Laramba Family Wellness Model: Integration, Sustainability and Transferability

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INTRODUCTION

The National Heart Foundation (NHF), Territory Health Services (THS) and the Laramba Community have developed a Laramba Family Wellness Model. The current NHF funded project, which includes a full time project officer will cease in December 2000. Strategies to achieve sustainability through integration and support by mainstream health and other services together with community control are presented with an outline of some issues to be considered for transferability to other communities.

BACKGROUND AND OVERVIEW

Initially the Laramba Family Wellness project focused on improved management of diabetes and nutrition through appropriate treatment and education, but has evolved to a comprehensive model of primary health care (PHC). The model has encouraged an environment of collaboration, mutual respect and understanding for the development of healthy communities and improved treatment and prevention of chronic disease. Further, the project has developed a sense of community ownership and control through increasing community involvement in needs assessment, planning, resource allocation, service delivery and evaluation. A range of inter and intra sectoral health promotion/education interventions have been developed within this environment. As well as a community development, primary prevention focus, this model also has a clinical and secondary prevention component that is supported by visiting health specialists.

Within the community, the community council, school, women’s centre and store have all been active in the project. Many of these initiatives are now supported and largely managed by the community.

The Centre for Remote Health is contracted to monitor and evaluate the project and has utilised a participatory action research approach to monitor and evaluate the program. Interim evaluation reports have been communicated to community leaders and to the technical advisory group of the project, which consists of district and regional health managers and providers. The interim evaluation is demonstrating positive outcomes through increasing levels of community involvement and leadership.1

The active engagement of the steering committee and the community in the project has resulted in a refocusing of the original objectives to include areas of priority identified by the community. It has also assisted in broadening the original scope of the project.
INTEGRATION AND SUSTAINABILITY

Involvement of community and local health staff

A vital component of integrating project activities into mainstream services is to ensure that the local health staff and community are involved from the beginning. A strength of the Laramba project is that it emanated in the first instance from consultation of THS staff with the local community. At this time the community indicated that they wished to have a higher level of understanding of diabetes and risk factors and improved health care. One of the key components was that the health care services and interventions should be undertaken with the local community. The original proposal initiated by THS staff, was to develop a community-based diabetes education program for the improved management of diabetes. The aim was to provide a remote community with access to a service equivalent to that provided by an urban diabetes education centre, to ensure that local staff have the knowledge and skills for risk factor identification and intervention, and the management of diabetes through an “… holistic co-ordinated community empowerment approach”\(^2\). This proposal was not funded by THS. Following further consultation and development of the idea with the community and THS, the NHF funded the project as a demonstration project which commenced in February 1999.

Prior to the commencement a series of discussion had been undertaken with THS managers and clinical staff, including the staff based at Laramba. A workshop was held in Alice Springs in December 1998 at which all the key stakeholders discussed the proposal. As a result of the workshop a technical advisory group and an evaluation group was convened. Both these groups had representatives from THS, the project team, the evaluating team and the community steering group. The initial and ongoing involvement of these groups is a key component of integration and sustainability.

Prior to the commencement and in the early stage of the project there was cautious support from THS’ managers. This ranged from enthusiasm to concern that the project would result in increased costs for THS. However as the project has developed many of the fears have been allayed and support for the concept has grown.

Development of activities

The development of the project, and the involvement of the community, THS and other organisations has been commensurate with increasing the levels of trust and co-operative working relationships.

The original project focused on providing optimal clinical care for people with diabetes through community-based interventions in the store; ensuring a wider range of healthy food choices which are identified by “shelf talkers”; school activities around physical activity and good nutrition; women’s cooking sessions; men’s and women’s hunting and two way cultural sharing with non-Aboriginal staff; community garden and youth employment and training program; sports days; health promotion including care of white goods; screening for disease in conjunction with the clinic; best practice disease management through adherence to the Central Australian Rural Practitioners Association (CARPA) Standard Treatment Manual\(^3\); specialist visits (physician, podiatrist, diabetes educator); men’s, women’s and family education and activity days. The support of THS staff and the high degree of community involvement, should ensure that these initiatives will continue.
Integration of activities

Strategies have been put in place to ensure initiatives commenced through the project can continue. The NHF initiated a specific integration process early in 2000 involving various sections of THS. The process has been slow moving but includes health promotion staff undertaking to maintain linkages with the community and the community nutritionist undertaking to visit Laramba on a monthly basis to support the community-based workers who will continue in their role under the Community Development Employment (CDEP) program. The community garden has been largely taken over by the Laramba Council and the young men look after the garden through the CDEP program. The clinic staff are working with the THS Health Development Unit to run the adult health assessment and the physician visits are scheduled to continue.

The high degree of inter and intra sectoral collaboration and integration is demonstrated in the following diagrammatic representation of the “model”. In this case “Model” refers to a set of concepts and principles involved in developing sound primary and secondary health care and holistic community-based initiatives that focus on health living. Major factors are community involvement/empowerment and inter/intra sectoral collaboration. These are not new concepts. However this program has taken a systematic approach to implementation, monitoring and evaluation of the interventions therefore making it possible to showcase and garner support for the process. The strength of this is the community participation which is demonstrated through the two way learning, and the involvement of local and visiting health professionals and the linkages with non health organisations such as education, employment and training. It is this degree of collaboration that should support integration and sustainability of the initiatives. The model is therefore descriptive of a community development process that may be applicable in other parts of the region. For this type of process to be transferred to other areas the model needs to be adapted according to the needs and structures of another community.
Figure 1  Model for the prevention of lifestyle disease in a central Australian community

