Can Get Health in Canterbury Project Outcome Evaluation

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Can Get Health in Canterbury

Can Get Health in Canterbury (CGHiC) is funded by Sydney Local Health District (SLHD) and the Central Eastern Sydney Primary Health Network (CESPHN), in partnership with the Centre for Primary Health Care and Equity (CPHCE), University of New South Wales (UNSW).

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- Burmese Rohingya Community in Australia (BRCA)

Collaborators

- Lakemba, and Hampton Park Primary Schools, and Lakemba and Wiley Park SaCC
- Muslim Women Association
- Canterbury City Community Centre
- SLHD Dental Hospital
- Save the Children
- NSW Refugee Health
- NSW Service for Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS)
- SLHD Health Promotion

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The Can Get Health in Canterbury project is supported by a partnership between Sydney Local Health District, Central and Eastern Sydney PHN (CESPHN) and the University of New South Wales Centre for Primary Health Care and Equity (CPHCE). The project is underpinned by values of equity and community engagement and works in collaboration with Canterbury communities and community organisations.

Executive Summary

This fourth evaluation of the Can-Get-Health in Canterbury (CGHiC) program once again demonstrates that it is effective in improving access to services and programs, improving individual and community health literacy and addressing underlying social determinants of health within the limits of its budget and influence. CGHiC was established in 2014 as a collaboration between Sydney Local Health District, Central and Eastern Sydney Primary Health Network (then Inner Western Sydney Medicare Local) and the UNSW Centre for Primary Health Care and Equity, as a place based initiative in the most disadvantaged local government area of inner Sydney.

CGHiC aimed to reduce health inequalities in a disadvantaged community. There exists a substantial body of literature on how to go about this through interventions at individual, community and system levels[1] [2]. The examples of approaches and strategies from national and international research focus on upstream factors (i.e. changing macro-level social and economic policies, improving living and working conditions); and midstream and downstream factors (i.e. improving the equity of the health care system, involving local communities in health initiatives, empowering individuals and strengthening their social and family networks; and changing health damaging behaviour)[3].

Attempts to tackle inequalities by focusing on upstream factors are likely to result in the greatest impact on population-wide disparities; however, societal level changes are the most difficult to bring about, and the most politically challenging.[4] Can Get Health in Canterbury (CGHiC) is a place based intervention that sought to address midstream and downstream factors through an emphasis on the individual, community and service delivery levels.

This evaluation used a variety of methodological approaches including analysis of previous evaluations, online surveys, interviews and review of internal documentation, to examine the impact of CGHIC. It has demonstrated that CGHIC has been effective in achieving its key outcome indicators: improved health and capacity building of communities and individuals; capacity of service providers to meet health needs of Culturally and Linguistically Diverse (CALD) communities; achievement of the strategic directions and objectives of SLHD and CESPHN; impact on health research and innovation. Table 1 provides examples of these (details of which can be found in the full report).

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[1] Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017.

[2] Golden SD, McLeroy KR, Green LW, Earp JA, Lieberman LD. Upending the social ecological model to guide health promotion efforts toward policy and environmental change. Health Education and Behaviour 2015, 42 (1_suppl), 8S-14S https://doi.org/10.1177/1090198115575098

[3] Health inequalities in Australia: morbidity, health behaviours, risk factors and health service use March 2006 Queensland University of Technology and the Australian Institute of Health and Welfare

[4] Ibid., 2006

Table 1: Examples of Impact of CGHiC

	Example1	Example 2
Impact of the CGHiC on the health and capacity building needs of the communities and individuals targeted by the project	Rohingya Little Local: Burmese-Rohingya Communities of Australia (BRCA) was allocated $10,000 to identify communities and promote health and well-being. They chose to organise a soccer tournament and a community picnic for 300 people.	A Bangladeshi Women's Circle was established to promote their health and wellbeing. The group met weekly for eight weeks and discussed issues of interest to them such as reproductive and women's health. Childcare was provided. After this several women found ongoing employment and others were participating in education.
Impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities	CGHiC soon realised that there needed to be a workforce to deliver health literacy programs in community languages. South Western Sydney LHD trained four bilingual educators (BCE). This proved to be an effective model and the ongoing Cultural Support Worker Program was developed based on this.	Continuing professional development events were organised for GPs, practice nurses and allied health on refugee health. This increased knowledge and referral pathways between GPs and refugee and mental health services.
Impact of CGHiC in SLHD and PHN strategic directions and objectives	Senior managers in the LHD and PHNs have officiated at events and CGHiC has been presented to the CESPHN Clinical Council and senior groups in the LHD to highlight local needs. This has led to increasing recognition of the need to target Canterbury for service development.	CGHiC has provided practical examples of ways in which dental assessments and health promotion could be conducted in community settings including Schools and local events.
Impact of CGHiC on health research and innovation	CGHiC explored access to afterhours care in Canterbury. This found that children under 2 years of first-time mothers were more likely to the Emergency Department. This led to the establishment and evaluation of a first-time mothers' group program for Bangla and Chinese mothers.	CGHiC explored how it could support general practices with predominantly CALD populations to provide more integrated care. This led to a unique study of the role of bilingual community health workers as navigators which is ongoing.

CGHIC is a maturing model for local health services to invest in structures to improve health in ways that promote inclusion, local leadership, and innovation. It provides a platform for other programs to be supported and developed (examples of which include the community health worker in general practice and the Central and Eastern Sydney Primary and Community Health Cohort). It has also facilitated the inclusion of migrant groups in the management and delivery of a broad range of programs.

The communities targeted by the project are now better positioned to identify health damaging behaviour, adopt protective practices and utilise the resources and services available to manage their health needs. In this regard the project has been effective in ameliorating some of the adverse effects of social disadvantage on health and well-being.

The project targeted four communities identified in the needs assessment as having significant health needs and facing specific barriers to accessing health information, resources and services. These communities were Chinese (for the first 2 years of the project), Arabic speaking, Bangladeshi and Rohingya. According to the Australian Bureau of Statistics (ABS) these 4 communities represent a total of 14% of the Canterbury population or approximately 50,000 people in 2016[5]. These are significant numbers and projects such as CGHiC, if properly implemented should have positive health impacts on these communities, either through direct participation in the activities, or indirectly through the ripple effect of community capacity building and leadership.

Evaluating these impacts is however a complex task for several reasons. Measuring changes in agency, social capital and health literacy in communities is not a straightforward task and very resource intensive. Demonstrating causal links between these impacts and better health outcomes is even more problematic. Nonetheless, social capital through capacity building receives academic attention as a potentially important factor in health research.[6] There is also strong evidence linking social capital to the health status of various individuals and neighbourhoods. Despite gaps in research on how social capital operates, the evidence indicates that a wide range of community associations and community capacity building can improve individuals' and communities' health status through social integration and ties[7]. Exploring social capital in future work may be a useful strategy.

Can Get Health in Canterbury takes an asset-based approach which recognises social capital and capacity building as protective and promoting factors in improving health and wellbeing. The manner in which CGHiC executed this approach had some unique characteristics including the following:

- Strong community partnerships and community co-design approaches
- Strong networks and partnerships with service providers, business, community and government organisations in Canterbury
- Emphasis on building leadership capabilities, particularly for women

[5] City of Canterbury Community profile https://profile.id.com.au/canterbury-Bankstown/birthplace
[6] Yamaguchi A. Effects of social capital on general health status. Glob J Health Sci. 2014;6(3):45–54.
[7] Ibid., 2014

- Strong governance and project monitoring and review structures including a Management Committee and a Steering Committee with representation from communities, funding bodies and service providers.
- An emphasis on addressing health inequities through academic research and practice across all program areas

The evaluation also sought to explore future governance structures and position CGHiC within SLHD and CESPHN. CGHiC has delivered significant outcomes for the participating communities, community leaders, service providers, project partners, and for research and innovation. As a model for health equity the project has also demonstrated a capacity to address some of the structural barriers preventing disadvantaged communities from accessing health.

CGHiC also has shown a strong alignment with SLHD Strategic Plan, particularly in relation to focus area 1: Our Communities, Partnerships and the Environment. Central to this focus area is an approach to health planning and delivery that involves the communities through co-design methodologies, capacity building activities and empowerment models of community engagement. The focus area also emphasises action to address health inequities through downstream (individual and community-based activities) and upstream activities (advocacy, promoting safe environments, service development). Currently CGHiC demonstrates an example of SLHD using co-design, capacity building and empowering approaches to working with CALD communities.

The project has had a significant impact on community leaders, particularly women. These impacts include many non-health outcomes such as access to education and employment opportunities. A follow up of the Bangladeshi women enrolled in the Bangladeshi Women's Circle in 2017 has revealed that many of them are currently studying or employed. These positive outcomes were linked by the women to the skills, knowledge and networks gained through their participation in the project.

Given the strong association between education and employment, and better health [8] these changes are important indicators of the success of community-led, multisectoral approach to health equity through capacity building approaches. Participating communities in CGHiC benefited by understanding how health is connected to other goals important to them, and that improving education, housing, safety, employment, or the environment can also help improve health and mitigate health inequity[9].

[8] Hahn RA, Truman BI. Education Improves Public Health and Promotes Health Equity. Int J Health Serv. 2015.

[9] National Academies of Sciences, Engineering, and Medicine 2017. Communities in Action: Pathways Health Equity. Washington, DC: The National Academies
Press.

Based on the above findings the evaluation of CGHiC had identified the following recommendations for each of the 4 evaluated areas and the future of the project:

1. Impact of the CGHiC on the health and capacity building needs of the communities targeted by the project:

Recommendations:

1.1. To shift the role of CGHiC Project Officer from activity-oriented tasks to a more facilitator and manager role supporting local services in the design and implementation of activities.
1.2. To maintain and further strengthen the community-led approach to health equity in Canterbury through partnerships with CALD communities.
1.3. To identify and develop linkages with other disadvantaged communities in Canterbury in order to expand the impact of the project to other groups from low SES.
1.4. To continue and expand partnership outreach activities, such as oral health checks at school, given their effectiveness in reaching large number of children and families.
1.5. To continue supporting the delivery of hospital tours for newly arrived migrants and refugees given the important role they play in health literacy.
1.6. To maintain the focus on building the leadership and capabilities of community leaders through training, mentoring and resources.
1.7. To expand opportunities for small funded projects targeting capacity building for CALD women

2. Impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities

Recommendations:

2.1. To maintain and further strengthen the linkages and partnerships with service providers and organisations in Canterbury given their crucial role in the achievements of CGHiC.
2.2. To explore stronger linkages with other SLHD funded projects targeting CALD communities (i.e. Cultural Support Program, Multicultural Health) in order to coordinate approaches to health literacy interventions and utilise existing resources and human capital.
2.3. To expand partnerships to include non-health providers such as local businesses, TAFE, housing, employment services, police, and universities given their critical role in addressing the social determinants of health.
2.4. To explore the role of service providers in advocating change and reform to address social determinants of health
2.5. To develop resources and information for local government agencies on structural determinants of health and specific actions they can take to address them (HERDU).

2.6. To continue supporting local organisations to strengthen their capacity to address the health and wellbeing needs of CALD communities.
2.7. To consider a scheme to fund local service providers to deliver CGHiC activities
2.8. To recognise the role of participating organisations in advancing the goals of CGHiC (i.e. equity awards, newsletters, etc).

3. Impact of CGHiC in SLHD, PHN and HERDU strategic directions and objectives

Recommendations:

3.1. To continue and further strengthen the community-led approach given its strong alignment with SLHD focus area 1 which requires involvement of communities in health planning and delivery through co-design methodologies, capacity building activities and empowerment models of community engagement.
3.2. To maintain the partnership between the District, CESPHN and HERDU as a model of health intervention informed by health equity research and evidence-based methodologies.

4. Impact of CGHiC on health research and innovation

Recommendations:

4.1. To increase the research outputs and dissemination of information about CGHiC and its impacts on health literacy and capacity building
4.2. To conduct further research on innovative approaches to address health inequity issues in SLHD
4.3. To expand opportunities for SLHD, CESPHN and HERDU to participate in forums, conferences and research on social determinants of health
4.4. To use data and evidence from CGHiC to inform decision making on strategies and activities to reduce inequities within the District.

5. Future arrangements to ensure its sustainability

Recommendations:

5.1. To retains the name, and overall objectives of the project given that CGHiC has come to be identified as a brand or trademark for a distinctive way of addressing health and wellbeing issues in the community
5.2. Ensure CGHIC retains its community-led model, capacity building emphasis and partnerships approach given the effectiveness of these approaches in meeting the health and wellbeing needs of the targeted communities.
5.3. To increase its visibility through greater research and dissemination strategies
5.4. To maximize the use of existing capabilities in SLHD and CESPHN

The Next steps: Ensuring the sustainability of the Project

One of the objectives of this evaluation was to explore the future of Can get Health in Canterbury, including its approach and position within SLHD and CESPHN and the role of HERDU. In order to examine the impact of changes in model, governance and funding, this evaluation conducted interviews and surveys with key stakeholders to ascertain their views on these issues. In addition a feedback form was sent to members of the executive team and key stakeholders asking them to consider possible future scenarios for CGHiC and to comment on what they regarded as the key elements the project needed to retain to ensure a successful transition.

Based on the answers and feedback provided, the following 3 scenarios for the future of CGHiC were developed:

1. The Project retains current funding and organisational structures and implements the recommendations identified in this evaluation. The role of CGHiC Project Officer shifts from activity-oriented tasks to a new focus on facilitation, oversight and management activities aimed at strengthening local networks and partnerships and supporting local services in the design and implementation of activities. The links between CGHiC and other SLHD projects is strengthened in order to expand capacity and utilise existing human capital (i.e. Cultural Support Program). HERDU supports project through research on best practice in health equity interventions and evaluation.
2. The project is structurally located within the Clinical Services Integration and Population Health Directorate in SLHD. An ongoing role for HERDU in providing critical thinking, evidence base and research and evaluation capability would be important. With time the CGHiC model could be replicated in other priority areas across SLHD, and also look at other non-CALD populations in the Canterbury area. It also has an important role to play in the development of place-based models in SLHD.
3. The Project funds community organisations/service providers to deliver the objectives of the project. Each organisation has a Project Officer in charge of CGHiC. Performance indicators linked to funding and strong focus on outcomes. CESPHN supports Project Officers in identifying strategies and designing activities. The recommendations identified in this evaluation are implemented. HERDU supports project through research on best practice in health equity interventions and evaluation.

Regardless of the scenario, governance structure and funding model, the feedback from the surveys and interviews identified the following key characteristics the project needs to retain in order to remain effective:

- Strong community partnerships and community co-design approaches
- Strong networks and partnerships with service providers, business, community and government organisations in Canterbury

- Emphasis on building leadership capabilities, particularly for women
- Strong governance and project monitoring and review structures including a Management Committee and a Steering Committee with representation from communities, funding bodies and service providers.
- An emphasis on addressing health inequities through academic research and practice

In order to maintain these key characteristics, the following resources were identified:

Human resources

- Continued involvement of CHWs, continued personnel through HERDU for research, innovation and evaluation.
- Increase staff capacity including bilingual and bicultural workforce.
- Human resource requirements could be drawn from existing partner workforces.

Financial resources

- Shared resources across PHN, LHD and other organisations. Funding for pilot or developmental activities (e.g. Little Local).
- Goods and Services budget for program delivery.
- Greater funding allocated for the project and its activities.

Governance structures

- Management committee should continue to engage a broad range of organisations.
- Financial accountability should be reviewed regularly (i.e. 6-monthly).
- Increase targeting of organisations that can really engage with the goals and objectives of the project
- Advisory or reference group with membership across SLHD and key community partners

Networks

- Strengthening and broadening networks across the community through engagement in management, communication, research and development activities. This has been greatly facilitated by involvement of CHW.
- Continue focus on a broad range of issues and approaches including redesign and innovation in health care delivery as well as health promotion.
- Greater connection into wider range of networks and supportive 'wrap around' services.
- Maintaining existing CHGiC networks; Diversity Hub networks; Population Health networks; SLHD networks

Other (specify)

- A clear transition plan should be developed which incorporates the experience and expertise of key staff and members.
- A physical location in the operating area.

For communities, service providers and partner organisations in Canterbury, CGHiC has come to be identified as a brand or trademark for a distinctive way of addressing health and wellbeing issues in the community. Maintaining this trademark should be a priority for the next stages of the project given its demonstrable impacts outlined in this evaluation.

Introduction

Rationale for the evaluation

Can Get Health in Canterbury (CGHiC) commenced in a structured way in February 2014. The aim of the project is to reduce health inequity in the (former) Canterbury local government area. The Sydney Local Health District (SLHD) and the Central Eastern Sydney Primary Health Network (CESPHN) jointly fund the project, in partnership with the Centre for Primary Health Care and Equity, University of New South Wales (UNSW).

Canterbury Local Government area was chosen because of the greatest socio-economic disadvantage identified in the area. To address health equity, the Can Get Health Project in Canterbury (CGHiC) aimed to:

- Improving access to comprehensive primary health care services
- Increasing individual and community health literacy
- Identifying and working with relevant stakeholders to address at least one the social determinant of health

In order to meet these objectives CGHiC has implemented over 25 projects since 2013 addressing the following priority areas:

1. Child, family and women's health.
2. Mental health.
3. Capacity building and workforce development
4. Chronic disease prevention and management.

Based on an analysis of the socio-demographic characteristics of Canterbury, the following communities have been targeted by the project: Priority populations:

1. Bangladeshi community
2. Arabic speaking community
3. Chinese speaking community
4. Refugees and Asylum Seekers- specifically the Rohingya community from Myanmar (Burma).

After 6 years in operation the CGHiC Project funding bodies, SLHD and CESPHN have requested an assessment of the Project's impact on the targeted communities, and a review of current governance models. The evaluation will therefore seek to assess the following:

1. impact of the CGHiC on the health and capacity building needs of the communities and individuals targeted by the project.

2. impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities
3. Impact of CGHiC in SLHD and PHN strategic directions and objectives
4. Impact of CGHiC on health research and innovation

The evaluation will also seek to explore future governance structures and position of CGHiC within SLHD and CESPHN. These will be discussed in the conclusion and recommendations.

Governance of the evaluation

The evaluation has been overseen by the CGHiC Advisory group, which has been in place since the development of the project in 2013. The membership of the Advisory includes community members, local service providers, members of SLHD, PHN and The Health Equity and Research Unit.

Methods

This evaluation sought to assess the outcomes of the program as identified in the program logic, which identified the following outcomes:

- Improved health literacy among marginalised groups
- Increased awareness of and capacity to access appropriate service
- Improved links to existing services and programs
- Improved health services reach to priority communities
- Systems are better equipped to identify and address gaps and inequities in service delivery

In order to evaluate the impact of the program on the above outcomes, the evaluation focused on the following:

- Changes in the targeted communities' capacity to access, advocate and utilise health resources and services
- Changes in the knowledge, capacity and commitment of stakeholders to identify and respond to the health inequity issues in Canterbury
- Impact of CGHiC on social determinants of health

The evaluation also sought to identify future directions for the program including the following:

- Role of key stakeholders in the delivery of the project
- Governance structures (auspice organisation, reporting and accountability systems)
- Research themes, collaborations, and outputs

Evaluation questions

The evaluation sought to answer the following questions:

a. What changes have taken place among the program participants as a result of the CGHiC?
b. What changes in terms of knowledge, skills and action to address health inequities in Canterbury have taken place among the participating organisations as a result of the CGHiC?
c. What opportunities in research and innovation occurred as a result of CGHiC?
d. What lessons can be learnt from CGHiC for SLHD, PHN, local services in Canterbury and in other health district areas?
e. What changes in the program objectives, structure and governance are needed to ensure its sustainability?

