An evaluation of the Healthy Clarence Communities Project

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Southern Cross University

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Reasearch collaboration

This evaluation and research project was undertaken by researchers from the Regional Initiative for Social Innovation and Research (RISIR), a research initiative of Southern Cross University. The project team worked with the Clarence Valley Council and in particular with Patty Delaney, co-ordinator of the Healthy Clarence Communities project.

The Healthy Clarence Communities Project is part of the National Partnership Agreement on Preventative Health Initiative funded by the Australian Government.

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The research team would also like to take this opportunity to thank the many people and organisations who contributed to this evaluation.

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We would like to thank sincerely the Clarence Valley Council for the opportunity to evaluate this valuable initiative. In particular we acknowledge and thank the program coordinators, Dan Griffin and Patty Delaney. Their commitment and energy enriched both the project and this research.

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Executive summary

Introduction

While regional economies, towns and centres strive to forge futures in markets and societies empowered by globally connected information, by global trade, and by global travel, some communities find themselves less able to participate in, and enjoy, all the benefits of regional life. The communities most at risk of exclusion include low income households, sole parent families, older Australians, the unemployed and under-employed, Indigenous Australians, people with a disability, and refugee and asylum seekers. Exclusion is characterised not only by exclusion from economic and social life but also by rising incidences of diseases of lifestyle and social disadvantage: obesity, diabetes, diet and lifestyle-related diseases, as well as mental health issues. This constitutes one of the most significant challenges facing regional economies and communities in both Australia and in equivalent communities throughout the western world.

This evaluation of the Healthy Clarence Communities Project, a federally funded Healthy Communities Initiative in the Clarence Valley, suggests that neither a laissez-faire 'hands off' approach, nor an over-reliance on government funding provide sustainable responses to the regional health challenge. This report highlights strategies that, with a whole-of-community approach, could help build the foundations of a more inclusive, engaged and healthy regional community.

The project

The Healthy Clarence Communities Project (HCCP) was a multi-layered program of community-based physical activity and healthy lifestyle activities co-ordinated by the Clarence Valley Council. It was delivered throughout the Clarence Valley Local Government Area (LGA) by a team of local health and fitness providers. Funding for the Project was provided by the Federal Department of Health and Ageing as part of its Healthy Communities Initiative.

The project sought to increase local participation in physical activities and healthy lifestyle programs and had a focus on increasing levels of participation within five target groups: Aboriginal and Torres Strait Islanders, the long-term unemployed, people over 65, overweight people, and those with a mental or physical disability.

The HCCP comprised 14 different primary programs and activities over the three-year life of the project. Those programs included walking, gentle exercise, weight loss programs, tai chi, aqua fitness, gym workouts, and cooking and nutrition classes.

The evaluation occurred both at a micro level (within each program) and at a macro level (across the Project as a whole). It comprised an analysis of both quantitative and qualitative data and was undertaken by a multidisciplinary team of researchers from Southern Cross University's Regional Initiative for Social Innovation and Research (RISIR).

What began as an evaluation of a program about losing weight and getting fit became an exercise in appreciating the challenges inherent in delivering a multi-faceted community-based preventative and restorative health program into a regional community covering more than 10,000 sq. km. The challenges were significant. Clear very early on however was the determination of the Clarence community to be inclusive and to find, for everyone, innovative solutions.

The findings

The HCCP was a place-based project that to a significant extent succeeded in improving the health and well-being of project participants and re-engaging these people with their local community. There is evidence too that it succeeded in building self-confidence and self-worth at an individual level, and similarly succeeded in being socially inclusive and more broadly cohesive. **The HCCP project has been characterised throughout by strong leadership from the Clarence Valley Council, the outstanding work of key people, including the program coordinators, and by inspiring community altruism.**

A significant success of the HCCP was the levels of engagement of traditionally hard-to-access communities – Indigenous communities and men. A number of programs were delivered within Indigenous communities during the HCCP, namely HEAL, Foodcent$ and Living Large Taking Charge. Participation rates, particularly amongst men, as well as reported levels of satisfaction and engagement represent a significant Project achievement.

Evidence of community buy-in is provided also by the response from businesses: over 50 local service providers, entrepreneurs and organisations became involved in the delivery of the programs. This network includes the regional emerging health and well-being entrepreneurs: rural women who lead walking groups, community organisations running outdoor exercise classes, and local gymnasia providing a range of programs tailored for older people and those with chronic health conditions. The commitment to HCCP by each member of that group represents a significant asset to the Clarence LGA, one that can be leveraged into the future to grow health and community engagement across the Clarence Valley.

The Strategy

The report concludes with a series of practical recommendations to the Clarence Valley Council. Whilst the first recommendation recognises the importance of additional government funding the remaining recommendations are not contingent on obtaining block funding, rather they are designed to provide the basis for a sustainable, healthy living strategy:

1. Develop a costed strategy for maintaining and growing the successful programs that comprised the HCCP. That strategy, developed in collaboration with relevant state government departments AND local providers, be put forward to state and federal governments for support.

2. Recognise, enable, and encourage actively the role of local businesses, service providers, and social entrepreneurs to develop health programs within the community. Council procurement and planning policies, particularly around food and food outlets, can be used to stimulate localised food economies in food growing, processing, marketing, and consumption.

3. Ensure that planning decisions reflect the need for healthy facilities such as community gardens, edible streetscapes, walk and cycle ways, swimming pools, and community exercise spaces. Those facilities must be appropriate for diverse cultural and health needs. Ensure that planning processes, such as development applications, are as simple as possible to encourage community organisations and health entrepreneurs to actively engage in the creation of healthy public spaces.

4. Ensure that all new housing developments (of, say, 3+ homes) include plans for community gardens and shared exercise spaces. This opportunity is to target developers, enabling them to build not just new estates, but enriched communities.