Community Support Links for the Project

Council  School  Womens Centre  CDEP Program  Clinic  Community Elders and Traditional Owners  Strong Women Workers  Store

Community-based workers  Two-way learning  Project Officer

NHF  Centralian College  Podiatrist  Dept of Sport and Recreation  Territory Health Services
- Environmental Health
- Central Australian Nutrition
- Visiting Clinic Staff
- Health Promotion
- Strong Women, Strong Babies, Strong Culture
- Growth Assessment and Action
- Oral Health
- Preventable Chronic Disease Strategy
- Lifestyle Team

Professional Support Links for the Project
TRANSFERABILITY

The Laramba Family Wellness Model is being proposed as a model of PHC that could be implemented when the Central Australian zonal health plan is introduced. The zonal health plan is to provide health services to zones based on language groups. The funding and services will be managed by Aboriginal led health councils. The Laramba model is being advocated to be adopted by the zones both by the project team and community leaders.

To assist with the process of determining the transferability of the model an economic evaluation is planned. The study will analyse clinic attendance, hospital costs, and patterns of drug prescription. A prediction about the potential cost of implementing the intervention on a regional basis will be formulated. This will take into consideration utilisation of available resources from within THS.

The transition to other areas will need to be carefully monitored and evaluated. This could be done using the established monitoring framework, in order to detail, document and feed back the factors that measure the success or otherwise of the transferability and sustainability of a successful community directed health development process.

EVALUATION

The current evaluation framework for the Laramba Family Wellness Model ranges across activities that relate to primary prevention, secondary prevention and community participation and control. It measures attainment of project objectives against health indicators that are specific to each project objective. An illustration of these indicators is described in the table below:

<table>
<thead>
<tr>
<th>Primary prevention indicators</th>
<th>Secondary prevention indicators</th>
<th>Community control indicators</th>
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<tbody>
<tr>
<td>♦ Improved community support systems for primary prevention (council, CDEP, school, store participation)</td>
<td>♦ Number of visits and range of resource people</td>
<td>♦ Community directed inter-sectoral action plans and programs</td>
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<tr>
<td>♦ Changed nutrition patterns (as evidenced through store turnover)</td>
<td>♦ Number of client contacts</td>
<td>♦ Community participation in evaluation</td>
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<tr>
<td>♦ Increased knowledge of risk through community dissemination of health information (camps, school education, womens resource centre, CDEP program).</td>
<td>♦ Reductions in diabetes related hospitalisations.</td>
<td>♦ Mobilisation of local resources for project activities (including generation of local employment)</td>
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<tr>
<td>♦ Sustainable resourcing of nutrition programs (health system resource supports for primary prevention programs).</td>
<td>♦ Improved management of diabetes, as evidenced by improved adherence to standard treatment protocols</td>
<td>♦ Initiation of activities from local leaders (community control of needs assessment).</td>
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</table>
The evaluation indicators will be used as the basis for monitoring the sustainability of the interventions initiated through the project. The ongoing monitoring is planned over a two year period once the formal project has finished. This will provide valuable information about integration leading to sustainability.

The same indicators can be used to monitor and evaluate the model if it is transferred to other areas with adaptation to local environments.

CONCLUSION

The major aim of the **Laramba Family Wellness Model** is to create an environment of collaboration, mutual respect and understanding for the development of healthy communities and improved treatment and prevention of chronic disease. Further the project aims to develop a sense of ownership and control via needs assessment, planning, resource allocation, service delivery and evaluation.

The next stage is to ensure that interventions are integrated into community and health care processes thus ensuring sustainability. Transferability and adaptation to other community settings in the region will be promoted through evaluation of the health, economic and community benefits of the model.

REFERENCES


AUTHORS

Patricia E Field is National Program Director, Rural Remote Aboriginal and Torres Strait Islander Programs for the National Heart Foundation. Her background is in nursing and health service management in rural and remote areas with a major focus on Aboriginal health in the last 10 years.

Since joining the National Heart Foundation in January 1998 Patricia has been involved with developing strategies for rural and remote areas and Aboriginal peoples and Torres Strait Islanders across the spectrum of primary and secondary prevention and acute care.
Patricia’s current activity include:

♦ developing co-ordinated strategic approaches to health service delivery that include health service providers, Commonwealth, State and Territory governments, non-government organisations, and academic institutions;

♦ developing alternative models of health service delivery in order to improve access to health services for all people; and

♦ developing research priorities, particularly in the areas of rural, remote, Aboriginal and Torres Strait Islander people.

Alison McLay is originally from Victoria, but has spent the last 15 years in the Northern Territory living and working in a variety of settings across the NT, including clinical and community positions in both urban and remote areas. She has been employed by NHF as the Project Officer for the Laramba Diabetes Project since February 1999. During this time Alison has worked in partnership with the community-based workers to increase the knowledge of diabetes risk factors and consequences and improve the management of diabetes at Laramba.

Alison’s passion is to facilitate Aboriginal people/communities to be able to develop and implement programs to address their poor health status. She acts as mentor for local Aboriginal people who wish to pursue study and work in the field of nutrition.

John Grundy has a background in the provision of remote primary health care services, both as a medical practitioner and senior manager. Prior to taking up his role as Director, he was a Senior Research Fellow at Menzies School of Health Research with a special interest in remote health systems research. He was also a Senior Public Health Medicine Specialist with Territory Health Services and program leader for the Public Health Research Program of the Co-operative Research Centre for Aboriginal and Tropical Health. He has also had considerable international experience as a public health and health service management consultant.