In order to answer these questions, the following methods were used:

1. Review of previous evaluation findings and documentation including Management Committee meetings, work plans, reports and activities' evaluations.
2. Analysis of data collected on CGHiC by international intern student conducting research on the project as part of her Masters of Community Psychology.
3. Online surveys:_The survey targeted all the stakeholders and participating organisations including the following:
   - Canterbury-Bankstown Council
   - Ethno-specific organisations
   - Health service providers
   - Local schools
   - Local media
   - Community leaders
   - Allied health professionals

The survey was tailored to different stakeholders using the following criteria:

- Group 1: Participating organisations and project partners
- Group 2: Community leaders (individuals and organisations from the CALD communities who participated in the program/activities).

The survey sought to identify the impact of the project on these organisations/communities, including changes in knowledge, skills and practice as a result of their participation in the program. It also sought to ascertain their capacity and current strategies to address health inequalities in Canterbury as a result of the program. The final survey questions were developed and approved by the Project Steering Committee.

A total of 20 survey responses were received, 16 from participating organisations and 9 from community leaders.

4. Focus groups/interviews:_The focus groups and interviews sought in-depth exploration of issues and themes identified in the online survey. The range of questions and topics for discussion with the community leaders representing the targeted communities had a focus on the impacts of the program on their ability to access and utilise health information and resources and changes in the capacity of the community to advocate and advance their health issues and needs.
A total of 6 interviews were conducted, 2 with community representatives and 4 with participating organisations.

The evaluation will be overseen by the CGHIC Advisory Group. Weekly updates will be provided, and monthly meetings will be scheduled to monitor its progress.

Timeline

Activity	Outcome	Timeframe
Initial drafting of survey questions by CGHIC Advisory Group	Online survey completed – (QUALTRICS)	January 2020
Administration of the Survey and analysis of data	Survey sent to all stakeholders and initial data analysis	February 2020
Focus groups	Focus groups conducted with key stakeholders	March-April 2020
Case studies	In-depth interviews	April 2020
First draft of evaluation report for CGHIC Advisory group	Analysis of first draft and findings	May 2020
Final report	Final report approved by Steering Committee	May 2020

CGHiC: History and Conceptual Framework Guiding its Practice

Can Get Health in Canterbury (CGHiC) was launched in October 2013 and formally started in February 2014. The (former) Canterbury local government area (LGA) was selected as the setting for this project based on research that the Canterbury population has a higher level of risk factors for health inequity. These include higher levels of socioeconomic disadvantage, with a disproportionately high number of people in Canterbury considered to be among the most disadvantaged in Australia (ABS 2016), and high numbers of migrant and refugee communities, many of them with limited English language skills. Canterbury LGA is the most disadvantaged LGA within the IWS catchment, with an index score of socio-economic disadvantage of 922. Unemployment levels in Canterbury LGA are the highest across the IWS catchment. The percentage of the total homeless population that are living in 'severely' crowded dwellings (69%) is also notably higher than the state (33%)[1]

CGHIC has been the object of 3 evaluations in 2014, 2015 and 2016. The 2014 evaluation was conducted by Sydney Local Health District and Inner West Sydney Medicare Local. The evaluation had a clarificative orientation and sought to identify the inputs, outputs and intended outcomes of the program and future evaluation plans. Its goal was to provide a program logic to guide the implementation of the activities and strategies.

The following table summarise the evaluations the project has undergone since its inception in 2013:

Development of Evaluation Framework 31 Oct 2014	• Conducted by ARTD Consultants • Program Logic Models • Evaluation Plan
1st Evaluation October 2013 to June 2015	• Conducted by ARTD Consultants & Thomas Powell-Davies
2nd Evaluation July 2015 – September 2016	• Conducted by Centre for Refugee Research, University of New South Wales.

The 2015 evaluation was conducted by ARTD Consultants and tis objective was to assess the impact of the program and the appropriateness of its activities in achieving its goals. The evaluation concluded that CGHIC was effective in the development of collaborative partnerships and networks with key stakeholders and build the capacity of LSHD and CESPHN to deliver effective programs to the target groups.

The 2016 evaluation was formative, and it focussed on identifying the strengths of the program and potential areas for future development. It concluded that the program increased the capacity of CESPHN and SLHD to respond to health equity issues, raised the profile of health inequity in the Canterbury area among key stakeholders in the area, and increased the ability of the targeted communities to seek and access resources, advocate for their needs and increase their capacity to act collectively to address their health priorities and needs.

Conceptual Framework

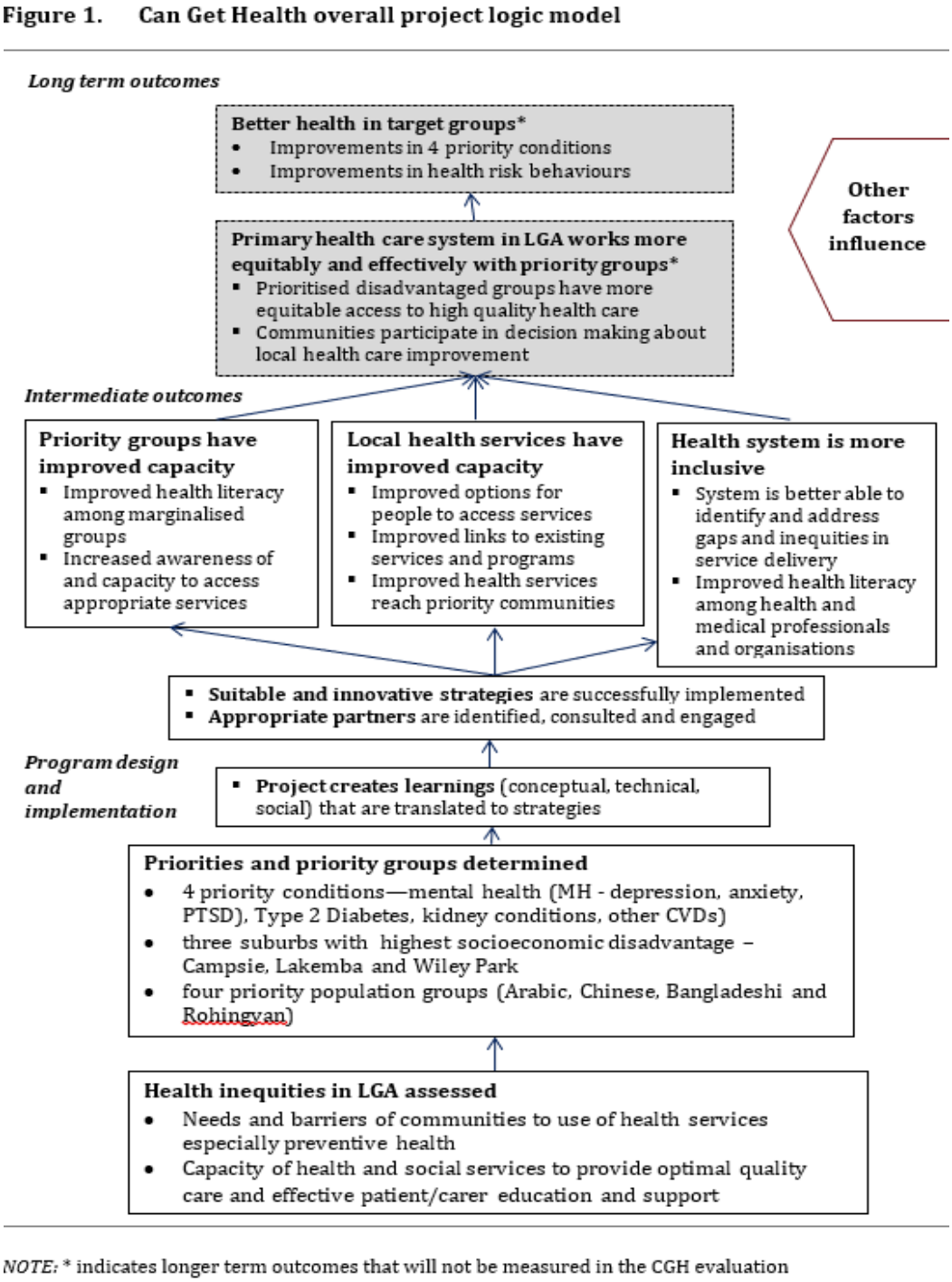
The Project was developed based on a literature review which found that the supply of health care services (including preventive services and programs and some diagnostic/treatment and management services) was not optimal; that some health services were not sufficiently 'health literate' to reach all members of their client/patient population groups optimally; that some health services are inaccessible to some population groups (cost or location or both) and are under-utilised; that some population groups resident in Canterbury have low levels of health literacy limiting their capacity to make positive health choices across the life span; and that the population of Canterbury has higher than average levels of behavioural risk to health.

During the initial planning stages of the program, extensive consultation and data analysis were undertaken. Consultation included engaging key residents and community groups, local non-government organisations, and government organisations to identify key priority groups, health issues and a plan of action. Consultations were integral in building trust with the community and identifying[2] community groups and organisations that CGHiC could partner with to implement specific activities. Following the consultation, the three key partners were engaged to formally establish the CGHiC program, including program funding and workforce. The consultation process also led to the development of the program objectives, priority populations and focus areas. These processes will be described in more details in the results.

Program Logic

CGHiC Project has evolved throughout the years and the objectives and priorities have changed in response to evaluations and consultations with partner organisations. The initial program logic (figure 3) developed in 2014 identified 3 intermediate outcomes, 4 priority conditions and 4 priority groups:

Figure 4. Program logic 2014



Evaluating the long-term outcomes of CGHiC is beyond the scope of this evaluation. Instead the evaluation has focused on the intermediate outcomes. Capturing long term outcomes including health outcomes, reduction in morbidity, disability and mortality rates requires a design intervention and evaluation model informed by longitudinal approaches and the use of control groups. However, based on the evaluation findings regarding changes in the capacity of the targeted communities to learn about and utilise health services, the evaluation will seek to make

some inferential conclusions on the long term impact of the project on the health outcomes of its participants.

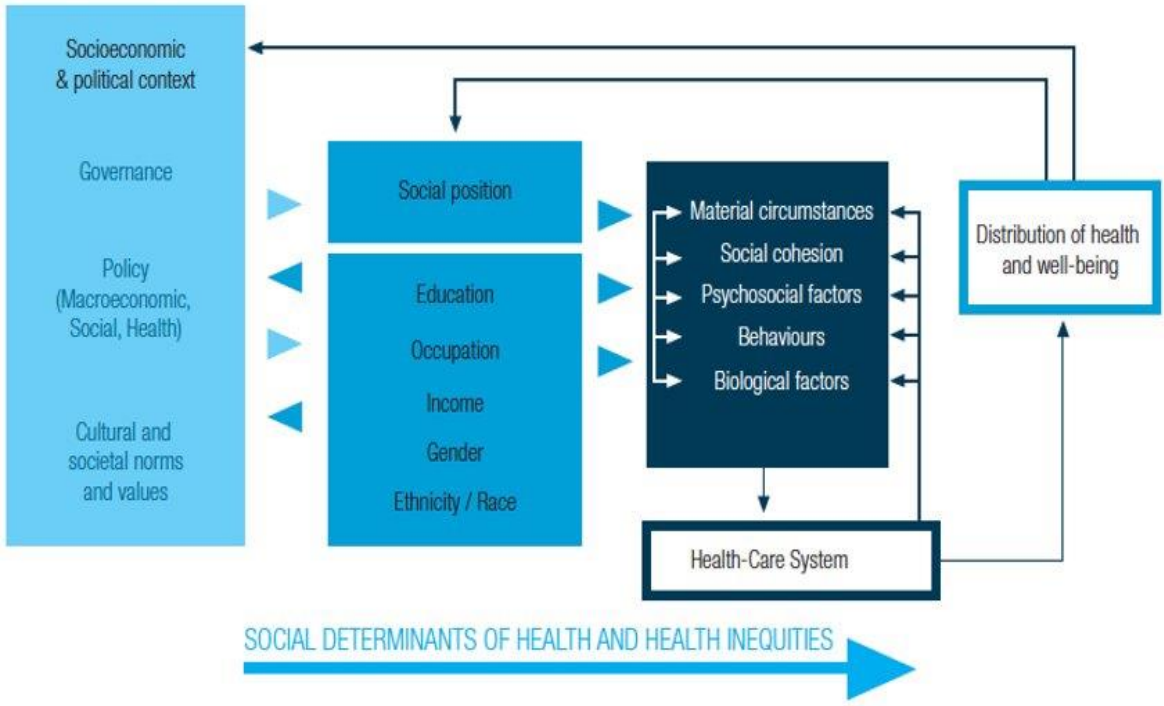
CGHiC has had various reviews and changes in focus and priority areas. The 2017-2018 CGHiC program logic was informed by a Project Planning Workshop held on February 2017 and discussions with partner organisations and others working in the area. The priority groups remained the same with the exception of the Chinese community which was no longer targeted due to the existence of various organisations and programs targeting them. In 2018-2019, the four priority areas of work were:

- Child, family and women's health
- Mental Health
- Capacity Building (including workforce development)
- Chronic disease prevention and management

Health Equity Framework

CHGiC was envisaged as a health equity project targeting the Canterbury area and specific population groups with high levels of socio-economic disadvantage, and access and equity issues preventing them from optimal health outcomes.

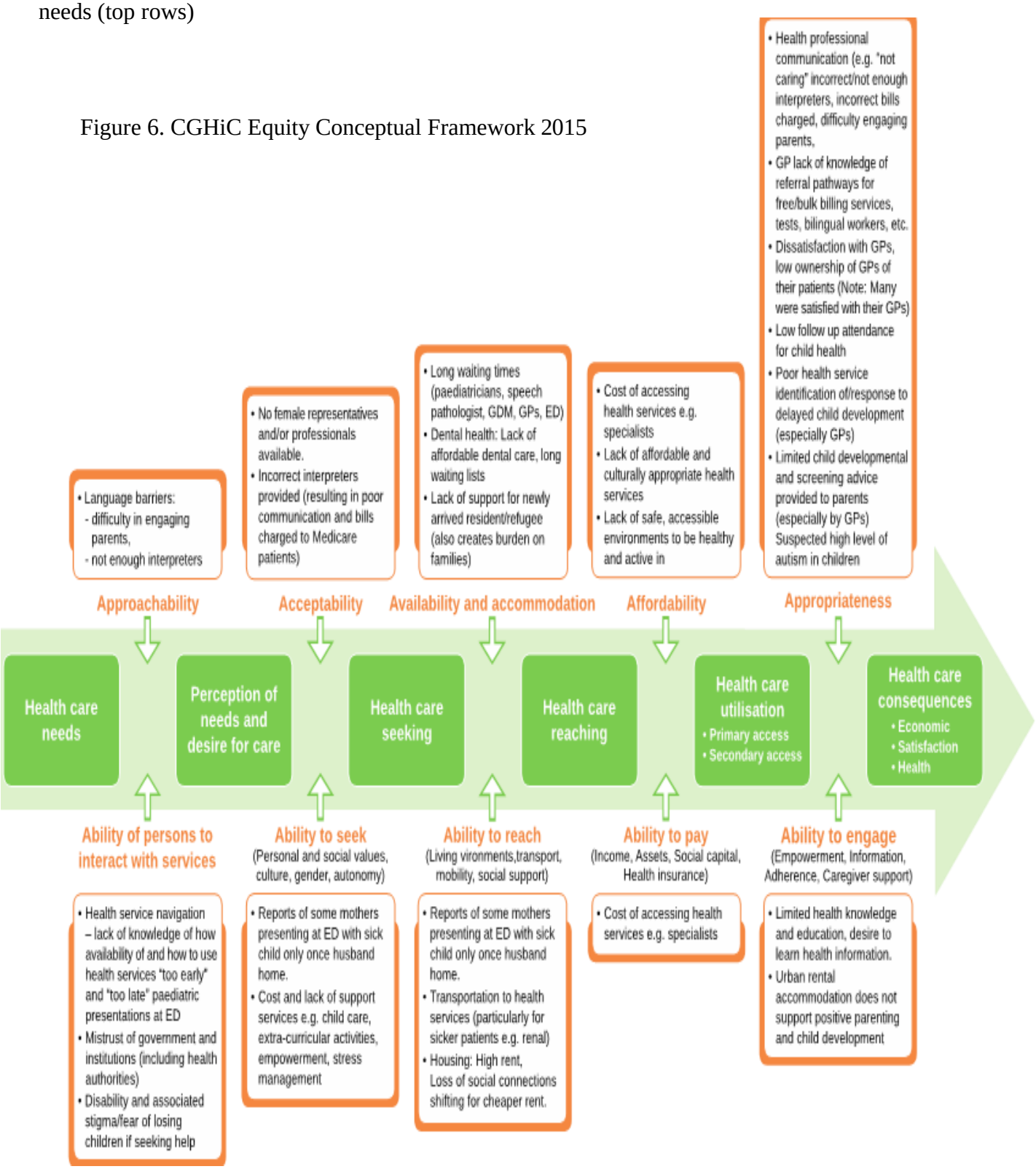
Figure 5. The social determinants of health



The model used by the CGHiC in 2015 to map the ways in which factors such as structural and socio-economic barriers translate into poor health utilisation and health outcomes, is based on the conceptual framework of access to health care developed by Levesque et al. (2013).

Guided by this framework CGHiC was initially focused on developing initiatives and interventions that sought to build the capacity of individuals and communities in the ability areas (bottom row) as well as strengthening the capacity of health and community providers to better respond to their needs (top rows)

Figure 6. CGHiC Equity Conceptual Framework 2015



Specific work plans were developed by CESPHN Project Officer to address each of these priority areas. The range of activities and strategies used have changed throughout the years due in part to new approaches to building the capacity of the communities, limitations in human and material resources and a more strategic and less hands-on approach. Since 2017 the project has moved away from an activity-based focus towards a coordinated process and therefore focusing more on a community lead versus a community engaged process.

Changes have also taken place since 2013 on the governance arrangements for the project and staff running the project. The project funds two positions, a 0.9 FTE project officer (employed by CESPHN) and 0.4 FTE Community Partnerships Fellow (employed by UNSW/SLHD HERDU). Funds from the project have also been used to employ a casual community network worker to assist with the activities targeting the Bangladeshi community. The CGHiC project officer was based in the CESPHN corporate membership team. However, in July 2018 the position transitioned to the CESPHN Population Team. The Community Partnerships Fellow position has also been impacted by changes in staff and periods when the position has been vacant. This has had an impact on the academic and research outputs for the project.

