A National Aboriginal Health Strategy

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Reprint

REPORT OF THE NATIONAL HEALTH STRATEGY WORKING PARTY

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ABORIGINAL AUSTRALIA - THE REALITY AND NOT THE MYTH

In the planning of any National Aboriginal Health Strategy, the reality of Aboriginal Australia must first be addressed.

But many of the realities of Aboriginal Australia - both pre- and post-colonial - have been obscured by the processes of both history and "history-in-the-making" throughout the last two hundred years.

There is a great deal of truth in Napoleon's assertion that only conquerors write history - but there is even more truth in the assertion that only conquerors celebrate it.

Dressed in the hand-me-downs that are the legacy of dispossession and dispersal, Aboriginal Australia could hardly have felt at home at White Australia's extravagantly self-congratulatory, glitzy bash last year.

But the vulgar trumpettings, the epicly Philistine commercialism of the idolised nouveaux-beer-riches, and the raucously adolescent displays of iron-fisted jingoism that were so much a feature of the Bicentennial Celebrations all seemed entirely justifiable to a White Australia intoxicated by the "pioneering spirit".

For this is a history forged in the cauldrons of colonisation, a history in which the processes of mystification have been very much at work for the last two hundred years.

It has served to sanitise a convict past that was not nearly as noble as the headline-grabbing, declaratory utterances of last year would have had the world believe. And those who prefer to think that White Australia's convict beginnings brought civilisation to these shores would do well to remember that "these poor souls" who came in chains were not always the innocent victims of a brutal class system but, more often than not, as Robert Hughes has seen fit to point out in "The Fatal Shore", the bona fide murderers, thieves, and rapists of what Britian once called its "criminal classes". Moreover, those who were sent here to keep "these poor souls" in chains were seldom of much "better stock", hardly that elite of Britian's colonial service that comprised the British Raj in India and hardly of the same ilk as some of those men of vision went to New Zealand or to East Africa. Notwithstanding this, the early Australian colonies were to become the only ones in the whole of the British empire to which Britain "transported" its own free labour force and this, plus the elements that comprised it, had horrendous implications for the Aboriginal people.

Not even to be kept alive for their labour, as indigenous people were in other parts of the British Empire, Australian Aborigines were to become the only indigenous people throughout the whole of this Empire to be shot for sport, to be massacred en masse, or to have their waterholes poisoned.

But, even after the transportation to the Australian colonies of a convict labour force was abolished, the colony of Queensland was to avail itself of indentured slave labour from the Pacific until the introduction of the White Australia Act, after Federation in 1901, made it necessary for Queensland to put an end to slave traffic the same year.

The colonising lust for land with nobody already in occupation of it continued well into this century with White Australia still preferring to ignore the existence of Aborigines, even as a potential labour force.

As a result, it was not until World War I broke out while Australia's cattle industry was still rapidly expanding in the far outback that the severe depletion of a union-protected White Australian labour force meant Aborigines finally began to be recognised as a viable work force - albeit a very much underpaid one.

And, whilst White Australia has readily admitted that it once "rode on the sheep's back", it has never been prepared to admit that, as the cattle industry began to eclipse the importance of the wool industry, White Australia also rode on the backs of black stockmen in the outback.

But history has done much more than give support to the widespread and persistent notion amongst White Australians - and, to some extent, amongst Aborigines themselves - that Aborigines are hopelessly unreliable as a work force because "they're too lazy to work".

Most of all, official Australian history of the last two hundred years has had to give credence to the legal fiction of "terra nullius" - White Australia's most cherished self-sustaining myth.

As a result of this, history has tried to ignore the existance of Aboriginal Australia and, where this has not been possible it has used all the processes of mystification to deny, diminish, and to deprecate the dispossessed.

Without the means to de-mystify White Australia's history and dismantle its mythology, Aborigines continue to be the subject of so many misconceptions.

To name but a few:

there was nothing here of value before the coming of the white man;

if Aborigines were here, they occupied the continent, not so much as human beings, but in no more orderly a fashion than the rest of the flora and fauna, of which they were part (as the wording of "possession in the name of King George III of the land and everything in it" suggests);

if Aborigines were to be considered as human beings, then they, like everyone else, must have come from somewhere else (usually, it is always suggested, from the Southern Indian peninsula, since this fits the white man's pre-conceived ideas of migration and enlightenment always coming from the North to the South);

that the "beastly, un-Christian practices to which missionaries and early settlers reacted with such shocked excitement" (Robert Brain, "Rites Black and White") and the absence of any churches were clear proof of a wanton Godlessness and the absence of any spirituality;

that, in an extended family system, Aborigines bred indiscriminately. (This was brought about because early settlers made these observations from a purely ethnocentric viewpoint, without realising that such extended family systems include many ceremonial relatives who are not blood relatives but who are addressed and referred to as such. In fact, a very effective selective breeding system, developed over many thousands of generations and known as the "skin" system, requiring elders to know all their peoples' geneologies for eight, sixteen, and sometimes thirty-two generations back, precluded any in-breeding; and modern geneticists have now realised that Aborigines have known a lot more for thousands of generations about "cross-cousin" marriages than the Royal Families of Europe.);

that the rules for healthy living in a predominantly nomadic society are really only a display of backwardness and ignorance and that such mechanisms as "walkabout" were not an effective economic measure, hygiene device, and sometimes a spiritual reinforcement as important as the Church's Retreat, but nothing more than an indication of unreliability and inconsistency;

that, despite the fact that, in some Aboriginal languages there are as many as 4,000 words for different parts of the body, Aborigines were so primitive that they knew nothing about the anatomy - not even that copulation could lead to conception;

> that a 50,000 year-old oral tradition reflecting many levels of formality in language as a vehicle for "holding the law" and "carrying the knowledge" should give way to a society in which it is far more important to be literate than articulate, a society which follows "the letter of the law" rather than "the sound of the law" and which reveres "a man of letters" rather than "a man of sound"; that the use of English, as the language of the conqueror and the only worthwhile measure of any real intelligence, should prevail, and that official policies of stamping out the Aboriginal languages have been warranted - all this despite the fact that these languages are so highly evolved and complex that fluency in them might require a working vocabulary of up to 30,000 words compared to the 2,000-word vocabularly required for fluency in English; and
>
> that, in the absence of monarchs, presidents, sultans, maharajahs, or chieftans and without any parallel to the rise of the Nation States of Modern Europe after the 15th Century, Aboriginal rule by Council of Elders and the protocol of co-existance and avoidance did not add up to any recognisable system of administration.

Given such heavily inculcated beliefs amongst White Australians, it should come as no surprise that a survey conducted amongst medical undergraduates at the University of Queensland this year showed that ninety per cent of them believed Aborigines were to blame for their own problems.

White Australia's self-supporting mythology has spared Contemporary Aboriginal Australia no less than it has traditional Aboriginal Australia.

As a result, Aborigines are yearly subject to fashions in the white man's thinking and choices are confined to stereotypes created by history. Once in vogue were those of us who were "not real dark" but, unless such people wear T-shirts or badges declaring their Aboriginality today, it is generally assumed they must be ashamed of it.

Exceptions have always been made for those who demonstrate the hallmarks of success in the white man's world and those who have refused to feel exceptional - and grateful for it - have generally been seen as having traitorously rejected the white man's acceptance of them as one of his own.

And so, the football hero will not be treated as shabbily as his kith and kin as long as he is as careful as Jane Austen to hide any intelligence he might have, as long as he is always the toothless tiger, affable, sociable, and no more of a threat to the dominant society in Australia than a gladiator would have been to Ancient Rome.

But with changes in fashions, the pristine noble savage of the tea-towel subculture variety (the only "real Aborigines") have more recently been courted as a colourful aberration to the mainstream "Australian way of life".

Clearly, Aborigines and Aboriginal Australia labours under the imposed definitions of White Australia.

It is White Australia that tells us who is Aboriginal and who is not; when we can be Aboriginal and when we cannot; what is "typical" Aboriginal behaviour and what is not; and that we're "all the same" except when it suits White Australia for some of us to be "different from the rest".

But to look at the reality:

The fact is, however, that Aborigines are not and never have been any more homogeneous than the English or the French.

This cannot be overlooked in any problem-solving exercise in contemporary Aboriginal Australia, especially in the development of a National Health Strategy.

Enormously diverse living conditions throughout a continent with such a varied land formation, flora, and fauna dictated the evolution, over many thousands of generations, of a society that had to be heterogeneous for the sake of its own survival.

And, while this heterogeneous pre-colonial society is very much extant, held together as it always has been by a complex system of co-existence through protocol and avoidance, it has nevertheless been greatly modified, even in the farthest-flung parts of Australia.

But these post-colonial modifications have tended to make for a greater rather than a lesser heterogeneity in Aboriginal Australia today.

This is despite the growth of a pan-Aboriginalist Movement and the politically expedient "stick-togetherism" it has fostered in the last fifty or sixty years.

For, added to the existing heterogeneity that came out of the soil before colonisation, new dimensions in diversity have been introduced by the manner in which the conquest of Australia has taken place. This conquest has not happened overnight. It is a process that, in many parts of Australia, continues to this day.

While it began with European settlement in the south-eastern corner of the continent it has continued with a frontier that has fanned out at a varied pace to the west and the north, reaching some parts of the far outback only in the last fifty years or so. This has done much to create varying degrees of adjustment or resistence to the demands of a dominant Western major society on the part of the Aboriginal people. Added to this is the fact that the white people who arrived with Captain Cook were somewhat different from those who began to arrive in the Northern Territory late last century and throughout the first half of this century, they themselves, having come from a society that has changed greatly from the days of Georgian England a society that has undergone many changes at its source and many locally influenced changes in Australia.

But the spread of the white frontier has also been accompanied by an enormous "Balkanisation of the Blacks" - a process aptly referred to in Africa by Nigerian writer, Wole Soyinka, as "The Diaspora of the Blacks". This has meant that Aborigines have not just remained on their land and been overtaken by the white frontier and the greatly changed living conditions that it has brought with it. It has also meant that Aborigines have been "relocated" to accommodate this white frontier.

Obviously, then, in formulating health policies and strategies, it is important to take account not only of the effects of the white frontier on those who still live on their traditional land but also of the effects of a growing inapplicability of rules once appropriate for healthy living. But, equally, it is important to consider that effects of the imposed Diaspora on the great majority of Aboriginal people who have been shunted around from one end of Australia to the other in order to make way for "white settlement" and who have since mostly found themselves in the most appalling living conditions in enforced close settlements.

This Diaspora, this Balkanisation, has been so extensive that, in accordance with arbitrarily applied and expedient definitions of Aboriginality, it has resulted in the removal of some of the Pitjantjatjara and Pintubi to Papunya and some of the Pitjantjatjara to places as far away as Adelaide and Goulburn Island; some of the Walpiri from the north-west of the Northern Territory to Darwin and Warrabri, between Alice Springs and Tennant Creek; the children of the Kalkadoon and Kurtja peoples around Mt Isa and Normanton to Bribane; the Darwabada to Yeppoon near Rockhampton, to Stradbroke Island, Mackay, and Townsville; people from the north-west of NSW and the south-west corner of Queensland to Cherbourg; and people from all over Queensland to Palm Island. Aboriginal people were moved from all parts of NSW to Cummeragunja and from all parts of Victoria to Corranderk in the Dandenongs.

More sinister, however, was the Diaspora of the Tasmanian Aborigines, herded, as they were, into one corner of the island in an attempt to exterminate them completely.

Whilst children who did not meet with the requirements of an imposed definition of Aboriginality based on a blood quantum theory or mere cosmetic conformity were often removed to cities to be raised in isolation from the influence of Aboriginal parents, to be "domesticated" and "civilised", and taught to aspire to nothing more than mediocrity in the white man's world, whilst seeing their Aboriginal ancestry as a cross to bear; others were taken to places such as Palm Island, once considered to be conveniently far enough away from white settlement to become the largest Aboriginal settlement in Australia by the early sixties as an orphanage and penal settlement.

But, for the most part, Aboriginal reserves such as Papunya, which, by the late seventies, had surpassed Palm Island as the largest Aboriginal settlement in Australia, were established on land with such inadequate water supplies that it was of no use to the pastoral industry. These kinds of reserves, of which there are many, were to prompt world-renowned Australian opthalmologist, Professor Dame Ida Mann, when she was asked in the thirties what drugs she would prescribe for outback Aborigines with so much trachoma, to remark: "Drugs? I'd prescribe water. If governments were to put the water on, nobody would have trachoma!" And, while these reserves have provided cheap labour pools for the surrounding pastoral industry, it should be remembered that they fit the description of "concentration camps without barbed wired" because most of them were established in conjunction with official policies of Smooth the Dying Pillow.

The denial of land rights clearly makes Aboriginal health a sovereign issue.

The disastrous state of Aboriginal health has been well-documented for many years in numerous Government and Parliamentary reports and, whilst the findings of these reports are not contradicted by this report, this report outlines for the first time a comprehensive National Aboriginal Health Strategy.

And the purpose of this report and its recommendations is to outline the manner in which this National Aboriginal Health Strategy will:

(1) Introduce fundamental changes on a preventative health-care basis to effect lasting improvements in Aboriginal health;

(2) Alleviate the acute, existing health problems in the short term, while effecting (1) and without adopting a panaceaic approach that might make the application of (1) more difficult in the longer term; and

(3) Ensure a more cost-efficient approach to improving Aboriginal health on a preventative health-care basis in both the longer term and the shorter term as outlined in (1) and (2).

But in seeking to meet these requirements, it has been necessary for all those involved in this report to recognise the enormous diversity of lifestyle in Aboriginal Australia that is now largely due to Australia's post-colonial history and its continuing conquest.

As a result, it has been found that it cannot be emphasised enough that not all Aboriginal communities are entirely traditional anymore, not all Aboriginal communities are the same, and that, because these communities do not conform to some arbitrary norm, there are no general standards that can be applied with any surety in the provision, or assessment of effectiveness, of primary and preventative health care programs.

> (Mr John Newfong, a distinguished writer and journalist has been commissioned to provide this section of the report, Aboriginal Australia - The Reality and Not the Myth, using excerpts from his book, "A Black Light").

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ABORIGINAL PEOPLES' CONCEPT AND PERCEPTION OF HEALTH

Aboriginal culture is the very antithesis of Western ideology. The accent on individual commitment, the concept of linear time, the switch in focus from spiritual to worldly, the emphasis on possession and the pricing of goods and services, the rape of the environment and, above all, the devaluing of relationships between people, both within families and within the whole community, as the determinent of social behaviour, are totally at variance with the fundamental belief system of Aboriginal people.

"Health" to Aboriginal peoples is a matter of determining all aspects of their life, including control over their physical environment, of dignity, of community self-esteem, and of justice. It is not merely a matter of the provision of doctors, hospitals, medicines or the absence of disease and incapacity.

Prior to colonisation Aboriginal peoples had control over all aspects of their life. They were able to exercise self-determination in its purest form. They were able to determine their "very-being", the nature of which ensured their psychological fulfilment and incorporated the cultural, social and spiritual sense.

In Aboriginal society there was no word, term or expression for 'health' as it is understood as in western society. It would be difficult from the Aboriginal perception to conceptualise 'health' as one aspect of life. The word as it is used in Western society almost defies translation but the nearest translation in an Aboriginal context would probably be a term such as "life is health is life."

In contemporary terms Aboriginal people are more concerned about the "quality of life" Traditional Aboriginal social systems include a three-dimensional model that provides a blue-print for living. Such a social system is based on inter-relationships between people and land, people and creator beings, and between people, which ideally stipulates inter-dependence within and between each set of relationships.

> ABORIGINAL SPIRITUALITY WAS, AND IS, ESSENTIALLY LAND-CENTRED.

Aboriginal people were totally dependent on the land and on all it could provide. To cope with this, they developed a social organisation that would enable them to use their natural environment successfully.

The Aboriginal health methods practised then are often still prominent in the delivery of health care in many Aboriginal communities today. This is despite the introduction of Western style health systems which are primarily interested in the recognition and treatment of disease. Aboriginal medicine seeks to provide a meaningful explanation for illness and to respond to the personal, family, and community issues surrounding illness have survived. Aboriginal medicine and practices are a complex system closely linked to land based cultural beliefs. For this reason, Aborigines in contemporary Australia see health as a sovereign issue.

In the world of modern medicine, Aboriginal practices are being recognised and accepted and should be further encouraged as an important part of an appropriate and culturally sensitive approach to health care.

The growing acceptance of Aboriginal practices has now extended to the fields of nutrition, pharmacopeia, and most importantly the law.

This Working Party therefore sees health as:

> "Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole-of-life view and it also includes the cyclical concept of life-death-life."

Our working definition of primary health care is:

> "Essential health care based on practical, scientifically sound, socially and culturally acceptable methods and technology made universally accessible to individuals and families in the communities in which they live through their full participation at every stage of development in the spirit of self-reliance and self-determination."

A corollary of self-determination is responsibility. Aboriginal people exercised this with respect and regard for ALL.

This contrasts with the view commonly held by the general community that the health of people is the domain of the specific agencies established to provide care. The Health Department, the general practitioner, the specialist and the hospital were seen as the principal means of securing the desired improvements in the health of the community. Simply put, these agencies were expected to do what was required to make people healthy.

For governments this has meant a pre-occupation with diseases and organisations rather than with underlying, often non-medical, causes of ill health.

Political Realities

Political realities that pertain to health in Aboriginal Australia must also be addressed.

Aboriginal people often feel that the motivation for government action in Aboriginal health come as a response to intermittent political pressure, rather than from a commitment to effective long-term solutions for future generations. The art of the "quick fix" seems to be the norm. Expedient gestures for Aboriginal problems are made by government and any commitment lasts only until media attention has eased or until the next election.

The National Aboriginal Health Strategy Working Party (NAHSWP) attempted to establish a mechanism that would enable, as far as possible, full and complete consultations with Aboriginal communities and their organisations, professional organisations, and other interested bodies to try and ensure that any National Aboriginal Health Strategy that is developed is supported by the Aboriginal community and by the Australian community at large.

The Working Party recognises that no matter how sound the strategy, or how broadly it is supported within the community, it will fail if there is a lack of political will and commitment on the part of governments.

However strong political will is, in itself not enough to carry change. What is needed is a preparedness and capacity to convince both decision makers and the public of the merits of the strategy. The Working Party is conscious that this may not be an easy task, particularly in the present political climate. However the Working Party is convinced that without a campaign to publicise the merits of the strategy, strongly supported by those who endorse the principles on which it is based, the Report may be condemned to a life gathering dust on politicians office shelves.

At the present time there is a growing concern on the part of Governments and Oppositions in Australia's Parliaments with the effectiveness of the special programs of assistance for Aboriginal people.

This concern, reflects in part the hardening of general community attitudes to assisting Aborigines. More likely it has arisen through increasing demands for smaller and leaner government.

There is also disturbing evidence of a move away from a position of co-operative, bipartisan political support in Aboriginal affairs.

This Working Party which arose out of the perception by Commonwealth, State and Territory Ministers that, despite the commitment of significant resources over the past 15 years, there has been little or no obvious improvement in the health status of Aboriginal people.

Ministers are continually being assailed with allegations of duplication, competition, and waste in the health services area. There is also a growing belief amongst politicians, and particularly Ministers, that sufficient resources are currently available to make significant improvements in Aboriginal health and that the task is to redirect and focus those resources.

Yet is must be remembered that it was the demands of the community controlled Aboriginal Health Services that all Governments, whether State, Territory or Commonwealth should formulate and endorse a truely national Aboriginal health strategy, which accepted the fact that Government agencies responsible for improving Aboriginal health were failing dismally.

It is clear from the views expressed to the Working Party during their consultations that this view cannot be sustained. There is too much evidence of unmet, even unknown need, to suggest that a mere re-arrangement of resources will achieve the significant improvements that the disastrous state of Aboriginal health clearly demands.

At the same time Aboriginal organisations have been appealing to international forums such as the UN to coerce governments into increasing the level of real resources allocated to Aboriginal organisations. At the international level this has led to criticism of Australia's domestic performance in regard to Aboriginal people and charges of hypocrisy in relation to its international condemnation of the policies of South Africa and France.

There is also a growing sense of failure by governments and bureaucracies in dealing with the range of Aboriginal "problems" and neither Ministers nor their Departments have been able, or indeed have even tried to develop a coherent, consistent long-term policy which achieves specific goals and objectives to a reasonable time scales.

Political behaviour of Ministers and Governments, generally pre-occupied with short term electoral considerations and funding by annual appropriation is strongly detrimental to the long-term planning necessary to effect fundamental changes in improvements in Aboriginal health.

It must be understood that the recognition of Aboriginal community rights by Government so far have been essentially "placatory measures", and, at least, a panacaeic approach.

The Australian state by way of its Governments must address the very real issue of Aboriginal Peoples' indigenous rights. If this is not done in the implementation of this Report will see much of the same of what colonialist-Australia's history now tells us, and at the very most, only marginal, if any, improvements are likely to occur.

ABORIGINAL COMMUNITY CONTROL AND PARTICIPATION

In order to achieve the necessary improvement in Aboriginal health, Aboriginal people believe they must again be able to control their destiny and to accept responsibility for their own decision-making. In the area of health, this has seen the development of Aboriginal Health Services which function in accordance with the principles of community participation and control and which operate alongside the mainstream services.

The impact of introduced diseases such as smallpox, the common cold, venereal and other diseases is well documented in Australian colonial history.

Similarly, but not as prominent, are the military campaigns and other organised ventures which claimed Aboriginal lives and land.

The toll, in terms of Aboriginal life and societal relationships, interactions, and structures was dramatic. These impacts have had a lasting consequence for Aboriginal people and their communities. Much, if not all, of the health status of Aboriginal people is a direct consequence of this history.

Some submissions, supported by community consultations, argued, that this as far as Aboriginal people are concerned its process has changed only in manner since colonial times. The continued dominance by non-Aboriginal society and its systems remains an underlying concern for Aboriginal people.

Development, controlled by one group of people, will invariably reflect the norms and values of that group. The imposition of non-Aboriginal concepts and practices on Aboriginal people provokes resistance, limits effectiveness, and violates international standards for the protection of cultural rights.

Defining Aboriginal Community Control

Some definitions of community control in terms of health, which have been put to the Working Party, include:-

> "Community control is the local community having control of issues that directly affect their community:"

Implicit in this definition is the clear statement that Aboriginal people must determine and control the pace, shape and manner of change and decision-making at local, regional, state and national levels.

Community participation and control of the means by which Aboriginal people have in countering the systems imposed on them by non-Aboriginal people. Such imposed systems must be modified to accommodate Aboriginal aspirations if an appropriate and effective national health strategy for Aboriginal people is to be developed.

COMMUNITY ATTITUDES TO COMMUNITY CONTROL

Community attitudes to Aboriginal community control will obviously vary. Some Aboriginal communities are equipped to maximise gains from the community control process while others simply don't have the resources level of community development to even contemplate assuming responsibility and control of their own affairs. Many of the submissions received by the Working Party supported the concept of community control.

The Aboriginal Community Recreation and Health Services Centre of South Australia Incorporated in their submission stated that:

> " Aboriginal community controlled Health Services are the most likely means of achieving improvements in Aboriginal Health."

and Victorian Aboriginal Health Service Co-op Ltd stated:

> "We will welcome government cooperation and collaboration, but your history and our history demand that such takes place ON OUR TERMS."

In their submission to the Working Party the Royal Australian College of General Practitioners pointed out:

> "Aboriginal people should be closely involved in and have control over health resources. There should be opportunities for Aboriginal people to gain adequate training and acquire administrative skills for positions of authority. We support the concept of community controlled Aboriginal medical services."

The Department of Aboriginal Affairs stated that:

> "...State and Territory Governments are responsible for the health of Aboriginal people in the same way as they are for all other citizens."
>
> and went on to say that ..."Assistance is also provided to Aboriginal community-controlled health services in the belief that Aboriginal people must be more closely involved in all aspects of the health system if there is to be a real and lasting improvement in Aboriginal Health."

In a submission from Deakin University it was outlined that the newly formed School of Nursing had put forward suggestions in developing strategies to maximise the involvement of Aboriginal people in their own health care.

> "Deakin's contribution to this aim could be to educate Aboriginal people as Registered Nurses to enable them to work in the Aboriginal community taking over the supervisory role that non-Aboriginal nurses frequently have over Aboriginal Health Workers, as well as to work as independent practitioners, and in the mainstream health organisations".

Outlining his concerns a former Senior Health Worker employed by a government organisation submitted that:

> "The communities believe that the rural sisters working in the clinics should come under the control of their community councils. In too many communities white people were having the say and not the Aboriginal people. The Aboriginal people and white people should all be working together to solve the health problems".

It was obvious from the consultations that community control and participation was paramount in the minds of many people, both Aboriginal and non-Aboriginals.

Taking into account the different developmental stages of communities and the current expectations being placed on community councillors and leaders it is little wonder that the concept of Aboriginal community controlled health services in some cases are contemplated with awe. The reluctance of some communities to change the status quo relates directly on the fact that they are already floundering, without adequate resources and support, in dealing with every day administrative problems affecting their communities. Most agreed however that when the time was right they would establish their own communtiy controlled health service.

A typical response in favour of local Aboriginal community controlled health services was:

> "People would work for the people and would provide a service that people would trust"

In general, non-Aboriginal people recognised the need for more Aboriginal participation but were noticeably reserved when discussing the need for Aboriginal control. Many had little or no idea as to the implications of Aboriginal community control and were too far entrenched in the current health system, based on the medical model, to promote or contemplate an alternative.

BENEFITS OF COMMUNITY CONTROL/PARTICIPATION

The benefits of Aboriginal community control and participation can already been seen where Aboriginal health service and other Aboriginal community controlled organisations exist. The mere fact that community control shuns dependence on non-Aboriginal systems is a benefit. It promotes responsibility, understanding and allows communities to be active participants. As a result communities are able to identify health problems and possible solutions, contribute to needs based planning, be involved in ongoing evaluation.

Communities become active participants rather than passive recipients, and the development processes that emerge allows from the design of structure to meet the specific health needs of Aboriginal people rather than attempting to "fit" Aboriginal people to the extisting system.

Community control rids the systems of paternalism, promotes awareness and raises self esteem. The latter being crucial to the overall well being and health of Aboriginal communities.

In the document "Formulating Strategies for Health for All by the year 2000" the World Health Organisation identified that:

"Measures have to be taken to ensure free and enlightened community participation, so that notwithstanding the overall responsibility of governments for the health of their people, individuals, families and communites assume greater responsibility for their own health and welfare, including self-care."

The benefits of Aboriginal community control and participation are numerous, some are listed below:

- provides a service which is acceptable to the community it serves;
- prevents covert and overt racism from doctors, nurses, receptionists and other non-Aboriginal staff working in Aboriginal health;
- prevents unethical behaviour;
- prevents presumptions about lifeways and illnesses which may lead to inaccurate diagnosis;
- has a social and cultural awareness of the people it serves;
- provides appropriate cultural support for patients both pre and post diagnosis;
- has a priority commitment to raising the health status of the people it serves;
- offers training, education and employment to Aboriginal people.
- provides culturally acceptable staff;
- provides flexibility;

Provides a resource for the non-Aboriginal community in the following ways:

- relevent training arena;
- a culturally appropriate medium to use as a research base;
- a culturally appropriate information centre.

Aboriginal Health Centres generally evolve as a multi purpose resource centre to be used for seeking advice, reference material, human resources etc. (this of course depends on the size and functions being carried out by a particular community controlled health service). Larger services such as the Victorian Aboriginal Health Services, the Perth Aboriginal Medical Service, Perth, the Aboriginal Medical Service, Redfern and the Broome Regional Aboriginal Medical Service clearly demonstrates this multi functional role.

EXECUTIVE SUMMARY

CHAPTER 1 - INTRODUCTION

To date there has been no agreed national Aboriginal health strategy, nor have there been the co-ordinating mechanisms or a comprehensive data base to ensure and measure the success of such a strategy.

With this in mind Commonwealth, State and Territory Ministers for Aboriginal Affairs and Health agreed to the establishment of the National Aboriginal Health Strategy Working Party at a meeting in December 1987.

Terms of Reference for the Working Party are:

a. Report on Commonwealth/State and community funding arrangements, including financing of primary health care services and social health programs in Aboriginal Communities.

b. Develop strategies to achieve improvements in the short and long term, taking into account specific health problems, health service provision, administrative and funding arrangements, Aboriginal participation, research and data collection and ongoing monitoring.

c. Develop strategies to maximise the involvement of Aboriginal people in their own health care.

d. Consider intersectoral co-ordination including Commonwealth, State, local and health service agency responsibilities.

e. Develop a mechanism to monitor progress towards achieving targets, taking into account performance indicators developed as part of the policy.

f. Provide an interim report to the Ministerial Forum on Aboriginal Health in 1988 and a final report to the Ministerial Forum in 1989.

An extensive consultation process was undertaken by Working Party members with Aboriginal communities and groups throughout Australia. This process is described in detail in this Chapter and Appendix I.

In addition, the Working Party received a large number of written submissions. Relevant quotes and comments are drawn from these submissions, which provided a valuable framework for consideration of Aboriginal communities views.

CHAPTER 2 - CURRENT STATE OF ABORIGINAL HEALTH

This chapter reviews previous Government initiatives, compares available statistics and factual data with those of non-Aboriginal Australians, and discusses demographic, socio-economic and other factors which influence Aboriginal health status and the delivery of health services. Brief mention is made of the number of Aboriginals in the workforce in Australia.

The Working Party recognises that the data is by no means comprehensive, due to the fact that no national database exists at this time, however there is clear evidence that Aboriginal people have the worst health of any identifiable group in Australia.

CHAPTER 3 - COMMONWEALTH/STATE RESPONSIBILITIES

The Terms of Reference direct the Working Party to report on Commonwealth/State funding arrangements.

Many authorities have responsibility for various policies and programs which directly or indirectly affect the health of Aboriginal people and each of these was taken into account in the deliberations of the Working Party.

This Chapter outlines the roles and responsibilities of various Commonwealth, State and Territory Governments, and other authorities, and describes specific programs as they relate to Aboriginal people. Where possible details of current funding arrangements and expenditure are provided although in some instances expenditure on specific populations cannot be identified eg. when mainstream programs are utilised. Attention is drawn to the obvious connections between the provision of essential services such as water, sewerage and electricity and health status.

The need to define and co-ordinate Government responsibilities is emphasised and co-ordinating mechanisms discussed.

Generally the Working Party is critical of existing arrangements and expressed concern that formal Commonwealth/State co-ordination mechanisms in Aboriginal Affairs do not exist in most States and Territories, although the fact that the New South Wales and Victorian State Aboriginal consultative and advisory bodies do include some Commonwealth representation was noted.

The Working Party sees the need for the establishment of an ongoing national forum and made the following recommendations as the means by which co-ordination can be improved, services rationalised, monitoring and evaluation mechanisms established and improvements in health status achieved.

The Working Party recommends that:

- the Aboriginal health function remain within the portfolio responsibility of the Minister for Aboriginal Affairs;
- the Australian Health Ministers Council (AHMC) and the Aboriginal Affairs Council (AAAC) establish a Council of Aboriginal Health as a Standing Committee to both Councils;
- there be ongoing joint annual meetings of Commonwealth/State/Territory Ministers for Health and Aboriginal Affairs with the purpose of:
  - reviewing the implementation of the National Aboriginal Health Strategy;
  - reviewing regular reports from the Council of Aboriginal Health; and
- these arrangements to be reviewed in five years.

That there is recognition of the need for the existence of a National Aboriginal Community Control Health Organisation:

a) and that there be established a formal relationship between the National organisation and any bodies emanating from decision of the National Aboriginal Health Strategy Working Party;

b) such formal relationship shall include representation from community controlled organisations.

<u>Council of Aboriginal Health</u>

The Council of Aboriginal Health should meet quarterly and its functions should include:

- reviewing progress towards the implementation of the NAHS, recommend any necessary changes to the strategy to the joint Ministerial Forum, paying specific attention to intersectoral collaboration;
- reviewing annual implementation reports from the various Commonwealth/State/Territory Governments and Aboriginal community organisations involved in health; and

- oversighting the development of a national data base of Aboriginal health statistics.

The Working Party recommends that:

- the establishment of a permanent Secretariat within the Aboriginal Affairs portfolio to service the Council; and

- the Council for Aboriginal Health and its Secretariat be jointly funded by the Commonwealth, States, and Territories and the the Commonwealth bear the costs of community representatives involved in the Council.

Office of Aboriginal Health

The Working Party recommends that:

- the ATSIC Bill be amended to privide for the establishment of an Office of Aboriginal Health to have the following functions:

  - organise and, where appropriate, undertake the regular assessments described in Chapter 12, Monitoring and Evaluation;

  - monitor and evaluate the Commonwealth sector activity in Aboriginal health with regard to the goals outlined in this strategy;

  - co-ordinate the implementation of Aboriginal health programs in the Commonwealth sector;

  - promote intersectoral collaboration in the Commonwealth sector and furnish reports as required by the Council, State, Territory and Commonwealth Governments;

  - one of the appointed Commissioners to the proposed ATSIC be a health commissioner and be a member of the Council of Aboriginal Health; and

  - Ministers agree to set up in each State and Territory a tripartite forum similar to the Council of Aboriginal Health in order to examine, promote, and resolve issues relating to intersectoral collaboration with the State

and Territory. The first task of the forum will be to finalise arrangements for ongoing mechanisms to promote intersectoral collaboration. These were originally outlined in a World Health Organisation publication Primary Health Care. (Theory to Action, EURO Reports and Studies No. 69)

In recommending the creation of an Office of Aboriginal Health within the portfolio responsibility of the Commonwealth Minister for Aboriginal Affairs the Working Party has proposed an organisational arrangement which was not supported by the majority of community organisation representatives who attended the national conference in Adelaide on 27 and 28 February 1989.

The conference delegates were strongly of the view that any new organisational arrangements should ensure complete independence and autonomy from the Department of Aboriginal Affairs. They considered that these conditions could only be assured by statutory means which would also allow the new body to have independence and direct access to the Minister for Aboriginal Affairs.

In deciding to recommend that the Office of Aboriginal Health be created as a non-statutory body within the Aboriginal Affairs portfolio, the Working Party considered that the needs of co-ordination, particularly of funding sources at the Commonwealth level, would be best served. As recommended, the Office of Aboriginal Health would have a direct relationship not only to other portfolio agencies but, just as importantly, to other Commonwealth Departments, such as the Department of Employment, Education and Training, Australian Construction Services and Department of Community Services and Health, which have a direct impact on the provision of health services to Aboriginal people.

The Working Party does, however, share the concerns of the conference delegates as to the Office's independence and autonomy and believes that these problems can be at least minimised, if not totally eliminated, if a Commission under the proposed ATSIC legislation could be designated as having a direct responsibility for health issues.

CHAPTER 4 - HEALTH SYSTEMS INFRASTRUCTURE

The Working Party recognises the need to identify the key components of the health systems infrastructure and their relationship to the successful delivery of services.

In this Chapter three key infrastructure components i.e. health resources, arrangement of resources and management and economic support, are identified and examined.

The existing approach to Aboriginal health, and the current provision of services and resources are seen as frequently inadequate, inappropriate and inequitable.

There is strong argument for the adoption of community controlled Aboriginal health services as the most appropriate service type, and for the transfer of primary level health services to community controlled Aboriginal health services, with States retaining responsibility for secondary and other level health services.

Requirements for health facilities and service provision are identified together with funding proposals aimed at providing remuneration packages which will attract and retain appropriate staff.

The Working Party recommends that:

- minimum standards be developed for existing and future primary level facilities, particularly Aboriginal community controlled health services;
- the Commonwealth and States establish a clear and uniform policy and program for the provision of funds to enable community Aboriginal Health Services to purchase suitable buildings and other community facilities;
- in the interim $23 million be provided over the next 3 years for structural and other user oriented improvements in the existing primary level facilities of health services;
- there be a significant increase in the number of Aboriginal health services;
- priority in funding new services be given to the more remote and isolated areas;
- appropriate awards and conditions be developed drawing on the contents and experience of the Northern Territory and Western Australian Aboriginal Health Awards, the VAHS Award, CAAC and Nganampa Awards and other proposed State and National Awards;
- funding cycles of Aboriginal health services be extended to provide for 5 year budget and funding cycles;

- funding for services be released in one block for each year;

- the States/Territories should ensure that an appropriate range of secondary level services are available to Aboriginal communities, including specialist services;

- the States/Territories, as a matter of urgency expand, and where neccessary introduce, Aboriginal hospital liaison staff in areas where Aboriginal utilisation of services is high, or where there is a specific need in an Aboriginal community;

- the States/Territories examine the environment of existing and future secondary level facilities and promote the use of facilities familiar and culturally acceptable to Aboriginal people and communities. Aboriginal communities must be fundamentally involved in the design and negotiation process;

- the regular sharing of information between primary and secondary levels of care should occur to assist both in the planning, management and evaluation of service to particular communities;

- there should be a clear division of responsibility for funding. Multiple source funding and duplication of services create program management and administrative difficulties;

- primary level Aboriginal health services presently being delivered by State governments should be transferred to existing or proposed Aboriginal community controlled primary level services; and

- $417 million be provided over the next five years to enable these immediate needs to be met.

Essential services such as sewerage and water supply systems, and communication systems are viewed as integral to effective health systems infrastructure and recommendations are made to improve the effectiveness, adequacy and apropriateness of these essential services. A report prepared for the Working Party by Australian Construction Services provides practical technical information on available options for sewerage and water supply systems, and comparative costs of various systems.

The Working Party recommends that:

- the Commonwealth and all of the States and Territories fund communities to undertake joint assessments of essential services and community infrastructure needs in Aboriginal communities, outstations and settlements to ensure the Aboriginal people have standards of essential services and living acceptable to them;

- adequate funding be provided to communities to provide appropriate and adequate sewerage and water supply systems to remote Aboriginal communities as identified in the joint assessments of essential services and community infrastructure needs;

- funding also be allocated to communties for the implementation of community acceptable local essential services/infrastructural development programs;
- education courses be introduced to train key community personnel in aspects of hygiene, proper toilet use, sewerage disposal and water supplies, and to carry out maintenance repair work;

- at least two people from each community be sponsored to attend such courses; and

- where town-based maintenance services are inadequate to meet community need, service teams be established to work from a central base to ensure teams are available within each region.

Areas identified as needing new or expanded Aboriginal health services are included.

CHAPTER 5 - Training and Education Issues

The Working Party recognised the importance of the role of Aboriginal Health Workers who have become "an integral part of the clincial staff of the Aboriginal health services." Further "their roles and functions have evolved with the development of the AHS's". Their success is linked to their close association with, and infinite knowledge of the communities they serve.

In this Chapter importance is placed on Aboriginal Health Worker programs. The content of various programs, including the core curriculum from four States and the Northern Territory are compared. The issue of accreditation and registration of Aboriginal Health Workers is raised.

The Working Party recommends that:

- to ensure stability and co-ordination in the planning and funding of Aboriginal health worker training the Commonwealth initiate negotiations with State agencies, including training providers, and Aboriginal communities at the regional or State level to develop adequate training resources for Aboriginal Health Workers;

- the Commonwealth, State and Territory Governments, in conjunction with the Aboriginal community health section, encourage health education and training institutions to develop uniform accreditation standards for Aboriginal Health Worker courses to assist mobility and to enable health workers to gain entry to the related health and professional education and training arenas;

- secure employment and career opportunities be created for Aboriginal Health Workers and other Aboriginal workers in the health field; and

- funding for professional development for Aboriginal Health Workers and other workers in the Aboriginal health sector should be part of the recurrent budget of organisations.

Appropriate education and training of health professionals, including cultural, social and professional orientation and preparation to work in the field of Aboriginal health are viewed as significant to the provision of appropriate health care.

The Working Party supported calls for more Aboriginals to undertake medical, nursing and paramedical courses and examines the reasons for the low entry of Aboriginal students into these courses.

Ways in which students can be encouraged to undertake tertiary studies are discussed, based on the experiences of tertiary institutions which have introduced special procedures and support structures. The reviews are supported by the findings and recommendations of The Committee of Inquiry into Medical Education and Medical Workforce (Australian Medical Education and Workforce into the 21st Century, April, 1988).

The Working Party recommends that:

- tertiary institutions responsible for undergraduate and post-graduate medical, nursing, and paramedical courses by approached to include the compulsory study of Aboriginal culture and history and health issues as part of formal course work;

- where possible, Aboriginal people should be involved in the development and teaching of these units;

- course work foster a primary health care approach to professional practice, adopting the principles of community control and participation, health awareness, health promotion and health education;

- where clinical experience is a component of formal studies, or necessary for professional registration, opportunities are provided and placements actively sought for supervised clinical experience to be undertaken in Aboriginal health services, remote communities, and other appropriate health care facilities;

- professional staff participate in orientation programs prior to their employment in Aboriginal health services or within Aboriginal communities. This orientation should include both professional orientation and social expectations of their roles and be followed up with ongoing professional development throughout the employment period;

- negotiations with professional organisations commence immediately with the aim of introducing culturally appropriate and relevant post graduate and continuing education programs. Where possible, Aboriginal people should be involved in the development and presentation of these programs;

- encouragement be given to professional journals and other publications to increase their content with regard to Aboriginal health issues and other aspects of Aboriginal culture which has an influence on wellbeing;

- every effort should be made to attract and retain Aboriginal people in courses of study which will qualify them for careers as health professionals;

- Aboriginal students should be exempt from payment of the tertiary graduate tax to encourage them to undertake tertiary studies;

- health services must be provided with resources to allow communities and their health services to accept placement of students; and

- that action be taken to implement recommendations, 5(iii), 5(vii), 6(iv), 6(v), 7(vii), 8(iii), 8(iv), 11(xiv), 12(iii), 12(iv), 12(v) of the Committee of Enquiry into Medical Education and Medical Workforce;

Other service providers, particularly teachers, police and corrective services staff are seen to have a major impact on Aboriginal health.

The Working Party recommends that:

- more opportunity be given to Aboriginal people to become service providers, for example teachers, police, trades people by establishing community based education and training programs;

- educational and training courses for other service providers include the study of Aboriginal culture, history and health issues. Particular emphasis should be placed on the inclusion of formal units in teacher education course work. Where possible Aboriginal people should be involved in the development and presentation of this material;

- where practical experience is a component of formal studies, opportunities are provided and placements actively sought for supervised practical experience to be undertaken in Aboriginal communities;

- culturally appropriate orientation programs, continuing education programs and in-service studies be developed and presented, where possible, by Aboriginal people;

- police and prison staff should receive adequate preparation for their role in relation to Aboriginals through appropriate orientation and training programs; and

- programs should include:

    - Aboriginal health issues and the effects of culture, tradition, socio-economic status and dispossession on health status;

- effective communication skills which recognise these factors;

- the recognition of signs and symptoms which could be indicative of specific health problems, e.g., hypoglycaemia, epilepsy, cardiac disorders;

- an understanding that medical conditions, medication, alcohol and other substance abuse can alter behaviour, and lead to confrontational behaviour;

- appropriate action when there is the slightest suspician of health problems including alcohol or other substance abuse, e.g., referral to medical practitioners, utilisation of Aboriginal support systems and community groups criteria for transfer to hospital or another suitable, supervised medical environment treatment to be instituted in the case of medical emergencies; and

- resources be provided for the education and training of Aboriginal people to replace non-Aboriginal people where there are no Aboriginal people to perform these duties and that these arrangements be included in job contracts for non-Aboriginal people.

CHAPTER 6 - INTERSECTORAL COLLABORATION

The Working Party recognises that improvements in health status depends on the co-ordinated and measured interaction of many areas or sectors of development. This Chapter defines intersectoral collaboration and its philosophical framework before convering perceived barriers, cultural and socio-political considerations, housing, environmental and public works, education and employment.

The need for a proposed mechanism to achieve better intersectoral collaboration is argued.

The Working Party recommends:

- the establishment of mechanisms for intersectoral collaboration anchored to the Aboriginal Affairs portfolio, but independent from existing agencies.

CHAPTER 7 - HEALTH SERVICES IN THE TORRES STRAIT ISLANDS

The Working Party recognises the distinct status of the people of the Torres Strait area.

This Chapter describes the islands which make up the Torres Strait and provides a social history.

Current health services are outlined and the specific health issues and current social and environmental issues are discussed, taking into account the uniqueness of the people and their traditional and cultural beliefs.

It is recommended that:

- the present Hospital Boards be expanded to the maximum number of nine members and renamed and restructured as a Health Services Board for the region;

- there would be benefit to the people of the Torres Strait Islands if an acceptable researcher/dietitian/nutritionist were to undertake a detailed and specific study on the value of traditional food in the Torres Strait Islands, with a view to convincing health care providers, such as Governments, that the problem of diabetes in the Torres Strait Islands is serious;
- each Island store is equipped with adequate refrigeration capacity and general storage to ensure sufficient food supply, both regular lines and diabetic foods, to fully span the period between supply ships;

- where no such system exists, appropriate waste disposal systems be planned and installed on each inhabited island, as well as in each of the Northern Peninsula Area communities;

- all health care clinics be provided with a 24 hour telephone service; and

- roads considered relevant to communities be sealed.

A detailed proposal supports community control of all its Government funded health services through expansion of Hospital Boards.

CHAPTER 8 - SPECIFIC HEALTH ISSUES

Aboriginal people identified a range of specific health issues which concerned them during the process of community consultations. These perceived health issues were supported and augmented by submissions to the Working Party, and other letters, papers, articles and personal representations.

This Chapter outlines broad strategies to overcome specific health problems.

The Working Party deliberately recommends strategies which are not prescriptive and limiting, but can be adapted at the State, local and community level according to specific requirements and conditions.

Emphasis is placed on the need for the development and evaluation of culturally appropriate, relevant health promotion, education, and prevention programs in addition to purely curative programs. Resource and staffing issues are addressed in this context.

The Working Party points out that strategies for the prevention of lifestyle, or creed any other diseases, which have proved effective in non-Aboriginal communities cannot be assumed to be appropriate for Aboriginal communities.

The Working Party is concerned that any attempt to set targets before a full range of services is provided will inevitably lead to limited success in the achievement of those targets.

Whilst the Working Party has "set" some specific targets, these should be viewed as indicative only. Achievable, measurable and realistic targets must be based on essential baseline data which is not currently available. Further, the Working Party believes that targets must be set in conjunction with Aboriginal people and service providers.

CHAPTER 9 - WOMEN'S BUSINESS

Whilst women's health issues cannot be isolated from the general health issues that affect men, families and the communities at large, and are not seen as separate by Aboriginal women, it is believed that it is appropriate to include a Chapter on Women's Business in the report.

The Chapter explains the philosophical basis for a wide range of strategies covering many specific issues.

In addition to suggested strategies, the following recommendations are made:

- the establishment (after consultation with Aboriginal women) of culturally appropriate birthing centres where Aboriginal women's law and culture will be strengthened and maintained;
- the provision of education programs that explain and encourage regular breast and cervix cancer screening;
- the provision of facilities that make regular breast and cervical cancer screening accessible and acceptable to Aboriginal women;
- the introduction of culturally appropriate and accessible ante natal classes be introduced for Aboriginal women;
- these classes must be designed and presented by Aboriginal women where possible;
- alternative, culturally appropriate means of health service delivery must be developed in areas which are poorly serviced;
- education programs must be developed that include:
  - the benefits of early antenatal and postnatal care:
  - practices and procedures which constitute health antenatal and postnatal care;
  - the consequences of poor or late antenatal and post natal care;
- health care deliverers must ensure that Aboriginal women are fully informed of any birthing procedures should they be required such as:
  - forceps delivery;
  - episiotomy;
  - caesarean section;
  - local anaesthetic (epidural);
  - general anaesthetic;
  - induced labour;

- possible marks on newborn child; and
- complications that may arise.

- advanced education programs for those Aboriginal Health Workers who wish to specialise in women's health issues be developed;
- extra support be given to Aboriginal women who are taken into custody if they are pregnant, breast feeding or have children;
- funds be made available to Aboriginal community groups to develop audio visual and other health education material for ante and post natal care;
- the Commonwealth, State and Territory Governments allocate funds for:
  - upgrading specialist gynaecology and obstetric facilities and services, within regions and districts in the remote areas;
  - upgrading and equipping regional and district hospitals in remote areas to cater for birth deliveries; and
- culturally appropriate community awareness and education programs, which outline reasons for screening, outline the procedures involved, the recommended action following abnormal results and the likely consequences of abnormal results should be explained.

These programs should promote:

- yearly pap smears for women;
- monthly breast self-examination; and
- every Aboriginal woman be shown the technique of breast self-examination, and be encouraged to use it, (doctors and aboriginal health workers do this).

CHAPTER 10 - ALCOHOL AND OTHER SUBSTANCE ABUSE

The Working Party and Aboriginal communities identified alcohol and substance abuse, and its complications and manifestations as one of the major health problems facing Aboriginal people.

It is considered that alcohol abuse is not only a disease in itself but it is also a major contributing factor to the complications of many other medical conditions. In addition to this, it contributes to social disharmony and dysfunction, resulting in trauma, for example road accidents, physical violence and neglect of children.

This Chapter examines the extent of the problem, and seeks to understand the use of alcohol in Aboriginal communities, including the social implications.

It is acknowledged that alcohol is ultimately a symptom of far wider problems, namely dispossession, alienation and discrimination.

The Working Party examined various treatment programs and was emphatic that most treatment regimes, which are not designed for Aboriginal people, are culturally, socially and traditionally inappropriate and ineffective.

There was concern expressed at existing laws in relation to alcohol, and the association made between alcohol, suicide and deaths in custody.

The Chapter also addressed the issues of petrol sniffing and psychoactive drugs.

The Working Party recommends that:

- funds to be made available for accredited courses for Aboriginal drug and alcohol workers employed by Aboriginal health services and rehabilitation services throughout Australia;

- more educational programs be made available to adults and children in Aboriginal and non-Aboriginal communities on the effects of alcohol and other drugs;

- positive media campaigns using well known Aboriginal role models, be designed and promoted throughout Australia to dissuade Aboriginal youth from abusing alcohol, cigarettes, or any other drugs of addiction;

- educational projects be developed that clearly demonstrate the associated problems of excessive consumption of products that can be abused;

- a system of legally approved visitations to detainees by staff of Aboriginal medical services and councellors from alcohol rehabilitation programs be developed;

- detoxification and rehabilitation projects be provided with additional resources to address the needs of patients who have undergone treatment and the special needs of their families;

- people suffering problems of addiction should not, wherever possible, be removed from their community environment to obtain treatment;

- A network of community based organisations be developed as an urgent priority. For example, there are no effective community based rehabilitation programs north of Cairns in Queensland;

- greater liaison with police to avoid locking up people simply because they are drunk;

- a system of safe houses needs to be developed, where people who are intoxicated can be taken instead of being locked up. The circumstances leading to many deaths in custody clearly indicate the need for this type of facility;

- the setting aside of specific areas and facilities where people can go to without disrupting other community members;

- consideration be given to developing some means of preventing, or at least substantially reducing, the present widespread practice of cashing Social Security cheques at hotels or liquor outlets. The co-operation of the liquor industry should be sought;

- the following procedures should be followed when an intoxicated Aboriginal person is picked up:

    - taken to a sobering up centre/safe house;

    - referred for medical assessment; or

    - sent to a half-way house or a rehabilitation centre depending on the outcome of the medical assessment report.

- the restructuring of programs currently being provided so that those undergoing treatment can be given meaningful training to enable them to find a useful place in their community structure when they complete the program;

- follow-up mechanisms be established to monitor the progress of clients who have undertaken a rehabilitation program and to provide appropriate support;

- staff of Aboriginal health services, rehabilitation services, and other associated organisations need to be provided with adequate and appropriate education to equip them to treat people with problems of addiction;

- such education should have a formal accreditation process to enable graduating staff to obtain employment in similar programs throughout Australia;

- all existing and future Aboriginal alcohol and substance abuse programs be monitored and evaluated for effectiveness;

- that information about the types of programs being used to reduce alcohol or substance abuse should be readily available to other communities;

- on those communities that request it a system of Community Workers be established who would be empowered by law to confiscate liquor and vehicles from intoxicated people within prescribed areas of the communities;

- the States and Territories implement uniform legislation to provide for heavy fines, in the order of $10,000, and to allow for confiscation of vehicles, aircrafts or vessels used in the illegal sale of alcohol in Aboriginal communities;

- to enable Aborigines the opportunity of redressing the current dramatic problems of alcohol and substance abuse, an additional of $5 million in Direct Grant Funds in 1989-90 and an additional $10 million per year for the next four financial years until 1993-94 be provided;

- Commonwealth/State and Territory Governments set aside a percentage of the revenue obtained from liquor sales tax and excise to provide funding for alcohol awareness, prevention and rehabilitation programs for Aboriginals; and

- each community should have control over their own alcohol and other drug abuse rehabilitation programs as they know the root causes involved and the individuals having abuse problems.

The Working Party endorses the following recommendations from the Interim Report of the Royal Commission into Aboriginal Deaths in Custody.

"In jurisdictions where drunkenness has not been decriminalised, Governments should legislate to abolish the offence of public drunkenness.

The abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain facilities for the care and treatment of intoxicated persons.

Legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons."

- In the States and Territories where public drunkenness has been decriminalised, adequately funded alternative facilities for the care of intoxicated persons should be urgently established and maintained to meet the demonstrated needs.

- All Governments should combine to set up a national task force to examine the social and health problems created by alcohol and confronted by Aborigines in many localities, to assess the needs and the means to fulfil the needs, including legislative action, and the establishment of appropriate facilities for short and long-term care, education and training. The Aboriginal Health Services and other medical resources should be well represented in such a project which should be essentially health-orientated".

- The additional funds requested are necessary to provide adequate resources to the existing projects and to enable new programs to be implemented. For example, in the Torres Strait, the Northern Peninsula area of Queensland, the Gulf area of northern Queensland, the development of research projects necessary to prepare curricula for training of counsellors; also the provision of

essential capital equipment to projects, the development of a uniform salary structure for alcohol rehabilitation workers, and public awareness projects to deter youth from becoming involved in substance abuse all of which have been unavailable due to lack of funding. The above programs plus the provision of salaries for Aboriginal staff to work in State controlled organisations are considered essential.

All such additional funding should be on a dollar for dollar basis with the State and Territory Governments.

CHAPTER 11 - ABORIGINAL HEALTH RESEARCH

Aboriginal people have an on-going concern that research is frequently imposed on Aboriginal communities, with those communities usually having no control nor redress. The benefits of research to Aboriginal people is questioned and there is a widely held, strong view that such existing research is of little direct or indirect benefit and is often detrimental.

This Chapter scrutinises broad ethical issues associated with research in Aboriginal communities, including consultation, consent and review with the people concerned.

The Working Party is firmly of the view that where possible Aboriginal people should be involved in all stages, including the actual research investigation if appropriate, and that research material and data should remain the property of the community.

Limited or inappropriate funding has been evident in the past.

The Working Party believes that specified funds should be directed to identified priority research areas in the future.

The Working Party recommends that:

- ethical guidelines, on Aboriginal health research as outlined in this Chapter be adopted nationally by research institutions and researchers;

- the paper 'Report of the National Workshop on Ethics of Research in Aboriginal Health', be adopted as the basis for considering Aboriginal health research proposals;

- the NH&MRC should annually set aside a fixed proportion of research monies it administers for research projects in Aboriginal Health; and

- the Commonwealth Government set aside two million dollars per annum for research projects conducted by, and specific to, Aboriginal communities and Aboriginal community controlled organisations.

Additional funds should also made be available from Department of Employment, Education and Training to assist Aboriginal people to develop and enhance research skills.

