Chapter 8

THE COMMUNITY – THE STAGE ON WHICH THE PRINCIPLES AND PRINCIPALS, POLICY AND PRACTICE, PLAY OUT THEIR PARTS

*Man was born free; and he is everywhere in chains. One thinks himself the master of others, and still remains a greater slave than they* (Rousseau 1762).

8.1 INTRODUCTION – UNRAVELLING A MAZE

“Primary health care – now more than ever” is the alternative title for the 2008 World Health Report (WHO 2008). The report is a call for renewal, from earlier interpretations of PHC principles and the local implementation of, often, selected elements, to its original intent. This was a transformative interpretation; a whole system approach concerned with reform and social justice in a complex and changing world, and one that more than ever responds to the health challenges of today and prepares for those of tomorrow (WHO 2008: xv). Underpinning PHC’s initial and continuing concern with inequity and addressing social disadvantage was an implicit challenge to political will and for governments to invest in people and infrastructure, and development more broadly. The same challenge exists today, in both resource-rich and resource-poor countries. This social justice and ‘making a difference’ is the PHC that underpins this case study of Menindee.

The purpose of the study is to explore the complexity of PHC in one small community, as the stage on which the principles and principals, policy and practice, come together. Its intent is to tease out the many threads that help create a ‘good’ primary health care service in a remote location. Inevitably, it is impossible to describe all the threads, so detail is lost and the picture is incomplete particularly when there is no economic component. However, it is possible to explore issues that were identified in the two studies and consider these in the context of recurring
themes from the literature relevant to PHC – specifically complexity, inequity and health services (PHC; quality; and prevention and chronic diseases). Together these provide useful insights for those responsible for PHC policy development and those implementing and evaluating PHC approaches.

The chapter begins with a synthesis of the two studies and discusses issues identified in the context of relevant themes from primary health care, complexity and social determinants discourses. It then addresses the four thesis questions before examining the relevance of the study, its limitations, and issues requiring further clarification when considering primary health care in smaller communities.

8.2 THE STUDIES COMBINED

8.2.1 Overview

The findings of each study are briefly discussed in the relevant chapters and summarised in Tables 6.38 (for the five quantitative studies) and 7.4 (for interviews with staff and community members). Together, the studies illuminate the issues impacting on PHC services such as Menindee, fulfilling the intended outcomes of this mixed method approach, namely “completeness” and “illustration” (Bryman 2006; see Table 5.2).

Table 8.1 provides a further summary of the study results, broadly grouped with the relevant recurring themes from the complexity, PHC and social inequity literature summarised in Table 4.5 (see page 114). While a number of the issues have relevance to more than one theme, broadly speaking they all are related to five main themes: the social determinants and Indigenous health; community size, resilience and change; chronic disease programs and prevention; vulnerable groups; and a complex adaptive systems perspective.
<table>
<thead>
<tr>
<th>Literature</th>
<th>Study 1</th>
<th>Study 2</th>
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<tbody>
<tr>
<td>Systems are more than the sum of their parts:</td>
<td>High rates of risk factors for chronic disease in adults and children</td>
<td>Communication barriers and messages not being heard</td>
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<td>interactions and communication key to successful systems</td>
<td>High rates of chronic disease and undiagnosed chronic disease</td>
<td>Varying perceptions of the meaning of collaboration, cooperation and partnership on the part of the partners</td>
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<td>Higher mortality rates across all ages with disparity in median age of death between Indigenous and non-Indigenous population</td>
<td>Health staff at local and regional level respectful of each other’s contribution at the same time frustrated with how each does particular things</td>
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<td>Indigenous women particularly at risk of teenage pregnancy, smoking, low birth weight, late antenatal care and high infant mortality rates</td>
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<td>Effects of inequity begin early, are cumulative and complex</td>
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<td>Significant extra funding for Indigenous programs at both community and health service level</td>
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<td>Political will and whole of government approaches required to address major social and health issues</td>
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<td>Alcohol, violence and abuse significant social issues which require fundamental social change</td>
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<td>Socially disadvantaged face challenges every day and remote communities and Indigenous populations are two particularly disadvantaged groups</td>
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<td>Personal behaviour change difficult when social environment not supportive</td>
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<td>Health systems and society more broadly need to balance the paradox of individual responsibility and social responsibility for health</td>
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<td>Common expressions of community solidarity at odds with an inability to address fundamental social problems</td>
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<td>Recognised need for accessing girls pre-pregnancy age and the importance of a healthy start to life</td>
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<td>Issues with accessing services external to Menindee</td>
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<td>Literature</td>
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<tr>
<td>Responsive (health) systems require good monitoring, surveillance and evaluation components</td>
<td>Information systems need to be more “useful”</td>
<td>Monitoring and evaluation processes improving but still limited</td>
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<td>Changing demographics and an ageing society will impact on communities and health systems</td>
<td>Declining population: losing young population and an increasing older population</td>
<td>Changing community demographics and their impact acknowledged, with adolescents particularly vulnerable</td>
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<td>Social change and community resilience</td>
<td>Strong sense of community resilience being tested by environmental conditions and rising levels of community stress; local health staff are also community members</td>
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<td>Majority concerned for the education, employment and long-term wellbeing of adolescents and their current lifestyle choices</td>
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<td>Education makes a difference generally and health literacy is an issue, with health professionals often underestimating a client’s level of understanding</td>
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<td>Literacy skills of many in community may be underestimated</td>
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<td>Mental health needs of communities frequently underestimated</td>
<td>High levels of mental distress</td>
<td>Mental health services overstretched and only able to provide “bandaid” care</td>
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<td>Real change in population health requires real prevention, done well with multiple strategies</td>
<td>Major causes of mortality: cardiovascular disease, cancer and injuries require different strategies</td>
<td>Offering a range of traditional health service prevention activities but limited in ability to address broader primary prevention initiatives when large new programs are being implemented</td>
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<td>Literature</td>
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<td>Prevention, early detection and good management of chronic diseases and</td>
<td>Difficulties targeting younger adults for health prevention</td>
<td>Barriers to accessing services exist more for preventive activities</td>
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<td>their risk factors and ultimately on healthy ageing</td>
<td>Initial and on-going management of large numbers with chronic disease</td>
<td>than for acute services</td>
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<td>Positive impact of chronic disease programs</td>
<td>Providing access to prevention activities for younger adults</td>
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<td>Demands of frequent attenders with chronic disease's</td>
<td>(particularly men) more difficult</td>
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<td>Potential for prevention and early intervention</td>
<td>Opportunistic brief interventions routine practice for most</td>
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<td>when majority of community use health service with some regularity</td>
<td>New chronic disease programs are intensive and effective and</td>
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<td>staff requires significant support through change</td>
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<td>Variable responses from clients to becoming more</td>
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<td></td>
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<td>effective self-managers</td>
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<td>Skills of health practitioners to engage clients in</td>
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<td>effective change behaviour limited</td>
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<td>Potential negative role model of health service staff</td>
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<td>Safe, quality health care a fundamental patient right yet</td>
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<td>While culturally appropriate services are generally</td>
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<td>proving difficult to deliver</td>
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<td>perceived to be provided, there is a recognition</td>
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<td>that cultural differences can be both</td>
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<td>underestimated and not fully understood</td>
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<td>Literature</td>
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<td>Participation fundamental to engaging a community but is often a token activity</td>
<td>Variability in supply of external health specialists</td>
<td>Participation is variably understood and encouraged</td>
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<td>Use of PHCWs</td>
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<td>Maintaining continuity of services – particularly crucial when service providers require time to build trust with clients</td>
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<td>Positive benefits of relatively stable and committed workforce</td>
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<td>The skill mix of those at the front-line needs to better reflect the real services they can provide, balancing clinical and population health skills</td>
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I stated in the introductory chapter that this was a whole of community study. PHC should be inclusive of the whole community, including being responsive to the specific issues of specific groups. Health issues relevant to Aboriginal culture and history are influenced in part, by interactions, or not, with the health service, and so should be addressed in that context. The effects of culture and history are inextricably linked but interpretations of “culturally appropriate PHC” are often more closely aligned with the “socially acceptable methods and technology” rhetoric in the Alma-Ata Declaration (WHO/UNICEF 1978:3). This is important, but it often results in a shallower interpretation or consideration of ‘culture’. Daaleman and Elder’s principles of the life course include that lives are lived in an historical time and place and linked to the lives of others around them (2007). The impact of history on one particular culture is a reason for discussing social determinants and Indigenous health after the studies, rather than in the preliminary chapters.