Despite these challenges and new approaches to addressing the project priority areas, CGHiC has remained, from its inception, focused on addressing health inequities through a community-led and place-led approach consisting of the following elements:

A community-led approach:

CGHiC Project adopted a community-led approach to health. This approach is based on the premise that changing situations of disadvantage and social injustice cannot be achieved by top-down solutions alone. Because of the complexity of the factors that contribute to and perpetuate inequality and disadvantage, including institutional discrimination and the sense of alienation experienced by disadvantaged groups and individuals, change also requires community-led action, whereby those who are affected by social injustice bring their collective experience to bear in defining the issues they face; identifying what needs to change; identifying solutions and acting for and influencing change.

A community-led approach to health is not a new concept; it has (explicitly or implicitly) informed the work of community health initiatives in the UK for many years. Internationally, it is the approach to health improvement and addressing inequality that is advocated by the World Health Organisation and is the approach that underpins international policy and practice frameworks for health promotion like the Ottawa Charter (WHO, 1986). A community-led approach to health improvement is concerned with supporting communities experiencing disadvantage and poor health outcomes to identify and define what is important to them about

their health and wellbeing; the factors that impact on their wellbeing and take the lead in identifying and implementing solutions.

The approach to social change based on the premise that working with CALD groups to build their capacity to define, identify, negotiate services and address their health needs is based on a theory of *fundamental causes*[3] which argues that health inequity is the result of the unequal distribution and availability of flexible resources (knowledge, financial, social connections, educational, power, status) to avoid risks and adopt protective strategies. Resources can be deployed at the individual level, as when people use resources to construct a healthy lifestyle, or at a contextual level, as when people use resources to gain access to salutary contexts such as good neighbourhoods, safe jobs, and robust social networks. Because flexible resources are deployed to avoid whatever risks may exist and adopt whatever protective strategies may be available, the association between SES and health appears in different places and at different times.

The community-led approach used by CGHIC has the following characteristics:

1. Involvement of the targeted communities (Bangladeshi, Chinese (2014-2015), Rohingya and Arabic speaking) in the identification, planning and design of health interventions and capacity building activities
2. Specific emphasis on building leadership and skills of community leaders
3. Focus on the 4 priority areas with each of the communities
4. Funding of bilingual community workers from each of the target communities to support planning and implementation of activities
5. Close engagement with community leaders and ethno-specific organisations

A placed based approach:

In addition to a focus on particular population groups the CGHiC used a place-based approach which focused on the whole social and physical environment in the Canterbury area. The combination of people- and place-based approaches allowed the Project to focus on building collaborative approaches with local services and health providers in the area to tackling health inequalities for the target populations.

The development of place-based approaches has been prompted by a number of factors. These include evidence of the importance of geography, evidence that place matters for people's well-being, and for children in particular, evidence that social networks and social connectedness matter for people's well-being, and evidence of growing health and social inequities despite the overall growth in economic prosperity[4]. In order to address place-based issues the CGHiC sought to address through capacity building and health literacy interventions, the inability of local services to respond effectively to the complex needs of

CALD families and communities, and more broadly, the difficulties in engaging vulnerable families in health programs.

The placed based approach used by CGHIC has the following characteristics:

1. Strong involvement of key local service providers in the planning and design of activities for the targeted communities through membership of Management committee and Advisory Group for the Project.
2. Needs assessment of the needs and capabilities of local service providers to respond to the health needs of vulnerable communities
3. Focus on health literacy and staff professional training on health equity issues
4. Use of expertise, human capital and resources from local organisations
5. Small grants and funding provided to projects addressing health priorities in specific site and with specific communities (i.e. Lakemba Little local, Rohingya Little local). The approach is modelled on the UK's The Big Local initiative where a community identifies and organises activities that will improve their own health. Consistent with the Big Local initiative (Orton et al. 2016).

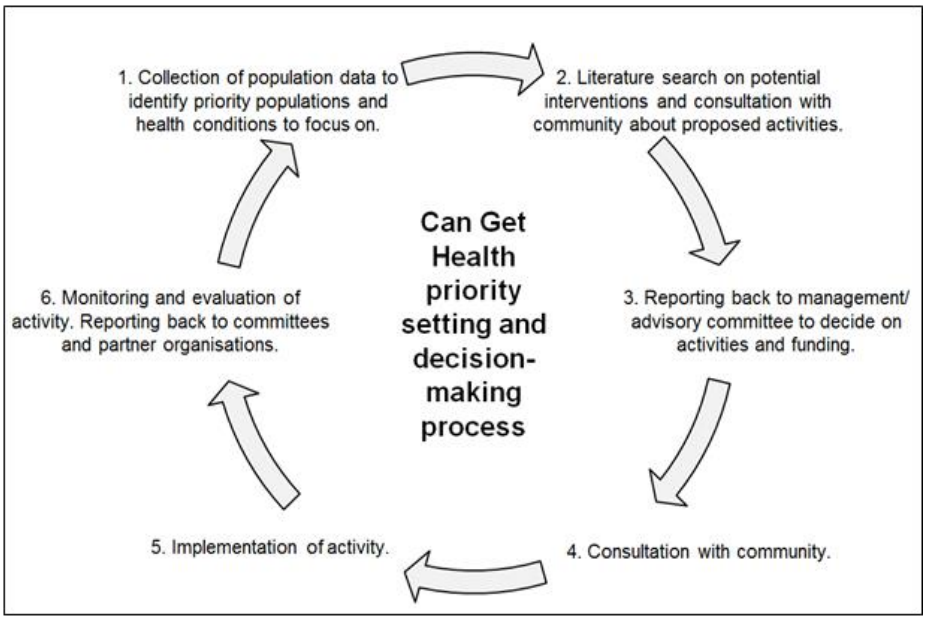
The combination of a placed based and community-based approach is an innovative characteristic of the CGHiC Project and one which allowed the project to harness the assets of communities and services to seek joint solutions to address their needs.

Continuous evaluation and review processes

CGHiC is also characterised by the inclusion of an evaluation plan for all its activities followed by a process of review and planning conducted with the support and input from the Advisory and Management Committees. The strategies the project uses to monitor the effectiveness of its activities include evaluation surveys, formal and informal feedback from project partners and participants, reflection tools, and consumer experience surveys. Formal evaluation reports include the following:

- Oral health assessment and health promotion event report (2018)
- Tour of Canterbury Community Health Services and Hospital (2019)
- Parenting program – Tuning in to kids (2019)
- Bangladeshi Women's Circle – Evaluation Results (2017)
- Certificate II Skills set vocational Course for Rohingya Women Group (2019)
- Mental health forum for community workers evaluation (2018)

This continuous cycle of evaluation, review, planning and implementation gives the project a strong evidence-based platform to rationalize and substantiate changes to the work-plan, areas of priority and choice of activities. The following chart represents this cycle of planning, implementation and review used by the project:



An important component of this evaluation is to ascertain the extent to which this combined model represents an effective health equity strategy for achieving the project's outcomes.

Governance

The Project was designed as an inter-sectoral partnership, governed by three key partners:

- SLHD – which provides community health services and local hospitals
- Central and Eastern Primary Health Network (CESPHN), who provide a link to general practitioners and other health workers within the area.
- Health Equity Research and Development Unit (HERDU) located at the Centre for Primary Health Care and Equity (CPHCE) in the University of New South Wales (UNSW), who provide academic input and guidance to the projects.

Both SLHD and CESPHN provide financial support to the CGHiC program. All three partners are involved in the governance, strategic direction and decision making of the program.

CGHiC was initially funded until the end of 2015 with 1.2 EFT. In 2016 the Project was funded to using the following arrangements:

- Part time Project Officer – funded by CESPHN
- Part time Bangladeshi Community networker - funded by CESPHN
- Part time Community Partnerships Fellow – funded by SLHD
- Project expendables:
- $30,000 – funded by SLHD on an annual basis and any rolled over SLHD funding from the previous financial year

1. **CESPHN project officer 0.9 FTE:**

Purpose of the Project Officer:

- Strengthen the capacity of primary health care system in Canterbury through the promotion of activities in the areas of health lifestyle, child health and injury prevention, refugee health, chronic disease prevention and management, domestic violence awareness, mental health, ensuring project sustainability and culturally appropriate service provision.

Relationships

- Identify appropriate internal and external stakeholders to consult and engage in program design and implementation;
- Identify partnership opportunities and develop collaborative relationships with relevant health professionals, community organisations and others.

Research and planning

- Coordinate and analyse focus groups to assess concerns, needs and ideas of stakeholders
- Conduct literature searches as input for policy, program development & evaluation
- Contribute to development of program timelines in conjunction with the Management Committee;
- Work with the CESPHN Planning team to monitor the prevalence of risk factors linked to the priority areas
- Identify community barriers to using health services and develop sustainable and innovative approaches to reducing gaps in service provision.

Running activities

- Implement, measure and review program plan and activities;
- Develop high quality resources;
- Develop and implement educational activities which are targeted, appropriate and sustainable.

Reporting

- Attend and minute relevant Management and Advisory Committee meetings, documenting decisions and taking the appropriate follow up action;
- Prepare reports on program activities and outcomes

2. **HERDU Community Partnerships Fellow or equivalent 0.4 FTE:**

The purpose of the Community Partnerships Fellow is to:

- Provide academic support for the Can Get Health in Canterbury Project and plan for ongoing sustainability
- provide support in the implementation of the project
- work with CESPHN and SLHD to build sustainability of the program.

3. Bangladeshi Community Networker:

In 2016 it was decided to provide funding for a Bangladeshi Community Worker to assist CGHiC with the coordinating, planning and implementation of activities targeting the Bangladeshi community.

Advisory Committee

The project is guided by an Advisory Committee that meets four times a year. The Advisory Committee provides expert stakeholder input into the direction of the project, as well as promote the project within their own organisation. There are Terms of Reference for the Advisory Committee.

Membership of committee:

- Sydney Local Health District – senior managers of Population Health, Community Health, Health Promotion; Multicultural Health; Community Support Program
- CESPHN - Manager Population Health, Mental Health; General Manager; CGHiC Project Officer; Bangladeshi Community networker
- UNSW – HERDU- Director, Senior Research Fellows; Community Partnerships Fellow
- Education - School as Community Centre Facilitator
- Canterbury Hospital – Community Participation Manager; Director of Medical Services
- Local GP
- Community Representative: Bangla speaking, Arabic speaking,
- Metro Assist (Migrant Resource Centre) – Settlement Grant Program Officer
- NSW Refugee Health Service

Can Get Health in Canterbury Advisory Committee, service staff and community members

Management Committee

The Management Committee meets every 2 months. The Management Committee gives guidance and support to address operational issues and has the authority to endorse or approve over the life of the project. There are Terms of Reference for the Management Committee.

Membership of Committee:

- Sydney Local Health District – senior managers of Child and Family Health, Diversity programs and Strategies
- UNSW – HERDU- Director, Senior Research Fellow; Community Partnerships Fellow
- CESPHN - Population Health Manager; CGHiC Project Officer; Bangladeshi Community Networker

Working Group

A Working Group meets every fortnight to provide more immediate support to the two staff members- Project Officer and Community Partnerships Fellow
Membership of Working Group:

- UNSW – HERDU- Director, Senior Research Fellow; Community Partnerships Fellow
- CESPHN - CGHiC Project Officer

Major partners

- Metro Assist
- Burmese Rohingya Community in Australia (BRCA)

Collaborators

- Lakemba, and Hampton Park Primary Schools, and Lakemba and Wiley Park SaCC
- Muslim Women Association
- Canterbury City Community Centre
- SLHD Dental Hospital
- Save the Children
- NSW Refugee Health
- NSW Service for Treatment & Rehabilitation of Torture & Trauma Survivors (STARTTS)
- SLHD Health Promotion

Evaluation Findings

As indicated in the introduction, this evaluation of the CGHiC has sought to assess the following:

1. Impact of the CGHiC on the health and capacity building needs of the communities and individuals targeted by the project
2. Impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities
3. Impact of CGHiC in SLHD and PHN strategic directions and objectives
4. Impact of CGHiC on health equity research and innovation

The evaluation also sought to explore future governance structures and position of CGHiC within SLHD and CESPHN. These will be discussed in the conclusion and recommendations.

Findings on each of these areas were analysed using the evidence from the 3 evaluation methodologies:

- Analysis of previous external evaluations, internal documentation and activity evaluations, reports and research on CGHiC
- Analysis of data from online surveys and focus groups/interviews
- Analysis of impact of individual activities/programs (Case studies)

1. Impact of the CGHiC on the communities targeted by the project

Assessing the impact of the activities and interventions implemented by CGHiC on participating communities, has been a key priority for the project since its inception. The strategies used include, activity evaluations, consumer experience surveys, observations, reports and feedback from participants and staff involved in the activities. This type of evaluation is often limited to capturing immediate impacts of the intervention rather than long term changes. However as mentioned earlier, evaluation findings associated with changes in the capacity of the targeted communities to learn about and utilise health services, can be used to make some inferential conclusions as to the potential long term impact of the project on the health outcomes of its participants.

The 2015 and 2016 evaluations of CGHiC did not specifically look at the impact of the project on the communities, focusing instead on the outputs and strengths of the model. Given the fact that capacity building is an "ongoing process" of which many results are mostly not directly visible after a certain intervention, the use of process indicators is often a preferred option. Previous evaluations were thus able to focus on aspects of the project such as its outputs, the networks established and the achievements of the project in increasing the profile and awareness of CALD health equity issues in Canterbury. These findings, as it will be discussed later in this evaluation, were pivotal in preparing the ground for important initiatives by SLHD to better meet the needs of CALD communities.

In order to address the challenges raised by a focus on outcomes this evaluation will avoid making causal links between activities and health outcomes for the participating communities, focusing instead on the following impact indicators:

1. Changes in knowledge about health issues and services
2. New skills and resources to access information and services
3. New networks of support and information
4. Specific actions taken to address health issues or concerns.

The sources of data used to ascertain the impact of CGHiC on the above indicators derive from interviews and online surveys with community leaders and participating organisations conducted as part of this evaluation, a review of the data collected in the last 6 years by the various Project Officers including activity evaluation surveys, formal and informal feedback by participants and staff, and recent interviews with CGHiC participating organisations, conducted as part of a Masters by Research work by an international student placed at HERDU in 2020[5] The following table presents the indicator framework used to evaluate the impacts of CGHiC on the participating communities:

Indicator framework used to evaluate the impacts of CGHiC on the participating communities:

Activities 2013-2020	**Changes in knowledge about health issues and services (health literacy)**	**New skills and resources to manage health and wellbeing issues (health literacy)**	**New networks of support and information**	**Specific actions taken to address health and wellbeing issues**
Priority areas: Child and Maternal Health, Mental Health, Chronic diseases and Capacity Building Examples of activities: • Bangladeshi Women's Circle • Oral Health Checks • Chronic disease management • Heal prevention • Rohingya Little Local • Hospital Tours • Parenting Programs • Capacity building training • Community health checks • Promotion of CESPHN Psychological Support Services (PSS) • Mental health programs (i.e. mental health and mindfulness programs) aimed to reduce stress and mental illness in the community • Supporting Arabic Health in Canterbury project – Cancer Screening awareness and creation of video addressing barriers to bowel cancer test uptake • Arabic Community Networker contract • Canterbury Hospital tours – Rohingya group and mixed group	Variables: • Capacity to identify risk factors associated with chronic diseases, illness and disability • Capacity to identify protective factors associated with chronic diseases • Capacity to identify the symptoms of key health conditions • Capacity to identify key health and community services in their area.	Variables: • Capacity to use information to make changes and use new skills to manage health issues • Capacity to identify the role and services provided by health and community organisations • Capacity to seek information from health and community providers • Capacity to communicate effectively and negotiate issues effectively.	Variables: • Capacity to access support and resources from new networks • Capacity to share information and resources to advance the interest of the community • Capacity to act collectively to advocate for health services or community issues • Capacity to advance health and wellbeing priorities through linkages to influential others.	Variables: • Capacity to demonstrate leadership in addressing health and wellbeing concerns • Capacity to access services to meet identified needs • Capacity to navigate services and make informed lifestyle choices to maintain health and wellbeing.

There is ample evidence of changes in knowledge about health issues and services among participating communities. This evidence has been collected through an analysis of project and activity evaluations conducted after each intervention. Evidence of impact was also collected through an online survey with community leaders. The following section will analyse and specific examples of impact for each of the impact indicators. This will be followed by an analysis of the impact of the project on community leaders.

Specific examples of impact

Impact indicator 1 - Changes in knowledge about health issues and services:

1. The Oral Health Project (2018 and 2019) for the Rohingya community sought to support the oral health needs of the community. Oral health assessments were conducted with Rohingya children from local schools in Canterbury and oral health promotion talks with parents were conducted (Please see below case study for detailed information of this activity).

The two activities were each attended by more than 100 parent/carers and children. Pre surveys with parents, as well as follow ups showed changes in knowledge about risk factors associated with poor oral health including smoking and chewing tobacco and paan, sugary drinks and food, unregular tooth brushing. Information and discussion of protective factors to maximize good oral health was also provided and welcomed by parents who were previously unaware of these health issues.

Oral health Program2017-2019

Changes in knowledge about health are important elements of health literacy. The oral health project increased participants health literacy as evidenced in the fact that children and parents indicated that the program has given them new information about good oral health practices. Follow up appointments at Canterbury Hospital Dental Clinic were attended by 84% of the

children, which provides further evidence of the increased understanding by parents and children of the risk factors associated with oral health and the protective strategies available to ensure good oral health outcomes.

Follow up interviews with community leaders indicate the community has better knowledge of oral health issues and what they can do to ensure good oral health outcomes for themselves and their children.

2. Tour of Canterbury community health services and hospital (2019): This event sought to address a common barrier to accessing health services for migrant and refugee communities, namely, the lack of familiarity and knowledge of how primary health care operates in Australia. The activity also sought to increase participants' health literacy by providing them with information about key health services and programs available at the hospital. The tour was attended by 16 women from diverse cultural backgrounds recruited through links with Wiley Park School as Community Centre which was a partner in this project.

The impact of this activity on the participants knowledge about health issues and services (health literacy) was evaluated through a survey and informal feedback provided during and after the activity. All the participants agreed that the following knowledge and skills had been acquired as a result of the activity:

- I know how to get to the hospital if I need to.
- I will be able to find what I need to within the hospital if I need to.
- I feel comfortable using the hospital or community health services if I need to.
- I know how to make an appointment with community health services

The skills and competences gained through activities like this have enormous impact on families and communities and can be decisive when faced with a health crisis. Not knowing where to go in a hospital or who to talk to has prevented migrant and refugee families from accessing key health care services, particularly access to specific services: mental health, dental care, sexual and reproductive care, child & adolescent care and victim of violence care[6]. Therefore, activities that build the capacity of communities to engage effectively with the health system play an important role in addressing individual factors associated with health inequities.

Impact indicator 2- New skills and resources to manage health and wellbeing issues:

1. Parenting program – Tuning in to Kids- Emotion Coaching in 2018, 2019 targeting the Bangladeshi community. The parenting program objective was to increase knowledge of positive parenting techniques, share experiences and connect to resources to support positive parenting. The courses ran for 6 weeks and were delivered in Bangla language. The facilitator of the course was Mrs Feroza Yasmin, a fluent Bangla speaker, and who was trained as a Tuning into Kids facilitator in 2017.