CHAPTER 12 - MONITORING AND EVALUATION

Monitoring and evaluation, if it is to benefit Aboriginal communities, must also be consumer and community orientated. This Chapter looks at the meaning of monitoring and evaluation and their relationship to primary health care.

The Working Party considers ways in which the process of monitoring and evaluation can be tested to ensure that it will satisfy the purposes for which it is intended.

In response to the need for a national data base, four components are identified as priority areas for which appropriate mechanisms and methodologies of monitoring and evaluation should be developed. These are health service delivery, systems, infrastructure and intersectoral collaboration, environmental and social health, and vital statistics and sentinel health events.

Monitoring and evaluation of these key components is considered to be a gauge of success or otherwise of a national Aboriginal health strategy.

The Working Party recommends that:

- funds should be made available to community controlled health agencies to prepare and conduct a suitable public awareness program to encourage Aboriginal people to identify;

- the co-operation of community agencies in such an initiative is fundamental to achieving maximum coverage;

- State and Territory agencies involved in the collection of relevant data should provide sensitivity education for staff who are likely to be expected to ask these questions;

- the forthcoming meeting of the Ministerial Forum for Aboriginal Affairs and Health reaffirm and give renewed commitment to the establishment of a system for the collection and collation of sound and valid national Aboriginal and Islander vital statistics. In particular, the achievement of the following is proposed by December 1989:

  - recording of Aboriginality or Islander on all Hospital admissions and separation forms, and

  - the recording of Aboriginality or Islander on notifications of Birth, Stillbirths and Death.

- there be further development and implementation of a Sentinal Health Events Program in Aboriginal health;

- evaluation of the Sentinel Health Events program could be undertaken by the state level tripartite working group, recommended in Chapter 3;

- an Advisory group comprising elected/selected representatives from Aboriginal health services together with support from the Australian Institute of Health be requested to prepare the detailed program pro forma by September 1989. The staged implementation of the program, should be geared to commence by February 1990 with the first national collection undertaken in the first half of 1991;

- the Family Health Program, presently being piloted and evaluated by the Victorian Aboriginal Health Service, be further developed as a basis for monitoring and evaluation at the community level;

- the proposed Office of Aboriginal Health negotiate with those bodies responsible for the design of the program to broaden its application nationally; and

- given a stated preparedness by those bodies involved to undertake such negotiations the staged introduction of the Family Health Program could commence in the 1989/90 financial year and be completed by the conclusion of the 1990/91 financial year. National collections and collation of data from this program could commence therefore on a limited but reliable basis in fiscal year 1989/90; and

- the proposed Office of Aboriginal Health be responsible for the monitoring and evaluation of practices and programs of Commonwealth agencies involved with the National Aboriginal Health Strategy. In particular, the Office would assess and report on the Commonwealth sectors preparedness and progress towards successful intersectoral collaboration.

Other functions of the Office of Aboriginal Health would include:

- a triennial assessment of key infrastructural matters of concern to the Strategy e.g., health workforce and facilities, and the organisation of resources and economic support;

- a biennial assessment of environmental conditions in Aboriginal communities including housing, water, sewerage and waste disposal, dust control and other relevant factors;

- an annual assessment of the progress towards successful intersectoral collaboration within the Commonwealth sector and nationally;

- an annual assessment of Aboriginal vital statistics;

- a triennial assessment of the Sentinel Health Events Program; and

- the following indices and indicators be established:

  - Sentinel Health Events (provider based): untimely, unnecessary death; unnecessary disease; unnecessary disability

  - Family Health Program (consumer based): prevalence of disease; environmental and social health; service provision and utilisation; primary health care and servicing coverage

- Health Systems Infrastructure
  - health staff
  - resources including skills transfer
  - health facilities
  - organisation of resources
  - economic support
  - systems operation including movement within and between levels and stations of care

- Environmental Conditions
  - housing
  - water
  - sewerage and waste disposal
  - other environmental factors

- Intersectoral Collaboration
  - budgetry) co-
  - policy) ordin-
  - program) ation
  - political/executive support
  - service provision at community level

- Aboriginal and Islander Vital Statistics
  - births
  - deaths
  - morbidity
  - maternal/perinatal collections
  - hospitalisation - separations

- Cultural and Social Wellbeing
  - cultural integrity
  - attitude to health and well being
  - racism.

With regard to environmental conditions the Working Party recommends that:

- the Commonwealth Minister for Aboriginal Affairs appoint a technical/community advisory group representative of Aboriginal interests and appropriate technical expertise to provide, by October 1989 such standards. The Office of Aboriginal Health should chair this Advisory Group.

With regard to health systems infrastructure the Working Party recommends:

- a specific research project be established to undertake this task with a management committee drawn primarily from Aboriginal health services. This complex task, if commenced by April 1989 could nevertheless be completed by September 1989, thus allowing sufficient leas time for its negotiated incorporation in the 1990/91 financial year.

CHAPTER 1

INTRODUCTION

1.1 TERMS OF REFERENCE

Report on Commonwealth/State and community funding arrangements, including financing of primary health care services and social health programs in Aboriginal Communities.

Develop strategies to achieve improvements in the short and long term, taking into account specific health problems, health service provision, administrative and funding arrangements, Aboriginal participation, research and data collection and ongoing monitoring.

Develop strategies to maximise the involvement of Aboriginal people in their own health care.

Consider intersectoral co-ordination including Commonwealth, State, local and health service agency responsibilities.

Develop a mechanism to monitor progress towards achieving targets, taking into account performance indicators developed as part of the policy.

Provide an interim report to the Ministerial Forum on Aboriginal Health in 1988 and a final report to the Ministerial Forum in 1989.

1.2 ESTABLISHMENT, ACTIVITIES AND METHODS OF OPERATION OF THE WORKING PARTY

At a meeting of the Commonwealth, State and Territory Ministers for Health and Aboriginal Affairs in December 1987 it was agreed that a Working Party would be established to develop a National Aboriginal Health Strategy. A Working Party was established and Ms Naomi Mayers, Director of the Aboriginal Medical Service Co-operative Limited, Redfern, was appointed by the Commonwealth Minister for Aboriginal Affairs, Mr Gerry Hand, as Chairperson of the Working Party.

1.2.1 Activities and Methods of Operation

The Working Party has met regularly throughout Australia since its establishment, thus enabling Aboriginal people, State and Territory Government officers to meet with Working Party members in their home States. Meetings were held as follows:

1988	April 7-9	Melbourne
	May 25-27	Sydney
	July 20-22	Alice Springs
	September 7-9	Mackay
	October 11-13	Hobart
	November 14-16	Perth
1989	November 29	Adelaide
	December 1-2	Adelaide
	January 18-19	Adelaide
	March 1	Adelaide

In developing the strategy the Working Party and Secretariat Officers undertook consultations and discussions with Commonwealth and State Departments, Aboriginal community groups and other interested bodies and individuals.

> Members were sensitive to the need for direct consultation with Aboriginal women who traditionally have a major responsibility for health and welfare in Aboriginal communities.

The consultation process is described in more detail in Appendix I of the Report.

Following the first meeting of the Working Party the Chairperson wrote to approximately 1 600 Aboriginal and non-Aboriginal authorities, organisations and groups with an involvement or interest in Aboriginal health issues, inviting them to make written submissions to the Working Party. The activities of the Working Party were also publicised through professional journals and other publications.

In response to the invitations and articles approximately 120 formal submissions were received. A list of those who made submissions is in Appendix I of the Report. Various letters, position papers, articles and other material were also received, and taken into account by the Working Party.

The information and views received in both consultations and written submissions proved to be of immense value to the Working Party, and enabled the concerns and wishes of Aboriginal people throughout Australia to be included in this Report.

1.3 MEMBERS OF THE NATIONAL ABORIGINAL HEALTH STRATEGY WORKING PARTY

The Working Party consisted of 19 members, with membership comprising:

- 2 Commonwealth Government representatives (including the Chairperson)
- 8 State Government representatives
- 9 Aboriginal Community representatives

CHAIRPERSON - COMMONWEALTH DEPARTMENT OF ABORIGINAL AFFAIRS
(Appointed by the Minister for Aboriginal Affairs)

Ms Naomi Mayers,
Administrator
Aboriginal Medical Service Co-operative Limited

COMMONWEALTH DEPARTMENT OF COMMUNITY SERVICES AND HEALTH

Dr Tony Dick
Medical Services Advisor
(Until 20 May 1988)

Dr Cathy Mead
Medical Services Advisor
Communicable Diseases and Social Health Branch
(From 23 May 1988)

NEW SOUTH WALES

Mr Sol Bellear
Co-ordinator
New South Wales Aboriginal Health Resource Committee (G)

Mr Shane Houston
Chairperson
Tharawal Aboriginal Corporation
Campbelltown (C)

VICTORIA

Mr Kevin Coombs
Manager
Koorie health Program Development Unit
Health Department of Victoria

Mr Alister Thorpe
Director
Victorian Koori Community Representative
(From 10 October 1988)

SOUTH AUSTRALIA

Ms Barbara Wingard
Aboriginal Health Worker,
Aboriginal Health Organisation
Murray Bridge (G)

Ms Clara Coulthard
Chairperson
Pika Wuja
Port Augusta
South Australia (C)

QUEENSLAND

Dr Rod Davison
Director
Aboriginal Health Program
Department of Health (G)
Queensland

Mr Les Collins
(Aboriginal Community Health Representative)

Mrs Ellie Gaffney
Aboriginal/Islander Community Representative
(Aboriginal Co-ordinating Council and
Islander Co-ordinating Council)
Queensland
(From 25 May 1988)

WESTERN AUSTRALIA

Ms Rosanna Dean
Co-ordinator
Aboriginal Education
Health Department of Western Australia (G)

Mr Ted Wilkes
Director
Perth Aboriginal Medical Service (C)

TASMANIA

Ms Valerie Judd
Department of Health Services
Tasmania (G)
(Until 20 July 1988).

Ms Elizabeth MacFie
Department of Health Services
(from 14 October 1988)

Ms Dyan Shaw
Flinders Island (C)

NORTHERN TERRITORY

Mr Brian Dixon
Director
Aboriginal Health Branch
Northern Territory Department of Health and
Community Services (G)

Ms Chris George
Administrator
Anyinginyi Aboriginal Health Service
Tennant Creek (C)

AUSTRALIAN CAPITAL TERRITORY

Mr Ian Todd
Assistant General Manager
Community and Health Development
ACT Community and Health Service (G)
(Until 2 September, 1988)

Mr Gary Powell
Assistant Director
General and Sectoral Development
ACT Community and Health Service (G)
(From 7 September 1988)

Mrs Ruth Bell
Yass (C)
(Until 19 July 1988)

Ms Lynnette Hawley
Canberra Aboriginal and Torres Strait
Islander Consultative Committee
Canberra (C)
(from 20 July, 1988)

(G) GOVERNMENT NOMINEE
(C) ABORIGINAL COMMUNITY NOMINEE

SECRETARIAT

Mr Ken Wanganeen, Secretary to the Working Party

Ms Jan Herbert

Mr Alan Woods (from May 1988)

Mr Joseph Murphy (from July 1988)

Ms Maree Guinane (May-November 1988)

Mr Gary Powell (November 1988)

Ms Lorraine Leigh

Ms Vanessa Thomas

CHAPTER 2

CURRENT STATE OF ABORIGINAL HEALTH

Aboriginals have the worst health of any identifiable group in Australia, they carry a burden of poor health and mortality far in excess of that expected from the proportion they comprise of the total Australian population. This state of affairs has been documented on many occasions and there is considerable literature describing Aboriginal ill health. Most of it is focussed on particular medical conditions or geographical regions.

Aboriginal health has been the subject of several government initiatives. In 1973, a National Plan for Aboriginal Health was proposed. A major aim of this plan, which was in fact no more than a statement of intent, was

> "To raise the standard of health of the Aboriginals of Australia to the levels enjoyed by their fellow Australians".

It was an initiative of the Commonwealth Department of Health in consultation with the Department of Aboriginal Affairs and was to be implemented jointly by Commonwealth, State, Territory and Aboriginal Agencies within ten years. By 1979, when the House of Representatives Standing Committee on Aboriginal Affairs brought down its report on Aboriginal Health, it was clear that this target would not be reached. The Committee reported the state of Aboriginal health as being intolerable and made eighteen recommendations and twenty-four suggestions to improve the situation. The Committee gave highest priority to the provision of basic environmental health facilities, especially safe water supplies, resulting in the establishment of the Aboriginal Public Health Improvement Program. This program, which ran from 1981 to 1985, was responsible for the provision of essential facilities to Aboriginal communities. By 1988 however, many Aboriginal communities still do not have a safe and reliable water supply.

Data provision by State and Territory Departments of Health and the Australian Institute of Health is gratefully acknowledged.

Despite some improvements since the 1970's, Aboriginals continue to die at higher rates, at younger ages, and to be admitted more often to hospital. Aboriginal communities, though sharing similar disadvantages and a common heritage, vary widely, with their health problems (though often only by degrees), reflecting the different physical and social environments. Despite these differences the standard of Aboriginal health is low throughout the country.

Aboriginals use more hospital services for almost all disease categories than other Australians; overall death rates are up to four times higher, and are higher for almost all disease categories, and life expectancy is up to twenty-two years less. The causes of the lower health status are complex, but the social and economic inequalities suffered by Aboriginals are clearly of central importance.

There has been an increase of 42% in the Aboriginal population counted in the Censuses of 1981 and 1986, due largely to improved data collection methods with the result that more people identified themselves as Aboriginals. Difficulties of enumeration characterise all statistical collections which identify Aboriginality, including those for mortality and morbidity, and these difficulties have a major impact on the validity and reliability of the available statistics.

The 1986 Census counted 227,645 Aboriginals and Torres Strait Islanders, who between them comprised 1.45% of the total Australian population. Although Aboriginals comprise a small proportion of the total, they are over-represented in the available morbidity and mortality statistics.

Sources of routine health related data include notifications of births, deaths, cancers and communicable diseases; certification of cause of death or of perinatal death; and maternal/perinatal and hospital morbidity collections. Not all of these statistical collection systems provide for the identification of Aboriginality.

It is only recently that systematic identification of Aboriginality has commenced in hospital and vital statistical collections. In 1974, Commonwealth, State and Territory Governments agreed to establish a national Aboriginal health statistical collection based on hospital records. A Task Force of Commonwealth, State and Territory agencies was established in 1984 and recommended procedures for the collection of these statistics. Agreed positions were reached between the Task Force and State or Territory Governments (except Queensland) providing for the identification of Aboriginals on notifications of births and deaths, and in hospital morbidity and maternal/perinatal statistical collections where these exist. However, by 1988, the goal of a national statistical

Table 1. Summary of Aboriginal Identification June 1988

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Birth notification forms	- Jan 89	In Place Nov 86	No	In Place Aug 85	No	No late 88	In Place Feb 88	In Place Jan 85
Death notification forms	In Place 1981	In Place Nov 86	No	In Place Aug 85	In Place Mar 85	No Late 88	In Place Feb 88	In Place Jan 88
Medical certificates of cause of death	No	No	No	No	In Place	No	In Place	No
Medical certificates of cause of perinatal deaths	In Place	No	No	In Place	In Place	In Place	In Place	In Place
Hospital morbidity	In Place	In Place	Partly in Place 1/88	In Place	In Place	No	In Place 1977	In Place
Maternal / perinatal collection	In Place 1981	In Place Nov 86	In Place	In Place	In Place	In Place	In Place 1972	In Place
Cancer registry	No	In Place Jan 88	No	In Place	In Place 1980	No	In Place 1981	No
Communicable diseases notification forms	No	No	In Place	No	No	No	In Place	No

Source : Australian Institute of Health

collection has still not been fully realised, and in some jurisdictions, identification of Aboriginality has been implemented only in the last three years. Table 1 shows the current status of identification of Aboriginality in the various health-related statistical collections.

A continuing problem exists with the identification of Aboriginality at the point of completion of statistical returns. Hospitals and other institutions are responsible for this and it is widely considered that under-enumeration of Aboriginals is common. The working definition of an Aboriginal or Torres Strait Islander is:

> "a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander, and is accepted as such by the community in which he or she lives."

Staff often fail to inquire whether patients identify themselves as Aboriginals and this results in misclassification of Aboriginals as non-Aboriginals, and probably leads to an underestimation of the poor state of Aboriginal health.

The Aboriginal population has several distinctive demographic features, it is relatively young and the birth and mortality rates are higher compared with the total Australian population (Figure 1). About 40% of Aboriginals are less than 15 years old, compared with 23% of the total population. Only 4% of Aboriginals are 60 or over, compared with almost 15% of the total population. This population structure is similar to those of third world countries.

2.1 BIRTHS

The most reliable recent estimates of fertility for Aboriginals from Western Australia and the Northern Territory reveal fertility rates roughly twice those of the total population. This difference in Aboriginal births was in the age group 24 years or under (Figure 2). Teenage pregnancies proceeding to delivery in the Northern Territory and Western Australia are eight times more frequent in the Aboriginal than in the total Australian population. Older Aboriginal women have relatively higher fertility rates than Australian women as a whole.

The young average age of Aboriginal mothers, the closer spacing of births and higher parity rates combine with other risk factors to increase the rate of at-risk pregnancies. Common risk factors for Aboriginal mothers include poorer nutritional status, less antenatal care, and higher rates of cigarette and alcohol consumption, although the prevalence of these risk factors vary across Australia.

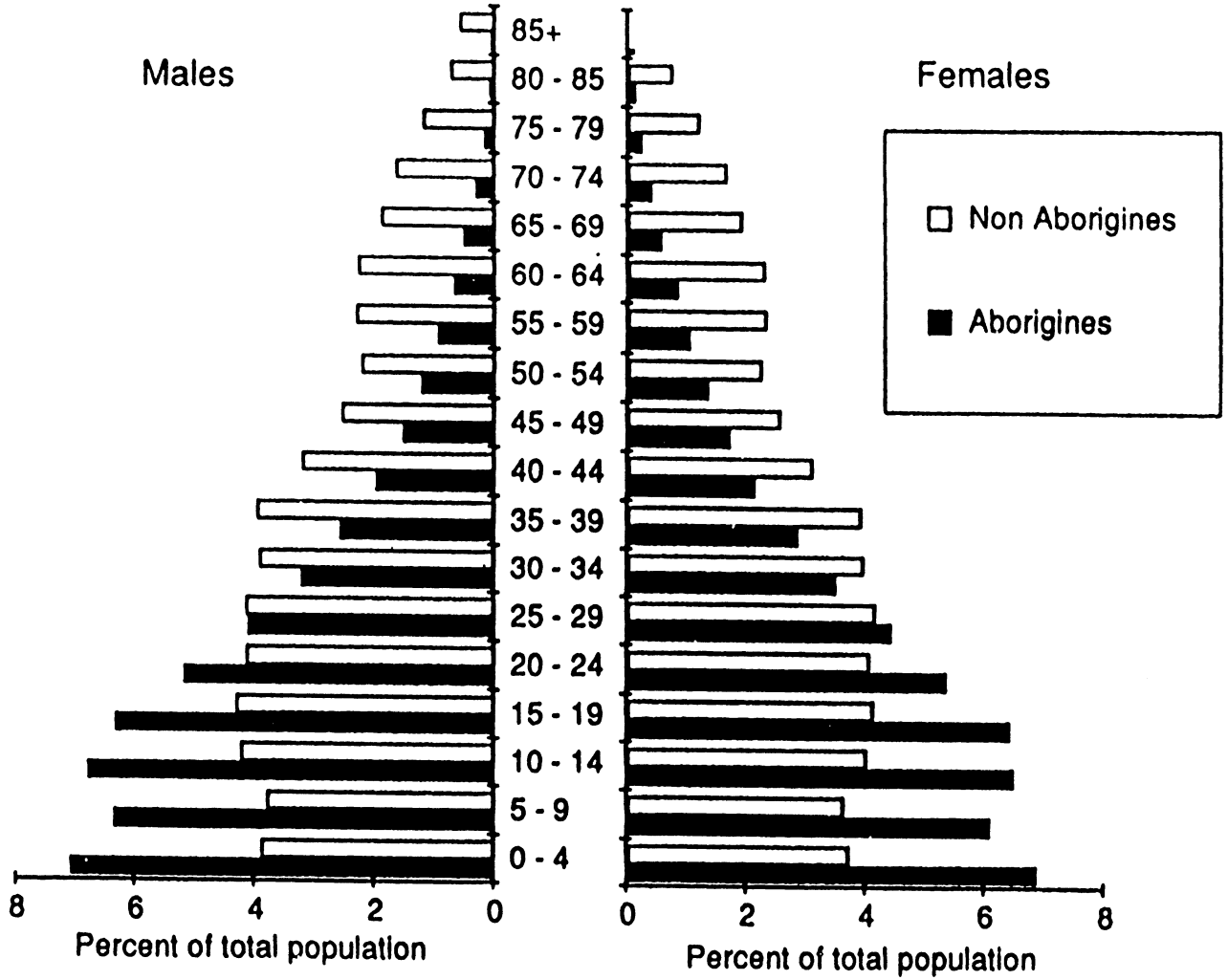


Figure 1. Population Pyramids

Source: ABS Census 1986.

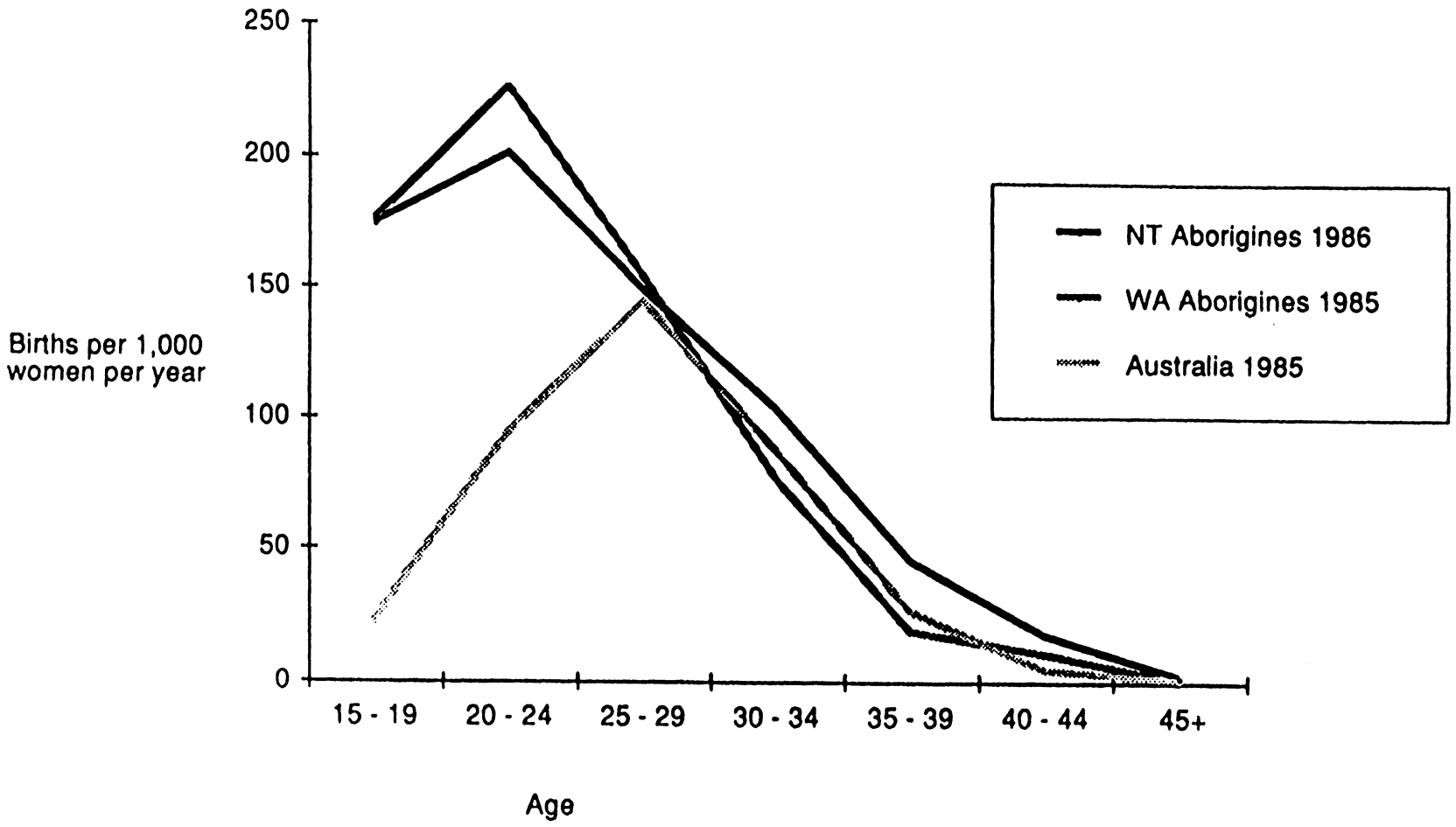


Figure 2. Age-Specific Fertility, Aborigines and Non-Aborigines

Source: AIH, from WA and NT Health Departments, and ABS.

Aboriginal pregnancies are more likely to result in preterm delivery, low birth weight, and particularly in the metropolitan areas, are more likely than non-Aboriginal pregnancies to result in termination.

The most reliable available recent data (from WA 1983-1985 and NT 1986) shows that low birth weight (less than 2,500 grams) babies accounted for between 13% and 15% of Aboriginal babies born. Such low birth weight infants are at greater risk of neonatal and post-neonatal illness and death. These proportions are more than double low birth weight infants born to non-Aboriginals (6%). At birth, Aboriginal babies are less healthy than their non-Aboriginal counterparts.

2.2 DEATHS

Across Australia and in all age groups Aboriginals experience higher mortality rates than non-Aboriginals.

Perinatal and infant mortality rates provide some indication of a population's overall health status. The perinatal mortality rates for Aboriginals are between 2 and 3.6 times higher than for non-Aboriginals, (Figure 3) despite substantial improvements particularly over the last 20 years. It should be noted that data is not available in all States and Territories, and that statistical collections identifying Aboriginal perinatal and infant mortality rates in 1985 covered only 37% of Aboriginal births.

Age-specific mortality is higher in all age groups for Aboriginals (Figure 4). The difference is most marked in the middle years of life, between 25 and 44 years of age. Only at advanced ages does morbidity of Aboriginals approximate that of non-Aboriginal Australians.

As a consequence of high mortality Aboriginals have a shorter life expectancy than non-Aboriginals. The expectation of life is reduced in all States and Territories. Reliable data to allow the calculation of Aboriginal life expectancy at birth is not available in all States and Territories. Estimates have been prepared from the data available which show that life expectancy of Aboriginals is less than for non-Aboriginals in all States and Territories. These estimates reveal life expectancies between 54.7 and 58.1 years for Aboriginal males, up to 22 years less than for all Australian males and between 62.6 and 67.6 years for Aboriginal females, up to 15 years less than for all females. Many Aboriginal deaths of people in their thirties and forties (figure 4), i.e. people of working age, pose a serious social and public health problem and these deaths of young working age people pose serious social and public health problems.

Since the Aboriginal and total Australian populations differ in age structure, comparisons of mortality rates can only be made after age standardisation.

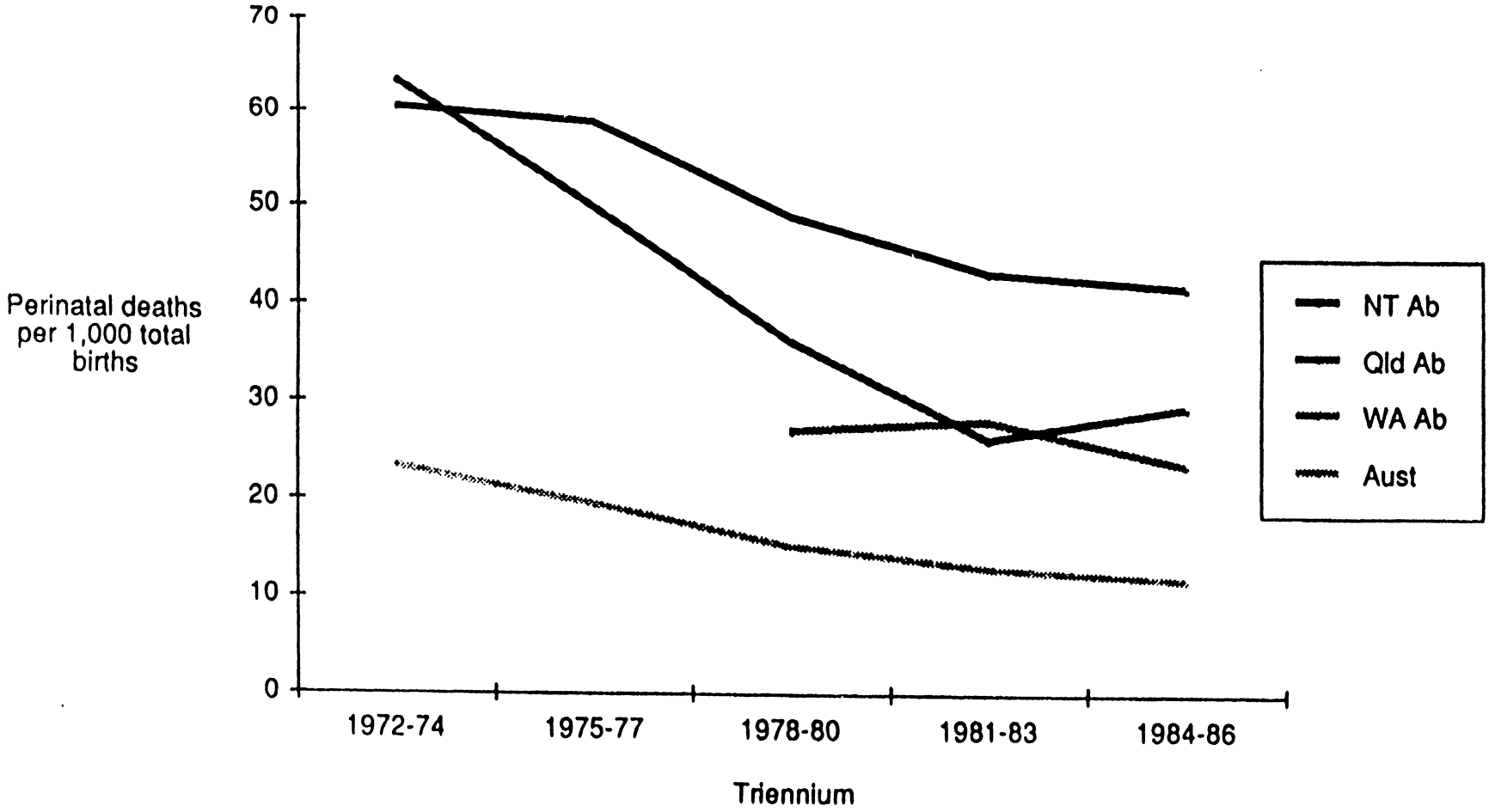


Figure 3. Perinatal Mortality Since 1972

Source: AIH, from NT, Qld and WA Health Departments and ABS. Qld rates refer to 14 Reserve Communities.

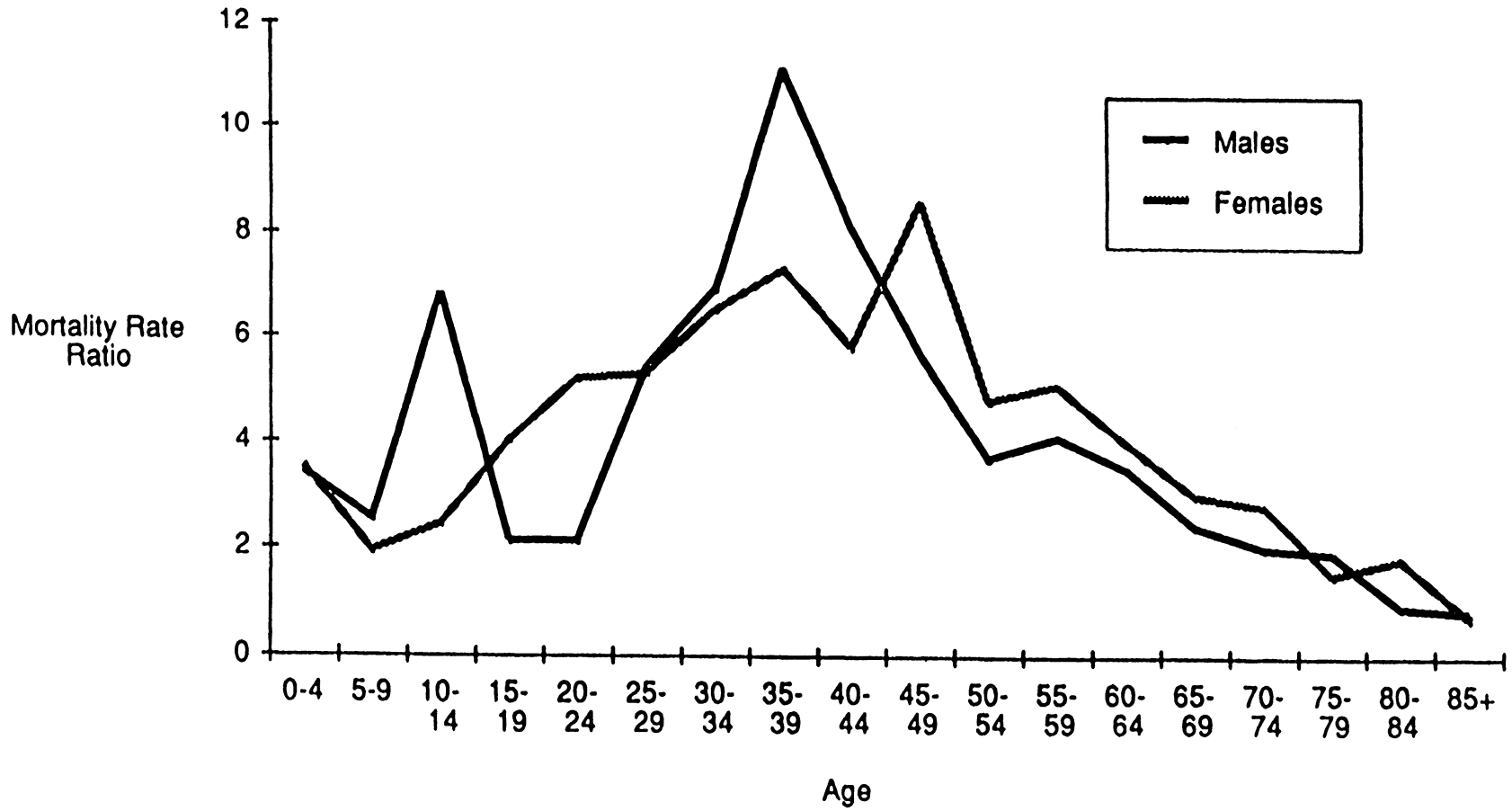


Figure 4. Age-Specific Mortality Rate Ratios, 1985, SA, WA &NT Aborigines Compared with the Australian Population

Source: AIH, from SA, WA and NT Health Departments.

Combined data from South Australia, Western Australia and the Northern Territory for 1985 shows that the actual mortality for all causes is 2.8 times higher than would be expected if Aboriginal mortality rates were the same as those for all Australians.

After grouping causes of death according to chapter headings of the International Classification of Diseases, Ninth Revision (ICD-9), Aboriginals' actual mortality for most causes is between 2 and 8 times higher than expected. This is the case, with only minor exceptions, for all causes of death. With the exceptions of perinatal conditions in females and congenital conditions in males, there is greater mortality among Aboriginals than among the total Australian population. Thus, the spectrum of Aboriginal mortality is wide and no single cause is responsible for the excess mortality. The major causes of Aboriginal and non-Aboriginal deaths, with their standardised mortality ratios are given in order of importance in Table 2.

TABLE 2

Causes of death of Aboriginals in rank order of importance, males and females, Western Australia, South Australia and Northern Territory.

	Males		Females	
Rank	Cause	SMR	Cause	SMR
1	Circulatory system	2.1	Circulatory system	2.1
2	External injuries	3.0	Respiratory system	8.0
3	Respiratory system	6.2	External injuries	3.8
4	Neoplasms	1.0	Neoplasms	1.3
5	Genito urinary system	12.8	Infectious, parasitic	22.8

Source: AIH, combined data from WA 1985, SA 1985 and NT 1983.

Diseases of the circulatory system are the leading cause of death for both males and females, with Aboriginals experiencing over twice the non-Aboriginal rates. Injuries, respiratory system diseases, genito urinary system diseases and infections and parasitic diseases are responsible for deaths at many times the non-Aboriginal rates. However, some of these causes are specific to certain ages, for example, the majority of deaths due to infections and parasitic diseases occur in the first five years of life.

2.3 ILLNESS

Difficulties in interpretation of hospital derived statistics are compounded by the likelihood of differential access of Aboriginals and non-Aboriginals to hospital services, non-identification of Aboriginality in hospital statistical returns, and possible differences in hospital admission practice between States and Territories.

Morbidity patterns may be inferred to some extent from analysis of hospital separation statistics, which record the principal diagnosis made during each hospital stay. Hospitalisations are only one aspect of the care of ill health and hospital based statistics do not necessarily reflect the true extent of morbidity within a community. Much illness is untreated, self treated, or treated in primary care settings. Consequently, these episodes are not recorded in hospital statistical collections. Hospital statistics record events, not individuals and people may be admitted to hospital more than once in a year, without this fact being apparent in the statistics.

Aboriginals are admitted to hospital between 1.6 and 3.2 times more frequently than non-Aboriginals (Figure 5). Since the Aboriginal and non-Aboriginal populations have different age structures, both Aboriginal and non-Aboriginal rates have been directly standardised to the World Standard Population to allow comparison. The higher rates of hospital admission occur in all States and Territories, where data are available, and also for nearly all diagnoses when categorised according to chapter headings of ICD-9 (Figures 6 and 7). Only for neoplasms (cancers) are Aboriginals generally hospitalised at lower rates than non-Aboriginals, except in South Australia this is not the case, where respective hospitalisation rates for cancer are nearly equal, indicating the rise in importance of this cause of morbidity.

The leading causes of admission to hospital for both males and females are respiratory system diseases and injuries. Paradoxically, Aboriginals appear to be hospitalised for circulatory disease at a rate less than might be expected from the predominance of this cause of death. Evidence suggests that much Aboriginal circulatory system disease is undiagnosed and untreated.

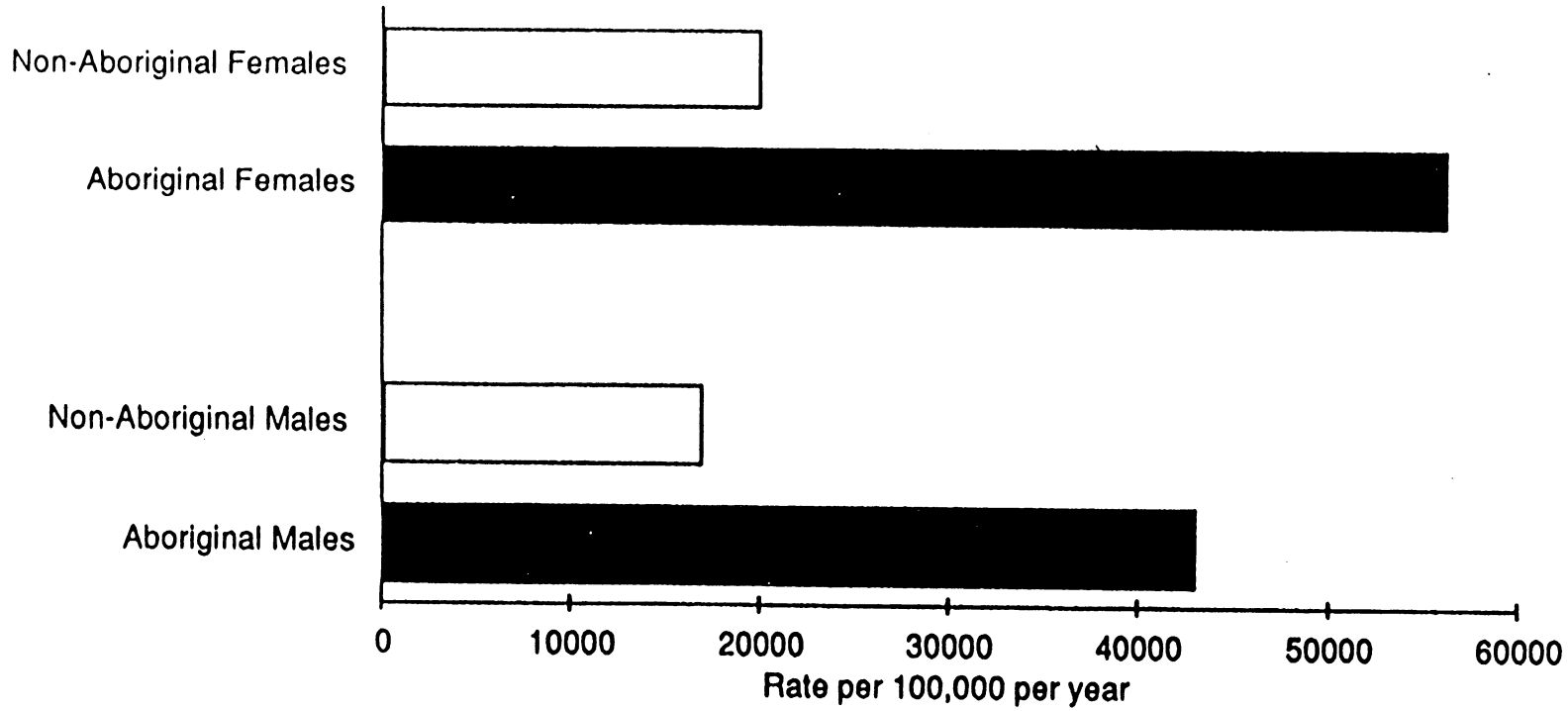


Figure 5. Standardised Rates of Hospital Separations, All Causes, Aborigines and Non-Aborigines, WA, SA, and NT

Rates directly standardised to the World Standard Population for comparison. Source: AIH, from WA (1986), SA (1986) and NT (1984) Health Departments.

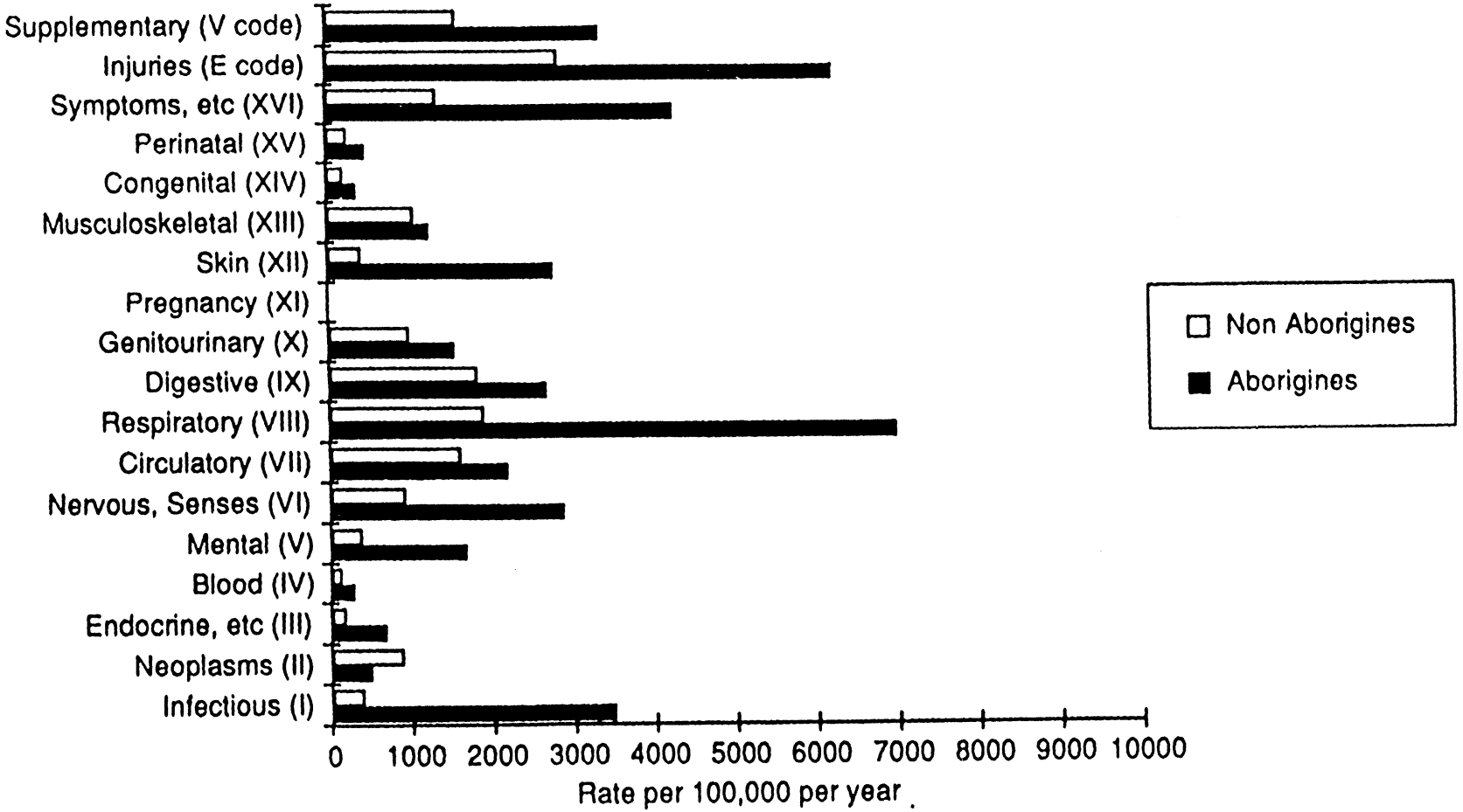


Figure 6. Standardised Rates of Hospital Separations, Aboriginal and Non-Aboriginal Males, WA, SA and NT

Rates directly standardised to the World Standard Population for comparison. Source: AIH, from WA (1986), SA (1986) and NT (1984) Health Departments.

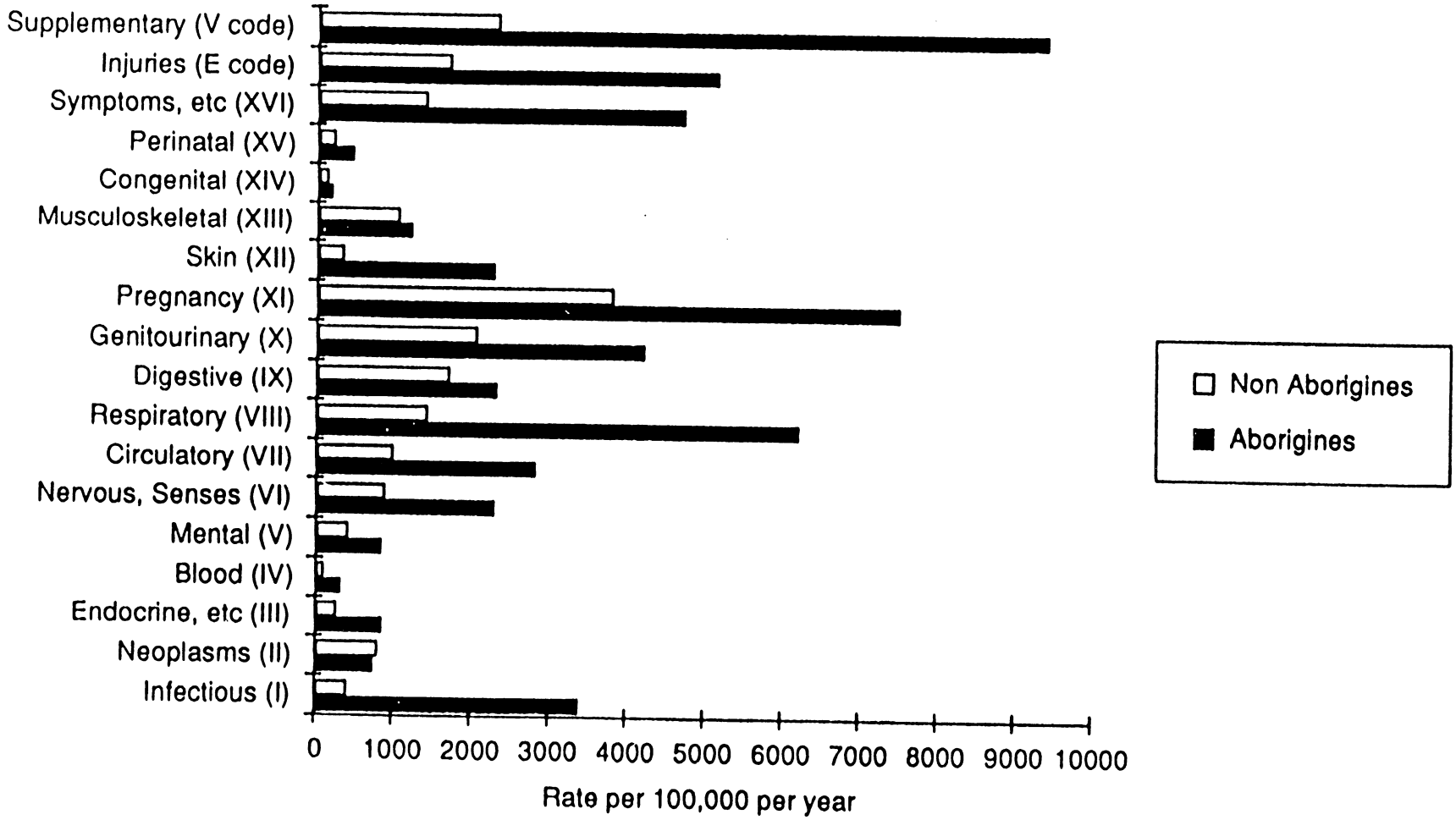


Figure 7. Standardised Rates of Hospital Separations, Aboriginal and Non-Aboriginal Females, WA, SA and NT

Ratos directly standardised to the World Standard Population for comparison. Source: AIH, from WA (1986), SA (1986) and NT (1984) Health Departments.

Although certain data on specific conditions are not always available specific diagnoses are responsible for disproportionate numbers of hospital admissions. Aboriginals in WA 1986 and NT 1984 were admitted to hospital at rates eight to fifteen times higher than the non-Aboriginal rates for pneumonia. High blood pressure resulted in hospital admission at a rate five to eight times greater than for non-Aboriginals. These diseases or their precursors may be relatively easily treated or managed in primary care settings within the community and represent areas in which gains in Aboriginal health might be made. Diabetes was responsible for rates of hospital admission between two and fifteen times that of the non-Aboriginal population. It has been estimated that diabetes occurs in 12% of the Aboriginal population compared with 2.3% of the non-Aboriginal population. Ischaemic heart disease did not result in hospital admissions to the same degree in the Aboriginal population as in the non-Aboriginal population, despite the higher Aboriginal mortality from this cause.

These patterns of hospitalisation are characteristic of the nature of Aboriginal health. There is a double burden of morbidity, both of infectious diseases common to developing countries, and of lifestyle diseases common to developed countries. The causes of these problems are associated with wide ranging social disadvantage.

Data on conditions treated by primary health care services are not routinely available. The Australian Bureau of Statistics periodically conducts a health survey which inquires about conditions suffered by a random sample of Australians in the preceding two weeks, including those self-treated and those treated by health care services. Aboriginality is however, not identified in these surveys and they cannot be used to examine Aboriginal health.

Over a period of 5 days in August 1988 the Aboriginal Medical Service based at Redfern rendered 333 medical services to 232 patients in its medical clinic. The nature of these services is shown in Table 3. Over a period of 6 days, 205 patients were seen in the dental clinic, with 332 services delivered. These figures do not include the use of other services offered by the AMS.

TABLE 3

Services provided to 232 patients at the Redfern Aboriginal Medical Service, 1988.

		No	%
Endocrine, Nutritional, etc	Diabetes mellitus	10	3.0
	Obesity, Weight check	18	5.4
Mental		19	5.7
Nervous system, senses	Neurology	3	0.9
	Eyes	12	3.6
Circulatory	Cardiac	5	1.5
	High BP, BP check	8	2.4
Respiratory	Upper respiratory	58	17.4
	Lower respiratory	19	5.7
Digestive		11	3.3
Genitourinary	Renal	4	1.2
	Gynaecology	20	6.0
Pregnancy	Antenatal	5	1.5
Skin		8	2.4
Musculoskeletal		28	8.4
Injuries	Trauma	12	3.6
Other categories	Chiropractor	7	2.1
	Surgical	20	6.0
	IV Drugs	7	2.1
	Immunisation	10	3.0
	Blood tests	26	7.8
	Certificates & Results	23	6.9

Source: Redfern AMS

There is a strong demand for Aboriginal health services, over a 12 month period in 1986-87 15% of patients at the Redfern Aboriginal Medical Service were prepared to travel over twenty kilometres to attend for primary medical care and 36% were prepared to travel the same distance for dental care.

Several of the major communicable diseases of childhood may be prevented by appropriate immunisation. These diseases include diphtheria, tetanus, whooping cough, poliomyelitis and measles. The immunisation status against several of these diseases, of Aboriginal children is generally poorer than of non-Aboriginal children (Table 4) and is insufficient to protect the community. There are significant variations in immunization status according to geographical location, some States and locations report higher than national rates.

TABLE 4

Immunity statistics for vaccine preventable diseases of childhood, Aboriginal and non-Aboriginal children

	Aboriginals	Non-Aboriginals
Diphtheria tetanus pertussis completed course	41.7%	73.3%
Polio completed course	46.8%	71.8%
Mumps immunization	30.5%	46.8%
Measles immune	43.2%	64.5%

Source: Bridges-Webb et al Childhood Immunisation and Infectious Diseases Survey, 1988

Children attending a random sample of general practitioners and Aboriginal children attending selected Aboriginal health services.

Immune by criteria of Advisory Committee on Immunisation Practice of the Centers for Disease Control. The data include 3.3% of Aboriginal and 1.1% of non-Aboriginal children who contracted measles over the age of twelve months. These children are now immune but must be regarded as immunisation system failures.

To protect the entire community against these diseases it is necessary to attain high levels of immunisation.

The nutritional status of Aboriginals is characterised by child undernutrition and adult obesity. Aboriginal infants have a lower average birth weight, but frequently have normal growth over the first six months of life. After six months of age, there is a reduction in growth and 14% of Aboriginal infants and 22% of children in W.A. have been reported as being underweight.

Aboriginal adults are commonly overweight or obese. In a study of 751 Aboriginal adults from many communities throughout South Australia, 64% of the women and 50% of the men were overweight or obese. Body weight is an important factor in the development of a number of conditions, particularly diabetes, high blood pressure and heart disease.

Other important health problems for Aboriginal children include diarrhoeal disease and ear disease. Gastroenteritis is a prominent cause of hospital admission or attendance at health services. Among Aboriginal children ear disease is common. Perforated ear drums, mostly as a consequence of otitis media, have been reported in 10% of Aboriginal children. Hearing loss has been reported in over 15%, compared with a prevalence of deafness of 3.4% in non-Aboriginals.

Leprosy in Australia occurs disproportionately greater in Aboriginals. Between 1982 and 1986, 19 new cases were reported in the NT (0.11 cases per thousand per year) and 31 in the Pilbara and Kimberley Regions of WA (0.46 cases per thousand per year).

Aboriginals contributed 7.9% of all cases of tuberculosis notified in 1986. Between 1983 and 1986, 169 new cases were reported among Aboriginals (a crude rate of 0.35 per thousand per year), 14 times the rate among non-Aboriginals, excluding cases among immigrants and refugees from areas where tuberculosis is endemic.

