

Engaging Rural Communities Using a Videoconference Health Education Program: Lessons Learned and the Way Forward

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Abstract

Women's Health Queensland Wide (WHQW) has led the world in using videoconference technology to deliver health education sessions to rural communities. Each session enables up to 12 rural, regional or remote Queensland towns to simultaneously participate and interact. Programs have included sessions on women's gynaecological, reproductive and emotional health issues as well as relevant community and welfare presentations.

In 2002, an impact study was undertaken that demonstrated benefits to the community beyond mere participation in education sessions. Communities described social capital benefits and there was an overwhelming acceptability by participants for the use of this technology to deliver health education.

WHQW has proven that videoconferencing can be used for more than health education and is a strong proponent for the future role of technology in engaging communities. However, the potential for technology to be used by and to engage communities is hampered by a number of issues. These issues include, but are not limited to, access, infrastructure location and ownership, and funding models of technology providers.

This paper will discuss the success that WHQW has had in engaging communities via videoconferencing, the social capital benefits for communities under the principles of bonding, bridging and linking and outline some recommendations to ensure the future viability and sustainability of technology to continue to engage communities.

Keywords

Health education, women, rural and remote, community capacity building, videoconferencing

Introduction

This paper will describe how Women's Health Queensland Wide (WHQW) uses technology platforms to deliver health information to rural communities. Results from a 2002 impact study of a videoconference health education program will be discussed using The Benevolent Society's (Hampshire and Healy 2002, Hampshire 2000) components of community engagement — bonding, bridging and linking and issues around continued sustainability and viability of this program — will also be discussed.

Background

WHQW is a Brisbane-based non-government health promotion organisation. Services include a telephone health information line, free lending library, resource development and distribution and health education program. Since 1997, these services have been provided on a state-wide basis. While most of the services provided by WHQW can meet their state-wide responsibility using traditional technology platforms such as telephone, post, and email; these platforms have not been suitable for the health education programs.

Telemedicine networks utilise videoconference technology to deliver clinical services to patients in rural and remote communities (Forrest 1999; Phillips 1999; Schiffman et al. 1998; Dossetor et al. 1999), training and professional development activities to the health care workforce (Lindsay and Bannan 2000; Gupta et al. 1998; Kingsnorth et al. 2000), and ongoing support to individuals with specific health needs (Hufford et al. 1999; Stroetmann et al. 2000). Because of their reach within rural Queensland, WHQW was interested in using the telemedicine network as a means of providing rural health education. A successful rural health education program via videoconferencing has been conducted by WHQW since 2000. This world-first project combines technology with an innovative delivery model to bring together health professionals, community members and to link them with other communities across the state.

Other technology platforms currently being trialled at WHQW for health education are videostreaming and 'voice café' — a voice and sound interactive private internet chat room with many meeting and group facilitation features.

Videoconferencing

Virtually every community in Queensland has a publicly accessible videoconferencing site, more per capita than anywhere else in the world. Many of these are in health facilities, and others are located in shire and community premises. Sites are linked via 128 kbps ISDN lines. Queensland Health's Statewide Telehealth Services provides the bridging for and supports WHQW to deliver its community health education programs via videoconferencing.

Videoconferences usually take place during the day, with speakers presenting short talks lasting up to 30 minutes, on a wide range of women's health topics. Events last for 90 minutes, with the majority of time allocated to questions and answers between speakers and audience members at remote sites. A typical videoconference involves 12 sites, with a group of women and health professionals at each remote site and the WHQW host and speaker in Brisbane. Eighty-nine communities have participated to date, many on repeat occasions. Support material is available on WHQW's website.

The program delivery model involves WHQW working with locally-based facilitators in participating communities. Facilitators nominate their communities to take part and 'own' the event locally. Responsibilities of the local facilitators and WHQW are clearly defined. Because of the content of the education sessions and the way Queensland's videoconference infrastructure is managed, these local facilitators have generally been Queensland Health staff.

Audience feedback is collected from all attendees via a self completed questionnaire, with upwards of 95 per cent stating that videoconferencing is a suitable medium and that they would attend future events. Other papers (Faulkner 2001; Faulkner and McClelland 2002; McClelland 2001; McClelland 2002) have discussed the feedback from these programs.

The impact study

A study to try to gauge the impact of this program on participating communities was undertaken in late 2002. Telephone interviews were conducted with the local facilitator. Interviewees represented 43 of the 64 towns that had participated at that point.

Definitions of the relationships that characterise social capital (Woolcock 2000) are particularly relevant to projects that involve delivering services into pre-existing communities. He describes these relationships as being:

- Bonding — connections to people like you
- Bridging — connections to people 'not like you'
- Linking — connections to people in positions of power.

Michael Woolcock's definitions grew out of his own work in the area of international aid projects, but the work of The Benevolent Society in building on his original definitions is particularly relevant to the non-profit, community-based human service organisations in modern-day Australia (Hampshire and Healy 2002; Hampshire 2000).

The Benevolent Society has adapted Woolcock's definitions and, instead of 'social capital' has substituted the term 'community engagement' as being more easily understood and relevant. In the society's hands the relationships are redefined as:

- Bonding — with family, close friends and a close network
- Bridging — to a wider network(s) within the community, immediate reference or support group
- Linking — to institutions, business, government.

The society identifies all three dimensions as essential to the wellbeing of individuals and society as a whole, with its core message being that while each of these is critical to developing community engagement, none is adequate on their own.