In Menindee, both staff and clients generally perceived that culturally appropriate services were provided and that there were no structural barriers to most accessing these services. There was recognition that cultural differences could be underestimated and not fully understood, and that ways to improve the cultural appropriateness of all service components was core PHC business. Staff were aware of health differentials and both the chronic disease and Healthy Start programs were seen as having the potential to improve health outcomes and the RFDS emergency data (see page 233) provides some preliminary evidence that the chronic disease program may be beginning to make a difference – for individuals. The emphasis of this program is still on changing individual behaviours, yet staff acknowledged two difficulties with this. The first is a lack of skills in assisting with change behaviour and the second is the difficulties individuals face in making changes when there are unsupportive environments within the broader family and community. The first can be addressed by specific skills training, but the second is much more complex and brings us into Rose’s realm of “why did this patient get this disease at this time?” and the broader socioeconomic determinants of health (Rose 1985).
The categorisation of the multiple determinants of death of an Indigenous woman in the Northern Territory (CAAC 2006) included the consequences of poverty, unemployment and poor education opportunities, reflecting the social determinants at play in “But why is Jason in hospital?” (see page 90). But there any similarities end. Alcohol, violence, an ineffective justice system, an ineffective health system, the alcohol industry, and poor personal management skills are identified, with the final determinant being a “highly visible social inequality promoting feelings of subordination, disrespect, anger or resentment, despair and lack of control, all factors known to induce self-destructive behaviour and violence towards others nearby” (CAAC 2006: 3). In Far Western New South Wales, local action plans developed by the Community Working Parties of the Murdi Paaki Region all identify drug and alcohol issues, either directly or in association with violence and dysfunctionality, as ‘a key health priority area’, noting also that there are high levels of mental health co-morbidity (Battye and Hines 2007). Trudgen describes the “living hell” that is the consequence of a proud culture being misunderstood, ignored and made to feel worthless by the dominant Balanda (Euro centric and White) culture (2000:59; 158-175). He notes that the physical violence and its consequences in a community came with changes to alcohol availability in the 1970’s but that the violence that “destroys a person’s soul” was the result of over 200 years of dispossession and colonialism that has impacted on the physical, spiritual and social fabric of communities (Trudgen 2000: 175). Gray et al (2004), Carson et al (2007) and Brady (2008) also remind us that understanding the complexity of ill-health, including drug and alcohol use and misuse, requires understanding the context of historical colonialism, dispossession and alienation and resulting institutionalised racism, marginalisation and poverty.

In a paper prepared for the 2007 Symposium on Indigenous Health Social Determinants, Nettleton et al suggest that worldwide, Indigenous health inequalities have their roots more in the social determinants than in any notion of “indigeneity” (2007: 26). Certainly, most social determinants models or frameworks, including those in Chapter 4, have culture as a component, but what characterises Indigenous social determinants is a history that frequently includes loss of self-determination, human rights abuses and alienation from land, cultural roots and cultural practices,
which are closely aligned with concepts of health and well-being that are linked to land and kin.

Alcohol and violence, social determinants and Indigenous health are included together for a reason (see Table 8.2 (1)). The discourse on social determinants emphasises that the effects of inequity begin early, are cumulative and complex and that political will with whole of government approaches are required to address major social and health issues. Broad social action is required that goes well beyond the health sector. This applies to all vulnerable groups who are structurally disadvantaged, including Indigenous populations if they are so affected.

Alcohol and violence are issues identified in Study 2, along with the perceived inability of the community to address this fundamental problem. As already noted, staff and community members acknowledged that personal behaviour change was difficult, even impossible, when the social environment was unsupportive of those changes. Alcohol and violence problems are not Indigenous-specific problems but Brady (2008) makes the point that ongoing historical grief, combined with kinship and social obligations and associated group drinking, has reinforced current habits of drinking and behaviours associated with drinking. For Indigenous people, any PHC interactions where alcohol is a factor will be more complex than many health professionals will be prepared for - but understanding this history and its consequences is required if more effective prevention, early intervention and management strategies are to be developed with their clients. Interactions for other reasons are also likely to be influenced in subtle ways by the consequences of this history.

Study 1 identified the greater burden of mortality and morbidity that Indigenous Australians in the Murdi Paaki region experience compared with their non-Indigenous counterparts – across all ages. While addressing this inequity requires addressing the broader social determinants, the Indigenous factor in the Australian context is important. From a Human Rights perspective the inequality in health status is linked to the long-standing systematic discrimination that has not given the same opportunities to Indigenous Australians as has been afforded non-Indigenous Australians. The government, therefore, has an obligation to address this (Calma
The Central Australian Aboriginal Congress (CAAC) makes it very clear that without government level strategy and radical social and economic reform across a broad front “there will be no decisive change” (CAAC 2006: 3-4). More than political will is implied: what is needed is political “must” with increased resources made available. This has begun to happen with the Australian government initiative to “close the gap” between Indigenous and non-Indigenous Australians in a generation (reflecting the 2008 WHO initiative). However, Altman et al (2008) caution that the disparities are so great that, while this might be “good political rhetoric”, without fundamentally new approaches to ensuring structural change, which take time, closing the gap will take significantly longer.

8.2.3 Community size, resilience and change

Changing demographics and an ageing population is a theme in the literature with particular relevance to smaller rural and remote communities and both studies identified key issues. Not only is the population ageing, and this will impact on health service requirements into the future, but young people are leaving to seek education and employment opportunities not available locally, and young adults and their families are having to move as employment opportunities disappear. With changing economic times and changing demographics, small communities in particular are being challenged because community size reflects available resources, opportunities and choices, including the issues of attracting and keeping health staff noted on page 111. Although small communities may be under pressure, resilient communities can survive and revive (Kenyon and Black 2001). Resilient communities are those where there is a personal and collective capacity of citizens and institutions to respond to, adapt and influence the course of social and economic change. (Centre for Community Enterprise 2000:2).

A report considering the future of Indigenous communities in Cape York notes a number of factors important for successful and viable communities. The first reiterates the importance of employment, income, health, safety, housing, basic infrastructure and education and that when there is inequity, programs need to consider and respond to these. The report stresses that demanding individuals change their attitudes and lifestyles and not changing the environment in which they live and
work and which gives them little choice or support to make changes is fruitless. Secondly, when needs are great there will be constraints on programs, but communities, like individuals, can make choices. They may be strongly constrained choices but they are choices nevertheless. Thirdly, governance, which at its most basic is about who in the community makes decisions or controls decision-making, is intensely political and there is high potential for conflict of interest in Indigenous communities (CYI 2005).

Both the concept of resilience and the factors associated with viable Indigenous communities have implications for Menindee. Addressing inequity is required. This involves community members having the skills to change, and any differences between local Indigenous groups being put aside and all working together for the whole of the community. During the interviews a number of Indigenous community members suggested that different groups were in conflict with each other. Furthermore, the view that there was an inability to address fundamental social problems, suggests that some assessment of ability or readiness for change would assist community leaders identify areas for skills development and develop realistic strategies.

The idea of community capability (or capacity) reflects the characteristics of a community able to identify, mobilise and address the social and health problems it faces. It requires the community to assess its sense of community and how members participate in community endeavours. It requires community leaders to examine their skills and styles of leadership, and identify and develop skills they may be lacking. The community must assess available resources, existing networks and their cooperative capabilities. Finally, decision makers must reflect on the factors that really affect all sections of the community as well as have the skills to analyse and assess their ongoing activities (Goodman et al 1998). Assessing community capability is part of the process of assessing how ready a community is to change. Just as individual readiness to change has different stages, with each stage requiring different strategies to assist change, so too communities will be at different stages of readiness to change and require different strategies to assist them on their path (Plested et al 2006).
Community capacity, with the related concepts of empowerment and social capital, has implications for PHC in general and Menindee in particular. ‘Empowerment’ is ultimately about people having authority over their lives and developing confidence in their own abilities, and ‘social capital’ encompasses the attitudes, spirit and willingness of people to engage in collective, civic activities to “add value” to their community and work for the common good, not just factional interests (Cox 2002: 9). If the burden of chronic disease and ill-health is to be reduced in the future individuals and communities will have to make changes and it will be the role of local PHC services to determine how they can best contribute to developing the skills for this.

Community development is a principle of both PHC and health promotion. If the goal of community development is about achieving lasting change to issues that affect people’s health and lives (Auer et al 1993: 163) I return to the two questions posed earlier (see page 50). Firstly, what is the role of health professionals and service providers if community development is about equity and social justice, removing structural disadvantage, real community participation, and enabled communities improving their social and physical environment? Secondly, if disadvantaged community members can only ultimately control their lives when the systematic inequalities that exist in social systems above the level of the community are eliminated, how does this effect PHC practice?