Evidence of hepatitis B infection is prevalent amongst Aboriginals. Surveys have found,that while there is wide geographical variation,up to 90% of adult Aboriginals have markers for past infection with this virus and up to 25% may have the infectious antigen. The prevalence of hepatitis B markers in all Australians is less than 1%.

2.4 SOCIAL INDICATORS

The poor underlying state of Aboriginal health are measures of their social disadvantage within Australian society. Aboriginals are poorer, experience greater unemployment, have lower educational attainment, live in poorer housing and have lower access to facilities taken for granted in most of Australia.

Aboriginals are more likely to live in rural locations where service provision is often reduced. In the 1986 census about 33% of the Aboriginal population was recorded as living in communities of less than 1,000 people, compared with 14% of non-Aboriginals.

Aboriginals, as individuals and as families, have lower annual incomes than Australians (Figure 8). The median annual incomes for Aboriginals are 65% of those for all Australians (Table 5). Aboriginals receive 53% of this income as Social Security entitlements compared with a national figure of 11%.

TABLE 5

Median annual incomes of Aboriginals and all Australians.

	Aboriginals	All Australians
Individuals	$ 6 220	$ 9 600
Families	$16 300	$24 500

Source: ABS, Census 1986.

Unemployment amongst Aboriginals is higher and the rate of participation in the labour force is lower (Table (6).

TABLE 6

Labour force participation of Aboriginals and All Australians over fifteen years of age.

	Aboriginals	All Australians
Employed	31.3%	54.4%
Unemployed	17.1%	5.5%
Not in labour force	46.6%	37.9%
Not stated	5.1%	2.2%
Total	100.0%	100.0%

Source: ABS Census 1986.

Aboriginals frequently do not complete secondary education (Figure 9). They leave school at an earlier age, and do not to acquire post-secondary qualifications to the same extent as all Australians. Only 9% of Aboriginals have post-secondary qualifications, compared with 30% of all Australians.

Aboriginals are greatly over-represented in the prison system, making up 14.5% of all prisoners counted in the 1986 National Prison Census (data excludes Queensland which does not identify Aboriginality). In proportion to their population Aboriginals are nearly twelve times more likely to be in prison than non-Aboriginals.

Aboriginal housing has been linked to the poor state of Aboriginal health. There is a substantial housing shortage. In 1985, it was estimated that an additional 17,593 dwellings were needed to meet the need for housing. The estimated cost of construction of these dwellings was $1.1 billion. By September 1987, these estimates were for an additional 16,179 dwellings costing $1.3 billion.

Aboriginal housing is often substandard, lacking basic facilities such as reticulated hot and cold water, sewerage and electric power. Overcrowding is a significant factor in the development of communicable diseases and other ill health. The 1986 Census counted an average of 4.4 persons occupying a house where the head of the household was an Aboriginal compared with 2.9 persons per dwelling for all Australian households. Many households have much higher numbers of residents.

2.5 HEALTH SERVICES FOR ABORIGINES

Health care services for Aborigines are provided by both Government and non-Government organisations. Non-government organisations are generally community-controlled Aboriginal health services. They are funded from a variety of sources, predominantly from the Commonwealth Department of Aboriginal Affairs. Currently, DAA funds 64 health services across the country who employ 416 professional staff providing health care. Of these, 70 are doctors, 108 registered nurses and 217 Aboriginal health workers. Other professional categories make up the remainder.

2.6 PARTICIPATION OF ABORIGINALS IN THE HEALTH WORKFORCE

An important component of the Aboriginalisation of health care services is the employment of Aborigines at all levels of the health workforce. The 1986 Census counted a total of 1,337 Aborigines in health related occupational groups. This number included fourteen Aboriginal doctors and one dentist; 437 registered and 392 enrolled nurses, and fifty five dental nurses. Five of the registered nurses were Directors of Nursing. There were smaller numbers of Aborigines employed as health professionals, including physiotherapists, pharmacists, radiographers, chiropractors and others. State and Territory Aboriginal Health Worker Programs record 657 Aboriginal health workers employed in both Government and community-controlled health programs. The 1987 Higher Education Student Statistical Collection recorded sixty-one Aborigines undertaking vocational health related courses, including sixteen medical and twenty-four nursing students.

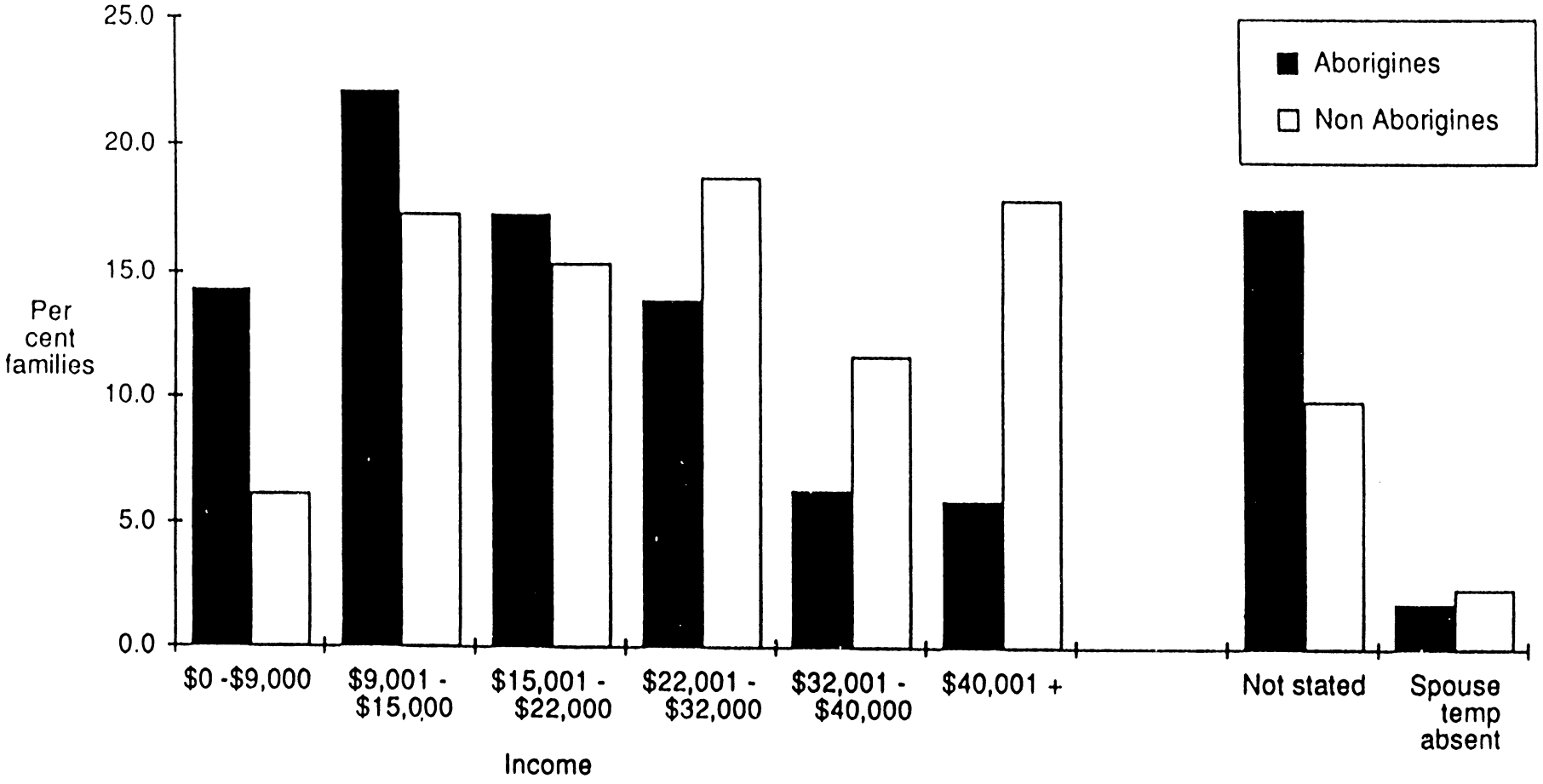


Figure 8. Family Income per Year, Aborigines and Non-Aborigines

Source: ABS Census 1986.

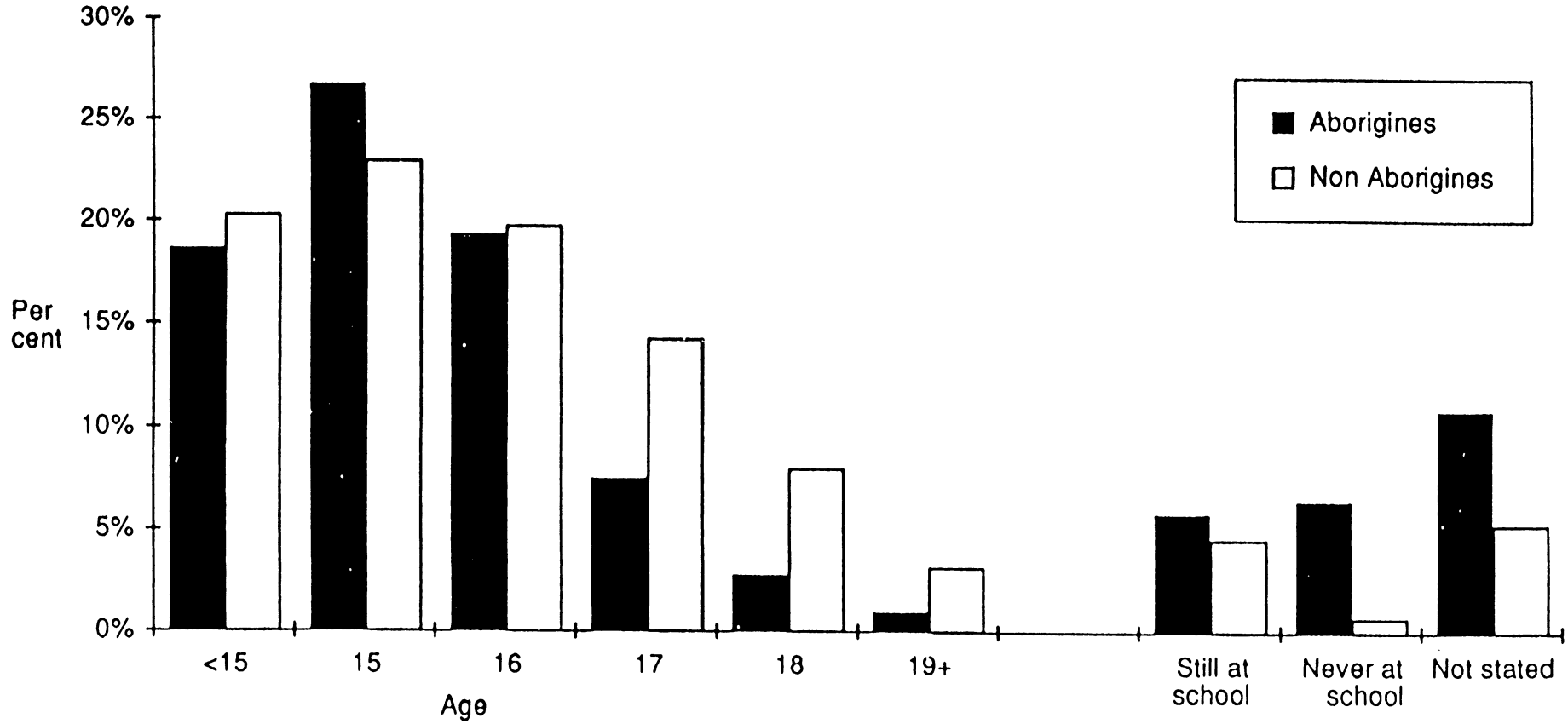


Figure 9. Age Left School, Aborigines and Non-Aborigines Over 15

Source: ABS Census 1986.

CHAPTER 3

COMMONWEALTH/STATE RESPONSIBILITIES

The Working party is of the opinion that increased Aboriginal participation in and control of primary health care services is one important step towards improving Aboriginal health and this growth should therefore be encouraged.

Such primary health care services must include effective preventative health programs and not just curative services if any real improvements are to be achieved.

The continued existence and expansion of these health services is very much dependent on setting out clear responsibilities and relationships between the Commonwealth, State, and Territory Governments, especially within the areas of primary service delivery, funding, health worker training, and essential services and housing provision. This will involve commitment and co-operation from State/Territory Governments and the Commonwealth which, to date, has not been an obvious feature of Aboriginal health care delivery.

The frustrations of improving Aboriginal health within the context of Commonwealth and State/Territory responsibilities is summarised in a submission received by the Working Party from the Victorian Aboriginal Health Service Co-operative Limited.

> "Federal Government after Federal Government has been more concerned about its political relationship with States and Territory rather than justice for Aboriginal people, and their moral Rights".

Consultations around Australia reveal that considerable effort and resources are required in many Aboriginal communities to ensure an adequate and satisfactory standard of essential services and access to health care. A key feature of improving the health of Aboriginal people must be the co-ordination of resources provided for such services by Commonwealth, State/Territory, and local Government authorities.
The Working Party recognises that overcoming historical friction in Commonwealth, State and Territory relationships, and the indifference of local government, to Aboriginal health funding and responsibilities will be essential to the development, acceptance, and implementation of a National Aboriginal Health Strategy.

The purpose of this Chapter is to provide an overview of Government agencies involved in provision of health care and health-related services to Aborigines and a description of the programs of these agencies.

3.1 COMMONWEALTH RESPONSIBILITIES

The Commonwealth's direct intervention in Aboriginal health in the States follows changes to Section 51 of the Constitution, brought about by the 1967 Federal Aboriginal Referendum.

Although this referendum gave the Commonwealth powers to override legislation where Commonwealth and State legislation conflicts, the Commonwealth's powers are concurrent with those of the States and do not in any way diminish State Government jurisdiction or responsibility.

Commonwealth and State relations in some Aboriginal program policy areas are determined by the formal agreements concluded between the Commonwealth and the States, except for Queensland, following the Aboriginal Affairs (Arrangements with the States) Act 1973.

In the 1987/88 financial year, the Department of Aboriginal Affairs expended $41.076 million on health funding. A further amount of $45.56 million was expended on health-related infrastructures and essential services such as water, sewerage and power.

In addition to this funding, the States and Territories provided just over $19.11 million in 1987/88 for specific Aboriginal health programs.

3.1.1 Funding Arrangements

Commonwealth funding for Aboriginal health in the States is effected by the provision of grants to the States (States Grants), to Aboriginal organisations by DAA, or directly to individual Aboriginals by way of medical and hospital benefits and by payments to doctors through Medicare arrangements. Commonwealth funding for public housing is provided by the Department of Community Services and Health to the State and Territories under the Housing Assistance Act 1984.

Two major categories of health grants are made by the Commonwealth:

- grants to State health authorities and Departments and

. grants-in-Aid to community organisations such as Aboriginal Medical Services.

The States and the Northern Territory provide some joint funding with the Commonwealth for Aboriginal organisations and they also provide funds for Aboriginal health either through their mainstream programs or special joint funded programs e.g. HIV/AIDS.

An indication of the trend in funding by the Department of Aboriginal Affairs is set out in Table 1 for expenditures recorded since 1983-84 and of estimated expenditures in 1988-89.

Commonwealth Direct Funding for Aboriginal Health

TABLE 1.

	$ million					
	1983/84	84/85	85/86	86/87	87/88	88/89
Grants for Aboriginal Advancement	12.722	20.401	22.764	24.701	28.119	33.661
States Grants	15.780	16.087	15.060	13.367	12.964	13.117
Payments to the NT Govt	-	-	0.059	0.064	-	0.031
Total	28.502	36.488	37.883	38.132	41.083	46.809

Apart from showing a progressive increase in expenditure from $28.502m in 1983/84 to $46.809m in 1988/89, it also indicates a marked percentage decrease in the provision of funds to State Governments for Aboriginal health programs. Following negotiations with the States, DAA funding of State Grants for Victoria, South Australia, and NSW have been dramatically reduced. As part of the negotiated agreement most of the savings have been transferred to Grants-in-Aid programs for health within those States.

The States have, in most cases, continued to provide the same level of support from their own funds for the programs formerly funded by DAA.

Queensland and Western Australia still receive substantial funds under the States Grants program.

The rationale of the negotiated progressive reduction in the States Grants program in favor of direct grants to Aboriginal controlled projects has been based upon the following broad considerations:

- State Governments have a responsibility to provide health care facilities for all who reside in their State regardless of racial origin. Once this responsibility is fully accepted, the Department of Aboriginal Affairs would presumably have additional funds available to devote to projects of a specific nature, controlled by Aboriginal organisations; and

- for some considerable time now, Aboriginal people have had a desire to control their own health delivery programs and this has been a stated objective of Departmental funding.

Table 2 provides details of total expenditure on health by DAA from 1985/86 to the 1988/89 (estimated) financial years by State and by percentage of Aboriginal population.

The percentage of funding by State compared with the percentage of Aboriginal population in each State discloses a degree of apparent disproportionate funding, especially in NSW, Queensland and the Northern Territory.

The distribution of the National component of the appropriation may redress this imbalance.

Of interest is the 27.32% of funding allocated to WA with its 16.6% of the Aboriginal population.

3.2 STATE GOVERNMENT RESPONSIBILITIES

Arrangements for Aboriginal health services differ from State to State in the degree of funding, advice, and direct service delivery provided by each of the State and Territory Governments. In a number of States and Territories, it is difficult to isolate all health-related expenditure on infrastructure items, e.g. sewerage, which are specifically for Aboriginal people.

Aborigines, as citizens, are entitled to the services of all the existing mainstream health and support programs provided by State and Local Government bodies. There is, however, no easy method of assessing utilisation rates.

The hospital system would be the most significant service used by Aboriginal people in the health area but, in most cases, statistical data on utilisation is unreliable.

Other significant State-funded and State-operated services impacting directly on health include the school medical and dental services and baby health services.

TABLE 2 HEALTH FUNDING BY THE DEPARTMENT OF ABORIGINAL AFFAIRS - 1985-1989 BY STATE

	NSW	VIC/TAS	QLD	SA	WA	NT	NATIONAL	TOTAL
	$	$	$	$	$	$	$	$
1985/86	5 030 430	2 886 350	8 076 132	3 035 548	11 647 599	6 904 082	302 000	37 882 141
1986/87	5 235 786	3 082 898	7 684 408	5 868 891	11 800 871	4 404 970	55 227	38 133 051
1987/88	5 716 371	3 246 585	8 144 133	5 531 664	13 032 659	5 405 125	-	41 076 537
1988/89	5 484 346	3 321 800	9 004 500	5 606 282	12 788 400	4 769 400	5 834 000	46 808 728
% Funds	11.72%	7.09%	19.24%	11.98%	27.32%	10.19%	12.46%	100%
% Pop.	26.5%	8.4%	26.9%	6.3%	16.6%	15.3%	-	100%

1985/86 DAA Annual Report
1986/87 DAA Annual Report
1987/88 Final Financial Returns
1988/89 Computer Print Master Program

3.2.1 Essential Services - Water, Sewerage and Electricity

Responsibility for the provision of water, waste, disposal, power, and sanitation services rests with local, State and Territory Governments, and Commonwealth funding for such facilities comes through general revenue-sharing and reimbursements (General Purpose Grants), Loan Council funds, or Grants Commission funds. The Commonwealth does not direct the allocation of these funds.

3.3 THE NEED TO DEFINE AND CO-ORDINATE GOVERNMENT RESPONSIBILITIES.

Examining the relationship between Government and community based health services reveals diverse efforts at co-ordination between these services in individual States or between regions in individual States/Territory.

In most areas where consultations were held there were no formal mechanisms for co-ordinating efforts between the States, health authorities, the community controlled health services, DAA, or the other relevant agencies. The provision of essential services was also affected by a lack of any formal mechanisms to co-ordinate State or regional efforts to provide such services.

The South Australian Strategic plan for Aboriginal health highlights the need for Commonwealth and State Governments and local community controlled services to reach some formal agreement on each of their respective responsibilities for source funding. Several sources of community agency funding were cited as causing confusion over accountability.

These concerns were typical of those raised in the submissions received by the Working Party from other Commonwealth State/Territory Government departments and community agencies.

The DAA submission stated:

> "There are many agencies involved, either directly or indirectly, in working to improve Aboriginal health. A bewildering array of Commonwealth, State, and local government bodies, Aboriginal community organisations, and independent welfare, charitable, religious, and indefinable interest groups and individuals are involved in some aspect of Aboriginal health. NONE CAN HOPE TO ACHIEVE ANY REAL AND LASTING IMPROVEMENT IN ABORIGINAL HEALTH UNLESS THEY ARE WILLING TO CO-OPERATE WITH OTHER INTEREST GROUPS TO THIS END." (Working Party's emphasis.).

The Northern Territory Government submission stated:

> "The current complex and multiple funding arrangements are a significant impediment to the delivery of comprehensive and co-ordinated health services. Furthermore, multiple funding arrangements create an unnecessary burden upon local health services with limited management expertise."

The South Australian Strategic Plan stated:

> "Improved health status (for Aboriginal people) will only be achieved through a structured and co-ordinated approach towards the formation of detailed community development action plans. This process requires the involvement of all government agencies which provide services to Aboriginal people and includes such areas as housing, sanitation, water, welfare, and education." (Aboriginal Health Strategy - South Australian Health Commission.)

3.3.1 Co-ordination Mechanisms

Formal Commonwealth/State general co-ordination mechanisms in Aboriginal Affairs do not exist in most States and Territories. The New South Wales and Victorian State Aboriginal consultative and advisory bodies do, however, include at least some Commonwealth representation.

At the State and Territory level there are no comparable co-ordinating mechanisms similar to the Commonwealth Interdepartmental Working Group (IDWG) although there are consultative committees in New South Wales and Victoria.

While the history of the Commonwealth IDWG on Aboriginal health is not considered to be ideal by any standards it has provided a forum for Commonwealth Government agencies to address Aboriginal health initiatives and policy.

The basis for the framework for Commonwealth, State and Territory relations and responsibilities, as outlined in this proposed strategy, is that the various levels of Government, associated agencies, and the community need to ensure the co-ordination and, where appropriate, the integration of health policy and delivery of health and essential services.

Achieving the optimum level of co-ordination and integration between the organisations involved in health care needs:

- commitment by all parties, Commonwealth, State, Territory and community controlled organisations to the principles of intersectoral collaboration (which are discussed later in Chapter 6 of this report);

- clear delineation and definition of each Government's functions and responsibilities in the major areas of Aboriginal health;

- a commitment to funding of primary, secondary, and tertiary health care services, health-worker education, education and training of health professionals, and the provision of essential services; and

- a forum for continuing co-ordination and dialogue between the Commonwealth, State, Territories and the communities.

Some precedents for focussing on and agreeing to formalise some State and Commonwealth efforts in service programming found in the Commonwealth/State Housing Agreement (CSHA) and the Community Employment Program (CEP). Both the CSHA program and the former CEP were based on a legislative frameworks at the Commonwealth level with additional administrative guidelines to assist interpretation at the State and Territory level.

At present no legislative or administrative agreement exists between the Commonwealth and the States in the field of Aboriginal health.

For example, the 10-year plan developed for Aboriginal health and announced by the Commonwealth Minister for Health in 1973 was never formally endorsed by State and Territory Governments.

Commonwealth health policy accepts that the administration and co-ordination of health services delivered in a State or Territory are the responsibilities of that State or Territory.

A protocol between State authorities, DAA, and communities in particular regions may well be a way of improving the quality and speed with which services are provided to communities.

The Working Party recommends that:

- the Aboriginal health function remain within the portfolio responsibility of the Minister for Aboriginal Affairs;

- the Australian Health Ministers Council (AHMC) and the Aboriginal Affairs Council (AAAC) establish a Council of Aboriginal Health as a Standing Committee to both Councils;

- there be ongoing joint annual meetings of Commonwealth/State/Territory Ministers for Health and Aboriginal Affairs with the purpose of:

  - reviewing the implementation of the National Aboriginal Health Strategy;

  - reviewing regular reports from the Council of Aboriginal Health;

- these arrangements be reviewed in five years;

- that there is recognition of the need for the existence of a National Aboriginal Community Controlled Health Organisation:

  - a formal relationship be established between the national organisation and any bodies emanating from decisions of the National Aboriginal Health Strategy Working Party; and

  - such formal relationships shall include representation from community controlled organisations.

3.3.2 Council of Aboriginal Health

The Council of Aboriginal Health should meet quarterly and its functions should include:

- reviewing progress towards the implementation of the NAHS, recommend any necessary changes to the strategy to the joint Ministerial Forum, paying specific attention to intersectoral collaboration;

- reviewing annual implementation reports from the various Commonwealth/State/Territory Governments and Aboriginal community organisations involved in health; and

- oversighting the development of a national data base of Aboriginal health statistics.

The specific questions that the Working Party believes must be addressed by the tripartite forums are:

- What machinery exists at local and more central levels for intersectoral action in health? How does it function? How could it be improved?

- How much planning, decision-making, and financial control are delegated to the local level? What effect would increased delegation of control have on prospects for intersectoral planning and action at local level?

- What specific activities are being undertaken jointly with sectors other than health? What sectors are involved? Was planning undertaken locally, or more centrally? How could intersectoral activities be improved?

- How much integration is there between preventative, curative, and rehabilitative services? Does this occur at all levels?

- How effective is the referral process between primary, secondary, and tertiary care in meeting actual health needs? Is two-way communication between levels adequate?

The Working Party recommends that:

- the establishment of a permanent Secretariat within the Aboriginal Affairs portfolio to service the Council; and

- that the Council for Aboriginal Health and its Secretariat be jointly funded by the Commonwealth, States, and Territories and that the Commonwealth bear the costs of community representatives involved in the Council.

3.3.3 Office of Aboriginal Health

The Working Party recommends that:

- the ATSIC Bill be amended to provide for the establishment of an Office of Aboriginal Health to have the following functions:

  - organise and, where appropriate, undertake the regular assessments described in Chapter 12 Monitoring and Evaluation;

  - monitor and evaluate the Commonwealth sector activity in Aboriginal health with regard to the goals outlined in this strategy;

  - co-ordinate the implementation of Aboriginal health programs in the Commonwealth sector;

  - promote intersectoral collaboration in the Commonwealth sector and furnish reports as required by the Council, State, Territory and Commonwealth Governments;

  - one of the appointed Commissioners to the proposed ATSIC be a health commissioner and be a member of the Council of Aboriginal Health;

> Ministers agree to set up in each State and Territory a tripartite forum similar to the Council of Aboriginal Health in order to examine, promote, and resolve issues relating to intersectoral collaboration within the State and Territory. The first task of the forum will be to finalise arrangements for ongoing mechanisms to promote intersectoral collaboration. These were originally outlined in a World Health Organisation publication Primary Health Care. (Theory to Action, EURO Reports and Studies No. 69).

In recommending the creation of an Office of Aboriginal Health within the portfolio responsibility of the Commonwealth Minister for Aboriginal Affairs the Working Party has proposed an organisational arrangement which was not supported by the majority of community organisation representatives who attended the national conference in Adelaide on 27 and 28 February 1989.

The conference delegates were strongly of the view that any new organisational arrangements should ensure complete independence and autonomy from the Department of Aboriginal Affairs. They considered that these conditions could only be assured by statutory means which would also allow the new body to have independence and direct access to the Minister for Aboriginal Affairs.

In deciding to recommend that the Office of Aboriginal Health be created as a non-statutory body within the Aboriginal Affairs portfolio, the Working Party considered that the needs of co-ordination, particularly of funding sources at the Commonwealth level, would be best served. As recommended, the Office of Aboriginal Health would have a direct relationship not only to other portfolio agencies but, just as importantly, to other Commonwealth Departments, such as the Department of Employment, Education and Training, Australian Construction Services and Department of Community Services and Health, which have a direct impact on the provision of health services to Aboriginal people.

The Working Party does, however, share the concerns of the conference delegates as to the Office's independence and autonomy and believes that these problems can be at least minimised, if not totally eliminated, if a Commission under the proposed ATSIC legislation could be designated as having a direct responsibility for health issues.

3.4 THE CURRENT ROLE OF THE DEPARTMENT OF ABORIGINAL AFFAIRS

Responsibility for the provision of physical health services to Aboriginal people (except in the NT) rested almost totally with State Governments prior to the establishment of the Commonwealth Office of Aboriginal Affairs in 1968 and subsequently the Department of Aboriginal Affairs in December 1972.

Since 1984, the Department of Aboriginal Affairs has been solely responsible for the funding and administration of all Commonwealth programs relating to Aboriginal health. The Commonwealth Department of Community Services and Health retains the broad policy responsibility for Aboriginal health matters.

It is stated DAA policy that projects supported through States Grants must comply with Commonwealth Government policy in the field of Aboriginal Affairs.

The Department of Aboriginal Affairs' submission to the Working Party emphasised that:

> "...the role of DAA in Aboriginal health is primarily that of a funding and resource agency for Aboriginal community organisations and State Governments."

Significantly, the submission goes on:

> "DAA is not involved in the delivery of (actual) health care to Aboriginal people, it does not have professional expertise in health, nor does it seek to make policy decisions on health issues, although there are occasions when decisions on funding and resource allocations involve consideration of health policy aspects."

Neither the Department of Aboriginal Affairs nor the Commonwealth Department of Community Services and Health have a direct role in the provision of health care services to Aboriginal people. This service provision lies with the community controlled Aboriginal health services and the general Australian health care system which is administered by the State and Territory Governments.

Both the Departments of Aboriginal Affairs and Community Services and Health meet regularly to discuss policy, project and program development, and evaluation. An Inter-departmental Working Group (IDWG) has brought together the Commonwealth Departments of Aboriginal Affairs, Community Services and Health, Finance, Prime Minister and Cabinet and the National Aboriginal and Islander Health Organisation. However, this IDWG has not functioned during the life of this Working Party.

WA and Qld are now the only two States in receipt of State Grants (Health) funding from DAA.

3.4.1 Grants to the States

The Department of Aboriginal Affairs also administers grants under the States Grants (Aboriginal Assistance) Act 1976, in accordance with Section 96 of the Commonwealth Constitution.

The States Grants program and the Grants in Aid program also fund primary health care provision in Western Australia, N.T., and Queensland through the respective State Health Departments.

3.4.2 Direct Grants to Aboriginal Organisations

DAA funding for Aboriginal health is also provided by Grants in Aid to Aboriginal Health Services and for a community infrastructure program for the development, provision, and maintenance of essential community facilities and services, such as sewerage and water.

In 1987/88 more than $40 million was provided under the health service function as grants to Aboriginal health and rehabilitation services and as grants to State Departments of Health. A further $45 million was provided to Aboriginal organisations for the development, provision, and maintenance of essential facilities and services such as water and sewerage.

The Department has considerable influence over primary health care provision by virtue of its powers to determine the funding of some 64 Aboriginal community controlled health services.

3.5 THE ROLE OF THE ABORIGINAL DEVELOPMENT COMMISSION

The Commission seeks to advance the economic and social well-being of Aboriginal people by:

- assisting communities and groups of Aborigines to acquire land;
- assisting Aborigines to engage in business enterprise; and
- assisting Aborigines to obtain finance for housing, and to provide such finance.

The most important of these functions as far as health is concerned is undoubtedly the provision of adequate housing for Aboriginal people.

This has been a major priority of ADC funding for a number of years.

Grants are provided to some 400 Aboriginal housing organisations to plan, build, buy and administer low-rental housing for Aborigines and low-interest repayable loans to individuals wishing are provided for purchase their own homes.

Other Commission activities which can be considered to have a health impact include the purchase and support of large community based enterprises, often pastoral properties, but just as often community stores. This is an important factor in ensuring Aboriginal communities in isolated areas can have access to a better diet.

It has also provided funds in a more direct way for the purchase of buildings which accommodate community centres and often health facilities.

Similarly, the Commission's activities in the Torres Strait Islands is expected to make a significant impact on the social fabric of the Islanders, especially where it has enabled some Islanders better access to fresh water supplies and fresh foods.

3.6 THE ROLE OF ABORIGINAL HOSTELS LTD

Aboriginal Hostels provide temporary hostel accommodation to meet the varied needs of Aboriginals who are in employment, training and education are aged; supporting and expecting mothers; transients and fringe-dwellers; who might be undergoing alcohol rehabilitation programs; and who might require accommodation while receiving outpatient treatment or convalescing after medical treatment.

In addition to operating its own hostels, Aboriginal Hostels funds approved organisations to run hostels under the Third Party Hostel Grants Program.

3.7 THE ROLE OF THE DEPARTMENT OF COMMUNITY SERVICES & HEALTH

The Department of Community Services and Health has a number of specific programs designed to assist Aboriginal people and these are discussed briefly below. DCS&H also seeks to encourage Aboriginals to make greater use of its wide range of mainstream programs by employing Aboriginal liaison officers in an endeavour to make services more accessible. Brief details of these programs can be found in Appendix II. Total funding by DCS&H on specific Aboriginal programs in 1987/88 was $82.272 million. See Appendix III.

These programs include housing and supported accommodation, hospital and residential services, community programs, children's services programs, disability programs, and emergency relief and specific assistance with transport costs for people seeking health and specialist medical services.

3.7.1 Rental Housing for Aboriginals Program

The Rental Housing for Aboriginals Program is a Commonwealth funded program under the Commonwealth/State Housing Agreement.

Many Aboriginals do not apply for assistance under the program but apply under mainstream public housing programs because the acquisition component of this program cannot keep pace with the need for rental housing.

The latest survey (September 1987) of housing needs by the ADC and DAA indicates a need for an additional 16,179 dwellings with an estimated cost of $1.274 billion. The current RHAP funds are only $70 million.

3.7.2 Supported Accommodation Assistance Program

This is a joint Commonwealth and State/Territory program in which grants are made to non-profit organisations, local government authorities, and charitable trusts to provide accommodation and related support services for homeless people.

Services which are operated by Aboriginal organisations or which have predominantly Aboriginal clients received a total of $4.6 million in 1986/87 from both Commonwealth and State sources.

Research is currently being conducted into the relevance of SAAP to remote Aboriginal communities.

3.7.3 Hospital and Residential Programs

The Aged and Disabled Persons' Homes Act allows for the establishment of government sponsored Aboriginal facilities and up to 100% capital funding for Aboriginal projects and other disadvantaged groups.

There are now nine hostels and three nursing homes (total 251 places) specifically set aside for Aborigines. Sixteen projects are under development making available an extra 247 places.

Expenditure in 1987/88 was $12.73 million, of which $1.611 million was for recurrent funding.

3.7.4 Childrens's Services Program

Several types of services are provided through this program:

- multifunctional Aboriginal Children's Services;
- Aboriginal Playgroups;
- Aboriginal After-School Care;
- Aboriginal Vacation Care; and
- Aboriginal Children's Services Workers.

Funds are provided to State, Territory, or Local Government authorities, and to non-profit organisations.

The program funds eleven Aboriginal child care agencies and the Secretariat of National Aboriginal and Islander Child Care.

Managerial development for Aboriginals is identified as an important subsidiary goal.

Expenditure in 1987/88 was $7.3 million, of which $5.6 million was for recurrent project funding.

3.7.5 Commonwealth Rehabilitation Service (CRS)

Currently the CRS has around 320 Aboriginal clients, 3% of its total workload. The level of disability in Aboriginal communities is not known.

The CRS is seeking to improve its services by the development of outreach centres in the NT, improved liaison between the CRS and AHS, and the employment of Aboriginal Rehabilitation Officers.

3.8 THE ROLE OF THE DEPARTMENT OF EMPLOYMENT, EDUCATION AND TRAINING

The major source of funding for training health workers and other health para professionals is through the Aboriginal education and training function in the Department of Employment, Education and Training (DEET).

DEET provides funding in a number of States for a number of health-related courses for Aboriginal people through the specific provisions of AUSTUDY and through its AEDP program. These range from Aboriginal health worker training in Aboriginal medical services to funding an enclave for Aboriginal medical students in Newcastle.

While recognising that training arrangements may be appropriate in individual States, it is clear to the Working Party, from consultations and submissions, that there is no coherent national approach to training requirements.

The Miller report of the Committee of Review of Aboriginal Employment and Training programs, which is the most comprehensive report on Aboriginal employment and training needs, made no specific mention of its impact on improving health.

This is a significant demonstration of the lack of a co-ordinated approach to the better development of Aboriginal health worker and para professional training.

3.9 AUSTRALIAN CONSTRUCTION SERVICES

Australian Construction Services (ACS) is the Government's contract works authority carrying overall responsibility for the Commonwealth construction and maintenance program. ACS aims for provide a 'one step' shop for the full range of construction services. ACS provides a service to Aboriginal communities and government agencies such as DAA and ADC with specialist technical, design, and construction advice in the fields of housing, water and sewerage services.

3.10 HEALTH INSURANCE COMMISSION (HIC)

The 64 Aboriginal Health Services often fund part of their operations through the payment of benefits by the HIC to these services under the bulk-billing provisions of Medicare. The use of direct billing under Medicare as a source of funding for Aboriginal Medical Services is a dilemma for policy makers and services alike. Under HIC guidelines, Medicare benefits are not payable for services provided by nurses or paramedics such as Aboriginal Health Workers, health screening services and health education services, yet these are often critical elements of programs run by Aboriginal health services.

3.11 THE ROYAL FLYING DOCTOR SERVICE (RFDS)

All States and the Northern Territory use the RFDS as an important part of health services to remote communities. The RFDS provides regular fortnightly or monthly visiting clinic services to isolated communities and is often the only means of evacuating patients in emergencies.

The RFDS is funded by Commonwealth and State grants in addition to private fund-raising.

3.12 NEW SOUTH WALES

In 1988/89, $5.19 million was allocated to Aboriginal health in this State in addition to what is spent on Aboriginal health through mainstream services such as hospitals. Of these funds:

- $2 million is provided for Enhancement Programs, e.g., drug and alcohol workers, dental vans, public health workers; and
- $3.19 million is for employment of some 117 Aboriginal health staff throughout NSW and costs of programs conducted by those staff, e.g., women's/children's health, diabetes, elderly people's health.

An Aboriginal Health Unit in the Department of Health is responsible for Aboriginal health policy in NSW and provision of advice and assistance to Departmental staff. The Unit also conducts and co-ordinates specific programs, e.g. Drug and Alcohol Free Day Campaign.

An important feature of Aboriginal health policy and program development in NSW is the Aboriginal Health Resources Committee (AHRC), comprising the Aboriginal medical services and the Aboriginal Health Unit. This Committee (which is jointly funded by the State and the Commonwealth) meets quarterly to discuss programs, prioritise services, and advise the State and Commonwealth Governments on issues concerning Aboriginal health and related matters. The AHRC is also funded to undertake specific projects.

All DAA funding for Aboriginal health in NSW is provided as direct grants to community organisations. The State Government makes available additional funding for specific programs in existing community-controlled health services.

The State also contributes directly, and indirectly, to improvements in health, such as housing and infrastructure. The Housing on Aboriginal Land Program (HOAL) is a State initiative which, through the State Housing Department, will see the construction of 300 houses on Aboriginal land over a two-year period. A budget allocation has not yet been determined for this program.

The HOAL Program also includes road works, water supply, and other sources where these are necessary to service the additional houses.

The State Government has also agreed to joint fund projects under the Commonwealth's Priority Communities Development Strategy. For 1989/90, the program will involve a major upgrading or provision of services and houses at Brewarrina. The State contribution is expected to be $1 million.

Under the Aboriginal Land Rights Act 1983 (NSW), the State also funds Land Councils. Land Councils increasingly have been contributing to costs associated with the provision and maintenance of infrastructure facilities such as water and sewerage.

Other Government agencies relevant to Aboriginal well-being are the NSW Office of Aboriginal Affairs, the Department of Public Works for Water and Sewerage, the Housing Commission of New South Wales, and the State Electricity Commission.

3.13 VICTORIA

The Department provides direct mainstream service delivery for Aboriginal people in the areas of hospital services, psychiatric services, children's health services, environmental health, drug and alcohol services, and health promotion.

It has overall responsibility for all health, community health centres, hospital, and associated services administered directly or supported financially by the State Government.

The Victorian Government retains a Koorie Health Unit within the Victorian Department of Health, which provided $1.17m in 1987/88 for Aboriginal health services.

The Department's Koorie Health Unit has two major objectives:

- the maximum involvement of the Aboriginal community in the formulation of health policy and the design and implementation of programs directed towards Aboriginal; and

- greater access to, familiarity with, and utilisation of the public health system by Aboriginal people in Victoria and the improvement of health care knowledge.

In the policy area, the Unit incorporates the views of Aboriginal communities through the Victorian Aboriginal Health Resources Consultative Group. This group is made up of Aboriginal community health services (five throughout Victoria, which are Commonwealth funded) and other Aboriginal community organisations wishing to develop health care programs. The Minister and the Department take advice from this group on the needs of Aboriginal people.

The Unit ensures that Aboriginal organisations are aware of program and support funds available from the Department and assists in the formulation of submissions and proposals for new Aboriginal program initiatives (e.g., in health promotion, audiology, and community health funding).

Specific Departmental programs for the Aboriginal community are:

- Women's and Children's Health Program

  $180,000 has been provided in 1988/89 to permit the employment of staff to work with Aboriginal co-operatives and communities on women's and children's health issues. A co-ordinator has been appointed and a program is being developed.

- Diabetes Education Program

  $15,000 has been provided in 1988/89 to provide education for patients and families about the prevention and management of diabetes. The annual diabetes camp, held since 1985, is a key element in the program.

- Hospital Liaison Program

  Eighteen Aboriginal Liaison Officers are employed in public hospitals throughout the State. They provide direct support to Aboriginal patients and their families and play a key role in making public hospitals accessible to Aboriginal people.

- Hepatitis B Program

  The Department is to supply vaccine for Aboriginal children under 5 years.

- Mental Health

  Two positions are provided for mental health workers attached to the VAHS and Mont Park Hospital complex.

- Health Promotion

  In 1987/88 an amount of $40,000 was provided for health promotion.

3.14 QUEENSLAND

The health services provided by the Queensland Government to Aboriginal citizens are provided through the Queensland Department of Health and the Department of Community Services and Ethnic Affairs (DCS&EA) which primarily serves Aboriginal people. The majority of services sought by Aboriginal people are within the mainstream and there is evidence that Aboriginal utilisation of such services is much greater than that of the general population.

It is impossible to estimate accurately the total expenditure by the Queensland Government on mainstream health services to Aboriginal people, who numbered over 61,000 at the last census.

In the 1987/88 financial year the Health Department and the Department of Community Services and Ethnic Affairs spent $15.05 million on curative services for Aborigines and Torres Strait Islanders living on Aboriginal communities and outer islands of the Torres Strait, a population of approximately 19,500.

This does not include expenditure on other services such as metropolitan hospitals or the extensive mainstream services of other Divisions of the Health Department, including School Health, Child Health, Specialised Health Services, Psychiatric Services, Alcohol and Drug Dependence Services, Community Medicine, or the Aboriginal Health Program.

For these 19,500 citizens the figure of $15.05 million may be a gross underestimate.

3.14.1 The Aboriginal Health Program (AHP)

The Aboriginal Health Program (AHP) commenced operations in 1972 and in the 1987/88 financial year the budget was over $5.07 million.

The purpose of the program has been to raise the health of Aborigines to a level equal to that of the rest of the community. The ideal is to assist Aboriginal people to attain a state of health characterised by the Alma Ata Declaration.

The Aboriginal community is consulted regularly, to identify needs and concerns, to seek advice on the appropriateness of programs, and to ensure that cultural factors are respected. This consultation occurs in the following ways:

- Aboriginal and Islander Community Councils and Aboriginal and Islander organisations are regularly consulted by Field Teams (Public Health Nurses and Health Assistants) whenever activities or recruitment is planned; and

- Regional Medical Officers and Regional Nursing Supervisors also consult community Councils and organisations directly.

The AHP seeks to maximise Aboriginal participation in service delivery and is in active contact with 53,517 of the 61,000 Aboriginal persons in Queensland.

The AHP actively promotes and conducts preventative health activities involving Aboriginal people and specially trained professional staff using a campaign approach as follows:

- surveillance of various health parameters, including voluntary screening to detect undiagnosed illness, targetting specific conditions known to be of high prevalence in Aboriginal communities, and arranging treatment and follow-up where necessary;
- co-ordinating public health activities, involving infectious disease prevention and control;
- promotion of healthy lifestyles and healthy practices using a campaign approach;
- health education activities using the self-help health care model; and
- promoting utilisation of existing services (government, private, Aboriginal health services).

Aboriginal staff (including Public Health Nurses, Field Officers and Health Assistants/Health Workers) advise non-Aboriginal staff about their communities and, where possible, deliver the services to their people.

3.14.2 Training of Aboriginal Health Workers (AHWs)

The AHP has always placed a high priority on training of its Health Workers and Health Assistants.

In-service training courses in the AHP, providing a Certificate of Competence, is awarded to those staff who achieve a defined standard. Negotiations have begun with a CAE and with a TAFE college in order to develop mutually acceptable curricula and criteria for Health Worker Certificate and Associate Diploma courses, and the CAE concerned is currently reviewing AHP training courses with a view to accreditation.

In addition, the AHP will continue to develop the Distance Education model for Health Assistant training, and some or all of such subjects/modules may qualify staff for exemptions at a tertiary level.

3.14.3 Other Activities and Programs Included in AHP

Support and assistance is also provided to:

- Trachoma Programs;
- Aboriginal and Islander Health Services;
- SCAN Teams;
- Speech Therapists;
- Rehabilitation Programs;
- Alcohol and Drug Dependence Services; and
- Hospitals and agencies requiring assistance with communications and follow-up.

Further details are provided in Appendix IV.

3.14.4 The Aboriginal and Islander Health Advisory Council

In 1982 the State Government responded to calls for greater community participation in Aboriginal health services by the creation of the Aboriginal and Islander Health Advisory Council (AIHAC). By providing this forum, Aboriginal people in Queensland have the opportunity to provide advice to the Minister through a process beyond any bureaucratic influence.

Members of the AIHAC are all Aboriginal people who are appointed annually to the Council by the Minister for Health. Invitations to sit upon the Council have been extended to a wide range of people including members of the Aboriginal Co-ordinating Council, members of Islands Co-ordinating Council representatives of Aboriginal community controlled health services, staff of the Aboriginal Health Program, Aboriginal Hospital Liaison Officers, and general members of the Aboriginal communities.

3.15 WESTERN AUSTRALIA

The State Department of Health is responsible for Aboriginal health policy and programming in Western Australia.

In 1987/88, $67.9 million was spent on health services for Aboriginal people including all mainstream hospital services, nursing home care, itinerant health care, and Royal Flying Doctor services.

The Health Department believes there is currently an unacceptably low health status of Aboriginal people and is committed to redressing the imbalance in the mortality and morbidity rates between Aborigines and non-Aborigines.

Because of the nature of the many socio-cultural, physical, and psychological factors which have been identified as contributing to the present situation the Department's health program for Aborigines includes a strong commitment to:

- Aboriginal self-determination;
- Aboriginal participation in the development and implementation of services which affect them;
- promoting Aboriginal self-esteem;
- providing modern diagnosis, treatment, rehabilitation, and health promotion/education services to all Aboriginals at a level which is equal to that available to the rest of the population; and
- following an intersectoral approach in dealing with Aboriginal health problems.

The Department proposes to establish an Aboriginal health unit and is undertaking a review of its Aboriginal Health Education section.

It also provides $3.65 million for a number of specific programs directed towards Aborigines, including:

- the employment of Aboriginal Liaison Officers at hospitals in the Kimberley and at Port Hedland;
- a health inspection service at a cost of $103,000 in 1987/88. This service provides an Environmental Health program for Aboriginal communities in the Kimberley, a Regional Health Surveyor at Derby, and an Aboriginal Environmental Health Worker at Broome. These officers also assist in providing the Environmental Health Worker Training Program in the Pilbara;
- various health promotion and education services for Aborigines which covers subjects such as immunisation, alcohol and drug abuse, and HIV/AIDS; and
- the training of Aboriginal Health Workers under a joint Commonwealth/State funded program which cost the Commonwealth $346,500 and the State $180,000 in 1987/88 to train almost 800 staff.

Other State Government authorities which have an impact on Aboriginal health services are the Aboriginal Affairs Planning Authority, Alcohol and Drug Authority, Building Management Authority, Department of Community Services, State Energy Commission, Homeswest, Water Authority, and, at the local level, Shire Health Surveyors.

3.16 SOUTH AUSTRALIA

The South Australian Health Commission's legislation includes provision for an Aboriginal Health Organisation. In 1987/88, the South Australian Government directly expended $2 million on Aboriginal health services provided by the Aboriginal Health Organisation, the Pika Wiya, Ceduna/Koonibba and Nganampa Health Services.

The broad objectives of the Aboriginal Health Organisation acknowledge "the unacceptably poor health status of Aboriginal people" and endorses the WHO principles proclaimed at Alma Ata as the basis of change.

The Aboriginal Health Organisation seeks to:

- develop systems of appropriate primary and preventative health care for the Aboriginal people of South Australia; and

- facilitate the implementation of these systems to provide access for all Aboriginal people.

The Aboriginal Health Organisation conducts, through TAFE, accredited Aboriginal Alcohol Worker and Health Worker in-Service training. This is jointly funded by the South Australian Health Commission and the Department of Aboriginal Affairs.

Community based programs designed to improve Aboriginal health, conducted by AHO, include AIDS, STD, Women's health involving ante-natal care and family planning, and renal surveying and follow-up. Aboriginal hospital liaison workers are also provided in some areas to provide a cross-cultural link between Aboriginal clients and the mainstream health care system.

Currently, there is a Combined Aboriginal Health Services forum, convened by the Aboriginal Health Organisation, and it is expected to form the basis of an Aboriginal Health Council.

It was proposed in the May 1988 SA Aboriginal Health Review to establish an Aboriginal Health Co-ordinating Unit in the South Australian Health Commission, which will include policy development, research, and liaison within and outside the Commission. Where community controlled services are non-existent, the South Australian Aboriginal health plan suggests the establishment of local Aboriginal health committees.

The Aboriginal Works Unit within the Department of Housing and Construction carries the responsibility of organising and co-ordinating essential services such as water, sewerage, electricity, and land servicing for Aboriginal communities in South Australia.

The Aboriginal Housing Board works closely with the Housing Trust of South Australia in the provision of housing for Aborigines in South Australia.

3.17 TASMANIA

The Tasmanian Government's health policy is that mainstream services ought to be able to provide health services for Aboriginal people. Where these services, or access to them, are deficient, a liaison/advocacy model should be developed. The exception is Cape Barron Island, where mainstream services are not available and a nursing service has been established for the Aboriginal community. This service also provides health care for the 12 or so non-Aboriginals living on Cape Barron Island.

Funding of this service is shared between the Commonwealth, through a Department of Aboriginal Affairs States Grant of $44,000, and the Department of Health Services' provision of $30,000.

3.18 NORTHERN TERRITORY

The Northern Territory Department of Health and Community Services is responsible for Aboriginal health in the Northern Territory in addition to those community based health services that are funded by the Commonwealth. Primary health care as defined by the World Health Organisation at Alma Ata is accepted by the NT Government as its approach to Aboriginal health care.

Approximately a quarter of the Northern Territory population is Aboriginal. However, it is estimated that just under half of the 1987/88 budget of $194m of the Department of Health and Community Services is allocated to Aboriginal health related activities.

The Department is also responsible for medical evacuations from most Aboriginal communities and provides regular visits by doctors to communities which do not employ their own doctors.

The Aboriginal Health Branch aims to ensure that Aboriginal people have access to primary, secondary, and tertiary health care and to increase their active participation in all aspects of the health care systems.

Specific Aboriginal Health programs include:

- Aboriginal Ear Health Program;
- Trachoma Program;

- Under 5's Health Program;
- Women's Health Program;
- Aboriginal Health Promotion Program;
- Nutritional Surveillance Program; and
- Dental Health Program.

Additionally, Aboriginal people make significant use of mainstream health services in the Northern Territory.

The Northern Territory Government's submission to the Working Party gives emphasis to self-management with two approaches operating in the N.T., namely Grants-in-Aid to community councils and Aboriginal health worker management of local health services.

The Northern Territory Department of Health and Community Services has an Aboriginal Health Branch which develops policy and monitors the implementation of various programs relating to Aboriginal health.

The Department employs 290 health workers, funds the entire health worker training program and funds all health clinics, facilities, and supplies of medicines in those communities that are not operating under the Grants-in-Aid program.

In addition, the Northern Territory Health Promotion branch includes an Aboriginal Health Promotion Section.

The Department is currently undertaking a reassessment of its policies for Aboriginal health in the Territory.

3.18.1 Grants-In-Aid to Community Councils

In 1987/88, $2.6 million was provided by way of Grants-in-Aid for Aboriginal health projects. The Northern Territory Department of Health and Community Services also provides professional advice and support to these communities and evaluates these health services annually.

3.18.2 Aboriginal Health Workers

The Northern Territory Government has a major commitment to the training and employment of Aboriginal Health Workers.

The Northern Territory Health and Allied Professionals Registration Act (1985) recognises Aboriginal health workers as a professional group. In accordance with the Act the Aboriginal Health Worker Registration Board of the Northern

Territory was established in 1986. Under the requirements of the Act, Aboriginal health workers must be currently registered in order to practice. The new structure now incorporates wages and conditions under a NT industrial award which comprises five levels for Aboriginal health workers including, more senior positions in administration, supervision, education, and practice.

Training courses are conducted through three regional training centres at Alice Springs, Katherine, and Nhulunbuy. Following recruitment, trainee health workers are enrolled in a "Basic Skills Training" course which must be completed before the health worker becomes qualified and is eligible to apply for registration with the Aboriginal Health Workers Registration Board of the Northern Territory.

Elements of traditional culture are incorporated into the health service for Aboriginal people because:

> "the NT Aboriginal Health Worker training program emphasises a bi-cultural approach where the best elements of both cultures are incorporated into health service".

The training program is currently being revised.

It is proposed to expand the curriculum and develop an undergraduate education course which should lead to a widely recognised, accredited qualification. This will prepare Aboriginal Health Workers for higher education studies (Associate Diploma) in courses specifically relevant to Aboriginal primary health care.

In 1979 the House of Representatives Standing Committee on Aboriginal Affairs stated in a report on Aboriginal health that

> "the Aboriginal Health Worker Training Program developed in the Northern Territory should be a model upon which the state training programs are based".

State utilities providing essential services for Aboriginal people in the Northern Territory are:

- the Power and Water Authority for sewerage, water and power;
- the Department of Transport and Works for road, airstrips drainage, barge landings, and public toilets;
- the Department of Lands and Housing for town and land development and housing.

3.19 AUSTRALIAN CAPITAL TERRITORY

Aboriginal people in Canberra are primarily serviced by mainstream health services provided by the Australian Capital Territory Community and Health Service.

The Aboriginal community at Wreck Bay on the South Coast is also part of the Australian Capital Territory and the Australian Capital Territory Community and Health Service provides a registered nurse which services the community.

Canberra and the surrounding region are also serviced by a part time community based Aboriginal medical service. The demand is being monitored to assess the need for greater resourcing.

CHAPTER 4

HEALTH SYSTEMS INFRASTRUCTURE

4.1. INTRODUCTION

All available indicators demonstrate the gravity of Aboriginal health needs. Efforts to address the "national calamity" have hitherto been inadequately resourced, lacking in co-ordination, penalised by politics, dominated by the medical model and generally inhibited by the broader community's lack lustre concern for Aboriginal health.

For many years Aboriginal communities were, and in many cases are still expected, to tolerate third rate, peripheral health services which are premised on common but inadequate and inaccurate perceptions of Aboriginal health need, culture and aspirations.

The domination of Aboriginal health care by the medical model approach fitted well with other assimilationist policies of the period. In general, Aboriginal health programs and activity were awkward appendages to the existing system and its institutions.

