all rocky here. And sometimes we don't know, you know, because we're just trying our ideas and we have to put a soil on top of here and plant something. And we're cleaning up that area, this one, and this is the area that we are thinking that we're going to make a path later on. Make a path, put a lawn, barbecue area, plant more trees and sitting in the shade and children can play and we can make the barbecues, some things like that, Christmas party or birthday party in the lawn and, you know, this sort of thing.

**FEMALE SPEAKER:** This is bush potato, that one is where you see is sweet potato, but this one here is bush potato, but still Yurimu people eat them, we eat them.

**MALE SPEAKER:** Still keeping the native tree because we know the season or calendar. This is our season, like, a seasonal calendar. We can't read the foreign tree.

**MALE SPEAKER:** This is the seasonal calendar, things that would teach young people what to eat, the traditional foods. And for later on when their kids grow up to be able to inherit this kind of food gatherings.

**MALE SPEAKER:** If we see different flowers come up, turtle is ready. If we see another flower comes up different, well, the crab is ready. The horses is ready. Everything in the sea is ready according to a seasonal calendar that we can see different flowers come up.

**MALE SPEAKER:** Healthy lifestyle is very, very important for our young children. And that is why we need to educate our children to eat better food.

**TIMMY GALALINGU:** Healthy life is better to walk around and do a little bit of shopping at the little shop, I mean, little canteen to buy some chips and cokes, or sort of like junk food, that's no good. The adults will get real sick. This food is better for you.

**MALE SPEAKER:** The element that impresses me about this one is that it's not one where the council drives the issue. It's very much been driven by the people themselves as part of the project. They've identified the issues. They've identified the people that they consider have got the necessary skills to become involved in this Home Gardening project. The training element that has been provided. And the council explores a supporting network.

**MALE SPEAKER:** So that's all I do well for this garden, so I can help the community to make them well and make them happy. When we eat from somebody we feel weak. But when we plant and work ourselves, we feel happy.

**MALE SPEAKER:** It's much healthier now. So the people is getting the idea to be able to look after themselves.

**FEMALE SPEAKER:** The remote community of Ouyen in north-west Victoria aimed to raise awareness, increase physical activity and provide an opportunity for management of diabetes in towns along the Mallee Track.

**MALE SPEAKER:** Our program is called "Diabetes Management Along the Mallee Track", which encompasses all our service centres such as Underbull, Patchy Wallop, Walpea.

**MALE SPEAKER:** The farmers service their tractors like they're made of gold, but when it comes to looking after their own bodies, they say, "She'll be right, we'll look into it next week." And so they let everything just go by the way until something seriously happens.

**FEMALE SPEAKER:** The Rural Chronic Disease Initiative enabled us to improve the management and access of clients out in these rural isolated communities into a specialised area and a diabetes educator. It also enabled doctors to link into a person who has specialised knowledge in the management of diabetes.

**MALE SPEAKER:** Well, in my case, I've just been told I need to get my fat levels down, so I've got to do some walking, so that's something, I'll have to change a few habits, I suppose.

**FEMALE SPEAKER:** I'm not a diabetic, but we are 30 miles away and we're really only as far as the phone because Pauline has been a really good lifestyle. And I'm interested to come along just to see that he comes straight home.

**FEMALE SPEAKER:** Since this program has started, it's made people more aware of diabetes and even those that haven't got diabetes are talking about it. How they must look after themselves and change their eating habits instead of, you know, watch their fat intakes, and things like that so that they're not quite as obese. And yes, so I think it's just been wonderful for this community to have this program and to hear so many people talking about it.

**MALE SPEAKER:** It's just sensational, they can get access to 40 young men all around the same age group from 30 to 40 or 45 and do all their screening. And as it's turned out, we had one young gentleman that wasn't very old picked up with some of the screening last time around, which is great. You know, that obviously saved some major illness down the road and you can't ask for any more than that, it's worth its weight in gold.

**MALE SPEAKER:** A lot of people in smaller communities may not have access to big test and specialist. And if they are aware of the complications to watch for the signs, and if the signs and

symptoms for diabetes, a lot more would be diagnosed earlier and the patients will be part of their own treatment which helps in the management of diabetes on the long road.

**FEMALE SPEAKER:** If I had to travel to Mildura, take days off, and things like that, I wouldn't be doing it. It's been great for our community, I think. You know, it's encouraged a lot more people to do something about it.

**MALE SPEAKER:** This screening and engagement of community helps to demonstrate to the community that healthy lifestyle is a choice for them.

**MALE SPEAKER:** We are getting better control of the diabetes and we are getting more patients involved with that. They are able to take care of their diabetes and manage it themselves. We are actually getting a lot of people to go off medications and control their diabetes with diet because they now know it's not only the medications that help.

**MALE SPEAKER:** This is about health, and we get community participation because we make it fun. We have a walk program where 250 people are walking on a regular basis and have knocked up in eight months – nine months – over 50 000 kilometres. We have a group in Ouyen called "The Foot Sloggers" who can't stop telling you how far they've walked and how good they are. And they're a community of only 250-odd out in the middle of nowhere, but they are walking. So we make it fun and this what health is about.

**FEMALE SPEAKER:** And it's made people more aware that you can prevent these things rather than sit back and just wait for things to happen. You can help yourself if you really need to.

**MALE SPEAKER:** It's convenient. It's for our benefit. It's something we can all join in and be part of and for other people who think, well, wouldn't it be great to have a service like this in my community – my local community. We'll get hold of your health professionals and say, "Look, don't do it on an individual basis, let's look at our community and do it on a community basis and invite groups like the CFA, the farm groups, the women's groups, the schools, any sort of group that you might have in the town, Apex, Rotary, whatever it might be.

And then people are not so self-conscious about it because they're doing something as a group and an organisation and actually doing it, not just for themselves, but for their community at large, and I think that's a great approach and a great way to get things done.

**FEMALE SPEAKER:** The success of these community projects, the result of a number of key factors, flexibility of approach, innovation, can we do it another way? Integration, what can we link into? People, who are the care enablers? Resources, what do we already have here? Maybe you've been inspired by the experiences and drive of these three communities to implement a similar project in your community to assist. The Australian government is prepared this resource kit to help other communities find similar ways to improve their own health.

**DI WYATT:** As you can see, the projects were very diverse, both in the type of projects they were and the communities in which they were implemented. Now, let me introduce you to the stars of that show which, I hope, you all enjoyed. The first star to come forward is Bernard Denner. Bernard, as I said, is with Mallee Track and Bernard was the project manager for their diabetes program. So, Bernard, come and tell us a little bit more about it.

**BERNARD DENNER:** Thank you, very much, Di. As some of you know, my main work has been in men's health, so this program that we developed at the Mallee Track was based on my work over the last ten years in men's health and getting communities to participate. The Mallee Track is remote in Victoria. We're the only designated remote area of Victoria. We are very remote. And we actually don't have any Aboriginal community at all right across there, so there's an hours drive between Ouyen and Murrayville at the different centres. Part of our success is our partnerships and, as some of the video has already displayed, partnerships are extremely important. And it's a range of partners that we are involved in to make it all work.