The latest government discussion paper on PHC contains two relevant comments. The first is on the need for greater preventive care, where it acknowledges groups at increased risk of disease whose overall circumstances “make it hard to make changes” (Department of Health and Ageing 2008:22). The second states that: “changes in health behaviour occur when communities are informed about and accept the need for change”. It goes on to say that this is facilitated by better models of sustainable care that are responsive to community needs. Such models engage the community in identifying needs and planning appropriate services with them and there is better collaboration and co-ordination between the multiple players providing services (pp.33-34). It also notes that these are areas not done well. A reason for this difficulty with community engagement activities may lie in different understandings of PHC. Acknowledging the many definitions while not providing
one, the discussion paper is focused on a PHC that is “the part of the health system that most people interact with most of the time” (p.10), as they visit the GP or a clinic. If such discussion papers do not fit this element into a whole system approach where there is explicit acknowledgement of the need for social justice and for structural disadvantages to be confronted, hard though this may be, it is understandable that health professionals do not recognise the need to engage with their communities in more productive ways.

As Menindee, a small town suffering the effects of a long drought, and a diminishing population, faces its future, both community members and PHC workers will require enhanced skills for change. These needs will be different in each community and health service.

8.2.4 Chronic disease programs and prevention

Within the broad theme of prevention, early detection and good management of chronic disease and their risk factors and the ultimate impact of these on healthy ageing, the studies identified issues in Menindee that provide lessons for similar communities developing comprehensive chronic disease programs. Tables 8.2 and 8.3 summarise the attributes that underpin modern chronic disease programs such as that being developed in Menindee. Table 8.3 is a summary of the PHC, community development and chronic disease principles, along with dimensions of quality care that have been discussed in the introductory chapters. Table 8.4 summarises the components of the Australian National Chronic Disease Strategy (National Health Priority Action Council 2006). The strategy reflects the same principles and attributes as shown in Table 8.3 but is important because it acknowledges the need to address underlying disadvantage with whole-of-government and whole-of-community approaches to achieve substantial and sustainable change. It also stresses the need for prevention that begins early, care that is comprehensive and evidence based and there is an acknowledgement of the mental ill-health burden, which requires action. The summaries in Table 8.3 illustrate that it is difficult to distinguish between PHC and major chronic disease programs, not surprising given the increasing emphasis on prevention and addressing the roots of chronic disease in the
Table 8.2  Principles, action areas and implementation actions of the National Chronic Disease Strategy 2006

Principles
Adopt a population health approach and reduce health inequalities
Prioritise health promotion and disease prevention
Achieve person centred care and optimise self-management
Provide the most effective care
Facilitate coordinated and integrated multidisciplinary care across services, settings and sectors
Achieve significant and sustainable change
Monitor progress

Action areas
Prevention across the continuum
Early detection and early treatment
Integration and continuity of prevention and care
Self-management

Implementation actions
Building workforce capacity
Developing strategic partnerships
Enhancing investment and funding opportunities
Developing infrastructure and information technology support

Source: National Health Priority Action Council 2006: 9-12
### Table 8.3  Summary of PHC, community development and chronic disease principles with attributes and dimensions of quality health care

<table>
<thead>
<tr>
<th>PHC</th>
<th>Chronic Diseases</th>
<th>Dimensions of Care</th>
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<tbody>
<tr>
<td><strong>WHO’s principled integrated PHC</strong></td>
<td><strong>Principles of chronic disease management</strong></td>
<td>IOM and NSW Health</td>
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<tr>
<td>Builds on Alma-Ata principles of equity, universal access, community participation and intersectoral approaches</td>
<td>Evidence-based decision-making</td>
<td>Safe</td>
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<td>Population health issues and public health functions</td>
<td>Population rather than individual focus</td>
<td>Effective</td>
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<td>Ensures services to vulnerable groups</td>
<td>Prevention in all interactions</td>
<td>Patient-centred</td>
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<td>Integrated and seamless care, with prevention, acute care and chronic care across whole health system</td>
<td>Quality focus</td>
<td>Timely</td>
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<td>Continuous evaluation with action for improving performance</td>
<td>Integration, coordination and continuity</td>
<td>Efficient</td>
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<td></td>
<td>Gathering and using information for change</td>
<td>Equitable</td>
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<tr>
<td><strong>FWAHS PHC principles</strong></td>
<td><strong>Attributes good chronic disease programs</strong></td>
<td>Consumer participation</td>
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<td>Equity in health and access</td>
<td>Patient centred with self-management</td>
<td>Access</td>
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<td>Cultural appropriateness</td>
<td>Informs community lifestyle change</td>
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<td>Community involvement</td>
<td>Evidence based with standard protocols</td>
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<tr>
<td>Consumer responsiveness</td>
<td>Quality focused</td>
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<tr>
<td>Continuity of care</td>
<td>Integrated and collaborative teamwork across organisations</td>
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<td>Multidisciplinary teamwork and intersectoral collaboration</td>
<td>Population focus with recall and reminder systems</td>
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<td>Programs planned and evaluated</td>
<td>Flexibility and adaptability built in</td>
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<td>Transparency in priority setting and resource allocation</td>
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<td>Services continually developed</td>
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<td>Research based action</td>
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<td>Staff valued with participative decision-making</td>
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<td>Focus on prevention</td>
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**Community development principles**
- Ecological principles: Holism, sustainability, diversity, organic and balanced development
- Social justice principles: Addressing structural disadvantage, empowerment, need definition, human rights
- Valuing the local principles: Valuing local knowledge, culture, resources, skills and processes
- Process principles: Immediate goals and ultimate visions, integrity of process, conscious raising, participation, cooperation and consensus, pace of development, peace and non-violence, inclusiveness and community building
- Global and local principles: Linking the global and the local, and anti-colonial practice

Sources: Table 3.1 (page 50); Tables 3.5 and 3.6 (page 63); Table 3.8 (page 66); Table 3.9 (page 72); Table 3.10 (page 74); and Table 3.11 (page 76)
latter. For this reason, both chronic disease and PHC-related issues are discussed together.

The Adult and Child health checks identified a large number of individuals who needed to be started on comprehensive care plans for existing chronic disease or who were at risk of chronic disease and required better prevention and early detection strategies developed with them. The initial wellness check in any community, particularly an Indigenous community, is going to create a large volume of work. Even with the best systems in place and good staffing levels, it is going to be difficult for staff to cope with the initial workload. If there are other stressors in a community local staff can be doubly stressed. Those responsible for program development and implementation will be under pressure to demonstrate favourable outcomes to the funding body. Such circumstances require there be not only strong support for all staff through these periods of change but that communication be open and effective.

The interviews occurred at an important point in a change process and suggested that some staff were under considerable stress at this time. They acknowledged the support they received, but felt some of their concerns were not heard. A personal communication 18 months after the interviews is revealing: paraphrased slightly she said that ‘we were in a continual daze at the time and only now realise how much stress we were experiencing’ (and continued: ‘perhaps we should write a paper on it and share the lessons learned’). This is important because a feature of Menindee is its stable and supportive workforce. A community without this characteristic may find it difficult to manage the implementation of such an intensive program.

The occurrence of regular checks according to care plans, and encouraging individuals to develop better self-management skills begins to make a difference: both in terms of less frequent complication episodes or progression of complications. Those who were unable, for whatever reason, to begin to better manage themselves, continued to make frequent visits (a personal observation over the month of the interviews). Both staff and clients expressed the difficulties of changing behaviours without supportive changes occurring in their broader environment.
A number of issues around prevention were highlighted. Study 1 identified difficulties targeting younger adults for health prevention interventions and Study 2 suggested that men in particular had difficulties accessing services; some gave structural reasons (health service hours not in line with working hours); other reasons were less clear but most likely cultural. There seemed to be no such barrier if acute services were required. Given the current burden of chronic disease, prevention and early intervention strategies targeting increasingly younger age groups are important so strategies to ensure these are effectively delivered will be required.

Brief interventions were routine practice for most staff and with the majority of the population regularly using the service, this aspect of prevention activity is potentially useful. Many staff (of all categories), however, felt their skill to engage a client in effective behaviour change counselling was limited. Both clients and staff expressed a concern that the general literacy skills of many in the community may be underestimated: this means health literacy levels will also be low.

Menindee offers the range of traditional health service prevention activities, including smoking, physical activity and nutrition, alcohol, safe sex, immunisation, prenatal health and emotional well-being. There is limited capacity to address broader primary prevention initiatives, particularly when large new programs are being implemented. There is also the question of how staff can be involved in the multiple strategies required of effective primary even primordial prevention that addresses adverse socioeconomic determinants.

There were a number of workforce issues identified in the studies. Maintaining continuity of services could be a challenge when specialist services were provided from another site, themselves subject to difficulties with recruitment and retention of staff. Clients were most vulnerable to discontinuity when it was related to services that required time to build trust (those with a large counselling component). At the local level Menindee had two positive factors related to staffing. Most staff are long-standing community members committed to a primary health care approach and from the days of the FWHS, has invested in the continuous training of their PHCWs, focusing on both clinical and population health skills. From the beginning of the chronic disease program they have functioned as effective and valued case managers.
Mental health services were a challenge for all staff. Study 1 identified high levels of mental distress and that the current NIR information system did not easily allow the extent of this to be clearly identified. Study 2 showed that mental health services were overstretched and only able to provide “bandaid” care. The early years of an individual’s life were important for good mental health and there was a real need for mental health prevention strategies. A part of the chronic disease strategy, well-being checks (the K5) identified increasing numbers who required some intervention. Much of this could be provided by generalist PHC workers but some felt they did not have the skills for this.