Early policies of "mainstreaming" were predicated on the belief that the existing health system, the services it provided and the personnel who staffed it were equipped and capable of meeting the overwhelming challenge of Aboriginal health need.

While the system progressively conceded the employment of "Aboriginal advisors", thereby hoping to accommodate those attributes of Aboriginal cultural and social acceptance necessary to suggest validity and appropriateness of services. Much of what was done provided little more than "band aid" curative services. There was no coherent attempt to systematically establish, beyond the acceptance of the lack of proper public health facilities and the lack of personal hygiene practices by the Aboriginal people, the range and extent of Aboriginal ill-health or the causes of it.

Not surprisingly, it was in part the continuing inability of this system to meet Aboriginal needs and expectations that contributed to the evolution of community controlled Aboriginal medical services, in 1971. These community services were intended to provide innovative clinical and health development services where cultural imperatives, social realities and technical necessities are taken into balanced account.

Substantial differences in approach, content and Aboriginal participation are easily recognised between the operations in the public sector and the Aboriginal health services. These differences were evident in many submissions to the Working Party and during the community consultations. A submission from the South Australian Health Commission stated that difficulties and inadequacies have arisen because of the system's

> "failure to recognise and adequately address the very fundamental differences in the belief system on which concepts of health and illness are based in Aboriginal and western cultures."

Submissions from communities strongly echoed this view. Problems arising from the variation in the political and philosophical approach to Aboriginal development issues between the Commonwealth, State and Territory governments and between Aboriginal communities and governments per se have further inhibited the reconciliation of cultural imperatives within the general health service delivery structures.

The Working Party is of the view that these factors have contributed to the uneven and largely ad hoc development of mechanisms for the promotion of, and programs in, Aboriginal health and wellbeing over the last 30 years.

The Working Party has concluded that a national strategy must closely examine structural and service delivery aspects of Aboriginal health need with a view to achieving a re-orientation of the health system as a whole. This re-orientation must redress the identified deficiencies, and facilitate the establishment and operation of a planned and responsive national Aboriginal health process.

4.2 SERVICE AND INFRASTRUCTURE - WHAT IS THE RELATIONSHIP?

The successful delivery of services, at all levels of the health care system, depends on a co-ordinated integration of a number of key components. While these components are more often than not once removed from the personal interface they are nevertheless essential components of a wholistic system and approach to health based on the provision of primary health care. In any national Aboriginal health strategy, attention to the structure or nature of the system in which services are provided is essential.

An important element of any strategy must be the outcome of the inter relationship and the interdependence of the various components of the health system, so that strategic and fundamental decisions can be made that will maximise improvement to Aboriginal health and wellbeing.

One paper presented to the Working Party described the process thus:

- identify the key components in the system required to deliver health care programs at the various levels;
- define the functions of these components;
- specify the activities and institutions required to deliver health care programs; and
- indicate the necessary interaction between activities and communities at each level.

The W.H.O. Health for All program suggests that central planning structures and processes should aim to enable communities to plan and deliver their own primary health care initiatives. Consequently re-orientation of the health system, if it is to redress historic shortcomings, must move to incorporate progressive socio-economic and socio-political elements which are culturally sound, comprehensive and in which the Aboriginal communities have confidence.

In a practical sense community participation and control is seen by most as the principal vehicle for achieving this.

The Working Party endorses this view.

4.3 KEY INFRASTRUCTURAL COMPONENTS IN THE HEALTH SYSTEM AND THEIR ROLE

In an elementary examination of the infrastructure of the health care system three major components are evident. These are:

- health resources;
- arrangement of resources and management;
- economic support;

Having identified the essential components it is necessary to consider their roles.

4.3.1 Health Resources

A broad range of human and physical resources are necessary to support the delivery of services. Four principle groupings have been identified:

- Health Workforce encompasses the many and varied categories of personnel involved in the delivery of health services.

  "Each personnel category must be understood in terms of its legitimate functions and related tasks, types of training, number and distribution, relationship within other health personnel and other attributed such as possible substitutability".

- Health Facilities are the actual facilities, buildings and plant that comprise the physical structure of the system ie, hospitals, community health centres, first aid posts, ambulance facilities, surgeries, laboratories and pharmacies. Also included in this group are other facilities, generally described as essential services such as waste disposal, safe water supplies and sewerage disposal systems.

- Health Equipment and Supplies includes the extensive range of equipment, drugs and other medical consumables needed for the system to fulfill its functions. This includes other equipment which is necessary but not strictly medical e.g. transport.

- Health Knowledge is the exchange of experience and understanding of health and disease, and of the various disease prevention, treatment and rehabilitation process. It includes technical data such as statistics and other "scientific" information and qualitative health information.

4.3.2 Arrangement of Resources and Management

Resources should be organised so that they satisfy basic needs. The different elements and resources in health systems must be organised so that they function in an appropriate manner, promoting maximum co-operation, and achieving maximum contribution towards agreed goals.

4.3.3 Economic Support

Every health system is in need of additional resources over and above income generated through the user pays approach. Many of the services within the health sector are specialised, are often of limited availability and may be very expensive.

Several possible sources of economic support exist, not all however are applicable to Aboriginal health development.

Whatever the combination the overall amount provided must be adequate to finance the implementation and evaluation of the designed programs and the system as a whole.

Outside the health sector, programs that are health related, such as housing projects and the provision of an adequate waste disposal systems require support which comes predominately from the public sector.

4.4 CURRENT STATE OF HEALTH RESOURCES

Having identified the elements of health resources and their function with the health infrastructure it is now necessary to comment upon the adequacy of the resources in relation to the services that they are to provide.

4.4.1 Health Workforce

The people who provide the service providers are arguably the most important elements of any health care system. They not only provide the technical service or treatment but the manner in which it is provided impacts upon clients and largely determines the clients attitudes to seeking and receiving treatment or other services, e.g., counselling, nutrition, from the primary care providers.

For many Aboriginal people, and perhaps for most, Aboriginal health services are seen as the major providers of primary health care where such services are available. In situations where there are no Aboriginal health services, Aboriginal people use the general community's primary health care, or mainstream facilities.

While it is important to recognise the role each of these types of organisations play, it should be realised that many Aboriginal people do not feel comfortable using such services because of staff attitudes and lack of appreciation of cultural differences. They often delay seeking assistance until their condition becomes acute. Under these circumstances the medical treatment they require is generally more extensive than would otherwise have been the case.

4.4.2 Health Facilities

The provision of properly designed and equipped health facilities is probably the second major determinant in the type and quality of health care provided.

While the physical facilities of the general practitioners, the community health clinics and most public hospitals have been built to meet specific purposes this is not the case for the vast majority of Aboriginal health services. Most of the Aboriginal health services are operating out of rented buildings which are seriously inadequate, in terms of the functions they are required to serve. As well, the premises are often rented and this fact discourages expenditure on improvements which would allow for more efficient operations.

The Working Party believes that the health services should be funded to purchase appropriately designed buildings which meet the needs of their clients and the staff of the services. The buildings should be located conveniently to the client population and offer ready access to public transport, parking and other facilities. The Working Party also supports the concept of developing minimum design standards for all future Aboriginal Health Service building requirements.

A number of very specific and necessary needs were identified by various organisations.

These include:

- adequate space for proper service provision;
- maximum use of natural light and proper ventilation;
- adequate numbers and types of ablutions within the building;
- refrigerators for drugs;
- availability of kitchens;
- non-threatening waiting rooms, corridors and consulting room layouts;
- areas for health education programs antenatal classes, group support etc;
- areas for children to play safely while parents receiving treatment or other services; and
- adequate staff amenities.

It was suggested also that consideration should be given for buildings to be easily expanded by at least 10% to allow for future expansion or change.

The Working Party recommends that:

- minimum standards be developed for existing and future primary level facilities, particularly Aboriginal community controlled health services;
- the Commonwealth and States establish a clear and uniform policy and program for the provision of funds to enable community Aboriginal Health Services to purchase suitable buildings and other community facilities; and
- in the interim $23 million be provided over the next 3 years for structural and other user oriented improvements in the existing primary level facilities of health services.

4.4.3 Health Equipment and Supplies

The requirement for medical equipment and supplies is closely allied to the physical structures necessary to house the providers of health care. Again, mainstream community services are usually well furnished with modern equipment. The need to seek funds to purchase medical consumables, especially drugs, is generally minimal in these services as they are either paid for by the Government or by patients as part of the user pays principle which operates in private practice.

In contrast, the Aboriginal health services operating from inadequate and poorly equipped buildings are often faced with the need to provide comprehensive primary health care with outdated equipment and inadequate supplies. It was suggested that in some instances the health services lacked even standard and basic equipment, the examples given were for nebulisors and glucometers.

In many remote and rural locations the paucity of essential equipment and supplies has meant that people in need of urgent services have either had to travel considerable distances or be evacuated often at the risk of suffering further bad health.

The Working Party believes that programs to ensure that essential equipment and supplies are readily available to Aboriginal health services will achieve greater cost and health efficiency than is presently the case.

Community consultations revealed that there is a growing concern with the cost and provision of essential drugs to clients. Many Aboriginal health services are greatly worried about the widening gap between the level of funds provided for this purpose and escalating costs.

Similarily, where clients obtain prescriptions from private practitioners at State hospitals the associated costs generally prohibit compliance with prescribed treatment or management. It seems from the number of times that these concerns were raised with the Working Party that the Government's safety net provisions for welfare recipients and other low income groups are not working in the Aboriginal community.

The Working Party is aware of the poor level and condition of equipment in many primary level services. Many existing Aboriginal health services referred to the difficulties created in service delivery as a result of an acute lack of capital to replace, expand or substitute existing equipment for more appropriate technology.

The Working Party is aware that the National Aboriginal and Islander Health Organisation is presently reviewing both recommended equipment and essential drug lists and that once completed it may be appropriate to incorporate this into the broad funding approach.

4.4.4 Health Knowledge

Governments and Aboriginal communities have discussed for many years the establishment of appropriate data and information networks at national, State and Territory and community levels. An Interdepartmental Working Group operated for a number of years with a view to improving government data and information collection.

However, community level information and data collection, and interpretation capacities have been largely overlooked. The Working Party believes this has inhibited health improvement.

Up to 17 years of valid, accurate and largely reliable data and information exists in the various primary level Aboriginal health services. This vast resource remains largely untapped because of lack of resources, both personnel and equipment, as well as broad based community suspicions about the reasons for collecting information and data. A general ignorance on the part of federal sector agencies as to the proper collection, and interpretation of information sources has also ensured that this information and data remains largely untapped.

The Working Party is of the view that the establishment of appropriate mechanisms for and negotiated access to information and data in appropriate organisations would assist in the achievement of the goals of the National Strategy. This issue is discussed further in Chapter 12.

Consideration also needs to be given to what measures can be developed to allow for a greater exchange of information in between the various professional and para professional groups involved in Aboriginal health.

4.5 CURRENT ARRANGEMENT OF RESOURCES AND MANAGEMENT

At present, resources devoted to Aboriginal health are divided in 3 broad categories:

- services available from general community health program;
- services available through identified public sector Aboriginal health initiatives; and
- services provided through Aboriginal health services.

The management of these resources is dictated by the underlying philosophical approach to the provision of the services. In practical terms this means that resources are organised either according to:

- the profit motive e.g., private practice;
- community/public sector bias which may include some profit motivation, and a level of state direction. The latter can be coupled with some degree of community participation and control; or
- community participation and control.

Governments and communities should be clear on divisions of responsibilities, financial obligations and other aspects of the health system operation at all levels and recognise that "the degree of formality of organisational arrangements and relationship will vary". However, failure to establish key co-ordination, development and monitoring mechanisms will only result in continued to be ad hoc and largely inappropriate planning for Aboriginal Health Services.

While there is a lack of sufficient hard evidence the Working Party believes that the Aboriginal controlled Aboriginal health services have made a sinificant contribution to the improvement in the health status of Aboriginal people. It was impressed on the Working Party members during the consultation process that the existence of such services resulted in Aboriginal people actively seeking medical assistance before the conditions became acute. Similarly, anecdotal evidence was presented to demonstrate the effect that easy access has had in improving the health status with communities. A case in point in the operation of Pika Wiya health service in Port Augusta which seems to have had a major effect on hospitalisation rates and the length of stays of Aboriginal people in the local hospital.

The Working Party is also convinced that if the clinical records of the Aboriginal health services could be properly analysed they would support the claims of the services that they make a significant contribution to improving the health status of their communities.

The Working Party believes that the community controlled health services provide an attractive alternative primary health care facility for most Aboriginal people.

It was also obvious from the may requests made of Working Party members for their support in obtaining a local health service that many communities saw them not only as a viable alternative but in many cases as essential. Appendix V lists the areas in which the communities requested the provision of a local service. Subject to each area being able to demonstrate the viability to provide an economic and efficient health service the Working Party recommends that:

- there be a significant increase in the number of Aboriginal health services; and

- priority in funding new services be given to the more remote and isolated areas.

At present there is no co-ordinated national approach to health planning and even within States and Territories it seems that the development of health programs or initiatives owes as much to good luck as to good organisation. While programs and initiatives can be agreed at a national level the actual implementation and control should remain at the local level if the potential for change is to be maximised.

Issues which affect staff performance, such as conditions of employment, are vitally important for Aboriginal health services (and State or Territory clinical services) which have to compete in the market place for appropriately qualified staff. Good conditions and remuneration not only attract staff but are an important element in retaining staff and hereby reducing staff turnover.

The availability of adequate financial resources to pay a suitable salary to Health Workers in the clinics servicing Aboriginal communities has not been readily available. The amounts paid to these professional staff is not sufficient incentive to attract new staff nor in some cases adequate to retain existing staff.

The financial remuneration available for private practitioners and the salary package provided by private hospitals and health clinics cannot be matched by Government or Aboriginal controlled health services.

Aboriginal health services, particularly those in remote locations, experience considerable difficulty in attracting and retaining suitably qualified and experienced medical and nursing staff.

Apart from the inadequacy of the salary packages, often the living conditions on these communities are such that few but the very dedicated would consider accepting them. The housing is often of a poor standard, the cost of living is excessively expensive and little or no recreational facilities are available. There is often little to attract married staff especially those with children as educational facilities are below the standard they would enjoy in their major centres. Social as well as physical isolation has to be endured.

Other aspects which are considered essential and need further consideration include:

- sufficient financial support to enable the service providers the ability to recruit, train and retain the staff necessary to provide an adequate service,

- adequate financial support to acquire the essential capital equipment eg, medical equipment, housing for staff, hospitals, clinics, motor vehicles, training and administrative machinery necessary to maintain an ongoing service; and

- revision of the community infrastructure to ensure that the medical facility is an integral part of the community and that the community supports the facility.

In order to rectify this situation a dramatic restructuring of the salary and remuneration package able to be offered by these services needs to be implemented.

New industrial agreements have recently been negotiated between the unions and Aboriginal health services in Western Australia and the Northern Territory. The VAHS is currently engaged in negotiations in the State Conciliation Commission for a new salary structure for its professional and para professional staff.

The situation is not just one involving doctors, dentists and registered nurses. It goes much further.

The consultations undertaken by the Working Party clearly established the desire by health providers, especially those who receive less remuneration e.g., Health Workers, enrolled nurses, field workers, alcohol counsellors, for a uniform salary structure, negotiated entitlements and a superannuation scheme that would provide an incentive to remain in the system of health care delivery.

All Aboriginal Health Workers consider their role is an important one but, except for the NT, there is no structured scheme that enables them to advance to positions of authority or recognise clincial expertise.

The development of educational programs designed to enable training to be undertaking whilst on the job, with a minimum time away from their homes and communities is considered by many to be essential. Currently the majority of training facilities require trainees to be absent for lengthy periods from their families and from their communities. A system of on-the-job training needs to be implemented as the majority of Aboriginal health workers in the more remote communities do not adapt to lengthy periods away from their home environment and their families.

In order to bring about the changes necessary to implement an efficient and effective health service to Aboriginals throughout Australia there is a need for Commonwealth/State and Territory governments to dramatically increase the funding provided for Aboriginal health.

The following example highlights the magnitude of the additional funds necessary.

The Victorian Aboriginal Health Service at Fitzroy in metropolitan Melbourne currently employs the following staff at the indicated salary structure funded by the Commonwealth Department of Aboriginal Affairs.

CURRENT SALARIES

DESCRIPTION	QTY	AMOUNT
ACCOUNTANT	1	31 736
ADMINISTRATOR	1	30 095
BOOKKEEPER	1	24 025
CLEANER	1	17 631
CLERICAL ASSISTANT	1	16 231
CLERK (PUBLIC RELATIONS OFFICER)	1	19 658
DRIVER	1	16 231
FIELD OFFICER	2	32 452
GARDNER/HANDYMAN	1	17 282
HEALTH WORKER	6	103 692
MEDICAL PRACTITION	1	53 162
MEDICAL PRACTITION	2	94 952
MEDICAL PRACTITION	1	23 738
NURSE - ENROLLED/ NURSING AIDE	2	34 564
NURSE - REGISTERED	1	21 396
RECEPTIONIST	1	16 231
SOCIAL WORKER	1	23 386
OFFICE MANAGER	1	24 025
OTHER RELIEF SALARY CATEGORY	1	27 579
WORKER'S COMPENSATION	1	5 800
LEAVE LOADING	1	8 427
LONG SERVICE LEAVE	1	6 417
Sub Total Salaries:		$648 710

Recent negotiations for an industrial award are likely to result in a consent agreement which will result in substantial increases in the salary levels of staff employed in the following positions :

DESCRIPTION	QTY	AMOUNT
NURSE - ENROLLED/ NURSING AIDE	2	46 854
NURSE - REGISTERED	1	21 396
RECEPTIONIST	1	23 427
SOCIAL WORKER	1	23 386
OFFICE MANAGER	1	24 025
OTHER RELIEF SALARY CATEGORY	1	27 579
WORKER'S COMPENSATION	1	5 800
LEAVE LOADING	1	8 427
LONG SERVICE LEAVE	1	6 417

CURRENT SALARIES

ACCOUNTANT	1	31 736
ADMINISTRATOR	1	30 095
BOOKKEEPER	1	24 025
CLEANER	1	23 427
CLERICAL ASSISTANT	1	23 427
CLERK (PUBLIC RELATIONS OFFICER	1	23 427
DRIVER	1	23 427
FIELD OFFICER	2	46 854
GARDENER/HANDYMAN	1	23 427
HEALTH WORKER	6	140 562
MEDICAL PRACTITION	1	54 476
MEDICAL PRACTITION	2	98 074
MEDICAL PRACTITION	.5	24 519
Total		754 787

The above table does not increase the cost of other salary related oncosts.

The net increase for this one service is in the order of $106,077 or an overall salary increase in the order of 16.35% If one was to extrapolate the increased cost of the total Aboriginal health service delivery based on the above percentage increase the net cost to funding authorities would be in the order of $4.385m.

An average 65% to 68% of recurrent expenditure is allocated to salaries.

The Working Party recommends that:

> appropriate awards and conditions be developed drawing on the contents and experience of the Northern Territory and Western Australian Aboriginal Health Awards, the VAHS Award, CAAC and Nganampa Awards and other proposed State and National Awards.

4.6 ECONOMIC SUPPORT

The manner and level of economic support is generally provided through the annual budgetry cycle. This has largely inhibited the proper growth of health improvement initiatives at the primary health care level. The lead time in most patterns of ill health stretch beyond the stop-start pattern of annual funding cycles.

4.6.1 Difficulties with Current Funding Arrangements

Both the Aboriginal Health Services and State Departments of Health, which receive funds from DAA, are extremely critical of the system of annual appropriation. Aside from the question of the adequacy of level of such funds the criticisms are of the stop-start nature which such funding arrangements engender and of the lack of ability to engage in any meaningful forward planning.

All of these issues need to be addressed and the Working Party has estimated that there is a requirement for a 10% increase in current funding levels just to redress the basic needs of adequate salaries, appropriate equipment, adequate medical supplies and to make minimal improvements to the buildings out of which the health services operate.

The provision of adequate buildings for all services, including any new services, would require a further increase in the funds provided for capital purposes. On the basis of providing a specific multi-purpose building as suggested in the proposal by the Pt Lincoln Aboriginal Organisation each service would require a minimum of $200,000 for construction costs, nett of any land costs.

It is obvious that, while an immediate 10% increase would rectify most, if not all, of the basic concerns of the services it would also provide a reasonable solution to meeting the requirements:

- to allow proper planning; and
- flexibility to deal effectively with changing priorities and emerging new issues.

Consultations have clearly indicated a wide spread dissatisfaction with the consistancy and reliability of the existing community level annual budgetry negotiations. It has been reported that often extraneous considerations influence these negotiations to the detriment of health improvement management efforts, and personal and political consideration.

For this reason the Working Party believes that in addition to a 3 to 5 year funding cycle, urgent action should be taken to design and implement a formula based funding strategy for primary level health care initiatives.

While there is an obvious need to reform the present funding arrangements the Working Party believes that it is necessary to properly investigate any new funding mechanism. To this end the Working Party supports the move to more fully explore the possibility of introducing some form of formula funding.

By its very nature formula funding offers a multiplicity of possible options and any investigation is unlikely to result in the recommendation of any single formula that would be applied Australia wide. Rather it is likely to result in a variety of formulae according to the particular circumstances of the individual communities.

Initially, any formulae that emerge may well become more complex as the various health factors are incorporated. But each must contain an inbuilt flexibility which allows for an appropriate positive response to changing health status of the communities.

Factors which would need to be considered in developing any funding formula will include:

- population;
- age distribution;
- life expectancy;
- access to existing health facilities;
- existing health status (if available);
- housing status;
- access to water, power and sewerage services;
- access to transport;
- known morbidity patterns; and
- known mortality patterns.

While this list is obviously not exhaustive it would cover the key factors affecting the provision of health services.

Most importantly any research must be aimed at providing practical applications across the broadest possible range of communities.

New funding solutions need to be considered and adopted even if they are limited, in the first instance, to trials.

4.6.2 Other Resource Implications

Inherent in most of the recommendations contained within this report is a requirement for a greater level of physical and manpower resources. While these requirements can all be expressed in money terms, doing so may not provide the true situation in regard to the availability of the physical and manpower requirements.

As indicated previously, the Working Party has sought to recommend to governments a national stragegy that will affect significant, lasting, long-term improvements to the health status of Aboriginal health. It believes that the best way of achieving this results is by:

- upgrading water, sewerage, and power utilisation systems in communities;
- providing adequate and appropriate homes for Aboriginal people;
- upgrading facilities and conditions in existing AHSs;
- providing greater manpower resources, particularly in the form of Aboriginal Health Workers, within communities;
- providing additional support in the area of alcohol and substance abuse; and
- providing sufficient funds to allow vitally needed research into Aboriginal health issues to be undertaken.

The achievement of the above requires a phased approach to allow for the integration of the new measures into the existing programs in a manner that minimises dislocation. In particular, there will be a need initially to increase the number of new Aboriginal Health Worker positions slowly to maintain pace with the possible expansion of institutions which will be required to train new health workers. Similarly, the supply of doctors, dentists, nurses and other professional staff is limited, particular if the demand for trained personnel is for remote locations. Nevertheless, the Working Party envisages that there is a requirement for some $417 million over the next 5 years if the improvements in health status are to be realised. This figure does not include the costs associated with providing appropriate homes for all those Aboriginal people who are currently poorly housed.

The Working Party has accepted that there is a need to bring the funding of the primary level of care into a more reliable and consistant format.

A detailed explanation of the current funding arrangements for Aboriginal health services is contained in Appendix VI.

As the Working Party has already endorsed the proposition that any improvement in the health status of Aboriginal people is of a necessity a long-term issue, it agrees with the above criticism and strongly supports the suggestion of at least a three year, and preferably a five year, guaranteed block grant

funding arrangements. Such an arrangement would cover the bulk of the normal operating costs and capital costs in relation to essential capital items. It would also allow flexibility in responding to any specific clinical and preventative issue that might arise.

The Working Party recommends that:

- funding cycles of Aboriginal health services be extended to provide for 5 year budget and funding cycles;

- funding for services be released in one block for each year;

- the States/Territories should ensure that an appropriate range of secondary level services are available to Aboriginal communities, including specialist services;

- the States/Territories, as a matter of urgency expand, and where neccessary introduce, Aboriginal hospital liaison staff in areas where Aboriginal utilisation of services is high, or where there is a specific need in an Aboriginal community;

- the States/Territories examine the environment of existing and future secondary level facilities and promote the use of facilities familiar and culturally acceptable to Aboriginal people and communities. Aboriginal communities must be fundamentally involved in the design and negotiation process;

- the regular sharing of information between primary and secondary levels of care should occur to assist both in the planning, management and evaluation of service to particular communities;

- there should be a clear division of responsibility for funding. Multiple source funding and duplication of services create program management and administrative difficulties;

- primary level Aboriginal health services presently being delivered by State governments should be transferred to existing or proposed Aboriginal community controlled primary level services; and

- funds as indicated in Table 1 below be provided over the next five years to enable these immediate needs to be met.

TABLE 1

NEW INITIATIVES FUNDING

	1989/90	1990/91	1991/92	1992/93	1993/94	Total
Infrastructure/ Environmental Health	20	65	65	50	50	250
New AMSs	7	12	18	20	3	60
Upgrading AMS	8	10	5			23
Aboriginal Health Worker Education Program	3	3	3.5	3.5	3	16
Alcohol	5	10	10	10	10	45
Health Research	2	2	2	2	2	10
Establishment of Council Office of Aboriginal Health	1	1	1	1	1	5
Food Supply	0.1	0.1	0.2	0.2	0.2	0.8
Specific Diseases Items	2.5m	1.5m	1.5m	1	1	7.5m
	$48.5m	$104.6m	$106.2m	$87.7m	$70.2m	$417m

TABLE 1

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Alcohol	5	10	10	10	10	45
Health Research	2	2	2	2	2	10
Establishment of Council Office of Aboriginal Health	1	1	1	1	1	5
Food Supply	0.1	0.1	0.2	0.2	0.2	0.8
Specific Diseases Items	2.5m	1.5m	1.5m	1	1	7.5m
	$48.5m	$104.6m	$106.2m	$87.7m	$70.2m	$417m

The selection of the most appropriate sewerage system whether it be deep sewerage, reticulated effluent, flushing or dry type septic, VIP latrine or absorption drain type, will depend on a number of factors such as:

- topography or natural features of the area such as hills, rock outcrops, subsurface rock, ground slope, vegetation, water courses and ground water levels;
- seasonal changes in the ground water level and the absorption capacity of the soil;
- flood levels;
- the nature of the soil for its suitability to either absorb effluent or to provide water tight treatment ponds;
- the location of community water sources such as bores, creeks and rivers for possible pollution effects;
- natural resources such as course sand, gravel or rock for use in constructing absorption drains;
- the area of land available for treatment ponds;
- restricted areas due to sites of significance or sacred sites;
- the accessibility of a community for specialist maintenance personnel during the wet;
- the adequacy of existing water and power supply systems;
- prevailing wind direction for location of treatment ponds and VIP latrines; and
- present and future population numbers.

Any decision to install a Cistern Flush or Dry Type septic system or a VIP latrine involves discussions with the Community Chairman and members to determine:

- the communities desire for a particular type of system;
- their reasons for the acceptance or rejection of a type previously used;
- their understanding of the need to upgrade a present system to one more efficient;

- the suitability of a particular type for the Community and their understanding of its proper method of use and maintenance;
- the number of persons who will use each proposed installation; and
- the location of the proposed installation.

The success of any program to improve toilet and water supply systems is dependent on effective community awareness and system maintenance programs.

ACS suggests that the improvement of sanitation in a community cannot be completely achieved by the construction of a toilet, a disposal system and a water supply system. It is essential that the community be made aware of the proper use of a facility and its maintenance requirements. An ongoing follow-up program involving visiting medical personnel, health workers, health surveyors and the community is required to ensure that a facility is properly used, kept clean and maintained.

Because of the isolation and remotedness of many communities from town centres, health information services and plumbing maintenance services are often unavailable when needed. It is therefore suggested that selected community members be trained to advise on matters relating to hygiene, proper toilet use, sewerage disposal and water supplies to carry out repair and maintenance work.

Any scheme to provide training would require a substantial commitment in persons and funds. It would need to be on-going, have an effective advertising/information program to encourage support from community leaders and have the support of the Education and Health Departments, the Water Authority and Local Authorities.

The trained persons would form a team working from a central base to service the communities within the region.

The need for a service team would depend on the proximity of town services to communities.

A service to be effective would need to be located such that an urgent call out would be attended within 24 hours.

Apart from emergency work, a service team's normal duties would include the inspection of community sanitary and water supply facilities for potential health problems, advising communities when necessary on matters relating to the correct use of these facilities, and the carrying out of preventative maintenance such as the cleaning out of septic systems and the re-washering of taps. An efficient, capable service team could also install new septic systems, water tanks, windmills, pipelines, etc.

A service team would require a base office/workshop with a telephone and perhaps a radio communication facility, a vehicle, maintenance quipment, tools and a basic material stock.

For a service to operate effectively persons involved including those in isolated remote communities would need to be remunerated for their services.

The broad strategy for implementation of the NSW study includes provision for a development plan outlining the basic needs and indicative costs of improving each community, maintenance and service cost projections, the role of local government, financial management plans and provision for Aboriginal employment and enterprise on the development of each community. A full list of regional costings in New South Wales are provided at Appendix VIII.

The Working Party is also aware of the DAA's 'Priority Communities Development Strategy' (PCDS) which again represents an indicative need for essential services in Aboriginal communities throughout Australia. This program targets specific Aboriginal communities for a total upgrade of infrastructure including waste, sewerage, housing and roads to a level acceptable to the general Australian community. Over two years total expenditure is expected to be $49 million. Most funding allocated in this program is for 'total upgrades' of communities although some funding has been allocated for essential services of a critical nature in particular communities. Thursday Island has been specifically allocated $15.9 million.

The Department of Aboriginal Affairs has expressed anguish at the "failure or omission" of State, Territory or local governments to provide funding for adequate water supplies, waste disposal systems and associated power facilities. The Department is called upon to provide funds to accelerate essential service provision in many communities. Budget information provided by the Department estimates the cost of just providing adequate water supplies and waste disposal to communities in need of such facilities at around $112 million at March 1988 prices.

The PCDS is additional to other components of the Community Infrastructure Program.

4.7.2 Outstations and their Resource Organisations

This program allows Aboriginals and Torres Strait Islanders to establish and maintain small communities on their own land, or on land to which they have a right of occupation and free to follow a lifestyle of their own choice.

4.7.3 Town Campers Assistance Program

TCAP provides resources for Aboriginal and Torres Strait Islander people living in sub-standard camp conditions or the fringes of towns and cities and which lack shelter, drinking water, electricity and waste disposal.

4.7.4 Accelerated Community Infrastructure Program

This is a joint Commonwealth/State cost shared program to assist development of community infrastructure on Aboriginal communities.

4.7.5 Aboriginal Communities Development Program

ACDP is a joint Commonwealth and Western Australian Government program designed to provide housing and infrastructure in Aboriginal communities with a emphasis on developing newly tenured communities.

The Working Party recommends that:

- the Commonwealth and all of the States and Territories fund communities to undertake joint assessments of essential services and community infrastructure needs in Aboriginal communities, outstations and settlements to ensure the Aboriginal people have standards of essential services and living acceptable to them;

- adequate funding be provided to communities to provide appropriate and adequate sewerage and water supply systems to remote Aboriginal communities as identified in the joint assessments of essential services and community infrastructure needs;

- funding also be allocated to communties for the implementation of community acceptable local essential services/infrastructural development programs; it is considered essential to adopt the UPK and CAAC water project type approach, not the Western development type approach, for upgrading inefficient or inadequate sewerage and water supply systems, and to develop a routine and systematic maintenance for new or existing systems;

- education courses be introduced to train key community personnel in aspects of hygiene, proper toilet use, sewerage disposal and water supplies, and to carry out maintenance repair work;

- at least two people from each community be sponsored to attend such courses; and

- where town-based maintenance services are inadequate to meet community need, service teams be established to work from a central base to ensure teams are available within each region.

4.8 OTHER PHYSICAL INFRASTRUCTURE REQUIREMENTS

As well as the direct provision of physical facilities for Aboriginal health services and for the predominantly government funded community clinics and hospital systems there is a further need for facilities to ensure adequate access by client groups to health services.

There has already been reference made in this chapter to the need for water reticulation, sewerage systems and housing which can be considered as part of this infrastructure.

Some 30% of all Aboriginal people reside in communities in rural or remote areas. These communities range from the isolated island of the Torres Strait and Bass Strait to the remote communities in central and northern Australia. Not only do these communities have to contend with the problems caused by physical isolation but often have to contend with extremes of climatic conditions. Within these communities there is often a lack of reliable ground or water transport capable of meeting even the minimum transport needs of community members.

To people living in these communities the question of access is more than just stepping down the street to catch a bus or train. In these situations many communities do not enjoy reliable communications, communication is subject to the vagaries associated with radio telephone or two way radio skeds. Even in those communities where reliable telephone facilities exist, maintenance requirements often mean that they are unavailable for long periods of time. In such circumstances it is often difficult to receive medical advice and more importantly to summon medical evacuation services.

Many communities do not have an adequate road network linking outstations with the central community and nor the central community linked by reliable, all weather road access to centres containing appropriate levels of medical and other essential services.

In the desert areas shifting sands rather than torrential rain fall disrupt the minimal roads that exists and most communities do not have the equipment, or indeed the training, to regrade or repair this basic system.

Similarly many communities, particularly those which can be isolated during the tropical wet, lack all weather airstrips which would allow for medical evacuation by air in case of acute or severe illness, or major trauma.

In addressing these needs governments need to ensure that the local government also plays its part as well.

These questions of access are not only important for the provision and receipt of direct medical services, but obviously there are additional indirect benefits to health by providing the means by which communities can be supplied with appropriate foodstuffs, especially consumables such as; milk, eggs, fresh fruit, meat and vegetables. However having ensured the supply of these goods to communities, it is often forgotten that there is a further need to provide adequate refrigerated storage facilities to ensure the maximum benefit from fresh food supplies.

CHAPTER 5

TRAINING AND EDUCATION ISSUES

5.1 ABORIGINAL HEALTH WORKER (AHW) EDUCATION PROGRAMS

The Aboriginal Health Worker (AHW) has become an integral part of the staff of the Aboriginal health services and their roles and functions have evolved with the development of the AHSs.

The AHW program is recognised throughout Aboriginal communities as one of the most important factors in efforts to improve Aboriginal health status. One of the major factors in the success enjoyed by the AHWs is the fact that they have a close association with and an intimate knowledge of the communities they serve. This knowledge and association arises from the fact that they are generally members of that community who have been selected by their peers to undertake the training program and ultimately to work as an AHW in that community.

In any primary health care facility it is the health worker who is the first point of contact for service and as such the health workers bridges the "cultural chasm" separating traditional and western world views. They relate western beliefs to an Aboriginal conceptual framework, making it possible for Aboriginal patients to understand what is being said and to assess the validity of the statements. They make it possible for the health centre's teams to communicate with Aboriginals in language and concepts that they understand.

5.1.1 The Role of the Aboriginal Health Worker

On completion of the twelve month period of training the qualified Health Worker will be expected to become an integral member of the staff of the health service. Within Aboriginal health services the Health Worker will be exposed to and participate in the full range of programs. They are likely to include:

- preventative health programs;
- nutrition;
- STD's;
- mental health services;
- clinical services;
- geriatric care;
- drug and alcohol counselling;
- environmental health programs;
- health promotion programs;

- counselling children;
- history taking and clinical records maintenance;
- under 5's clinic;
- opthalmology;
- microbiology;
- immunisation;
- family planning clinics;
- dental hygiene; and
- public health issues.

In their career, they will be expected to:

- assess;)
- treat;) short term goals
- refer where appropriate;)
- to provide people with the ability to make their own decisions;) medium
- induce the motivation and incentive; and) to long
- aim for optimal health for themselves and their communities.) term goals.

In their career, they will be expected to:

- plan an conduct preventive programs; and

- plan and conduct health promotion activities.

These longer term goals will enable members of the community to fulfill the role of teacher and pass on the skills they have learned as health agents.

5.1.2 Objectives of Aboriginal Health Worker Education Programs

As a course of primary health care, the education program aims to provide students with the skills, knowledge and understanding they require to carry out basic health education and preventative, clinical and referral functions necessary for operation as safe practitioners.

In addition, the health worker program educates students in clerical skills and management tasks associated with the administration of a community health service.

The program incorporates elements of traditional culture and the emphasis is on a bi-cultural approach where the best elements of both cultures are built into the health service.

Courses are designed to take maximum advantage of the qualities that are sought in potential AHW's, namely:

- the ability to convey Aboriginal practices to other health personnel who may, and often do not, have the ability to work in a cross-cultural context;

- the ability to understand the relationships between environmental living conditions and health outcomes in the community;
- the ability to translate strict medical orders and advice into a practical health plan the client is likely to adopt; and
- the ability to combine modern health care principles and practices with cultural practices.

In more formalised teams the general aims of the Health Worker Education Program are:

- to provide a program to meet the needs of Aboriginal people participating in community health services (whether community controlled or Territory operated);
- to establish Health Workers in their roles by developing their confidence and self-determination;
- to provide motivation by exposure of the Health Worker to facts related to Aboriginal health;
- reinforcement of the importance of Aboriginal Health Workers as the key personnel in community controlled health services; and
- recognition of graduates from the education program as qualified health professionals in the field of Aboriginal health.

In seeking to achieve these aims the training institutions seek to provide the trainee with a broad exposure to a wide range of issues and/or techniques relating to Aboriginal health.

Table I provides a list of the core curriculum from four States and the Northern Territory.

TABLE I

Course Content

	AMS NSW	QLD SA	GOVT QLD	GOVT NT	AMS WA
Primary health care (clinical Care)	X			X	
Socio-Cultural	X	X	X	X	X
Mental Health	X	X		X	X
Prevention of disease	X		X	X	
Environmental Health	X	X		X	X
Health & related systems	X	X	X	X	
Growth & Development	X		X	X	X
Personal development	X	X		X	X
Office procedures/ Administration	X	X	X	X	X
Techniques & Programs for change		X	X	X	X
Health promotion	X	X	X	X	X
Dental	X		X		
Literacy skills/ Communication	X	X	X	X	X
Professional development	X	X		X	
Aboriginal politics		X		X	X
Community Development		X	X		X
First Aid (St Johns)	X	X	X		X
Drugs		X		X	X
Alcohol		X		X	X
Law			X	X	
Nutrition			X	X	X
Traditional health services				X	X

The recognition and salary offered to trained Aboriginal Health Workers varies enormously between the States and the N.T.

Koori Kollij in Victoria and the N.T. Department of Health and Community Services Health Worker Education program represent the two ends of the spectrum in regard to formal accreditation and recognition of qualifications.

The Kollij issues its own certificate/diploma of achievement which is only recognised by AHSs, while in the N.T. a much more formal approach has been adopted.

The Northern Territory Health and Allied Professionals Registration Act (1985) recognises Aboriginal Health Workers as a professional group. In accordance with the Act the Aboriginal Health Worker Registration Board of the Northern Territory was established in 1986. Under the requirements of the Act, Aboriginal health workers must be currently registered in order to practice.

Pre-requisites for registration are:

- Basic Skills Certificate (or equivalent); and
- character reference.

As well a revised career structure with five levels for AHWs has been approved by Cabinet (June 1988). The structure recognises the need to acknowledge AHWs as members of a career service in positions as administrators, supervisors and educators.

Acknowledgement of Health Worker training is important not only for its recognition of skills acquired but also for the mobility that formally recognized/accredited qualifications can confer on the holder.

The Working Party recommends that:

- to ensure stability and co-ordination in the planning and funding of Aboriginal health worker training the Commonwealth initiate negotiations with State agencies, including training providers, and Aboriginal communities at the regional or state level to develop adequate training resources for Aboriginal Health Workers;

- the Commonwealth, State and Territory Governments, in conjunction with the Aboriginal community health section, encourage health education and training institutions to develop uniform accreditation standards for Aboriginal Health Worker courses to assist mobility and to enable health workers to gain entry to the related health and professional education and training arenas;

- secure employment and career opportunities be created for Aboriginal Health Workers and other Aboriginal workers in the health field; and

- funding for professional development for Aboriginal Health Workers and other workers in the Aboriginal health sector should be part of the recurrent budget of organisations.

5.2 EDUCATION OF HEALTH PROFESSIONALS

Health professionals working with Aboriginal people are not merely the providers of care, treatment or cure, but are frequently called upon to assist in times of life crisis, to advise on housing, legal, and employment problems, and when other major problems arise for individuals or communities.

Yet in the past scant attention has been paid in the content of health related education programs to the relevance of cultural, tradtional, political, and socio-economic factors of Aboriginal history and Aboriginal society to Aboriginal health and well-being although correlations do exist between these factors and must be taken into account if there is to be a marked improvement in Aboriginal health.

As a result unrealistic expectations, culturally inappropriate care and treatment, poor communication, and intolerance based on lack of understanding and general dissatisfaction on both sides can be the consequences of this terrible omission.

Until tertiary institutions recognise the need for, and benefits of, culturally appropriate, relevant, academic content and clinical experience when designing courses for all health professionals, there will continue to be difficulties in attracting and retaining health professionals to work amongst Aboriginal communities and a limited understanding of Aboriginal health issues.

This applies equally to medical, dental, nursing and other paramedical general, and specialist studies at both the under-graduate and post-graduate levels.

The Working Party is of the view that the style and content of health courses also need to be re-appraised so as to reflect a primary health care approach, rather than the traditional medical model, and should demonstrate practical linkages between community empowerment, social justice, equity and health.

An underlying philosophy focussing on the well-being of the whole community rather than on the medical management of the individual patient's presenting problem is of paramount importance. Courses must also provide participants with an understanding of the causes and nature of Aboriginal health needs including the promotion of a practical and conceptual understanding of intersectoral collaboration.

This broader emphasis has the benefit of encouraging health professionals to undertake an advocacy, awareness raising, and community educational role which can have a significant positive impact on the process of health attainment.

Course content must encompass the knowledge and skills required in community settings; nurses and health workers give evidence of the lack of preparation for the skills and expertise required in remote areas, particularly when there is no permanent medical practitioner based nearby.

In their submissions Nursing Associations pressed for the introduction of post-graduate courses to take into account the knowledge and skills which are realistically required in remote settings.

Where possible, opportunities to undertake formal clinical experience with Aboriginal health services, remote communities, and other facilities which provide services for large numbers of Aboriginal people enhance course work and link academic studies to the realities of professional practice.

These views are supported by a recent study undertaken by Dr Richard Copeman ("Medical Students, Aborigines and migrants : evaluation of a teaching program". The Medical Journal of Australia, Vol 150, January 16, 1989, pp 84-87)

The study examined the knowledge and attitudes of fourth year medical students to Aboriginal and migrant patients before and after the introduction of a teaching program designed to overcome poor communication between Aboriginal patients and doctors. A relevant lecture and tutorial, and clinical contact with an Aboriginal patient demonstrated a modest improvement in some attitudes.

The results suggested that more clinical contacts, video-taped consultations and a student log book could be used effectively to further the benefits of such a program.

"The changes in attitudes that were brought about by this brief clinical exposure to Aboriginal and migrant patients mostly were positive, although limited in extend. This suggests that further teaching and clinical experience with Aboriginal and migrant patients may be even more effective and also might help to overcome the tendency towards stereotyping."

"Student attitudes to Aboriginal and migrant patients may be enhanced by the improvement of their general skills of communication and consultation with all patients. If students are not proficient at the skills of consultation with patients in general, they are even less likely to be proficient at consulting with Aboriginal or migrant patients. However, proficiency at consultation is not enough on its own. As was stated by the hospital resident doctors who were interviewed by Mobbs, an appreciation of the culture and background of Aboriginal patients is essential if doctors' consultations with Aborigines are not to be frustrating and ineffective for both patient and doctor."

"There are a number of ways in which teaching in this could be improved. The development of students' appreciation of the cultural background of such patients should begin in medical sociology or behavioural-science courses in the early years of the medical course. In those courses, students could be exposed to well Aborigines and migrants and could be helped to gain an appreciation of different cultures and of the effect of cultural background on illness and illness behaviour."

"Later in the course, videotaped consultations could be used to introduce students to the difficulties of consulting with such patients. In the later years of the course, students usually will come into contact with further Aboriginal patients - at least in Queensland where Aborigines and Islanders comprise 2% of the population. They also will meet many more migrant patients. In order to ensure that they do each see and interview a number of Aboriginal and migrant patients during their training, a log-book record of such interviews could be kept by each student. Tutorials could then be held in the final year of the medical course at which students would present case histories of Aboriginal and migrant patients. Aboriginal and migrant health workers could be resource persons for these tutorials.

> Finally, as many students as possible should be encouraged to undertake their general-practice attachments, clinical electives and research electives with Aboriginal Health Services, the Royal Flying Doctor Service, at Aboriginal settlements or with doctors and health centres that cater for migrant communities."

In addition to the inclusion of culturally appropriate, formal coursework and clinical experience, there is a need for orientation programs prior to employment in Aboriginal communitites, and informal continuing education and in-service programs and opportunities to assist health care professionals in developing and maintaining their knowledge, skills, and understanding of Aboriginal health issues. Because many people work in geographic and professional isolation, ongoing dissemination of information needs to be undertaken in creative and innovative ways e.g., by video, in professional journals, and other publications.

Professional isolation is a real issue, identified by individuals and professional organisations in their submissions and personal representations. Study leave, as a significant means by which the geographic and professional isolation can be countered has been discussed elsewhere in the report. However its importance is reemphasised here. In their submissions several professional organisations expressed their wish to become actively involved in post-graduate and continuing education programs, and in the supervision of health professionals during clinical experience and as a means to counter professional isolation. This is seen as both desirable and beneficial.

Special encouragement must be given to eligible Aboriginal students to undertake medical, nursing, and paramedical studies. As qualified health professionals, Aborigines would become role models for their people and could choose to work exclusively with Aboriginal people if they so desired. Aboriginal entry to, and retention in, health professional courses, are dependent on a number of practical steps and interventions. At the moment relatively few Aboriginal students aspire to, or reach tertiary level studies.

In the short-to medium-term problems related to Aboriginal pariticpation in the workforce will be increased as general nursing education, once considered a viable occupation for young Aboriginal women, becomes a tertiary-education-based qualification, and the subsequent demand for places in Enrolled Nursing Courses rises. During the consultation process the Working Party consistently heard of large numbers of applicants for minimal places in hospital-based training programs.

A further deterrent is the recently introduced tertiary graduate tax. Working Party members expressed major concerns regarding effect of this tax on Aboriginal enrolment in tertiary institutions.

During early school years, medicine, nursing, and other health orientated courses need to be presented as viable and achievable options to young Aboriginal students, and assistance given where necessary, in those subjects which are pre-requisites to entry to tertiary studies.

The Working Party was firmly of the view that academic standard should not be the only criteria for entrance to tertiary institutions. Other qualities and attributes must be taken into account including potential, ability and determination to succeed, and lack of previous opportunities, work experience and community involvement.

The University of Newcastle, Faculty of Medicine, points out the need for careful selection procedures, and ongoing support and liaison structures designed to assist students with studies during the course to help them adapt to university life and provide assistance with regard to economic, housing and other day-to-day practicalities. In its submission the University pointed out that:

> "Experience in the U.S. in the training of black teachers found that attrition was high in institutions of higher education dominated by another culture dissimilar to that of the minority students. Students experienced several forms of alienation including feelings of social isolation, a lack of cameraderie, and loss of goal orientation. Black students also felt a lack of identity and or self-esteem and indicated that their cultural needs were not met."

Therefore, maintenance of their cultural identity was of particular importance.

Whilst special quotas may attract Aboriginal students to tertiary studies, academic institutions consider that existing eligibility criteria for entrance must be met, i.e., students will not be accepted just because of their Aboriginality.

The University of Newcastle submission summarises the situation well:

> "We do not believe that the employment of Aboriginal doctors and the improved training of white doctors to work in the area of Aboriginal health will cause an overnight improvement in Aboriginal Health."

> "Land Rights, provision of basic services, control of Aboriginal services by Aboriginal people and training of Aboriginal health support staff will play a profound role in changing Aboriginal health status. Aborigines must, however, be one of the last groups on earth not to have a substantial number of their own doctors. Some American Indian physicians are the third generation in their family to practise medicine. Their training is supported actively by the United States Government."

The Working Party took into account the Report of the Inquiry into Medical Education and Medical Workforce (Australian Medical Education and Workforce into the 21st Century, April 1988) during its deliberations. It was considered that certain sections of the report addressed the issues already raised, and considered certain recommendations to be both relevant to and timely in the achievement of satisfactory service delivery.

In particular the recommendations are:

- the importance in appropriately designed curricula that would give the students the knowledge, attitudes and skills needed to meet new challenges during a professional lifetime.

  > "Medical schools aim to provide exposure to general practice, early in the course as well as providing at least a month's block experience in general practices or community health centres late in the course." (Recommendation 5(iii))

- in relation to the need for wider skills amongst health professionals, the Working Party noted the recommendation that:

  > "Assessments be designed to reinformce education objectives (e.g., integration of knowledge, problem-solving, attitudes and skills as well as knowledge). It is imporant that skills in medical counselling and communication should be assessed. (Recommendation 5(vii)).

- The Working Party agreed with the recommendation which would enable wider general practice experience in the pre-registration period:

  > "Medical Boards accept the principles that the preregistration years should:

- be served in more general posts with, by negotiation, opportunity for positions relevant to future vocational training; and

- include a substantial component in general practice, community health centres or other suitable placements outside the hospital system, and more to implement requirements to those effects as soon as possible." (Recommendation 6(iv))

Further

> "Funds (and training for supervisors) be made available for community health centres, general practices and other community placement agencies to provide placements for preregistration trainees in the second year experience, such funds to be provided by the Commonwealth Government (as currently happens with first year Family Medicine Program trainees)." (Recommendation 6(v))
>
> "Clinical training of undergraduates and preregistration trainees should be carried out in a range of facilities including teaching hospitals, general hospitals, general practices, community health centres and other community settings to ensure that at registration doctors appreciate the spectrum of health, disability and disease in the community, the relative importance of various disorders and disabilities and the extent of community resources available to handle them." (Recommendation 7(i)).

Of major significance are the recommendations that:

> "Community health centres and other community placement settings should accept a role in the education of undergraduates and preregistration trainees, be recognised as having that role, be funded accordingly and their staff trained appropriate." (Recommendation 7(vii))

and

> "Educational programs designed for vocational training of general practitioners provide the knowledge, skills and attitudes needed ... to practise effectively in rural areas; to work with Aboriginal and other communities with particular health problems..." (Recommendation 8(iii))

- With regard to the need for training in specialised areas of primary care:

  "The special training and continuing education needs of practitioners who provide primary medical care outside the traditional general practice setting be recognised, and that the appropriate professional colleges should assist in meeting their needs." (Recommendation 8(iv)).

  "State departments of Health review alternative strategies to use of the Employer Nomination Scheme to fill vacancies : for rural areas, by such measures as greater use of non-medical staff, better transport networks, regular visits from medical staff in nearby areas, secondment from hospitals; for urban areas, by making unpopular posts more attractive, for example by creating several part-time positions instead of one full-time position, cross appointments with teaching hospitals, or use of career medical officers ..." (Recommendation 11(xiv))

- With regard to the socio-econic imbalances in studen intake:

  "Universities monitor the socio-economic and ethnic mix of entry into medical school, keep special entry programs under review, and evaluate and modify them to meet their objectives." (Recommendation 12(iii))

- Further:

  "The special entry schemes at the Universities of Melbourne and Sydney for disadvantaged students be carefully evaluated to determine whether they are in fact broadening the socio-economic background of students and to assess the level of support that students need when they are admitted under special schemes" (Recommendation 12(iv))

  "Medical schools set up schemes, where they do not already exist, to provide financial and social support for students in need. The financial support could take a number of forms, such as special scholarships or student loans." (Recommendation 12(v))

The Working Party recommends that:

- tertiary institutions responsible for undergraduate and post-graduate medical, nursing, and paramedical courses by approached to include the compulsory study of Aboriginal culture and history and health issues as part of formal course work;

- where possible, Aboriginal people should be involved in the development and teaching of these units;

- course work foster a primary health care approach to professional practice, adopting the principles of community control and participation, health awareness, health promotion and health education;

- where clinical experience is a component of formal studies, or necessary for professional registration, opportunities are provided and placements actively sought for supervised clinical experience to be undertaken in Aboriginal health services, remote communities, and other appropriate health care facilities;

- professional staff participate in orientation programs prior to their employment in Aboriginal health services or within Aboriginal communities. This orientation should include both professional orientation and social expectations of their roles and be followed up with ongoing professional development throughout the employment period;

- negotiations with professional organisations commence immediately with the aim of introducing culturally appropriate and relevant post graduate and continuing education programs. Where possible, Aboriginal people should be involved in the development and presentation of these programs;

- encouragement be given to professional journals and other publications to increase their content with regard to Aboriginal health issues and other aspects of Aboriginal culture which has an influence on wellbeing;

- every effort should be made to attract and retain Aboriginal people in courses of study which will qualify them for careers as health professionals;

- Aboriginal students should be exempt from payment of the tertiary graduate tax to encourage them to undertake tertiary studies; and

- health services must be provided with resources to allow communities and their health services to accept placement of students;

- that action be taken to implement recommendations, 5(iii), 5(vii), 6(iv), 6(v), 7(vii), 8(iii), 8(iv), 11(xiv), 12(iii), 12(iv), 12(v) of the Committee of Enquiry into Medical Education and Medical Workforce.

5.3 EDUCATION OF OTHER SERVICE PROVIDERS

Service providers, other than health professionals, have the potential to have a major impact on Aboriginal health. However, they cannot effectively meet their responsibilities to Aboriginal people unless they too are aware of and understand Aboriginal health issues and the effects of culture, tradition, socio-economic status, and dispossession on health status. An appreciation and acceptance of these influences has the potential to, for example, reduce the cultural barriers between children in the classroom or increase tolerance in the workplace.

Teachers have a significant and pivotal role in the success of health awareness and health education programs. Information must be presented in a culturally acceptable way using examples and materials which are relevant and meaningful, and should emphasise the principles of self-determination and community control.

Of course this educational role is not confined to disease prevention, but extends, for example, to the use of new facilities and equipment, simple hygiene, and community development. The position of teachers also enables them to identify possible health problems amongst students and alert parents or health professionals, if appropriate.

Teachers have the potential to increase the learning capacity and academic performance of Aboriginal children through the use of appropriate teaching methods which have been designed to overcome, for example, hearing problems. It is important, however, that teachers recognise that poor academic performance can be related to health problems and to refer students with problems to appropriate health services for assessment.

Therefore teacher education needs to expose undergraduate students to Aboriginal culture and history, health, socio-economic, and political issues and encourage their application to day-to-day classroom activities.

The Royal Commission into Aboriginal Deaths in Custody identified the nexus between the attitudes and behaviour of police and corrective services staff, and the physical and mental health of Aboriginals in custody. Aboriginal deaths in custody can and must be reduced, and physical and mental trauma minimised.

Working Party members also considered that similar principles were applicable to police, prison officers and prison medical and nursing staff.