The 3 programs run in 2018 and 2019 were attended by more than 30 parents, mostly women but also some men. The feedback provided by parents and the facilitator during and after the training provided strong evidence of impact on how parents understand and manage their relationship with their children. All the participating parents stated yes when asked if they had learnt the following outcomes:

Some of the feedback from the facilitator regarded parents' responses to the training include the following comments:

At one of the sessions, one of the dads was excited sharing his parenting as he has started the "Emotion Coaching Parenting" on his child and he was getting good outcomes.

One of the dads has believed that he has started to connect/make a bond with his loving daughter.

One of the women participants told me she will be also applying the information to her "Family Day Care". She was so impressed and enjoyed being the program.

Parenting Program Participants 2018

Feedback from the participants support the above findings with many parents indicating the program has given them new skills to better manage their children and create more harmonious family relationships. Some of the comments include:

I connected to the group and increased my knowledge. Really happy to be part of the training

I learn different type of parenting and to follow the parenting guide. And to listen to my child and show sympathy

Impact Indicator 3- New networks of support and information:

One of the key goals of capacity building projects with disadvantaged communities is to strengthen their ability to utilise their social and cultural capital to advance their health and wellbeing needs and goals. Developing and utilising networks of support and information is an important form of social capital and there is strong evidence that CGHiC played an essential role in building this form of capital through various projects including the following:

1. Rohingya Community Gathering Project (2018): This event brought together the Rohingya community to discuss their key health and wellbeing issues and propose solutions. The event was facilitated by CGHiC team and attended by 34 members of the community including children and community leaders. The consultation was based on the Centre for Refugee Research's Reciprocal Research methodology [7] which allowed participants to name problems and issues within their communities in a positive and empowering context.

The opportunity to come together to discuss problems and needs as well as identify solutions allowed the Rohingya community to gather their internal expertise and combined knowledge. The evaluation of the activity conducted by CGHiC after the event, indicated that the project strengthened the links between the community members and became a source of support and information for all. Some of the evidence includes the following reflections:

> *They were discussing health literacy, mental health and the participation of women in the community in general. Computer classes were mentioned, along with women's basketball, and an indoor exercise facility. They also discussed possible solutions to these problems and barriers within those proposed solutions (e.g. access to a culturally and linguistically appropriate GP).*

> *It was noted by the women in the group that the food cooked in most Rohingya homes contains a lot of oil, and this causes people to put on weight. In particular, this is a problem for women as they cannot exercise as easily outside of the home as men can, so they put on more weight and stay at home unable to lose the weight, causing their self-esteem to be affected and affecting their health in other ways. The solution proposed was to have specific facilities for women and children and to promote women's health through a place where women can get together and share their knowledge and experiences.*

The emphasis on community-led analysis of the problems and solutions were empowering experiences for the Rohingya community because it demonstrated the knowledge and expertise the community members have on their own health matters and the benefits of sharing this information and making collective decisions to address their health needs. Some of the recommendations that came from this community gathering event included addressing place-based determinants of health such as

- Changes in the physical environment: better social and recreational activities in Canterbury, more green spaces and parks for children to spend time outdoors;
- Increased access to bilingual health staff including GPs and nurses in Canterbury;
- Access to affordable healthy food options in Canterbury;
- Access to affordable and culturally sensitive childcare in the area.

The Rohingya Community Gathering Project also played an important role in preparing the ground of a major project to build the capacity of the community, which will be discussed next.

2. Rohingya Little Local Project: 2018-2020 CGHiC provided $10,000 funding to the Rohingya community in the Canterbury area for projects that the community deemed appropriate to meet their health and wellbeing. The project was modelled on The Big Local program in the UK, an area-based initiative, which funded 150 relatively disadvantaged neighbourhoods across England to conduct projects to address their health and social needs.

The Rohingya Little Local sought to replicate this model at a smaller scale by providing funding to support the decision-making processes of the community, community-based solutions to health issues, and strengthen their capacity to conduct funding application, design and manage projects and work collaboratively with service providers. Can Get Health Project Officer group supported them through the process including providing information and resources on grant application, forming a new organisation, and registering for charity tax deductions (Please see below case study for in-depth analysis of this model).

Rohingya Little Local meeting

The funding provided to the community was utilised for two major events:

- A soccer tournament and dinner for the Rohingya community (across Australia): A total of 8 teams and 172 people participated in this event.
- a community picnic with activities for women and children

The soccer tournament and dinner marked a pivotal moment for the Rohingya community in Australia, as evidenced in the feedback from participants and organisers. Key changes that occurred as a result of this event included:

- The expansion and strengthening of social connections. A community representative described these connections as particularly beneficial for recent refugee arrivals in Lakemba who are new to the health system and cultural context in Australia. It also benefited community members who despite living in Canterbury for a few years had little opportunity to link to other community members.
- The social and health benefits of the event identified by the participants included new opportunities to work together for future soccer events, better mental health and sense of wellbeing for the participants and their families and increased awareness of the role of exercise for mental and physical health.
- The soccer tournament made explicit the important role sport plays in mental health and social inclusion for disadvantaged communities. The community leaders and organisers identified these key benefits particularly for young people, who were able to connect to other community members, and gain information, support, useful linkages to other social and economic opportunities and recognition as valuable community members. These findings echo research on the role of sports for social cohesion and health promotion (Nathan et al 2010)[8]

Soccer Tournament

The second event conducted by the Rohingya Little Local was a community picnic. The event was conducted at Parry Park, Punchbowl Rd, Lakemba in June 2019 and attended by more than 300 people including more than 50 children. The activities conducted during the picnic included health information, games for children, women circles where cooking, games and discussions were being conducted. Outdoor activities included a jumping castle and games and football.

Community Picnic 2019

An evaluation and debriefing conducted after the event identified key benefits of this activity including the following:

- A safe place for women and children to come together and express their culture and identity through music, language, games and food
- Empowerment of women by participating in planning and running of the event
- Opportunity for women to work collectively to enhance their community health and wellbeing
- An opportunity for young children and teenagers to feel empowered through cultural expression
- An opportunity to enhance family harmony and relationships through play-based learning activities with children.
- An opportunity for men to provide culturally appropriate catering. Traditionally the men do the meat catering for these events. The men will travel to farms to decide on the animal that will be used and that the catering itself is a cultural experience and way of reconnecting.

Community Picnic 2019

Some of the quotes from the participants exemplified the positive outcomes of this event bringing the community together:

The teenager girls coming. My daughter [coming] to this event for the first time. Also, I see lots of girls coming, as it is separate activities. Some teenagers are not interested in the community, so this is a good sign. Also seeing the men playing tug-of-war. And children having a jumping castle. I love so many things!

This event is good for us in many ways. A lot of people, they come, we don't see them [in the community] and especially the family members. So in this event, we introduce each other and when we join together and when the children and family members, like the women, most of the time doesn't go out, this day they saw each other so it was a very good time for the women.
I'm involved in many organisations and .... My children now know a [relative family friend]. It's a good relation at the picnic, a good sign, a good start. Lots of teenagers, [previously] no talking, no sharing, now chat, chat, chat! Teenagers meeting other teenagers at the picnic.

Other important outcomes of this event include increased awareness by the community of collective action and partnerships with government institutions such as local Council to access resources such as soccer fields and meetings spaces that can be supplied in-kind.

An internal evaluation of the Rohingya Little Local and the two projects described above, concluded that the project had achieved the following outcomes:

- Enabled community empowerment and collective control over funding decisions relating to their health and wellbeing,
- Supported social connection, and cultural expression
- Enabled organisational learning and better understanding of the role of community in addressing health and wellbeing
- Empowered women with no previous experiences and opportunities in community leadership and community action to work collectively to address their health needs.

3. Building the skills and capacity of community leaders – Bangladeshi and Rohingya communities- through training, mentoring and support. A key objective of CGHiC was to build the capacity of the communities by supporting the professional development and training of their community leaders and representatives.

Community leaders were supported to attend training, co-write reports and participate in national and international conferences on the project. These opportunities build their confidence and capacity to represent their communities, advocate for their health and wellbeing issues and become a point of contact and support for the communities. Interview

with the community leaders for this evaluation indicated that CGHiC has played a central role their personal and professional development.

Some of the outcomes of this emphasis on building community leadership includes strengthening the social capital of the Bangladeshi and Rohingya communities and their ability to take collective action to address their health and social needs. The following examples illustrate this point:

> *When I started with CGHiC I was not able to help the community. I did not know how the system in Australia operates. Now I can help other women and they all ring me when they need to contact the doctor or go to the hospital.*
>
> *Through the project I was able to apply for grants and now I know what needs to be done to get funding for projects. We did not know this before.*

Capacity Building activity – Community leaders 2018

Impact indicator 4 -Specific actions taken to address health and wellbeing issues:

In order to ascertain the impact of CGHiC on specific actions taken by the project participants to address health and wellbeing issues , this evaluation looked at interventions which had specific health outcomes such as changes in behaviour or lifestyle and the adoption of protective strategies to minimize health risks. The following programs were identified as an example of interventions seeking these objectives:

1. The Bangladeshi Women's Circle: (2017-2020) a partnership with Metro Assist (formerly a Migrant Resource Centre) to run weekly two-hour group meetings for Bangla-speaking women in Lakemba. The sessions were organised and facilitated by Moushumi Martin and Rohena Jahan (Metro Assist), and Feroza Yasmin (CGHiC – Bangladeshi community networker). The sessions covered arrange of topics including chronic disease prevention, physical activity and health, healthy diets and social participation. These sessions have been attended by women and children.

A formal evaluation of the program was conducted, and the following outcomes were identified by the participants and organisers:

- Most participants reported increasing physical activity, walking more and regularly or walking instead of driving. One participant described how she now walks 20 minutes to drop and pick up her son from the bus station on a daily basis.
- Dietary changes were also reported by all participants- mainly increasing vegetable intake and decreasing or avoiding "junk food" and carbohydrates.
- Participants suggested to form a walking group in the Lakemba area to encourage Bangladeshi women and children to exercise and connect with each other.

These outcomes extended to other family members, given the role women play in looking after their children and extended family.

2. Healthy Me Healthy You Program (HMHY) – Arabic speaking women in the Canterbury area (2017): This program was designed to increase the physical and mental health of participants through a physical exercise program and health information sessions. The program was targeted at older women, women living alone and women with young children.

The program consisted of 8 weeks covering different topics to create a holistic lifestyle change. Each session covered information from a health expert, exercise session from the personal trainer and a healthy refreshment.

Healthy Me Healthy You Program

The program was attended by 19 women and an evaluation was conducted after each session and a final evaluation at the end of the program. The evidence gathered through the surveys and feedback from participants indicate many of the topics and issues covered during the sessions were new to the women and prompted changes in lifestyle and personal attitudes. The list of specific impacts cited by the participants include the following:

- looking at my food choices
- eating for health
- read more
- positive approach with others
- including healthy habits in daily routine life
- doing exercised 2 times a week, daily
- I have been more mindful of how much I eat
- I have made time to move and work towards getting fit

Some of the comments from the participants include the following:

> *I would like to thank [facilitator] for facilitating this workshop. She has gone above and beyond in showing us how to be healthy and fit. She and [fitness trainer] have helped me to make positive changes in my life and to create healthy habits. The speakers who*

came to present their topics were very articulate and made things very easy for us to understand. I would gladly attend another's workshop like this and would recommend it to anyone.

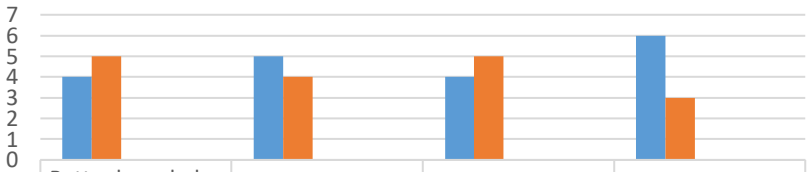
As pointed out above, the benefits and changes that take place on the participants as a result of these programs trickle down to other family members and the community, becoming a form of social and cultural capital strengthened through the networks and links formed throughout the program.

Impact of CGHiC on communities: feedback from community leaders

In order to ascertain the impact on communities, the evaluation sought feedback from community leaders and key staff who had direct contact with the participating communities. An online survey was sent to community leaders, and, as pointed out in the methodology, a total of 9 responses were received.

Community leaders were asked to rate the rate a list of statements using a Likert scale from strongly agree to strongly disagree.

What changes (if any) have taken place in your community as a result of their participation in the CGHiC Project?



	Better knowledge of health programs available and how to access them	Increased confidence in contacting health services	Increased use of services available	Increased networks of support for my community
Strongly Agree	4	5	4	6
Agree	5	4	5	3
Unsure	0	0	0	0
Disagree	0	0	0	0
Strongly Disagree	0	0	0	0

As the table indicates, all the respondents agreed and strongly agreed with the statements, indicating that CGHiC was successful in achieving the following impacts on the participating communities:

1. Increased networks of support for my community

2. Increased use of services available
3. Increased confidence in contacting health services
4. Better knowledge of health programs available and how to access them

Community leaders were asked to identify specific ways in which their communities benefited from CGHiC. The following benefits were identified:

> *Women's feel connected to broader community. They gained health benefits and were so motivated to pass on this information to their own community.*
>
> *Overall, they are more conscious towards on health issues.*
>
> *Bangladeshi Women's Circle sessions provide health and services information which rises awareness in the community and an enabling them with understanding of their own health and adapt healthy ways of life.*
>
> *Women's have increased knowledge and confident of accessing the health services. Reduce social isolation of Bengali women and felt connected with boarder community.*
>
> *Great outcomes for communities, good that local people with the language ability and cultural knowledge were trained and employed to run programs. Very effective in engaging communities*
>
> *Every time we run a new course for women, we have new participants. This is because the program has been effective, and we have been able to support the women to become independent and access the services and opportunities in the community. They don't need to come anymore, or now they don't have time because of work or study.*

The impact of CGHiC on the participating communities includes many non-health outcomes such as access to education and employment opportunities. A follow up of the Bangladeshi women enrolled in the Bangladeshi Women's Circle in 2017 has revealed that many of them are currently studying or employed. These positive outcomes were linked by the women to the skills, knowledge and networks gained through their participation in the project.

Given the strong association between education and employment, and better health [9] these changes are important indicators of the success of community-led, multisectoral approach to health equity through capacity building approaches. Whether health is the end or the means to an end, participating communities in the CGHiC benefited by understanding how health is connected to other goals important to them, and that improving education, housing, safety, employment, or the environment can also help improve health and mitigate health inequity[10].

These capacity building and social capital outcomes for the participating communities should lead, as pointed by the research on social capital and health[11] to translate into positive health and social outcomes including increased utilisation of health services and use of knowledge and resources as protective factors against health risks.

Conclusion: Impact of CGHiC on the Communities targeted by the project

The focus of CGHiC on community-driven solutions to health inequities has meant less emphasis on interventions that target a single health condition, and more attention to community-level changes and impacts on health through a holistic lens. Measuring the impact of these community-level changes is not a straightforward task. Whilst there is a recognition of the importance of 'social capital' for the health outcomes of communities (Putnam, 1993), there is limited research on how to measure these impacts.

This evaluation sought to establish the links between, and measures of, capacity building and social capital, and how they relate to health outcomes by identifying key indicators associated with social capital including changes in knowledge, skills, self-efficacy, changes in practice, behaviour change, networks of support, individual and collective empowerment to address health and wellbeing needs and issues.

Building the capacity of communities, as the above examples have demonstrated, requires a multi-sectoral and multilevel collaborations and approaches. CGHiC was able to bring together community organisations, government, health providers, local businesses and individual community members to seek solutions to the problems that affected the whole community. The range of activities, programs, resources developed through the last 6 years has meant that the targeted communities have been able to tap into rich networks of organizations working together to effect health improvement.

This evaluation did not use control group design methods and therefore it is not possible to make comparative analysis with communities not targeted by the project. However, there is significant research which indicates that communities with comprehensive system capital — rich networks of organizations working together to effect health improvement— experienced significantly lower death rates from preventable conditions (e.g., cardiovascular disease, diabetes, and influenza) compared to communities without this capital[12] The evidence from this evaluation indicate that the emphasis of CGHiC on priority areas such as chronic disease prevention, community education, mental health, women and children's health and capacity building have been effective in mitigating some of the health consequences of social inequalities.

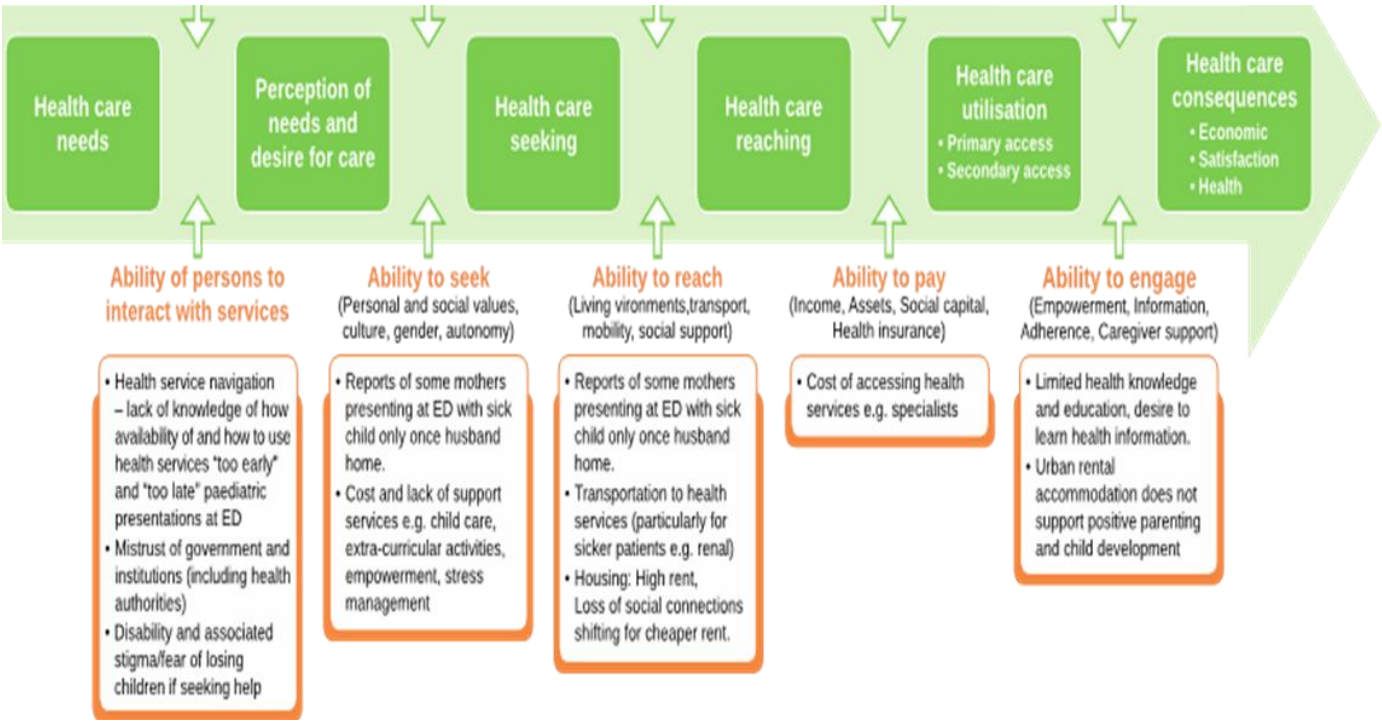
The programs and activities analysed in this evaluation were only a sample taken from more than 25 capacity building projects conducted since 2013. The evidence used to measure impact included participants' feedback, interviews with community leaders, observations and formal evaluations conducted after each activity.