Responsive information systems, with good monitoring, surveillance and evaluation components are fundamental to good PHC and chronic disease programs. Study 1 suggested the NIR needed to be made ‘more useful’. In Study 2, staff were becoming familiar with the recall and reminder systems but there were issues. Ferret™ was a Maari Ma instigated system and staff were also continuing with the NIR registers. At the database level the two systems could not interface. The GPs also had their own system. If “gathering and using information for change” (Table 8.3) is to be encouraged, the systems to support this must be in place.

8.2.5 Vulnerable groups

One of the elements of WHO’s principled integrated PHC is ensuring services to vulnerable groups. Traditionally Indigenous populations are identified as a vulnerable group, but for Menindee the chronic disease program was specifically developed to address the needs of the Indigenous population, with the non-Indigenous population benefiting from the increased services (Menindee’s services were equally available to everyone). Local health staff, clients with mental health conditions and those with poor health literacy are vulnerable groups who have already been mentioned. This section highlights the needs of two groups in particular – adolescents and pre-pregnant age girls.

While Study 1 could only identify a declining population and a loss of young people, in Study 2 the majority of those interviewed were concerned for the education,
employment and long-term well-being of adolescents and the lifestyle choices they were making. For adolescents who did not plan to leave the community there were few opportunities and a general feeling of despair. Younger children, with little to occupy them or not wanting to be at home where there was alcohol and abuse, congregated with older children and adolescents and were influenced by them. Adolescents had little contact with the health service and ways to engage with them in meaningful ways were being sought.

In Study 1 Indigenous women in the Murdi Paaki region were at risk of teenage pregnancy, smoking, having very low birth weight infants (with high infant mortality rates), and booking late for antenatal care. Menindee (Study 2), although the number of births was small, illustrated the value of antenatal-related activities. Teenage pregnancies had decreased since contraceptive programs targeting younger women began and all pregnant women were actively encouraged to attend for antenatal care; this care would be provided in their home if they were uncomfortable in the health centre. Smoking rates were high and this impacted on birth weights. As part of the overall chronic disease strategy, the Healthy Start program includes accessing younger girls before they leave school (or become pregnant), providing them with knowledge and skills around the importance of a healthy start to life.

Developing more effective communication strategies and messages for and with this age group would be an important first step for the PHC service to consider.

8.2.6 Insights from complex adaptive systems

The reasons for introducing complex adaptive systems as a lens through which to reflect on Menindee’s health service were explored in Chapter 2. This approach uses the attributes and metaphors as ‘triggers’ for better understanding community and client interventions and understanding organisational issues.
Interventions and change through another lens

A CAS approach emphasises the need to understand systems and their sub-systems that are nested within each other, interact with each other, and co-evolve. Those interviewed identified alcohol and violence as community concerns and alcohol provides an example of one of the most complex systems to be understood if there is to be change. As both a poison and a commodity (Babor et al 2003), alcohol is associated with at least six systems (Holder 1998). Apart from understanding the social, economic and health consequences of alcohol, how it is consumed and the social norms of the community around alcohol and its use, other systems to be considered include formal regulations and controls, legal sanctions and retail sales. Only when all the interconnections are identified can multi-strategy programs required for primary prevention community interventions be developed. However, another system is interconnected with alcohol, and with everything requiring a community to act. This ‘shadow system’ (Plsek and Greenhalgh 2001) is a community’s stage of readiness and its competence to address identified social concerns as this determines the interventions that will be most appropriate (see page 303).

Not understanding the interconnectedness of these systems is one explanation why alcohol-related intervention and health promotion activities have had such poor outcomes in Indigenous communities. Not only have interventions been inappropriate but also evaluation strategies that reflect the complexity of programs have been missing (Strempl et al 2004). Poor evaluation practices are not restricted to Indigenous communities or alcohol programs and have been a recurring theme in the health promotion literature (Nutbeam 1995; McQueen 2000; see page 48). The message for health services and others involved is clear: as community interventions become less focused on individual behaviour change and begin - with multiple strategies - to address systems issues the evaluations that accompany them “must also develop in complexity” (Goodman et al 1996: 34). This has implications for the skills those involved will need to do this effectively.
The interconnectedness of health determinants also has implications for interventions. The variety of health determinants models in the literature reflects the extent to which those developing a model map the interconnectedness of the systems and sub-systems involved. Although all acknowledge the complexity of interactions between the components, some are presented simply (Stronks 2002 – see page 85) and others with greater complexity (Dahlgren and Whitehead 1991 – see page 84; WHO model in Solar and Irwin 2005 – see page 86). As with the alcohol systems, if those responsible for health program development choose to focus on one-dimensional ‘cause-effect’ strategies, there is little likelihood of successful outcomes since the effects of the other interconnected systems are so strong. Health promotion models like PRECEDE-PROCEED, which analyse needs across multiple levels, are likely to be more effective (Green and Kreuter 1999).

Shadow systems also impact on individuals. Health staff and clients both expressed the difficulties in changing behaviour. They provided reasons including: health education advice that ignored the social environment of recipients did not work; clients found it hard, or “I found it hard” when there was no support from family, or a lack of choices (such as exercise options or food availability). Recognising a shadow system component in regular client encounters could prove illuminating. Some information is routinely sought, but not necessarily in the context of how the component ‘parts’ affect the ‘whole’.

A final metaphor for thinking about interventions and change is the “butterfly effect”. Trying to understand how a butterfly beating its wings in one location may eventually cause devastation elsewhere is a colourful way to think about “initial conditions”. The Healthy Start program provides an example of the importance of “initial conditions”, and small changes having a large effect. Thelen calls it “an exercise in parsimony”, how relatively small elements built into programs around the time of birth may start positive “developmental cascade” that continues through childhood. (2005:266). In contrast, small negative insults in early childhood can have lasting consequences.
The organisations through another lens

Glouberman and Mintzberg’s separate “world’s of health care and disease”, with each functioning apart from the others - unnecessarily disconnected, with “unreconciled values, incompatible structures and intransigent attitudes” cannot be said to represent Menindee (2001: 67). However, it does act as a reminder that when the sub-systems of ‘cure’, ‘care’, ‘control’ and ‘community’ do not see themselves as part of a larger system each has the potential to create conflict and misunderstanding with the others.

A healthcare system is a set of connected, interdependent parts, comprising the users and the providers, with single units of care embedded in larger units that are connected to others. Menindee Health Service is embedded in the larger unit of GWAHS and managed by Maari Ma. Services are provided by local staff and by visitors employed by Broken Hill Health Service, the RFDS, Maari Ma or GWAHS.

Each of these units comprises interacting individuals. They can influence and be influenced by others, can change ideas, behaviours, their way of thinking, and how they work and relate to each other. Relationships are sustained through communication and other forms of feedback and there are varying degrees of interdependence between the individuals. Some individuals appear to ‘steady’ a group and dampen pressures for change, others create excitement and enthusiasm for the new and there may be others who ‘stir up’ trouble (stable and strange attractors). Members of a group can exert much effort for change and see little effect, and sometimes a seemingly insignificant event can have a large effect so there is an element of unpredictability to outcomes. Members of the group may explore possibilities together, and find new ways of doing things or they can become so entrenched in ‘old behaviours’ that they see no need for change and so change becomes difficult. Yet, when it seems there is chaos and confusion, and nothing is working they can start something new.

In a CAS, agents are the basis of the system, and in the units described above each individual is an agent. The functional unit of Menindee Health Service is also an
agent as is each organisation - and the preceding comments apply to all agents: their actions are interconnected and results can be unpredictable; they exchange information, give feedback and are constantly acting and reacting to each other.

It is from the interactions of the parts (whether the system and its shadow systems, the sub-systems, the units, the organisations or individuals) that the strength of a complex adaptive system comes: these interactions are the key (Holland – in Lewin 1999: 220). In Menindee there seemed to be at least two levels of interaction. On one level, the relationships were strong and there were individuals in both organisations creating excitement for the changes, supporting staff, and programs were progressing. On another level, the two organisations had less positive interactions.