The results from the impact study were analysed in terms of the social capital relationships of bonding bridging and linking, and particularly The Benevolent Society's reworking of the definitions of those relationships for non-profit organisations in contemporary Australia. The impact study found that some participating communities report an improvement in these relationships.

The results

Although most women attended the events alone, interviewees reported women talking about the event to family and friends, and some excellent examples occurred of groups of older women from aged care facilities attending in groups and following up by going to the public library together to use the Internet. These demonstrated examples of bonding.

Examples of bridging relationships included increased collaboration between services within communities, improved communication, and more peer-to-peer professional support across professional boundaries. Some reported an increased use of services, changes in their own practice and a variety of follow up events with a social focus. Some used the events to host lunch barbecues, or evening cheese and wine.

Over one-third of interviewees were able to name specific events that had occurred in their communities as a direct result of taking part in the videoconference, including workshops, meetings, discussion groups, displays, video nights, etc. with others commenting on a general change in approach.

There were examples of flow-on effects to increased use of other services in the community, like Internet access points, and of collaborative projects such as sharing facilities and working together on promotional activities for the whole community.

Linking examples consisted of better support to residents and staff of the communities through developing a relationship with services they didn't know existed. Respondents also described better quality of contact with some outside services/departments as a result of participation. The locally-based professional staff acting as local facilitator was also able to build their own knowledge and direct questions to the presenter who would often be a respected specialist.

Results — relationship with program model

The activities that the health professional has to undertake as the local facilitator in this model were critical to these outcomes. The relationship with this person is the linchpin of the success of this model.

The local health professional plays a key role in owning the event for the community, promoting and publicising it, hosting it on the day and developing follow-up activities. The event does two major things for this person: gives their role in the community more definition (as described by Ian Plowman's (2004) 'effective leadership'); and encourages them to work more collaboratively across both their own and other sectors (because they have to, to get the audience). Along the way, though, many also reported building better professional supports, and improving their own content knowledge.

The project demonstrates that a well-designed community education event can have a beneficial impact on professional support and social capital relationships in participating communities, creating added value beyond the information content of the program itself. It can contribute to enhancing health professional and community networks and relationships, thereby assisting viability.

Replicability

It is possible to question the replicability of this program to other organisations by saying that WHQW was unique. While WHQW had unique motivators to deliver rural health education via technology platforms: a state-wide responsibility, with no means of delivering face-to-face rural health education services; an IT staff member whose role involved identifying ICT platforms appropriate to its service delivery; and no established rural health education programs. Other community organisations also began to use videoconferencing to enhance their service delivery. Many of them have used WHQW's model and found similar benefits in relation to community engagement.

In 2003, the focus of the program delivered by WHQW included the increased participation by other community services and agencies. This participation led to an increased request by community services to further develop their usage of this technology platform. The only reason much of this has not been realised is because of some of the barriers that will be addressed in following sections.

Other uses for videoconferencing

Videoconferencing can be used by health services and non-government organisations in many other ways to engage communities. Some other examples of how videoconferencing has been used at WHQW include:

- enabling rural communities to participate in research via focus groups
- peer support networks for isolated individuals
- outreach in launching government policies or consumer activism
- special events such as a memorial service for families who have experienced a neonatal death or miscarriage
- increasing rural representation on committees and boards in South East Queensland.

Barriers

So, we have in Queensland a unique problem (a community with First World expectations, a huge geographical area, dispersed population, and communities struggling to maintain service levels and viability) but also unique advantages (excellent technology/telecommunications infrastructure and skills already in place). We believe the solution lies in using the infrastructure creatively and effectively to improve health and social outcomes.

The major problem with the current funding environment is that access to videoconference facilities and bridging is controlled by Queensland Health using a 'telecommunications model' (i.e. users pay according to how long they are connected), whereas we would argue that this platform delivers such obvious benefits to the communities and such obvious potential savings to government that a 'roads model' would be more appropriate (i.e. a common infrastructure, paid for through public funding, but available for all to travel). Because of the fees and charges introduced by Queensland Health around their videoconferencing facilities, from now on each participating site in our videoconferences, where a Queensland Health worker is present, will have to pay a \$15 registration fee and the dial-up costs.

There is already a stated government objective of a "whole-of-government approach to using videoconferencing as a means of reducing costs". A 'telecommunications' approach to funding will always make this impossible to achieve, as it assumes that we are only talking about in-government costs (e.g. fares for public service travel, etc.) and that these are payable by funded departments for use of the government-owned videoconference infrastructure.

However, Queensland Health documents say that government business includes working with and for communities and the ability of non-government organisations to continue to provide programs to assist Queensland Health to meet its health outcomes can only be achieved if the non-government sector equally has access to infrastructure such as videoconferencing. This includes viable means for non-government organisations to meet current government fees and charges around videoconferencing.

Conclusion

In Queensland, we have a model that works in health, and the results of the impact study suggest it delivers benefits to health professionals and the community beyond the content of the event that it really does 'engage communities' in real ways, putting words into action. The infrastructure is there, the health professionals are there and programs are there, but there has to be an initiative to move forwards with a commitment to ensuring broader access to technology platforms managed by the government especially when there are demonstrated benefits for the government.

Proper trialling and evaluation in other content areas are needed. Potential areas for service delivery include families, disability and seniors' services, primary industries and natural resources, economic and business development, and non-profit and volunteer organisations.

It would be a sad indictment of the Smart State (Queensland) indeed, if here in Queensland we actually have something world-first and innovative that could be a useful and simple means of assisting rural communities to innovate, grow, and maintain viability and we lost it, all because of a telecommunications funding model that limited community engagement.

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