And staff, you have to involve all the staff. It's no good just having a small team because there's no sustainability, so there's a whole range of staff. And as we did not have a trained diabetes

educator, so we got one of the nurses and she put up her hand and we sent her off to complete her course as a diabetes educator, so we don't have to – and we involved two practices.

But it worked because it was around existing programs, certainly in the men's health area, early intervention screening sessions over three years, the Walk Australia Program, the Neighbourhood House Lifestyle, a DVA Program for Veterans and, as I said, the men's health. So it was all part of that. It was based on community needs. I collect paperwork. Anyone who comes to any of my sessions has to fill out four pages. So we looked at a settings approach, which is the CFA, the schools, the workplaces. We based it around the GP practice and we looked at the national health priorities, and also very, very important was the local diabetes support group; you can't work without them.

New point of care technology which has created a lot of interest. We're remote, an hour drive, or a two hours drive to go and get a blood test. We weren't going to have any of that. So we have taken on the new point of care technology and we have the people responsible sitting in the front here – is screening tools, Q and A support, all this very – not used a lot by remote health services, but we did it. There's the team from Flinders University that are here and there's resources that everyone is sitting on now, but you can follow them up. And we got them because they were very experienced in this area and all around Australia with some 60 Aboriginal sites. So our site was the first site – non-Indigenous site – to take on this sort of technology of screening.

So it was based on community driven outcomes and that was taken over, sessions we conducted in 2003 which indicated 78 per cent of those attending – and I'm talking about hundreds – cholesterol, blood pressure, diabetes, this is what they wanted to know about, this is what they wanted to do. And then in 2002, to further support that, these are the things that just one men's health night in a community of less than 300 where 120 men turned up by themselves, no wives there to pull them home early; we had it at the pub, so we were cool. And the wives didn't come because they knew someone was going to win a romantic dinner for two, so they left them there. So these are the things that we found out that the community wanted.

And then there was the community response to see that we were on track. It's from the doctor's surgery, the doctor's surgery have concentrated on the diagnosed diabetics. With the CFA, using them as the workplace setting, these were people who were being screened that we had no knowledge of what their condition was, and this is their response. These resources are over there too.

And in the doctor's surgery, this is the whole attitude towards this new way of dealing with them where it was a one-stop shop, they came to the practice. We sat in another room with our nursing staff, the diabetes educator, all our machines. Before those people left, they were fully diagnosed. They didn't have to wait for pathology tests, or anything like that. And they weren't allowed out of the room until we were happy that they were going to comply with the maintenance. We had revolving doors.

The CFA, they just responded beautifully to it, and they just wanted it more, as you heard from the CFA. We started it with the men's health program, we continued it for diabetes. So, the ongoing. 250 people walking 95 000 kilometres now, the new hospital exercise program, the new well-being program for war veterans, is all an outcome of this project. A new community health nurse service which we've never had before. Risk assessment each month. The screening in the GP practice and the appointment and training of a diabetes educator – our own diabetes educator. And the support of Flinders University ongoing which is still there 12 months after the project.

And of course the one I missed out was the Tennis for Blokes. Forty blokes played three seasons of tennis, so because they were on the court and they came off, we screened them. And the one they were talking about would have been a great loss to the community because he was a primary school teacher in his thirties. He had no idea of his cholesterol or diabetes history. It was terrible. He was at the GP the next day.

Barriers. Access to technology and training in remote areas is a big issue. Remoteness, staff and time restraints. Long-term commitment from management, not just while the project is there. They need to find the money before the project is over.

Regional support – as you know, we involved people right up in Mildura. Valuing project managers in the health system – you don't have to be a nurse to be a good project manager. Don't knock the people that aren't nurses. Overcoming old ways and behavioural change from the community and the health services, as we saw from those people, and the GPs; all this is very important. Key indicators – the RCDI team and their workshops had a huge impact on the way that we conducted the program.

The RCDI workshops were fantastic. Management, community needs, partnership with providers, doctors, etcetera, etcetera. Commitment to best practice, we employed – and it's cost us a few thousand dollars to employ Flinders, but we wouldn't be without it. Professional development training, and not to be scared of new technology, and that's the end. Do I have any time up my sleeve?

**DI WYATT:** You did all right, actually, Bernard. You stayed pretty well on time. You actually went for six and a half minutes. We all enjoyed Bernard. I'd like to introduce you to the second star of the show, and that is David Hayward from Texas. David was also the project manager for "Texas – A Healthy Town" project. David.

**DAVID HAYWARD:** Thanks, Di. I always seem to draw the short straw. I get stuck behind Bernard, which is a hard act follow. As Di said, I was the project officer in charge of the "Texas – A Healthy Town – hang on, I'll just bring it up and have a look at it. Our project basically looked at building capacity to increase physical activity and improve healthy eating habits, with a particular focus on partnerships.

The actual video you saw is fairly self-explanatory. The kid actually also contains a more extended version of those three sites. So I won't go into the details of the actual project as such, but look at more the key enablers and some of the lessons that we actually learn from the project. Most people would consider money to be the key enablers, as far as success in community-based projects.

However, you can achieve a lot with limited financial resources. And our experience with our project, in particular, found that some of the keys to success were a supporter sponsor – in our case, it was the Texas Multipurpose Health Service and the Southern Downs Health Service District. And in any case, it could be a local government or a local community organisation, but they need to be committed to achieving the goals and outcomes identified by the community and prepared to commit the human resources to project management. And sometimes this might mean actually reorienting some of the roles and responsibilities of their existing staff.

They also need to have realistic expectations of what can and can't be achieved for a project of this sort, and accept that engaging communities does take a lot of time. Projects may need to be planned in stages. And the sponsors also need to be prepared to support some ongoing work that builds on the success of the actual project.

The second one is credibility in the community. When you're choosing your project staff, you need to ensure they have a passion for the work and some established credibility in networks

within that community. It's very difficult to implement a project in a rural community if you don't have the trust and respect of that community. Country people can be very cautious of strangers coming into their community to implement a project. They're more accepting of someone who has existing community links and it listens and works with them to implement some strategies that suit their individual communities. I can't overstress this because it takes a long time to build up relationships in rural communities.

The last one, time. As Di intimated before, time is the most valuable resource in working in whole of community projects. Usually, a project funding goes to limited periods such as 12 months. If you're going to have some sustainable outcomes it's very difficult to achieve those in 12 months. It's generally too short, and you can spend all that time, actually, in the consultation and planning process. With the Texas project, we were lucky in that we'd actually been doing a physical activity project the 12 months prior to actually starting our Healthy Town project. And a lot of the consultation and networking had already been done. This allowed us to sort of piggy back on that work that had been done, and so we hit the ground running, and we probably achieved more in 12 months than we would normally have if we'd started from scratch.