As a small PHC health service responsive to the needs of the local community, Menindee had its own priorities and control over the programs developed and the way services were provided. As part of the larger GWAHS and NSW Health systems it was influenced by their priorities, programs and expected outcomes. As the chronic disease program began in earnest local staff perceived they had lost control and had had to give up some of their community-based and community-loved activities. They expressed a concern that Maari Ma had its own agenda. They saw Maari Ma as an Indigenous organisation with an Indigenous-focused agenda, and because of extra funding received for Indigenous-specific programs, an imperative to produce positive outcomes within time frames dictated by the funding agencies. Their concerns were not that Maari Ma was an Indigenous organisation but that the demands that flowed through to them, were as being driven by Maari Ma’s agenda rather than reflecting a concern for Menindee. When external facilitators were brought in to help with planning exercises and they used material with another location’s name on it was seen as planning ‘for’ rather than planning ‘with’ local staff. At the same time local staff had high regard for Maari Ma staff, appreciated the benefits of the extra funding, could see the value of the program and found the planning exercise useful. Maari Ma staff also held Menindee staff in high regard, and for each incident cited had a considered and reasonable response.
In a CAS the boundary is a helpful metaphor. A boundary exists when systems with different characteristics come together and where “information gets distorted and behaviour misinterpreted” (Eoyang 1997) if there are no mechanisms in place to transcend them. Warfield (1999) noted that as an organisation grew there was a disconnect with those in lower levels so that each no longer understood the other’s language. Good communication based on information sharing, trust, time and effort are part of the positive feedback loops that allowed organisations to learn and grow. The narratives from staff of both organisations indicated some significant difficulties in hearing each other. The lack of control that local staff experienced had the potential to contribute to work-related psychological strain (Bordia et al 2004) and this would also affect the ability to communicate effectively.

This example was chosen for three reasons. Firstly, it provides the opportunity to consider the role of boundaries in CAS and what Bennet and Bennet call intelligent CAS: the right information gets to the right place at the right time (2004:60). Secondly, the interviews occurred at a time of change. An important point to make is that interactions must be directly observed – in-depth and over time to understand interdependencies. While this was outside the scope of this study, I did experience the stress of the staff. While I hesitate to describe Menindee as being “at the edge of chaos”, or perhaps on ‘the ordered side of the edge of chaos” what this attribute represents is the ability of CAS units to interact in healthy, innovative ways to find a solution – they adapt or risk destruction. However, the fact that the levels of stress in the local staff was unrecognised is of concern. The third reason for the example has to do with the way Regional Maari Ma staff responded to the local health service community activities. The issue is not their quality or whether they were core business PHC but rather the paucity of community development principles in the interactions.

A CAS approach is not applicable to all systems and while some caution its overambitious use (Paley 2007), it is of value in addressing the ordinary, practical problems of health care delivery particularly where understanding change is important (Griffiths 2002; Rowe and Hogarth 2005).
8.3 THE FOUR STUDY QUESTIONS

8.3.1 Question 1

Is a PHC approach appropriate for Menindee?

If primary health care:

- “Is focused on keeping healthy people healthy, improving the health of the community and responding to individuals who need treatment and care”, as defined in Healthy Horizons (National Rural Health Policy Forum 1999);

- Is about social justice and equity, looking at the causes of ill health, balancing prevention and promotion with treatment and rehabilitation (comprehensive health care) but with a real focus on health promotion and working with people, particularly the vulnerable, to assist them in making decisions about their health;

- Is about collaborative networking locally, a partnership relationship with the secondary and tertiary sectors, with consumer and community involvement;

- Is about balancing health care priorities so that immediate needs are met in ways that contribute to addressing longer term more macro level priorities in ways that are sustainable;

then a PHC approach is appropriate everywhere. The product may be different from location to location but the approach is universally relevant.

8.3.2 Question 2

To what extent was a PHC approach being applied in the chosen community during the time period of the study?

The response to the question is found in how well Menindee reflects WHO’s ‘principled integrated PHC’, FWAHS PHC principles, the principles and attributes of chronic disease programs and community development principles in general. The
elements of these (in Tables 8.2 and 8.3) are reflected in the definition of PHC in section 8.3.1. Also influencing how the extent a PHC approach is being applied are responses to the questions raised in Chapter 1 (pages 4-5). In total, 12 broad areas are considered in assessing how Menindee is travelling on its PHC journey. These are focused on equity, culture, community and consumer involvement, collaborative efforts, quality comprehensive care, population and prevention, and using information for change. The full list is indicated in Table 8.4.

Table 8.4  Attributes considered in assessing Menindee’s PHC journey

| 1. Equity in health                  |
| 2. Equity of access                  |
| 3. Cultural appropriateness         |
| 4. Community involvement            |
| 5. Consumer responsiveness          |
| 6. Interpersonal communications     |
| 7. Comprehensive care and continuity of care |
| 8. Prevention focus                 |
| 9. Population focus                 |
| 10. Quality care                    |
| 11. Multidisciplinary teamwork across organisations and sectors |
| 12. Gathering and using information for change |

1.  

Equity in health: From the Health Checks and from existing information systems, the Menindee PHC service understands the community health profile and the long-term health problems if chronic diseases and premature mortality are not addressed. The Indigenous population has significant inequity in health outcomes, and the life course focus of Healthy Start and the Wellness checks particularly target this group. The structural disadvantages underlying the inequity are more difficult to address. These require strategies from community and society more generally; primary prevention strategies that the health service could be a partner in are difficult to undertake when large, comprehensive programs such as the chronic disease program are being developed and implemented.
2. Equity of access: As far as possible geographical, cultural and financial barriers to accessing the health service have been minimised and there is access to health care for all. Acute care is available 24 hours but some community members indicate they have difficulty accessing other services during clinic hours. It is the prevention-focused programs that this mostly affects and staff provide some components of these programs at work sites when possible. Access to secondary and tertiary care can be a challenge from remote sites and some who ‘choose’ not to access services when these are required, do so because their choices are constrained.

3. Cultural appropriateness: The majority of Indigenous population indicate that the services and programs are provided in ways that are sensitive to their needs and wants. There is continual input from community representatives and Indigenous PHCWs to continue improve all aspects of the service. The slight disparity in attendance by the Indigenous population suggests that there may be room to improve this aspect of the service. The men in particular are being approached to see how programs such as the Wellness check can be delivered in alternate ways and locations where they are comfortable.

4. Community involvement: At one level, community members are involved in decision-making about health and their own care. The Health Advisory Committee provides a voice for and to the community and contributes to debates about health services. There is community representation on Maari Ma’s Board and this would provide feedback of concerns and issues to the health service. In addition, local health staff sit on a number of community committees. In this study it was not possible to assess the depth of community involvement that is implied in community development definitions of participation. As traditionally, power in decision-making relating to health services sits with the health service provider; those involved need to be sensitive to this possibility and continue to ensure there is not an imbalance in power.

5. Consumer responsiveness and interpersonal communications: Staff advocate for and represent the best interest of the clients, consider the physical, emotional and social aspects of the client’s health and the community context of planning care, engage the client as a partner in ongoing care and decision-making, and are
beginning to develop the self-management skills of clients. There were two areas where both clients and staff identified improvements could be made. There were still a few problems with the interpretation of messages (jargon was used) and health literacy issues could receive more attention. Many acknowledged the extent of poor literacy levels and how people were ‘ashamed’ and tried to hide the extent of this. If general literacy levels are low, health literacy levels will also be affected.

6. Comprehensive care and continuity of care: The service provides, either directly or indirectly, access to a full range of services to meet health care needs, across the continuum of care: including health promotion, prevention, diagnosis and treatment of common conditions and referral to other secondary and tertiary care if required. The service endeavours to provide an individual with continuity of care with a preferred provider locally if that is their wish, as well as ensuring there is continuity between the primary health care team and other health care providers. As with all services, there will be problems and most of these arise with referrals to major tertiary centres – distance, costs, being away from family, and communication problems can occur. There are also difficulties when external services cannot be provided locally because of recruitment and retention issues at the regional site. Providing dental services is often a challenge, however at the time of the interviews catch-up services were being provided.

7. Prevention focus: The emphasis of both the Healthy Start and Keeping Well program is primary prevention and these are long term strategies in their infancy. The prevention activities that are integrated into each client interaction, linked as they are to acute care and chronic disease management, are more focused on secondary prevention. Most staff try to ensure that those who infrequently use the service receive appropriate prevention-related care, such as brief interventions for smoking and alcohol, and immunisation catch-up, although it was not possible to personally determine if there were ‘missed opportunities’. Education is a significant component of care plans and there is screening of well populations and ‘at risk’ groups. Many staff felt they lacked prevention-related skills such as stages of change management and the service would improve if these were enhanced.
8. Population focus: The population focus of PHC and chronic disease programs is the inequity factors in the environment that contribute to one group having poorer health than another. On one level it includes paying particular attention to the needs of the vulnerable and at risk, and Menindee is focused on these, although there are some groups such as adolescents and those with mental ill-health whose needs are not being fully met. On a second level, staff must work with the community to mitigate some of the structural issues where they can. There is currently limited capacity, both skill wise and resource wise, for this area of activity.

9. Quality care: Clinical procedures and care plans reflect current best practice and accepted standards and continual quality improvement processes are in place. Issues arise when there are conflicts between guidelines (at the time of the interviews Diabetes Australia guidelines used in care plans and guidelines being used by the GPs were different).