Based on this data the evaluation has been able to identify causal links between activities and changes associated with social capital indicators. The changes that occurred have

positioned the Bangladeshi, Arabic and Rohingya participating communities in Canterbury on a more equal playing field in relation to accessing modes of social capital and resources for health prevention and health management. The specific changes identified include the following:

- Changes in knowledge about health issues and services
- New skills and resources to manage health and wellbeing issues
- New networks of support and information
- Better knowledge of health programs available and how to access them
- Increased confidence in contacting health services
- Increased use of services available
- Specific actions taken to address health and wellbeing issues
- Access to educational and employment opportunities

These impacts addressed some of the ability areas identified in the Levesque framework developed in 2015 to guide the implementation of the CGHiC Project.



Ability to reach (access to transport, affordable rent, and childcare) and ability to pay (high cost of specialist services, poverty) are critical issues not addressed by the project. They form part of the 'upstream' structural barriers or fundamental causes – inequalities in income, wealth, power, status which require direct efforts to address the causes of health inequalities.

Equally important the project has been effective in supporting the development of leadership and empowering women. This is particularly important in the context of gender equity. The Department of Health recognises gender as a key social determinant of health and wellbeing. Gender roles and gender relations can affect women's capacity to access resources such as income, education and employment, which themselves promote health. These inequalities can create, maintain or exacerbate exposure to risk factors that endanger health.

Through the various gender specific activities delivered by CGHiC including leadership and empowerment of community leaders, women participating in the project have been able to increase their ability to exercise choice, make decisions about their personal and professional life and health choices. Specific interventions to support women in areas including maternal health, mental health, chronic conditions and preventive health, parenting, managing stress and goal setting are important priority areas identified by The Department of Health, National Women Health Strategy 2020-2030.

In conclusion, this evaluation has identified that building community capacity to shape health outcomes is an essential component of advancing health equity[13] and CGHiC has been an effective strategy to achieve these objectives.

However, it is also important to recognise that capacity building, health literacy and empowerment are not enough to meet the challenges of health inequities. There is clear and strong evidence that the most effective interventions to address health inequities combine upstream and downstream approaches. Community solutions, such as those described in this evaluation, have the best chance of being effective in addressing health inequities when implemented in the context of an enabling environment with supportive laws and policies.

Some of the objectives identified in the program logic developed for CGHiC (see page 18) were to address key organisational capacity barriers through interventions aimed at improving the capacity of local services to better meet the needs of CALD communities. The next section of this evaluation will discuss these efforts and evaluate the extent to which changes have occurred at the service provider level.

2. Impact of the project on the organisational capacity of service providers

Evaluating the impact of CGHiC on the capacity of organisations and health services to better meet the needs of migrant and refugee communities was an important objective of this evaluation. CGHiC works with community support organisations and interagencies in Canterbury, such as Metro Assist (Migrant Resource Centre); Canterbury City Community Centre (council funded), Settlement Services International (SSI); Canterbury Child and Family Interagency (CCFI), and, community specific welfare organisations from the three communities of focus. The activities and programs delivered throughout the last 6 years have been conducted through collaborations and partnerships with these organisations. The project also delivered training, information and resources to service providers with the goal of increasing their health literacy and skills in relation to CALD communities.

In order to assess the impact of these collaborations and activities with service providers across Canterbury, the following sources of data were utilised:

- Evaluation surveys conducted after each session/activity
- Online survey to participating organisations
- Other evidence of change (new programs, strategies, resources as a result of participation in CGHiC)

Before examining the impact of CGHiC on the participating organisation it is useful to ascertain their role and contribution to the project. The online survey and interviews asked participating organisations to identify their level of participation and support for the project. The following section examines these findings.

Role and contribution of service providers in Canterbury to the CGHiC Project

As indicated in the introduction on the project, CGHiC funds 1 part-time Project Officer (CESPHN) and 1 part time Research Fellow (HERDU) as well as casual bilingual community worker. As a placed-based intervention, the model operates through partnerships and joint collaborations with service providers and organisations in the planning, delivery and review of activities. This model has meant that the success of the project is contingent on the strengths of the partnerships and the resources they provide to the project.

The data collected through the interviews and online surveys echoes the findings from previous evaluations which identified collaborations and partnerships as key factors in the

success of CGHiC. The project developed strong links with organisations and services in Canterbury including schools, GPs, ethno-specific organisations, Canterbury Hospital, community health centres, businesses, allied health and local government agencies. Through these partnerships, it was able to utilise infrastructure such as meeting and training rooms, human capital, expertise, resources, in-kind support and linkages to local migrant communities.

Specific examples of support identified by participating organisations include:

- Staff member was involved in an advisory capacity. In addition, Bilingual Community Educators (BCEs) were involved directly in various program activities.
- We provided a venue and also recruited participants for some projects. We also suggested community members who could support projects with recruitment or interpreting, childcare etc.
- Venue, Inviting Community and Coordinating the Groups
- Funding (I believe) and participation in committees and working groups
- The Cultural Support Program has worked with CGHIC by providing bilingual/bicultural support on initiatives e.g. Rohingya Oral Health even
- We help promote the event, increase the participants
- volunteer medical professionals facilitating 1-hour sessions for groups
- BreastScreen brochures and resources. Screening women in the Canterbury area at the BreastScreen Campsie clinic and the mobile van at the different location in the Canterbury (Bankstown) LGA
- Clinical staff, Oral Health Promotion information, dental screening, dental products, dental treatment after the event
- Venue for courses, stalls at markets and promotion to our various clients, information and discussion on health needs
- Ran a hospital tour

These are important contributions without which CGHiC could not have implemented its activities, as it has not a local presence in Canterbury. This is an important finding of the evaluation which highlights the strengths of the local partnerships model as a valuable and cost-effective strategy.

The next section will explore how these participating organisations were impacted by their collaboration with CGHiC.

The following indicators were used to assess the impact CGHiC had on their capacity to meet the needs of CALD clients:

- Changes in knowledge about health issues for CALD communities
- New skills and resources to meet the needs of CALD communities

- New program/strategies to address the health and wellbeing needs of CALD communities

The following table presents the indicator framework used to evaluate the impacts of CGHiC on the participating organisations and service providers targeted by the project:

Process indicators 2013-2020	Impact indicator 1 Changes in knowledge about health needs and access issues for CALD communities	Impact indicator 2 New skills and resources to meet the needs of CALD communities;	Impact indicator 3 New programs to address the health and wellbeing needs of CALD communities
• Mental Health Forum for Community Workers Seminar -How do I help a family with a disability? • Refugee and asylum seeker workshop - continuous professional development for GPs, Practice Nurses and allied health practitioners • Research and support for the bilingual community educator program (now called the Cultural Support Program at SLHD Diversity Strategies and Programs) • CALD working group at CESPHN; Multicultural Access Committee at Canterbury Hospital; Canterbury Bankstown Multicultural Committee • Research and support for the bilingual education program CALD working group • Partnerships and collaborations with service providers in Canterbury • Presentation and conferences on CGHiC • CDP education - Child development screening for culturally and linguistically diverse families • Canterbury-wide community worker training in parenting program 'Tuning in to Kids' • Canterbury Hospital tour and staff training	Variables: • Capacity to identify risk factors for CALD communities associated with chronic diseases, illness and disability • Capacity to identify key community organisations and ethno-specific services in their area.	Variables: • Capacity to deliver culturally appropriate programs • Capacity to identify the role and services provided by community and ethno-specific organisations • Capacity to seek information from health and community providers about CALD issues	Variables: • Capacity to implement new programs to address the needs of CALD communities • Capacity to reach CALD communities effectively

Evidence of impact

In order to ascertain the impact of CGHiC on participating communities, the evaluation conducted an online survey asking them to identify impacts covering the 3 indicators above. A total of 16 organisations completed the survey. The following table summarises their responses to the following question:

What changes (if any) have taken place at your organisation as a result of your participation in the CHGiC Project?

Question	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree	Total
Stronger linkages with other CGHiC participating organisations	9	6	1	0	0	16
More awareness of health needs of migrant and refugee communities	9	3	2	2	0	16
Increased capacity to support the health literacy of migrant and refugee communities	8	3	5	0	0	16
Implemented new programs/activities to support migrant and refugee communities	9	4	3	0	0	16
Better linkages with participating community(ies)	9	5	2	0	0	16

As the table indicates all the respondents identified impacts in all the variables covering changes in knowledge, new skills and specific actions to better meet the needs of migrant and refugee communities.

The evaluation also asked respondents to provide specific instances of impact for their organisations as a result of their participation in CGHiC. The following examples were provided:

Can you elaborate on any specific impact for your organisation as a result of your participation in the CGHiC Project?
In particular was the opportunity to access and provide GPs in Canterbury (CPD program) with education about refugee health services and pathways for an appropriate health assessment.
Some partner agencies had an increased awareness and appreciation for the work we undertake here. It was clear that we had strong connections with some target populations which other organisations needed to access. Our families had an increased understanding of how our organisation has a broad focus and could assist them in a number of ways - separate to the programs they already attended.
Networking with Bangladeshi Community
Our volunteers who attend the health promotion sessions with your groups, leave the sessions with: - Strengthened communication skills, in particular in dealing with culturally and linguistically diverse (CALD) individuals and communities - Relevant experience in communicating to audiences using an interpreter - Enhanced 'roundedness' as health professionals through educating others on diversity of health topics As an organisation, we are able to secure further funding to keep the project going when we receive feedback from participants and from the community representatives.
Refuge and migrant women that are new in the country and wouldn't have heard about our free screening service were introduced to the program through the Can Get Health Project. Education sessions have also been done by bilingual educators to women from these backgrounds about the importance of screening for the early detection of cancer which has improve the perception of breast cancer screening among this group and has encouraged them to book their appointments.
It has been a rewarding partnership and has led to potential new projects with other migrant communities.
We were able to deliver specific groups such as health and parenting in language.
We are more aware of the need to develop strategies to target refugee communities.
Mental Health First Aid Course, Occupational therapy, domestic violence, Reproductive health, parenting program, Window safety lock (to protect children falling from window) etc. Through these programs Bangladeshi community developed their health educational knowledge and implementing to their families. Instead of well educated, most women lost their confidence due to new country, environment, strange English accent, lifestyle etc. Now women have learnt - time management, how to go for job, further study to do some things and they have realized they have to come out from their home to get back their self-esteem.

Mental Health Training for community workers

These comments indicate CGHiC had concrete impacts on the participating organisations, and the collaborations and partnerships developed throughout the project has better placed them to address some of the health and wellbeing issues for migrants and refugees.

Some specific examples of impact include the following

a. Child development screening for culturally and linguistically diverse families – This CDP training session sough to enhance the capacity of health professional to conduct culturally sensitive screening of CALD communities. It was attended by 28 GPs, allied health professional and nurses.

The evaluation completed by the participants at the end of the session indicated that the following learning outcomes were met:

- Identify child development screening tools used in general practice and primary health care
- Identify common concerns of parents with their child's physical, mental and social development
- Identify psychological stressors impacting on the parenting capacity of refugee and asylum seekers
- Describe input of a specialized child development psychologist service
- Describe the referral options for child and family support services in the Canterbury area

Some of the comments from the participants as to the key learnings from the session included the following:

It was very informative and was a very good at displaying the various support for refugees and childhood programs in the community.

The key message for me was Look for the signs, systems to act early to refer to appropriate services.

To learn about mental health and be able to apply it at work; to be able to identify health issues in children.

Culture conflict affects people lives and health.

The pathways to identify issue and act early if there is something abnormal in children's development notes. Website – helpful link for reference.

b. Canterbury-wide community worker training in parenting program 'Tuning in to Kids'- This program trained community workers to deliver parenting skills programs to CALD communities. It was attended by 18 service providers and community leaders from local community and ethno-specific organisations.

Workers parenting training program

The skills community workers acquired through this training allowed them to better assist CALD families to address parenting issues. An interview conducted with one of the participants highlighted the importance of equipping workers and community leaders with skills to support CALD parents/carers parenting skills. The following comment illustrates this point:

> *For many parents raising their children in Australia is difficult. The culture of the school and the culture of home are sometime contradictory. Through the training I was able to help them understand their children better and develop more harmonious relationships.*

For community leaders the training allowed them to apply new knowledge to the specific needs of the community. The following comment is from a bilingual community workers and community leaders:

> *We were able to deliver specific groups such as health and parenting in language. Women prefer support in their home language rather than using interpreters, because we understand them better and we can discuss the issues in a way that is easier for them to understand and is culturally appropriate.*

c. The role of CGHiC in preparing the ground for new projects and strategies to improve health access for CALD communities – The Bilingual Community Education (BCE) Program and subsequent Cultural Support Program.

The partnership between SLHD, CESPHN and HERDU (UNSW) meant that CGHiC had access to expertise, linkages and resources from 3 key players in health: service providers and policy makers, training and support services and academic researchers. The Bilingual Education Program in 2017 was informed by experiences gained through CGHiC and research conducted by CESPHN and HERDU which identified that CALD communities, particularly those who are newly arrived (less than 5 years) to Australia, experience difficulties in accessing health services.

Barriers include lack of understanding of the Australian health care system, poor health literacy, concern for the cost of services, long waiting times for interpreting services, lengthy travel and wait times for preferred bilingual bulk billing GPs and the sensitivity and stigma associated with accessing services such as mental health, drug and alcohol and sexual health services. The model used by CGHiC as part of its capacity building approach, of employing and training community leaders from the targeted communities, to liaise, link and support their community members was recognised in the research on the BCE model as an effective strategy.

The establishment of the Central and Eastern Sydney Bilingual Community Education Program (CESPHN) was funded by an $80,000 grant from the Central and Eastern Sydney

Primary Health Network (CESPHN) and delivered by the Health Equity Research and Development Unit (HERDU). It consisted of a BCE Coordinator, Training and Education Officer, and a pool of trained Bilingual Community Educators, drawn from members of local CALD communities, and administrative support.

Bilingual Community Education Training 2017

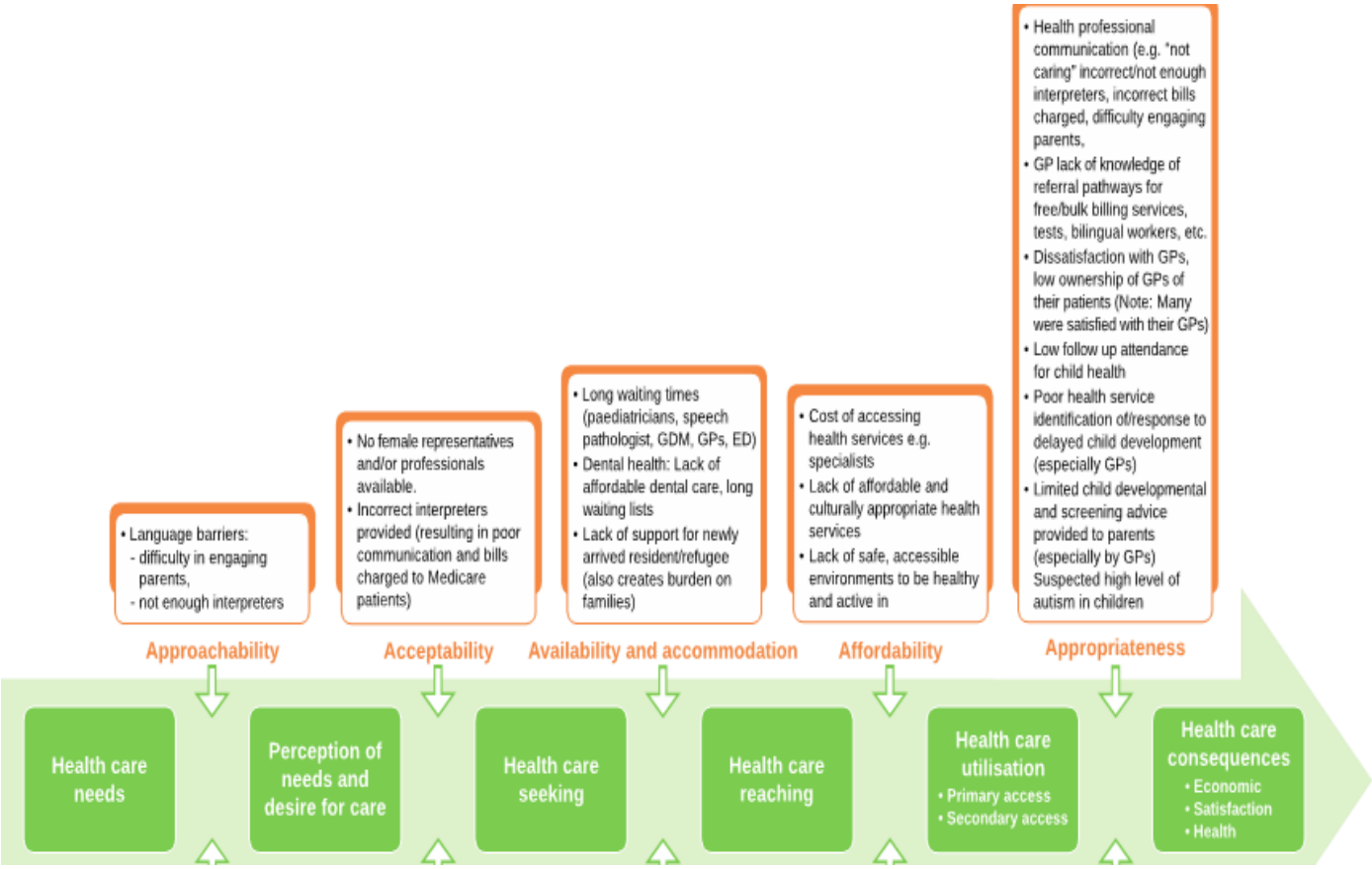
In 2018 the program transitioned into the current Cultural Support Program (CSP). The CSP is funded for three years by the SLHD, SESLHD and the Central and Eastern Sydney Primary Health Network (CESPHN). It is administered and hosted by the SLHD and is part of the Diversity Programs and Strategy Hub within Population Health. The role of the CSP workers is to provide cultural and linguistic input into the work of the LHDs. This includes:

2. strengthening links with CALD communities
3. assisting in media and campaign activities
4. developing culturally appropriate resources
5. delivering education sessions in the community
6. providing cultural and linguistic input into health promotion initiatives
7. participating in research activities

Conclusion: Impact of CGHiC on the organisational capacity of service providers

There is strong evidence that health service providers and community organisations play a crucial role in enabling or obstructing access to health resources and health care[14] Therefore they have a significant role to play in achieving health equity. While health care and community organizations alone do not have the power to improve all of the multiple determinants of health, they do have the power to address disparities directly at the point of access to health information, resources and utilisation of health services.

CGHiC was conceived as a health equity project and having an impact of the capacity of health services to address the barriers preventing CALD communities for achieving positive health outcomes was an important outcome indicator for the project. To reflect on the impacts of the project in this domain, it is useful again to refer to the 2015 model mapping the ways in which factors such as structural and socio-economic barriers translate into poor health utilisation and health outcomes developed by Levesque et al. (2013).