5. Continue to support the Healthy Communities website.

6. Exploit mobile technology, and in particular 'apps', to encourage use of the community's healthy living assets. The location of walking trails, bike tracks, outdoor exercise equipment, water refill stations, bike hire shops, local food outlets, and markets could all be made available in a 'Healthy Clarence Community App'. That tool should include an interactive map of the region. Local businesses offering healthy activities or food, locally grown produce, and so on, could also form part of this virtual community space.

7. Investigate the development of an app that allows individuals to record, using for example QR codes, their use of exercise infrastructure within the LGA. Each bike track, walking track, exercise space, and exercise infrastructure can have a QR code attached to it so individuals can log their use. A Healthy Communities competition could be established for the individual groups targeted in the HCCP to encourage their on-going engagement with health infrastructure and health programs.

8. Support the Clarence Community Champions and the Community Health Leaders in an ongoing way so they continue to provide to the community their services as mentors and spokespeople. They represent another valuable community asset, being of the community and understanding those with whom they live, work and exercise.

Where is the Clarence Valley ?

Clarence Valley Local Government Area (LGA) is located in the Northern Rivers region of New South Wales. It is approximately 300 kilometres south of Brisbane and 600 kilometres north of Sydney.

Covering an area of 1,0444,121 hectares the LGA was created in 2004. The region is named after the Clarence River, which runs though the LGA and enters the Pacific Ocean at Yamba and Iluka.

Clarence Valley is home to a number of rural townships, principally Grafton, Maclean and Yamba, and many smaller rural and coastal centres. The population of the Clarence Valley LGA is 49,960 people with a population density of 0.05 people per hectare.

The Clarence Valley, New South Wales: A Community Profile

Historically, the main economic activities of the region have been agriculture, forestry, fishing, tourism, provision of public services, and general commerce. The primary industries (agriculture, forestry and fishing), consistent with the experience of similar places, have been in decline for some decades.

Tourism, general commerce and the provision of public services (including healthcare) are the current main sources of employment.

The decline in some industries and the reliance upon others sees the Clarence Valley LGA characterised by below NSW State average income and economic participation, and above average unemployment and underemployment.

The project

Context and background

The Healthy Clarence Communities Project (the Project) was a multi-layered program of community-based physical activity and healthy lifestyle activities delivered throughout the Clarence Valley Local Government Area (LGA) over a period of three years (2011–2014). The Project was funded by the Federal Department of Health and Ageing as part of its Healthy Communities Initiative

Clarence Valley Council was one of 92 LGAs to receive funding pursuant to the Healthy Communities Initiative. The then Labour Government provided $71.8 million over 5 years (2009–2014) in order to 'increase the number of adults predominantly not in the paid workforce engaged in physical activity and healthy eating programs and activities'.

The Clarence Valley LGA is a place of outstanding natural beauty and natural resources. The Great Dividing Range, much of it forested, runs north–south parallel to the coast. High rainfall feeds the Clarence River. The Clarence Valley is characterised by beaches, national parks, state forests and agricultural land, much of it along the floodplains of the Clarence River.

Although not explicitly targeting LGAs with significant levels of social disadvantage, in practice the vast majority of the funded LGAs share a range of characteristics and demographics normally associated with social disadvantage. The Clarence Valley LGA is no exception to this rule. In 2011 the Clarence Valley scored 919.4 on the SEIFA Index of Disadvantage. The SEIFA Index measures relative levels of social disadvantage across a range of Census-based characteristics including low income[1], low educational attainment, high unemployment and jobs in unskilled occupations. The score of 919.4 positions the Clarence Valley LGA amongst the most disadvantaged 30% of LGAs across the country.

1 The median weekly income in the Clarence Valley is significantly below the national average. In 2011 the median income of a family in Clarence Valley was only $768 or 66.7% of the Australian median income (Australian Bureau of Statistics 2011).

Project aims and objectives

On one level the Healthy Clarence Communities Project was all about reducing weight and getting fit. The aims of the Project reflected those aspirations:

- Reduce the levels of obesity within five specific target groups: Aboriginal and Torres Strait Islanders, the long-term unemployed, people over 65, overweight people, and people with a mental or physical disability
- Reduce the barriers for the target groups to access healthy lifestyle information
- Increase participation of the target groups in physical activities and healthy lifestyle programs
- Build on existing programs and introduce national programs
- Develop Council policies and facilities that promote healthy lifestyles.

On another level however the Project sought to re-engage a wide range of people with their local community. The Project aimed to re-build confidence and self-worth at an individual level and to enhance social inclusion and cohesion at a community level.

The project framework

The Healthy Clarence Communities Project was a blend of 14 different project programs, each of which was located within three Project 'streams', namely:

- Local Programs and Activities
- National Programs
- Education and Training.

Rural health in Australia

The rural health statistics in Australia are concerning. In 2013 the Australian Council for Social Services (ACCOSS) and the Rural Health Alliance reported that 'avoidable mortality' rates are higher for rural areas and much higher in remote areas. Social commentator Bernard Salt in 'Beyond the Great Divide' (2001) writes that Australia can almost be seen as two distinct nations: the metropolitan areas and the rural, regional and remote. This is important because as Vines (2011) argues, apart from this inequality being inherently problematic, regional, rural and remote Australia is in fact the 'heart of the country'.

According to Smith, Murray et al. (2008) in the Australian *Journal of Rural Health*, health is generally worse in rural areas than in metropolitan areas in Australia and this is also true in the UK and the US. This is mostly due to the fact that levels of social disadvantage experienced in rural areas are generally higher than metropolitan areas. However the epidemiological factors for this trend need more research.