Economic quality and safe care: Achieving the desired results with safe, cost-effective and cost-efficient use of resources is a component of quality care; these are outside the scope of this study.

10. Multidisciplinary teamwork: In general, practitioners from the various health disciplines collaborate on providing on-going care. For local health staff, their day-to-day activities are built around collaborative teamwork. The main issue for Menindee is the less frequent visits of a range of practitioners and the need to collaborate other than face-to-face. There is greater potential for miscommunication and lack of communication in these instances, however Menindee staff are aware of this potential problem and work to limit its consequences.

11. Collaborative teamwork across organisations and sectors: on one level local staff collaborate with the small number of organisations and other sector representatives present in a small community and Maari Ma collaborates with a range of agencies locally, regionally and nationally. Views expressed on collaboration and the role of partners suggests that at times collaboration occurs more in name than in practice and that there is unequal valuing of some partners
12. Gathering and using information for change: Systems that provide timely surveillance, monitoring and evaluation information support are still in the early stages of development. Some systems in use do not interface with each other, the NIR does not provide ‘useful’ information and there are instances of multiple entry of the same information. A NSW Health community-focused system to address some of these issues has been in development for years. There are reminder and recall systems for chronic diseases and records are beginning to be audited. While there was little emphasis on evaluation of programs in the past, it is a core component of the chronic disease programs, but is still a new activity for many local staff, some of whom have expressed a wish to increase their involvement with regional staff in planning, and evaluation of the service.

This provides an overview of attributes that should be present in a health service with a PHC approach. As their program focus changed significantly in the year leading up to the interview phase the question is not so much whether the attributes were present, but the extent to which they were interpreted and implemented at this stage of the program. Three examples are useful to illustrate this: equity, population and individual focus, and collaboration. These three areas serve to represent the difficulties of implementing a PHC that “is about social justice and equity” and transforming communities, and each is addressed in section 8.4.

8.3.3 Questions 3 and 4

What are the barriers and enablers to developing a Best Practice PHC approach in Menindee and the crucial factors for developing successful programs in similar communities?

As it came time to answer these questions it became clear that the enablers of a good PHC approach in Menindee are the crucial factors for successful programs more generally, so both questions will be responded to as one.

‘Enablers’ or ‘facilitators’ are the factors that help to make something desired happen, while ‘barriers’, simply put, is the absence of these factors (Solberg 2007: \[\text{Page} 347\])
Best Practice is a term that encompasses a number of areas including evidence-based practice, lessons learned from others, promising practices, and good approaches. Implicit in all these is quality improvement: looking closely at what is done and needs to be done, considering the best available evidence from a range of sources and working together for the desired results.

Factors which are important for quality improvement include effective leadership, a collective vision of the change wanted with structures and systems to support this, people with skills and the resources to manage the change, good communication and involvement of all the players, and good information systems and evaluation processes (Solberg: 2007). Therefore, if skilled people are not communicating with each other effectively, with good information systems, adequate resources (including time), a supportive environment, and ways of measuring change, change will be difficult. Table 8.5 describes the ‘enablers of quality change’ in more detail.

Table 8.5  Enablers of quality change

<table>
<thead>
<tr>
<th>Strong effective leadership, both centrally and locally</th>
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<tbody>
<tr>
<td>Commonly understood framework and infrastructure for managing change process</td>
</tr>
<tr>
<td>People at all levels with change management skills</td>
</tr>
<tr>
<td>Adequate resources and time devoted to the change process</td>
</tr>
<tr>
<td>A mature and capable clinical information system</td>
</tr>
<tr>
<td>Good communication and measurement skills</td>
</tr>
<tr>
<td>A high degree of trust and teamwork</td>
</tr>
<tr>
<td>Individual accountability</td>
</tr>
<tr>
<td>A high degree of involvement and engagement by personnel at all levels</td>
</tr>
</tbody>
</table>

Source: Solberg 2007: 254

Before discussing Menindee’s enablers a comment on assessing enablers is required. Most enablers are person-oriented. For this reason recent research suggests, it is more important to understand the context and the underlying social relationships of those involved in creating a barrier, than to focus on the absence of a factor that helped contribute to what is then labelled a ‘barrier’. This requires a particular style of study. Rather than depending on the narrative of participants “for whom the
appearance of rationality offers important secondary gains”, direct observation studies provide better descriptions of contexts (Checkland et al 2007:100) and a CAS study, which includes observational components, would have provided more depth to understanding some of Menindee’s PHC barriers and enablers.

At the time of the study, Menindee had both positive and negative factors impacting on its ability to develop a model of ‘good PHC’. On the positive side, it had health staff with years of commitment to PHC, increased resources because a second organisation was involved, and it was undergoing the development and implementation of highly structured programs targeting a large proportion of the community. On the negative side, it was a community suffering the effects of years of environmental stress, and with the increased resources for a highly structured program targeting a large proportion of the community, had increased expectations placed on it. For this reason, as with all health services, there were factors that could be identified as either enablers or barriers.

However, and since this is not an evaluation, there is value in presenting their experiences as an enabler checklist of those factors that play a part in developing good PHC programs. These factors have all been identified in this chapter and Chapter 7, and this therefore serves as a summary.

Furthermore, as these are the factors that ‘help make something desired happen’ they also become crucial factors for developing successful programs in similar communities.

1. For Menindee, and communities like it, ‘good’ PHC is where all the elements of quality change are in place or are being actively developed (Table 8.4), and where the principles of PHC, chronic disease management and quality care (Table 8.3) are clearly in evidence, even if also still being developed.

2. Recognising that principles are easy to define and harder to implement, those involved must truly understand the intent and not just the rhetoric of primary
health care, community development, health promotion and other related
principles.

3. There is a stable workforce, with the right number of staff for the programs in
place, appropriately trained, resourced and supported. Staff are encouraged to
develop resilience, increasing their ability to adapt to change, and are
especially supported through periods of increased change and stress.

4. Indigenous Health Workers are encouraged and supported as front line PHC
workers in their community, with a training that balances population health and
clinical skills.

5. Those involved acknowledge that mental health issues are consistently under-
recognised and have fostering social and emotional well-being, as well as
providing acute and chronic care, as elements of their programs.

6. Meaningful collaboration, involving strong partnerships where the partners
value equally the others, and extensive intersectoral cooperation occur.

7. There is open and frequent communication between all the players, where
issues are heard and responded to.

8. There is meaningful consumer and community participation.

9. Those involved recognise that it is often difficult to make major changes in
lifestyle, if respective changes do not take place in the community, and seek
ways to address this.

10. Those involved recognise that individuals experiencing social and emotional
disharmony, or other stressors, may not be able to engage in self-management
and lifestyle change, and seek ways to address this.

11. Those involved recognise that adopting a PHC approach will not reduce
inequalities, but their focus is always on improving the opportunities and
choices for individuals and the community.
12. A life course approach (such as Healthy Start and Keeping Well), with its focus on reducing the cumulative effects of poorer social circumstances is being adopted.

13. Effective routine surveillance, monitoring and evaluation processes that identify changing contexts are in place.

14. Programs are advocating for the disadvantaged in their community, supporting their efforts with quality data.

8.4 RHETORIC AND REALITY

The debates on the rhetoric and reality of PHC have continued for over 25 years. An example from one of the earliest is instructive. One argument, that there should be selective PHC when resources were scarce (Walsh and Warren 1980; Unger and Killingsworth 1986) contrasted the argument that reducing child deaths from one cause only resulted in death from another cause if underlying poverty and lack of food was not addressed (Mosley 1983). While the language may have changed, from the beginning the debates continue to be between meeting immediate needs and addressing broader determinants.

Both PHC and chronic disease programs emphasise a population rather than an individual focus, yet there are mixed messages in this approach. In 2004, according to a NSW Health report, 76% of Indigenous premature deaths and 67% of total premature deaths in NSW were avoidable or could be reduced through health promotion, healthy lifestyle, prevention and early detection of disease and improved management and treatment of disease (Population Health Division 2006). While there are both individual and population-focused strategies in these activities, much of the activity of chronic disease programs is at least, initially, centred on individuals.
With its emphasis on a chronic disease strategy, Menindee is addressing the current burden of chronic disease with the intent to have a healthier population, with fewer complications, culminating in a healthier ageing population. The Healthy Start program focuses on giving infants the best start possible and limiting the insults that begin the cumulative ‘road to death’. Programs are structured and based on evidence, and there is a strong prevention focus. They are focused on developing the attributes of good chronic disease programs, in the spirit of the principles of PHC and chronic disease management. They are beginning to make a difference for “sick individuals”.

What of the “sick population”, though, those living in communities with higher levels of socio-economic disadvantage than others and higher levels of physical and psychological stress? This is a characteristic of smaller, remote communities, with fewer resources and opportunities available to them, and communities with Indigenous populations are affected by the consequences of their history. The fundamental reason for the emphasis on inequity and social determinants in the thesis is that population and public health in the 21st century recognises it is social and economic inequity that needs to be addressed if chronic diseases are to be ‘brought under control’. Furthermore, this requires political will. At the level of a small, remote health service, it may seem difficult to see how to impact on these broader determinants.