Some of the lessons we actually learned. Rural community consultation is vital. Our work in our previous project, the Physical Activity project, identified – we had some concerns about how effective we were in actually consulting the whole community. We had done the usual public meetings, and focus groups, and surveys, and stuff like that. But we had doubts about how representative of the community – you know, the feedback we were actually getting.

Most of our meetings were reasonably well attended, but we seemed to be seeing the same faces every time. I think probably everyone can relate to that. So we reviewed some literature on community development and actually spoke to a lot of people who work in the field. And we held a community development workshop and we had it facilitated by an expert in the field, a fellow by the name of, Jim Cavay.

And after we had our workshop, it really made us think about the ways we actually engaged our community. As a result, we changed some of our strategies. Instead of expecting people to come to us, we looked at ways of actually how do we get out to where the people are? Now, there are dozens of regular meetings, informal and formal meetings every month in the communities. And what we did was actually seek invitations to those meetings with people and went along and discussed the project to gain their support and also some input as to where they wanted the actual project to go.

The second one – there are no barriers only challenges. By that, I don't mean there are actually no barriers in running these projects. It's more about using positive language when you're actually dealing with communities. You find that if you start identifying issues as barriers to some of these communities, they start to look for excuses why things can't work. So we choose to look at what the challenges are, and then concentrate on finding some local solutions. It's a much more positive approach and it focuses people on actually achieving some desired outcomes. It provides a lot of satisfaction when you actually overcome it and see a difficulty.

Just one example of that is our netball and also the touch football competitions in our town looked like falling over because of public liability insurance, which is a big issue. I think the insurance premiums were about \$3000, or something like that, and they were finding, you know, the subs for playing were going to be ridiculously high to actually get the public liability insurance. But a lot of the people that actually participated in that were also high school students.

So the P&C looked at it and said, “Well, we’ll approach our insurers and see whether or not we can run it as a fundraiser”, and they got permission to do that. It cost them an extra \$500 a year in their premiums. But they actually ran it as a fundraiser. People were able to play their netball and touch, and they actually ended up making about \$1500 over and above their \$500 in funds for the P&C, so it was a win-win situation for both people. That’s just a good example of how community organisations can work together to solve some problems.

Ownership equals sustainability; that’s stating the obvious. But when developing networks and partnerships, it’s important that the inputs are shared by everyone in that partnership. If you have one dominant partner, generally speaking, when they pull back on some of their contributions, it tends to fall over, so it’s very important that people actually have some investment in the actual project to make it work.

So the program is actually, as I say, you know, sometimes they do need assistance to get up and running, but what you’ve got to do is be very careful that you don’t actually take over. That doesn’t mean to say from a health service point of view, we don’t actually run the particular programs; we do. But most of those are linked into other programs out in the community that are run by people.

Just in closing, I’ll be very brief. Working in communities for those who are actually thinking about doing some of these projects can be very rewarding but also, at times, it can be very frustrating when things don’t go wrong. So it’s important that you don’t throw your hands in the air and give up. If something does not turn out exactly how you think it should, analyse what went wrong and learn from the experience. And what we use as a motto in ours is, “Something is only a failure if you learn nothing from it.” So, there’s no such thing as a failure, only different degrees of success.

**DI WYATT:** Thank you. As you can see, there are lessons coming out from each of our speakers. There were nine specific projects funded within Indigenous communities as part of phase one of RCDI and we’re very privileged to have four of those who will now talk to you about their programs within their community. And the first one of those, indeed, is the one that you have already been introduced to in the video, and that is Galiwin’ku on Elcho Island. So it’s with great pleasure that I request, Djarti and Timmy to come up and talk about their project on Elcho.

**DJARTI:** Thanks a lot, visitors, sisters and brothers. First of all, I’d like to introduce Timmy. This is the guy that from his skills that he had taught by his father, his special skills of gardening, both for bush tucker and the Balanda Garden. I’d like to introduce Timmy to sort of show you what he does.

**TIMMY GALALINGU:** This is the island I’ve been grow up. My father just brought it to this world, because these is my world, and I’m part of this world. This is my dream about – that’s my dream, from my father, and that says on the calendar. So Steve will talk the rest of it, thank you.

**DJARTI:** That’s my grandson, his name is AJ, looks healthy. That’s me talking about showing some of the bush medicines for gum. That’s Timmy’s daughter and two kids, sons, in Tim’s backyard. And that’s Timmy showing some of your eye drop, bush medicine. That’s one of the spring water, a place called Turupu, where you saw on the first picture. And that’s the sacred Banyon Tree, you’re dreaming of Putarapi, spirit men, that is Turupu. That’s Timmy marrying with Tahepa.

**DJARTI:** Timmy, can you tell the audience what plant is that?

**TIMMY GALALINGU:** Well, that's my plants over there in the front yard. That's my wife and my kids. That's my house – little house. I've got chooks and hens on the other side.

**DJARTI:** That's the main street looking before some of the areas that where people these days is cleaning up now. That's the traditional owner and the chairman, Charles Yunupingu. That's Alfred. And that's Joanne Garngulkpuy and her father, Timothy. He's growing up his own garden too, Balanda Gardens, and also traditional bush tucker. That's one of them, pandanus, the roots that we use for toothache. And that's Joanne's father's banana gardens that he's been planting and growing. And that's my daughter Salina making flour damper, so that's handmade. That's me talking with my uncle Richard. He was talking about the garden. That's my home. That's my garden all around. That's my wife, my wife's sister, my grandson. That's one of the – a few of the bush traditional nuts, fruit.

So I'll tell you a little bit, the population of Elcho is about 80 K north-west from Gove Nhulunbuy, as you probably know, one of the mining – bauxite mining town. And there's about 1500 people now, but back in the missionary times when people lived at one place – now they've gone back to their homelands – it was about 3000 people, but they have shifted back to their homelands. So I'd like to thank Di Wyatt and some of the teams that we've worked together, all the teams, and Di Wyatt. Thanking Menzies School of Health in Darwin. And of course, Commonwealth, Canberra, for supporting my project. Thank you, very much.

**DI WYATT:** As you can see, Elcho Island is extremely beautiful and it didn't take much to entice us to go back and visit there a couple of times with this program. As I said, Thursday Island can't be with us because of the difficulties. But perhaps if Liz does a little quick snapshot – sorry, we're doing Collie. So Beth and James then, would you please come up and join us and talk to us about your project in Collie. Come on, James, up you get.

**BETH:** Now, I know we're not the shining light of these RCDI projects, but you really didn't need to overlook us like that. Okay, our project.

**JAMES:** [Aboriginal language] that's what it means there, your happiness.

**BETH:** Our aim was to work with the local people in partnership to promote strong and connected community. Collie is about 200 Ks south-east of Perth with a population close to 8500 and at the last census, 245 Indigenous people. The economy relies on farming, mining and power generation. This is our advisory group. When I first came to the project, a number of people on the group from the actual Aboriginal community were only about four regularly and we managed to fill that up quite a bit, and went and celebrated Christmas that year with the division. Our barriers, well, we had loads of them, and you can call them challenges or whatever you like but, hey, I don't care really.