The Working Party recommends that:

- more opportunity be given to Aboriginal people to become service providers, for example teachers, police, trades people by establishing community based education and training programs;

- educational and training courses for other service providers include the study of Aboriginal culture, history and health issues. Particular emphasis should be placed on the inclusion of formal units in teacher education course work. Where possible Aboriginal people should be involved in the development and presentation of this material;

- where practical experience is a component of formal studies, opportunities are provided and placements actively sought for supervised practical experience to be undertaken in Aboriginal communities;

- culturally appropriate orientation programs, continuing education programs and in-service studies be developed and presented, where possible, by Aboriginal people;

- police and prison staff should receive adequate preparation for their role in relation to Aboriginals through appropriate orientation and training programs;

- Programs should include:

    - Aboriginal health issues and the effects of culture, tradition, socio-economic status and dispossession on health status;

    - effective communication skills which recognise these factors;

    - the recognition of signs and symptoms which could be indicative of specific health problems, e.g., hypoglycaemia, epilepsy, cardiac disorders;

- an understanding that medical conditions, medication, alcohol and other substance abuse can alter behaviour, and lead to confrontational behaviour; and

- appropriate action when there is the slightest suspician of health problems including alcohol or other substance abuse, e.g., referral to medical practitioners, utilisation of Aboriginal support systems and community groups criteria for transfer to hospital or another suitable, supervised medical environment treatment to be instituted in the case of medical emergencies; and

- resources be provided for the education and training of Aboriginal people to replace non-Aboriginal people where there are no Aboriginal people to perform these duties and that these arrangements be included in job contracts for non-Aboriginal people.

CHAPTER 6

INTERSECTORAL COLLABORATION

The Working Party has recognised that the achievement of health depends on the co-ordinated and measured interaction of many areas or sectors of development.

While these components are more often than not one step removed from the personal interface they are nevertheless essential components of a wholistic system and approach based on the concept of primary care.

Aboriginal communities consistently spoke of the impact on health and well being of poverty, unemployment, poor housing, lack of educational opportunity, poor essential service provision, social dysfunction and dislocation caused by culturally inappropriate policies and programs, cost of living, transport, isolation and other socio-economic factors.

The Working Party received many complaints and expressions of dissatisfaction with what was generally considered inappropriate and inadequate policy and program responses from public sector agencies.

It is clear that any national strategy will need to address these issues, if meaningful, cost-efficient and enduring improvements in Aboriginal health and wellbeing are to be achieved.

Co-operation between, and where appropriate, integration of the different development programs offered by the different service agencies is essential. Nowhere is this need for co-operation more evident than in the provision of housing and essential services. Less evident, but as significant, is the need to co-ordinate and integrate programs designed to promote social and economic development.

Co-operation and integration can be achieved only when there is a clear definition of roles and a delineation of responsibilities.

As a tool of intersectoral collaboration health planners offers a clear mechanism to achieve this goal.

6.1 WHAT IS INTERSECTORAL COLLABORATION?

The concept of intersectoral collaboration is surprisingly simple. It recognises the

> "...dependency that exists between health and all other sectors of a community's activity. In health, intersectoral collaboration recognises the fact that improvement in health cannot be achieved through efforts of the health sector alone. Vital to the efforts to improve health and well-being are the contributions of a variety of sectors including agriculture, land, animal husbandry, socio-political, cultural, food, industry, education, housing, public works, and communications."

More formally, it might be defined thus:

> "INTERSECTORAL COLLABORATION is the systematic and planned identification and development of health objectives including the identification of health impact analyses in all health related policies and programs, as integral parts of sectoral policy, through the co-ordination of specific and workable agreements, at all levels for the co-ordination of health services with other activities contributing to health improvement."

Health agencies have a pivotal role in intersectoral collaboration efforts and should not be confined to limited medical spheres of disease orientated or disease specific relationships.

There is conclusive evidence that once the key linkages between sectoral activities and policies and the health sector are identified they will help to provide health planners and decision makers with a total picture of the process of development and health achievement. With this information conscious decisions about the content, direction, and priorities necessary for the successful implementation of a national Aboriginal health strategy can be made.

It follows, therefore, that health and national development strategies are linked. Both reflect moves to improve the quality of life in economic, social, cultural, and political terms. National development and health policies need to be carefully aligned and organised so that identified goals in health and goals of national development have common bases and traits.

Intersectoral agencies, it was suggested, should approach the task from a perspective of well being, which includes broader social and cultural parameters. These, as much as pathogenic factors cause ill health and must, in a regime promoting co-ordination of sectoral activities, be considered not only in the co-ordination plan but also in the national development goals to which co-ordination contributes.

> "As part of socio-economic development, the aim of health policy is to secure a fundamental change in the health status to help break the cycle of poverty and liberate the population to secure change that they have chosen and in which they participate."

Intersectoral collaboration at the community level is not common. This is not to suggest that communities have not attempted to promote this concept. Nganampa Health Council had tried in its recent report to promote community level co-ordination of programs and services on AP lands and has met with the traditional resistance from public sector agencies.

This complicates and inhibits efforts to promote collaboration as it is generally the community level where the process and logic of intersectoral collaboration is clearest and most practical. This barrier is typical of inadequately throughout development processes.

A number of key areas of intersectoral collaboration have already been identified in the definition adopted by the Working Group. These include land, cultural, food, employment, education, housing, and public works, communications and socio-political factors.

While the Working Party has highlighted housing, education, cultural, socio-political, housing and public works as to. important factors, it does not wish to diminish the importance of other sectoral contributions to health and well-being.

Processes and mechanisms which promote the participation of communities must also be developed and built into the co-ordination processes.

6.2 THE PROCESS OF INTERSECTORAL COLLABORATION

Intersectoral collaboration is not a random exercise in conferencing, nor is it a substitute for health planning. It is a means by which the community, health planners and decision makers engage in the implementation of an agreed health strategy.

The process is, of necessity, a flexible one. It involves the evaluation of the various factors associated with health and development and the identification of the key linkages between health and other sectors of development. Different linkages will affect different communities in different ways.

Having identified a range of relationships or linkages, health and development planners can focus attention and resources on the key areas which will facilitate progress.

The community sector has a critical role to play in matters relating to the structures for the provision of health and related services.

In many circumstances, structural and development concepts applicable to non-Aboriginal society may not in fact be appropriate to Aboriginal needs. For instance, the economic model with its emphasis on the enhancement of income is not necessarily the only key to overall development, health or well being.

Intersectoral collaboration may require the development of new and innovative methods of measuring the achievement of health and well being and a new assessment of the relationship between health and other sectors. Planners will need both quantative and qualitative information in order to be able to evaluate their actions and the impact on communities.

The process of intersectoral collaboration is a strategy to ensure that the various sectors work closely together. This may require changes in the way in which resources are organised and distributed, development plans are designed and in the process and methods of evaluation.

Such structural changes may be considered necessary in Commonwealth, State, Territory and community agencies. The central concern in any restructuring process is that the fundamental goals of equity, community empowerment, and social justice are paramount.

6.3 DEVELOPING AND ESTABLISHING MECHANISMS FOR INTERSECTORAL COLLABORATION IN THE CONTEXT OF A NATIONAL ABORIGINAL HEALTH POLICY

The infrastructural necessities of the non-Aboriginal community have largely been in place for many decades. The very great majority of housing needs are satisfied, safe water is assumed, and well developed private and public health sectors have been in operation since the late 18th century.

Aboriginal society, however, does not exhibit such characteristics. Typically, disease is more acute, housing is poor and overcrowded, nutrition is a problem, a reliable potable water supply is not always available, unemployment is high and educational attainment is low. Infrastructural needs are still under resourced and organisational relationships and needs under-developed.

In many respects Aboriginal health needs are typically those of a Third World population while the national health characteristics of the rest of Australia are those of a developed nation.

Aboriginal health has never been a central concern for the bulk of private and public health systems, notwithstanding Aboriginal use of general services.

In as much as great inequities exist between the health of Aboriginal and non-Aboriginal people, sectoral implications and concerns impact in a far more significant way in respect of Aboriginal health than in non-Aboriginal health spheres.

A national strategy promoting the health of Aboriginal people needs to be aware of these fundamental differences.

The development of mechanisms for intersectoral collaboration within the context of a national policy depends very much on the particular circumstances of each situation.

The Working Party has already detailed the benefits that it believes accrue from involving the individual and the community in the planning and implementation of health policies. Health planners need to be aware of the linkages between political and community development and the health sector.

Community organisations play significant roles in mobilising the communities at local, regional, State and national levels. Community participation promotes heightened awareness, preparedness to participate, the availability of functioning structures of organisations, and processes for the collection and advocacy of community views and reactions.

The World Health Organisation's global Health for All program and the subsequent international conference on Primary Health care at Alma Ata, recommends to governments that they

> "...incorporate and strengthen primary health care within their national development plans with special emphasis on rural and urban development programs and the co-ordination of the health-related activities with the different sectors".

6.3.1 Barriers to Intersectoral Collaboration

The practice and principle of Health for All calls on health planners and decision-makers alike to rethink their approach to community development.

Health planners should be aware of the potential for health advancement and community development through intersectoral collaboration. However, it may well be best if progress is taken in measured and careful steps. Impatient or unplanned pursuit of intersectoral collaboration may well yield an opposite result. A more structured and strategic approach is recommended as this will invariably mean greater education about, and political support for, intersectoral collaboration at national, regional, and local levels of health and development activity.

This may not be an easy task.

Commonwealth and State/Territory bureaucracies, politicians and indeed local community groups are well known for their stoic defence of what they see as "their turf".

These agencies have tended to see themselves as free standing authorities resistant to interference from other agencies. The vertical models of action and authority created in this would rarely interact horizontally, except at the most senior levels; and even at these levels whatever interaction occurs is guarded and poorly organised.

Most disturbingly, however, has been the lack of co-ordination between agencies of the Aboriginal Affairs portfolio and other Commonwealth departments. Communities have cited this inadequacy as having caused major problems for the implementation of health and development strategies. Some examples of this lack of co-ordination have been in the provision of equipment and housing and the provision of operational funding to Aboriginal organisations.

Traditional barriers to co-ordination such as sectoral defensiveness may mean that mechanisms for intersectoral collaboration need to be equipped with certain authoritative capacities. This may include addressing national decision makers at the most senior levels of government who could then direct that sectoral approaches reflect the desired process and content.

A major barrier to reconciliation of cultural imperatives and the western health system is the fact that the health system which exists in Australia has emerged from a history, experience and needs of another place and people. To refer to an earlier paper presented to the Working Party:

> "The health system is usually one of the most complicated of these entities, its development having taken place over the centuries, with inputs from peoples beliefs, science, commercial factors and other social forces, usually without any deliberate or systematic planning."

In each of these areas, it has been non-Aboriginal beliefs, science, commerce and social forces which have moulded the health system. Health planners and decision makers will have to be aware of this fact when considering linkages between social factors and the health sector.

6.3.2 Cultural and Socio Political Considerations

Culture impacts on all areas of concern in Aboriginal health and well being; it plays a special role in the process and substance of intersectoral collaboration.

United Nations reports have suggested that the imposition of

> "...Health service concepts and methods of another segment of society which show no regard for those of the indigenous populations provokes resistance and misunderstanding and may well violate international norms for the safeguarding of cultural rights."

The health sector must ensure that its operations are built upon a respect for, and operational appreciation of cultural idioms and practices. Health, as defined in this report, cannot improve where culture and society are defiled.

An important cultural attribute to be incorporated in health strategy is the role and status of traditional health practices and practitioners.

> "The imposition of modern practices and wholesale rejection of traditional medicine has been one of the most serious shortcomings of governmental health and medical care programs and reflects a bias against indigenous culture".

This will require changes in the medical education system and other sectors to recognise and enhance the role of traditional practitioners and practices.

To ensure that culture is protected and inequities reduced, communities must be closely involved in this process. Intersectoral collaboration is not simply a mechanism that functions between sectors of Government.

6.3.3 Housing, Environmental and Public Works

Housing, environmental and public health needs have always featured in the list of the essential needs of the Aboriginal community.

Consider the following diseases commonly found in Aboriginal communities:

- hepatitis B;
- gastroenteritis;
- scabies;
- trachoma; and
- upper respiratory tract infections.

Each of these are commonly spread where overcrowding, lack of adequate water supplies, poor sanitation, and poor control of environmental conditions prevail. The correction of these factors requires a co-ordinated and comprehensive response from a number of developmental sectors apart from health.

A recent report from the Nganampa Health Council has examined these and other environmental and public health factors and collated their finding into a comprehensive environmental and public health strategy. The report calls for a co-ordinated and hitherto unprecedented re-organisation of the way in which the services are provided on Anangu Pitjantjatjara lands.

It has been long accepted that a prerequisite to a healthy lifestyle is the provision of suitable accommodation. It has been shown time and again that better housing is critical in attaining the provision of better health, better education, better employment opportunities, better access to justice, and less trouble with the police.

The consultations conducted by members of the Working Party demonstrated that the need for appropriate housing for a high percentage of Aboriginals is critical.

A recent survey conducted jointly by the Aboriginal Development Commission and the Department of Aboriginal Affairs clearly established that 70, 000 people or 31 per cent of the Aboriginal population are homeless or, living in inadequate accommodation. The survey titled "1987 Aboriginal and Torres Strait Islander Housing and Accommodation Needs Survey", provides a comprehensive listing of housing needs on a community basis.

The current national backlog of 16,179 dwellings, costing an estimated $1,274,000,000 would take 10 years to meet at the current level of Commonwealth expenditure on Aboriginal housing.

The last Commonwealth Budget did highlight the need for better ancillary services such as water supplies but the Aboriginal Development Commission, the major providers of Aboriginal owned housing at a standard appropriate to proper health, devoted 20.3% less, in real terms 20.3% less in its housing budget. This is despite the fact that one third of all Aboriginals remain homeless.

The Working Party supports the need for Commonwealth, State/ Territory Governments to provide the necessary finances to redress the housing needs as indicated above and commends the Report to them.

The difficulty with housing as a major factor in health improvement as outlined above is only the first link in the chain of interdependencies relating housing to water sanitation and access to other services. Each of these dependencies demonstrate the need for greater intersectoral collaboration.

To make housing effective it is not sufficient merely to supply an adequate number of houses; it is imperative to provide houses which will allow people to live in a manner that is not only healthy but also socially and culturally acceptable.

This may include, for instance, larger yard areas, as evidence suggests that Aboriginal families use yard areas for a much greater range of activities, including the alleviation of overcrowding.

Therefore housing designs need not only take into account physical requirements of climate, type of land and building materials available, but also the social and cultural needs of the people.

Similar considerations are needed when providing water and sewerage to houses. In many of the remote communities water is at a premium and so it is important to design sewerage systems which take into account this fact. It is also necessary for those who are responsible for promoting public health issues to be able to provide community members with the education and training to use these facilities properly.
All of these are relatively simple but they demonstrate the need for effective interaction between a number of different service providers at the community level.

The nature of the change in design attributes can be developed from intersectoral collaboration between the housing, health, finance, and social development sectors.

The location of housing is often as important as what is constructed. This touches on policies and practices of acquisition and ownership of land.

The need for other basic infrastructure requirements such as communications equipment, roads and airstrips all demonstrate a similar need for interaction if the communities requirements for ready access to health facilities are to be realised.

In such areas, co-ordination between Commonwealth and State/Territory agencies is necessary to secure a change in the the process of development.

6.3.4 Education

> "It is widely accepted that formal education is decisive in improving health and reducing mortality".

Intersectoral action involving the health and education sectors can have a measurable impact on the health of communities.

With respect to improved education, it is suggested that health can be improved through increasing the availability of education for individuals and communities.

Where parents have benefited from a better education, particularly the mother or the primary caring parents, the health of children is seen to greatly improve.

Similarly, recent studies have shown a clear relationship between levels of education in adults and risk factors for heart disease and stroke and other diseases for which nutrition in major factors.

Two linkages that are suggested from the above are firstly, the development of strategies that improve Aboriginal attainment at primary, secondary and tertiary education, and secondly by including specific subject matter about health within curriculum.

Further, by including in teacher education curriculum components on Aboriginal health, its causes and effects, the contribution of the education sector to Aboriginal health and well being may be enhanced. One recent example of this has been the moves by the Australian Teachers Federation to educate teachers about Aboriginal hearing loss as a factor in Aboriginal children's school life and importantly their lack of scholastic achievement.

Co-operation between the health and education sectors, which reaches beyond the traditional limits of co-ordination, will assist in achieving Aboriginal health improvement.

Little emphasis, in tertiary medical education programs is devoted to the achievement of an understanding by medical students of the social, cultural and political implications and relevance of Aboriginal society & culture. Correlations do exist between the in patterns of health and well-being and variations in the economic, cultural, social and political approach to Aboriginal needs and aspirations.

Tertiary education programs need to teach more about health and well being; they need to go beyond the traditional medical approach.

The style and content of health courses, particularly for doctors and other technicians, needs to be reappraised so that they reflect a primary health approach and demonstrate practical understanding of community empowerment, social justice, equity and health. Courses should provide participants with an understanding of the causes and nature of Aboriginal health needs including the promotion of a practical and conceptual understanding of intersectoral collaboration.

Informal education programs can also have a significant impact on the process of health attainment in Aboriginal communities.

6.3.5 Employment

Many communities believe that a major part of these health problems are the result of high levels of unemployment and a consequential dependence on welfare hand outs. In many communities, whether urban, rural or remote, the traditional roles of men and women have been destroyed, or significantly eroded by, the diminution of the role of men as providers for their families.

Wide spread unemployment amongst Aboriginal people has been the most obvious mechanism of the destruction of gender roles as more individuals and communities become dependent on the basic necessities of western civilisation. To obtain these necessities, food, clothing, shelter, education, etc requires money. This then locks individuals and communities into dependance on the cash economy.

It is axiomatic in Australian society that, in order to provide adequate diet, clothing, shelter, education and medical care that the individual, and the community must have an adequate and reliable source of income. For most Aboriginals this has been impossible to achieve.

The national unemployment rate for Aboriginals is at least 60%, or some 6 times the national average, while in many communities the unemployment rate exceeds 90%. For many, the only source of income comes from Government support programs such as:

- unemployment benefits;
- widow's pension;
- supporting parents benefits; or
- payments received under the Community Development Employment Projects - working for unemployment benefits.

Such subsistence levels of income make it very difficult to provide for the basic necessities let alone rectify any of the deficiencies.

In terms of health, so many of the suggested remedies to the "lifestyle" diseases are based on promoting an adequate and nutritious diet. All too often the suggested remedies ignore the realities of the physical environment, social and cultural customs and practices, and levels of real disposable incomes. Good food costs more than filling "junk" food.

Apart from the direct income-related health issues there are the questions of social disharmony and domestic violence which are too often the companion to the hopelessness and despair engendered in both men and women by unemployment.

6.3.6 A Proposed Mechanism to Achieve Better Intersectoral Collaboration

Questions will undoubtedly arise as to whether intersectoral collaboration within a national Aboriginal health strategy should simply be a refinement of mechanisms already in place, or whether distinct and parallel mechanisms are required. Some may perceive such questions as whether such actions should be mainstream or separate services. The latter view is at best a dangerous oversimplification of the issues involved.

The need for strong, clear, and public commitment to the process of intersectoral collaboration from the executive area of government is fundamental. In most examples, however, a central authoratative and politically supported agency with a clear mandate is essential to the process of collaboration. This central agency can facilitate joint planning and broad consideration of health impacts in sectoral programs and policies.

The bulk of action in Aboriginal health and development is initiated by Aboriginal communities and funded by Commonwealth agencies, normally within the Aboriginal Affairs portfolio. The Commonwealth Government's health agencies, e.g., Commonwealth Department of Health and Community Services, have had far less formal, consistent, or practical involvement in Aboriginal health.

It has been long recognised that co-operation in Aboriginal Affairs has been inadequate. The Interdepartmental Working Group (IDWG) on Aboriginal Health, convened by the Department of Aboriginal Affairs was largely ineffectual. The Department of Aboriginal Affairs convened the forum when it suited their needs rather than allow it to develop as an appropriate co-ordination mechanism between sectoral interests. The general view is that such ad hoc groups are too vulnerable and too unstable to be able to promote adequately intersectoral collaboration.

Recognising these factors, the Working Party recommends:

- the establishment of mechanisms for intersectoral collaboration anchored to the Aboriginal Affairs portfolio, but independent from existing agencies.

A central agency with responsibility for this new approach will need to be very aware of the programs policies and informal activities of the different sectors if it is to be able to identify and co-ordinate the impact of the non-health sector.

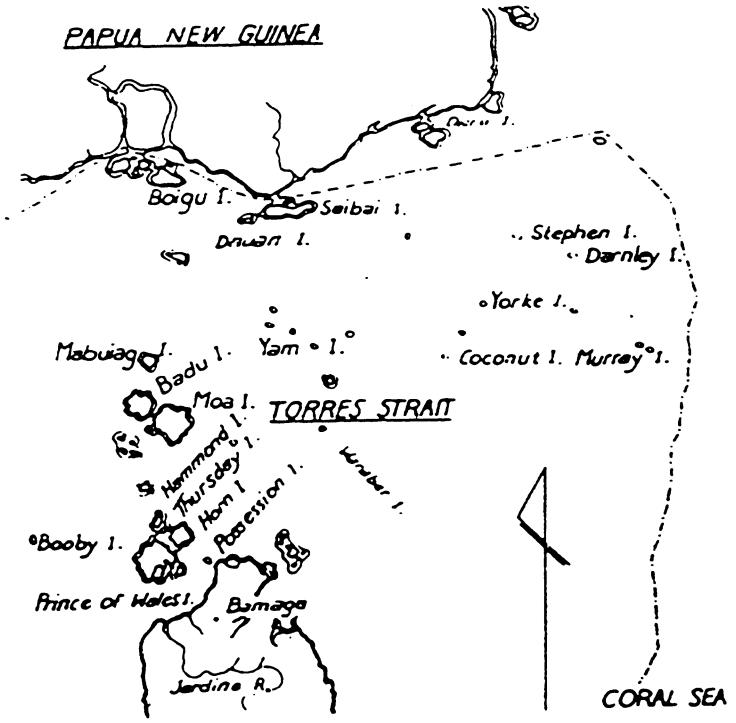
Full details of the presosed mechanisms for both the State and Commonwealth levels, are detailed in Chapter 3, Commonwealth/State Responsibilities.

CHAPTER 7

HEALTH SERVICES IN THE TORRES STRAIT

7.1 INTRODUCTION

This section is provided as a result of the Working Party recognising the distinct status of the people of the Torres Strait area. This section is written based upon traditional and cultural beliefs - which continue to this day. Specifically, these areas are shown in Map 1 below.



Map 1. The Torres Strait Region.
Source : Mr Billy Reid (Artist) in the Aboriginal Health Worker Journal (Volume 8 Number 1, 1984)

7.2 THE TORRES STRAITS ISLANDS

There are more than a hundred islands in the Torres Strait, of which fifteen islands are occupied and established as communities under a (State provided) Deed of Grant in Trust. Thursday Island was established as the administrative and commercial centre for the Torres Straits, whilst the Northern Peninsula Area was settled because of water shortages on some islands. Most of the islands are small, and many lack water which is suitable or fit for human consumption.

The islands are usually described in four categories.

7.2.1 The eastern group :

This group consists of Darnley, Murray and Stephen Islands which are described as small, high volcanic islands with relatively fertile soil and dense vegetation. The total population is 684.

7.2.2 The central group :

This group consists of Yorke, Yam, Warraber (Sue) and Coconut Islands which are described as small vegetated sand cays built up on coral reefs. The total population is 708.

7.2.3 The western group :

This group consists of Badu Island, Mabuiag Island, Kubin and St Pauls on Moa Island, (all with a total population of 1,250); as well as the Port Kennedy area - Thursday, Horn, Hammond and Prince of Wales Islands (with a total population of 4,310) Each are described as large high islands, partly covered with moulds of basaltic rocks, lightly vegetated in open areas, and mostly well watered.

7.2.4 The top or far western group :

This group consists of Saibai, Dauan and Boigu Islands - plus those people from Papua New Guinea who may legally visit under the Border Agreement; and the numerous illegal immigrants. The population is 911.

7.3 SOCIAL HISTORY

The Torres Strait people have been lifeguards and protectors of the Torres Strait Islands since time immemorial. Torres Strait Islanders earnestly maintain their own identity, but are a caring and sharing people. Their language, legends, stories and other cultural activities are still practiced today.

The Torres Strait Islanders strive for equal opportunities and recognition of the rights of their indigenous heritage, as is the right of any sovereign people.

The importance granted to health is demonstrated by the fact that it was one of the twelve major grievances that brought together the Torres Strait Islander people in January, 1988 - during their attempt to secede.

The rationalisation and integration of health services in the Torres Straits is long overdue and is now a priority.

While the Torres Strait Islands have been repeatedly exploited for their resources, very little has been done for the traditional owners in terms of alleviating basic problems in health, housing, food and other supplies, economic development and, until recently, education.

Because of the gross negligence by the State and Federal Governments of Australia, the Torres Strait Islanders fully supported the quest to secede. It was considered that independence was preferable to the abuse Islanders have had to endure. The British colonial law and order inflicted on the Islanders was never, and still is not, accepted by Torres Strait Islanders. Islanders recognise that as Australians, they have fought in the war to defend Australia. Underlying all the above, is the desire to be granted the basic human right of receiving a similiar quality of health facilities that other Australians accept as a norm.

7.4 CURRENT HEALTH SERVICES IN THE TORRES STRAIT ISLANDS

Health services in the Torres Straits and the Northern Peninsula Area are provided by the Queensland Government. The major problem has been that health services have been provided by different agencies - each with different philosophies and each with a different administration. Some have a limited degree of local participation, but certainly none offer community control.

The Queensland Department of Health provides the hospital services at Bamaga and on Thursday Island. Subject to financial constraints, clinics are also conducted on the outer islands. It also provides the Aboriginal Health Programme teams and the Maternal and Child Welfare clinic based on Thursday Island.

The Department of Community Services and Ethnic Affairs provides the Medical Aid Posts on each Torres Strait island community, the Maternal and Child Welfare clinic at Bamaga, as well as the pharmaceutical supplies to each Aid Post.

Current hospital health care services are neither appropriate nor effective for dealing with community health issues. The facility capable of managing a more meaningful and safe delivery of primary health care service would be a local community controlled health care board. The Board should be constituted as shown in Figure 2.

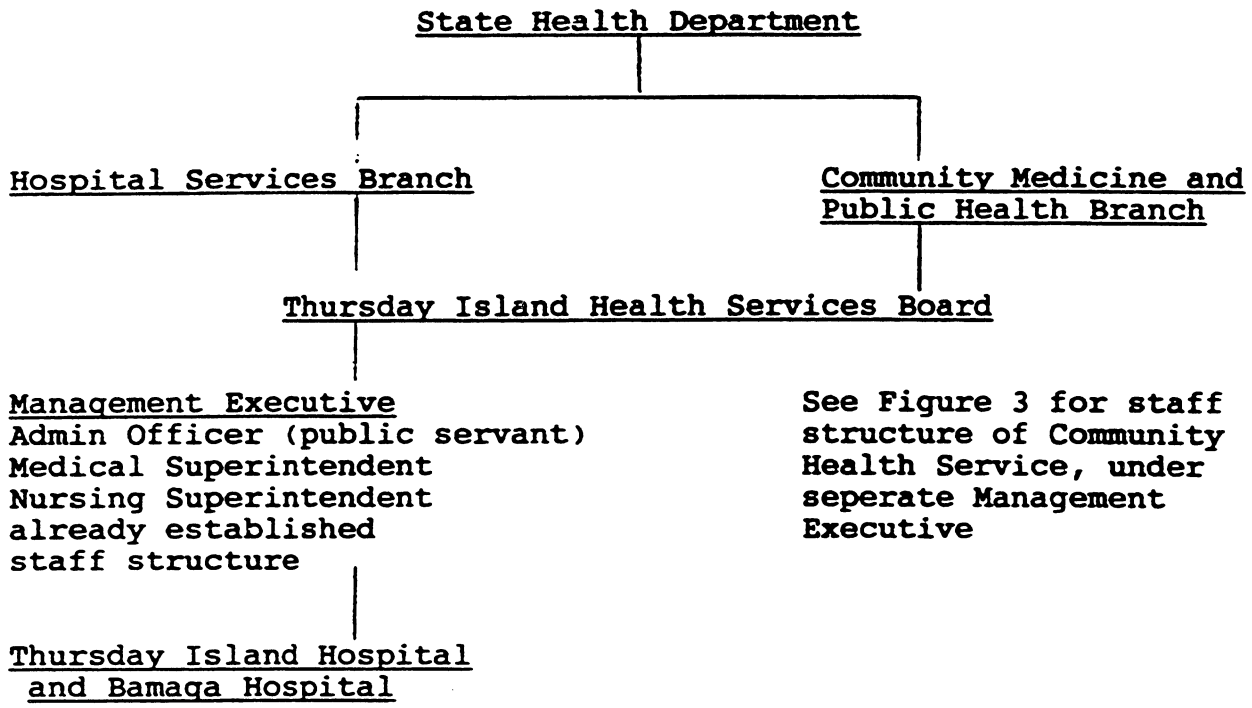


Figure 2. Thursday Island Health Services Board.

7.5 THE BOARD IN OVERVIEW

It is important to recognise that any rationalisation proposal must recognise the absolute necessity of seperating the Hospital Services from the Community Branch of the Board's Health Services. To help confirm and maintain this goal, both service branches will work for the same board locally with mutual liaison, co-ordination and co-operation, but with seperate budgets, management executives and control.

This Health Services Board should have the same charter (under current legislation) as a normal Hospital Board with respect to its ability to provide a full range of both hospital and community health services. It is important to note that historically, most hospital boards presently choose not to exercise their option to enter the field of community health.

The members of this Health Services Board should be appointed by the Minister for Health, from a list of nominees recommended by the duly elected, Local Government bodies in the region, using this model :

Number of Seats Appointee	
1	an appropriately qualified, in the health or management fields, resident of the Torres Straits;
2	Island Co-Ordinating Council nominees;
1	Torres Shire Council nominee;
1	Tamwoy / Abednego Council nominee;
2	community controlled Aboriginal or Islander organisations in the Torres Straits nominees;
2	Northern Peninsula Area nominees.

Local Government bodies would obviously need to specify, in detail, their requirements in the selection process of the Board Members nominees, from which the Minister for Health would appoint a panel. Applicants must have relevant experience or qualifications to effectively serve on the Board - people must not be appointed in token positions. Where applicants do not have the above qualifications, then training programmes must be provided in order to enable appointees to contribute for their full term on the Board.

7.5.1 Staffing issues

Figure 3 offers a detailed staffing proposal for the Community Health Branch of the Health Services Board. Training Torres Strait Islander people in the delivery of health care needs to be emphasised. Whilst there is a registered School of Nursing for enrolled nursing aides at Thursday Island hospital, Health Workers need to be trained and given similiar recognition and the granting of accredited qualifications. Also needed is a program to acquaint non-Islander staff with the culture of the people of the Torres Straits. This could be undertaken during an in-service orientation and be provide through the same school providing the Health Worker training.

It is recommended that:

- the present Hospital Boards be expanded to the maximum number of nine members and renamed and restructured as a Health Services Board for the region.

It is clear that the provision of additional resources is vital to the improvement to the quality of life and health of Torres Strait Islander people however, the restructuring proposed within this section is of equal importance. Without Torres Strait Islander people being empowered to fully participate in the health care system, the 'missionary days' will remain and so too will the current levels of poor health.

7.6 SPECIFIC HEALTH ISSUES

These may be described in three main categories :

- degenerative/lifestyle related diseases;
- sexually transmitted diseases; and
- imported infectious diseases - including from Papua New Guinea during traditional visits.

7.6.1 Degenerative/lifestyle related diseases

Diabetes/hypertension

- the number of registered diabetics/hypertensive indigenous adults in 1978 was 229, whilst in 1987, this figure had risen to 670. In 1988 there was 40% of adults aged 45 to 60 years old who were registered as diabetics;

- children are now being developed into future diabetics by well meaning parents and relatives giving them soft drinks, sweets, refined and fast foods. This risk could be avoided by ensuring adequate availability of appropriate foods through the Island stores. Diabetic Islanders are dying because the appropriate foods are not available in adequate quantity in all communities. They are dying from insufficient and ineffective health education programs which explain their diseases;

- remedial lifestyle education and behaviour modification programs demand a suitable community health service, not simply a hospital to cure the diseased people who are a result of the absence of such services; and

- this disease deteriorates and becomes a problem when most of the traditional diet is blocked, through a variety of means, from the Islanders and replaced by inadequate, inappropriate, and nutritional value food in the 'western diet'.

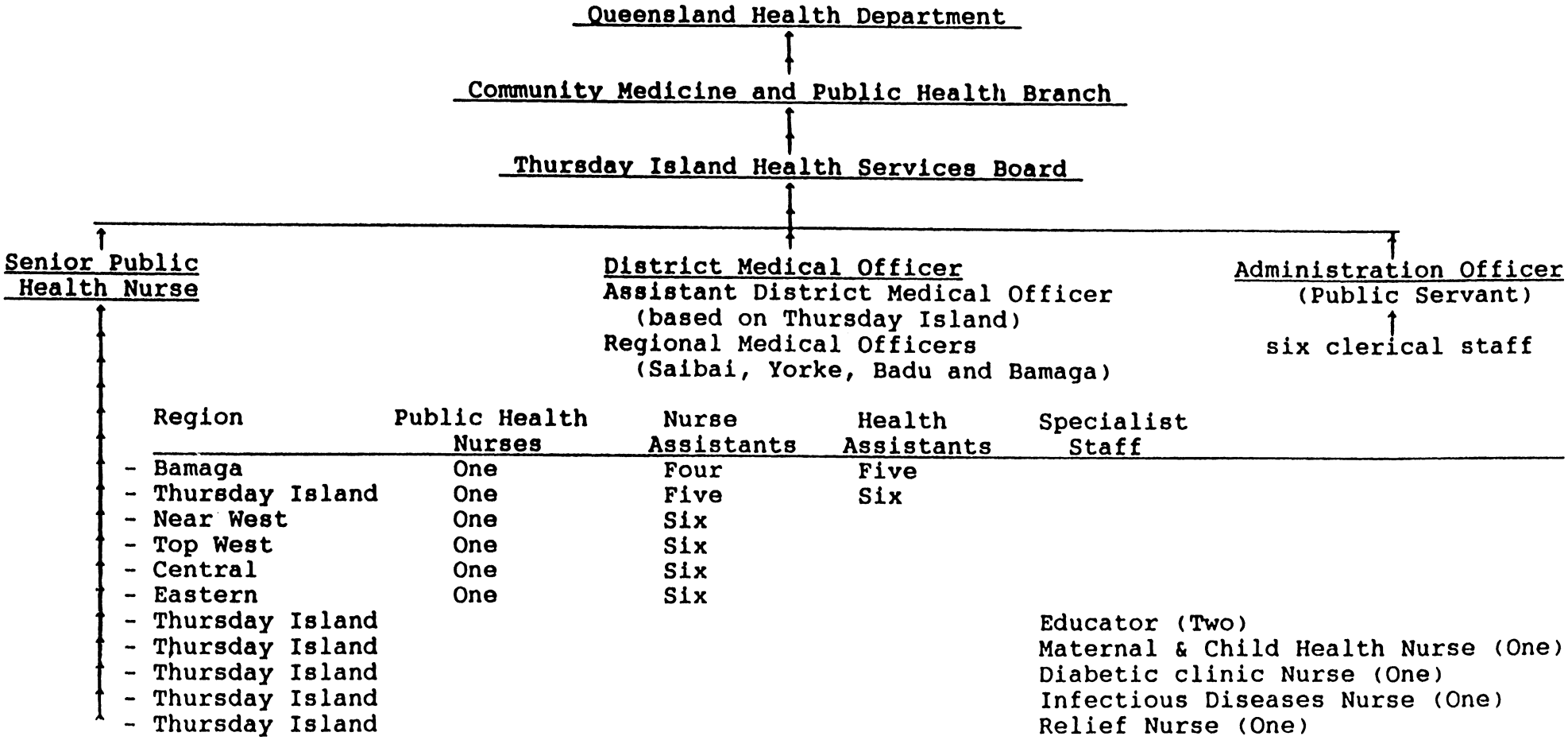


Figure 3. Detail of staff Structure of the Community Health Branch of the Health Services Board.

The Working Party recommends that:

- an acceptable researcher dietitian/nutritionist be apponted undertake a detailed and specific study on the value of traditional foods in the Torres Strait Islands with a view to convincing health care providers, such as Governments, that the problem of diabetes in the Torres Strait Islands is serious.

Alcohol related

- a report was undertaken during 1988 on this issue, and evidence indicates a major problem exists. A community health centre on Thursday Island could assist health staff to manage alcohol problems, assisted by counsellors, social and youth workers. This would include visits to the outer islands. A community based health centre could also assist in the management of child abuse and neglect cases stemming from alcohol related problems in families.

7.6.2 Sexually transmitted diseases (STD)

Sexually transmitted diseases (specific)

- over the past decade, actual new infections of STD's from this region was approximately 3,300. This figure paints an alarming picture and has direct relevance to the following items.

Hepatitis B

- the prevalence of hepatitis B markers in the Torres Strait Islander population lies between 20 - 60% (depending on the community surveyed) with an 'infectious carrier status' prevalence of 29% overall. The hepatitis prevalence in the general population is around 0.2%.

AIDS

- the above situation for sexually transmitted diseases is of serious concern when considering the potential risk the Torres Strait communities have with AIDS. There have already been cases of death in the Torres Strait communities.

- unless a major campaign of education for behavioural change is attempted by an effective community health care service, there will be a decimation of the Torres Strait Islander race.

7.6.3 Diseases Imported During Traditional Vistits

- under the Border Treaty Agreement, traditional visits between Papua New Guinea and the Torres Strait Islands became legally permissable. This policy has proved a political maze, as well as socially disruptive to the Torres Strait Islanders. The transient population movement across the 'open' border is in the vicinity of 4,000 plus annually - most of which are not documented visits and most vistors are unlikely to be vaccinated against disease.

Malaria

- there have been outbreaks of (local transmission) malaria on the islands and as far as Cape York. Such outbreaks are expensive in the control measures required - these include vector control, residual insecticide house-spraying, mass blood slide examination and mass drug administration.

- the last two outbreaks have been more difficult to manage, since the vector control measures previously used are now socially unacceptable, and have not been replaced with a viable alternative. Furthermore, the malaria involved now tends to be drug resistant cerebral malaria, which is more difficult to treat.

Tuberculosis

- between 1978-1987, fifty-two new cases of tuberculosis have been treated in the Torres Strait Islands. The prevalence is fourteen times the State average for Queensland. Twenty nine per cent of these patients have been coastal Papua New Guinea villagers - either permanently or temporarily resident in Torres Strait.

Hansens (leprosy) disease

- there have been thirteen new cases of leprosy diagnosed in Torres Strait, five of whom have been infections, five were in Primary School, and nine were new cases. The probable source of infection was traced to one infectious lepormatous person, originally from a coastal Papua New Guinean village. This infection rate is 76.7 times the Queensland State average.

7.7 CURRENT SOCIAL AND ENVIRONMENTAL ISSUES

7.7.1 Food

Availability and accessability - traditionally, Torres Strait Islanders were mainly dependent upon the sea for their basic food supplies and the provision of freight for other food stuffs.

The cultivation of fruit and vegetables in island gardens has been restricted because of lack of water, and because much of the suitable land has been claimed for airstrips.

The hunting for high protein foods in the sea is somewhat retarded because prawn trawling nets uproot the seabed and catch more than just prawns. For example, baby dugong and other food sources are often lost to the community. For Islanders to return to these nutritional foods, they now need to fish even further from their respective islands - this then requires a far more expensive craft which is totally beyond Islanders' financial capacity.

Therefore, Islanders are now reduced to a heavy dependancy on supplies of food from south of Thursday Island. Air freight is impractical because many Islanders are dependent on social security payments for their cash income. Air freighting provisions can prove very expensive with a small cabbage on Murray Island costing around nine dollars.

People living in the Torres Straits need to be exceptionally skilled in home management. Also, there is a need to ensure that there is adequate holding capacity in the island stores to reasonably cover the period until the next shipment. This is especially necessary for freezer / cooler, diabetic, and pharmaceutical lines.

The Working Party recommends that:

- each Island Store is equipped with adequate refrigeration capacity and general storage to ensure sufficient food supply - both regular lines and of diabetic foods - to fully span the period between supply ships.

7.7.2 Housing

Housing throughout the Torres Strait Islands is a priority. However, even though it is a priority, the Working Party cautions against rushing into and accepting the quick but high cost option. These houses often prove to be unsuitable for both practical and social reasons. Applications for housing should be processed by a Torres Strait Islands Commission of Housing. Applicants should be assessed according to three factors:

- the needy and the homeless;
- length of residency in the Torres Strait; and
- traditional ties to the Torres Straits.

The Torres Strait Islands Commission of Housing should be formed by the amalgamation of all housing authorities in the Torres Strait Islands, currently between fifteen and twenty agencies. Not only would this reduce administrative costs, but community control and participation in the management board should reduce any opportunity for cronyism or nepotism in the allocation of employment and housing.

7.7.3 Water Supply

Although the Federal Government has funded water supply services for every island, at a cost in the millions of dollars, and these services are now at the stage of completion, the community consultation process found that nearly all the islands suffered some form of difficulty with water supply. On some islands, the water was visibly unfit for human consumption. There needs to be defined services to monitor the water supply and to train service maintenance staff - preferable local Islanders.

7.7.4 Waste Disposal

Because of inadequate waste disposal services, excreta and garbage is often washed back onto the beaches which then pose a serious health hazard. In some instances the people, mainly children, are walking, playing and swimming among faecal excreta. Further, the garbage breeds flies and mosquitoes.

Two qualified, health inspectors are required (resident in the Torres Straits) to service the Northern Peninsula Area and the outer Torres Strait Islands.

These staff would be to assist the Island people by advising appropriate sanitary/hygenic means for the disposal of refuse.

The Working Party recommends that:

- that, where no such system exists, appropriate waste disposal systems be planned and installed on each inhabited island, as well as in each of the Northern Peninsula Area communities.

7.7.5 Access to Communication

Communication mediums in each community have been improved to some extent, however communication at the health care clinics needs to be upgraded by the provision of a twenty four hour telephone service. This facility is required for emergencies and to allow health workers to liaise with other health workers either at Thursday Island or at other clinics.

The Working Party recommends that:

- all health care clinics be provided with a 24 hour telephone service.

7.7.6 Power

The provision of universal twenty four hour electricity supply is not an immediate goal for the people in the Torres Strait Islands. Whilst it is desirable, it is simply not the most pressing problem today. It is hoped that this issue is considered and acted upon at the appropriate time and not simply used as a political issue.

7.8 A COMMUNITY DEVELOPMENT STRATEGY

Returning briefly to the introduction to this section, 'the rationalisation and integration of the primary health care services is long overdue and should be a priority'.

The underlying principle to the following strategy is that the community is given control of all its government funded health services by expanding the present Hospitals Boards to the maximum number of nine members and renaming it as a 'Health Services Board' for the region. This Health Services Board should then be funded to provide health services under two seperate branches:

- a Hospitals Section - operating the Thursday Island and Bamaga hospitals. The Thursday Island hospital requires upgrading of staffing and facilities to cope with the increasing population, and the full range of tropical and exotic diseases;

- a Community Section - operating a new Community Health Service which should be formed by full amalgamation of the existing Department of Community Services and Ethnic Affairs, Aboriginal Health Program, and Thursday Island Hospital Community Health Services. Because of the population, distances and transport availability to receive safe health services, there should be five regional doctors in the Torres Strait Islands, resident, on:

- Saibai to service the top western islands and the international visitors;
- Yorke to service the eastern and central islands as well as the Papuan visitors;
- Badu to service the near western islands;
- Bamaga to service the five communities (Cowal Creek, Umagico, Bamaga, New Mapoon, and Seisa) of the Northern Peninsula Area;
- Thursday Island to serve as an Assistant District Medical Officer.

Additionally, there should be a small hospital or a larger clinic with some holding beds where a doctor is resident. The clinics and accommodation on the communities should be upgraded to meet the needs of both the population and the staff - doctors and health workers.

CHAPTER 8

SPECIFIC HEALTH ISSUES

8.1 GOALS AND SHORT AND LONG TERM STRATEGIES FOR HEALTH IMPROVEMENT

The overall goals for both Aboriginal people and the Working Party's recommendations regarding provision of services and co-ordination of services have been outlined in Chapter 4.

This section of the report deals with goals and strategies for specific health problems.

The Working Party believes that while it is necessary to provide immediate treatment for the acute problems, current resources need to be provided for primary care, but this must not be at the expense of the resources needed to address the underlying causes.

It is essential that Governments, Health Departments, community controlled health services and private practitioners utilise strategies for specific health problems as part of an integrated co-ordinated health policy. There is a danger that Governments and policy makers will implement a myriad of specific health programs (e.g. Trachoma program) without integrating these into existing services and policies.

Accordingly, the strategy must include health measures to address the acute problems, the initiation of health promotion programs and specific prevention strategies, e.g., immunisation, and non-health measures that involve political and social change.

A high level of co-operation between community controlled health services, and secondary and tertiary services is essential. There is some evidence that, despite high levels of hospital admission, this still represents an under utilisation of hospital services for the level of morbidity in Aboriginal communities.

The Working Party believes that the implementation of specific preventive health programs is clearly the responsibility of community controlled primary health care services with appropriate support from other service providers.

In order to achieve an appropriate balance of preventive and curative programs within these primary care services, there needs to be clear delineation of responsibility for implementing and overseeing preventive programs. Where this lies within individual services it will be a matter for them to determine in conjunction with Aboriginal Public Health Workers, Aboriginal Health Workers, medical staff or nursing staff, depending on skills, interest, population served, etc.

As indicated in the list of research priorities, (see Aboriginal Health Research), strategies for prevention, particularly of lifestyle diseases need extensive research in Aboriginal communities. For other high priority specific diseases, an adequate level of appropriate service provision in local communities is the key factor.

Strategies for prevention of lifestyle, or indeed any other diseases which have proved effective in non-Aboriginal communities cannot be assumed to be appropriate for Aboriginal communities.

Innovative strategies which address local community responsibility, use of local resources, behaviour modification, compliance with treatment, self-esteem etc., need to be developed and evaluated and then made available to communities for implementation.

Particular issues which need to be addressed in developing strategies are appropriate Aboriginal cultural processes, language and literacy levels, use of audio-visual material, cultural sensitivity, appropriateness, role and acceptability of various monitoring and evaluating techniques.

As poor nutrition is a major factor contributing to poor health in Aboriginal communities it should be the focus of particular attention. Availability and cost of nutritious food are major issues in many Aboriginal communities. The practicalities of ensuring access to appropriate food should be seen as a priority for community based health services, along with education about nutrition. As indicated in the proposed budget specific funds should be allocated for a research project in this area.

The proposed budget specifies a sum of $7.5 million be allocated over five years to address the specific disease issues. A significant proportion of this must be devoted to the development and evaluation of preventive health strategies. Aboriginal Health Services, State Health Promotion Units, State Aboriginal Health Units, non-Government organisations such as Diabetes Australia or the National Health Foundation, or academic institutions must be contracted as per the NH&MRC and NAIHO guidelines to develop and evaluate strategies which could then be made available to local services.

Funding for implementation of preventive programs and provision of equipment, etc. for preventive strategies must be part of ongoing funding of health services rather than separate 'add-ons'. This will ensure an adequate profile for preventive programs and integration with treatment services. Separate or special funding is only appropriate for development, trial or evaluation of strategies.

But the attainment of goals for improved health through the application of short - and long-term strategies will need to be adequately funded and staffed. This will mean additional funding for education and training programs to ensure that these staff are available.

It is envisaged that short and long term recruitment will occur concurrently at the primary and secondary levels of health care, as an increased delivery of the former will quickly flow on through referrals to an increased demand for the latter.

Aboriginal Health Services, in order to achieve the goals proposed, will need to employ more doctors, dentists, nurses, dental nurses, dental assistants, and health workers in order to improve the quality and availability of primary health care. Additionally, they will require greater availability and accessibility to some aspects of secondary level care that are already in existence. This means they will have to provide more visiting specialists and clinics such as ear-nose-and-throat clinics, nutrition clinics, diabetes clinics, gynaecological clinics, psychology clinics, paediatrics clinics, etc., and there will be a flow on to the public sector.

State Government bodies (predominantly involved in secondary level care) are as likely to be affected by a need for increased resources as Aboriginal Health Services. Other private specialist services provided by private enterprise are also likely to be affected.

State Government bodies will need to expand and increase services which provide, for example, X-rays, dentures, dental laboratory work, optical services, pathology tests, STD clinics, renal clinics, and surgery because of increased referrels from Aboriginal Health Services.

As well as an increased demand for appropriately trained personnel, there will likely be a need to expand facilities and update technology.

The specific health strategies suggested in this section should not be imposed on a national basis; all strategies should be developed and implemented according to local priorities.

Where "targets" have been set in years, these estimates are based on achievable targets once a full range of services have been provided as outlined in the general recommendations.

In this paper the terms "excess mortality" and "excess morbidity" refer to the difference between the mortality and morbidity rates suffered by Aboriginal people for a certain disease, and the comparable rates for non-Aboriginal people.

Such "excess mortality/morbidity rates" are usually expressed as a factor eg "excess mortality of 2.5 x" indicates that for a certain disease Aboriginal people die 2.5 times more frequently than non-Aboriginal people.

The Working Party is concerned that any attempt to set targets before a full range of services is provided will inevitably lead to limited success in the achievement of those targets.

Whilst the Working Party has "set" some specific targets, these should be viewed as indicative only. Achievable, measurable and realistic targets must be based on essential baseline data which is not currently available. Further, the Working Party believes that targets must be set in conjunction with Aboriginal people and service providers.

8.1.1 Medical Consultations with Aboriginal People

Many medical practitioners state that they treat all patients in the same way and that the same techniques of history-taking, diagnosis and treatment apply to all races. This approach denies the reality of cultural and law differences between Aboriginal and non-Aboriginal people and the fact that these differences constitute a barrier to effective communication and therefore proper health care. Unless medical practitioners change this approach, many Aboriginal people will continue to suffer and die needlessly.

8.1.2 Spectrum of Disease

Although all people suffer from the same diseases, many diseases are much more common in Aboriginal people. Medical practitioners must recognise which diseases are more common in Aboriginal society, and which diseases are the major causes of Aboriginal morbidity and mortality. These diseases need to be high on the differential diagnosis list whenever Aboriginal patients are seen.

8.1.3 Aboriginal Concepts and Aboriginal Culture

Medical practitioners must attempt to understand some of the concepts of health, cultural background and the history of oppression that Aboriginal people have faced. Much more understanding could be gained by medical practitioners, if they would get to know Aboriginal people, develop mutual trust and respect, and show their acceptance of Aboriginal ways.

8.1.4 Aboriginal Poverty

Medical practitioners must understand that Aboriginal people as a group live in extreme poverty. This is a fact of life for rural and urban Aborigines. Even Aborigines who hold well-paid jobs may be living in poverty, because Aboriginal society is based on sharing with others, and that one income may be required for several families. This poverty has implications when expensive treatment regimes or procedures are recommended, e.g., storage facilities and refrigeration may be inadequate.

Health professionals need a thorough understanding of the spectrum of Aboriginal health problems, and of the social, cultural and economic background of their patients to allow them to understand what Aboriginal people are saying, to advise on appropriate treatments and to explain the diagnosis and treatment to the satisfaction of both parties.

This requires time, sympathy and flexibility on the part of health professionals, and willingness to be educated about Aboriginals and their health, at both Australia wide and local levels.

These issues are discussed in more detail in the Chapter on Training and Education Issues.

8.2 CARDIOVASCULAR DISEASE (CVS)

8.2.1 Nature of the Disease

- high death and morbidity rates from ischaemic heart disease (heart attacks and heart failure); and
- high death and morbidity rates from cerebrovascular disease (strokes).

8.2.2 Cause

- atheroma causing coronary and cerebral vasculature to be compromised.

8.2.3 Aetiological Factors Include:

- poor diet (saturated fats, obesity);
- hypercholesterolemia;
- diabetes;
- cigarette smoking;
- hypertension;
- heredity;
- inadequate exercise; and
- stress.

8.2.4 Goals

- to reduce the incidence of Cardiovascular disease; and
- to reduce the mortality from CVS disease in Aboriginal people.

8.2.5 Target

- to reduce the excess mortality for CVS disease by 50% within 10 years and by 100% in 25 years.

8.2.6 Specific Objectives

- smoking prevention and reduction;
  - to encourage non-smokers, in particular young people to remain non-smokers; and
  - to encourage, motivate and help those who smoke, to stop.
- hypertension control
  - to detect all those whose blood pressure is elevated and to reduce and maintain their blood pressure at normal levels.
- exercise promotion
  - to encourage people to take sensible regular exercise as a normal part of life.

- healthy nutrition
  - to promote bush foods;
  - to encourage fitness and discourage obesity;
  - to promote a diet which is low in fat (especially saturated fat), refined sugars and salt, but which is high in fibre; and
  - to enable better control of diabetes when it is present.

8.2.7 Specific Strategies

- smoking prevention and promotion
  - educate children about the benefits of not smoking, using accepted Aboriginal role models (sports persons, leaders etc.);
  - for those who are smoking, provide specific advice, support and encouragement to cease (including self-help groups), develop culturally appropriate programs. Aboriginal Health Workers, nurses and doctors may need special training to undertake this role.
  - encourage smoke free zones in Aboriginal services; and
  - promote anti-smoking campaigns amongst Aboriginal people.
- hypertension control
  - provide the opportunity for, and encourage all Aboriginal adults to have their blood pressure measured at least every year. This can be performed as part of an individual health consultation when an individual presents for other problems, or as part of a community screening program;
  - for those whose blood pressure is elevated provide advice, education and counselling on the health risks and mortality associated with hypertension;
  - provide advice, support and encouragement to reduce salt, saturated fat, refined sugar and alcohol intake, to achieve weight reduction, to have regular exercise and to stop smoking;

- provide appropriate medical treatment to reduce blood pressure levels to normal; and
- provide facilities for regular monitoring and life-long follow up to ensure that hypertension is controlled.

- exercise promotion
  - encourage regular exercise as a habit in conjunction with weight reduction programs . An exercise program should ideally start in early childhood in the school. Older people can be encouraged to engage in exercise such as walking.
  - ensure that an adequate range of sporting and recreational activities are available in all communities;
  - encourage and promote traditional food gathering and hunting activities, walks to traditional sites, ceremonial dancing etc.
- healthy nutrition
  - provide facilities for the recognition and assessment of obesity (Body Mass Index greater than 25) to all Aboriginal adults at least every 5 years from the age of 20. This could be offered as community screening programs or as individual screening when patients present for other reasons;
  - provide culturally appropriate, realistic and ongoing advice about affordable, acceptable and appropriate nutrition, and counselling and assistance with weight reduction to all persons found to be obese. Aboriginal Health Workers, nurses and doctors may need special training to undertake this role;
  - encourage and support the use of traditional foods by Aboriginal people;
  - encourage an understanding amongst non-Aboriginal people of the benefits of traditional foods and hunting and gathering activities;
  - investigate and to take action to protect traditional foodstuff/sources from non-Aboriginal exploitation;

- research ways of increasing traditional foodstuffs, e.g. farming, land management;

- to legislate for Aboriginal people to enable them to hunt for traditional food in any area without prosecution;

- ensure that an adequate range of fresh foods which are low in fat (especially saturated fats), refined sugars and salt, but high in fibre is available to all Aboriginal people at prices comparable to those in metropolitan areas. Economically viable freight subsidies will be necessary, as in many areas food prices are exorbitant (e.g. Working Party members noted the cost of $9 for half a cabbage); and

- provide stress management programs.

8.2.8 Resource Implications of the Strategies

It is clear from the reports on the consultation process that many areas in which Aboriginal people live are grossly underserviced in comparison to the rest of Australia. Effective strategies for the resolution of health problems rely on the adequacy of appropriate service providers both in terms of quality and quantity.