According to Anna Peeters of the Obesity and Population Health IDI Heart and Diabetes Institute, Australia's figures are bleaker than the US and the UK. 'We are seeing a selectively greater increase in more severe obesity, and there are some disadvantaged socioeconomic groups particularly at risk' (Monash University 2013). 'The history of obesity sees that obesity has tripled to 30% from 10% in 1980. The number of people in the healthy weight range has decreased from 65% to 30% in that time.'

The Impact of the Health Environment

It is important to try to understand what is leading to this health epidemic. Most researchers have found that the factors of 'obesigenisis' are complex and multi-faceted.

One clear factor is the 'health environment' in which people find themselves and the corollary of this is that obesity is not an individual moral failing. According to obesity researcher, Crowley (2013), 'Obesity is a medical condition not a personality failing'. He states that in the same way that depression was until recently seen as a personal moral failing so now is obesity. Indeed, stigma and discrimination are pervasive and likely itself to lead to psychological impacts (Pulh & Heuer 2010).

Zoe Williams (2011) writes that 'Obesity is about poverty and cheap food, not moral fibre' (*The Guardian* 14 December 2001). In this article Williams refutes the often-common attitude that obesity and associated lifestyle issues can be attributed to individual people's personal moral failings rather than being associated with, or a symptom of, social disadvantage.

Most programs took place on several occasions throughout the lifetime of the Project. They were delivered by various 'providers' in many different locations across the LGA.

The project programs

The Project comprised six locally designed exercise and healthy living programs, four national exercise and healthy living programs, and four training and education initiatives.

The national programs

In addition to the funding already available to LGAs, the Healthy Communities Initiative funded six not-for-profit organisations to expand their healthy lifestyle programs nationally with the aim of ensuring the availability of each program to a majority of the LGAs participating in the Healthy Communities Initiative.

The HCCP included the following national health programs:

- **Heartmoves**: gentle physical exercise program
- **Beat it**: targeting people at risk of diabetes, heart disease and metabolic syndrome
- **HEAL**: encouraged cognitive and behavioural changes around the relationship between eating and exercise habits, targeted the Aboriginal and Torres Strait Islander population
- **Heart Foundation Walking**: free community-led walking groups.

The local programs

The six local health programs comprised a range of place-based initiatives and enabled the Council to respond to locally identified need and interest throughout the duration of the HCCP. The low cost physical activity program in particular facilitated the delivery of a number of popular programs by local providers including outdoor fitness, beginners circuit, aqua fitness and tai chi.

The HCCP included the following local programs:

- **Outdoor exercise centres**: designed and located in Iluka and Yamba and providing a free exercise option
- **Community Champions**: individuals nominated by organisations as representing target groups. Their role was to raise awareness of the Project and promote healthy living
- **Budgeting for Health**: a program to equip participants with the knowledge and skills necessary to live a healthy lifestyle on a minimal budget and delivered as "Food Cent$" by the Aboriginal Medical Service.

- **Taster Days**: held annually in order to promote healthy lifestyles, project programs and activities.
- **Low-cost physical activity program**: subsidised classes delivered by a range of local providers across all the communities.
- **Clarence Valley's Biggest Loser**: an already established, successful Rotary-organised event in Grafton. Project funding enabled the expansion of the contest across the valley.

Education and training

The Project's four education and training activities comprised three 'train the trainer' programs and a program to train community health leaders within each target group. Trainers were trained to deliver Beat it, Heartmoves, and HEAL programs as part of the Project. The community health leaders were trained to encourage healthy eating/physical activity within the target group and to organise health-promoting activities within their local community.

The evaluation

The programs of the Healthy Clarence Communities Project were subject to one and in some cases two reporting/evaluation regimes.

Providers of the four national programs were required to provide quantitative data direct to KPMG, the government appointed program advisory service. The data collected by KPMG recorded levels of participation in the national programs across the country. The data collected by KPMG was not made available to the respective LGAs, including the Clarence Valley. Instead, participating LGAs were advised to implement alternative additional data collection methods in order to comply with the reporting requirements. Providers of the national programs were therefore subject to two reporting regimes.

Providers of local programs were not required to provide data to KPMG. They were however required to report on levels of participation in order that the Council could comply with the reporting requirements attached to the funding.

The Regional Initiative for Social Innovation and Research (RISIR), Southern Cross University, carried out a detailed evaluation of the Healthy Clarence Communities Project. From October 2012 to March 2014 the research team collected information and feedback from program participants, program providers and Clarence Valley Council staff via Participant Questionnaires, Provider Activity Logs, stakeholder focus groups, Reference Group meetings and ongoing discussions with Clarence Valley Council staff.

The Role of Empty Calorie Food

One factor influencing rising rates of obesity is the availability, relative affordability, and marketing of food and drinks that are high in calories and often low in fibre and nutrients. This is sometimes referred to as 'empty calorie' food (Drewnowski 2005).

According to research by the US National Institutes of Health 40% of energy consumed by 2-18 year olds in the US comes from empty calories found in solid fats and added sugars. These came from just 6 sources; soda, fruit drinks, dairy desserts, grain desserts, pizza and whole milk (Wein 2010).

Changes in people's diets are happening relatively quickly and are being noticed, chronicled and warned against by experts such as Michael Pollan. Pollan argues that if you prepare your own meals, i.e. cook from basic organic ingredients, it's hard to become obese (2013, p. 194). He laments the loss of collective social cultures of food growing, harvesting, preparation, cooking and eating.

Findings

Barriers and enablers

The delivery of the HCCP has seen the emergence of a number of meta themes. The themes show a high degree of consistency both across programs but also through time.

The themes constituted 'enablers' or 'barriers' to successful delivery and consequent achievement of successful outcomes for the broad range of health initiatives included under the HCCP. The themes are either 'enablers' or 'barriers' depending upon whether they are successfully addressed, or not.