Guided by this framework CGHiC sought to address issues of approachability, acceptability, availability, affordability and appropriateness. Based on the evidence presented in this evaluation it is possible to argue that CGHiC was effective in some of these areas, particularly in relation to acceptability and appropriateness, as the examples of impact cited above indicate. The role of the CGHiC partners in setting up the ground for other projects such as the Bilingual Education Program had also a significant organisational capacity impact as it brought a new governance structures, funding and resources to address systemic barriers to health utilisation and health information for CALD communities.

Specific evidence of organisational capacity changes for other participating organisations in the CGHiC include new strategies by community organisations to reach migrant and refugee communities, stronger linkages with other services in Canterbury, more awareness of health needs of migrant and refugee communities, and new programs to support migrant and refugee communities including case management services for the Bangladeshi community.

3. Impact of CGHiC in SLHD and CESPHN goals and objectives

The extent to which the CGHiC model can be judged as effective in addressing the priorities of SLHD and CESPHN requires an analysis of the following:

a. The role and impact of the project in advancing the goals of SLHD Strategic Plan
b. The role of the project in addressing CESPHN Needs Assessment and Activity Work Plans
c. The alignment of the CGHiC model with the SLHD Equity Framework
d. The alignment of CGHiC with the Framework for working with Cultural and Linguistic Diversity in Sydney Local Health District
e. The significance of the CGHiC model and outcomes on health inequalities research

a. The role and impact of the project in advancing the goals of SLHD Strategic Plan

Can Get Health in Canterbury sits within the SLHD Strategic Plan 2018-2023 focus area 1: Our communities, Partnerships and the Environment. Central to this focus area is an approach to health planning and delivery that involves the communities through co-design methodologies, capacity building activities and empowerment models of community engagement. The focus area also emphasises action to address health inequities through downstream (individual and community-based activities) and upstream activities (advocacy, urban development, service's capacity building).

Two previous evaluation of CGHiC in 2015 and 2016 emphasised three key strengths of the project:

- its ability to involve communities though co-design methodologies, and
- its focus on empowerment models of community engagement
- the partnerships and collaborations developed with health and community service providers in Canterbury

The 2015 evaluation concluded that the successful engagement of local communities provided a strong level of trust that could be built on in future work. It recommended the next stage of the project further refines the capacity and approaches required to address health inequity in the Sydney LHD and CESPHN into the future in order to ensure the project match the available resources.

The 2016 evaluation conducted by NSW Centre for Refugee Research recommended that CGHiC continue to work with the four communities it partners with, while piloting a model of working more intensively with individual communities on a rolling basis. The Bilingual Community Educator model proposed by SLHD, linking with CGHiC activities, was regarded as a positive step in this direction.

The project's major achievements identified in the evaluation were:

- engaging a wide range of health and community stakeholders,
- establishing relationships with four ethnic communities in the Canterbury area including the Rohingya, Bangladeshi, Arabic-speaking and Chinese,
- getting health equity on the agenda of (some) health service providers.
- small group courses in health awareness and education have been an initial and important strategy of CGHiC.
- clear intention to develop activities that address the structural determinants of health as the domestic violence video developed by Metro Assist and Kids Don't Fly in partnership with a bilingual worker from the Bangladeshi community demonstrate[15].

The evaluation participants also identified areas for further partnership. These include developing advocacy strategies targeting local and state members of parliament and suggestions from women in the Punchbowl area to advocate with local council about improving park safety and facilities. Also identified was the need to further engage with general practitioners, noting that this has been a challenge in the past. The 2016 evaluation recommended:

- Working collaboratively with SLHD Multicultural Health and Health Promotion to develop a mainstreamed approach to health education, thus freeing up CGHiC to work on addressing the structural determinants of health inequity.
- Discuss whether CGHiC should move beyond engaging community members and organisations as key 'informants' to more active and wider community engagement through community-led activities, as recommended by many participants in this review.
- Engaging other actors including GPs, and broader advocacy.
- Measuring outcomes and impact as a tool for learning.
- Looking inwards to create a culturally safe environment and developing reflexive practices.

The evaluation concluded that CGHiC is supported by committed, diverse and appropriate stakeholders and it is placed to both sustain its current focus on place-based multicultural health equity through expanded partnerships and community engagement.

This current evaluation confirms some of the findings from the 2015 and 2016 evaluations described above, particularly in relation to the impact of CGHiC on the capacity building needs of the targeted communities and the community-led approach to achieving these goals.

Given the significance of these results to the goals of the SLHD Strategic Plan, we can therefore conclude that CGHiC has played an important role in advancing its goals and objectives. The model of community-led, place-based intervention and embedded monitoring and review to address the changing nature of the migrants and refugee needs, has allowed CGHiC to prioritize community engagement and co-designed interventions, intense focus on priority health areas and capacity building through collaborations and partnerships to build the agency of communities to address some of their health issues and priorities.

b. The role of the project in addressing CESPHN Needs Assessment and Activity Work Plans

CESPHN recognises in its Needs Assessment Guide the significant cultural diversity across the region. The Guide identifies CALD communities as more vulnerable to poor health outcomes due to issues related to access including limited English language skills (and by extension low health literacy), general lack of awareness of services available, limited support networks, cultural barriers, and confidence in authority.[16] CGHiC is cited in the Guide as a CESPHN strategy to reduce health inequities for marginalised CALD communities in the Canterbury area by improving access to appropriate primary health services, improving health literacy, and working with stakeholders to address a social determinant of health.

Key priority areas identified in the Needs Assessment including mental health require specific interventions for CALD populations given their significantly underrepresentation in access to mainstream health services. The Guide recognised that more targeted, low intensity models may be more appropriate for CALD communities. One example of such activities cited in the document is CESPHN commissioning of a mindfulness program for Arabic and Bengali speakers.

CGHiC played an important role in promoting and linking the Bangladeshi and Arabic speaking community to this program. CESPHN evaluation of the program have found that it has had wider benefits in addition to building resilience and skills for managing mental wellbeing. It has also been observed that the program has improved mental health literacy within the targeted communities, and has fostered open communication about mental illness, thereby de-stigmatising mental health[17].

The Needs assessment has also identified Botany, Canterbury and Kogarah-Rockdale areas as having the highest rates of ED attendances for the 2015-16 period. These three sub-regions

are characterised by at least one of following factors: low health literacy, greater than 25% CALD population and socioeconomic disadvantage. The Guide recommends strategies specifically targeting Aboriginal and/or Torres Strait Islander peoples, CALD groups, paediatrics, and vulnerable populations. CGHiC is a specific example of such interventions targeting CALD communities. Despite the absence of outcome indicators associated with hospital admissions, CGHiC has impacted on the communities' understanding of the role of Primary Health Care services and community health and this should in the long-term impact on ED attendance rates.

c. The alignment of the CGHiC model with the SLHD Equity Framework

SLHD adopted a new Equity Framework called A *Framework for improving health equity in Sydney Local Health District*, developed by HERDU in 2019. It committed SLHD area to strengthening their action on health inequity across the organisation in five key areas:

1. Leadership and commitment: Making equity a priority for the District and making it a part of reporting systems and quality improvement activities.
2. Engagement and partnerships: Involving disadvantaged and marginalised communities in decisions about their health and health care; and committing to long term partnerships with communities and other organisations to address problems in health equity and the social determinants of health.
3. Organisational and workforce development: Providing more training, better information and other forms of support to help clinicians, services, planners and managers identify and address inequities.
4. Resource allocation: Allocating and targeting resources to provide access to health care to all groups in the population, in proportion to need, and address the causes of unequal health.
5. Research and evaluation: Using data and evidence to inform decision making and undertaking research and evaluation on how best to reduce inequities within the District.

The evidence collected from the two previous evaluations of CGHiC as well as this current review, point to strong accomplishments of the project in areas 2 and 4. Engagement and partnerships are one of the biggest strengths of CGHiC as evidenced through examples of activities and work plans which centred on long term partnerships with communities and organisations to address problems in health equity. The project also demonstrated a strategic use of resources (human resources, material and physical) evidenced in deliberate investments in population groups with the highest health issues and needs.

CGHiC has been effective in addressing these areas through a combination of the following approaches:

- community-led, place-specific interventions
- Strong networks and partnerships with local service providers and organisations
- Partnerships and employment of community leaders and bilingual educators
- Multiple interventions aimed at building different capabilities
- Top down (i.e. Information sessions) and bottom up (i.e. funding of community projects) strategies to translate knowledge and skills into practice.

CGHiC has had modest impacts on area 3, with some activities such as professional training and resources made available to clinicians and health allied professionals to increase their capacity to identify and address health inequities. This area requires further work which could include, as recommended in previous evaluation, closer links between SLHD and CESPHN for building capacity within the organisations for advance this equity area using the CGHIC model.

Area 5 also requires further work, particularly in relation to undertaking research and evaluation on how best to reduce inequities within the District. The experiences and lessons learnt from CGHiC need to be disseminated through different channels including forums and presentations with SLHD and CESPHN staff and administrators. The model used by CGHiC to advance the health equity needs of disadvantaged groups in Canterbury also need to be tested against national and international literature on health equity approaches. This evaluation seeks to address some of these unmet areas by providing an analysis of the significance of the CGHiC model and outcomes on health inequalities research and in health inequities in the District.

d. The alignment of CGHiC with the Framework for working with Cultural and Linguistic Diversity in Sydney Local Health District

The Frameworks presents the District's vision for improving the health and wellbeing of the migrant communities and ensuring health services are responsive, patient and family centred, well integrated, equitable and accessible[18]. In order to achieve the goals of the Framework SHLD has established the Diversity Programs and Strategy Hub (Diversity Hub) within the Population Health clinical stream.

As mentioned earlier in this evaluation, CGHiC has played an important role in the development of some of the strategies currently adopted by the Diversity Hub, including the new Cultural Support Program model. This Program recruits bilingual/bicultural workers from a range of priority CALD backgrounds, who will have a broad scope of practice in working with District and community-based services. The Diversity Hub will provide a system where District services can access subject matter expertise and guidance to inform

health service decision making and program development, a key milestone identified in the NSW Plan for Healthy Culturally and Linguistically Diverse Communities 2018-2023.[19]

SLHD has identified CGHiC as an example of a program which have been specifically tailored to meet the needs of CALD communities and meet the goals of the Framework. The District has also committed to continue maintaining its investment in the program. The evidence from previous evaluation and this current review provide strong indication that CGHiC has been effective in meeting the goals of the Framework, particularly in relation to the following areas:

- Equity
    - Providing culturally and linguistically appropriate and accessible care that is tailored to a person's demographic, socioeconomic or geographical background.
    - Equity involves identifying and targeting for action, those groups who experience particular inequities in health status, health risk factors or access to health services.
- Engagement and partnership
    - Working in collaboration with CALD patients, families, communities and service partners to improve CALD health and wellbeing.
    - Engaging in meaningful partnership with community leaders and groups
- Community empowerment and participation
    - Fostering empowerment and participation from the diverse communities within the District at all levels of the health system to improve healthcare, support self-management, develop understanding of community needs and capture perceptions and understandings about healthcare appropriateness and delivery

The model used by CGHiC, as evidenced through the analysis of the data in this and previous evaluations, aligns with the equity objectives and capacity building and partnerships principles of the Framework. The project also addresses some of the internal mechanisms identified in the Framework, that focus on maintaining and improving the capacity of SLHD to identify and meet the specific needs of all CALD communities and to address health inequalities experienced by these groups. This has been achieved, as previously discussed, through activities and programs aimed at enhancing the capacity of service providers to deliver effective care to CALD communities including training and information sessions for GPs and allied health professional.

e. The significance of the CGHiC model and outcomes on health inequalities research

There now exists a substantial body of literature on tackling health inequalities[20]. The examples of approaches and strategies from national and international research fall into the following categories:

Upstream or structural factors:

- changing macro-level social and economic policies
- improving living and working conditions

Midstream and downstream factors:

- improving the equity of the health care system
- involving local communities in health initiatives
- empowering individuals and strengthening their social and family networks; and
- changing health damaging behaviours (Oldenburg et al. 2000)[21].

Attempts to tackle inequalities by focusing on upstream factors are likely to result in the greatest impact on population-wide disparities; however, societal level changes are the most difficult to bring about, and the most politically challenging.[22] In contrast, policies and interventions that focus on midstream factors might benefit the groups or areas that are targeted, but they are unlikely to reduce health inequalities at the national level.

CGHiC sought to address midstream and downstream factors through an emphasis on capacity building and health literacy at the individual, community and service delivery level. As this evaluation has indicated, the project has been effective in key outcome indicators for these areas. The targeted communities are better positioned now to identify health damaging behaviour, adopt protective practices and utilise the resources and services available to manage their health needs. In this regard the project has been effective in ameliorating some of the adverse effects of social disadvantage on health.

As pointed out by the AIHW report on health inequalities in Australia[23] the evidence about the causes of socioeconomic health inequalities points to the need for a 'whole of society' approach to the problem. Health inequalities originate from societal-level conditions associated with housing, employment, education, income, transport and so forth, and reducing inequalities requires action from all sectors including housing, employment, education and welfare agencies. Actions taken within the health sector such as increase in resources, information, bilingual education, have limited impact and ignore the socio-economic factors impacting on health outcomes.

CGHiC was conceived as a place-based intervention focusing on the specific issues of the targeted communities in the Canterbury area. The project addressed this place-based focus by developing partnerships and collaborations with local government, health and community

organisations. The impact on the site was however limited, due partly to the priority given to the needs of the targeted communities rather than the environmental, social and health needs in Canterbury. However, some significant outcomes were achieved in Canterbury including the following:

- Partnerships with Canterbury Hospital to support access to comprehensive Primary Health Care for disadvantaged communities
- Supporting the delivery of high quality, accessible, culturally competent and safe publicly funded health system through professional training activities

Providing healthcare in community settings is also recognised as particularly successful in increasing access for marginalized groups such as culturally and linguistically diverse communities[24] CGHiC utilise settings such as schools, and ethno-specific organisations to conduct health promotion and access to preventive health including oral health for children and mental health for parents. These activities were successful in engaging the communities and provide strong evidence of best practice in community engagement and placed-based interventions.

Key areas where further work needs to take place in Canterbury include addressing housing issues, access to transport, unemployment and underemployment, childcare and green areas. This requires collaborations with key players such as local government, educational providers, private business and commonwealth departments.

4. Impact of CGHiC on health research and innovation

The impact of CGHiC on health research and innovation was assessed through a review of the studies and initiatives conducted since the project was conceived in 2013 and the extent to which they represented new knowledge and practice in health equity.

In terms of new knowledge, CGHiC was instrumental in exposing the level of disadvantage and needs in the Canterbury area, particularly in relation to migrant and refugee communities from CALD backgrounds.

Some key research includes the following:

- Literature review of health issues and needs in Canterbury area (2014)
- Community forum on health issues impacting on CALD communities in Canterbury (2017) (see page 39)
- Analysis of Oral Health Needs of Rohingya Community (2017)
- Community Health Workers in General Practice
- Bilingual Community Educators Program

Key Conferences and presentations on CGHiC:

- Australian Evaluation Society 2019 International Evaluation Conference
- The 2018 Australian Association for Academic Primary Care Conference
- The 2017 International Union for Health Promotion and Education (IUHPE)
- 2019 International Conference on Integrated Care
- 2016 Allied Health professional Conference
- Sydney Innovation and Research Symposium 2019
- Equity Fest 2019

Key Training on health needs of targeted populations:

- Centre for Education and Workforce Development – training on Rohingya communities, mental health, migrant populations in Canterbury
- CESPHN Clinical Council training
- Refugee Support Workshop
- Mental Health Training for GPs
- Mental health Training for Community Workers
- GP and PN training - Child Developmental Screening. Delivered in partnership with NSW Refugee Health Services, STARTTS, and SLHD Child and Family Nursing.

One of the most significant impacts of these research outputs was an increased awareness by local health and community providers of the extent and level of health needs and barriers to

health literacy service utilisation and in Canterbury. CGHiC worked closely with SLHD and CESPHN to support new approaches and strategies to address these issues. As a result, some new and innovative programs were implemented including:

- The Bilingual Educators Program - which transitioned into the Cultural Support Program and is currently administered by the Multicultural Health Unit. see page 74).
- A current pilot project with GPs in Canterbury called Community Health Workers in general Practice. This pilot came as a result of research identifying lack of bilingual and accessible information at GP centres to link CALD communities to key services in the area.
- Organisational responses to Christchurch NZ massacre at Islamic Mosque, 2019 in partnership with Muslim Women's Association. The objectives of this activity were to express outrage at the tragedy and encourage primary health professionals and SLHD staff to be aware of the support needs of patients affected by the events.

These examples indicate that CGHiC has play a central role in uncovering some of the social determinants of health in Canterbury including income, education, housing and employment disparities and their impact on health. The emphasis on migrant and refugee communities has also contributed to better understanding of their health issues and the development of comprehensive approaches to addressing them.

Conclusion

Feedback from key stakeholders indicated that CGHiC has benefited the partners SLHD, CESPHN and The Centre for Primary Health Care and Equity (CPHCE) in specific ways including the following:

For CPHCE the project allowed:

- stronger partnership with disadvantaged and CALD communities both in Canterbury and beyond and responsiveness to their needs (e.g. in response to Christchurch shootings).
- a springboard to other research projects and programs on refugee health, health literacy, community health workers, mental health.
- a platform for translation of our research in areas such as health literacy, refugee health, integration of health care between community and hospital.

For CESPHN, and SLHD the project supported their goals and objectives, as the following comments indicate:

- The project has always featured in the multicultural profile for SLHD and it also features in the strategic direction of UNSW- CPHCE due to the equity focus.
- At CESPHN, the objective of improving access to primary health care has always been more difficult to achieve, given the systemic and multi-factorial nature of such a change. But I believe that the project has engaged well with the local hospital and SLHD services and that future gains will be made from this start.
- CESPHN wants to understand vulnerable populations and to respond accordingly and I believe CGHiC has given that view of what's happening on-the-ground, albeit within the scope and capacity of the project."

Conclusion and recommendations

The evaluation of Can Get Health in Canterbury has been a complex task for several reasons. One of them relates to the nature of the project and its objectives. Measuring changes in agency, social capital and health literacy in communities is not a straightforward task. Making links between these impacts and better health outcomes is even more problematic, due partly to the subjective and non-quantifiable nature of these outcomes. Nonetheless, social capital receives academic attention as a potentially important factor in health research.[25] There is also strong evidence linking social capital to the health status of various individuals and neighbourhoods. Despite gaps in research on how social capital operates, the evidence indicates that a wide range of community associations and community capacity building can improve individuals' health status through social integration and ties[26].

Can Get Health in Canterbury falls into the category of an asset-based approach which recognises social capital and capacity building as protective and promoting factors that affect health and wellbeing. The manner in which CGHiC executed this approach had some unique characteristics including the following:

- Strong community partnerships and community co-design approaches
- Strong networks and partnerships with service providers, business, community and government organisations in Canterbury
- Emphasis on building leadership capabilities, particularly for women
- Strong governance and project monitoring and review structures including a Management Committee and a Steering Committee with representation from communities, funding bodies and service providers.
- An emphasis on addressing health inequities through academic research and practice

The project implemented strategies to address some of the structural barriers preventing CALD communities from accessing services, through activities that sought to increase the capacity of services and organisations in Canterbury to better meet their needs. These include partnerships with health services to deliver information on mental health and chronic diseases; joint projects such as hospital tours; outreach programs such as children oral health checks at school, and specific training on topics such as refugee health and mental health.