We started off the project with an Aboriginal health worker and she gave up and went home, basically, and that was really a reflection of the apathy in the community. They are really a hard crowd to work with and, you know, like, they don't even turn up for their own NAIDOC celebrations, so it's not just about health, like, they're not just avoiding their health.

**JAMES:** I'm in that community.

**BETH:** We had relationship issues between different families as well. So if you put on an activity and one particular family was coming, then you could count out the rest, and that sort of thing happened a lot. And then there were closer people, like, they all put their name down the list, and then a couple of days later, they've changed their mind. And once one changed their minds, several others did, so you ended up with next to no one again.

We also had a lot of deaths in the community throughout the project and this just really impacted on our momentum in being able to continue to put on the activities. And we also had difficulties employing suitable co-workers as well. It took six months — James was working with me the whole time — but it took him six months to wake up to the fact that he could actually get paid for it.

**JAMES:** You didn't tell me a thing.

**BETH:** You lie. The enablers — being an outsider was actually a plus for me, because I didn't have history with the town which is a significant thing.

**JAMES:** See how I look after you.

**BETH:** Okay, that's enough. So the advisory group were telling us at the start that Collie was a very racist community, and that's probably a fair statement. But when you walk around town with James, he knows everyone, black, white, or otherwise, and it takes forever to get through them all because everyone wants to stop and say hello. So we had to really think about that, and I realised that it was probably more about projecting a positive image rather than actual racist overtones.

So we went off to the Collie Show with a group from the CDEP to display their art and craft. And from that, they actually saw that people were interested in what they were producing and they got some sales out of that. So it wasn't really anything to do with their chronic disease, but we really had to help them improve their own self-image and sense of worth in the community.

The Christmas pageant was another successful — we had two people from the advisory group who actually took that on and organised the whole thing themselves. We just supplied the money and, what not, for the decorations, etcetera. And I got a phone call the day after the pageant from one very excited young lady who said, "They actually applauded us, it was amazing." So those sorts of things were actually really big for those people involved.

Then we just had a range of different activities to try and get people involved because we never had the same group of people turn up. There were always, maybe one or two the same and three or four others that we hadn't seen before. So it was really hard to get an idea of who we were actually working with and helping. But we just left the door open, did quite a few different things there.

And the biggest enabler of all is actually a you beaut new Holden ute, because the day I turned up into town and went to visit James, he was just so impressed with the ute, that was the end of it. So I had a new best buddy and we worked very well together, and it was really, really important to have his local knowledge and the local relationships because that counteracted with me being not from the community.

I've just got some pictures here of people enjoying our activities and getting a bit of traditional bush knowledge there and, of course, the belly dancing was a raging success. The lady there in pink, Di Davies, is actually the alcohol and tobacco worker at the hospital, and she's one of the ongoing relationships that we managed to develop through the project, so that's one success, please note — yeah, okay, and us.

**DI WYATT :** I think you might have to describe — the other relationship out of this was these two.

**BETH:** Okay, so he followed me home, big deal.

**JAMES:** You followed me.

**BETH:** No, I didn't tell you about that because a month later, you went missing, and I'm not going to tell you what I'm driving now, but it worked.

**JAMES:** At least we sit .....

**BETH:** Yes, okay, that's enough. So really the lessons, I guess, with Collie, it is a tough town, and when I told people that I was going to work there, they said, "You're mad. Don't bother going there. We've been trying to work with those black fellas up there for years and they just don't care. They don't want to do anything." So I went. Well, why wouldn't you? But it's really about taking time to build those relationships and with one year funding, you really can't do that. And I think with our project, we need to really think about funding and get a lot smarter and maybe a little entrepreneurial and involve the industry, and stuff, in town and just to help continue that support.

That's our motto. It actually came from him because there are a few very dedicated people in town, but it's really about the finding the way to go about doing it and, basically, that's where we're at. You know, like, you can think about project, in terms of planting seeds, but I really only think that we prepared the grounds. We didn't actually get to plant much of anything. So yes, that's us, thank you.

**DI WYATT:** I was going to leave that little announcement till last, but you gave me the perfect one. I was going to say that the one big success that everyone around Australia involved with the project has been celebrating is the wonderful partnership between these two. As I said ...

**JAMES:** You'll have to get a drink of water now.

**DI WYATT:** Okay, thank you for that, that's just wonderful. As I said, we're just going to — before I forgot Collie, so I'll never be forgiven for that, will I? But the next one is, indeed, Thursday Island, and I'd like Liz to give you a just quick overview of what the Commonwealth understood as the objectives of that project, and then I'll just give you a quick overview of what you observed when we were there.

**LIZ:** I think Thursday Island did actually send some slides, and I'll think I'll just fit through those photos. The Torres Strait was a different project in that it was about providing training for Aboriginal health workers on all of the islands outside of Thursday Island around the prevention and management of diabetes. They brought in trainers into Thursday Island and provided training for a number of community representatives and health workers, so that they could ensure that they could address diabetes at home rather than when it became acute and they had to ship people over to Thursday Island. That was pretty much it.

**DI WYATT:** When we went up, Marlene and I spent some time on Thursday Island. What we felt were the major enablers of the project were that they had integrated this project into their overall service planning, so it was already an integrated part of what they were doing. And they had ensured that they had strong partnerships, both within the health services within the communities and with the diabetes educators in Cairns who provided them with the first skills development. I think the major outcome of the project, indeed, was the capacity building and skill development that you do now have people on each of these tiny little islands who have got increased skills and knowledge in prevention and management of chronic disease.

I think there were some barriers to this program and, probably, the major one is distance, the isolation, and that really does need to be taken into account. There were some difficulties with their reporting and with understanding what was going on with the program until we actually sort of went out there. But whatever you do within those areas, distance is going to be a disadvantage..

**FEMALE SPEAKER:** Excuse me, I'm from Thursday Island. I wrote the ...(inaudible)... at the hospital and I could probably comment on at least some of the pictures ...(inaudible)...

**DI WYATT:** Fine, would you like to come up and give us a little bit of an intro?

**FEMALE SPEAKER:** I'm a bit of a reluctant speaker.

**DI WYATT:** No, that's fine, if you take us through and so people can actually get to know, because again also Thursday Island is a very beautiful island.

**FEMALE SPEAKER:** It is. I suppose it is really important to remember it's 15 islands, and Thursday Island is the nucleus, and that's where the hospital is based and it's servicing a really wide area. And to ship patients in, it's a logistic nightmare really, because you're relying on planes, on helicopter, on four wheel drives, dinghies, all sorts of transport that have to be co-ordinated to get that person into the hospital. So it's really important that health workers out in the communities have got as much knowledge as possible, and not just knowledge, but as much confidence, I suppose, to deliver a service.