Specific needs include:

- Aboriginal health workers working within a community structure who have specialist training to enable them to implement the strategies for:

  - healthy nutrition;

  - exercise promotion;

  - smoking prevention; and

  - stress management.

- a combination of doctors, nurses and Health Workers to implement the strategy for:

  - hypertension control.

- a campaign approach using voluntary health screenings to achieve a significant reduction in mortality from heart disease as often the individuals are unaware of the risks of their lifestyle, and contributing factors which are not obvious, e.g., hypertension.

- primary health care provided by services in which there is full community participation and control.

- specific resources for these services, which enable a full range of preventive, promotive and curative health services.

Until fully integrated community controlled services are established and organised to provide screening and health promotion campaigns, there is a role for State and regional services to assist community controlled services.

8.3 DIABETES MELLITUS

8.3.1 Nature and Significance of the Disease

Diabetes affects 3.4% of the non-Aboriginal population. Maturity onset (Type 2) diabetes affects from 7.8% (coastal NSW) to 40% (some islands in the Torres Straits) of the Aboriginal and Islander population. Furthermore, Aboriginals are developing maturity onset diabetes at a younger age (20-30 years old as compared with 40-60 years old in the non-Aboriginal population).

The complications of diabetes include coronary artery disease cerebrovascular disease, renal disease, blindness, peripheral arterial disease (gangrene), repeated infections and peripheral nerve damage. Diabetes also causes an excess mortality (up to 9 x the rate of the rest of the Australian population).

8.3.2 Cause

- a combination of genetic, nutritional and lifestyle factors.

8.3.3 Aetiological Factors include:

- genetic predisposition;

- diet and dietary changes;

- lack of excercise; and

- stress

8.3.4 Goals

- to reduce the incidence of maturity onset (Type 2) diabetes;

- to reduce the morbidity caused by diabetes;

- to reduce the mortality caused by diabetes;

8.3.5 Target

- to reduce the incidence of diabetes and its complications by 50% over the next 10 years and by 100% over the next 25 years.

8.3.6 Specific Objectives

- healthy nutrition
  - to encourage fitness and discourage obesity: and
  - to promote a diet lower in fat, (especially saturated fat) refined sugars and salt, but which is high in fibre.
- exercise promotion
  - to encourage regular exercise as a normal part of life.
- detection of undiagnosed diabetes and management of people with diabetes
  - to improve the detection of undiagnosed diabetes and the management of people with diabetes.

8.3.7 Specific Strategies

- healthy nutrition
  - establish diabetic clinics in Aboriginal health services.
  - provide education programs for Aboriginal health workers to become specialists in diabetes.
  - to provide culturally appropriate, realistic ongoing advice about affordable acceptable and appropriate nutrition, counselling and assistance with weight reduction and dietary change to all persons found to be obese or diabetic.
  - ensure that an adequate range of fresh foods which are low in fat (especially saturated fats), refined sugars and salt, but high in fibre is available to all Aboriginal people at prices comparable to those in metropolitan areas. Economically viable freight subsidies will be necessary, as in many areas food prices are exorbitant.

- encourage and support the use of traditional foods by Aboriginal people.

- exercise promotion

  - in conjunction with weight reduction programs encourage regular exercise as a habit;

  - encouraging exercise by ensuring that an adequate range of sport and recreational activities are available on all communities;

  - encourage and promote traditional food gathering and hunting activities, walks to traditional sites, ceremonial dancing etc.

- screening for diabetes

  - provide facilities for measurement of fasting blood glucose (and, if necessary, glucose tolerance tests) on all Aboriginal adults every three to five years and on pregnant Aboriginal women as they present. This can be performed as part of an individual consultation when a person presents for other problems, or as part of voluntary community screening programs as part of a concerted campaign;

  - encourage annual urinalysis and/or random blood sugar testing for all Aboriginal adults.

- control and management of individuals with diabetes

  - provide advice and education on the health risks and mortality associated with high blood sugar;

  - establish a chronic disease register for diabetes in every Aboriginal health service. This would improve management and followup of patients with diabetes;

  - establish diabetic clinics in every Aboriginal health service for complication screening, (including ophthalmology and foot care) dietary support, education, and to encourage regular review of people with diabetes;

  - provide advice, support and encouragement to reduce salt, saturated fat, refined sugar and alcohol intake, to achieve weight reduction, and to encourage regular exercise and cessation of smoking.

- provide appropriate medical treatment to reduce blood sugar levels to normal. Care should be taken in the use of oral hyperglycemic medication. The emphasis should be on weight reduction and dietary changes, and life-long follow up to ensure that blood sugar levels are controlled.

- provide specialised care and management to women with diabetes in pregnancy.

8.3.8 Resource Implications of the Strategies

- Aboriginal Health Worker diabetes specialists are the appropriate staff to implement strategies for:

  - healthy nutrition; and

  - exercise promotion.

- doctors, nurses, dietitians and health workers who provide advice and treatment to Aboriginal people with diabetes require specific education programs which equip them to recognise and appreciate:

  - the high prevalence of diabetes amongst Aboriginal people;

  - the young age at presentation;

  - the background cultural social dietary and hereditary factors in the aetiology;

  - the sorts of difficulties Aboriginal people have with standard diabetic diets; and

  - the need to encourage use of traditional foods wherever possible.

Until fully integrated community controlled services are established and organised to provide screening and health promotion campaigns, there is a place for State and regional services to assist community controlled services in these matters.

8.4 CHRONIC LUNG DISEASE (INCLUDING LUNG CANCER)

8.4.1 Nature of the Disease

Chronic lung disease is a cause of significant morbidity in Aboriginal people.

It is also a cause of excess mortality (up to 4.5 x the rate in the wider Australian population).

Lung cancer causes an excess mortality of 2 x the rate in the wider Australian population.

8.4.2 Cause:

- multiple factors

8.4.3 Aetiological factors include:

- cigarette smoking (active and passive);
- repeated respiratory infections;
- inadequately treated respiratory infections;
- environmental pollutants (e.g. asbestos, dust, smoke);
- asthma;
- bronchiectasis; and
- poor housing.

8.4.4 Goals

- to reduce the incidence of chronic lung disease;
- to reduce the morbidity caused by chronic lung disease; and
- to reduce the mortality from lung cancer and chronic lung disease in Aboriginal people.

8.4.5 Specific Objectives

- assessment and treatment to provide adequate and appropriate health services with facilities and adequately trained staff so that every Aboriginal person will have:
  - access to basic respiratory function testing;
  - adequate clinical assessment of the respiratory system on an annual basis; and
  - follow up treatment facilities when required.
- smoking prevention and reduction:

- to encourage, motivate and help smokers to cease smoking.

8.4.6 Specific Strategies

. health service provision that ensures access to appropriate immunisation for children, and access to early diagnosis and treatment for respiratory disease.

. anti-smoking campaigns appropriate for and situated in Aboriginal communities.

There will be a need for specific funding for culturally appropriate anti-smoking campaigns for the Aboriginal community. Initially, these should be developed on a national, State, Territory or regional basis. Where appropriate campaigns may be adapted by community controlled health services to suit local conditions.

8.4.7 Resource Implications of the Strategies

Governments must accept that the health services provided to a great many Aboriginal communities throughout Australia are under-resourced in terms of appropriately trained health workers, nurses, doctors and equipment, and it is essential that this be redressed.

Only when services are properly resourced will it be possible to provide high quality respiratory function testing, adequate clinical assessment and management and follow up, including patient counselling, which includes explanations of the significance of findings and the need for treatment.

8.5 PNEUMONIA

8.5.1 Nature of the Disease

Pneumonia is a severe infection of the lungs which causes up to 10 x excess mortality in Aborigines compared to non-Aboriginals.

Factors that Account for the excess incidence and the increased severity include:

. overcrowding;

. low immunity and general debility;

. repeated upper respiratory infections;

- alcohol related problems; and
- late diagnosis.

8.5.2 Goals

- to reduce the incidence of pneumonia; and
- to reduce the morbidity and mortality from pneumonia.

8.5.3 Target

- to reduce mortality from pneumonia by 50% within five years and by 90% within 10 years. This target begins when a full range of appropriate health services and environmental infrastructures are in place.

8.5.4 Specific Objectives

- to ensure that all Aboriginal families have adequate provision of appropriate housing or dwellings;
- to provide culturally appropriate education, health promotion and self-help health care campaigns so that parents and other carers of children will recognise the signs of severe respiratory illness and seek early management;
- to ensure that all clinicians (doctors, nurses and health workers) who treat Aboriginal people are adequately educated in the incidence, severity, diagnosis, and appropriate management of pneumonia in Aboriginal people.

8.5.5 Specific Strategies

Pneumonia is curable in most cases. Strategies must concentrate on early diagnosis and prevention campaigns.

Early diagnosis implies early presentation to the health service, and correct early diagnosis and treatment by the health worker, nurse or doctor.

- to achieve this, health services need to be culturally appropriate and accessible. Health workers, nurses and doctors need to be adequately trained on the severity, significance, possible dire consequences, and appropriate treatment strategies for managing pneumonia in Aboriginal people;

- education for parents and carers of children is needed so that children are brought to the health services earlier. Self-help health care programs may be the appropriate means to achieve this;

- vaccines to prevent the common bacterial pneumonias are currently being introduced, and they may need to be widely used in Aboriginal children in some areas once safety and efficacy have been established.

8.5.6 Resource Implications

Resource implications include funding of health services, and education programs for staff.

New vaccines are expensive. To reduce grossly excessive mortality from pneumonia, Governments must provide funds for such vaccines.

8.6 ASTHMA

Nature of the Problem

Asthma is a major cause of morbidity and mortality, being the fifth most common cause of death in the Australian community. It is no less a problem for Aboriginal communities across Australia.

Asthma is defined as reversable airways obstruction. It is a common disorder in childhood often improving as the child matures, but it also frequently first occurs in adulthood and it can be severe.

Aetiological factors and triggers that may precipitate an attack include:

- atopy;)associated
- allergy;)with
  - house dust mite;)childhood
  - other allergens; eg pollen)asthma
- respiratory infections;)particularly
- smoking;
- environmental Pollutants;
  - herbicides/pesticides;
  - dust;
  - passive smoking; and
- stress/anxiety.

8.6.1 Goals

- to decrease the incidence of asthma;

- to decrease the morbidity caused by asthma; and

- to decrease the mortality from asthma.

8.6.2 Objectives

- to improve the early diagnosis of asthma;
- to improve the management of asthma ie prevention of anti crisis and better day-to-day management;
- to encourage non-smokers to remain non-smokers;
- to encourage those who smoke to stop; and
- to ensure that all patients and their carers are educated about asthma and its management.

8.6.3 Specific Strategies

- ensure access to comprehensive, culturally appropriate community-controlled primary health case for all Aboriginal people;
- to develop and culturally appropriate patient education programs which would emphasize the skills necessary for asthmatic crisis prevention and management;
- that Aboriginal medical services develop protocols for investigation and management of a crisis;
- that treatment regimes be simple and comprehensible;
- that funds be made available for communities to have access to nebulizers, peak flow meters, spacers, and the necessary pharmaceuticals so that patients have these for free;
- local community strategies to address the problems of identified environmental pollutants; and
- stress management programs for patients and their families.

8.7 Kidney Diseases and Renal Failure

8.7.1 Nature and Singnificance of the problem

Renal failure and severe kidney disease are much more common in Aboriginal people. Papers submitted by the Australian Kidney Foundation indicated that:

- in south Australia, Aborigines require dialysis 7-8 times more commonly than non-Aborigines per head of population;

- in New South Wales in 1981, it was found that Aborigines died from kidney disease 5 times more commonly than non-Aborgines.

8.7.2 Aetiological Factors

- in North Queensland studies, it is apparent that one of the causes of this excess morbidity and mortality is type II (maturity onset) Diabetes mellitus which was identified as the cause of the renal failure in 35% of Aboriginal patients, but only 8% of the non-Aboriginal patients.

- Aborigines suffer from all the other causes of kidney disease and renal failure including Glomerulonephritis (in the past, there have been outbreaks of Glomerulonephritis in some communities resulting from outbreaks of Streptococcal skin infections), reflux, hypertension and chronic infections. Because of lack of resources there is often late diagnosis and unneccessary kidney damage and renal failure.

8.7.3 Goals

- to reduce the incidence of kidney diease and renal failure;

- to reduce the morbidity caused by kidney disease; and

- to reduce the mortality caused by diabetes.

8.7.4 Specific Objectives

- early detection of kidney disease;

- to detect all those with kidney disease;

- appropriate management of kidney disease;

- to provide appropriate management for kidney disease, including facilities for dialysis and renal transplant when appropriate;

- prevention and control of diabetes:

  - to prevent the development of type II diabetes;

  - to detect all those with undiagnosed diabetes;

  - to arrange appropriate management for those diagnosed as having diabetes.

- prevention and control of hypertension:
  - to detect all those whose blood pressure is elevated;
  - for those with hypertension, to reduce and maintain their blood pressure at normal levels.

8.7.5 Prevention and Control of Glomerulonephritis

- to prevent streptococcal skin infections;
- to provide early and effective treatment for streptococcal skin infections when they occur.

8.7.6 Specific Strategies

- early detection of kidney disease:
  - all health practitioners must be made aware of the need to test Aboriginal people for kidney disease in order to prevent kidney damage and renal failure;
  - community-controlled health services community hospitals and aid posts and state health departments must co-ordinate services so that all Aboriginal children and adults have simple urinalysis performed annually;
  - any persons found to have abnormalities on urine testing must be investigated appropriately.
- appropriate management of kidney disease:
  - those found to be suffering from various kidney diseases will need appropriate treatment and possibly specialist consultations;
  - those suffering renal failure will require access to renal dialysis in either home or hospital, particular problems exist in obtaining renal dialysis for the large number of patients in rural areas;
  - renal transplant surgery is a sensitive issue for many Aboriginal patients, and may involve traditional beliefs about the body and its organs before and after death. Staff involved in renal transplant units must undertake delicate negotiations on this matter in each individual case; and

- renal transplant surgery is a difficult problem also in respect of tissue typing and the difficulty of finding matched tissue from cadavor sources. There have been several cases where live organ donation (eg from other family members) has had to be used.

- prevention and control of diabetes:

  - see the particular strategies listed under 7.3 Diabetes Mellitus.

- prevention and control of hypertension:

  - see the particular strategies for hypertension listed under 7.2 Cardiovascular Disease.

- prevention and control of Glomerulonephritis:

  - skin infections should be tested vigorously and swabs should be taken to check for nephrotogenic streptococci, wherever outbreaks of skin infections occur;

  - patients who have been treated for streptococcal skin infection should be followed up to detect blood and pathogen in the urine;

  - if glomerulonephritis occurs, it should be treated vigorously with the assistance of specialists.

8.7.7 Resource Implications of the Strategies

The comments made under this heading in the Cardiovascular Disease section 7.2.5 also pertain here.

In addition, doctors, nurses, dieticians and health workers who provide advice and treatment to Aboriginal people with kidney problems, require specific education programs which equip them to understand and be aware of:

- the high prevalence of kidney disease and its effects on Aboriginal people;

- the young age at presentation of kidney disease;

- the matters relating to transplant surgery outlined above.

Government will need to allocate resources to provide renal dialysis services in remote areas.

8.8 EAR DISEASE

8.8.1 Nature of Disease

- chronic perforated eardrum with discharging ears with or without hearing loss and consequent social, educational and psychological problems.
- chronic serous otitis media ("glue ears"), hearing loss and/or hearing distortion and consequent social educational or psychological problems.

8.8.2 Cause

- no definite cause proven.

8.8.3 Possible Aetiological factors include:

- undetected and therefore untreated initial episode of otitis media;
- chronic upper respiratory infections;
- undernutrition;
- overcrowding;
- chlamydia infections;
- eustachian tube differences; and
- low immunity.

8.8.4 Goals

- to reduce the incidence of ear disease;
- to reduce the social, educational and psychological consequences of hearing loss;
- to conclusively evaluate the effectiveness of various approaches for reducing the problems of ear disease;
- within the next two years (ie by the end of 1990) to provide facilities and adequately trained staff so that every Aboriginal child will have access to annual audiometry and tympanometry testing, and otoscopic examination (important for the treatment of asymotomatic otitis media);

- within the next two years (ie by the end of 1990), to provide appropriate and accessible hearing aid or headphones for use by all Aboriginal children who require them;

- within the next two years (ie by the end of 1990) to gain endorsement by all State Education Departments for specific awareness programs for teachers of hearing impaired children, and appropriate methods of dealing with such problems in the classroom;

- establish by 1990 a multicentre trial to conclusively evaluate the effectiveness of various strategies for prevention and management of glue ears and discharging ears in Aboriginal children;

- within the next two years (by the end of 1990), drawing on the experience of established programs (eg NT & Qld Health Department hearing programs), establish throughout Australia, self-help programs for parents and children regarding the management of discharging ears; and

- to ensure that adequate speech therapy services are available to all those who require them.

8.8.5 Specific Strategies

- ensure access to annual audiometry, typmpanometry and otoscopy for all Aboriginal children. To achieve this, services must be upgraded as detailed in consultation reports for individual communities;

- community controlled health services, community hospitals and aid posts, and State Health Departments must co-ordinate services so that an annual community screening is performed on all children to detect undiagnosed ear disease and hearing impairment or distortion;

- appropriate hearing aids or headphones must be provided immediately to all Aboriginal children who require them;

- there is a need for further research and evaluation to determine the appropriateness of amplification appliances. The 'Walkman' headphones have certainly been a success in classroom situations, but are generally limited to that environment;

- the National Acoustics Laboratory (NAL), State Health Departments, community hospitals, Aid Posts and community controlled health services must co-operate in order to determine (often temporary) requirements for amplification and to provide the appliances;

- awareness programs for teachers should be introduced as a matter of priority. Many States have specialist teachers for the hearing impaired. Similar skills and knowledge must be provided for all teachers who deal with significant numbers of Aboriginal children. This will require the endorsement and co-operation of State Education Departments as discussed elsewhere in this report;

- the attention of those responsible for designing and outfitting school class rooms must be drawn to the need for specific acoustic properties to offset the difficulties experienced by children with hearing impairment;

- effective self-help programs have already been established and these need to be developed and introduced so that parents and children:

  - understand and accept the importance of keeping ears dry until perforations have healed;

  - understand, and perform regularly;

    - dry ear toilets to remove secretions;

    - the need for effective nose blowing to clear reservoirs of infection;

- establishment of a multi-centre trial will enable the conclusive evaluation of various strategies for prevention and management of ear disease;

  - this will require effective collaboration between Aboriginal communities, State and Territory health authorities, NAL, and academic institutions. Before embarking on such a trial, comprehensive analysis of existing hearing conservation programs (e.g. QLD, NT) should be performed;

  - strategies to be evaluated include:

    - medical interventions e.g.;

- antihistamines;
- antibiotics;
- nasal inhalations;
- nasal and aural hygiene; and
- immunotherapy.

- Surgical interventions e.g.;
  - tympanoplasty;
  - insertion of grommets;
  - adenoidectomy; and
- prevention strategies - these will rely on investigations into the possible aetiological factors detailed above.

8.8.6 Resource Implications

To conduct high quality audiometry, tympanometry and otoscopy for all Aboriginal children, it is essential that health workers, doctors and nurses receive adequate training and have adequate time to conduct these necessary procedures.

The supply of hearing aids and headphones to all children who need them will constitute a significant increase in resources needed to purchase equipment, either through NAL or other bodies. It is essential that appropriate funding allocations be made as hearing impairment and distortion is a fundamental cause of a great number of social, educational and psychological problems of Aboriginal children and adults.

Clearly the above strategies require the co-ordination of a combination of community controlled primary health care services and health departments, hospitals, and NAL.

Education Departments must allocate funds to train teachers working with Aboriginal children in understanding and dealing with the needs of impaired and distorted hearing in children.

Health services must accept the responsibility to teach parents and children, to perform ear toilets to clean away discharge. Primary health care service funding must include a specific component for health education and health prevention, and staff need to be specifically trained in effective techniques of health education.

The establishment of a multi-centre trial in collaboration between the Aboriginal community, academic institutions and Health Departments will necessarily be a costly exercise, but it is long overdue as the costs of widespread hearing impairment and distortion throughout the Aboriginal community are enormous.

8.9 DIARRHOEAL DISEASES

8.9.1 Nature of the problem

Diarrhoeal diseases in Aboriginal children still cause excess morbidity and mortality, although some improvement has been achieved in recent decades.

8.9.2 Causes

- viral gastroenteritis (including rotaviris);
- bacterial gut infections (including shigella, campylobacter);
- enteric parasites (including giardia);
- malabsorption (including lactose intolerance).

8.9.3 Aetiological Factors Include:

- inadequate supplies of clean water;
- inadequate sanitation systems;
- overcrowding;
- poor hygiene; and
- decrease in breast feeding.

8.9.4 Goal

- to reduce the incidence of diarrhoeal diseases; and
- to reduce morbidity and mortality from diarrhoeal diseases.

8.9.5 Target

- to reduce morbidity from diarrhoeal disease by 50% within 5 years, and by 90% within 10 years (Such targets begin when a full range of appropriate health services and environmental infrastructures are in place).

8.9.6 Objectives

- to ensure that all communities and dwellings have appropriate and adequate supplies of clean water, with taps inside houses;
- to ensure that all communities have adequate hygiene and sanitation systems;
- to ensure that all Aboriginal families have adequate and appropriate housing or dwellings;
- to provide culturally appropriate education, health promotion and self-help health care campaigns so that mothers and other carers of children will understand the importance of food hygiene and personal hygiene in preventing diarrhoeal disease;
- to ensure that all clinicians (doctors, nurses and health workers) who treat Aboriginal children, receive adequate training to understand, manage and prevent diarrhoeal disease. This includes the prevalance, severity, diagnosis, significant consequences and appropriate management of diarrhoeal disease and dehydration in Aboriginal children; and
- to promote (and educate mothers to) the importance of breast feeding.

8.9.7 Specific Strategies

- the recommendations for specific strategies for water supply, sewerage and housing matters are relevant to the prevention and management of diarrhoeal disease;
- health services must undertake culturally appropriate health education activities to promote food hygiene, personal hygiene and to encourage breast feeding;
- that health education address the need for parents to be aware of the danger of dehydration in children with diarrhoeal disease and vomiting;
- all doctors, nurses and health workers who work with Aboriginal people must learn to recognise the signs of dehydration, the principles of oral replacement therapy, how to assess the severity of illness and when evacuation and/or hospital admission is appropriate; and

- all community controlled health services and State Aboriginal Health Units must co-operate to improve diagnosis and management of intestinal parasites.

8.9.8 Resource Implications of the Strategies

Recommendations with regard to the improvement in water supply, sewerage and housing apply equally here.

Special education and training programs will be required to ensure that health workers, nurses and doctors are properly equipped for their roles.

Health services require specific funding so they can develop and undertake health education and health promotion activities. There is a place for Regional or State or Territory health services to develop such programs in consultation with local communities so that information and effective programs can be shared and modified to avoid costly duplication of resources in every local area.

8.10 TRAUMA/INJURY FROM EXTERNAL CAUSES

Deaths due to trauma are a major concern in Aboriginal communities.

8.10.1 Aetiological factors include:

- Alcohol and drugs;
- substance abuse;
- car accidents; and
- injuries, e.g., stabbings, bashings, burns, domestic violence, accidents at work and home.

8.10.2 Specific Strategies

- the development and presentation of culturally appropriate, safety education programs including;
- safety in the home, with an emphasis on child safety e.g. prevention of falls, burns, poisoning;
- safety in motor vehicles with an emphasis on the installation and promotion of the universal use of car restraints;
- water safety e.g. swimming classes, encouragement to fence water holes and ponds; and

- the implementation of the strategies here recommended especially with regard to alcohol and other drugs.

8.11 VACCINE PREVENTABLE DISEASES OF CHILDHOOD

In many areas of Australia, Aboriginal children are less likely to be immunised against the vaccine preventable diseases of childhood. They suffer more cases of these diseases and frequently have more severe disease than non-Aboriginals.

Warning: There must be strict adherence to guidelines for ensuring that Aboriginal children are free from infection (e.g., colds, fever, bronchitis) or severe malnutrition when vaccination is performed. If infection or severe manlnutrition exists, vaccination must be postponed.

8.11.1 Causes

- viral and bacterial diseases of childhood viz: measles, mumps, diphtheria, tetanus, whooping cough rubella, hepatits B. and polio.

8.11.2 Goal

- in the absence of any contra-indication, achieving the immunisation of Aboriginal children against measles, mumps, diphtheria, tetanus, whooping cough polio, and others where appropriate.

8.11.3 Target

- to achieve satisfactory immunisation rates against these diseases in Aboriginal children within 3 years of the establishment of the full range of services as recommended in this report.

8.11.4 Strategies

- all Aboriginal and other health services with a responsibility for Aboriginal children should make a policy of appropriate immunisation a priority. This should be achieved by follow up of children, aided if possible by a centralised record keeping system. This should be computerised to minimise errors and delays;

- immunisation schedules should be as simple and comprehensive as possible to maximise protection. Schedules must be appropriate to the epidemiology of the diseases among Aboriginal children, but wherever possible adherence to the NHMRC guidelines should be the ideal;

- health services should educate communities and parents on the benefits and risks of immunisation and on the risks of not immunising children so that Aboriginal people can make fully informed choices for their children;

- health services should pay attention to the logistics of an immunisation program. Timely supplies and adequate storage of vaccines is essential. The cold chain must be preserved to the point of vaccination;

- health services should conduct remedial campaigns to ensure that children not yet immunised are offered vaccine;

- ongoing monitoring and research is needed to ensure that vaccinations used are effective and safe; and

- as new, effective and safer vaccines become available, these should be incorporated into the strategies.

8.11.5 Resource Implications

Immunisation is one of the most cost-effective interventions to improve child health. Establishment of continuing immunisation programs will require the provision of extra resources to Aboriginal health services for:

- campaigns to educate communities and parents on the need for vaccination;

- vaccines;

- vaccine storage and transportation;

- administration of vaccine to children;

- record keeping and centralised (computerised) record system. Because of the mobility of Aboriginal families, there may be a role for Regional or States and Territories recording and follow up systems; and

- a system for contacting parents of children due for vaccine doses.

8.12 HEPATITIS B.

8.12.1 Nature of the Disease

Hepatitis B. carriage is very common in the Aboriginal community. Queensland studies have shown that 3.4% of Aborigines and 11-12% of Torres Strait Islanders in some communities are carriers of hepatitis B. (for non-Aboriginals the figure is 0.2%); 40% of Aborigines and 60% of Torres Strait Islanders have markers of past infection with hepatitis B. (for non-Aboriginals the figure is less than 5%).

The initial infection can be severe and lead to death. The carrier states are associated with an increased incidence of chronic active hepatitis, cirrhosis and hepatocellular carcinoma.

At the moment most Aboriginal people do not see hepatitis B immunisation as the number one health priority, and health workers in Aboriginal communities agree. Aboriginal people do not yet enjoy optimal immunisation coverage against infections for which immunisation is routine e.g., tetanus, whooping cough, measles etc.

Aboriginal people will not complete the course of immunisation if they feel the immunisation is being forced upon them, is discriminatory or that it is not important.

8.12.2 Aetiological Factors Include:

- the cause is the hepatitis B. virus, which is spread by blood, placental and sexual transmission. Markers for the disease are so common that other methods of transmission need to be investigated (e.g. through open sores or traditional practices); and

- there is also a possible aetiological association with overcrowding and inadequate water, sewerage and garbage disposal services.

8.12.3 Goals

- to reduce the incidence of Hepatitis B.;

- to reduce the morbidity and mortality caused by the hepatitis B. virus; and

- to prevent the introduction and spread of the Delta hepatitis virus.

8.12.4 Targets

- to achieve universal immunisation of all neonates; and
- to achieve universal immunisation of all children and sexually active adults.

8.12.5 Specific Strategies

- any immunisation campaign must have an awareness and education program attached to it, for example educating people about hepatitis B. - what it is, how you get it, what it can do to your health. Then fully informed consent is possible and must be guaranteed;
- counselling regarding infant hepatitis B immunisation should occur as part of the routine antenatal care. An informed decision can then be made by the prospective parents before the delivery.
- antenatal screening of all (Aboriginal and non-Aboriginal) pregnant women to discover their hepatitis B. status should be introduced;
- funds must be made available to immunise:
  - all new born Aboriginal and non Aboriginal babies;
  - all under 5's in the Aboriginal community;
  - all Aboriginal people who are in close contact with someone who has hepatitis B, or is a carrier; and
  - once resources are available vaccination should be offered to all sexually active adolescents and adults.

8.12.6 Resource Implications

Adequate quantities of hepatitis B vaccine must be made available to primary health care services and to State and Aboriginal Health Units.

State and Territory, regional and local community controlled primary health care services, must co-operate to co-ordinate the implementation of the Hepatitis B. Immunisation Program.

Funding must be made available to develop and implement health awareness and education campaigns.

8.13 Sexually Transmitted Diseases (S.T.D.'ε), and Human Immunodeficiency Virus (HIV) Infection / AIDS.

8.13.1 Nature of the Problem:

The experience of Community-Controlled Health services and State and Territory Government Programs, supported by submissions from the National Venereology Council of Australia indicate that Sexually Transmitted Diseases (S.T.D.'s) are a significant health problem in Aboriginal communities. The following S.T.D.'s in particular are identified:

- syphilis;
- gonorrhoea;
- donovanosis;
- chlamydia;
- pelvic inflamatory disease (P.I.D.);
- genital warts; and
- hepatitis B;

Both the acute infections and their sequelae, which include congenital infection in the newborn, secondary infertility, dysplasia of the cervix, chronic liver disease and others, contribute to the excess morbidity that Aboriginal people endure.

In addition, there is clear evidence of the presence of HIV ie. AIDS virus infection in some Aboriginal communities in rural, urban and remote Australia. A number of Aboriginal people have already died from AIDS. In most capital cities today there are Aboriginal people with HIV infection and/or AIDS.

It is important to recognise that even if education and prevention strategies stopped the further spread of HIV today, there will still be a significant number of Aboriginal people who will be sick and requiring care and services over the next few decades.

The most common way that HIV infection spreads in any community is as a sexually transmitted disease. While it is important that we recognise this and integrate HIV education and prevention, treatment and caring into the broader context of our primary health care programs, the urgency of the threat that HIV infection currently poses to Aboriginal communities demands that it be given particular attention in this document.

8.13.2 Sexually Transmitted Diseases

Causes for the excess prevalence of S.T.D.'s among Aboriginal people include:

- undetected infections, and therefore inadequate treatment, associated with a number of factors but in particular inadequate access to primary medical care;
- destruction of Aboriginal society, and traditional laws and codes of behaviour;
- breakdown of family structures; and
- alcohol and other drugs.

8.13.3 Goals:

- to reduce the incidence of S.T.D.'s; and
- to limit the further spread of wart virus.

8.13.4 Specific objectives:

- to ensure that all Aboriginal people have access to culturally appropriate primary health care services for diagnosis, treatment and follow-up, counselling and education in regard to S.T.D.'s;
- to encourage Aboriginal Health Services and communities throughout Australia to develop programs that will educate people (especially young sexually active people) about S.T.D.'s, and promote behaviour change that will help limit their spread; and
- to develop strategies that ensure that condoms become more accessible and acceptable in Aboriginal communities.

8.13.5 Specific Strategies

- Aboriginal Health Worker Advance Education Programs in S.T.D's are required. These programs may include teaching and clinical experience in the techniques of internal examination where appropriate.
- it may be appropriate that some S.T.D. screening be routinely performed (with the fully informed consent of the patient) when pap smears are taken eg. for chlamydia;

- Pap smears should be encouraged when S.T.D. screening is indicated;

- procedures that guarantee the confidentiality of patients presenting with S.T.D.'s are crucial if health services hope to provide an effective and acceptable service for their clients and their community;

- a system that encourages the adequate treatment and follow-up of patients with S.T.D.'s should be established in all Aboriginal health services; and

- health services should encourage the development of a relationship with the local venereology specialists where they exist. They may assist with advice and back-up services.

8.13.6 Resource Implications

Resources are required:

- to establish advanced health worker education programs in S.T.D.'s;

- to develop education programs in S.T.D.'s for Aboriginal people especially the youth; and

- to provide adequate, accessible and appropriate primary health care services for Aboriginal people.

8.13.7 Human Immunodeficiency Virus (HIV) Infection and AIDS

Cause:

HIV is the cause of AIDS. This virus is mainly spread by sex that involves the transfer of body fluids (semen,vaginal secretions) from an infected person, and by blood. The most common way it is spread through blood in Australia, is by intravenous (iv) drug users sharing needles and syringes. Pregnant women infected with the virus may pass on the infection to their unborn child.

8.13.8 Goals:

- to prevent the further spread of HIV infection in the Aboriginal community;

- to provide the necessary support and counselling services to those affected by HIV infection (people at risk, people infected, and their families); and

- to provide the necessary support counselling and caring services to those sick with HIV infection and AIDS.

8.13.9 Specific Objectives:

- Aboriginal Community leaders need to be given the information and education that will encourage them to put HIV infection/AIDS high on the agenda in Aboriginal Communities;

- culturally appropriate and locally based education programs are needed so that Aboriginal people understand what HIV infection is, the threat it poses, how it is spread and how it can be stopped in Aboriginal communities. These education programs must be maintained indefinitely. There is a need to develop education and prevention programs that are targetted to meet the needs of specific groups within the community eg the youth, young homosexual men, iv users etc;

- Aboriginal communities need to be resourced and supported in the development of locally based prevention strategies appropriate to each community;

- appropriate counselling, testing and information services need to be provided for all Aboriginal people who require them; and

- counselling, support and caring services need to be provided for all Aboriginal people who have HIV infection.

8.13.10 Specific Strategies

- there have already been significant initiatives by Aboriginal Community Controlled Health Services and by State Aboriginal Health Units in the field of education resource development and distribution, and in the development and implementation of education programs. These efforts need to be recorded and collated, and made available to other Aboriginal communities; and

- a National Conference on Communicable Diseases convened by The National Community Controlled Health Services would provide a forum where:

  - the experience of the last few years could be shared especially in the development of education programs and their evaluation;

- a consciousness raising process among Aboriginal leaders could be encouraged; and

- the ethical, social and philosophical issues that HIV infection prompts could be explored.

- Aboriginal Health Worker advanced education programs in HIV (and other S.T.D.'s) are needed. These programs must include:

    - counselling skills re HIV/S.T.D.'s for those who may be at risk, those who are infected, those who are sick and their families;

    - health promotion, especially the design, implementation and evaluation of HIV education and prevention programs;

    - domiciliary care of those who are sick, of people with AIDS.

- Aboriginal Health Worker Advanced Education programs in HIV (and other S.T.D.'s) are needed. These programs must include:

    - counselling skills re: HIV/S.T.D.'s for those who may be at risk, those who are infected, those who are sick and their families;

    - health promotion, especially the design, implementation and evaluation of HIV education and prevention programs;

    - domiciliary care of those who are sick, of people with AIDS;

    - strategies to give particular groups within the Aboriginal community access to on-going education are required eg people in prisons need access to continuing education and counselling services in this area;

    - testing and screening for HIV infection should be provided within the context of an integrated primary health care service;

- all testing and screening should only be done when there are cast-iron assurances that confidentiality of results will be maintained between each patient and his/her health care provider; and

- individual testing for HIV infection must be voluntary and accompanied by fully informed consent and pre/post-test counselling (whether the result be positive or negative).

- community screening programs for HIV infection:

  - should not be the focus of HIV prevention and should not be allowed to consume resources for education and prevention strategies;

  - must be preceded by an education program which has been developed in consultation with the community concerned, and which has been implemented and evaluated prior to the commencement of screening;

  - must be accompanied by the implementation and maintenance of prevention strategies in the community; and

  - must have the individual's informed consent, be voluntary and accompanied by the guarantee of confidentiality and counselling as described above.

8.13.11 Resource Implications:

The need for resources for HIV education, education research and evaluation, prevention and caring/support programs are immense. The present Commonwealth and State funding of education programs should continue and be expanded

Specifically, resources are required for:

- the education of Aboriginal Health Workers as described above;

- the establishment of Community Education Programs and educators in communities;

- the development of prevention strategies, including the supply of condoms, counsellors, and IV needle exchange programs where appropriate;

- the education and employment of carers who provide domiciliary and other support care at home. Support services will become progressively more important as the number of people with HIV-related illness and AIDS increases. This will require another funding process which should not be allowed to interfere with the funding needed for education and prevention. This new funding process should begin immediately; and

- a National Aboriginal Conference on Communicable Diseases as described above

8.14 OCULAR DISEASE, INCLUDING TRACHOMA

8.14.1 Nature of the Disease/Problem

Trachoma is a chronic conjunctivitis causing significant corneal blindness in middle aged and elderly Aboriginals. No non-Aboriginal Australians are currently threatened by trachomatous blindness.

Repeated inoculations of the organism are required for the clinical disease to occur. Casual and ephemeral contact doesnot spread the disease. It is a disease that affects to varying degrees most members of the living unit when home hygiene is poor.

The disease is readily recognised clinically. The presence of the infecting organism may be verified by culture and or fluorescent antibody staining techniques.

Screening for trachoma has been and is being done in most Aboriginal "at risk" groups and age specific prevalence rates for each aspect of the condition are available.

8.14.2 Aetiological Factors Include:

- association with infection by Chlamydia trachomates;

- inadequate water supply, sewerage, housing and other essential services.

8.14.3 Goals

- to reduce the incidence of trachoma amongst Aboriginal communities; and

- to introduce public health neasures aimed at preventing trachoma amongst Aboriginal people.

8.14.4 Diabetic Retinopathy

As trachoma recedes as a cause of blindness in Aborigines, blinding diabetic retinopathy is increasing and will soon be the major cause of blindness amongst Aborigines.

It is estimated that 10% of diabetics have vision threatening retinopathy.

A pilot project has been set up to measure the extent, severity, and type of diabetic retinopathy in Aborigines, and produce guidelines for the best management of this form of blindness throughout Australia.

Aetiological Factors include diabetes.

8.14.5 Goals

- to reduce the incidence of diabetes amongst Aboriginal people.

8.14.6 Specific Strategies - Ocular Disease including Trachoma

- eye health screening and treatment programs should be introduced into those States not currently served by State Trachoma and Eye Health Committees (e.g. New South Wales, Victoria, Western Australia);
- eye health programs should be introduced at the primary level of care, through Aboriginal health services;
- transfer of skills to Aboriginal health workers is essential;
- intra-ocular lens implant surgery (i.e. new cataract surgery) should be made available free to Aborigines requiring this treatment;
- public health measures to improve living conditions, e.g. water supply, must be introduced as a matter of urgency;
- health awareness and education programs which focus on nutrition, hygience and eye care should be developed and introduced to all at-risk people; and
- there is a need to integrate primary health care services with specialist trachoma and ocular programs.

8.14.7 Resource Implications

Any expansion or continuation of existing programs, and the introduction of new programs will require the injection of funds. Screening, diagnosis, treatment and prevention require skilled personnel and specialist equipment, and must be undertaken on a regular basis.

Public health measures are integral to the improvement of all specific health problems, and funds must be made availabel to improve water supply, housing, sewerage and health awareness programs to ensure their proper use.

8.15 DENTAL HEALTH

Dental health has emerged as a major problem in Aboriginal communities. Most, if not all children are catered for by the School Dental Service whilst attending primary school. This does not however extend to orthidontal services.

Limited access to dental services, high costs, lack of awareness and fear lead to poor dental health amongst Aboriginal people.

A study on the Orana region of New South Wales has shown a very poor standard of dental health in comparison to the non-Aboriginal population. In the 6-8 year age group Aboriginal children had a 67% higher prevalence of carious teeth and over 90% more carious tooth surfaces than non-Aboriginal people on the average, three of their first permanent molars were decayed. Using a disease severity index, it was shown that caries progressed much faster and were more destructive in Aborigines by a margin of a 117% in the 6-8 years group and 50% in the 10-11 years group. At the mean age of 20.4 years, young Aborigines had 55% of their teeth severely affected by caries; 10% of their teeth were already lost, but only 3.5% received restorative treatment.

The population as a whole is exposed to a high risk of oral disease for several reasons, notably:

- flouride deficiency of water;
- scarcity of dentists;
- high turnover of dental staff in the region; and
- diet high in sugar.

The Aboriginal community is at an even higher risk than the population generally, particularly because of poor nutrition. In Schamshula's study the Aboriginal population examined was characterised by a high prevalence of dental caries and periodontal disease, poor oral hygiene, lack of awareness of oral health needs, and exhibited no evidence of sustained dental care.

A comprehensive oral health program was recommended. The poor oral health status was attributed to poor nutritional status in early childhood, together with cultural and environmental factors, particularly, low socio-economic status. Attention to these was perceived on the basis of a long-term remedy. (Schamshula et al, Oral Disease Status of the Aboriginal Population in the Brewarrina and Walgett Areas of NSW, 1979.)

The magnitude of poor dental health among Aborigines is highlighted by:

- many Aborigines live in areas remote from dental facilities;
- Aborigines do not generally seek dental care unless pain persists; and
- gum disease and periodontal disease is generally prevalent and has been noted even among primary school children.

(Wright N: Aboriginal Dental Health, Submission to Task Force.)

There is also an increasing orthodontic problem arising in Aboriginal school children due to several factors, one being the early loss of deciduous dentition.

The Working Party is concerned at the lack of suitable dental services available to Aboriginal communities, not only in country areas but urban areas as well. Dental Services must be geared to the needs and feelings of the Aboriginal people and as such should be incorporated into the primary health care plan. Problem areas identified included:

- dental health education including preventative measures;
- provision of clinical dental services on a regular basis (6 monthly dental examinations); and
- orthodontic service.

8.15.1 Strategies

Dental Health Education and Preventative Measures

- funds must be made available for the education of Aboriginal Health Workers in the special field of dental health and hygiene education;
    - selected health workers, preferably those who had already completed basic skills could receive in-service training in oral health and hygiene and then return to their respective communities to put their training into practice; and
    - the emphasis of the training given to health workers in the oral health field should be that of prevention rather than treatment;
- fluoridation of community water supplies should be promoted in addition to regular oral hygiene and balanced nutrition. The community primary school and pre-school should be targeted with the co-operation of the teaching staff; and
- teaching staff must be made aware of their role in dental health and hygiene education.

Provision of Clinical Dental Service:

- at the present time access to regular dental services in remote areas is very limited and where it is available Aboriginal patients forego treatment due to fear, shyness or financial considerations. It is therefore imperative that Aboriginal community controlled health services be established so that communities can identify with the service when presenting for treatment;
- problems occur in providing regular dental treatment in remote areas due to the high turnover of staff and the lack of dentists willing to work in these areas;
- in relation to the Aboriginal communities identifying with the services, the dental service must be part of an overall health care plan and not be treated as an isolated element. All Aboriginal health services should have a dental component included in their structure; and
- Aboriginal mobile dental vans or units should be regionally located to service the out-lying Aboriginal communities in those regions.

Orthodontic Services

- it is apparent that there is a considerable orthodontic problem induced by social and dietary changes among Aborigines and that this will increase in future years with the establishment of more dental services. For example, the present waiting list for orthodontic treatment at Redfern is 3-4 years and this will increase unless steps are taken to provide more treatment;

  - in NSW it is only patients in Sydney and the surrounding districts who have access to orthodontic treatment; and

  - Aboriginal people in country areas find travelling to Sydney for treatment financially impossible and it is essential that other regional centres be funded to establish orthodontic services.

The Working Party recommends that:

- funding be provided for the education of Aboriginal Health Workers in the field of dental health and hygiene;

- the provision of dental services is a necessary component in the overall establishment of Aboriginal Health Services in remote areas;

- mobile dental units be attached to some Aboriginal Health Services to service regional areas;

- funds be allocated for the provision of regional orthodontic services; and

- local councils to monitor levels of fluoride.

8.16 MENTAL HEALTH

Aboriginal people who work in health recognise that mental health is a major part of ill health. While Aboriginal health services have been aware of the needs in this area for over ten years, requests for resources have always been met with the 'low priority' response from government agencies. They seem to only respond to the high visibility needs or those that receive media attention.

Mental distress is a common and crippling problem for many Aboriginal people and appropriate services are a pressing need.

Advances in the understanding and treatment for mental health problems have been impressive since World War II; this progress has yet to benefit Aboriginal people. Culturally appropriate services for Aboriginal people in the mental health area are virtually non-existant.

Mental health services are designed and controlled by the dominant society for the dominant society. The health system does not recognise or adapt programs to Aboriginal beliefs and law, causing a huge gap between service provider and user.

As a result, mental distress in the Aboriginal community goes unnoticed, undiagnosed and untreated.

Aboriginal controlled research into Aboriginal mental health is an urgent priority. Consideration should be given to understanding the legacy of 200 years of colonisation.

Aboriginal people must be given the resources to develop the framework within which mental health problems can be understood and addressed.

8.16.1 Nature of the Problem

It is clear that Aborigines suffer the same major psychiatric disorders as others, though culture will influence presentation and treatment. However a major part of the mental distress that exists in the Aboriginal community falls outside of these categories and is related to "reality" factors.

There is a need to identify more clearly the nature of mental health problems among Aborigines.

8.16.2 Aetiological Factors in Mental Health Problems

Rather than providing a list the Working Party has decided to attach a paper "200 Years of Unfinished Business" presented by Sr. Pat Swan of the Aboriginal Medical Service at Redfern. This is attached as an Appendix. Readers of this report need to study this paper in full in order to gain at least some understanding of the social and mental health problems of Aborigines today.

8.16.3 Specific Strategies

- Aboriginal health worker advanced education programs in mental health issues are needed;

- mental health professionals must listen carefully to what Aboriginal people are saying, and seek Aboriginal help when they don't understand;

- mental health professionals must understand Aboriginal history - the real life situations of alienation, poverty, and powerlessness;

- a framework (cultural and historical) needs to be developed by Aboriginal people, within which problems can be defined and understood from an Aboriginal perspective. Without this framework services only treat the symptoms without comprehending the problem;

- programs must include the education and support of community based and controlled Aboriginal Mental Health Worker teams that can go into the home in crises;

- Mental Health Services which are culturally appropriate and accessible to Aboriginal people are required. Ways of making this possible include:

  - employment of Aboriginal liaison officers whose role is communication between psychiatric ward and units, and Aboriginal Health Service staff and community; and

  - employment of specialist psychiatric Aboriginal Health Workers working in the area of mental health in their communities and who also can provide domiciliary care;

- adolescent services must be specifically designed to address the needs of this 'at risk' group;

- establish specific Aboriginal Community Controlled Psychiatric Services;

- that traditional healers be recognised and, employed in Aboriginal mental health programs;

- resocialisation and enculturation services along the lines of the Aboriginal organisation "LINK-UP" an organisation established by Aboriginal people to trace and re-unite the stolen generations; and

- the adequate resourcing of "LINK-UP". Link-Up currently has only 2 staff to cope with the extensive national workload.

8.16.4 Resource Implications

Community psychiatric services and psychiatric wards and units will require specific additional funding throughout Australia in order to employ Aboriginal staff.

Community controlled health services will need to include education and employment of mental health workers in their submissions.

Funding will be required for research.

8.17 DOMESTIC VIOLENCE AND MENTAL HEALTH

Domestic violence, which is frequently associated with alcohol consumption, cannot be attributed to any one cause. Domestic violence has its roots in institutionalisation, incarceration, loss of role, loss of parental and role models, low self-esteem, and alienation.

Non-Aboriginal women's refuges sometimes exacerbate the problems for Aboriginal women by imposing their understanding of domestic violence as a feminist/separatist concern. Most Aboriginal women do not accept this culturally alien non-Aboriginal analysis of the situation and they do not find it helpful in a crisis. However, safe houses, staffed by Aboriginal people, with appropriate support services as described below, are neded.

8.17.1 Nature of the Problem

Some of the factors identified as adversely affecting mental health in Aboriginal communities include those that deny identity, remove or reduce communication and remove options for future decision making. These factors are also seen to contribute to domestic violence. It needs to be stipulated that domestic violence is meant to include all forms of domestic violence, i.e. violence which is perpetrated against women, men and children. In other words, the Working Party does not wish to conceptualise domestic violence as a separatist concern, but one which incorporates all members of families who suffer from domestic violence.

8.17.2 Aetiological Factors Include:

- overt and covert discrimination;
- isolation;
- theft of land and loss of language and culture;
- loss of economic independence and enforced dependence on welfare;

- powerlessness;
- high level of imprisonment;
- alcohol and drug abuse;
- poverty;
- high unemployment levels;
- a history of forced childhood separation from parents - in one survey (VAHS 1986) 65% of respondents had been separated from a parent during childhood (for non-Aboriginal people the rate is 29%) and 47% had been separated from both parents (for non-Aboriginal people the rate is 7%); and
- low education attainment.

8.17.3 Specific Objectives

- to provide safe houses for those who are victims of domestic violence until the crisis subsides;
- when possible and where needed, to provide support services designed by Aboriginal people specifically for Aboriginal people who are exposed to domestic violence and sexual abuse; and
- where only mainstream services operate, to ensure that Aborigines are employed so that the service can better cater for cultural differences and beliefs.

8.17.4 Specific Goals and Strategies

Immediate Crisis Intervention:

- safe house - staffed by an Aboriginal Crisis Team.
  - support services from a multi disciplinary team which includes:
    - counselling;
  - counselling for families:
    - early intervention strategies;
    - relaxation and behaviour self-management programs;
    - communication and assertiveness training; and

- crisis counselling to be incorporated into the Aboriginal Health Worker education programs.

- programs to enable women to form mutual support groups:

  - an Aboriginal Health Service doctor;

  - legal assistances;

  - Social Security assistance; and

  - support from other relevant welfare authorities.

- programs that address the needs of perpetrators e.g., to help men who can be violent in the home.

8.18 CHILD ABUSE and NEGLECT- INCLUDING SEXUAL ASSAULT AND INCEST.

8.18.1 Nature of the Problem

Traditionally, Aboriginal culture and law protected children from abuse, including neglect, child sexual assault (C.S.A.) and incest.

For the past 200 years Aboriginal children have been torn from their families, institutionalised, and subjected to all forms of abuse.

Many Aboriginal men and women are survivors of past government policy which enforced the systematic removal of Aboriginal children, a system within which physical and mental abuse, and sexual assault commonly occurred.

Many generations of Aboriginal people have been denied normal childhood development, bonding to families, and any form of positive relationship (love). As a result parenting skills are often lost for ongoing generations.

8.18.2 Specific Strategies

- awareness and culturally appropriate information on the dangers and issues of child abuse and C.S.A. to be developed and made readily available;

- counselling for C.S.A. victims and incest survivors and their families; and

- strategies to prevent child neglect need inclusion;
- the development of education programs for Aboriginal counsellors in the skills of family therapy and other counselling needs of C.S.A. victims and incest victims;
- the establishment of support networks (individual and group; formal and informal) for parents who have difficulties with parenting;
- the provision of realistic resources to enable the national Aboriginal organisation "LINK-UP", to assist communities to develop services to address the needs of the stolen generations as follows:
  - on-going counselling services for LINK-UP clients and their families including re-culturalisation, re-parenting, and assertiveness education;
  - education programs for Aboriginal counsellors;
  - research into relevant archives and community records for the tracing of family members; and
  - resources for family reuniting.
- realistic resources for those Aboriginal agencies involved in providing services to Aboriginal children and their families, e.g., Aboriginal Health Services, Child Care agencies, and teacher aides;
- Education programs for their staff to gain the necessary skills in the following:
  - identifying children at risk;
  - crisis intervention;
  - support and backup services;
  - child protection laws;
  - counselling skills; and
  - psychological issues including reallocation.

insistence that non-Aboriginal agencies dealing with Aboriginal children should refer and consult with Aboriginal agencies in the communities where they exist. In communities where Aboriginal agencies do not exist non-Aboriginal agencies and their staff must be sensitised to the special needs of Aboriginal children and their families.

CHAPTER 9

WOMEN'S BUSINESS

Health for Aboriginal women is not seen in the context of "white women's" issues or problems, but as part of their overall well being, which is inextricably linked to that of their families and communities. Tradition, culture, and ceremonies provide meaning and significance to life events, and the loss of these important factors in themselves threaten the health and wellbeing of Aboriginal women.

Women's business is not normally discussed openly or widely in a public forum, however women's health issues need to be debated widely by Aboriginal women first before agreement can be reached on comprehensive, representative strategies.

For many reasons, it is therefore appropriate to adopt the traditional format for the discussion of women's business and men's business in separate meetings before decisions taken at such meetings are conveyed to a joint meeting.

This is not to say that women's health issues can be isolated from general health issues affecting men, children families and the community at large.

While many Aboriginal people do not live traditionally, these traditional Aboriginal formats for discussion are the ones with which the majority of Aboriginal people feel most comfortable.

There are, however, some broad matters which the Working Party believes can be included in the National Aboriginal Health Strategy at this point.

9.1 MATERNAL AND CHILD HEALTH SERVICES

9.1.1 Nature of the Problem

The health of Aboriginal women during pregnancy and of Aboriginal children is significantly worse than that of their non-Aboriginal counterparts. Aboriginal women are more likely to have high risk pregnancies, related to factors such as dispossession, extreme social disruption, alienation.

Aboriginal babies are more likely to be are born with lower birth weights predisposing to higher perinatal mortality and morbidity. Documented growth of Aboriginal children is less than optimal with a picture of undernutrition and infection. Postneonatal mortality (death rates) and morbidity,(illness rates) particularly due to infections exacerbated by poor growth, are major preventable problems.

9.1.2 Causes

The causes of these problems are complex. Health services can address some of these problems however broad social and economic improvements will be required to resolve the problems fully. A major part of Aboriginal infant mortality is associated with maternal youth, high parity (lot of children) and close birth spacing. This can only be improved by social change through a program of culturally appropriate community education, awareness and access to new medical methods together with adequate services to allow Aboriginal women to control their own fertility.

The growth of Aboriginal children is impeded by frequent infection and by poorer nutritional intake, itself a consequence of poverty. Improvement in child nutrition will require a reduction of poverty in addition to services which can detect and treat growth failure.

9.1.3 Goals

- Aboriginal mothers and children should have access to health services which offer appropriate maternal and child health care. Accessibility of Aboriginal Health Services is vital to the success of such a program. Health services for Aborigines should be enabled and committed to deliver comprehensive maternal and child health programs;

- sex education and family planning services should be made available from local health services to allow Aboriginal women to control their own fertility. It is essential that these programs be provided in a manner which is consistent with and sensitive to local Aboriginal values. This would most appropriately be achieved by a community controlled health service;

- antenatal care should be vigorouly promoted by all health services provided for Aborigines. Health services should encourage women to attend early in pregnancy. The concept of shared care should be utilised more fully with sharing of pregnancy care between Aboriginal Health Services and obstetric units. Obstetric units should recognise the cultural, social and medical needs of Aboriginal women. If medically safe, and desired by women, a policy of delivery at their home community and of early discharge from hospital, with adequate domiciliary postnatal care, should be followed. Sensitisation of hospital units to Aboriginal culture is necessary, so that those women who choose hospital delivery can do so in an environment which supports Aboriginal values; and

- promotion of breast feeding is the primary strategy to ensure adequate growth in the first 6 months of life. This should be in conjunction with a monitoring program to detect any failure of growth or develcpment. All Aboriginal children under five should have access to a comprehensive child health service, which should be conducted by a local Aboriginal health service. Family oriented nutrition education is necessary for those children whose growth falters with the introduction of weaning foods. This is the time of highest risk for young Aboriginal children when their health should be closely monitored and families may require the greatest support.

