



International Indicators of Good Health Practice for Remote Areas

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1996 ABC Rural Woman of the Year
and Chairman of the Board of Savannah Systems Pty Ltd**

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If one looks at rangeland Australia or the remote bush from the global perspective, a social, economic and geographical pattern emerges in common with many other countries which are often referred to as 'Third World'.

In both there is a physical or geographical remoteness from the decision making centres and major population centres.

Culturally and historically the people are different: their dreams, aspirations, their ceremonies, their reason to be are all different.

People in those areas have little influence on the decisions and laws that govern their lives.

Infrastructure is poorly developed, and often not suitable; their economic base is not fully developed; there are fewer services and inferior communications systems; health problems are more common; morbidity rates are higher and education standards lower. The differences with their major population centres go on.

Put in those terms the problem seems to have an obvious solution: more money and more people make better results.

To find out how many more are needed, a consultant comes and speaks with the people. Normally they speak only to the people who are available during the working week, who speak the same language as the consultant and who are reachable in the town. The consultant is told that more money and more people are required to fix the problem.

This means that the consultant never did speak to the people who had the problem. Of course, the consultant arrived at the wrong conclusion and made the wrong recommendations.

The reality is that the real problem was never addressed.

What was needed was communication between the people who had the problem and the service providers. To achieve this a dialogue was needed which was cross-cultural, and which clearly identified the problem and what could be done to resolve it.

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We need to recognise that all too often existing services are inappropriate and without innovation and modification will not provide the means for effectively addressing the needs of communities.

Unless service providers have an open mind, really listen to people in the communities with whom they are dealing and provide services which are consistent with the culture of those communities, they will fail.

In the end communities must be given not only sufficient information to decide between the service options available to them but they must also be empowered to decide on how and by whom their services will be provided.

Eventually, communities will themselves design and provide many of the services required to meet their particular needs.

The gap.

The challenge.

The Himalaya Good Health Clinic was set up in 1977 at the invitation of the community of State-less people that it was to serve. They were refugees who had settled into an environment and culture that was foreign to their experience, after being ousted from their own. Their leaders were desperate.

Health problems that they had not suffered before as a people had reduced their numbers to less than half. Alcoholism was on the rise; there was also violence, diabetes, tuberculosis, pulmonary disease, dysentery, skin disease, parasites, psychosis and immune system breakdown.

I went knowing little of their culture, only that it was different from my own, and from any I had experienced in the bush of Australia, the slums of Manchester, England or the desert of Saudi Arabia. They were nomadic people who had settled as a community, whose population ranged between 300 and 800 people depending on the season and the cultural obligations.

For three years I worked with the Himalayan community. During that time their health improved dramatically. While I treated their parasites, showed them how to balance their nutrition with the new foods, trained people in their community in various levels of health care, and showed them how to bridge the gap between western culture, local culture and their own so as to access available health care, it became obvious that their primary problems were due to the stress of being culturally dislocated.

The stress caused upsets to their nutrient uptake, particularly the b complex vitamins, which further spiralled them into classic symptoms of dysentery, skin disease, paranoid schizophrenia (in severe cases), healing problems, immune system fragility, and social problems.

Once this cycle was relieved, and with the collaboration of their traditional cultural mentors, their society began to mend. Their nutrition improved, their health improved, their dealing with the new requirements of hygiene improved.

This was reflected in the children's capacity to learn, the women's management of their families and the industry with which the community progressed. Other people worked with them in developing their skills for enterprise using skills which existed in their tradition.

After 3 years I left the clinic to the community. It still exists, as does the community's good health, but their way of running it and the total system have evolved to what is culturally appropriate to them.

They took it for themselves and can now, within their system, deal with the challenges they face.

Many of the ways the community developed with my help to solve the cultural differences would look strange in an anglo society, but there it worked. The importance was that it was relevant enough for the community to feel empowered to evolve their own ways to adapt to the new life.

I should explain that what I have just described was achieved at a cost of only \$10,000 over three years for a population varying between 300 and 800 depending upon the season.

The outcomes were achieved by selecting the areas which would have the biggest pay back, both immediately and in the long term, and which empowered the community to take charge of their own affairs.

I am sure it will not have escaped your attention that my example shows that it is not necessary to have large sums of money or large numbers of people to get results, make a real difference and enable communities to assume a strong, positive approach to the future.

After that time in the Himalayas, I worked in central America and the Pacific. I saw similar challenges, from similar causes. It was no different when I returned to bush Australia.

Our approach needs to be to health, not to ill health. It has to be culturally relevant. It must address the root causes of the cessation of good health.

Unless these principles apply, it will result in a band-aid approach to treating specific illnesses, rather than in ways of preventing the causes of illness.