The reality is that PHC requires three levels of action: strategies that target upstream, intermediate and downstream determinants.

The upstream, wider social determinants require political will, with the added imperative that this is a human rights issues for Indigenous populations affected by a history of imposed structural disadvantage. This requires significant policy change, and not political rhetoric: the recurring theme of the literature is that the Australian government is good at the latter but less effective with the former.

The intermediate or, for this example, the community social determinants, require communities that are empowered and helped to address their issues and priorities. It is at this level that the intent of community development operates. Skills
development that builds capabilities and a sense of common purpose and collective action requires all those in a community to bring their resources together, to work collaboratively and seek extra resources as required. The PHC service will be one of the players in this. Yet, ‘community participation’ is complex. It may be a principle of PHC and community development, and even a human right, but is more often a term that reflects a process, with the ‘participation of the community’ like the rungs of a ladder. These reflect degrees of participation: from ‘nothing’ through receiving information, is consulted, advises, plans jointly with, has delegated authority – to has control (WHO 2002f: 14). Every step up the ladder towards genuine empowerment requires an equivalent change in mainstream practice (Hoggett 1995).

Productive participation requires commitment, understanding and openness to change, competencies and resources (WHO 2002f: 17-18) and there are many barriers. Some of those are highlighted in Table 8.6, placed here for two reasons. Firstly, these reflect the elements discussed in 8.3.2 as important for community resilience and change; their similarity is not surprising given resilience and change requires empowered communities. The second reason has implications for successful PHC programs. There is increasing attention being given to the poor outcomes of many Indigenous health projects (Strempl et al 2004; Clapham et al 2007). The reasons for this closely mirror barriers to community participation, reinforcing the need for health professionals (and others) to develop more sensitive and effective processes for engagement with communities that truly reflect the spirit of participation and community development.

The third level of action is concerned with addressing the downstream or individual determinants and these require help with personal change in health behaviours and choices. Behaviour change is difficult and has been a theme throughout the thesis. Both the individual and the health provider require a range of skills and supportive environments, within the health service and in the broader community. In addition, almost universally, the time and effort required for these activities is underestimated (Cohen et al 2005). There is an added challenge for smaller communities. The literature on successful behaviour change emphasises a comprehensive approach and the importance of drawing together all the services required to address people’s health needs (Woolf et al 2005). Areas with smaller populations also require a
comprehensive approach and integration of all the providers, but this will have to be
done in a different way for there will be fewer services locally available and
integration and innovation skills become important.

<table>
<thead>
<tr>
<th>Barriers to community participation*</th>
<th>Factors associated with sustainable programs in Indigenous communities+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personnel issues</strong></td>
<td><strong>Factors consistently impeding success+</strong></td>
</tr>
<tr>
<td>Reduction in social capital</td>
<td>A lack of funding, and vertical rather than integrated funding</td>
</tr>
<tr>
<td>Lack of time of community members</td>
<td>An inadequate skills base</td>
</tr>
<tr>
<td>Lack of leadership</td>
<td>Organisational and family issues</td>
</tr>
<tr>
<td>Lack of relevant skills and knowledge of community members</td>
<td>A lack of information to set priorities</td>
</tr>
<tr>
<td><strong>Planning issues</strong></td>
<td></td>
</tr>
<tr>
<td>Adherence to one approach or process</td>
<td>A lack of support structures</td>
</tr>
<tr>
<td>Top down or bottom up planning</td>
<td>Distance</td>
</tr>
<tr>
<td>Inappropriate program focus</td>
<td>The competing interests created by multiple projects operating in one community at the same time</td>
</tr>
<tr>
<td>Inappropriate program evaluation</td>
<td></td>
</tr>
<tr>
<td>Lack of funds and resources</td>
<td><strong>Key factors for successful programs+</strong></td>
</tr>
<tr>
<td>Lack of sustainability</td>
<td>Adequate funding and resources</td>
</tr>
<tr>
<td></td>
<td>Skilled and committed personnel</td>
</tr>
<tr>
<td></td>
<td>Functioning organisations and good project management</td>
</tr>
<tr>
<td></td>
<td>Community control and respect for community protocols</td>
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<tr>
<td></td>
<td>Community acceptability and involvement</td>
</tr>
<tr>
<td></td>
<td>Strong partnerships</td>
</tr>
<tr>
<td></td>
<td>Understanding the underlying factors relating to the issue</td>
</tr>
</tbody>
</table>

Sources: * Howat et al 2001: 261
+ Clapham et al 2007: 282-283
For many practitioners, PHC is a continuum of care in a landscape largely determined by location, the skills of practitioners, the management system, the resources available and engagement with the community. Figure 8.1 is a representation of the reality of PHC at the delivery end for places like Menindee, where those involved are trying to balance the needs of immediate and long-term health care with those of promoting a healthier community. As well-structured chronic disease programs now being advocated begin to see clients with increasing self-management skills, better outcomes and less demands on traditional clinical services, there is the potential for there to be much more population-focused activity; if resources are not reduced when the anticipated client numbers reduce. Current prevention and early intervention strategies focusing on the vulnerable and ‘at risk’ are well established and practitioners will say they do health promotion. The reality is that this is still the least understood component of PHC and practitioners lack the requisite skills.
It could also be said that collaboration or cooperation is one of the aspects of PHC that is less understood than it should be. In a good PHC model there is a seamless flow between primary, secondary and tertiary components of the health system and good collaboration with other key stakeholders, which also includes the community. Partnerships and cross sector collaboration are required because problems are complex and no one sector can handle them alone. By working together, there is greater potential to work out practical ways of dealing with common problems. There are advantages, disadvantages and constraints related to collaboration and cooperation, but the intent is that the organisations have agreed to work together for a common purpose. The quality change enablers noted in Table 8.5, and in particular leadership, communication, trust, teamwork and a high degree of involvement and engagement of all those involved, are aspects of the collaboration and engagement with people from other organisations, because these interactions are focused on change.

When Leutz was examining how acute and chronic disability services were integrated in the United States and the United Kingdom he identified five laws that “perhaps have no scientific justification” but which serve to help those involved in integration do a better job (Leutz 1999: 100). The fifth law states that: “the one who integrates calls the tune”. He is commenting on the fact that frequently it is the voice of the powerful health system and financial system that overrides the other voices of those involved in these collaborative endeavours. Partners may have different roles and responsibilities but the act of collaboration is about coming together as equals and developing solutions together; it is not about one partner exerting power over others. There is a tendency in PHC collaborations for the voice of the health service to ‘drown out’ the voices of the other partners. The result will be less effective outcomes and the potential for partners to disengage from the process.
8.5 RELEVANCE OF STUDY

The intent of this case study is not to generate theoretical propositions generalisable to other groups. Rather, as an exploration of PHC in action in one unique community, sharing many of the challenges being faced by similar small and remote communities, it illustrates particular social contexts and themes that have relevance to those whose experience it is, and may have relevance to others, such as those embarking on major chronic disease programs.

Within current national and state health strategies primary health care, chronic diseases, prevention and Indigenous health are priority areas, as is providing services to those living outside metropolitan and regional centres. Menindee provides a microcosm for examining these issues as one. A long history of PHC-focused small programs, community wellness checks that identify a large burden of chronic disease and the potential for ill-health at a young age for both the Indigenous and non-Indigenous population, has resulted in the development and implementation of a more focused and well-resourced chronic disease program.

It identifies some of the challenges that those involved in implementing such programs face when there is great change, when there is disparity in general and when some are expressing despair at their perceived lack of choice, and it has implications for policy makers, program planners and practitioners, and all those who are partners in community development.

The themes are not new but they are ones that continue to impact on the ability to develop a primary health care model that is transformational, rather than one that only provides a continuum of care, and they all appear in the list of enablers of PHC in the previous section.

For those who are contemplating major chronic disease / PHC programs, the study supports the particular importance of the following on effective PHC in similar communities:
1. Individuals and communities require skills for change and change is more complex when there is significant inequity.

2. Change is stressful and management need to support their staff through this process. For both staff and clients, when you are busy and stressed it can be difficult to focus on anything but the immediate.

3. Prevention may be emphasised, but primary prevention for individuals is very different from primary and primordial prevention required at the community level, when structural disadvantage is confronted.

4. Empowerment, capacity building, resilience, community change and participation are interconnected and health professionals and community members require greater understanding and skills in community engagement and capacity development.

For those focusing on ‘One Stop’ health services and ‘Super Clinics’ Menindee provides a useful model of the services that can be provided when there is a range of health professionals (not just GPs and Nurse Practitioners) with both clinical and population health skills. Prevention activities are to be a major focus of these initiatives and Menindee reinforces the message that if there is to be effective prevention the skills associated with behaviour change and broader understanding of social contexts are required.