The project targeted 4 communities identified in the literature review as having significant health needs and facing specific barriers to accessing health information, resources and services. These communities were the Chinese (for the first 2 years of the project), Arabic, Bangladeshi and Rohingya. According to the Australian Bureau of Statistics (ABS) these 4 communities represent a total of 14% of the Canterbury population or approximately 50.000 people in 2016[27] The impact of CGHiC has been more pronounced on the Arabic, Bangladeshi and Rohingya communities due to a combination of factors including strong links, training and support of

community leaders, access to bilingual staff from key organisations in Canterbury and methodical application of needs analysis to the tailoring and delivery of programs.

This evaluation sought to ascertain the following:

1. Impact of the CGHiC on the health and capacity building needs of the communities and individuals targeted by the project
2. Impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities
3. Impact of CGHiC in SLHD and PHN strategic directions and objectives
4. Impact of CGHiC on health research and innovation

The following table summarises the outcomes of CGHiC on each of these 4 areas:

SUMMARY OF OUTCOMES OF CAN GET HEALTH IN CANTERBURY (4 AREAS – 4 GOALS)				
AREAS	Impact on the communities targeted by the project:	Impact on the organisational capacity of service providers	Impact on SLHD and PHN strategic directions and objectives	Impact on health research and innovation
GOALS	Increasing individual and community health literacy	Identifying and working with relevant stakeholders to address at least one the social determinant of health	Improving access to comprehensive primary health care services	To support research and innovation on health equity
EVIDENCE OF IMPACT	Changes in knowledge about health issues and services	Changes in knowledge about health needs and access issues for CALD communities	Strong alignment of the project with the goals of SLHD Strategic Plan	The Bilingual Educators Program Pilot and current Cultural Support Program
	New skills and resources to access information and services	New skills and resources to meet the needs of CALD communities	Strong alignment of the project with CESPHN Needs Assessment and Activity Work Plans	Pilot project with GPs in Canterbury - Community Health Workers in general Practice.
	New networks of support and information created	New program, strategies to address the health and wellbeing needs of CALD communities	Strong alignment of the project with SLHD Equity Framework	Organisational responses to Christchurch NZ massacre at Islamic Mosque.
	Increased leadership and capacity of women to support their community and lead change			
	Specific actions taken by the targeted communities to address health issues or concerns	Strong linkages with other services and organisations	Strong alignment of the project with The Framework for working with Cultural and Linguistic Diversity in SLHD	Research and presentations on health issues, health equity and CALD communities in Canterbury

Based on the above findings the evaluation of CGHiC had identified the following recommendations for each of the 4 evaluated areas as well as the future of the project:

1. Impact of the CGHiC on the health and capacity building needs of the communities targeted by the project:

Recommendations:

1.1. To shift the role of CGHiC Project Officer from activity-oriented tasks to a more facilitator and manager role supporting local services in the design and implementation of activities.
1.2. To maintain and further strengthen the community-led approach to health equity in Canterbury through partnerships with CALD communities.
1.3. To identify and develop linkages with other disadvantaged communities in Canterbury in order to expand the impact of the project to other groups from low SES.
1.4. To continue and expand partnership outreach activities, such as oral health checks at school, given their effectiveness in reaching large number of children and families.
1.5. To continue supporting the delivery of hospital tours for newly arrived migrants and refugees given the important role they play in health literacy.
1.6. To maintain the focus on building the leadership and capabilities of community leaders through training, mentoring and resources.
1.7. To expand opportunities for small funded projects targeting capacity building for CALD women.

2. Impact of the project on the organisational capacity of service providers to better meet the health needs of CALD communities

Recommendations:

2.1. To maintain and further strengthen the linkages and partnerships with service providers and organisations in Canterbury given their crucial role in the achievements of CGHiC.
2.2. To explore stronger linkages with other SLHD funded projects targeting CALD communities (i.e. Cultural Support Program, Multicultural Health) in order to coordinate approaches to health literacy interventions and utilise existing resources and human capital.
2.3. To expand partnerships to include non-health providers such as local businesses, TAFE, housing, employment services, police, and universities given their critical role in addressing the social determinants of health.

2.4. To develop resources and information for local government agencies on structural determinants of health and specific actions they can take to address them (HERDU).
2.5. To continue supporting local organisations to strengthen their capacity to address the health and wellbeing needs of CALD communities.
2.6. To consider a scheme to fund local service providers to deliver CGHiC activities
2.7. To recognise the role of participating organisations in advancing the goals of CGHiC (i.e. equity awards, newsletters, etc).

3. Impact of CGHiC in SLHD, PHN and HERDU strategic directions and objectives

Recommendations:

3.1. To continue and further strengthen the community-led approach given its strong alignment with SLHD focus area 1 which requires involvement of communities in health planning and delivery through co-design methodologies, capacity building activities and empowerment models of community engagement.
3.2. To maintain the partnership between the District, CESPHN and HERDU as a model of health intervention informed by health equity research and evidence-based methodologies.

4. Impact of CGHiC on health research and innovation

Recommendations:

4.1. To increase the research outputs and dissemination of information about CGHiC and its impacts on health literacy and capacity building
4.2. To conduct further research on innovative approaches to address health inequity issues in SLHD
4.3. To expand opportunities for SLHD, CESPHN and HERDU to participate in forums, conferences and research on social determinants of health
4.4. To use data and evidence from CGHiC to inform decision making on strategies and activities to reduce inequities within the District.

5. Future arrangements to ensure its sustainability

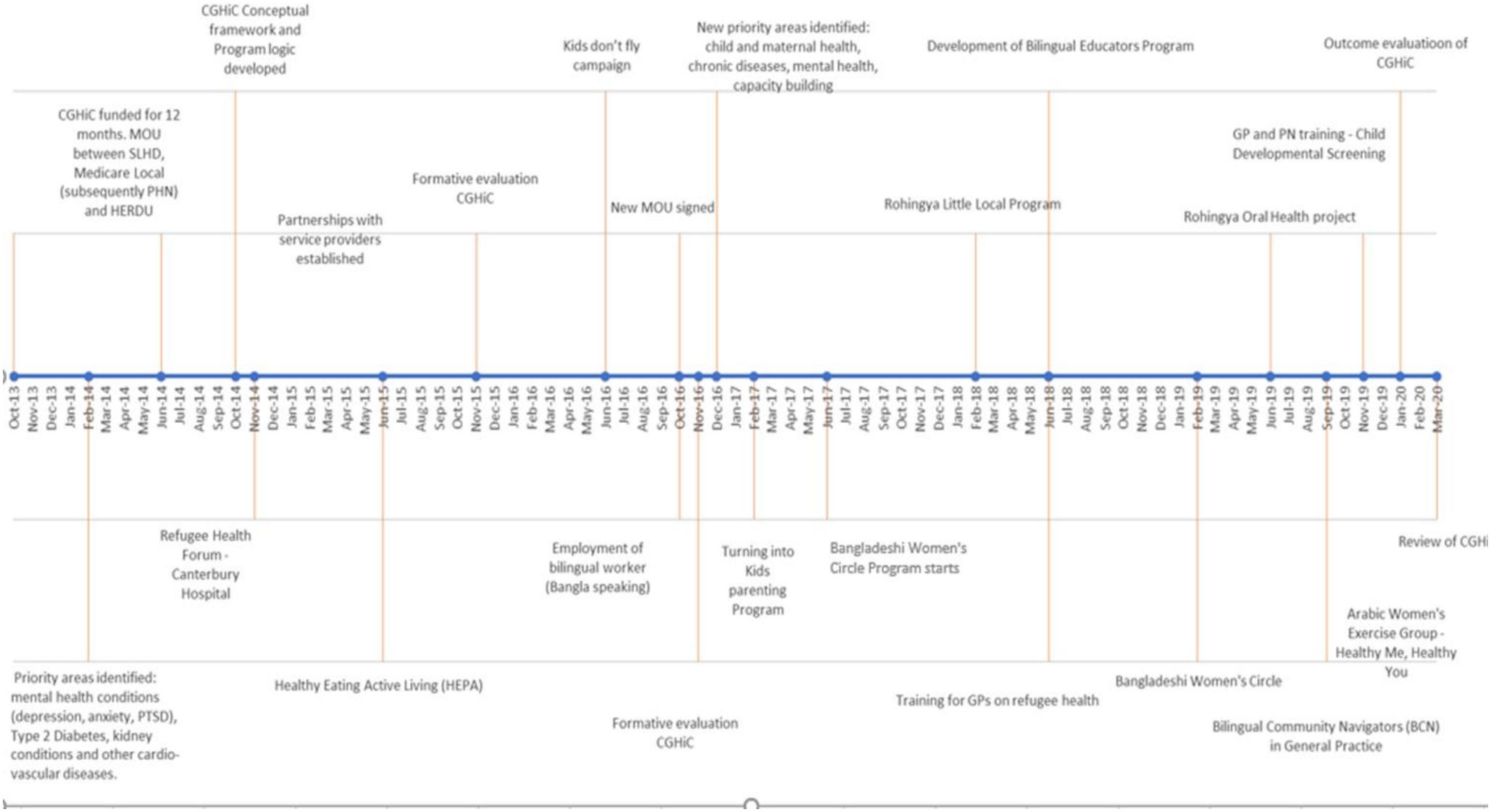
Recommendations:

5.1. Ensure CGHIC retains its community-led model, capacity building emphasis and partnerships approach given the effectiveness of these approaches in meeting the health and wellbeing needs of the targeted communities.
5.2. To increase its visibility through greater research and dissemination strategies
5.3. To maximize the use of existing capabilities in SLHD and CESPHN

Can Get Health in Canterbury: A timeline and key milestones (2013-2020)

Can Get Health in Canterbury started as a one year project in response to local health research which identified Canterbury as an area with significant socio-economic disadvantage, high numbers of migrant and refugee communities and high prevalence of health conditions including chronic disease, child and women's health issues and poor utilisation of primary health care services. The following section presents a timeline of the project, including changes to work-plans and priority areas in response to new research and needs identifications.

Timeline of key events and milestones CGHiC (2014-2020)



Timeline:

2013-2015:

The initial years (2013-2014) of the project were used to develop community relationships and articulating a new vision for health equity in the Canterbury area. An Advisory Committee and Management Committee were established in 2013 to oversee the project and provide support and links to key services and communities. Members of the Advisory group include NSW Refugee Health Services.

At the first meeting of the Advisory Committee, the scope of the project was refined in terms of the health conditions and the population subgroups that would be the foci of the project. Four priority health conditions were identified in 2013:

- mental health conditions (depression, anxiety, PTSD),
- Type 2 Diabetes,
- kidney conditions and
- other cardio-vascular diseases (including heart disease).

An implementation plan was developed to guide the work of the project. The six objectives of the plan were:

1. Identify needs of CALD communities and identify major barriers to use of health services especially preventive health services and programs
2. Assess and strengthen the capacity of health and social services to provide effective patient/carer education and support to ensure health literacy and optimise self-management
3. Engage Communities to
    - 3.1.1. increase the capacity and voice of excluded communities to contribute to building/strengthening access to and quality of the services and environments they need to become and stay healthy
    - 3.1.2. To support vulnerable communities to participate in decision making about the provision of quality of health care services.
    - 3.1.3. Implement strategies to increase health literacy within targeted communities
4. Develop a Communication Strategy for dissemination of information about the project
5. Develop a research and evaluation strategy.

The project also prioritised three suburbs within the Canterbury LGA which have the highest level of socioeconomic disadvantage – Campsie, Lakemba and Wiley Park. Within these suburbs the four priority population groups have been selected—those with Arabic, Chinese, Bangladeshi and Rohingya backgrounds. The initial work for the Bangladeshi community focused on children 0-4 years.

2013 -2015 work plan activities

Overall objectives:

- Identify needs of CALD communities and identify major barriers to use of health services especially preventive health services and programs using desktop information.
- Assess and strengthen the capacity of health and social services to provide effective patient/carer education and support to ensure health literacy and optimise self-management.

Engage community:

a) To increase the capacity and voice of excluded communities to contribute to building/strengthening access to and quality of the services and environments they need to become and stay healthy.

b) To support vulnerable communities to participate in the provision of quality of health care services

- Implement strategies to increase health literacy with targeted community.
- Develop a Communication strategy for dissemination of information about the project
- Develop a research and evaluation strategy

Coordination of project activities:

- Coordinate quarterly advisory group meetings
- Coordinate monthly management meetings
- Update newsletter – quarterly distribution

Promote healthy lifestyle and diabetes prevention in the Arabic communities:

- Deliver four Healthy Eating Active Living (HEPA) courses, in which participants are prepared for follow up walking groups
- Provide HEPA workbook provided in participants' preferred language.
- Ensure Get Healthy Line incorporated into referrals from HEPA courses.
- Engage and encourage partner organisations of HEPA courses to establish walking/physical activity groups and refer participants to Get Healthy Line
- Deliver updated campaigns alongside HEPA courses.
- Review previous social media (Facebook) and radio campaigns.
- Map existing physical activity and exercise referral schemes available in Canterbury and make recommendations
- Financially viable models with local Allied Health Professionals.
- Based upon the mapping exercise recommendations, identify, establish and promote referral pathways for exercise referral schemes.

- Explore the establishment of referral pathways for uncomplicated obesity and weight management.

Key programs and activities implemented 2013-2015

The first stage of the project was a needs assessment that gathered information to inform decisions about how to work on inequity in Canterbury. The needs assessment involved the following activities:

- A literature review to identify potential strategies to reduce inequities in health. ·
- An initial assessment of health disparities in Canterbury using the Local Government Area Health Profile and information on primary health care service use in the area from SLHD and IWSML.
- Mapping GP, Allied Health and Human Services covering Campsie, Lakemba and Wiley Park ·
- A refinement of scope of project through consultation

A number of strategies were implemented for each of the priority population groups, focussed on the priorities identified by the community, the priority health issues, and addressing gaps in service delivery for each of the groups, particularly around prevention. The project team worked with health and community services to trial or pilot initiatives which could later be led by the existing service providers.
Mental health was identified by GPs and others as an important health issue for the Chinese community. Mental health interventions with the Chinese community were:

- beyond blue roadshow in Campsie,
- information to raise awareness in posters, newspaper articles, social media, and
- two Mental Health First Aid courses.

How do you really feel today?' poster and social media campaign 2015

Diabetes prevention in the Arabic community focussed on:

- a 4-week radio campaign on 3 Arabic radio stations
- a 6-week 'Healthy Eating and Physical Activity' course and
- Messages on social media.

Healthy Eating and Physical Activity Course 2015

Bangladeshi community concerns about children falling from windows were addressed with

- A campaign `Kid's Don't Fly' providing resources in Bengali language and launched at Bangladeshi New Year celebrations in Tempe Reserve.
- A playgroup in Jubilee Park, Lakemba by Canterbury City Council's Mayor Brian Dobson.

Three further priority areas emerged during the conduct of this work in Canterbury:

- Increasing women's health literacy (Women's health course with Family Planning NSW) – Healthy Family Program with Rohingya women
- Improving the health of newly arrived refugees (Refugee forum and consultations with Rohingya community)
- Supporting health and social services to strengthen their organisational approaches to health literacy

Kids don't Fly Promotion 2016

Project initiatives also focussed on increasing knowledge and understanding among health service planners and providers about health inequity, and how this could be addressed.

The project shared information and learnings from the need's assessment with health services and the communities and linked up providers and community organisations. Project staff contributed a health equity focus to several local health plans including SLHD's Mental Health Plan, Health Promotion Plan, and Multicultural Health Plan.

CGHiC also partners with community organisations and services in Canterbury, such as SLHD services – Health Promotion & Multicultural Health & Child and Family Nursing; NSW Refugee Services, Metro Assist (Migrant Resource Centre); Canterbury City Community Centre, Settlement Services International; Canterbury Child and Family Interagency; local schools; Family Planning NSW and, community specific welfare organisations.

Healthy Family Program for Rohingya women 2016

Refugee Health Forum in Canterbury Hospital November 2014

Information about the work undertaken by the project was distributed via:

- Five Can Get Health in Canterbury (CGHIC) newsletters to a distribution of 120 people/organisations
- Three articles in the monthly newsletter of Inner West Sydney Medicare Local - Central Viewpoint. It is distributed to the over 3,000 GPs and Allied Health Practitioners.
- Two articles in SLHD Health Matters with a distribution of 1400 printed copies and available on SLHD website and Facebook pages. March –April 2015, May-June 2015.

In June 2015 the first evaluation of the CGHiC project was conducted by ARTD Consultants. The evaluation was primarily a process evaluation which assessed both the extent to which the project was implemented as planned and the immediate impacts of the work undertaken. A program logic was developed as part of the evaluation and used to guide effectiveness of the activities and strategies used to achieve the project outcomes.

The evaluation concluded that the CGHiC had been effective in mapping key health equity issues affecting the selected priority groups and using this information for future health-equity oriented initiatives. The project was seen by partner organisations as a catalyst for collaborative interventions to address inequitable access to health services.

The evaluation also found that the strategies implemented were suitable and innovative and able to reach into the communities with strong participation from the target groups in health education sessions and events. The project also achieved increased communication between local organisations which resulted in wide distribution of health education materials, such as the Kids Don't Fly brochures. Appropriate partners were identified and engaged. Stakeholders valued the guidance of academics from the UNSW with expertise in health inequity and engagement of some GPs, community partner organisations and community members.

The evaluation led to a new Monitoring and Evaluation framework which was jointly developed with all partners and included specific activities monitored against targets and timeframes

2016-2018

In 2016 a new MoU was signed between SLHD and CPHCE and the Project started implementing the recommendations from the 2015 evaluation. The following activities were identified in the new work plan:

2016- 2018 Work plan activities

<u>Priority area: Child and Maternal Health:</u>

- Support the delivery of healthy lifestyle programs for children: ongoing promotion of the Go4Fun program
- Promote community child health services to parents and families. Community development activities to support the needs of Bangladeshi families with particular focus on the health of their children.
- Continue to promote Kids Don't Fly campaign within the Bangladeshi community. Promote KDF among other community groups
- Promote the proposed SLHD family-based multidisciplinary weight management service for children and their families in the Canterbury Hospital catchment area

- GP engagement activity to be included in order to promote and improve early childhood health screening and use of the online well child checks to address developmental concerns.
- Promote the family-based multidisciplinary weight management service as for children and their families as well as through GP's Network and also via CESPHN channels.
- applications to the Multicultural Health Communication Service (MHCS) Awards

Priority area: Chronic Disease Prevention and Management:

- Support the delivery of the Healthy Eating Active Living (HEPA) programs to community groups and develop resources available in a range of languages.
- Arrange meeting with Population Health & Multicultural Health on 9 February to discuss future programs, clarify goals.
- Promote and raise awareness of the Get Healthy Coaching Service to community groups to improve access to participation in chronic disease programs

Priority area: Mental health:

- Build on DV video awareness activities with Metro Assist
- Pamphlet to be developed to be distributed to GPs/community organisations to support DV video use.
- Support group for DV victims to be run by Metro Assist to empower them to improve relationships with their partners at home. To be delivered by a Bangla speaking psychologist.
- Support the promotion of Psychological Support Services (PSS) offered through Sydney Mind Care in Campsie to improve access to a range of applied psychological therapies for underserviced and/or hard to reach populations.
- Work with organisations to promote and deliver a mental health programs (i.e. mental health and mindfulness programs) aimed to reduce stress and mental illness in the community. Liaise with Rebecca Adams (CESPHN) to gather more information about Mindfulness Programme that was run by SESLHD for Arabic Speaking communities.