You might have the knowledge, but it's difficult to get that out into the community. You have to have really good rapport with all the people in your community. And I think that's one of the main reasons why your project is so important, is to actually give people a little bit more confidence so that they can pass on information to their community.

Some of the communities only have 200 people, and then Thursday Island itself is 3000. So yes, there's all sorts of dynamics within each island, and each island has been treated as a very unique place for its unique culture. That's the main beach right there. You're looking over at Prince of Wales Island over there, and Horn Island over here, which is the island that you come in on to, then you catch a boat to get over to Thursday Island. If you come to the panel on Sunday, there's — I've got a little map.

That's the main street, the Federal Hotel, down here is the hospital right down the end there, that's only through the wet season right now. That's the main beach. Obviously, up here, fishing is a very big thing, and a very big part of the diet, all those dugong and turtles. That's the Royal Hotel. That's also the disco, that's also where there's a lot of — you don't want to go there at 2 o'clock at night. And that's down near the wharf.

**DI WYATT:** Has anybody got any questions, in particular?

**FEMALE SPEAKER:** I think we'd leave it to the panel.

**DI WYATT:** Thank you for doing such a wonderful job, and with the panel, I'm sure that we'll direct some questions to you. The last of the Indigenous projects to present to you today is, the project from Kempsey and Taree which is a multi-sighted project, so if Jo and Janine can come and join us and talk about their project.

**JOSEPHINE:** Our project is the — what we now call generally the Many Rivers Diabetes Prevention project. As we'll explain, there's a number of communities involved. Each location will, inevitably, provide their own name, but for the sake of presentation and discussion, that's the name at present. Janine, from Biripi at Taree, and myself, from the University of Newcastle, an occupational therapist as well, will be presenting our project to you.

**JANINE:** This was a program with an initiative or Durri Aboriginal Medical Centre in Kempsey due to the large numbers of people presenting to their medical service being diagnosed with diabetes. Also collaboration of University of Newcastle, Biripi Medical Centre is where I work, and a ..... nurse in Newcastle.

**JOSEPHINE:** The project had basically its seed funding through the Commonwealth and the Commonwealth showed great, I think, faith and breadth of mind in funding this project which is actually a project of research and development, which is quite different from some of the other projects you've heard about. Building upon that, we've received funding from other sources. I guess it's probably useful to give you this overview of the project as it's developed. We're taking a very longitudinal look at development, and the phases are up there on the board. We can discuss those in the panel.

Thus far, we've conducted community profile. We've looked at sharing groups, so we're looking at a prevention program that's aimed at kids. And we've talked to over three communities – Kempsey, Taree and Newcastle – 270 kids in focus groups. About 40 per cent of those kids were Aboriginal kids. We're talking to their parents – we're putting a lot of effort into talking with parents – and community members about physical activity and food habits, which are the determinants that are set in place very early, and are things that the communities are concerned about need to be remediated and attended to early on.

So this year, we're looking at validating surveys or questionnaires in food and physical activity for Aboriginal children. This is the first time this has been done in Australia, so we're embarking on that this year. And all the way through, gathering ideas to develop a program to trial, we hope, with funding that will happen in the next two years.

**JANINE:** These are key points for success: community initiative, concern, community support, which is really important, flexible funding support, team members from within the community, like the team members I work with, like from ..... and Durrie, they're great. We network all the time. We communicate and getting ideas from one another. What's working for us? What's not working? Keep community informed, so keep them up-to-date with what's going on.

**JOSEPHINE:** The lessons learned from the project so far are reiterated by the other projects. It's really important to allow time for the development phase and, I guess, we're looking at, particularly a project like this which has a long range view, it's just so important to spend the time and it's so necessary with Aboriginal communities to get community engagement and trust. Communities have a great deal of suspicion around anything to do with research, naturally, given the history of research projects in Australia. So that all has to be well and solid before you kick off.

One year funding being unrealistic which, I think, other projects have said allowing time for something like this, for grant applications and a fixed process. It's a huge one, a very important one, and it has to go through a couple of different processes, including the Aboriginal Health and Medical Research Council, and it takes time and it's important to do. And it's got to be acknowledged, in terms of timeframes of funding that it takes time to do that, it doesn't just happen overnight. A team member who is known to the community, and commitment at all levels which, I think, Bernard was also saying.

**JANINE:** Data ownership. We have a memo of understanding. We also have a steering committee which is made up of our CO from Biripi, CO of ..... and a CO of Durri, and also Michael Booth, Professor Wayne Smith and the University of Newcastle. All our data is stored under Uni Ethics Committee rules, then released to our communities after five years. Anonymity and confidentiality.

**JOSEPHINE:** We're embarking on writing some of this stuff up as well, The results from the focus group and also a newsletter out to communities about what we've found so far. And that's it, thank you.

**DI WYATT:** Okay, that is the presentations from the projects. . We're just going to change the format a bit now because we've got a very big group in the room, so we are going to hear from Liz Cotton from the Commonwealth Government now who will talk about the new project and then we will open it up for some discussion with the projects, and we will finish it there. So I would like to welcome to the microphone, Liz Cotton, from the Commonwealth Department of Health and Ageing who has had the management of this project within that organisation. Welcome, Liz.

**LIZ COTTON:** The funding for the Rural Chronic Disease Initiative was between the years 2000 and 2004, so the actual program finished in June of last year where we actually launched the resource kit, based on the learnings of all these projects. One of the things that happened, as the RCDI drew to a close, was that we undertook an internal evaluation of the program so that we could see whether or not there was a case to try and persuade the government to continue its funding. And in the last budget, we got a further four years funding in a slightly different format in that the focus was slightly shifted – can you hear me?

So the focus was slightly shifted in that we were now to concentrate the program into remote areas, as opposed to rural and remote areas. And that we were also to, actually, have specific risk factors that we were trying to address with the program.

So we are re-branding the Rural Chronic Disease Initiative and it's now building healthy communities in remote Australia, and these are going to be our aims that we are trying to continue to find local answers to local health problems but, specifically focusing on injury, on smoking, harmful alcohol consumption, healthy weight and nutrition, increasing physical activity, and we slipped another one in for healthy lifestyle so that that allows us to broaden the scope so that sort of activities like the Collie project of getting involved in things like, pageants, and the like, whereby you can actually start to break down some of the barriers that exist, that can then take you on to the next stage.

So, as I said, we are continuing with a very, very similar sort of focus for the RCDI in that the projects are going to continue to be preventive health projects, that they're very much about lifestyle behaviour change and that they are community driven. And again, we continue that the lifestyle changes are happening through provision of information that we're about creating activities within communities. And we're also very much about building up skills within those communities because given the short-term nature of the funding that we will always be giving, we have to try and build sustainability into some of those projects.