9.1.4 Specific Objectives

That every Aboriginal woman has access to and receives comprehensive ante natal care during pregnancy:

- to reduce the incidence of at risk pregnancy;

- to provide services for the detection and management of at risk pregnancy;

- to acheive a reduction of infant and maternal mortality and morbidity rates; and

- to reduce childhood undernutrition.

9.1.5 Specific Strategies

- education programs emphasising the importance of antenatal and postnatal care for mother and baby should be developed. This will include the development and distribution of resources that promote breast feeding, appropriate immunisation, etc;

- specialist Aboriginal Health Worker advanced education programs in antenatal care, breast feeding, post natal depression counselling, infant care, nutrition, family planning and gynaecology must be introduced;

- health services must have resources to employ Aboriginal health workers with advanced education in the fields outlined above;

- under 5's registers that monitor the progress of this age group should be established in every Aboriginal Health Service;

- education programs for pregnant women must be developed to address their needs and concerns. These programs should be designed and delivered by Aboriginal women;

- accessiblity of acceptable antenatal care in areas that are poorly serviced must be increased by utilising Aboriginal health workers with advanced education in this field;

- health services must develop protocols for antenatal care, ensuring that women receive comprehensive examinations and investigation, and one-to-one advice and counselling regarding breast feeding, hepatitis B immunisation etc; and

- play-group centres which could incorporate an education component and therapy where needed or parents should be established.

9.1.6 Resource Implications

Maternal and child health is a high priority for health services involved in the care of Aborigines. Major problems are the questions of acceptability and accessibility of services to Aboriginal people. Aboriginal Health Services are the most appropriate models for the provision of primary health care to Aboriginal mothers and children.

9.2 SEX EDUCATION

For Aboriginal women sexual matters were traditionally a closely monitored subject. The colonisation process and enforced breakdown in culture has particularly affected access to knowledge about sex, contraception reproduction, and birthing. Such matters were not discussed at random between individuals but rather were conveyed indirectly through

stories, ceremonies, and songs. For many, this important aspect of Women's Business has been destroyed as a result of the deliberate dispersal of Aboriginal people into reserves and onto islands and by the forced removal of their children. Thus traditional knowledge of sexual matters has been denied to future generations. This has left many Aboriginal women without the basic facts about sexual matters and without control over this aspect of their lives.

9.2.1 Goals:

- to increase education in the area of interpersonal relationships, sexuality, sexually transmitted diseases, contraception and pregnancy for school students, adolescents, and mature women;
- to promote and train more Aboriginal nurses, specialist Aboriginal Health Workers in the area of sex education and counselling for sexual problems;
- to provide culturally appropriate material on gynaecological problems such as:
  - sexually transmitted diseases;
  - pelvic inflamatory disease;
  - menstrual disorders;
  - sexual dysfunction;
  - infertility; and
  - change of life syndrome (compounds other medical problems which could be underlying causes of the above.)

9.3 WOMEN'S BUSINESS AND MAINSTREAM HEALTH SERVICES

When using mainstream health services Aboriginal women feel particularly vulnerable as non-Aboriginal health professionals display a great disregard for Aboriginal culture and law. Health policy should ensure the rights of Aboriginal women to maintain their dignity and have services provided by health carers who are sensitive and knowledgeable about Aboriginal women's health needs and have respect for their concerns.

It is essential that policy makers and program administrators are aware of the impact of Aboriginal law on the usage of services in non-homogeneous communities at the most basic level. It is taboo for women to talk about women's health issues and to be physically examined by male doctors and male health workers.

Therefore mainstream obstetrical, gynaecological, and general services and health care providers must be sensitive to the needs and cultural mores of Aboriginal women.

9.4 HEALTH AWARENESS, EDUCATION AND PROMOTION PROGRAMS FOR WOMEN

It should be recognised that Aboriginal culture and heritage is traditionally passed on through the spoken word.

Aboriginal people do not appear to gain much benefit from mainstream health education programs presented on television or in newspapers or magazines, although these are the major avenues for the dissemination of information throughout the general community.

If any health awareness, education, or promotion program is to be effective and have a lasting impact, it is essential that Aboriginal people participate at all levels, from the idea phase through to follow-up. Language, manner of presentation, visual cues and so on are of critical importance if the message is to be accepted. For example, a known and respected Aboriginal Health Worker will be listened to; a non-Aboriginal gynaecologist (no matter how well qualified) will not attract the attention of the audience.

9.5 FAMILY PLANNING

The use of oral contraceptives is not always acceptable or reasonable for many Aboriginal women. The initial visit to the doctors can cause embarrassment and shame.

It needs to be recognised that there will be social effects if families are spaced, and family planning measures may be resisted on this basis. Therefore the introduction of contraceptives will not be successful unless education programs take into account the implications of planned or spaced families.

There is a need for consultation with traditional Aboriginal women to gain information about traditional methods of contraception.Research into traditional methods of contraception is also needed, but research and investigation is only acceptable if carried out by Aboriginal women.

The use of Depoprovera amongst Aboriginal women, especially when it is not commonly prescribed as a contraceptive for non-Aboriginal women, is rejected as a first-line contraceptive by the Working Party.

The choice of contraception must ultimately rest with the individual. It is the responsibility of the health services to ensure that women can make informed choices.

Acceptable reversible contraception is a major health issue for Aboriginal women.

Too many find themselves with few alternatives relying on:

- abortion as a contraceptive (not acceptable to either the patient or the doctors caring for her); or
- a sterilisation procedure.

Options for Women are:

- no contraception:
  - resulting in a large family of children which poses many stresses (physical, emotional and financial) on the women; these stresses affect her and the children's health and well being:
- oral contraceptives:
  - problems exist with storage (especially in remote areas), and with acquiring the habit of taking them regularly;
  - women have fears of side-effects; and
  - they may be contra-indications present e.g. cigarette smoking, diabetes, hypertension.

These and other realities make oral contraceptives inappropriate for many women.

- Intrauterine devices (IUD's):
  - adverse publicity has made intrauterine devices unpopular;
  - many Aboriginal women reject the idea of having a foreign object inside their bodies permanently;
  - concerns exist regarding the side effects especially the possibility of infertility.

A history of pelvic inflammatory disease is a contra indication for IUD use. Many women have such a history. For these and other reasons, IUD's are often not appropriate.

- barrier methods e.g. diaphragms and condoms:

- these methods although free of side effects are more difficult to use and are slightly less reliable in preventing conception; and
- they require motivation and commitment, and living conditions that allow their storage and regular use. Not many men and/or women use them on a regular basis.

- depoprovera:
  - 3 monthly injectable drug (rejected by Aboriginal women).
- sterilisation:
  - a procedure commonly performed for women even in their 20's;
  - this procedure should be considered irreversible, though in many cases can be reversed by operation at a later date; and
  - vasectomy is a viable safe effective alternative means of family planning available to men.

9.5.1 Specific Strategies:

- explore traditional methods of family planning;
- promote breast feeding; it helps preven early conception;
- promote use of condoms and other barrier methods;
- break down the existing negative attitude in men and women to vasectomy as an alternative to female sterilisation;
- ensure that the choice of a contraceptive is an individual and informed decision; and
- improve accessibility to information about contraceptive choices, about termination of pregnancy, about fostering and adoption.

9.6 INFERTILITY

Infertility is a significant problem, often the result of tubal scarring secondary to pelvic inflamatory disease. (PID)

Education programs aimed at prevention of STD's and wider use of condoms would help decrease the incidence of secondary infertility in women.

The situation for women with infertility problems would be improved if specialists in the area provided easier access for infertile Aboriginal women to laparoscopic investigation, hence earlier diagnosis and the possibility of effective treatment.

9.7 CULTURALLY APPROPRIATE BIRTHING CENTRES

Hospitals do not take traditional laws into account at the time of childbirth, e.g., non-Aboriginal men are present at births - events which are traditionally women's business.

A strong feeling exists against women being taken away from their communities for childbirth yet many women are required to leave home up to six weeks prior to the expected birth date. As a result, they experience loneliness and cultural isolation and this enforced separation can lead to high levels of stress, depression and family breakdown.

Accommodation is not provided for the family at a time when there is a tremendous need for family support and cohesion.

The Working Party recommends:

- the establishment, (after consultation with Aboriginal women) of culturally appropriate birthing centres where Aboriginal women's law and culture will be strengthened and maintained;

- the provision of education programs that explain and encourage regular breast and cervix cancer screening;

- the provision of facilities that make regular breast and cervical cancer screening accessible and acceptable to Aboriginal women.

9.8 EARLY FIRST PREGNANCY

There is a trend amongst Aboriginal girls towards pregnancy in early teens. The social, economic and health implications of early pregnancy and motherhood are enormous, and there is a need to address this situation in its totality.

9.9 ANTENATAL AND POSTNATAL CARE

The problems of infant mortality and low birth weight babies and subsequent health problems in childhood are of major concern to Working Party members.

That hospitals and Aboriginal Health Services coordinate pregnancy information so that complications can be monitored by both agencies.

Improved antenatal and postnatal care can contribute to improvements in the health status of both mothers and children.

It needs to be recognised that Aboriginal women find the 'white system' of dealing with obstetric care and the differing health personnel responsible for each phase of pregnancy confusing and therefore there needs to be some continuity between ante natal and post natal care, confinement and education.

In addition, professional midwives working in the field of general obstetric care need to be seen actively delivering antenatal and post natal screening for Aboriginal women in the major remote areas of Australia. Both the professional and traditional midwives should be seen transferring skills and procedures to each other in the field of antenatal and post natal care.

Traditional Aboriginal midwives providing a service for Aboriginal women continue an important Aboriginal tradition; they are skilled and should be recognised as health professionals. It is the role of western medicine to provide medical support for these women when it is needed.

9.9.1 Goals

- to ensure that the Aboriginal community is aware of the importance of antenatal and postnatal care and regularity of new baby checks;
- to encourage attendance for antenatal care early in pregnancy;
- to promote postnatal care including advice on breast feeding, feeding problems, contraceptive advice including the advantages of spacing pregnancies and the need for cervical smears;
- to encourage regular baby checks and weight monitoring of new babies;
- to make available special education programs in ante natal and post natal care to Aboriginal Health Workers;
- to support the desire Aboriginal women have expressed for culturally appropriate birthing centres where Aboriginal women's law and culture will be strengthened and maintained;

- to make available life preparing/growth education programs for 12 year olds and over in schools and health centres; and

- to ensure that programs involve the traditional maternal health workers in the many areas where the Aboriginal women's law is enforced: (eg) Aboriginal women who are under a traditional bond during the ante natal stages.

The members of the Working Party believe that existing health programs could have a greater impact and be accepted by Aboriginal women if the recommendations listed below are adopted:

The Working Party recommends that:

- the introduction of culturally appropriate and accessible ante natal classes for Aboriginal women;

- classes must be designed and presented by Aboriginal women;

- alternative, culturally appropriate means of health service delivery must be developed in areas which are poorly serviced;

- education programs must be developed that include:

  - the benefits of early antenatal and postnatal care;

  - practices and procedures which constitute healthy antenatal and postnatal care; and

  - the consequences of poor or late antenatal and post natal care.

- health care deliverers must ensure that Aboriginal women are fully informed of any birthing procedures should they be required such as:

  - forceps delivery;

  - episiotomy;

  - caesarean section;

  - local anaesthetic (epidural);

  - general anaesthetic;

  - induced labour;

- possible marks on newborn child; and
- complications that may arise;

- advanced education programs are needed for those Aboriginal Health Workers who wish to specialise in women's health issues be developed;
- extra support must be given to Aboriginal women who are taken into custody if they are pregnant, breast feeding or have children;
- funds must be made available to Aboriginal community groups to develop audio visual and other health education material for ante and post natal care: or
- the Commonwealth, State and Territory Governments must allocate funds for:
  - upgrading specialist gynaecology and obstetric facilities and services, within regions and districts in the remote areas; and
  - upgrading and equipping regional and district hospitals in remote areas to cater for all birth deliveries.

9.10 CERVICAL AND BREAST CANCER SCREENING PROGRAMS

Surveys suggest that the incidence of abnormal cervical smears amongst Aboriginal women is four times greater than that found in non-Aboriginal women. The incidence may be masked because of the reluctance amongst Aboriginal women to submit themselves to screening procedures when examinations are carried out by either non-Aboriginal male or female health practitioners. In more traditional areas it is often expressed amongst Aboriginal women that breast cancer is a 'white womens' disease.

Screening programs also provide the opportunity to screen for pelvic inflamatory disease which is a major cause of infertility.

9.10.1 Specific Strategies:

- to develop appropriate Aboriginal community awareness and education programs that explain and encourage:
  - annual cervical (pap) smears;
  - regular breast self examination;

- to ensure that educational aids are culturally appropriate for and approved by Aboriginal women;
- provide the facilities that make regular breast and cervical cancer screening accessible and acceptable to all Aboriginal women;
- to encourage the training of specialist Aboriginal Health Workers (women's issues) to teach the technique of breast self-examination and to do cervical smears to increase accessibility and coverage of this test; and
- the introduction of a recall system which reminds health service staff and patients when repeat tests are due.

The Working Party recommends that:

- culturally appropriate community awareness and education programs, which outline reasons for screening, outline the procedures involved, the recommended action following abnormal results and the likely consequences of abnormal results should be explained.

These programs should promote:

- yearly smears for women; and
- monthly breast self-examination.

The Working Party also recommends that:

- every Aboriginal woman be shown the technique of breast self-examination, and be encouraged to use it, (doctors and aboriginal health workers do this).

CHAPTER 10

ALCOHOL AND OTHER SUBSTANCE ABUSE

10.1 INTRODUCTION

Alcohol abuse is not only a specific health problem in itself but it is also a major contributing factor to the complications of many other medical conditions. In addition to this, it contributes to social disharmony and dysfunction, resulting in trauma, e.g. road accidents, physical violence and neglect of children.

As a result, the Working Party has decided to treat alcohol as a separate issue, incorporating within it other types of substance abuse, especially where it affects children and young adolescents.

Alcohol abuse, its complications and manifestations have been identified by Aboriginal communities during the consultation process as one of their major health problems.

Non-Aboriginal Australia must recognise that alcoholism is an introduced illness caused primarily by political, social, economic and cultural deprivation imposed by non-Aboriginal society. Until such time that non-Aboriginal Australians as a whole accept this and acknowledge the need to redress this situation, there will be no lasting resolution of the alcohol abuse problem in the Aboriginal community.

Alcohol abuse is simultaneously a health problem, a cause of other health problems and a symptom of socio-political related problems.

The excessive use of alcohol and other drugs of abuse is also a major health and social problem in the wider Australian community. This is recognised by the National Campaign Against Drug Abuse and demonstrated in hospital records in every Australian State and Territory.

Discussions about the "Aboriginal alcohol problem" should be conducted in the light of this reality.

Most Aboriginal people agree that the health of too many Aboriginal people and the lives of their families and communities are being damaged and often dominated by alcohol. Many communities believe alcohol is the most significant (health and social) issue facing them.

10.2 ALCOHOL IN ABORIGINAL COMMUNITIES

10.2.1 Use of Alcohol in Aboriginal Communities

The extent to which alcohol is used by Aboriginal people has been documented and quantified for some communities. There is enormous variation in the extent to which alcohol is a part of Aboriginal community life. It is a mistake to generalise from the findings in one community to Aboriginal people nationwide.

Many Aboriginal communities particularly in Central and Northern Australia are declared alcohol-free by Aboriginal Councils at the request of their communities.

The effects of alcohol on health are mitigated by a good diet and the absence of other health problems. Among Aboriginal drinkers, a poor diet and the prevalence of other health problems, e.g. liver disease from hepatitis B, respiratory disease, diabetes, hypertension (high blood pressure), may exacerbate the detrimental effects of alcohol on health, both acutely and chronically.

The immediate effects of alcohol on the individual can cause immense social disruption in Aboriginal communities.

10.2.2 Understanding the Use of Alcohol in Aboriginal Communities

There is a burgeoning literature by psychologists, anthropologists, and social workers that attempts to explain the high prevalence of a hazardous level of alcohol use in Aboriginal communities. Aboriginal people, too, have spoken and written on the subject.

The central role that covert and overt discrimination plays against Aboriginal people by non-Aboriginal society is undenied.

Importantly, the more positive and functional role that alcohol plays in contemporary Aboriginal society has recently being acknowledged.

Drinking is usually a group activity in Aboriginal society and is altogether more visible than in non-Aboriginal society

Sharing alcohol promotes sociability and solidarity. It provides a place, an activity, and a purpose. Bain (1974) considers

> "the culture of alcohol consumption as a substitute for the traditional ritual life". Brady and Palmer (1984) describe alcohol use as

> "a conscious and determined statement of an alternative to compliance with the surrounding power structure".

While there never has been any evidence for the hypothesis, of a genetic basis for understanding supposed differences in the effect of alcohol on Aboriginal people has been discredited. However, this view persists in non-Aboriginal Australia. As Kamien (1978) points out,

> "The implication of the genetic view is that, if Aborigines cannot hold their liquor, they are an inferior species to the white man, who can."

Indeed, some authors suggest that it would be more appropriate to look for a biochemical difference that enables Aboriginal people to drink more than non-Aboriginal people with impunity the next day (Healy, Turpin and Hamilton, 1985).

Among academics, single-factor cause and effect explanations for heavy alcohol use are almost universally rejected. There is now the recognition of a complex and dynamic situation in which many historical, legislative, political and social factors interact to produce a social milieu in some Aboriginal communities in which alcohol figures prominently.

10.2.3 Alcohol as a Disease

Some Aboriginal people emphasise the individual disease concept of alcoholism (Hunt 1984, Sigston 1984, Bryant 1987, Potter 1985, Carroll & Wilson 1984), while incorporating a community approach to rehabilitation, for example the Aboriginal concept of Alcoholics Anonymous (AA).

However there is a consensus in the Aboriginal community that understands the "alcohol problem" from a community perspective, as a symptom (ultimately a symptom of dispossession) alienation, and discrimination which leads to loss of self esteem.

The Working Party believes that excessive alcohol use must be seen and dealt with as a community problem rather than solely as an individual's pathology. It is felt that the recognition of this is crucial to the development of a logical approach to prevention of alcohol abuse in future generations.

The report prepared by Fagan and Swan of the Aboriginal Medical Service in Redfern, for the Royal Commission of Inquiry into Aboriginal Deaths in Custody, on the Effects of Alcohol on Cognitive, Psychomotor, and affective Functioning in Humans states:

> "European professionals are absorbed in the concept of alcoholism as individual pathology and this obscures the real issues. A move must be made (away) from the disease concept of alcoholism if change and solutions are to be forthcoming."

So, while recognising the need for acceptable and accessible facilities for detofication and the vital role that Alcoholics Anonymous may play in rehabilitation for some, the Working Party is also concerned with prevention - the implementation of strategies that will facilitate structural changes in the wider society that will empower Aboriginal people and begin to address the underlying causes of the high prevalence of excessive alcohol use in some Aboriginal Communities.

10.2.4 Existing Treatment Programs

It has been recognised that cultural destruction has been the major contributing factor to the present predicament of Aboriginal people. Though recognition of this fact has been acknowledged, it has never been accompanied by the provision of the necessary resources to develop the essential community programs. Rather, Aboriginal people have been incarcerated in gaols to give the impression of concern for their safety. If they survive gaol, they are then subject to the "revolving door" recidivism of the system.

Any strategy aimed at reducing the excessive use of alcohol by Aboriginal people must address:

- the economic and political issues that govern Aboriginal disadvantage, and

- the regulation of Aboriginal daily life with regard to the use of alcohol, particularly as evidenced by the discriminatory legislation in force in the N.T. (Simmons, 1988).

The motivation for Government action comes from intermittent political pressure, rather than from a commitment to effective long-term solutions for future generations.

Aboriginal people endure the most severe social pressures with the least resources to protect them.

Most treatment regimes are based on the outdated Western disease model of alcoholism and the success of these programs to date has been measured in white terms but not on the basis of the needs of the Aboriginal clients. Wilson's review of treatment programs in 1986 demonstrates this clearly.

Aboriginal communities are not homogeneous. Consequently, there cannot be an across-the-board single solution to substance abuse or a "package deal" that can be applied nationwide. Each and every community needs to look at the causes and solutions taking into account individual pathology, physical, social, psychological, and cultural factors.

Until recently, Commonwealth, State and Territory governments placed all their emphasis on rehabilitation type programs. To date, the only rehabilitation facilities have been "all-in-together-blacks", for example, people with Korsakov's syndrome, chronic alcoholism, delirium tremens, young problem drinkers, all in together.

The need for rehabilitation programs has not diminished, indeed the number of programs need to be expanded, however little if any emphasis has been placed on awareness and preventative programs.

The need to create and place a strong emphasis on preventative and public awareness type programs is considered essential.

Resource providers, such as the Department of Aboriginal Affairs often do not have appreciation of the social and cultural factors that are associated with alcohol use in Aboriginal communities and therefore often provide only enough resources to treat one symptom of a multi-dimensional problem. Resources for education, for programs that address the total needs of the client population and Aboriginal health workers in this field, have been denied and are urgently needed.

The attitude of communities needs to be re-assessed. Rehabilitation centres should not be considered as punishment centres nor should those who receive treatment be considered outcasts by fellow community members.

Whilst acknowledging that certain State and Territory Governments have legislated for proclaimed places and the like, there is a need to expand upon this type of facility Australia wide.

There is also a need to examine how Aboriginal communities, often in remote localities, can administer and police such facilities and legally control those community members who abuse these centres.

There is wide agreement that the prevalence of alcohol related problems amongst Aboriginal is cause for much concern. Aboriginal themselves report that they experience interpersonal violence, socially disruptive behaviour, the neglect of family responsibilities and adverse health consequences resulting from their drinking.

The involvement of Aboriginal women in alcohol related problems has been largely ignored with an almost exclusive focus on male behaviour. There has also been frequent misunderstanding of what constitutes alcohol problems and the processes by which they develop and a lack of analysis at the local community level.

10.2.5 Alcohol, Aboriginal people, Non-Aboriginal People and the Law

Aboriginal are grossly over-represented in alcohol related court convictions and in hospital admissions for alcohol related diseases and accidents. Disregard for the law, particularly with regard to taboos on sexual liaisons, non-participation in rituals, and the imparting of 'secret-sacred' material has also been attributed to excessive drinking.

Alcohol does pose real problems for many Aboriginal communities. Non-Aboriginal stereotypes about the use of alcohol persist and aggravate the problem for Aboriginal people. Having introduced alcohol to Aboriginal people and then having used it as a weapon against them, non-Aboriginal people now blame Aborigines for their poverty, unemployment, and other problems, wrongly attributing the cause of all Aboriginal problems to their "abuse of alcohol".

The "Aboriginal Alcohol problem" that the non-Aboriginal community perceives and acts upon is fed by racism and is based on professed economic, social, and aesthetic concerns, not the well-being of the Aboriginal community (Simmons, 1981 Brady, 1984).

The non-Aboriginal response to the situation is legislative, discriminatory and often punitive.

This is well illustrated in the Northern Territory. Strictly enforced dress regulations keep most drinking outlets "white", leaving Aboriginal people little option but to drink outside or in crowded, depressing surroundings with people they would otherwise avoid.

While this situation is evident in Alice Springs (Simmons, 1988); (Brady, 1984) comment similarly on Tennant Creek:

> "The variety of (drinking) establishments enables the Europeans to sort themselves into chosen social and class groupings so that they may avoid encounters with certain others (e.g., management and workers, police and public). Aboriginal people do not have the same range of (drinking) environments at their disposal. This means that grievances, annoyances, and disputes may not be dissipated by a distribution between premises as they are with Europeans."

The Northern Territory Summary Offences Act (Section 45D) 1983, which prohibits the consumption of alcohol within two kilometres of a public place and/or licensed premise, endeavours to keep the streets "nice", "white" and "non-threatening" for tourists. This increases the likelihood of conflict with the police and also encourages Aboriginal to drink in the camps, thus causing further disruption to families.

Where facilities for Aboriginal drinkers are inadequate and unpleasant, drinking becomes an outdoor, street or park activity, in addition to being a group activity, Aboriginal drinkers are thus more readily exposed to police attention and more often apprehended for drinking offences.

In 1981, 23.6% of the Northern Territory population was Aboriginal. At the same time 50% of the prison population was Aboriginal and more than 80% of the Aboriginal people in gaols were convicted of alcohol-related offences (DAA 1983, ABS 1982-1984). This over-representation of Aboriginal people in prisons, the majority of whom are convicted of alcohol-related offences, is not peculiar to the N.T. It is repeated throughout the Australian States.

Whereas an intoxicated non-Aboriginal person is likely to be driven home, an intoxicated Aboriginal person is liable to spend the night in gaol and/or be charged with an offence.

10.2.6 Aboriginal People, Alcohol, Suicide and Custody

There is an association between the heavy use of alcohol and imprisonment, and between these two and depression and suicide. Alcohol appears frequently in the case histories of those who have died in custody. They may have been "locked up" because may have been drunk or because they committed an offence while intoxicated.

Aboriginal people with inadequate nutrition and probably some significant health problems (diabetes, heart disease, hypertension), struggling with a reality that creates mental health problems (eg, anxiety and depression) is more likely to drink alcohol to excess, more likely to come to police attention and more likely to go to goal when they does.

Once in custody, they are more likely to suffer discrimination and outright racism at the hands of their captors, more likely to be sick, less confident in asking for help of those in charge, who are less likely to be sympathetic. It is inevitable that the experience of incarceration (and isolation) exacerbates the "pain" in this situation.

The case histories of those who have died in custody reveals that many of the deaths occur within an hour or two of the deceased being arrested. Withdrawal symptoms or delirium tremens are unlikely to have dominated the clinical picture surrounding these deaths. Other factors must be operating.

Many intoxicated Aboriginal people are admitted to hospitals and detoxification units or are cared for in private homes when "drying out" (sobering up). Suicides in these situations are rare. The major factor in suicides would appear to be environment, i.e., police lock-ups and gaols.

10.2.7 What is to be done?

Alcohol and other drugs will always be available. Therefore, there is an urgent need to develop strategies that will facilitate a safe and sensible attitude towards their use, especially towards alcohol use among young people.

It must be recognised by funding authorities that the majority of Aboriginal controlled health services throughout Australia should be, and often are involved on a daily basis in the treatment of patients with substance abuse problems. The treatment of patients cannot be considered as being carried out by special alcohol substance abuse project staff only.

There is clearly a need to distinguish between the treatment of alcohol and other substances of abuse. One cannot, and should not, consider combining treatment for example of alcohol and heroin users in the same program.

It is also recognized that most of recommendations contained in this section can form part of the existing "all-out" effort to reduce sexually transmitted diseases. Alcohol and other substances of which users are so likely to fall victim contribute generally to the transmission of these diseases.

An all out effort is needed to reduce Alcohol and other Substance Abuse problems amongst Aborigines if the future of the race is to be given serious consideration.

The Working Party recognises and supports the need to develop strategies directed at persuading youth to live healthy lifestyles without becoming involved with alcohol and other substances of abuse as part of their life.

The youth of today is the future of Aboriginal Australia and for this reason there needs to be a special effort to discourage the use of any form of substances of abuse.

10.3 PETROL SNIFFING

The problem of petrol sniffing has surfaced in a number of Aboriginal communities.

Aboriginal youth are especially at risk from this form of substance abuse and special emphasis has been given to a project to dissuade them from becoming involved in this form of addiction. The Healthy Aboriginal Lifestyle Team (HALT) has been funded by the Department of Aboriginal Affairs to develop strategies to assist Aboriginal community leaders to come to grips with this particularly dangerous pastime.

The problem basically stems from a complete sense of frustration and boredom. There is little or no recreation facilities available for youth in most of the communities confronted with this problem. The lack of something meaningful to occupy their spare time encourages youth to experiment with these hazardous pastimes.

The provision of sport and recreational facilities would help to alleviate some of this frustration and provide an alternative to petrol sniffing.

The Working Party supports the need to develop specific strategies and implement a system of educational programs to dissuade youth from becoming involved in this form of abuse.

10.4 PSYCHOACTIVE DRUGS

The World Health Organisation defines psychoactive drugs as those that alter mood, cognition and behaviour.

Aboriginal drug and alcohol workers throughout New South Wales define heroin addiction as one of many addictions which affects the spiritual, emotional, mental and physical well-being of the Aboriginal person, families and communities.

Psychoactive drugs can be classed into three major groups on the basis of their effects on functioning of the nervous system

- stimulants (uppers);
- depressants (downers); and
- hallucinogens.

10.4.1 General Effects of Psychoactive Drugs

The effects of any drug depends on a number of factors:

- other drug use;
- amount taken;

- manner taken (time over which drug is taken, frequency, route of administration);
- individual factors (age, physical health condition, body weight, tolerance, past experience, mood and activities of the user);
- circumstances in which the drug is taken (the place, the presence of other people); and
- cultural factors that affect drug use.

Destructive psychoactive drug use does not happen in isolation, it is consistently linked with such factors as:

- cultural destruction;
- low self-esteem;
- a sense of powerlessness;
- a sense of frustration;
- poor interpersonal skills;
- low expectations;
- inadequate relationships;
- peer pressure;
- low educational attainment; and
- unemployment.

The pattern of use and the factors contributing to abuse differ from one age group to another, as well and from one community to another.

Heroin is one of the drugs of major concern. Heroin use became a significant problem in the Aboriginal communities in Sydney as early as 1982.

Aboriginal people are alarmed at the rate of deaths and destruction caused by the use of this drug. Youngsters in the Aboriginal communities can now obtain heroin easily and the number of users grows steadily each year. The available information suggests that heroin use is becoming a problem in other Aboriginal communities, especially urban communities outside of New South Wales.

It would appear that its use has not spread to any great extent in Aboriginal rural communities.

For heroin addicts, the desired dose is the largest amount they can tolerate so they risk overdosing with every deal. A habit often costs the user more than $200 per day and the only way to obtain this is by stealing, dealing and prostitution.

The Redfern experience has been that heroin and intravenous use of other drugs not only affects the individual user but threatens the fabric of Aboriginal society, already stressed by unemployment, chronic poverty, alcohol, etc.

Users have a dangerous and demanding career. Their health further suffers from neglect and from exposure to a spectrum of diseases, eg, HIV infection, Hepatitis from using and sharing contaminated syringes. Addicts' children are vulnerable to neglect and exposure to their parents' hectic lifestyle.

At present Aboriginal drug addicts bounce between bingeing, gaol detoxification and the streets.

Drug and alcohol rehabilitation is a difficult task in the best of circumstances and in any community. Most services available to Aboriginal people are culturally inappropriate and inadequate and have not been successful in attempting to intervene culturally or therapeutically in the vicious cycle that constitutes an addict's life.

The Working Party supports in principle the currently approved Substance Abuse Policy Paper of the Department of Aboriginal Affairs with appropriate amendments to incorporate the recommendations listed in this report. (Attached in Appendix IX)

A more comprehensive description of the problems and specific treatment and prevention strategies in an urban environment is provided in the Aboriginal Medical Service (Redfern) Submission in Appendix X.

A draft policy paper on Substance Abuse has also been prepared by the National Aboriginal and Torres Strait Islander Substance Abuse Council (NATSISAC) a body set up as a result of a conference in Adelaide in August, 1988. This draft is not acceptable to the NAHSWP but is included as a background paper to enable consideration of the urgency of the situation that confronts Aborigines throughout Australia.

Copies of this policy statement is at Appendix XI.

The Working Party recommends that:

- funds be made available for accredited courses for Aboriginal drug and alcohol workers employed by Aboriginal health services and rehabilitation services throughout Australia;

- more educational programs be made available to adults and children in Aboriginal and non-Aboriginal communities on the effects of alcohol and other drugs;

- positive media campaigns using well known Aboriginal role models, be designed and promoted throughout Australia to dissuade Aboriginal youth from using alcohol, cigarettes, or any other drugs of addiction;

- educational projects be developed that clearly demonstrate the associated problems of consumption of products that can be abused;

- that community employment programs be developed to overcome boredom which leads to alcohol abuse;

- a system of legally approved visitations to detainees by staff of Aboriginal medical services and counsellors from alcohol rehabilitation programs be developed;

- detoxification and rehabilitation projects be provided with additional resources to address the needs of patients who have undergone treatment and the special needs of their families;

- people suffering problems of addiction should not, wherever possible, be removed from their community environment to obtain treatment;

- a network of community based organisations be developed as an urgent priority. For example, there are no effective community based rehabilitation programs north of Cairns in Queensland;

- greater liaison with police to avoid locking up people simply because they are drunk;

- a system of safe houses needs to be developed, where people who are intoxicated can be taken instead of being locked up. The circumstances leading to many deaths in custody clearly indicate the need for this type of facility;

- the setting aside of specific areas and facilities where people can go to without disrupting other community members;

- consideration be given to developing some means of preventing, or at least substantially reducing, the present widespread practice of cashing Social Security cheques at hotels or liquor outlets. The co-operation of the liquor industry should be sought; and

- the following procedures should be followed when an intoxicated Aboriginal person is picked up:

  - taken to a sobering up centre/safe house;

  - referred for medical assessment; or

  - sent to a half-way house or a rehabilitation centre depending on the outcome of the medical assessment report.

- the restructuring of programs currently being provided so that those undergoing treatment can be given meaningful training to enable them to find a useful place in their community structure when they complete the program;

- follow-up mechanisms be established to monitor the progress of clients who have undertaken a rehabilitation program and to provide appropriate support;

- staff of Aboriginal health services, rehabilitation services, and other associated organisations need to be provided with adequate and appropriate education to equip them to treat people with problems of addiction;

- that mobile rehabilitation units be established to take alcoholics back to their country for a few months to assist them to get off the grog;

- such education should have a formal accreditation process to enable graduating staff to obtain employment in similar programs throughout Australia;

- that language and cultural courses be established in schools to encourage the survival of the culture and ensure a strong identity for Aboriginal children as part of a program to reduce alcohol and other substance abuse;

- all existing and future Aboriginal alcohol and substance abuse programs be monitored and evaluated for effectiveness;

- that information about the types of programs being used to reduce alcohol or substance abuse should be readily available to other communities;

- on those communities that request it, a system of Community Workers be established who would be empowered by law to confiscate liquor and vehicles from intoxicated people within prescribed areas of the communities;

- the States and Territories implement uniform legislation to provide for heavy fines, in the order of $10,000, and to allow for confiscation of vehicles, aircrafts or vessels used in the illegal sale of alcohol in Aboriginal communities.

During the consultation process, information was obtained that "Sly Grog Merchants" in North Queensland were charging $10 for a can of beer, $50 for a Casket of wine, while the fine for illegal selling of liquor is only $100.

- to enable Aborigines the opportunity of redressing the current dramatic problems of alcohol and substance abuse, an additional $5 million in Direct Grant Funds in 1989-90 and an additional $10 million per year for the next four financial years until 1993-94 be provided;

- Commonwealth/State and Territory governments set aside a percentage of the revenue obtained from liquor sales tax and excise to provide funding for alcohol awareness, prevention and rehabilitation programs for Aboriginals; and

- each community should have control over their own alcohol and other drug abuse rehabilitation programs as they know the root causes involved and the individuals having abuse problems.

The Working Party endorses the following recommendations from the Interim Report of the Royal Commission into Aboriginal Deaths in Custody.

"In jurisdictions where drunkenness has not been decriminalised, Governments should legislate to abolish the offence of public drunkenness.

The abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain facilities for the care and treatment of intoxicated persons.

Legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons.

- in the States and Territories where public drunkenness has been decriminalised, adequately funded alternative facilities for the care of intoxicated persons should be urgently established and maintained to meet the demonstrated needs;

- all Governments should combine to set up a national task force to examine the social and health problems created by alcohol and confronted by Aborigines in many localities, to assess the needs and the means to fulfil the needs, including legislative action, and the establishment of appropriate facilities for short and long-term care, education and training. The Aboriginal Health Services and other medical resources should be well represented in such a project which should be essentially health-orientated.

- the additional funds requested are necessary to provide adequate resources to the existing projects and to enable new programs to be implemented. For example, in the Torres Strait, the northern peninsula area of Queensland, the gulf area of northern Queensland, the development of research projects necessary to prepare curricula for training of counsellors; also necessary the provision of essential capital equipment to projects, the development of a uniform salary structure for alcohol rehabilitation workers, and public awareness projects to deter youth from becoming involved in substance abuse all of which have been unavailable due to lack of funding. The above programs plus the provision of salaries for Aboriginal staff to work in State controlled organisations are considered essential.

It is recommended that all such additional funding should be on a dollar for dollar basis with the State and Territory Governments.

CHAPTER 11

ABORIGINAL HEALTH RESEARCH

11.1 INTRODUCTION

Concern has always been expressed by Aboriginal people at the way researchers, be they anthropologists or medical scientists, are continuing to invade the privacy of Aboriginal communities in order to conduct research which appears largely designed to serve their own academic, political, or professional needs. This research is most often undertaken with little or no proper consultation with communities.

Research is frequently imposed on Aboriginal communities, with the Aboriginal communities usually having no control or redress. It rarely provides any benefit to the Aboriginal participants and is in fact often used in a detrimental manner by the media and governments.

Members of the Working Party share a common concern with communities that little, if any, of this research is actually directed or focussed on projects that are of, or likely to be of, a tangible benefit to their communities and, in fact, has often been the subject of dubious if not unethical medical practices

However the Working Party, like the community, is very much aware that there is a need to undertake a level of basic medical research into conditions prevalent in Aboriginal communities if there is to be any long-term solution found to many of the diseases that Aboriginal people suffer.

Cross-cultural research, and in particular, cross-cultural research in Aboriginal affairs, has difficulties which have remained largely ignored by researchers.

Every approach to inquiry research is based on a set of assumptions. The framework, the cultural, and philosophical value system within which the research is conceived, designed, and conducted comes into question in the cross-cultural situation, and deserves examination. The model within which research is conducted reflects the values of the dominant culture.

Clinical research into Aboriginal health has, until now, remained almost entirely in the hands of non-Aboriginal researchers. The dominant culture has thus had a monopoly on research. It has the economic and political power, the academic skills, and the resources.

The researchers define the problem to be explored and they frame the questions to be asked from their own cultural perspective. Very few recognise the assumptions implicit in that process, and in Aboriginal research, very few take the trouble to define the problem from the Aboriginal community perspective.

For instance, when speaking about psychiatric categories of diagnosis, Kleinman (1977) comments that the search for the same disorder in different cultures is not a useful basis for cross-cultural research, as:

> "by definition it will find what is universal and miss what does not fit in its tight parameters".

Further, Kleinman (1980) points out that:

> "Culture probably has its most profound and difficult to assess influence on psychiatry through the elaboration of conceptualisations of mental illness and psychiatric care that parade as value-neutral science but, in fact, represent a cultural construction of social reality that is only in part impirical, but also an admixture of professional ideaology and shared cultural bias".

This aspect of cultural psychiatry is virtually ignored by researchers. Psychiatric research is culturally based and ideologically biased. Researchers, like psychologists, can go, as Freud put it, only as far as,

> "their own complexes and internal resistances permit".

These factors have an impact on the conclusions researchers reach, and help to explain why mental health/illness research has had little success in exploring, in usefully describing and defining the Aboriginal situation.

Aboriginal research, rather than reflecting the fancy of the individual researcher, needs to become problem oriented and Aboriginal people should be defining the problems. Underlying issues will then be better understood and the way towards treatment and prevention made clear.

The research should clearly specify the issue under consideration and the community should be involved in framing the questions so that the research is relevant to their needs.

The Aboriginal community must actively participate in the research process, be kept fully informed, and have some say in how research findings are publicised and used. Only when research projects are subject to Aboriginal community influence, will they be both relevant and of benefit, to the community.

Such guidelines were written during the 1986 National Health and Medical Research Council (NH&MRC) sponsored conference, 'Research Priorities in Aboriginal Health'. Based upon this,

The Working Party recommends that:

- the following guidelines on Aboriginal health research be adopted nationally by research institutions and researchers.

11.1.1 Obtaining of Ethical Approval

- researchers should seek the approval of the participating communities and individuals by consulting and negotiating with them, the terms, scope and benefits of the proposed project.

11.1.2 Consultation Process

- researchers should demonstrate to funding agencies and or ethics committees that consultation with local communities has occurred and that the community is able to provide supporting documentation verifying this consultation;

- this material should:

    - identify research skills which will be shared through the proposed project. Where possible, the process should also be outlined;

    - provide evidence of meetings;

    - identify any overlap of materials;

    - identify the social and cultural imperatives of the community;

    - nominate the benefits of the project to the community;

    - detail the intent and methodology of the proposed research; and

    - demonstrate that the researcher has addressed the issue of ownership and publication of data.

11.1.3 Ongoing Review of Ethical Standards

- the continuing compliance with ethical standards can be exercised through research project funding. Both ethics committees and community controlled agencies should have responsibility to monitor these standards.

11.1.4 Social, Gender, and Cultural Issues

- researchers need to ensure they address potential social and cultural conflict. Consequently, researchers will be respectful of and adhere to community wishes when researching;
- gender - traditional and contemporary roles;
- parenting;
- family and community structures and responsibilities;
- invasions of the body and the handling of human specimens and products;
- the use of research material beyond the research process; and
- Aboriginal law.

11.1.5 Communication and Consent

- researchers must provide communities with all relevant information on the research and respect and adhere to the community's process of decision-making and the rights of individuals in that community to participate or not participate in ways they see fit.

11.1.6 Employment of Local People

- researchers should, on the advice of the local communities concerned, employ Aboriginal people to assist the research investigation if it is appropriate.

11.1.7 Ownership and Publication of Materials

- material identifying individuals or objects of a sensitive nature should not be published without approval. However, acknowledgement of research should properly account for the participation and assistance of Aboriginal individuals and communities;

- legally binding contracts should be drawn up between the community/individual and Researchers, giving the community ownership, censorship, copyright and publication rights of the final results. The contract should also provide details of the research process; and

- a particular concern is that future use of research material including pictorial matter should allow for the withdrawal of pictoral material when individuals die. Pictorial material should only be obtained with the consent of the community.

11.1.8 Exploitation of Community Resources

- researchers must reimburse the community for any costs which are incurred as part of research being undertaken in the community.

11.1.9 Other Considerations

It is essential that the ethics or research committees overseeing the study carefully assess the researcher's compliance with each of the above before granting approval. In addition to meeting the above guidelines, there are a number of other considerations which the funding body or appropriate ethics committees would be expected to oversee. These would include:

- priority being given to those proposals that address the most important achievable goals;

- the proposal should be subject to rigorous independent scientific review;

- the central hypothesis should be adequately substantiated from existing knowledge;

- the methodology should be adequate and appropriate to prove or dispose the hypothesis; and

- the research should be likely to contribute significantly to new knowledge.

11.2 THE PROCESS OF CONSULTATION

Arising from the NH&MRC conference, the National Aboriginal and Islander Health Organisation refined a proposal for consultations. Most aspects of this proposal have been endorsed by the majority of the Working Party. Specifically, the following process is recommended.

The initial points of contact for researchers should be :

- the elected community council) where
- the community controlled health service, or) these) exist,
- other community controlled organisations.

Researchers must be required to provide funding agencies and responsible ethics committees with appropriate documentation and other evidence which demonstrates that proper community consultation has occured.

The Working Party recommends:

- that the paper 'Report of the National Workshop on Ethics of Research in Aboriginal Health', be adopted as the basis for considering Aboriginal health research proposals.

This paper is contained in Appendix XII.

11.3 PROPOSALS : FUNDING AND RELATED ISSUES

11.3.1 Major funding

The Working Party has concluded that there exists a large number of Aboriginal Health problems which will require a significant research effort before the specific cause of many prevalent diseases in Aboriginal communities can be overcome. It is therefore considered that the NH&MRC through its Medical Research Committee (MRC) remains the most appropriate and affective body to promote and administer the necessary research while providing the safeguards for the Aboriginal community which the Working Party considers to be essential.

The Working Party recommends that:

- the NH&MRC should annually set aside a fixed proportion of research monies it administers for research projects in Aboriginal Health.

The Working Party also accepted the view advanced by a number of health services that there existed a need to provide individual health services with the financial resources to undertake specific research projects into issues that their communities considered to be priorities.

It was envisaged that this would provide the community health services with sufficient resources to carry out preliminary investigations into unusual conditions which were affecting their community at a particular time. It was suggested that a maximum amount of $20,000 for each health service.

The Working Party recommends that:

- the Commonwealth Government set aside two million dollars per annum for research projects conducted by, and specific to, Aboriginal communities and Aboriginal community controlled organisations.

Additional funds should also be available from DEET to assist Aboriginal people to develop and enhance research skills.

11.3.2 Funds Administration

Resources for the project should be administered by the community unless the proposal states otherwise. Where an alternative process is sought, this should not be to the detriment of the Aboriginal community or the guidelines to Aboriginal health research outlined above.

11.3.3 Assessment of proposals

> "The assessment process should begin in the community, and the community will decide how to conduct their review. Resources must be provided to the community for this process."

When assessing proposals specific to Aboriginal people, a member of the target community should be invited to participate (as a full member) on the review panel. This person, is vital to ensure assessments are made within culturally valid values. If appropriate, more than one person should be invited to participate on the review panel.

In the case of the NH&MRC, this community participation process should be extended to its principal committees, the Health Care Committee, the MRC, the Public Health Committee (PHC), the Public Health Research and Development Committee (PHRDC), and the Medical Research Ethics Committee (MREC).

Research priorities should be determined by communities after implementation of resources based on existing knowledge.

11.4 WORKING PARTY AGREED RESEARCH PROGRAMS

The Working Party, while considering new health programs and initiatives in this health strategy, includes the following issues as constituting some of the problem areas requiring immediate research. These are divided into social health and specific health issues.

11.5 SOCIAL HEALTH

11.5.1 Housing

The design of appropriate and acceptable housing designs to Aboriginal communities is an area requiring further research which includes a proper consultative process with commmunities to determine how communities wish to live and what health hardware and housing the community wants. Consultations conducted and submissions received by the Working Party have not only overwhelming criticised the lack of adequate numbers of houses but the inappropriate and inadequate design of housing in all types of Aboriginal communities. For example, housing in many areas lacked verandahs, cupboards, adequate space, used poor or incorrect materials, required too much maintenance, and facilities in them such as toilets and drainage were inadequate for the number of people needing to use them.

11.5.2 Food Supply

- research to develop proposals to implement:
  - subsidisation of food;
  - community ownership/control of transport;
  - community controlled enterprises to improve nutritious food supply; and
  - pricing policies to encourage corsumption of nutritious food;

  should be conducted:
- studies should also be conducted into the nutritional and medicinal qualities of bush products.

11.5.3 Education

- investigation of means for increasing community awareness and acceptance of the importance of education, in its many forms, in relation to self-esteem, employment and health.

11.6 SPECIFIC HEALTH ISSUES

The Working Party considered attention should also be given to research into specific health issues independently of the research projects mentioned earlier in this report. Research into specific health issues need not necessarily be funded from

the annual allocation of $2 million which the Working Party has recommended be set aside for research projects conducted by, and specific to, Aboriginal communities and Aboriginal community controlled organisations. Rather it is expected that funding for this research will come from the NH&MRC as part of the funding set aside specifically for research into health and related problems amongst Aboriginal people.

Academic institutions and research agencies would apply for funding for specific projects in the ususal way although the principles outlined previously should apply.

NH&MRC, in its submission to the Working Party acknowledges this priority stating:

> "The NHMRC, which has a responsibility for identifying national health needs and priorities, recognises that improvement in Aboriginal health must be a major national and NHMRC priority."

and considers that it could contribute to:

- programs of research and trainng;
- information gathering services; and
- monitoring and evaluation of programs;

through its existing committee structure and its support of Aboriginal Health Research and Training.

The need for research into specific health issues has been identified by the Working Party members following community consultations.

Working Party members recognise that some of these issues are already being pursued as part of narrower research projects which may require a wider perspective. In some instances research has already been completed, however the issues remain unresolved and would benefit from further research.

In nominating the following research areas/topics the Working Party is recognising the need for such research but is not making any statement as to the priority that should be given to an individual project.

Recommended specific health research programs are:

- investigation of means of decreasing the incidence of life style induced disease through modification of attitudes towards diet, alcohol, tobacco, exercise etc;

- development of appropriate strategies to deal with mental health problems, especially alcoholism;
- investigation of means of modifying attitudes to reduce the prevalence of sexually transmitted diseases and to reduce the risk of acquiring HIV infection;
- development of effective means for reducing the prevalence and effects of child abuse;
- investigation of the causes of ear disease and the development of effective means of prevention and treatment;
- investigation of the causes of respiratory disease and the development of effective means of prevention and treatment;
- investigation of the causes of gastroenteritis and the development of effective means of prevention and treatment;
- investigation of the prevalence and causes of pelvic inflammatory disease and the development of effective means of prevention and treatment;
- investigation of the prevalence of cervical carcinoma and development of culturally acceptable means for obtaining a high compliance rate with Pap Smears;
- investigation of the causes of renal disease and the development of effective means of prevention and treatment. This includes a study of the relationship of renal disease with a) obesity, b) diabetes and c) alcohol consumption;
- investigation of the causes of leukaemia (HTLV I) and the development of effective means of prevention and treatment;
- investigation of the prevalence and causes of other blood diseases and the development of effective means of prevention and treatment;
- investigation of the impact on health of Chlamydia trachomatis with particular reference to ear and chest disease originating in infancy and childhood, pelvic inflammatory disease in women and the delivery of low birth weight infants;

- development of effective prevention and treatment programs for diabetes, with an emphasis on diet and exercise;
- development of effective prevention and treatment programs for hypertension;
- development of effective prevention and treatment for vascular disease;
- assessment of the prevalence of liver disease, including hepato cellular carcinoma, in chronic hepatitis B carriers;
- development of effective treatments for hepatitis B related diseases;
- assessment of immune competence and its relation to both susceptibility to infections and to nutritional status;
- studies on the immune system and its competence in relation to both susceptibility to infections and to nutritional status;
- studies on the nutritional and medicinal qualities of bush products;
- assessment of the advantages and disadvantages of formula funding for health services; and
- the prevalence, and impacting social causes of, gout and hyperuricaemia in the Aboriginal population requires research.

The Working Party recognises that there should not be an imbalance towards areas of research in specific diseases. Rather it is recognised that there should be a swing towards a balancing emphasis on Social Health and the socio-economic and consequent mental stress basis for illness within Aboriginal communities.

CHAPTER 12

MONITORING & EVALUATION

12.1 INTRODUCTION

Monitoring and evaluation by the community is a powerful tool which could serve a useful purpose in promoting greater participation in the provision of Primary Health Care and contribute to a closer nexus between services and needs.

Communities have often had good reason to see the process of monitoring and evaluation as a means by which government might gather information about a community without that community's consent and/or the means by which government might coerce a community into adopting standards it might otherwise wish to reject. Differing priorities have meant that the focus of evaluation for administrative purposes differed greatly from the perceived health issues of communities.

This was especially so when the Department of Aboriginal Affairs expected community health services to complete "Performance Indicators" which the health services felt made unrealistic demands on such organisations and would have provided very little information useful in improving services delivered.

The Commonwealth and State Governments nevertheless have a joint responsibility, with the Aboriginal health services, in implementing monitoring and evaluation to ensure that:

- community participation and control is realised and that communities are satisfied with their health services; and

- the objectives for Aboriginal health contained in this national strategy are being achieved.

Monitoring and evaluation can provide the means by which progress can be measured and indicate what new goals, strategies, and policies might be identified. In practical terms this may mean the establishment of new services and facilities in response to changing needs.

The Working Party has endorsed the need for a wholistic approach to improving Aboriginal health. This approach will encompass social, cultural, political, economic, environmental and physical factors, not all of which are easy to quantify. They often depend on subjective assessments and value judgements.

Qualitative information is both pertinent and valid because it usually relates to the intangibles associated with the provision of health services.

12.1.1 Monitoring and Evaluation - What do they mean?

It is important to make the distinction between monitoring and evaluation, where that distinction exists.

Monitoring allows for the continuous measuring of progress towards a goal or objective. The Better Health for All Australians Report identified two key elements of monitoring health:

- documenting data on the current state of health; and
- measuring the extent to which the health, of the population might be approaching the stated target.

Evaluation is the analysis of information collected either in the monitoring process or at other appropriate times for the specific purposes of:

> "systematically determining the efficiency, effectiveness and appropriateness of programs, against some predetermined yardstick".

However, both monitoring and evaluation can be applied to specific programs, or the system as a whole.

Health, by the Working Party's definition, includes attributes of social justice, well-being and equity. The process of monitoring and evaluation must therefore be concerned with these issues as much as it is concerned with, for example, a percentage reduction in diabetes. Some would argue social justice and equity are more important. The Working Party believes that monitoring and evaluation should consist of an appropriate combination of both.

12.1.2 Monitoring and Evaluation and Primary Health Care

It is therefore necessary to ensure that sound monitoring and evaluation systems are set in place, as an integral part of the strategy itself as this will allow these functions to be mutually supportive.

Responsibility for monitoring and evaluation falls on those individuals or groups most closely concerned with the delivery of service. This requires that at each level of care, mechanisms should be developed and set in place and responsibility acknowledged for monitoring and evaluating activities, achievement of goals, and relationships within the various level of the health system. It also applies to the monitoring and evaluation of the policy function and to primary, secondary and tertiary levels of care.

It is essential that what is to be evaluated is clearly stated and that the reasons for evaluation is understood. Once this has been established it allows the evaluations to determine whether the information necessary for the process is available. Depending on the subject, information needs may include, political, social, cultural, economic, environmental, administrative, technical, demographic, scientific and epidemiological factors. The cost of obtaining such information is greatly reduced where it is collected as part of the ongoing operation of the system or service. Such capacities strengthens management control.

It is also necessary to have a clear picture of how and by whom the information is to be used. Is it to be used for budgetary purposes, for program management improvements, for appraisal of resource applicability, for other administrative purposes or for some ad hoc need?

12.1.3 Issues of the monitoring and evaluation process

The process of monitoring and evaluation relies on a number of "tests" that are intended, in various ways to determine the relative merits or demerits of particular initiatives or efforts within the system as a whole. Clearly, it is not always possible to apply the full range of "tests" to all situations. Planners and decision makers will need to determine which combination of "tests" is sufficient to satisfy their purposes.

The Working Party has accepted the following "tests", briefly described below, as key attributes to the process:

- relevance - How relevant is what is being measured to the process and achievement of goals according to the concepts of health outlined in the strategy or as identified by communities?

- adequacy - has the approach taken into account all the relevant factors?

- progress - what is being achieved in relation to what was planned;

- efficiency - the measure of productivity of the service in relation to the level of resources;

- effectiveness - is the level of achievement in improving the health and well being of Aboriginal communities. Effectiveness should include the identification of the level of satisfaction of the community with what has been achieved;

- quality - does the service fulfill criteria of care and service provision that might best satisfy the communities needs?

- impact - this should be seen in terms identifying the changes brought about by the strategy. It is possible to achieve a small improvement in one aspect of health or well being without making a significant contribution to the overall picture. In some circumstances the method of achieving these small improvements may produce a detrimental impact on other related areas of social or physical well being.

12.1.4 Monitoring and Evaluation - Information Collection

Several categories of information relevant to measurement of health have been identified. These include:

- traditional, including morbidity and mortality;

- service provision and utilization;

- physical (objective) state of health;

- self reported (subjective) state of health;

- behaviour that has implications for health; and

- environmental factors that influence health.

A variety of sources and methods for the collection, collation and interpretation of information within each of these categories exist. Routine vital statistical collections, life expectation and disease patterns are examples of traditional information sources; reasons for presentations and diagnosis, immunisation and family planning are examples for service provision and use; sentinal health events, maternal and child health programs, adult screening and early detection initiatives are examples of objective health status; other examples exist in the remaining categories.