The study supports the literature that the extent of mental “dis-ease” is underestimated and that social and emotional well-being enhancement should be a core component of community PHC. It could be argued that mental health activities and strategies would fit into the third area of community level core functions that are implicit in good primary health care practice (borrowing from the UK). At least in the medium term, though, being explicit about its importance, and not ‘hiding’ it in other components, increases awareness and attention given to what are increasing needs. So, the core functions implicit in good PHC practice become:

1. First contact care: acute assessment, diagnosis, care, treatment and referral
2. Chronic disease management, continuing care and rehabilitation
3. Public health: health protection and promotion programs that improve health and reduce inequalities (Department of Health UK 2002); and
4. Social and emotional wellbeing enhancement (and not necessarily in this order).

There is a final point to be made about the relevance of the study. At the time of the interviews, Menindee was a community reeling from the pervasive effects of a long drought. People were moving away to seek employment elsewhere and some of those remaining, already affected by the effects of social disadvantage, were under increasing stress. Those who in times past had been resilient were beginning to lose that capacity and the adolescents were expressing despair. The importance of community is acknowledged in PHC endeavours, but how is a community at the tipping point perceived by those involved and how does it recover? This is an area requiring further exploration.

8.6 LIMITATIONS OF STUDY

The limitations of a case study, with a mixed methods approach are outlined in Chapter 5, and limitations to the quantitative section are provided in Chapter 6. This section comments on four major limitations of the study as a whole.

The first is that the subject is too broad, and it is therefore not possible within the constraints of resources and thesis guidelines, to focus in-depth on all the aspects related to primary health care in this small community. In the interview phase, trying to explore so many areas with informants was risky: there was insufficient time to explore their stories in any great depth. However, a glimpse from each of their experiences added to a picture of PHC in Menindee, and helped to identify areas that can be explored more fully in the future.

The second limitation is that this is not an exploration of Menindee PHC from the perspective of complex adaptive systems, in spite of this being the focus of Chapter 2. A CAS approach has much to offer health systems that are highly complex and continually undergoing change but this requires a specific CAS-designed study.
However, because the systems involved are complex, its injunction to take ‘another way of thinking of and seeing your world’ can be invaluable, and the metaphors of a CAS can help Menindee and others do this. There are still many health professionals with little exposure to this approach so it seemed important to emphasise its value, even if only components of it were used to illustrate issues identified.

The third limitation is the most important. It is not possible to ‘unravel a PHC maze’ without considering economic issues. The cost of a health service is an important component of its sustainability, particularly as these costs continue to rise. In addition, there are economic dimensions to both effective and efficient care. The need for research on economic issues relating to optimal use of resources in PHC has been identified (Kalucy et al 2001: 7), including the need to assess the impact of inequalities in health. Menindee demonstrates many positive features of a rural health service but to contribute to the research on sustainable rural health services (Humphreys et al 2006) requires an economic component. With both a health service and an inequity component required, the complexity of such an analysis was outside the resources available for the study.

The fourth limitation, which is linked to Study 2, illustrates the difficulties associated with the principle of ‘participation’. Part of the qualitative section, that on health service utilisation, informed who was selected and asked to participate in an interview. It is very likely that the ‘voices’ of the most disadvantaged were unheard and not able to contribute to this study, except through the voices of those who did attend. Sometimes such an outcome is not obvious at the time a research strategy is developed and submitted for ethics approval.

8.7 ISSUES REQUIRING FURTHER CLARIFICATION

Definitions of primary health care vary and a number have been used throughout this thesis but one has particular relevance now. Primary health care is about collaborative networking locally, a partnership relationship with the secondary and tertiary sectors, consumer and community involvement, balancing health care
priorities so that immediate needs are met in ways that contribute to addressing longer term more macro level priorities and it must be sustainable.

Four issues arise from the thesis and need further clarification. These are related to health service gaps; partnerships and collaboration; workforce; and sustainability.

1. **Emerging issues and gaps in service**

Mental health needs have been consistently under-estimated. Fostering social and emotional well-being needs to become an explicit core primary health care function, as is acute and chronic care. Mental health services are having difficulty coping with the burden of acute needs and resources to facilitate preventive services are required. There has been significant mental health funding made available in recent budgets but this is often channelled into acute services. How to develop models of care that deliver effective preventive mental health services to remoter locations requires further research.

Adolescents in small communities offering few opportunities to challenge and foster their development are in crisis. These young people infrequently use health service facilities and there have been few programs for them. Health services need to be advocating for this vulnerable population and looking for effective ways to reach out to them.

2. **Partnerships and collaboration**

Partnerships and collaboration are about different groups working together for a common goal. There is only real collaboration when there are strong partnerships with those involved valuing each other equally; it should not be about power but it often is. Effective communication happens when those involved hear each other clearly.
3. Workforce

Having a sustainable workforce is already problematic for isolated communities. An appropriately trained workforce will be crucial for programs to be sustainable. Community health needs are changing and those responsible for accreditation and training need to be less protective of traditional professional roles and engage with service providers, communities, and health professional organisations in honest dialogue concerning appropriate categories of health workers and the skills they require. This is a theme that keeps recurring and needs attention with intent to develop solutions.

4. Sustainability

Sustainability of programs is a principle of primary health care and the continuing clarification of its domains (political, institutional, financial, economic, client and workforce) is important (Sibthorpe et al 2005).

Equally important are sustainable communities. Communities in crisis require additional support - increasing their capacity to address those issues that are affecting them. The health service is only one of several key players in addressing this challenge.
8.8 CONCLUSION

In remote communities such as Menindee, primary health care is an abstract idea and a concrete service with many possibilities largely constrained by the extent of shared purpose between providers and between providers and community. The power of the idea lies in its focus on good health care and the reduction of those inequalities that contribute to poor health and reduction in opportunities for the disadvantaged. The story of one community’s journey in challenging times is presented as a source of lessons for others intent on transforming the health of communities.
**Glossary**

**Age-specific death rates:** Calculated by dividing the number of deaths within each of the age groups by the corresponding population of each age group, expressed as a rate per 100,000 population.

**Birth weight:** The newborn infant’s first bare weight in grams.
   - *Low birth weight:* birth weight less than 2,500 grams
   - *Very low birth weight:* birth weight less than 1,500 grams
   - *Extremely low birth weight:* birth weight less than 1,000 grams

**Gestational age:** The duration of gestation measured from the first day of the last normal menstrual period, expressed in completed weeks. If the date of the last menstrual period is uncertain or unknown, an age estimate based on an ultrasound during the first half of pregnancy or by examination of the newborn infant is recorded as the gestational age.
   - *Preterm:* Births that occurred before the 37th completed week of gestation
   - *Term:* Births that occurred between 37 and 41 weeks of gestation
   - *Post-date:* Births that occurred after the 41st completed week of gestation

**Infant mortality rate:** The proportion live born infants who die within 364 full days after birth
   \[
   \frac{\text{Total number of infant deaths} \ (< 365 \text{ days old})}{\text{Total number of live births}} \times 1000
   \]

**Life expectancy:** The average number of additional years a male or female of a given age might expect to live if the age-specific death rates of the given period continued throughout his/her lifetime

**Livebirth:** The complete expulsion or extraction from its mother of a baby of at least 400 grams or 20 weeks gestation who, after being born, breathes or shows any evidence of life such as a heartbeat

**Low birth weight rate:** The proportion of live born infants weighing less than 2500 grams at birth
   \[
   \frac{\text{Total number of live born infants} \ (<2500 \text{ grams})}{\text{Total number of live births}} \times 100
   \]

**Neonatal mortality rate:** The proportion of live born infants who die within the first 28 days of life
   \[
   \frac{\text{Total number of neonatal deaths} \ (<29 \text{ days old})}{\text{Total number of live births}} \times 1000
   \]

**Perinatal death:** A stillbirth or neonatal death.
Perinatal mortality rate:
\[
\frac{\text{Total number of stillbirths + deaths in first 28 days}}{\text{Total number of births (live and stillbirth)}} \times 1000
\]

Preterm birth rate: The proportion of live births infants that are born prior to the 27th completed week of gestation
\[
\frac{\text{Total number of preterm live born infants (<37 weeks gestation)}}{\text{Total number of live births}} \times 100
\]

Stillbirth: The complete expulsion or extraction from its mother of a baby of a product of conception of at least 20 weeks gestation or 400 grams birth weight who did not, at any time after delivery, breathe or shows any evidence of life such as a heartbeat

Stillbirth rate: The proportion of births weighing 400 grams or more or having a gestational age of 20 weeks or more, that show no signs of life after birth
\[
\frac{\text{Total number of stillbirths (>=400g or >= 20 weeks gestation)}}{\text{Total number of births (live and stillbirth)}} \times 1000
\]
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