Taken together the themes add meaning and depth to the statistics and measures traditionally used to define the Clarence Valley as a region of high social disadvantage. Importantly however they also reveal a range of community assets, alliances and strengths together with a widely held intention to improve the collective health of the region.

Healthy Living Environments: The Community Response

The 'obesity epidemic' is clearly affecting individual people, families, communities, and economies. Health policy, including the National Strategic Framework for Rural and Remote Health, recognises the health differences between metropolitan and rural Australia. It recognises in particular the need to address avoidable mortality especially that resulting from obesity.

There has been a range of responses in the US, UK and Australia that include community-based capacity building (social capital) and ensuring 'healthy living environments' and 'healthy food environments' (Sallis & Glanz 2009). These seem to vary in emphasis between targeting vulnerable people in particular communities through to focusing more upon environmental factors that support healthy living choices.

1) Funding, resources & facilities

The participants look forward to this program. They want it to continue and would like to exercise more days each week. There have been improvements in health, weight, and blood pressure. Continued funding would make it easier to deliver this program in the future.

Provider: HEAL

The funding has been fantastic, making it worthwhile travelling the 100kms round trip I do each week.

Provider: Heartmoves

Public investment is required to ameliorate the lifestyle impacts of social disadvantage. Adequate funding needs to be provided for a community-based healthy activities program to succeed, particularly in a region characterised by high levels of social disadvantage.

I felt it was a shame that the Maclean Pool Management was opposed to the program and at first visit it was obvious that we were not wanted. The degree of opposition decreased as the program continued.

Participant: Aqua Fitness

Air-conditioning in the room would assist us while we are exercising.

Participant: Beat It

Physical resources required for success include suitable venues. This includes swimming pools and gyms/exercise venues. Venues should be conducive for exercising: warm/cool, dry, mosquito-free and appropriately private. Within the venues there needs to be heating/air-conditioning, gym and exercise equipment, and equipment designed to help people with a range of health challenges and disabilities. Skilled staff are needed to assist with using equipment and venue facilities, including cooking and kitchen venues and equipment.

Many people also suggested the building of walkways and cycleways to help make exercise easier and safer.

These programs always need funding assistance as they are generally used by low income earners and it is too costly to run the program without a subsidy.

Provider: Beginners Circuit

Make it easy to get to exercise programs, preferably free or cheap.

Participant: Tai Chi

Responding to the challenge: healthy communities in the United States

Obesity is equally of concern in the US, where the University of Washington Institute of Health Metrics and Evaluation (IHME) (2011) has found that average life expectancy is falling in some communities due to obesity. Poor African American men and women seem to be particularly vulnerable. A range of programs has been implemented including 'Healthy Communities' and the Centre for Disease Control's 'Communities Putting Prevention to Work'.

'Healthy communities' is a program designed to build social capital with community interest groups competing for funds to project manage a wide range of projects. A good example is the Colorado Healthy Communities Initiative. The Initiative involved 28 community coalitions in a funded program designed to improve local quality of life (Murray 2000).

'Communities Putting Prevention to Work' specifically targets vulnerable communities and individuals with a combination of education/information, program participation and social capital building. The emphasis is upon ensuring healthy environments with funding going towards food programs, community gardens, walkways and cycleways, as well as general exercise facilities such as gymnasiums and swimming pools.

Adequate funding is also required in order to ensure the programs are affordable. Programs need to be accessible in terms of cost to the participant and sufficiently resourced. Subsidising participation in healthy activities enables long-term engagement by excluded communities, encourages participation by local health and fitness businesses, and enables not-for-profit organisations to build internal capacity.

I would like to be more fit [and] these two classes are convenient and not expensive. I have osteoporosis.

Participant: Heart Moves and Heart Foundation Walking

In Victoria, Australia, the Neighbourhood Renewal Initiative has:

…introduced as a place-based social model of health that 'joins-up' government and builds inter-sectoral and community partnerships to tackle local sources of health inequality. Neighborhood Renewal intervenes in key material, psychosocial and behavioral pathways to morbidity and mortality by transforming poor housing, creating employment, improving education, rejuvenating local economies, reducing crime and building community resilience.

(Klein 2004)

Adequate funding is also required in order that the programs are widely available. Programs need to be offered in ways that tie in with affordable and accessible transport. Alternately they need to be made available in widely spread and sometimes geographically remote communities.

More advertising, especially doctors' surgeries.

Participant: Low Cost Physical Activity Program

Information, advertising, websites, and community newsletters need to be available widely and in plenty of time for potential participants to make inquiries and potentially enrol. Clearly this is resource intensive, again especially in contexts of social exclusion and isolation.

Long-term reliable funding is essential. Much of the emphasis of HCCP has been to build awareness around people's cultures of exercise, eating, and life in general. To sustain cultural shifts it is essential support be offered on a long-term basis. The people and communities who have, often courageously, faced personal health issues should be supported to continue to do so. At the same time they are often acting as mentors to others.

2) Organisation, administration & evaluation

Skilled and committed organisation is required as complexity and diversity permeates all aspects of the HCCP. There is a diverse range of health issues, participant communities, federal and local programs, and social conditions, all of which take place across wide range geographic locations and timeframes. The HCCP has linked local communities and individuals and their needs with the bigger picture – information, resources and organisations. **That linking role is essential.**

A high level of **administration capacity** is required to coordinate these activities into complex and diverse communities. Successful delivery depends upon disbursing funds, tracking expenditure against aims and objectives, and meeting reporting regimes. This represents an additional and often quite substantial barrier for local providers, particularly individuals.

Effective evaluation is required to support the delivery of the project and reporting on project outcomes. The complexity of the project design of HCCP places high demands on the personnel involved in organisation, administration and evaluation.

3) Social & community aspects

My whole look on life (has changed).