With the RCDI, as Di has already said, these were the key findings, and what we want to do is try and build these new projects on from there. And what we're doing is we've recognised that obviously one year funding, particularly undertaken through a competitive process where you say, "Everybody starts February the 15th. You've signed your funding agreement, you've got one year and everything finishes", doesn't quite work like that actually out on the ground.

So what we're doing is we are supporting projects to undertake the community consultation and project planning. We're also giving them some support in, actually – that's my next slide – no, it's not, somebody's turned my slides around – sorry, we are changing how we're choosing the projects. We have identified the direction that we're going to take the program is that we're going to be working with remote communities, in communities that are identified as having a high need. And also communities have low capacity.

Now, most of the people who are sitting here actually put in grant applications. We had 125 of them, and we chose 19. And then there was another competitive process for another group. If this is going to be our criteria, a competitive grants process will be a disaster. So rather, we're actually identifying communities by working with local government and other stakeholders,

and then approaching communities to see whether or not they are interested in participating in this program. We're offering a three stage sort of development for the project which hopefully will allow a little bit more flexibility and give the projects a bit more time to really get themselves established. A project planning period, which is not necessarily defined right at the outset.

Some communities, they know what they want, it's not going to take them much time to actually put together their plan. They may even already have it in the bottom drawer. Other communities need six months or longer to actually develop the relationships that they need to actually get the project to be up and running. Given the nature of the remoteness of some of the communities, we are also building in time the actual recruitment and project staff. In some areas, it took six months for them to actually get somebody on board. Again, we are actively encouraging the project to recruit somebody local or somebody with a very close local connection. However, as Collie again has demonstrated, actually sometimes there may be an advantage of bringing somebody in who isn't a part of that community.

And then, finally the person is in situ, and hopefully they're ready to go. We are giving two years of funding for the actual program. Everybody will say, "It's not long enough", but we have four years of funding, so that just allows us to bring on enough projects, hopefully, to get – we're aiming for between 40 and 50 projects to be implemented during this period.

Where are we at the moment? We are currently advertising for a consultant to undertake an evaluation of this program. We believe that we really need to get some evidence so that we can show that this sort of model actually works, is cost effective and perhaps can go beyond a four year cycle of funding, so if we can actually demonstrate that this is the direction that we should be taking.

One of the things that came out of the RCDI is that some communities felt they were rather overwhelmed by consultants. At one point, we had an evaluation consultant out there. We had the Monash team. We had an evaluation team also who were contributing to the tool kit. And everybody went, "This is just too much." So we just want to have one consultant and their job is to evaluate the program to give the project the skills that they need to undertake the evaluation, and also to identify the skills gaps and training needs and mentoring needs of each particular project. We're hopeful that we'll get that person on board shortly after Easter, and hopefully they can just get going and do the job. We are currently entering into funding agreements with 10 projects.

Unfortunately, as yet yesterday I heard the first one had been signed and that's in Western Australia in the Upper Gascoyne area, but at the moment we're looking at having – the dark blue area is the area that we are looking at establishing projects in. So, as you can see, Tasmania and Victoria are excluded from the program. New South Wales, there are a few bits, but not many. And the vast majority are going to be in South Australia, WA, the NT and Queensland. Thank you.

**DI WYATT:** Thank you, very much. We're now going to go into a panel discussion. We'll have about 20 minutes for some discussion and responses.. So I'd like to introduce my colleague, Marlene Drysdale, who is going to lead the panel discussion. , My colleague Steve Kirkbright will take a microphone that side, and I'll take a microphone this side. So please feel free to address your questions.

**MARLENE DRYSDALE:** First of all, as an Indigenous person, I'd like to acknowledge the traditional owners, the Arrernte people of this area, and pay my respects to them. I'm going to run the panel in this way: firstly, I'll get you to put your hand up if you've got a question for anyone and if you could identify yourself, who you are, and where you're from, and also the

person that you'd like to direct your question to. So we may start from the floor right now. Anyone would like to ask anyone a question, please, don't be shy.

**FEMALE SPEAKER:** I'm from Esperance. I would like to ask the people from Collie if they know Esperance and would they think that something like that would work in Esperance? Do you know where Esperance is?

**LIZ COTTON** We do know where Esperance is. Well, it's very remote, but I'm not sure that it – is it in the blue bit? Yes, it would be. Yes, with time and planning, like, with the new set-up, I don't see any reason why it wouldn't be an effective approach. I don't know the issues and concerns that Esperance has, other than I do know that a short while ago it had a very high concern around suicide and issues of that nature, so yes, I think it would be worth a try.

**FEMALE SPEAKER:** We do have a new unit, health unit in Esperance, Aboriginal health unit, which I don't know how it's working or anything. But I'd like to, when I go back, go and see them and see if they think something like this would work.

**MALE SPEAKER:** Would that be a branch of Kalgoorlie?

**FEMALE SPEAKER :** Well, we're in the Kalgoorlie region, yes.

**MALE SPEAKER:** Yes, but that would be the medical service that ran from Kalgoorlie. And if they put up a structure to get this – what we're doing, I'm pretty sure ...

**FEMALE SPEAKER:** But where, in Kalgoorlie?

**MALE SPEAKER:** No, not in Kalgoorlie, where it's needed.

**FEMALE SPEAKER:** Where it's needed? Thank you.

**MALE SPEAKER:** Yes, like, if you've got a situation in Esperance ...

**FEMALE SPEAKER:** Go to Kalgoorlie?

**MALE SPEAKER:** No, don't go to Kalgoorlie. Try and get it set up in Esperance.

**FEMALE SPEAKER:** Yes, but Kalgoorlie needs it more than we do, I think, truly.

**ROBERT:** Robert from Tamworth Aboriginal Medical Service, the country capital of New South Wales, unfortunately. Who worked out the blue shading areas of funding and all that stuff? How was it worked out, I guess? Simple question.

**LIZ COTTON** We're using ARIA, which is the Accessibility of Remoteness Index of Australia, because we had to come up with something. This is a tool that identifies communities on there sort of – how accessible services are to communities. So the areas that we're looking at are the ones which are classified as being remote and very remote. We have to come up with something to start off with. Unfortunately, we could run these projects probably in every community, so we have to start somewhere, and this seemed to be the best tool for us to use.

**ROGER HUTTON:** Roger Hutton from Lower North Health Service in South Australia. I'm a retired doctor who was in general practice and then subsequently in specialist practice. And for the last 10 years, I worked in rural South Australia. And I wanted to address my comment to the Monash team and I want to congratulate them, first of all, in what they attempted and what they achieved and the communities that they worked with is a great story. But I have two concerns, and I'd like to hear their comments about these concerns.

One concern is that although they had enormous community involvement, it still essentially was a top down approach and it was disease-orientated. Now, that's the conventional way we pretty well approach health care. Where I am in South Australia, we are trying to turn that on its head. Diseases are, but in themselves, symptoms. What a lot of these projects don't reach is what are the underlying psycho-social causes that cause people to become ill. Why do they smoke? Why do they eat too much, etcetera, etcetera.