Priority area: Capacity Building (including workforce development):

- Work with primary health care providers on engagement strategies to focus on the health and social needs of priority population groups. GP engagement strategies include establishing a RACGP Small Group Learning (SGL) Program with GPs in Canterbury.
- Application for award. The first application is for the CPR poster which was translated into Burmese for the ‘Healthy Families’ program in collaboration with CPR Kids and NSW Refugee Health Service. The second application is for the domestic violence video which was developed by Metro Assist.

Key programs and activities implemented in each priority area 2016-2018

Priority 1: Child, Family and Women's Health:

- Tuning into Kids (parenting program) training with 13 bilingual child & family workers from 11 NGOs, and speaking 10 languages other than English

Kids Don't Fly promotion

08 NEWS THEEXPRESS.COM.AU | TUESDAY, FEBRUARY 20, 2018

BANKSTOWN / STATEWIDE

Time to lock up for kids' safety

Window locks must be installed by the middle of March, **Danielle Buckley** reports

THE deadline for new window-lock legislation is just three weeks away, but will tragically be too late for a child who fell three storeys from a window in Bankstown last week.

The seven-year-old was playing near an open window at a block of apartments on the busy Chapel St when he slipped and plunged to the brick footpath below.

He remains in the Sydney Children's Hospital at Randwick in a serious but stable condition.

Accidents like these will hopefully become fewer by March 13 — the cut-off date for all strata buildings in NSW to be fitted with devices that prevent windows opening more than 12.5cm.

The legislation was first passed in 2015 after a push by The Children's Hospital at Westmead staff who were tired of seeing the steady stream of children landing in emergency departments.

"We were seeing 10-12 children each year who had fallen from windows at this hospital alone," Westmead's trauma surgeon Dr Soundappan Soundappan said.

"We felt it was important because it's awful seeing kids getting serious injuries from what is totally preventable."

So far, the hospital is yet to see a decrease in admissions for window accidents but Dr Soundappan said he hoped after March 13 the numbers would drop.

In the last three months window safety compliance companies, such as ASQB Window Safety, have been swamped with requests to install safety locks.

But company director Anthony Shakar said he fears that come March 13, many buildings still won't be compliant.

"We don't believe that all strata buildings will be brought up to standards by then," he said.

"If an accident does occur, the fine isn't the major issue, it's that the responsibility will come back to the owner."

Mr Shakar also said because the locks can be disengaged by occupants, education is also needed.

Canterbury local Feroza Yasmin has been doing a lot of work raising awareness about window safety after she was approached by the government-led Kids Don't Fly campaign.

As part of the campaign, Ms Feroza works with the Bangladeshi community handing out educational pamphlets highlighting the risk of falls, but said it was a significant issue for everyone, not just her culture.

Installing window safety devices is a requirement under the Strata Schemes Management Act 2015.

A spokesman for NSW Fair Trading said a fine of $550 will apply to non-compliant owners or to lot owners who obstruct an owners' corporation in the installation of the window safety devices.

Window deadline

- When: March 13
- Who: Responsibility is on owners corporations
- What: Under the reforms, openable windows that are less than 1.7m above the floor, and more than 2m above the surface outside must be fitted with safety locks
- Locks enable the maximum window openings to be less than 12.5cm

Feroza Yasmin has championed the Kids Don't Fly campaign which encourages residents to lock their windows. Inset: Locking devices are compulsory from next month. Main picture: John Appleyard

- Healthy Families' programs for the Rohingya Community women's group.
- Tuning in to Kids course in Bangla for parents
- Child development brokerage facilitating talks from SLHD, Community health on Child & Family Health Services and therapy
- Bangladeshi Women's Circle attended by 32 women: – partnership with Metro Assist – (Migrant Resource Centre) to run a weekly two-hour group for women at Lakemba Library Hub. Seven sessions were held which included: child development, occupational therapy, mental health, overview of SLHD healthy families and healthy children, Domestic violence, oral health and promotion of kids don't fly.
- Oral Health Session for Rohingya Women's Group at Lakemba

Bangladeshi Women's Circle

Priority 2: Chronic Disease Management & Prevention:

- Lebanese Muslim Association Community Wellness Expo (300 participants, including 21 women screened by Breast Screen)
- Promotion of HEAL physical activity program
- Supported Breast Screen mobile van in Lakemba. (91 women screened)

Priority 3: Mental Health:

- Domestic Violence awareness promotion – Bangla DVD launch (100 local community members and service providers). The video is available on You Tube as "Just Reach Out" https://www.metroassist.org.au/news/39/37/JUST-REACH-OUT-domestic-violence-awareness.htm
- Mindfulness program of SESLHD
- Body and Mind Wellbeing program (in Campsie) for the Chinese community in partnership with Chinese Australian Services Society (CASS) and SLHD
- Excursion to Taronga Zoo with Rohingya community (135 Rohingya community members): De-stress activity: excursion to Taronga Zoo with 135 In partnership with Burmese Rohingya Community in Australia (BRCA) and SSI – Settlement Services International (SSI).
- Due to political events in their home country of Myanmar, there are increased levels of stress within the Australian Rohingya community.

- GP & AHP training - ‘Mental Health in Immigrant Populations in Canterbury’ (31 participants – 13 GPs, 6 Practice Nurses, 7 Allied Health Professionals, 1 Practice Support staff)

Priority 4: Capacity Building:

- Can Get Health in Canterbury provided $10 000 in funding to the Burmese Rohingya Community of Australia (BRCA). The Rohingya Little Local aimed to increase social capital and support the Rohingya community in Canterbury through the funding of priority activities (as chosen by the community).
- Bangladeshi Community Networker contract
- Development of Bilingual Community Educator program in LHDs
- Publications in Bangla speaking newspapers
- Bangladeshi Community Networker contract
- Canterbury Hospital tour – Rohingya community members (who attended Healthy Families program in October/Nov 2016)
- CGHiC project presented at Equity Fest – SLHD conference
- Bangladeshi co-facilitator contractor (previously volunteer with Metro Assist) contracted
- Refugee Health CPD event at Riverwood for GPs and Practice Nurses – run in partnership with SLHD, SESLHD and NSW Refugee Health Service
- Refugee Health Forum at Canterbury Hospital for GPs, health professionals and community workers
- Small group learning program with General Practitioners focusing of refugee health.

Excursion to Taronga Zoo

In 2016 CGHiC was evaluated for the second time. The purpose of this evaluation was to ascertain the effectiveness of the activities in meeting the goals of the project and measure the impact of the project on the targeted communities and service providers. The evaluation was conducted by the Centre for Refugee Health and UNSW. The evaluation consisted of interviews with 17 stakeholders, one community group consultation and eight women who took were part of the "Health Eating and Physical activity (HEPA)" group.

The evaluation concluded that CGHiC has developed an innovative and localised model of a health equity focused project with community engagement employed as a major strategy.

Based on the evaluation findings a stakeholder engagement and co-design planning workshop was conducted in February 2017 and attended by 39 service providers in Canterbury area. The workshop sought to review the CGHiC Project including its priorities and plan for the next phase of the project. As a result of the workshop the following issues and actions were identified for each of the priority areas:

Child and Maternal Health

What priority population groups do we need to be working with in Canterbury?	What is the problem?
✓ Newly arrived groups ✓ New parents ✓ Vulnerable and disadvantaged groups ✓ Specific target groups	✓ Social isolation – new mothers who have recently arrived (trauma and stress are big issues) with minimal family support. ✓ Cultural barriers i.e. lack of translated resources and culturally appropriate services. ✓ Delayed child development – children not developmentally ready to start school. ✓ Organisations lack engagement and capacity building skills to target CALD groups, especially new emerging groups.
✓ Bangladeshi community	✓ Domestic violence ✓ Gestational diabetes ✓ Child development issues
✓ Rohingya community	✓ Social isolation ✓ Lack of routine affecting parenting skills ✓ Difficulty navigating and accessing the health system and services, due to language barriers and lack of knowledge of services
✓ Arabic speaking community	✓ Social isolation ✓ Difficulty navigating the health system

Who needs to be involved?
✓ Bilingual Community Educators ✓ Schools as Community Centres ✓ Health workers* ✓ Early Childhood Educators and Nurses ✓ Community leaders (informal/formal) and connected families ✓ Culturally based organisations
What kind of activities should we be doing?
✓ English classes*** ✓ Parenting programs and other open-ended soft entry point activities** ✓ Identification of families in need* ✓ Community leadership and mentoring ✓ Culture exchange workshops required for service providers to upskill and increase awareness of new emerging groups. ✓ Community hubs providing multi-faceted approaches to services

Emerging Needs/Refugee Health

What priority population groups do we need to be working with in Canterbury?	What is the problem?
✓ Rohingya community	✓ Many Rohingya people come from villages with undeveloped health systems, so they find it difficult to access health services when they move to Australia. ✓ Language is a major barrier as they do not have a written form of their language. Most of them understand Burmese and some of them also understand Bengali. ✓ Community representatives mentioned that they have been struggling to provide health literacy to this community. They emphasized that they are mostly uneducated and have limited knowledge of diabetes, hepatitis C and tuberculosis. ✓ Many pregnant women arrive in Australia and do not visit a GP or hospital until they are 5-6 months into their pregnancy. The main reason for this is the language barrier, and with women who already have children, as they tend to ignore hospital visits because they assume that pregnancy is something they've done before and so they feel they know everything they need to know. Many women are also unaware of the health system in Australia. Medicare and visas were also highlighted as barriers to accessing services, including GP appointments. ✓ Use of Thanakha powder is a big problem among Rohingya/Burmese women. They apply it to their faces to protect their skin from sunlight and for beauty purposes. The powder contains high levels of

	mercury, lead and arsenic. It has been made aware to the community, and products have been removed from supermarkets, however the issue still exists in this community. ✓ There is a huge oral health issue among Rohingya men caused by chewing tobacco. Most men are not even aware that it's a problem. ✓ Many Rohingya people have arrived in Australia having experienced time in camps. They often experience torture and trauma issues. ✓ There are not many Rohingya speaking GPs in Canterbury. There are only two or three identified GPs who speak the Rohingya language. Often Rohingya people visit those GPs who speak Bangla as this a similar language to Rohingya. ✓ Domestic violence is unreported among women in the community. There is a perception that any form of reporting can jeopardize the husband's visa process.
Syrian/Arabic speaking communities	✓ The Syrian community in the Canterbury area is very much hidden. It is difficult to access Syrian people in the area. They tend to go to family members in case they need any assistance instead of going to community support services/organisations. ✓ Torture and trauma issues, as reported in the Rohingya section above. ✓ Domestic violence issues, as reported in the Rohingya section above.
Migrants from Indian subcontinent	✓ Social isolation ✓ Difficulty navigating the health system
Bangladeshi community	✓ Domestic violence ✓ Child development issues
Who needs to be involved?	
✓ Schools as Community Centres ✓ Refugee organisations** ✓ Local health district/Health workers/GPs* ✓ Religious leaders/cultural leaders – Rohingya community have many community leaders ✓ Libraries	
What kind of activities should we be doing?	
✓ Working with Bilingual Community Educators and other bilingual staff. Need to employ BCEs to connect with the community to bring people together within their local areas to link them to services so that they feel more comfortable being involved in events and using health services. Use BCEs to encourage members to sign up to programs organised by service providers and make follow-up calls to participants. BCEs can be involved in taking people out for a day event and provide simple, health-focused information. Education events need to provide transport, food, childcare and interpreters. ✓ Some newly arrived groups require support with torture and trauma issues and need to be informed about health services available to them.	

- ✓ Work with GPs** GPs who see priority population groups need to be given certain incentives for seeing these families. GPs need to be connected within communities, but more engagement strategies need to occur with GPs, and they need to be upskilled in working with the Rohingya community.
- ✓ Working with media*. There is not any form of media provision in the Rohingya language.

2019-2020

The last 2 years of the CGHiC have been focused on implementing the strategies and activities identified in the 2016 evaluation and 2017 planning workshop. A key focus of the project has been to act strategically and prioritise health literacy activities utilising existing human resources. This shift from small group activities to larger community health events and activities has meant that CGHiC has been able to focus on meeting the information and capacity building needs of the targeted communities through activities such as:

- Developing resources such as health literacy information pamphlets and posters
- Supporting community organisations to build their capacity
- Delivering information, training and professional development activities with health staff and community leaders

The goals and objectives of the project were also refined:

Goal

To improve health and reduce inequities for marginalised culturally and linguistically diverse (CALD) populations in the Canterbury region.

Objectives

- Improving access to comprehensive primary health care services
- Increasing individual and community health literacy
- Identifying and working with relevant stakeholders to address at least one the social determinant of health.

The following work plan we developed to achieve these goals and objectives:

2019 Work plan activities

<u>Child, family and women's health:</u>

- Supporting newly arrived parents in Canterbury (Chinese and Bangla speaking) – Health Direct project

- Deliver Bangladeshi Women's Circle: health education group
- Deliver parenting program
- Deliver Mindfulness program
- Deliver Oral Health assessment (screening) and promotion for Rohingya school aged children

Chronic disease prevention:

- First aid course for refugee men or pain management course (TBC)

Mental Health:

- Deliver a Mental Health Forum for Community workers in Canterbury
- Create Bangladeshi language Domestic Violence poster

Capacity building:

- Offer range of professional development strategies to primary health care providers
- Start Rohingya Little Local project: community-led project
- Activity with the Community Participation Coordinator at Canterbury Hospital

Key programs and activities implemented in each priority area 2019-2020

Children, family and women's health:

- Bangladeshi Women's Circle - Parenting course, term 2 2019 – (2 hours/week x 6 weeks). This activity is a continuation of the 2018 strategy to deliver intensive support to the Bangladeshi community by targeting women and children. The activity is a partnership of Lakemba Bangla School, Hampden Park School and Metro Assist. The goal is to increase positive parenting skills, reduce social isolation of Bangla speaking women and increase capacity in individuals and community health literacy. Attended by 9 women.

Bangladeshi Women Circle

- Bangladeshi Women's Circle - Women's Reproductive Health, term 4 2019 - (2 hours/week x 5 weeks) Delivered in partnership with Metro Assist. The objectives of this activity are to increase knowledge among the participants of women's reproductive health, reduce social isolation of Bangla speaking women and improve access to PHC and capacity in health literacy

- Rohingya Oral Health Activity - primary-aged children & families 1/10/2019 – (1-day Sydney Dental Hospital SLHD Canterbury Oral Health Services). Delivered in partnership with Hampden Park School and Lakemba school. The objectives are to assess children's teeth and refer children for further dental care if required, increase knowledge of health nutrition and caring for teeth and improve access to PHC and capacity in health literacy Attended by 44 children and 53 family members.

Capacity Building:

- Canterbury Community Health and Hospital Tour, June 2019 – In partnership with Canterbury Community Health and Canterbury Hospital and Wiley Park School Community Centre (SaCC). The objectives of this activity are to familiarise participants with services in Community Health and the Hospital, improve access to PHC and increase capacity in health literacy. Attended by 16 women and 8 pre-school children.

Canterbury Community Health Services and Hospital tour- oral health service

- Men's family project - Male workers group (3-hour x 2 meetings). Delivered in partnership with Koorana Child & Family Services. The objectives are to bring together male workers in child and family related services and organisations to plan early intervention to strengthen men's role in families, identify and work with relevant stakeholders to address at least one social determinant of health. Attended by 16 male workers.

- GP and PN training - Child Developmental Screening. Delivered in partnership with NSW Refugee Health Services, STARTTS, and SLHD Child and Family Nursing. The objectives are to increase knowledge of the child developmental screening processes and requirements, to increase awareness of specific cultural factors in screening and to increase capacity in individuals and community health literacy. Attended by 28 staff: 8 GPs, 10 Practice Nurses, 7 AHPs.

Mental Health:

- Bangladeshi Women's Circle - Term 1 2019- Mindfulness- (2 hours/week x 5 weeks) Delivered in partnership with SESLHD and Metro Assist. The objectives are to reduce psychological stress in CALD communities, improve access to PHC and increase capacity in health literacy. Attended by 13 women.

- Bangladeshi Women's Circle - Term 3 2019 - Mental Health First Aid training, term 3 August 2019 – (2 hours/week x 5 weeks). Delivered in partnership with Health Promotion Unit- SLHD and Metro Assist. The objectives are to increase knowledge of mental health problems, increase confidence to provide initial help and in a crisis and increase capacity in individuals and community health literacy. Attended by 18 women - 7 of these were accredited as Mental Health First Aiders.

- Domestic Violence poster in Bangla language. The poster has been sourced from Nepean and Blue Mountains PHN. The objective of this resource is to provide a quality resource about what is domestic violence in the Bangla language, and increase capacity in individuals and community health literacy. The resource will be distributed in 2020.

Chronic Disease Prevention:

- Arabic Women's Exercise Group - Healthy Me, Healthy You. A partnership with Muslim Women's Association and Water Well project. The objectives are to increase the physical and mental health of participants through an exercise program and health information sessions, increase capacity in individuals and community health literacy. Attended by 19 women and 6 children

- Supporting Arabic Health in Canterbury - women's exercise and seniors' groups with cancer screening. In partnership with Tripoli and Mena Association, Water Well Project, Cancer Institute, SLHD Diversity Hub and Fitness provider. Funding ($10K) provided by CGHiC to address cancer screening & prevention and physical activity in the Arabic speaking community in Canterbury. The project also seeks to increase capacity in individuals and community health literacy. Currently running and attended by approximately 55 people.

- Supporting Arabic Health in Canterbury - Stay Tuned- video about barriers to bowel cancer screening. In partnerships with Metro Assist. Funding ($10K) provided to address low rates of bowel cancer screening in the Arabic speaking community in Canterbury. The objectives of the activity are also to increase capacity in individuals and community health literacy. The project will be run in 2020.

Enabling Activities:

- Bilingual Community Navigators (BCN) in General Practice: a scoping study (ongoing). In partnership Lakemba Family Healthcare, Dr Fariha Dib. The objectives of this study are to explore the efficacy of BCNs in providing navigation support to patients in a general practice setting, increase capacity in health literacy and identify and work with relevant stakeholders to address at least one social determinant of health.

- Assisting Newly Arrived Migrant Mothers project. In partnership with HealthDirect, and SLHD Child & Family Nursing. The objectives are to increase access to appropriate health care information and services for new migrant mothers and grandmothers, improve access to PHC and increase capacity in health literacy. Attended by 24 mothers & 5 grandmothers (Chinese and Bangladeshi).

- Organisational responses to Christchurch NZ massacre at Islamic Mosque March 15, 2019 in partnership with Muslim Women's Association. The objectives of this activity are to express outrage at the tragedy and encourage primary health professionals and SLHD staff to be aware of need to support clients.

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