Participant: Biggest Loser

The re-engagement of socially isolated, disadvantaged and culturally diverse communities through healthy living activities requires an **understanding of the characteristics, culture and challenges of different communities** in the Clarence Valley.

I was unfit and turned 60 and needed to get myself fit. It has helped me give up smoking.

Participant HEAL

Effective re-engagement also requires an **understanding of the depth of embedded social disadvantage** within the Clarence Valley. In particular an appreciation is needed of the impact of social disadvantage at an individual level i.e. social isolation, mental health issues, chronic health issues, lack of knowledge about proper nutrition, low educational levels and geographic immobility.

Although we knew all the members of our group we didn't used to mix socially. We now lunch together after our exercise.

Participant: Heartmoves

A long-term commitment to the programs enables ongoing support for participants' lifestyle change and encourages the **formation of new social relationships and groups**.

It was a good experience, participating with a group of women with the same goal.

Participant: Community Champion Program

I've lost weight, gained confidence and met some great friends. I don't ever want it to end, it's a great program.

Participant: Low Cost Physical Activity Program

Social and community-based healthy living initiatives can help build collective consciousness, offer important mentoring roles as well being supportive to people attempting to positively change lifestyles.

I've changed my eating habits and I'm more aware of how I cook. I'm trying to be healthier.

Participant: Foodcent$

Continued support from the Council and community (would make it easier to deliver this program in the future). I understand Patty has worked hard to build a relationship with the Aboriginal community. Once these barriers are broken down trust is given and the results come from consistent commitment from all stakeholders.

Provider: Community Champions Fitness Training

Good program design requires an understanding of the **cultural needs and social reality of Aboriginal and Torres Strait Islander communities and the active collaboration of trusted local health providers.**

The Bulgarr Ngaru Aboriginal Medical Service is an excellent example of such a provider. Bulgarr Ngaru worked in partnership with the Clarence Valley Council throughout the Project in order to offer access to the HEAL program for Aboriginal community members living in Malabugilmah (also known as 'Mala' for short). Bulgarr Ngaru's frontline staff have highlighted a number of key factors that led to the success of HEAL in the Aboriginal community:

- *Bulgarr Ngaru is a health service where the local community go for all of their medical and health needs. Having the HEAL program delivered by known, trusted and respected health service staff helped community members to feel comfortable with the group classes.*

- *Community leaders were identified and recruited to participate in the program. They proved to be great advocates for HEAL and assisted with further participant recruitment by spreading positive messages about the program within the community.*

- *Holding program classes at the Aboriginal Land Council building meant participants were familiar with the surroundings.*

- *The Aboriginal HEAL participant booklets were well received by those participating. It was felt that 'going with the books and not with technology such as PowerPoint slides helped the group to become more confident and chatty in sharing experiences and it encouraged them to ask lots of questions.*

- *Holding fortnightly cooking classes on the same day as HEAL encouraged attendance at both and proved to be a successful way of getting participants involved and built a strong sense of community..*

Significantly staff involved in the delivery of HEAL were able to adapt the national program in a number of respects in order to respond to the needs and priorities of the participants including:

- *Having a flexible approach to program delivery, in particular with participant attendance and collecting baseline and post program health assessment measures such as waist circumference, blood pressure and 6 minute walk test distance. It was important to conduct these measures when people were there attending the classes.*

- *It was important to sometimes allow participants to ask health-related questions not directly related to the HEAL program. Following up with the provision of additional information and resource handouts relating to these questions the next week. The fact that community members were there asking about health-related questions was viewed as important to their overall health care.*

- *Providing some participants with brief advice, encouragement and support to make an attempt to quit smoking.*

It would be good to see more men participate.

Participant: BEAT IT Beginners Circuit

Continue these programs and encourage young people.

Participant: Biggest Loser

I now feel more confident to try other things.

Participant: Tai Chi

It (the program) was excellent. The comfort and support I got from them was great.

Participant: Biggest Loser

Increasing access to drinking water: an HCCP initiative

Six months ago filtered water stations were installed at Wherrett Park Maclean, Whiting Beach Yamba, Iluka outdoor exercise centre, and Grafton, Yamba and Iluka skate parks. The water stations incorporate separate water bottle refill points, a bubbler and a dog water bowl, with all stations providing filtered water for active people and their pets.

Council metering has revealed that over the six months 42,800 litres of filtered water has been used. Highest use areas were the station near the exercise area at Charlie Ryan Park Iluka followed by the skate parks. Mayor Richie Williamson said 'These water stations deliver a range of sustainable outcomes by improving community health, and reducing unnecessary use of plastic water bottles.'

Mayor Williamson indicated that 'Council will explore the potential for their installation at other popular recreational areas'.

The water stations were made possible with funding assistance from the Healthy Clarence Communities Project, co-ordinated by Council in partnership with the Australian Government.

Press Release: Clarence Valley Council March 2014

Responding to the Challenge: Food Security and Economic Localisation

Food security is defined as 'the limited or uncertain availability of nutritionally adequate or safe foods' (Burns 2004). As the food industry has grown in recent decades, food is almost always grown remotely, harvested and prepared through industrial processes, and transported to retail outlets.

As has been chronicled by Burns and by Pollan (2013), and many others, local environments have often had their food environments depleted, and food and drinks are brought in that are generally high in added sugars and solid fats i.e. high in 'empty calories'. These industrialised foods and drinks are generally marketed aggressively via a supermarket system that in Australia is particularly tightly controlled by two dominant corporations (Boley 2014).

Emerging in response to this situation is a range of movements that aim to re-localise food growing, processing, and consumption. Local 'producers markets', community gardens and 'edible streetscapes' are helping to re-establish food sovereignty, supplying local food, revitalising local economies and to some extent re-establishing collective cultures that sustain local food growing, harvesting, process and eating (Pollan 2013).