Now, what we're trying to do in South Australia is actually create a situation where the community takes ownership of the decision-making process in health care. We're setting up a forum of people from the community who have nothing to do with health care community, they're just from the community, and they are going to be trained to liaise with the rest of the community to find out what it is that that particular community feels are its particular problems, not just in so-called health, but in all the other social parameters that make up wellness or illness. And that they will become a voice that the various levels of service provision have to listen to right down – and I note the word “down” – to the Minister herself.

We're in the early stages of this and we're having a lot of, as you can imagine, resistance to this idea, particularly from health professionals who actually feel quite threatened by this approach because they feel that, “What can the community tell us about health care? We're the experts, we're trained.” But I would like to sort of put that up as another way of approaching this very difficult problem, particularly applicable to rural and remote Australia.

I think the Aboriginal people – and I've talked to them – they believe quite firmly that if they could have much greater ownership of their health services, they would be able to do better and the Aboriginal people in my area have said the same thing. So I would like us all to think that we ought to get away from this top down approach, that we can empower our communities to actually take a major role in the decision-making process of what health services are delivered, how they're delivered, what is appropriate, and what isn't appropriate, and perhaps start thinking deeper than just the conventional disease orientation.

**MARLENE DRYSDALE:** Thank you.

**MALE SPEAKER:** Can I make a comment on that?

**MARLENE DRYSDALE:** Maybe I'd like Di to firstly respond to that as part of the RCDI question. And then maybe, Bernard, you could take over from that. Josephine, a very quick response.

**JOSEPHINE:** Okay, a very, very quick response is that one of the major findings of our consultancy was, indeed, the need to encourage, or the most successful programs were those that were community-based, community-driven, that we actually developed within the community by the community addressing specific issues real to them. So what that has in actual fact – it was part of our recommendations to the Commonwealth and I think that they have in actual fact incorporated those into the new guidelines for building healthy communities. So I think there is support for the issues that you have in actual fact raised. Thank you for that.

**BERNARD DENNER:** In all my work, most people die of ignorance or embarrassment, especially men. And ignorance is, they don't know their sick. That school teacher was a fine example that we did our very important point of care testing which is part of the community. We provide the opportunity every month, or every three months, they turn up in remote areas.

And in Underbool, where the CFA are, that is a very remote area with less than 200 people, if we didn't turn up, we got a phone call, “Where are you?”, or in one instance, where they'd

forgotten we were there and no one had turned up, and the word went out and men and women were getting off tractors, and all sorts of places, to get there. This is a community approach. But with the diabetes, we actually provided an opportunity for people to realise that they had a diabetes risk factor, because they had no symptoms. And if you know, in rural health, if you're a rural person and you don't have a symptom, you don't want to waste the time of the doctor because he's too busy, he or she.

In our case, we were able to take that factor out of that and say, "Look, we've given you a point of care, best technology, pathology test in the field and we're saying that, "You are going to the doctor", and it is a lifestyle change. And all the things that happen in the community indicated that, so it is a very much community approach.

**MARLENE DRYSDALE :** Thank you, Bernard.

**MALE SPEAKER:** As a result of that exercise – and I'm not criticising what you achieved at all, I think it's great – as a result of that, has that community now got a much stronger voice in determining, not just diabetes, but what other health services are delivered to that community? Are they really listened to by the local health service, by the regional service, by the department, that's what I've been trying to say? Do they actually ...

**MALE SPEAKER:** By the local health service, most definitely. But I've got to say, in all due respect, who's sitting on my right, certainly, not by the Federal Government or the State Government, and certainly, by their local health service.

**MARLENE DRYSDALE :** Josephine.

**JOSEPHINE:** Yes, I just quickly wanted to say that we're endeavouring to address that method in a different way. With our project, we were asked, as Janine said, by the Aboriginal Medical Service to look at preventing children from growing up to get diabetes. And the first thing we wanted to do, and we spent some time doing this, is talking to the children, talking to the parents and now talking to the community about what they see is happening with food intake and physical activity and what they would like to see happen. And that's taking time to do that, to talk to lots of people in three different communities and build it up from there, and trying to put then structures and networks in place that would enable it to be very much community-driven by each community's identified needs.

**MARLENE DRYSDALE** Thanks, Josephine. There's a question over here.

**FEMALE SPEAKER:** One thing, sorry, because that's started something in my brain, it's interesting you say that you're changing it and then you have that list of injury and alcohol and everything like that which till sounds very diseased-based to me. But we had a brilliant presentation this morning which is all about the torch project and it was about a play and it was about going really down to the issues in each rural town and they spent eight months doing it, talking to the people and providing this play. And I bet that play had more health – it would have masses of health benefits. And I think we have a children's festival in Carnarvon and we don't mention anything to do with good food or good anything. We just don't mention any health messages.

But during that two weeks when the kids are doing what they're doing, they learn how to make their healthy snacks, so when they come in, and the mother or father isn't there, they can eat it. And we had a Big Brother tent, and we had all that. And once the people who were giving me money said, "How come we've got no health messages. You should have some health messages." You don't need health messages. So I'm just reiterating what he is saying, that there's art you can use, and there's lots of other messages you can have. I'm so glad you've

added the healthy community at the end, so that you can do some of the festival stuff that's going on in Collie.

But what I wanted to know is, what's happening, if you say the money's run out, have they got another year in Collie and in other places now, this group, or do they have to apply into the next group?

**MARLENE DRYSDALE :** Well, maybe I'll ask Liz to answer that question.

**LIZ COTTON:** Well, as I said, we are not having a competitive process where people apply to us. We have established new criteria which, unfortunately, will rule out Collie because they wouldn't actually classify it as being remote or, very remote. However, some of the other projects that were funded previously, we are currently considering.

**MARISSA:** ...(inaudible)...

**FEMALE SPEAKER:** Hey, go, Marissa.

**BERNARD DENNER:** Victoria misses out completely.

**BETH:** Can I just make a comment? We didn't use specific health messages once I came on board with the project because it was quite clear, from the state of the community, that their basic needs weren't being met, so they really didn't give a hoot what their sugar level was, or anything else of that nature. And that's why I broadened the approach and did the community-based or community development stuff, because it allowed them to find some sense of their own worth because they really don't have that value within themselves which is – it's a really sad thing and it's a really hard thing to work with.

So while I'd love to go back to Collie at some stage, I'm kind of glad that I'm not just, at the moment, because I am – other than to visit James – but I am completely worn out from that project because of the – just, you know, having to motivate yourself every day to go up the hill and have those expectations, but then to have to throw them out when you got there because you knew you were going to be damned disappointed and not want to come back the next day if you held on to them. So it's a very draining process in a community like Collie as well.

**MARLENE DRYSDALE :** Just to keep it on track, there's a few questions out there. There's one here, and there's one over here, and then I'll come back to – we've got one, two and three, and the third one will be the last one sorry.