Participation in **healthy lifestyle activities overwhelmingly leads to increased happiness and self-esteem, body mobility, reduced social isolation**, inspiring and/or being inspired by other individuals, family and community members.

4) Education, practice & the broader context

I loved the challenge of changing the participants' mindsets, making them keen on fun and teamwork as exercise. I found they had challenges on knowledge about nutrition and I think a bigger part of the program should be based on nutrition classes.

Provider: Biggest Loser

I wanted to learn how to cook healthy meals for my children.

Participant: Foodcent$

It is almost universally recognised that the **corporate food culture** is negatively impacting the diets and wellbeing of people in the western world, particularly disadvantaged communities such as the Clarence Valley. Large corporate advertising budgets, including linking fast food companies to iconic Australian sporting events, prevalence of fast food outlets within the LGA, high levels of sugar/starch within many standard food items, alcohol-mediated sport identities, and **passive screen-based entertainment** need to be seen for what they are. At the least there needs to be a **secure and reliable availability of healthy foods and drinks in local communities. Government control** and counter-advertising have reduced the impacts of smoking – arguably this now needs to be applied to **unhealthy foods and drinks.**

A skilful delivery of healthy lifestyle messages is required to enable confident choices by individuals and to empower them.

I enjoyed coming because I knew I would walk away feeling good.

Participant: Heal

I enjoy exercising in water as it is easier on my joints. This means I can be more active in and out of water. I have also come out of myself more; I am more like my old self.

Participant: Aqua Fitness

The program is great. I always feel great and sleep well afterwards, It has made me realise I should do more.

Participant Aqua Fitness

I always enjoy watching the participants' fitness and health improve as the program goes through. I also like watching people who are not used to exercising get excited by the improvements it makes to their lives.

Provider: Beginners Circuit

The greatest education is the actual **participation in a healthy practice** that creates a range of benefits – mobility, social inclusion, improved health, elevated self-esteem, closer relationships, and more energy.

Understanding the importance of participation, and the factors that affect participation, informs future program design. Some of those factors include motivation and morale, influence of mentors and friends and family, local availability of the program, provider skills, perceived social benefits, affordable transport, long-term arrangements that can be made routine, effective advertising and widely available information.

5) Key people/resilient community & place

R is an excellent instructor. She takes our group to the limit (not over) of our ability. She helps those who lag behind. The workouts are fun and enjoyable. She deserves all the support the Council can afford to give her.

Participant: Aqua Fitness

I never knew I could turn my life around like this at age (73 years). "J" (personal trainer) has been wonderful and makes sure I do all my exercises correctly – people have remarked that I am brighter and happier. People from the gym stop me in the street to say hello and ask how I am progressing.

Participant: Community Champion

J is the best trainer. Go girl!

Participant: Low Cost Physical Activity Program

The programs require the active involvement of **key people and organisations – local entrepreneurs, inspirational mentors**, the Community Champions, motivated and skilled health and fitness professionals able to engage with challenged and challenging participants, **committed staff** within the Clarence Valley Council, and specialist health and wellbeing organisations like the Aboriginal Medical Service. **All have been essential to the success of the program.**

My wife started and I thought that I should.

Participant: BEAT IT Beginners Circuit

Mentors, friends and family all play significant roles in supporting and inspiring others. They too represent another community health asset.

It's a lot of hard work but it's definitely paying off.

Participant: Biggest Loser

I'm fitter, stronger and happier.

Participant: Low Cost Physical Activity

Clarence Valley community is **a place of resilience**. Many of the changes that have impacted the Clarence Valley, particularly its socially disadvantaged communities and individuals, originate from outside the LGA.

An important characteristic of the HCCP was the contributions of informal, non-traditional networks of community health organisations and professionals, local businesses, volunteers, program providers, and the Clarence Valley Council. Together they constituted a community-wide commitment to the Project. These informal community networks are especially significant given the size of the Clarence Valley LGA, the geographically scattered nature of the programs, and the LGA's distance from metropolitan centres.

Achievements and challenges

There can be little doubt that there were significant increases in participation of the each of the five target groups in physical activities and healthy lifestyle programs, both existing and newly introduced. Clarence Valley Council has also created policies and facilities that promote healthy lifestyles. Given the challenges inherent in delivering a program of this nature across such a large geographic area these represent significant project achievements.

The qualitative data generated by participants and providers suggests that participation in the HCCP enabled a wide range of people to re-engage with their local community and that the project helped rebuild confidence and self-worth at an individual level.

Engaging communities

Perhaps the most compelling observation of the programs run as part of the HCCP is that every program has a completion rate – participants starting compared to participants completing a program – of over 50%. A number of programs have completion rates in excess of 70%. This represents a very significant Project achievement. Those data are shown in Table 1.

Table 1: Summary of participants across 7 HCCP programs. Heal, Heartmoves and Heart Foundation Walking are national programs; the remainder local programs tailored to local needs by local providers. Heal, FoodCent$, and Living Large Taking Charge were designed for Indigenous participants.

Program	Overall Completions (%)	Male Participants (%)
Heal	53	50
Heartmoves	84	23
Heart Foundation Walking	77	-
Biggest Losers	51	10
FoodCent$	75	17
Aqua Fitness	88	40
Living Large Taking Charge	73	50
Beginners Circuit	66	5

In order to compare national programs with those locally devised, a comparison was made between Heal and Heartmoves (national) and Biggest Losers and FoodCent$. Both Heal and FoodCent$ were developed for Indigenous communities.

Figure 1 illustrates that comparison. Of the four programs, Heartmoves and FoodCent$ were the most successful with 84% and 83% of participants respectively completing each. The most popular program was Biggest Losers, with 195 individuals enrolling. A chi-squared test for independence indicated there were significantly more participants completing courses than not ($p < 0.001$) and that was true for both the national and local programs. Importantly, there were no differences in the completion rates for the national and local programs ($p > 0.05$). In other words, locally devised programs, tailored to the needs of individual communities, are effective at engaging and keeping engaged a range of different, traditionally less advantaged communities in health-related activities.