**JANE GREASON:** I'm Jane Greason. I just wanted to comment on ARIA, which isn't a measure of access, although it's called that. It's a measure of distance. It's a geographic information system. It doesn't look at burden of disease. It doesn't look at access to transport. It doesn't look at socio-economic factors. It causes serious issues when it's used as a specific measure to distribute resources.

The Department of Health and Ageing is actually reviewing them and has put out two projects for tender now. The proposal is to have some kind of new measure of remoteness and ruralness, or access. I don't know what the department is going to produce, but I understand that it will add to distance. It will add in socio-economic issues and burden of disease. And it would be terrific if this could be linked to that, that stage.

**LIZ COTTON** Unfortunately, we are looking to establish projects now. So when we were actually developing the criteria, one of the things that we, specifically, had to focus on remote. So this was one of the tools that we're using, it's not the only tool that we're using because, obviously, there are a few – a rare few – communities in remote areas that are very

prosperous, you know, some of the mining communities. However, outside of that, we are looking at socio-economic factors, rates of unemployment, numbers of Indigenous people within the community, burden of disease, all of those things. And the way that we're actually identifying the communities is by having a very broad picture of where that community stands and trying to ...

**FEMALE SPEAKER:** The problem is the initial exclusion.

**LIZ COTTON :** Yes. Well, we have to start somewhere. If we get new resources that we can use, then we will very likely be using those. But, for the moment, we're using this.

**MARLENE DRYSDALE** A question over here.

**IVAN LYN:** Ivan Lyn from Geraldton in Western Australia. My question is sort of more a nuts and bolts sort of question. I guess, things like physical activity and healthy eating, those sort of things, are traditionally the role that a lot of allied health people play. So I'm sort of interested of which of these projects utilises the services of allied health people, like physios for physical activity, dietitians, these sort of things. And if so, how did that go, and are there any suggestions for the way allied health are involved in these sort of projects, based on your experience?

**MARLENE DRYSDALE :** Bernard.

**BERNARD DENNER:** With our diabetes program, I might that I agree with plays and various things, but never ever underestimate when you've got 250 people walk in, it's not just their health, it's their well-being, it's the socialisation, it has a huge impact, and most of those people who walk in probably haven't done the diabetes .... walk in. So involving the whole community, from the diabetics point of view, we have a one stop shop using the new technology, and it's all sitting over there on the table, I hope it survived, so you can take it as you go.

But they came into a room at the doctor's practice where all the primary health care team were available before that person left the building. So if they lived an hour or two hours' drive away, they didn't have to come back, they were fully diagnosed and they might have been sent down the corridor to the podiatrist, to the dietitian, the physio, it was all there.

And on that day, once a month, every month, the allied health team knew they had to be there and they knew that they had time in their sheet to actually see the clients who were pre-booked for us to see. So it's very, very achievable and a lot more fun for the allied health because they were dealing with people who not just weren't sick, but just needed some maintenance and some help in the future. So it's a good way to go. They get a sense of purpose.

**FEMALE SPEAKER:** On our camp we had – the women's camp – we took out a massage therapist, Di, the alcohol and tobacco worker at the hospital and a couple of Aboriginal health workers and the belly dance instructor, and we did all that kind of stuff at the camp. And I know that the ladies, although there were only a few, they have been back and made contact with those people since then, so that sort of stuff is going on in Collie, you know. We were very conscious of those kind of relationships, and also with the local rep centre and the PCYC, those relationships are also still going quite strong in town.

**MARLENE DRYSDALE** One more question, Di, over that way.

**MILLIE PEARCE:** Millie Pearce from Hunter New England Area Health based in Moree. I've actually been working on a program that's just about to finish. It's been a six month program – nutrition, education and cooking classes with young Aboriginal mums. And it's been a

fabulous experience. But the thing I wanted to bring up is the lack of opportunities to continue programs. I think that communities often feel betrayed that there's no continuity to programs. People come in and often they're movers and shakers and try and get healthy community programs going, and then after a year or even six months, they drop off the face of the earth and I think that's really hard on the community.

And it's also hard for the next person who comes along, if there is any additional grants in the community, the next person who comes along has to deal with that community who probably feels quite hurt that they've had this loss of services. So is the Commonwealth Government addressing any – maybe looking at sustainability, looking at giving longer grants rather than the short-term grants?

**LIZ COTTON** Obviously, it's a major issue for all projects. And one of the things that we are trying – one of the RCD projects, though it's not here – I remember when we had a workshop, they said that – I'm trying to remember exactly what they said now. What did Jo say? It was about, you know, the project actually starts the day the funding finishes.

And actually trying to get – I think we need to be working with a project to say, "Okay, we have a limited amount of money, therefore we have to set realistic objectives and we've got to look at actually what this project is going to leave in the community once the funding is finished." And it's about trying to give the skills to people within the community so that they can actually continue those activities. So that if you were running a cooking program, make sure that somebody is learning those skills so they can teach their peers.

Breadmaking, ideally, getting project workers who are from the community so that they make what they're doing an everyday part of life. It's very unlikely that there is ever going to be unlimited funding for projects like this, so what we've got to do is start off by making very, very simple changes that become something that becomes part of everyday life, and that's what we're trying to do with these projects. So, if you look at the sort of work that Timmy is doing, by actually bringing back fresh fruit and vegetables and getting the community to feel it's their place and make that into something that happens when the money stopped and, hopefully, they'll carry on the gardening, they'll carry on looking after the environment around them, that's what we're aiming for.

**BERNARD DENNER:** Can I just add on that, is value add to what money you get. When you get money for this, value add to what is there. If you start up something new, and you can't sustain it in the community, it will go. But value add. When you get some money from the Commonwealth or the state, ring up your local council and say, "You can be a partner of ours", and they will give you some money. But value add, because the money runs out very quickly, six months, three months, 12 months, all gone. So value add it into the community, build up those partnerships and it won't go; it will be there afterwards.

**MARLENE DRYSDALE** Thank you, Bernard. Just to sum up a few comments that have come from the floor, I think there's a few cautionary notes that have come through, and I've heard them loud and clear, and one of them is that whenever the Commonwealth is funding these projects, to make sure it's built from the ground up and it's community controlled and that people have an input, and that way it will prosper and grow.

The second point is about where you're doing your selection, you can hear that people are feeling nervous about the demographics of the projects and how selection occurs, and I think that's a very clear message back to the Commonwealth.

I also hear from everybody on this table that there's a high level of burnout within the projects themselves, and a lot of that is about running. It's about continually chasing around that wheel.

And it's very clear what Collie said, that the timeframe is not fitting the projects. And I think even if we take those three points away, we've made some sort of start to a change. I thank you all for contributing today, and particularly the guys on the table here that have been part of the project, and I'd ask you to join me in thanking them very much.

**DI WYATT** And yes, I would just also like to also extend my thanks to you for participating and for my colleagues coming today. Thank you.