Engaging men

Across the programs men represented 28% of all participants. While not representing the population-wide proportion of men in the Clarence LGA that participation rate represents significant buy-in. A 1-sample t-test shows male participation rates significantly higher than 10%, the rate that might be predicted on the basis of other programs of this type ($t5 = 2.52$, $p < 0.05$). Table 1 describes male participation rates across the seven programs evaluated here.

Engaging Indigenous communities

The HCCP included three programs designed specifically for Indigenous participants and communities: HEAL, FoodCent$, and Living Large Taking Charge. Of those, HEAL was a national program, and the other two locally devised. As shown in Table 1, completion rates for the two locally devised programs were above 70%. Significantly, in two programs HEAL and Living Large Taking Charge, males represented half of all participants.

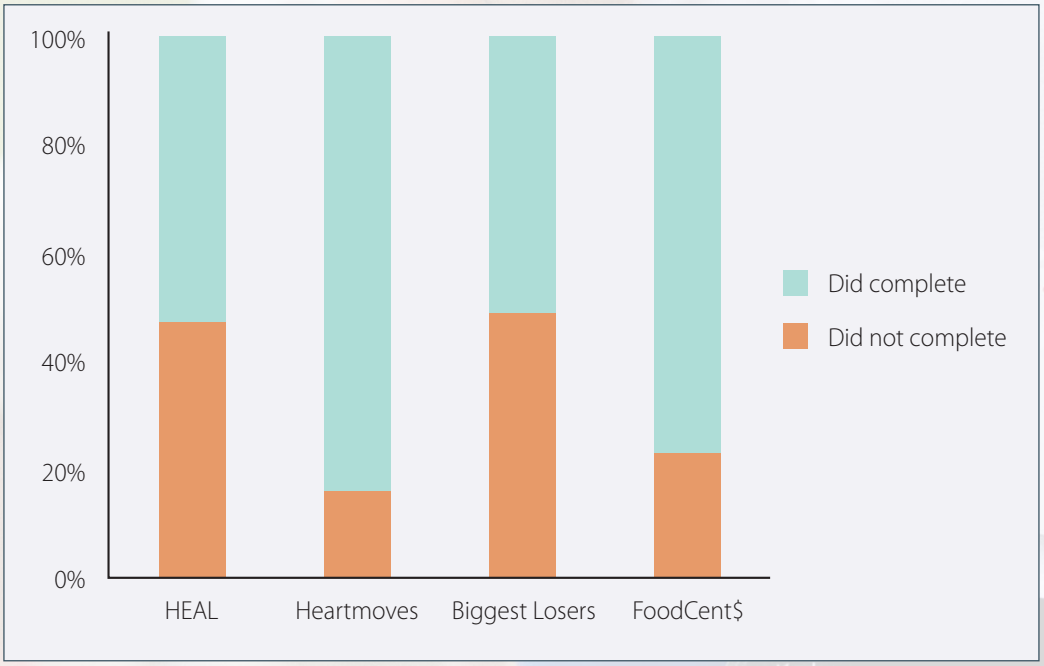

Figure 1: Completion rates for two national programs (Heal and Heartmoves, left columns) and two local programs (Biggest Losers and FoodCent$, right columns). Participant numbers of non-completers are shown as percentages in red. Individuals completing the programs are shown as percentages in blue. In all four cases more than half of those who started a program completed it.

What is not clear from these data, but was significant in terms of the success of the HCCP, was the formation of a network of collaborative relationships between more than 50 regional organisations and individuals including:

- Indigenous health and wellness organisations
- charities
- health professionals
- fitness providers
- community groups
- local businesses.

Those relationships form a significant community asset, one that will be key to the successful delivery of any future program of healthy activities. That asset was recognised by providers and participants as requiring ongoing support and engagement.

Where to next?

The Healthy Clarence Communities Project has succeeded in building the foundations of a healthy active community within the Clarence Valley. There is also evidence of widespread participation in, and enthusiasm for, healthy programs and activities. There is evidence as well of a well-established and diverse network of community-based health and fitness organisations. Both represent significant community assets. Ongoing investment and support for those organisations and their programs and for the community in general is now needed in order to maintain momentum and build on that success.

How that investment and support will be provided in the future is unclear but it may come from further government (state and federal) support. Accordingly it would be useful to develop a clearly costed strategy to take the HCCP forward. That strategy should describe how, and how much it would cost, to create, support and sustain the next phase of development. The success of the HCCP provides a solid basis upon which to seek further funding, providing governments with evidence for the likely success and challenges ahead. The HCCP outcomes provide the basis for future discussions with relevant state government departments including Health, FACS and the Office of Ageing in developing their future strategy.

This is not to say however that this initiative should remain dependent upon large government-funded programs in the long term. Local government has a key role to play in providing the leadership necessary to ensure the continued improvements in the health, wellbeing, and growing sense of community across the many towns and villages that collectively comprise the Clarence Valley.

There are many ways for Council to invest in, to enable, and to build upon this community's healthy living assets and strengths.

To that end, this report concludes with the following recommendations:

1. Develop a costed strategy for maintaining and growing the successful programs that comprised the HCCP. That strategy, developed in collaboration with relevant state government departments AND local providers, can then be put forward to state and federal governments for support.
2. Recognise, enable, and encourage actively the role of local businesses, service providers, and social entrepreneurs to develop health programs within the community. Council procurement and planning policies, particularly around food and food outlets, can be used to stimulate localised food economies in food growing, processing, marketing, and consumption.
3. Ensure that planning decisions reflect the need for healthy facilities such as community gardens, edible streetscapes, walk and cycle ways, swimming pools, and community exercise spaces. Those facilities must be appropriate for diverse cultural and health needs. Ensure that planning processes, such as development applications, are as simple as possible to encourage community organisations and health entrepreneurs to actively engage in the creation of healthy public spaces.
4. Ensure that all new housing developments (of, say, 3+ homes) include plans for community gardens and shared exercise spaces. This opportunity is to target developers, enabling them to build not just new estates, but enriched communities.
5. Continue to support the Healthy Communities website.

6. Exploit mobile technology, and in particular 'apps', to encourage use of the community's healthy living assets. The location of walking trails, bike tracks, outdoor exercise equipment, water refill stations, bike hire shops, local food outlets, and markets could all be made available in a 'Healthy Clarence Community App'. That tool should include an interactive map of the region. Local businesses offering healthy activities or food, locally grown produce, and so on, could also form part of this virtual community space.
7. Investigate the development of an app that allows individuals to record, using for example QR codes, their use of exercise infrastructure within the LGA. Each bike track, walking track, exercise space, and exercise infrastructure can have a QR code attached to it so individuals can log their use. A Healthy Communities competition could be established for the individual groups targeted in the HCCP to encourage their on-going engagement with health infrastructure and health programs.
8. Support the Clarence Community Champions and Community Health Leaders in an on-going way so they continue to provide to the community their services as mentors and community spokespeople. They represent another valuable community asset, being of the community and understanding those with whom they live, work, and exercise.

Appendices

Evaluation methodology

Importantly, RISIR did not have access to medical data or outcomes but focused its evaluation on the participation experiences of those involved – participants, providers and staff. The evaluation information sought was part quantitative (gender, postcode, number of participants and who enrolled and the number who completed), and part qualitative (self-description, motivation to participate, description of the experience, what would make the program easier to deliver, what would make the local community healthier).

This mixed method evaluation approach (Zikmund 1997) used the research process as described above and combined it with a search of relevant literature. The emphasis of the evaluation was formative (ongoing feedback) as well as summative (final appraisal). The formative approach allowed the RISIR evaluation team to develop a close working relationship with project stakeholders in the Clarence community as well as Clarence Valley Council.

The focusing upon the experiences of those participating in this initiative is a 'practice perspective'. The practice of delivering the HCC programs, as with putting anything into practice, can be complex, challenging, multi-faceted and not always easy to control or predict (Schon & Argyris 1996). For this reason several of the evaluation questions posed in the questionnaires and activity logs were open-ended and the focus group questions were semi-structured. This approach is also consistent with acknowledging social power differences between the evaluators and many of the participants. Using this method the evaluators were able to be sympathetic and responsive (Bourdiueu 1999).

The evaluation data and feedback was gathered regularly and accumulated throughout the project. The quantitative data gathered from the Clarence Healthy Communities programs (national and local) recorded the number of participants starting and completing the programs, their genders and the target groups from which they came, were entered by the respective service providers in their project activity log at the completion of the program. These project activity logs were collected by the Clarence Healthy Communities Co-ordinator and forwarded to the evaluation team for collation and analysis.

Qualitative answers were recorded and analysed for emerging themes on a continuous basis. It became apparent within the first 6 months that the responses were relatively consistent. Based upon this the RISIR evaluation team was able to target programs and communities if it was felt that there was insufficient or unclear data or feedback emerging.

This evaluation process also involved 'double-loop' learning processes (Schon & Argyris 1996). Information and insights gathered were looped back to program participants, providers, HCC stakeholders and staff in focus groups and the ensuing facilitated discussions recorded. This reflexive learning approach is participatory, aware of social power imbalances but also, according to Schon and Argyris, more likely to lead to deep organisational change.

Clarence Healthy Communities – Participant questionnaire

Many thanks for participating in this voluntary feedback process. This information about your experience of participating in a Clarence Healthy Communities program will help us understand more about the effectiveness of the programs.

All information entered into this activity log will be kept confidential.

1) What program did you participate in?

.....

.....

2) How would you describe your experience?

.....

.....

3) Where do you live? Give a postcode if possible

.....

.....

4) Male ☐ Female ☐

5) Why did you start this program?

.....

.....

6) Did you finish it? If not, why?

.....

.....

7) Please describe your experience of participating in the program

.....

.....

8) Has participating in the program changed anything in your life?

.....

.....

9) Do you have any suggestions about how to improve the health of our communities?

.....

.....

Again, many thanks for proving your valuable feedback on the Clarence Healthy Communities programs.

Project activity log for service providers

To be completed at the end of each program.

Date: .....

Name of Health Communities program: .....

Date of the Program: .....

How many people started the program?

.....

How many people completed the program?

.....

Where were the participants from? Give postcode if possible

.....

Please describe participants in terms of being in particular target groups i.e. ethnicity, disability, long-term unemployed, etc.

.....

.....

.....

How successful do you think your program has been? What has worked and what hasn't? Why?

.....

.....

.....

Do you think your program will lead to long-term change amongst the participants? If so why? If not why not?

.....

.....

.....

Many thanks for your help!

Disseminating new knowledge

Conference papers

Brennan, C., & Tucker, J. (2014), *Local entrepreneurs as agents of change and regional development: their role in delivering a place-based healthy communities initiative in regional NSW, Australia,* IRSPM Conference 2014.

Conference presentations

Brennan, C., & Tucker, J. (2013), *In the shadows of regional development: early findings of the Healthy Clarence Communities Initiative,* SEGRA Conference 2013.

Popular media

Tucker, J., & van der Zwan, R. (2013). It's not what you do it's the way that you do it. Lessons for public park exercise groups. Published in The Conversation.
https://theconversation.com/its-in-the-way-you-do-it-lessons-for-public-park-exercise-groups-12859
As of 30 April 2014: 3839 readers.

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