Health planners and decision makers need to assess the possible sources and methodologies for the collection and collation of health related information and determine which are most appropriate whilst keeping the collection of information to a minimum..

At a national level, Aboriginal health statistics and information mechanisms have been shown to be incomplete and in some cases non-existent. In many circumstances communities are reluctant to participate in the collection of information for fear of misuse or misrepresentation.

At the service delivery level data collections and analysis is under-resourced. The budgets of community health services do not include provision of resources which would allow the development or operation of detailed monitoring and evaluation mechanisms of the kind contemplated in this report. The Working Party believes the strengthening of the information capacities of primary level care providers is fundamental to improved monitoring and evaluation. The enhancing of such capacities at the community level will assist in terms of program budgeting and the development of valid and relevant performance indicators.

The Working Party is aware of ongoing developments of data management systems within the community sector and, although the relative merits of these systems are still unclear, their increased use demonstrates a preparedness on the part of communities to further develop these monitoring and evaluation processes.

The NSW Government has provided resources to assist community level services in data and information collection, collation, and interpretation. Similar and expanded resources should, the Working Party believes, be provided to all community health services. Aboriginal health services should be encouraged individually and collectively, to develop and prepare information and other evaluative reports as part of their management system.

While national and State collections of Aboriginal health data and information are generally acknowledged to be poor, some Governments have for some time collected limited, but detailed information on some aspects of Aboriginal health. For example, the Queensland Aboriginal Health Program has fostered the development of such mechanisms primarily for the Deed of Grant in Trust areas.

State and Territory Governments should be encouraged to re-appraise their efforts towards the establishment of appropriate routine collections of data on Aboriginal health. As discussed in Chapter II it is essential to have reliable data, identifying people of Aboriginal descent with regard to statistics on births, stillbirths, deaths, and hospitalisation rates. State Governments, or for that matter the national Government should exercise great care in determining what information is to be collected and for what purpose. All collections of information should be kept to a minimum.

12.1.5 Vital Statistics

The Working Party is conscious that in some circumstances, both within the Aboriginal and Islander communities and within hospital or related communities resistance to such action will be found. Safeguards against misuse of this information need to be set in place early and efforts to remove community resistance and scepticism about such recordings and promote the potential benefits to the community needs to be undertaken immediately if the 1989 goal is to be achieved.

The Working Party endorsed the view that the following components are necessary as a basis for a national Aboriginal vital statistics collection:

- birth notifications;
- death notifications;
- medical certificates on cause of death;
- medical certificates of causes of perinatal death;
- hospital morbidity, admissions and separations; and
- maternal/perinatal collections.

The inclusion of questions of Aboriginal status on other health collections is recognised by the Working Party as valuable. Priority should however be assigned to those collections mentioned above.

The Working Party is aware of the valuable work undertaken by the Task Force on Aboriginal Health Statistics in 1985 in moving all States and Territories towards a uniform national approach to Aboriginal health statistics collections. A summary of the positions reached during the life of the Task Force is at Table 1, Chapter 2, Current Health Status.

The Working Party is aware of a proposed Committee comprising various members including the Australian Institute of Health and the Australian Bureau of Statistics that is soon to undertake evaluations of recently established collections. The Working Party is of the view, however, that much more needs to be done to enhance the potential of these collections as health indicators.

Problems also arise when, for example, non-Aboriginal doctors are asked to complete a question relating to Aboriginality for a new born baby. "Whose Aboriginality is to be determined and who answers the question?" are issues that impact on these collections. The 1985 Task Force report contains a valuable discussion of this issue. The Working Party concurs with the conclusions reached by the Task Force, however, there is concern that identification of Aboriginality has been reduced in these collections to exclude community acceptance.

Aboriginal communities are sceptical towards inquiries from non-Aboriginal institutions and many staff of these institutions are reluctant to ask questions concerning Aboriginality. Such considerations have previously impacted upon the Australian Census collections and gave rise to the adoption of a strategy to encourage Aboriginal people to participate in the collection.

The Working Party recommends that:

- funds should be made available to community controlled health agencies to prepare and conduct a suitable public awareness program to encourage Aboriginal people to identify; and

- the co-operation of community agencies in such an initiative is fundamental to achieving maximum coverage.

The Working Party further recommends that State and Territory agencies involved in the collection of relevant data should provide sensitivity education for staff who are likely to be expected to ask these questions. The nature of the training should include an appreciation of the way in which Aboriginal people might view such questioning and why, the purpose of the question and the possible benefits to the process of improving Aboriginal health servicing.

Despite previous agreements between the States and the Commonwealth little progress has been achieved in this area. The Australian Institute of Health has previously convened an Interdepartment Working Group on Aboriginal Health Statistics which similarly had limited success.

The Working Party recommends that:

- the forthcoming meeting of the Ministerial Forum for Aboriginal Affairs and Health reaffirm and give renewed commitment to the establishment of a system for the collection and collation of sound and valid national Aboriginal and Islander vital statistics. In particular, the achievement of the following is proposed by December 1989:

  - recording of Aboriginality or Islander on all Hospital admissions and separation forms; and

  - the recording of Aboriginality or Islander on notifications of Birth, Stillbirths and Death.

12.1.6 The National Aboriginal Health Strategy - Mechanisms for Monitoring and Evaluation

The Working Party has identified a number of key areas of health and infrastructure for which it believes monitoring and evaluation mechanisms must be established.

Service delivery agencies should acknowledge responsibility for the establishment of self monitoring and evaluating mechanisms and methodologies. Funding agencies must ensure that sufficient specific resources are made available to incorporate monitoring and evaluation processes within the general management and service delivery approach of Aboriginal Health Services. The funding and design of monitoring and evaluation activities must be undertaken in close consultation with service clients and should concentrate on those functions most vital to the needs of the client community or group.

There are four components of the strategy for which the Working Party believes appropriate mechanisms and methodologies of monitoring and evaluation should be developed as a priority as they will provide a gauge the success or otherwise of the Strategy.

Health Service Delivery

- this includes matters of coverage, relevance, acceptability, quality assurance, efficiency and effectiveness, and impact

Systems Infrastructure and Intersectoral Collaboration

- monitoring of the content and interaction of infrastructural components, e.g. management, development of health resources, economic support, organised arrangement of resources and delivery of services and of the success of intersectoral collaboration initiatives.

Environmental and Social Health

- consideration of the appropriateness and adequacy of housing, water, sewerage, and waste disposal and other relevant environment factors. Social health factors such as individual and community well being, cultural integrity, employment, family support and community development, education, and skills development.

Vital Statistics and Sentinel Health Events

- mortality and morbidity statistics and sentinal health events in peoples lives which relate to unnecessary disease, disabilities and untimely death.

Establishing appropriate mechanisms and methodologies will depend on the particular circumstances however, a number of specific recommendations can be made which relate to the four categories mentioned above.

12.1.7 Sentinel Health Events Program (SHE)

This concept is based on the identification, investigation and intervention aimed at the elimination of untimely, and unnecessary death, unnecessary disease and disability.

The SHE approach is a process which focuses attention on the identification of preventable and/or treatable conditions in client populations.

The SHE program is compatible with all levels of the system and can provide a uniform and appropriate basis for the monitoring of progress towards the goals outlined in this report. Practitioners, managers and communities can use the SHE program to monitor and evaluate the identification and satisfaction of needs, intersectoral implications, quality of service delivery, pathogenic factors, the incidence of disease and the general state of health and well being within the community. Used as an evaluative process it strengthens the orientation of programs.

Adaptation and expansion of the program could be undertaken by the Aboriginal health services in conjunction with the proposed Office of Aboriginal Health and the Australian Institute of Health.

The Working Party recommends that:

- there be further development and implementation of a Sentinal Health Events Program in Aboriginal health; and

- evaluation of the SHE program could be undertaken by the state level tripartite working group, recommended in Chapter 3.

- an Advisory group comprising elected/selected representatives from Aboriginal health services together with support from the Australian Institute of Health be requested to prepare the detailed program pro forma by September 1989. The staged implementation of the program, should be geared to commence by February 1990 with the first national collection undertaken in the first half of 1991.

12.1.8 Family Health Program (FHP)

The FHP is based on the routine, but comprehensive examination of the familys', and later the communitys', physical and social health. This examination provides a base line action plan for health achievement for each family. Health workers undertake specific follow-up to address identified needs. Subsequent presentations or contacts with the the health services provides a mechanism for the monitoring the appropriateness of intervention strategies. A routine re-assessment, usually in the form of an annual family health check provides evaluation of the services provided and interventions mounted.

Base line data and information can be aggregated to provide useful and poignant health status snapshots for a complete community. Health care providers and managers can then apply any necessary changes to program definition and design. Further aggregations on a regional and/or national basis would form an important health indice.

In addition to examining the prevalence of disease, the FHP facilitates the collection of other social and environmental information in an easily understandable and usable form.

The Working Party recommends that:

- The Family Health Program, presently being piloted and evaluated by the Victorian Aboriginal Health Service, be further developed as a basis for monitoring and evaluation at the community level.

- the proposed Office of Aboriginal Health negotiate with those bodies responsible for the design of the program to broaden its application nationally; and

- given a stated preparedness by those bodies involved to undertake such negotiations the staged introduction of the Family Health Programme could commence in the 1989/90 financial year and be completed by the conclusion of the 1990/91 financial year. National collections and collation of data from this program could commence therefore on a limited but reliable basis in fiscal year 1989/90.

12.1.9 Office of Aboriginal Health

The Working Party recommends that:

- the proposed Office of Aboriginal Health be responsible for the monitoring and evaluation of practices and programs of Commonwealth agencies involved with the National Aboriginal Health Strategy. In particular, the Office would assess and report on the federal sectors preparedness and progress towards successful intersectoral collaboration.

Other functions of the Office of Aboriginal Health would include:

- a triennial assessment of key infrastructural matters of concern to the Strategy e.g., health workforce and facilities, and the organisation of resources and economic support;

- a biennial assessment of environmental conditions in Aboriginal communities including housing, water, sewerage and waste disposal, dust control and other relevant factors;

- an annual assessment of the progress towards successful intersectoral collaboration within the federal sector and nationally;

- an annual assessment of Aboriginal vital statistics; and

- a triennial assessment of the Sentinal Health Events Program.

The Working Party believes that the establishment and successful implementation of these assessments, linked to an assessment of cultural and social wellbeing will provide the fundamental mechanisms necessary for proper monitoring and evaluation of progress towards the goals outlined in this report.

The Working Party has endeavoured to select mechanisms that integrate daily activity and management, service provision and monitoring and evaluation. It is the Working Party's view that such integration is fundamental to the successful evaluation of both specific activity and the national strategy.

The Working Party recommends that:

- the following indices and indicators be established:

  - Sentinal Health Events (provider based)
    - untimely, unnecessary death
    - unnecessary disease
    - unnecessary disability

  - Family Health Program (consumer based)
    - prevalence of disease
    - environmental and social health
    - service provision and utilisation
    - primary health care and servicing coverage

  - Health Systems Infrastructure
    - health staff resources including skills transfer
    - health facilities
    - organisation of resources
    - economic support systems operation including movement within and between levels and stations of care

  - Environmental Conditions
    - housing
    - water
    - sewerage and waste disposal
    - other environmental factors

- Intersectoral Collaboration
  - budgetry)co-
  - policy)ordination
  - program)
  - political/executive support service provision at community level

- Aboriginal and Islander Vital Statistics
  - births
  - deaths
  - morbidity
  - maternal/perinatal collections
  - hospitalisation - separations

- Cultural and Social Wellbeing
  - cultural integrity
  - attitude to health and well being
  - racism

12.1.10 Implementation and Timetable

Valid and reliable measurement of all of the recommended indicators cannot be set in place immediately. Special efforts will be required to develop and implement the mechanisms, methodologies and process for collection, collation, analysis and dissemination of data. Attention to these special efforts must however commence immediately.

The active technical support and assistance of the Australian Institute of Health should also be sought in the establishment and of those effects.

12.1.11 National Assessment of Aboriginal Culture and Social Wellbeing

The Working Party endorses the concept of a regular national assessment of Aboriginal cultural and social well being. It was clear during the community consultations that Aboriginal regarded cultural and social well being as fundamental to the achievement of health. Communities commonly pointed to their collective and individual desire and capacity to assert their identity as indigenous people, their right to be free from racism and their dissatisfaction with "their lot" as barriers to the achievement of good health.

A biennial assessment as proposed by NAIHO, is designed to utilise a regime of subjective and qualitative indicators which cover these and other related areas of cultural and social wellbeing.

Given the nature of this proposed national assessment and the methodologies involved the Working Party believes that it is vital that community agencies be responsible for the design, organisation, collection, collation and publication of this biennial assessment and that appropriate technical expertise be drawn on to assist this assessment.

Further details of this proposal are contained in Chapter II relating to areas of Aboriginal Health requiring special research.

12.1.12 Intersectoral Collaboration

The Working Party believes that the establishment of mechanisms promoting successful intersectoral collaboration will depend largely, on the creation of the Tripartite Council and Office of Aboriginal Health as recommended in this report (Chapter 3). Given the Commonwealth budgetry cycle and the lead time necessary to appoint staff, such an agency could not be expected to be functional before the 1989/90 financial year.

Progressive attention to the key areas identified in this report should, we believe commence with those aspects mentioned in the summary above. The first annual assessment of progress towards successful intersectoral collaboration would usefully be undertaken in the 1990/91 financial year. This would allow some 18 months for the development and implementation of appropriate mechanisms, with the assessment being undertaken in the latter half of the 1990/91 financial year. Within this timeframe, recommendations to the federal Cabinet on the implementation of intersectorally responsive budgetry process can be compiled and proposed.

The investigation and establishment of such mechanisms will provide useful information on the extent to which intersectoral collaboration is presently practiced.

12.1.13 Environmental Conditions

The assessment of housing, water, sewerage and waste disposal issues within the context of this report requires the establishment of appropriate and realistic standards and design attributes which take into account cultural and other social values.

The Working Party recommends that:

- the Commonwealth Minister for Aboriginal Affairs appoint a technical/community advisory group representative of Aboriginal interests and appropriate technical expertise to provide, by October 1989 such standards. The Office of Aboriginal Health should chair this Advisory Group.

Communities must be centrally involved in the design and implementation of methodologies for this assessment.

The first assessment of environmental conditions should be undertaken in the first half of the 1990/91 financial year.

12.1.14 Health Systems Infrastructure

The most crucial element in the health infrastructure is the delivery of services component. Evaluation of each of the elements in this component depends on the establishment of appropriate and adequate standards in respect of the delivery of services. Within this context, the early implementation of formula funding for community controlled health services is fundamental. The identification of a formula will provide a basis for monitoring and evaluating available health staff resources, other process indicators, the quality of economic support and the degree of skills transfer, will assist in the development of innovative and quality assurance features within overall program and service delivery.

The development of an appropriate formula will require input from a number of quarters including, health care delivers, Aboriginal communities, health economists, government and statisticians.

The Working Party recommends that:

- a specific research project be established to undertake this task with a management committee drawn primarily from Aboriginal health services. This complex task, if commenced by April 1989 could nevertheless be completed by September 1989, thus allowing sufficient lead time for its negotiated incorporation in the 1990/91 financial year.

This indicative timetable would also allow the establishment of the Aboriginal Public Health Workers Program to be consolidated so that service provision at the community level might be readily incorporated.

Aboriginal Public Health Workers may provide the central link in this process.

The provision of Aboriginal Public Health Workers will provide the organisational and analytical skills required to complete the program.

PROVISION FOR ABORIGINAL IDENTIFICATION IN KEY HEALTH RELATED COLLECTIONS

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
Birth Notification Forms	In Place 1/89	In place 11/86	No	In place 8/85	No	No late 88	In place 2/88	In place 1/85
Death Notification Forms	In Place 1981	In place 11/88	No	In place 8/86	In place 3/86	No late 88	In place 2/88	In place 1/88
Medical Certificates of Causes of Death	No	No	No	No	In place	No	In place	No
Medical Certificates of Causes of Perinatal Death	No place	No	No	In place	In place	In place	In place	In place
Hospital Mortality	In place	In place	Partly In place 1/88	In place	In place	No	In place 1977	In place
Maternal/Perinatal Collections	In place 1981	In place	In place 11/88	In place	In place	In place	In place 1972	In place

APPENDICES

	TITLE
I	Consultation Process.
II	Other Services Provided by the Department of Community Services and Health.
III	Funding through the Department of Community Services and Health.
IV	Details of Other Programs Included in Aboriginal Health Program, Queensland.
V	Areas Identified as Needing New or Expanded Aboriginal Health Services.
VI	Current Funding Arrangements for Aboriginal Health Services.
VII	Sewerage and Water Supply Systems, Remote Aboriginal Communities - Australian Construction Services, Western Australia.
VIII	Community Infrastructure Assessment.
IX	Current Approved Department of Aboriginal Affairs Substance Abuse Policy.
X	The Aboriginal Medical Service, Redfern Youth Drug and Alcohol Program Submission, October, 1986.
XI	Amended Draft Substance Abuse Policy Paper prepared by the National Aboriginal and Islander Substance Abuse Council.
XII	Report of the National Workshop on Ethics of Research in Aboriginal Health.

APPENDIX I

THE CONSULTATION PROCESS

SCOPE OF CONSULTATION

Achievement of an effective, agreed National Aboriginal Health Strategy is largely dependent on the consultation process prior to and during the development of the Strategy. Therefore it was necessary to consult widely with the following groups:

- Aboriginal communities;
- Aboriginal health services;
- Aboriginal organisations;
- Commonwealth, State, and Local Government Departments and Statutory Authorities with responsiblity for or an interest in the provision of services which influence the health status of Aboriginal people;
- this includes intersectoral interests, e.g. environment, housing, education and training
- peak organisations representing medical, nursing and allied health professionals;
- providers of health services;
- other formal organisations with an interest in health promotion, education and care or Aboriginal health issues,
- nursing, medical and dental registration boards;
- academic institutions responsible for:
  - the educational preparation of health care professionals;
  - courses which are appropriate or desirable for Aboriginal students to undertake; and
  - research into Aboriginal health or related areas.

ABORIGINAL COMMUNITY CONSULTATIONS

The approach adopted for Aboriginal community consultations was pro-active and sought the early, active participation of Aboriginal people, not only in the development of the Strategy, but also in the identification of issues most relevant to them.

- when planning consultations the following factors were taken into account:
  - financial constraints;
  - time factors including cultural constraints such as initiation ceremonies;
  - concurrent consultations, for example Commonwealth House of Representatives Standing Committee visits to Aboriginal Communities.
- wide consultation took place amongst Aboriginal Communities, organisations, groups and individuals through Australia:
  - in most instances a small consultative group, made up of the two State representatives (the State Government representative and the Aboriginal community representative, or their nominees) together with a member of the Secretariat staff, visited selected communities for discussions and in some instances arranged for communities representatives to be brought from outlying locations to a central meeting place;
  - the findings were considered by the Working Party, and a draft report prepared to take into account the views of the Aboriginal people;
  - a meeting of community controlled Aboriginal health service representatives met to consider the final draft report prior to the presentation of a final report.

CONSULTATIONS WITH NON-ABORIGINAL AUTHORITIES AND ORGANISATIONS

Approximately 120 non-Aboriginal groups and organisations have been contacted or consulted or have provided written submissions during the course of the consultative process

Where appropriate, invitations or submissions were followed by personal visits to selected organisations to clarify submissions, or establish matters of fact.

Additionally, Working Party members have consulted personally with medical, nursing and paramedical staff of:

- community and State hospitals and nursing homes,
- community health centres,
- nursing posts,
- medical aid posts, and
- other locally based health care facilities.

These consultations were undertaken on an Australia-wide basis.

LIST OF SUBMISSIONS RECEIVED

Author	Sub. No.
Aboriginal Community Recreation and Health Services Centre of South Australia. Adelaide, S.A.	073
Aboriginal Education Council Sydney, N.S.W.	087
Aboriginal Health Organisation. Adelaide, S.A.	100
Aboriginal Medical Service, Redfern. Sydney, N.S.W.	101
Australian Association of Community Physicians Incorporated. Sydney, N.S.W.	056
Australian Association of Gerontology. Sydney, N.S.W.	034
Australian Catholic Health Care Association. Melbourne, Victoria.	044
Australian Community Health Association. Sydney, N.S.W.	058
Australian Council on the Ageing. Melbourne, Vic.	038
Australian Deafness Council : Chairman. Brisbane, Qld.	016
Australian Deafness Council : President. Sydney, N.S.W.	009
Australian Deafness Council : President. (Supplementary paper) Sydney, N.S.W.	091
Australian Diabetes Society. Melbourne, Vic.	041
Australian Institute of Health. Canberra, A.C.T.	092
Australian Kidney Foundation. Canberra, A.C.T.	025
Australian Medical Association. Canberra, A.C.T.	051

Ballarat and District Aboriginal Co-Operative Limited. Ballarat, Vic. 094
Bwgcolman Airways Aboriginal Corporation. Palm Island, Qld. 082

Central Gippsland Aboriginal Health and Housing Co-Operative Limited. Morwell, Vic. 097
Centre for Aboriginal Studies, Curtain University of Technology. Perth, W.A. 046
Centre for Clinical Epidemiology and Biostatistics, University of Newcastle. Newcastle, N.S.W. 055
Children's Services Office. Adelaide, S.A. 031
Commonwealth Office of the Aged. Sydney, N.S.W. 042
Community Services Division, A.C.T. Community and Health Service. Woden, A.C.T. 039
Consumers' Health Forum of Australia Incorporated. Canberra, A.C.T. 098
Coolum Coolum Aboriginal Co-Operative Limited. Horsham, Vic. 102
Council of Remote Area Nurses Australia. Freemantle, W.A. 050
Council of the Shire of Walgett. Walgett, N.S.W. 083

Deakin University. Geelong, Vic. 011
Department of Aboriginal Affairs. Canberra, A.C.T. 067
Department of Community Medicine, Monash University. Bentleigh, Vic. 086
Department of Community Services and Health. Canberra, A.C.T. 008
Department of Community Services and Health : Aboriginal Services Co-Ordinator. Adelaide, S.A. 027
Department of Employment, Education and Training. Melbourne, Vic. 089
Department of Health and Community Services. : Departmental Secretary. Darwin, N.T. 066
Department of Health and Community Services : Aboriginal Ear Program. Darwin, N.T. 026
Department of Health and Community Services : Drug and Alcohol Bureau. Darwin, N.T. 043
Department of Health and Community Services : Rural Services. Katherine, N.T. 035
Department of Ophthalmology, University of New South Wales. Sydney, N.S.W. 065
Department of Psychiatry, University of Queensland. Brisbane, Qld. 017
Dietitians Association of Australia. Canberra, A.C.T. 052
Division of Psychiatric Services, Queensland Department of Health. Brisbane, Qld. 099
Doctors' Reform Society of South Australia Incorporated. Adelaide, S.A. 064

Eastern Goldfields Aboriginal Corporation Resource Agency Incorporated. Kalgoorlie, W.A. 021
Elcho Island Council. Elcho Island, N.T. 019

Faculty of Medicine, University of Adelaide. (Preliminary submission) Adelaide, S.A. 022
Faculty of Medicine, University of Adelaide. (expanded submission) Adelaide, S.A. 061
Faculty of Medicine, University of Newcastle. Newcastle, N.S.W. 057
Faculty of Medicine, University of Queensland. Brisbane, Qld. 013
Family Planning Federation of Australia Incorporated. Canberra, A.C.T. 074

Gastroenterological Society of Australia. Sydney, N.S.W. 037
General and Sectoral Development, ACT Community and Health Service. Canberra, A.C.T. 063
Geriaction Incorporated. Sydney, N.S.W. 029
Goold, S.S. (Personal submission) Brisbane, Qld. 036
Gray, A. (Personal submission) Canberra, A.C.T. 063

Healthy Aboriginal Life Team. Alice Springs, N.T. 090
Hearing Aid Council of Australia. Melbourne, Vic. 010
Horne, S. T. (Personal submission) Bourke, N.S.W. 077

Jones, H. (personal submission) Galiwin'ku, N.T. 023
Jurnkurakurr Aboriginal Resource Centre. Tennant Creek, N.T. 006

Kalano Health Service. Katherine, N.T. 040
Karratha College. Karratha, W.A. 093
Kimberley Aboriginal Medical Service's Council (Aboriginal Corporation). Broome, W.A. 081
Koonibba Aboriginal Community Council. Koonibba, S.A. 028

Little, J. and Torr, S. (Personal submission) Katherine, N.T. 012

McLeod, D.W. (Personal submission) Perth, W.A. 001
Maternity Alliance. Sydney, N.S.W. 033
Medical School, University of Queensland. Brisbane, Qld. 024
Medical School, University of Queensland. (Supplementary submission) Brisbane, Qld. 068
Milikapiti Community Government Council. Melville Island, N.T. 079
Mooraridgi Community Advancement Co-Operative Society Limited. Mareeba, Qld. 076
Mount Isa City Council. Mount Isa, Qld. 088

Nalkanbuy Health Centre. Galiwinku, N.T. 069
National Venereology Council of Australia. Sydney, N.S.W. 085
Nganampa Health Council Inc. Alice Springs, N.T. 054
Norseman Police / Aboriginal and Community Liaison Committee. Norseman, W.A. 080
Northern Territory Association of Occupational Therapists Incorporated. Darwin, N.T. 062
Nurses Board of South Australia. Adelaide, S.A. 060

Pika Wiya Health Service. Port Augusta, S.A. 005
Public Health Association of Australia and New Zealand Canberra, A.C.T. 045

Queensland Nurses Union. Brisbane, Queensland. 007

Remote Area Nurses National Committee Executive. Canberrara, A.C.T. 003
R.P.S. Medicorp. Parramatta, N.S.W. 072
Royal Australian College of General Practitioners Sydney, A.C.T. 070
Royal Australian College of Obstetricians and Gynaecologists. Melbourne, Vic. 071
Royal Australian Nurses Federation. Melbourne, Vic. 030
Royal College of General Practitioners. Sydney, N.S.W. 082
Royal College of Opthamologists. Sydney, N.S.W. 015
Rumbalara Aboriginal Medical Clinic. Mooroopna, Vic. 103

Secretary for Aboriginal Affairs : New South Wales. Sydney, N.S.W. 018
School of Community Health, Curtain University of Technology. Perth, W.A. 047
School of Community Medicine, University of New South Wales. Sydney, N.S.W. 078
School of Pharmacy, Curtain University of Technology. Perth, W.A. 048
School of Sciences, Deakin University. Geelong, Vic. 053
South Australian Aboriginal Trachoma and Eye Health Programme. 050
South Australian Health Commission. Adelaide, S.A. 020
Special Client Services Branch, Department of Social Security. Canberra, AC.T. 032

Tangentyere Council. Tangentyere, N.T. 041
Tharawal Corporation. Campbelltown, N.S.W. 084

Uniting Church in Australia Frontier Services. Sydney, N.S.W. 075

Victorian Aboriginal Health Service Co-Operative Limited. Melbourne, Vic. 095

Watson, P. (Personal submission) Brisbane, Qld.	096
Western Australia Council on the Ageing Incorporated. Mt Lawley, W.A.	014
Western Australia Department of Health. Perth, W.A.	059
Worksafe Australia, National Occupational Health and Safety Commission. Sydney, N.S.W.	004
WuChopperen Medical Service Limited. Cairns, Qld.	049
Yalata Maralinga Health Service. Ceduna, S.A.	002

In addition to the preceding list of submissions, the Working Party took into account, various letters, reports, oral submissions, and research articles. Those contributing in this way included the following:

Author	Sub. No.
Australian Cancer Society Incorporated. Sydney, N.S.W.	018
Australian College of Paediatrics. Darwin, N.T.	019
Australian Institute of Criminology. Canberra, A.C.T.	032
Australian Orthopaedic Association. Sydney, N.S.W.	025
Australian Red Cross Society. Melbourne, Vic.	001
Cardiac Society of Australia and New Zealand. Sydney, N.S.W.	008
Centre for Clinical Epidemiology and Biostatistics, University of Newcastle. Newcastle, N.S.W.	011
Dental Board of Queensland. Brisbane, Qld.	021
Dental Board of the Northern Territory. Darwin, N.T.	016
Dental Board of Victoria. Melbourne, Vic.	022
Department for Community Welfare. Hobart, Tas.	004
Department of Aboriginal and Intercultural Studies, W.A. College of Advanced Education. Perth, W.A.	027
Department of Environment, Conservation and Tourism. Brisbane, Qld.	035
Department of Health and Community Services : Aboriginal Health Branch. Darwin, N.T.	006
Department of the Chief Minister. Darwin, N.T.	004
Doomadgee Incorporated. Brisbane, Qld.	031
Eaglehawk and Long Gully Community Health Centre. Bendigo, Vic.	012
Health Issues Centre. Melbourne, Vic.	002
Ikuntji Community Council Incorporated. Haasts Bluff, N.T.	034
Kombumerri Aboriginal Corporation for Culture. Runaway Bay, Qld.	007
La Trobe University. Melbourne, Vic.	011
Mawarnkarra Health Service Aboriginal Corporation. Roebourne, W.A.	036

National Aboriginal Mental Health Association. Port Adelaide, S.A. 030
National Campaign Against Drug Abuse. Canberra, A.C.T. 015
National Health and Medical Research Council. Canberra, A.C.T. 010
National Heart Foundation of Australia. Canberra, A.C.T. 013
New South Wales Nurses Registration Board. Sydney, N.S.W. 017
Nurses Board of Western Australia. Perth, W.A. 023
Nurses Registration Board of Queensland. Brisbane, Qld. 024

Office of Aboriginal Affairs. Adelaide, S.A. 003
Office of the Premier of New South Wales. Sydney, N.S.W. 026

Pharmaceutical Society of Australia. Canberra, A.C.T. 009
Public Health Association of Australia and New Zealand. Canberra, A.C.T. 007

Queensland Athletic Association Limited. Brisbane, Qld. 033

Umoona Community Council Incorporated. Coober Pedy, S.A. 029
Urapuntja Health Service Aboriginal Corporation Utopia, N.T. 014

Victorian Aboriginal Health Resources Consultative Group. Melbourne, Vic. 037
Victorian Nursing Council. Melbourne, Vic. 020

Women's Karadi Aboriginal Corporation. Glenorchy, Tas. 028

SUMMARY OF SUBMISSIONS FROM NON-ABORIGINAL ORGANISATIONS AUTHORITIES AND INDIVIDUALS (Other than Government Authorities)

GENERAL COMMENTS

Few submissions to the Working Party were disease-specific. Rather there was an emphasis on the inter relationships and interdependencies between the narrow definition of health and the broader issues of public and environmental health, socio-economic status, Aboriginal culture and traditions and other associated factors which have an impact on health.

Many respondents chose not to make submissions but indicated their wish to await the publication of the final report. The recommendations would then be taken into account in policy planning and program direction.

Further:

"It is obviously crazy to expect the health of a community to be able to be sustained if basic food, fresh, clean water and clean air, space and protection from the extremes of climate, are not provided or able to be obtained. Shelter from the weather, as well as protection from danger, is also necessary. Within the family and tribal group a role must be established by each member of the group and a status within the group defined, protected and accepted by the group as well as by those outside of the group. In addition to all of these requirements (many of which have not been met in any way by our present Australian society so far as the Aboriginal population is concerned), there are the specifically human needs for realisation of such value constructs as a need for Justice, Order, Truth, Beauty in the surroundings, personal achievement and establishment of a sense of identity.

The Family Planning Federation of Australia Inc. stated:

"That Aboriginal health problems are inextricably linked to social and economic status and that long-term and short-term strategies for improving Aboriginal health status need to be based on recognition of this."

"Also the essential 'infrastructure' for Aboriginal health must include among other things, community self-determination, adequate housing, adequate clean water supplies, education and the means of economic independence."

The Public Health Association of Australia and New Zealand also supported a wider concept of health.

"Aboriginal ill-health stems in a large part from their position as subordinate members of Australian society. Manifestations of this position include a lack of power in society and poverty. The burdens of infection and of lifestyle diseases both fall heaviest on the poorer members of society. Low incomes, poor housing, unemployment and poor educational achievement levels are all associated with increased rates of both infections and other third world diseases as well as of lifestyle diseases like obesity, hypertension, ischaemic heart disease and alcohol, smoking and other drug use.

All agencies whose aim is to assist in Aboriginal advancement, should examine their activities for their effects on health. For government and government sponsored organisations this should be an explicit requirement".

Low life expectancy

Low self esteem and self image

Mental health problems

Poor communications e.g. as telephone and postal service

Poor nutrition

Poor public health

Respiratory disorders

Skin infestation and infections

Problems living in an urban environment, including lack of home making and budgeting skills

Trachoma

Unemployment

Violence

Womens' Health

EXTRACTS FROM SUBMISSIONS

Health" in its Broadest Sense

A narrow definition of health was challenged by many.

The Royal Australian College of General Practitioners was of the opinion that:

> "The narrowly 'medical' actions of the community are wasted if the social, cultural, and spiritual aspects of the relationships between the various ethnic groups living in Australia are not examined and improvements implemented. Thus, it has now been demonstrated in several studies that improvement in housing alone, even with the provision of adequate fresh water, does not automatically lead to 'good health'. They are but one of the many interweaving and inter-dependent factors in the maintenance of this state of well being."

Specific problems which were consistently mentioned or identified in formal submissions.

Absenteeism from school amongst school age children

Cardio-vascular diseases

Child and maternal health

Communicable diseases including sexually transmitted diseases

Diabetes

Gynaecological and reproductive disorders

Hypertension,

Inadequate health promotion and education programs

Inadequate infrastructure and services, e.g. garbage collection, roads, services, water, electricity sewerage (on night soil disposal)

Gambling

Gastroenteritis, parasitic infestations and other gastro intestinal disorders

Hearing problems, otitis media

High infant mortality rate

Immunisation

Inadequate or non-existant culturally appropriate resource material to be used in Aboriginal education

Inadequate or inappropriate housing, homelessness

Inadequate preparation for health care professionals prior to working with Aboriginal people

Inadequate inservice education for staff

"Lifestyle" illnesses eg diabetes, hypertension, substance abuse, obesity, heart disease

Limited, inadequate, or inappropriate medical services.

Limited training and educational opportunities for Aboriginal people at alllevels

Land Rights

The Royal Australian Nursing Federation saw the importance of Land Rights to health in its broadest sense.

> "An increasing number of Registered nurses with experience working in Remote areas, in Aboriginal communities are politically aware and support Land Rights. They are integrating their personal awareness of social structures which create inequities into their practice".

Funding

Secure levels of funding, not annual grants, was seen by many as essential for improved health. Direct funding to Aboriginal controlled health services where appropriate was recommended in several submissions. The Doctors Reform Society of South Australia Inc referred to the funding for Aboriginal health services and programs, stating that

> "Even though Aboriginal people are widely acknowledged to be a very high risk group, poorly reached by mainstream health facilities, per capita expenditure on primary health care services is almost exactly the same as the national average".

Further in 1986, because less than half of this expenditure found its way to Aboriginal community controlled health services,

> "Community controlled services limp along, poorly administered, with high staff turnovers, not able to have the necessary impact on Aboriginal health problems. They are, to use a cliche, programmed to fail".

The Society saw priorities to be addressed immediately as:

- year-by-year funding at levels insufficient for development of programs with significant impact;
- bad management practices caused by insufficient funding;
- lack of structure and overall standards for health services;
- the problem of State government controlled health programmes being supported at the expense of community controlled primary care services; and
- the continued introduction of single purpose programs rather than an integrated approach.

Organisation and Administration of Health Services

A recurring theme in submissions criticised the duplication and overlap of services, and a lack of co-ordination leading to inefficiencies, gaps in some services and an avoidance of responsibility based on bureaucratic boundaries and responsibilities.

Targets and Performance Indicators

The Australian Association of Community Physicians Inc. point to the need to take both process and outcome into account in the development of targets and performance indicators.

Geriaction urges that:

> "the measurement of 'progress' is undertaken by both qualitative and quantitive analysis. We would wish that 'progress' be measured by an ideology developed by the Aboriginal population."

Primary Health Care

Primary health care was seen as vital if there are to be improvements in Aboriginal health. The Doctors Reform Society of South Australia Inc. identified the many cultural, geographic, academic, professional, bureaucratic, and other obstacles and dangers associated with provision of grassroots health care and cautioned against the assumption that Aboriginal primary health care is simply general practice slightly modified.

The Royal Australian Nursing Federation urged that primary health can be made accessible to all, rather than a medical/illness/curative focus and recognised that:

> "many nurses trained for registration or enrolment in Australia have been trained in the medical model and have difficulty integrating Primary Health Care into their practice, in whichever setting that may be".

National Data Base and Research Activities

The lack of a national data base upon which policy and program planning can be based and by which outcomes can be measured was of great concern. One example highlighted by the Australian Medical Association (AMA) is the fragmented and inconsistent data collection whereby hospital discharge abstracts are inadequate and inappropriate for data collection. The AMA points out the need to link the collection and analysis of data related to the current allocation of human and financial resources for Aboriginal health care to the outcome of services provided.

The Public Health Association of Australia and New Zealand sees the need for two types of information, firstly the routine collection of data on the health of Aborigines and secondly action orientated research into Aboriginal health. The need for feedback to Aboriginal people is also emphasised.

Other submissions encourage research and data collection conjointly with Aboriginal researchers and through Aboriginal medical services.

Health Service Provision

The problem of culturally or geographically inappropriate health services was raised frequently.

The Public Health Association of Australia and New Zealand considers that:

> "Aborigines require access to adequate, effective, appropriate and accessible health care services because there are special cultural needs among the Aboriginal communities and because Aboriginal health continues to be worse than the health of non-Aborigines. This may require separate Aboriginal Health Services, but where these are not provided (especially in a hospital care context), existing health care services must take action to make the care they offer appropriate to the needs of Aborigines. In places where institutions such as hospitals have large numbers of Aboriginal patients, Aboriginal health workers should be employed to act as 'cultural brokers' for both Aboriginal people and for the hospitals. Public institutions like hospitals should be required to make positive steps to make their services appropriate and acceptable to Aborigines, and should be formally required to institute appropriate mechanisms for consultation with Aboriginal consumers of the services and to advise on culturally appropriate policies and practices. In the case of hospitals, this should include Aboriginal representation on their governing boards where Aborigines make up a sizeable proportion of patients admitted."

Attracting, Recruiting and Retaining Health Care Workers in Remote Areas

Many submissions discussed the problems of both permanent and relief staffing in remote communities.

In many instances this was seen to stem from inadequate professional, social, and psychological preparation for, and orientation to, their roles. The safety of staff, particularly nurses working in remote areas, was an issue of considerable concern.

The Royal Australian Nursing Federation, in discussing the overall health problems stated:

> "The rapid turnover of nurses working in Aboriginal communities compounds the ineffectiveness of programmes. Lack of continuity in focus for community health programmes which have long term goals and intangible unquantifiable results often forces the nurses who are left to resort to crisis intervention illness treatment."
>
> "Strategies must be devised to facilitate retention of highly skilled nurses."

The Council of Remote Area Nurses, Australia expressed particular concern at:

> "the unsafe and inappropriate practice that results from inadequately prepared people working in remote area health services and associated government agencies.
>
> the lack of expert evaluation and progress monitoring of remote area health services.
>
> the lack of meaningful consultation and participation with Aboriginal people in health service planning, provision and evaluation.
>
> that nurses are the main providers of essential health services in remote Aboriginal communities yet there has been no funding for specific training in remote area nursing."

Recommendations from the Council were far reaching, encompassing service provision, intersectoral co-ordination, Aboriginal participation, monitoring progress and funding.

The Uniting Church in Australia Frontier Services described its long involvement in service to remote communities and stressed the following points:

"that although current nursing courses prepare people with these general skills Aboriginal Health programmes would derive much more benefit from staff with specific training for their role."

"At present, nurses take their general skills to their positions and learn the specific ones on the job, often by trial and error. This is not only a slow process, but it can also be very hit and miss. It can result in an imbalance of approach, a lack of continuity and cohesion in health care and the risk of unnecessary misunderstanding and trauma for carer and client alike."

"The lack of preparedness and culture shock is without doubt one of the main causes of attrition among bush nurses."

The Australian Association of Community Physicians Inc. advocate appropriate training for doctors working in Aboriginal health and see:

"One of the significant short term strategies to improve Aboriginal Health will be to provide Community Medicine training for doctors working in Aboriginal Health, to provide positions for Community Physicians in Aboriginal Health, and to attract appropriately qualified (medically and culturally) Physicians in enough numbers to be able to have an impact."

The Association also considers that:

"In the longer term a body of well trained specialists in Aboriginal Health, including Community Physicians, Researchers, medical practitioners, nurses etc. should be developed and continuing emphasis should be placed on Aboriginal people forming a major part of this body.

The Royal Australian College of General Practitioners and the Family Medicine Program suggested that locum relief could be provided for country GP's with significant numbers of Aboriginal patients and that more doctors be employed in Aboriginal medical services. This would be undertaken through the Rural Education Service.

Community Controlled Aboriginal Medical Services

Many submissions urged that community controlled Aboriginal medical services should be funded. The Royal Australian College of General Practitioners indicated their support for this concept of community controlled Aboriginal medical services, stating that Aboriginal people should be closely involved in, and have control over, health services.

The Public Health Association of Australia and New Zealand re-emphasised this.

> "A major determinant of acceptability of Aboriginal health care services is the degree of control which Aboriginal communities exert over the services."

The Royal Australian College of Opthalmologists also gives support for the establishment of community based Aboriginal medical services where Aborigines can direct and perform health activities and administer health organisations.

Training and Education

The need for support programs to enable Aboriginal people to receive training and education to become health care workers at all levels received attention in several submissions. This included the support for tertiary courses such as medicine and nursing in addition to formal training and accredited courses for health workers.

The Faculty of Medicine, University of Queensland outlined its policy and procedures which enable Aboriginal and Islander students to be admitted to the medical course.

The Faculty of Medicine makes three places available each year to applicants of Aboriginal and Islander descent. These places are outside the normal quota for the Faculty. All Aboriginal and Islander Students in year 12, and their guidance officers, are informed of the program. Ongoing support, advice and liaison is provided to Aboriginal students throughout their course.

Four students have entered the course under the special quota since 1985 (and at least one other student entered the course within the normal quota) and all are still studying.

The following points are made:

> "The small number of applicants is probably due to the small number of year 12 Aboriginal high school students adequately completing pre-requisite subjects. At present any relaxation of these criteria would make it very hard for students to be successful."

> "The success of the students following selection is attributed to the careful selection procedure, particularly the assessment of potential and the interview by a Faculty member."

4he Faculty of Medicine, University of Newcastle, submits that:

> "It is essential that Aboriginal students undertake the study of medicine and that all graduates whether Aboriginal or non-Aboriginal should have competence and skill in treating Aboriginal patients."
>
> "If Australian medical schools are to ensure a high retention rate among Aboriginal medical students then it is not enough just to provide special entrance for Aboriginal students."
>
> "Selection on the grounds of matriculation or tertiary results alone ignores the personal attitudes which are very important in determining not only success within the course but also the individual's practice of medicine."
>
> "Just as important as these internal factors are the external factors which determine success. These include the medical school, its philosophy of teaching, staff attitudes, non-Aboriginal student attitudes and the isolation of the student from family and community."

Aboriginal Health Workers

The need for an expanded role for health workers, in conjunction with culturally and professionally appropriate education and training was seen as a priority. The need for recognition of this increased preparation and responsibility in the form of registration or accreditation was also given prominence, as was the need for a career structure, continuing education and staff development.

Preparation for Work Amongst Aboriginal People

Many submissions pressed for the inclusion of Aboriginal culture and traditions in the content of professional courses, arguing the benefits which would flow from this include greater understanding of the health issues, attitudinal change, and staff retention.

Some tertiary institutions outlined their proposed curriculae describing the innovative nature and anticipated benefits.

Dr John Stuart, Senior Lecturer in Community Medicine and Paediatrics at the University of Newcastle stated:

"At present in the Medical School of the University of Newcastle, in which I am involved, a conscious effort is being made to introduce medical students to Aboriginal health problems. The University of Newcastle Medical School has four places each year specially for Aboriginal medical students and does make a special effort to expose students to Aboriginal health issues and teach about their special problems."

He continued

"I am also interested in Post-graduate Education of Doctors in the area of Aboriginal health. It saddens me to see that specialist positions in remote areas (e.g. Alice Springs) are often taken by overseas graduates, because no satisfactory Australian-trained doctor can be found. I feel that the reasons for this are partly related to post-graduate training programs in Australia which require doctors to follow fairly rigid patterns of training. There is often very little opportunity for doctors in training programs to spend time in remote areas and there is certainly no emphasis placed on Aboriginal health in the post-graduate diploma examinations. I feel that if the situation could be changed by putting greater emphasis on Aboriginal health issues in these examinations and allowing advanced trainees to spend time in hospitals in more remote areas such as Alice Springs and Darwin, it would encourage greater interest in Aboriginal health issues and hopefully produce a flow-on effect of more specialists being interested in working in these areas."

Curtin University of Technology submitted that:

"Transculturally, the teaching of Aboriginal Studies in schools/colleges and Universities will assist in a greater understanding of cross cultural philosophies and norms. The learning of such material is extremely important and should be seen as a positive injection into the minds of all that live in this country."

Professional Registration Boards

Medical, nursing and dental registration boards in each State and Territory were approached to make submissions. Whilst most did not see a direct role for them in the development of the strategy, the Dental Board of the Northern Territory stated that:

"The Dental Board of the Northern Territory has already considered the role of Aboriginal communities... and at the last review of the Dental Act of the Northern Territory, included provisions for Aboriginal health workers to provide specified dental services."

The Nurses Board of South Australia included the following comments in its submission:

> "The Board strongly supports the education of Aboriginal nurses within the existing nurse education system. Not only will an increased number of qualified Aboriginal nurses contribute to Aboriginal health, but it will bring knowledge of Aboriginal culture and health matters into the broader nursing community...
>
> Underdale College of Advanced Education in South Australia is committed to allocating approximately ten (10) places for Aboriginal nursing students within the nursing student enrolment numbers for 1989...
>
> The Queen Elizabeth Hospital, Woodville, South Australia, is also conducting an enrolled nurse program for Aboriginal nurses. This program is a one-off program for ten (10) Aboriginal nurses, and will be completed in October, 1988. It has been funded by the Commonwealth Government. Eight students are left in the program, however, it is indicated that most of these students wish to work in Adelaide."

Job Opportunities at a Senior Level

Many submissions recommended that Aboriginal people be given the opportunity to undertake the training or gain the educational qualifications and experience necessary to attain positions of seniority and responsibility in professional and administrative positions.

Dissemination of Information

The lack of information and articles about Aboriginal health issues in journals and other publications was highlighted. This included material of a clinical nature in addition to more general information.

Renal Disease

The Australian Kidney Foundation provided information on surveys conducted amongst Australian Aborigines. Dr D J Pugsley quoted a survey amongst 3,000 Aborigines carried out across South Australia between 1983 and 1986 which suggested that:

> "By a simple, and admittedly somewhat crude calculation, it can be estimated tht the presence of serious renal disease in the Aboriginal population, at least in South Australia, is around 10 times that found in other Australians".

Further:

> "Recent experience in the Renal Unit of the Queen Elizabeth Hospital South Australia has been that around 12-14 Aboriginal patients with kidney disease have started dialysis in each year. This Unit draws its patients from South Australia and the Northern Territory which have an estimated total Aboriginal population of 40-50000."

From his calculations, Dr Pugsley estimates

> "that around 7-8 times as many Aborigines as other Australians are requiring this sophisticated and expensive treatment."
>
> "The transfer of these patients living in remote areas to major metropolitan centres such as Adelaide, has created formidable social and financial problems."

Similar survey results in Queensland also point to an increase in renal disease and to a link with diabetes. Dr Peter de Jersey, Renal Unit, Townsville General Hospital states:

> "There has been an increase in recent years in the number of cases of kidney (renal) failure found in North Queensland. At 30 April 1988 there were 63 patients requiring dialysis (artificial kidney) treatment in North Queensland and 51 patients who had had a kidney transplant. Kidney transplants are not as easy to arrange for the Aboriginal population as for others because of the difficulty of tissue-type-matching and the need to use living donors rather than a cadaver donor kidneys because of these matching problems."
>
> "Figures in regard to diabetes which can frequently lead to kidney failure indicate that a higher percentage of aboriginals being treated for kidney failure in North Queensland have diabetes than is the case in other groups. For example, of 89 Caucasian patients with kidney failure requiring dialysis or who have had a transplanted kidney only 7 were diabetics, whereas out of 14 similar Aboriginal patients 5 were diabetics. There is probably no difference in the diagnostic categories of kidney disease in North Queensland, except for the preponderance of type 2 (Maturity Onset) diabetes in aboriginals and islanders".

Gastrointestinal Disease

The Gastrointestinal Society of Australia made the observation that:

> "The main gastrointestinal diseases which Aborigines experience are:
>
> . gastroenteritis, particularly in infants and children
>
> . chronic diarrhoea/malabsorption/malnutrition in older children and adults
>
> . parasitic infestations, mostly in children, including giardia and hookworm infections which cause anaemia and chronic ill-health
>
> . hepatitis.
>
> These diseases are more frequent and more serious in Aborigines than in other sections of the Australian community.
>
> The overwhelming reason for the seriousness of these gastrointestinal diseases in Aborigines is the inferior standards of housing, hygiene and nutrition which they experience since most of these diseases are infections which are spread in overcrowded unhygienic and contaminated conditions.
>
> There are other gastrointestinal conditions, such as lactose intolerance, which are much more prevalent in Aborigines than in whites and which probably have a genetic basis. This particular example has important nutritional and health implications, particularly for Aboriginal babies and young children".

It was indicated that means of overcoming the underlying public health causes of gastrointestinal diseases should be included in the aims of the strategy.

Ear Health Problems Including Hearing Loss

The alarming incidence of hearing loss and ear disorders amongst Aborigines was an issue of considerable concern. Submissions pointed to the connection between hearing loss and poor educational performance and achievement, and a case was made for urgent action.

The Australian Deafness Council sees:

> "Ear health issues as some of the most significant of the general health issues, particularly when the implications for pre school and school aged Aboriginal children with educationally significant hearing impairment are considered. In all states of Australia, but particularly in the Northern Territory, Western Australia, and Queensland, the problems continue to frustrate educationists, medical practitioners, health and community workers alike."

In his submission Dr Terry Nienhuys points out that:

> "Many Aboriginal people suffer mild-to-severe hearing loss due to recurrent otitis media (middle ear infections). The hearing-impairment is a serious obstacle to the development and school success of many Aboriginal school children. In the Northern Territory alone, current figures suggest that up to half of all Aboriginal children suffer an educationally-significant hearing loss. Of the 3,000-5,000 children who may be affected in the NT, fewer than 50 are currently receiving consistent audiologic and specialist educational support."

Sexually Transmitted Diseases

The National Venereology Council of Australia points out that:

> "High rates of gonorrhoea and genital chlamydia are generally recorded among Aboriginal people. High rates of morbidity from pelvic inflammatory disease (PID) and resultant pelvic pain, infertility and ectopic pregnancy could be expected from this. Chlamydia is also of concern due to its possible implication in the aetiology of chest and ear disease. These conditions cause significant morbidity among Aboriginal neonates and young children, while hearing loss compromises learning potential.
>
> Donovanosis is almost exclusively found among Aboriginal people of the Central Desert and Goldfields with extension into Northern West Australia and the Northern Territory, and among Aboriginal and Islander people of far North Queensland.
>
> Data on the prevalence of genital human papilloma virus in Aborigines are urgently required in view of the association with genital maligancy and its recent global increase. Anecdotal evidence indicates a corresponding increase among Aboriginal people in some areas.

> Genital ulceration due to syphillis is considerably higher than the non-Aboriginal population, though genital herpes is seldom seen. Human immunodeficiency virus (HIV) infection is less prevalent at present, but studies showing a possible increased risk of acquisition of HIV infection in the presence of genital ulcer disease indicate a serious potential for spread among Aboriginal people".

Culturally appropriate, participative education programs backed by adequate and appropriate diagnostic and theraputic facilities and properly trained health care professionals are suggested as ways to assist in overcoming the problems.

Diabetes

In a submission prepared by Dr James Bert in collaboration with Dr Kerin O'Dea and Joan Vickery for The Australian Diabetes Society the point is made that:

> "Non-insulin dependent diabetes is highly prevalent in Australian Aborigines when they make the transition to a Western lifestyle. The prevalence of diabetes among Australians of European descent is 3.4% while among Aborigines it ranges from 5 to 20%. Diabetes prevalence in Aborigines has been shown to be strongly influenced by both lifestyle and inherited factors, being lower in less Westernised groups. Thus, although Aborigines appear to be highly susceptible to non-insulin dependent diabetes the presence of lifestyle trigger factors (related to diet and level of physical activity) is necessary before this inherited susceptibility is expressed. This provides strong rationale for intervention strategies aimed at lifestyle change as the logical approach to what is unquestionably a serious and increasing public health problem. Such strategies are currently lacking".

Trachoma and Eye Care

The Royal Australian College of Opthalmologists pointed to the prevalence rates and severity of certain ocular and other eye conditions which prevail in Australia, and the linkages to adequate and appropriate health ammenities and facilities. The recommendations of the National Trachoma and Eye Health Program with regard to health amenities and service facilities which are seen as relevant to the strategy are:

"For all persons in rural Australia:

1. Housing sufficient to provide sufficient bed space, breathing space, cleanable surfaces and domiciliary shelter from sunlight for all persons living in the dwelling and to be appropriately screened to exclude those insects capable of transmitting disease.

2. Water within houses for the full range of its uses as a health amenity for drinking, cooking, bathing and showering, and for washing clothes and bedding.

3. A full range of food including fresh fruit and vegetables.

4. Facilities for appropriate storage of food - refrigeration and cupboard space.

5. Efficient water-based sewerage systems for garbage disposal for dwellings.

6. Continuation of the National Trachoma and Eye Health Program appropriately as its aims are achieved or being achieved to enable regular scheduled visits of skilled opthalmologists (or other adequately trained personnel) to monitor the prevalence and severity of trachoma and reinstitute treatment where necessary and to provide other diagnostic services for eye conditions, including surgery and the provision of suitable sunglasses for those industrially at risk from sunlight-induced ocular disorders in areas with more than 8 hours of bright sunshine per day...

7. Regular scheduled visits of suitable medical (or paramedical) persons to monitor, treat, direct and advise on the prevention of skin disease, nasal discharge, otitis media and respiratory disease."

Nutrition

In the submission from the Dietitians Association of Australia the impact of poor nutrition on the overall health status of Aborigines is emphasised. Recommendations address the need to fund nutritional programs, and to train and employ dietitians or nutritionists; for co-ordination of programs; for strategies to achieve long and short term improvement (including nutrition orientated data bases); for strategies to involve Aboriginal people; and for intersectoral co-ordination and mechanisms to monitor progress.

Alcohol Consumption

Excessive alcohol consumption and the resultant effects on health, family, and socio-economic status were brought out as a major contributor to Aboriginal health problems. Various programs and strategies were recommended. However, the major common thrusts were the requirements that the problem be recognised by the individuals themselves, their families and communities as a whole, appropriate support systems for the control of the sale of alcohol and for proper rehabilitation programs. Alcohol was seen as a symptom of more deep-seated problems, including unemployment and poor self esteem.

Women's Health

The Royal Australian College of Obstetritians and Gyneacologists re-iterated a long-standing interest in and a concern for the plight of Aboriginal and Islander women, particularly in rural and remote areas where relative isolation compounds existing health problems. Culturally appropriate services and facilities, properly trained Aboriginal female medical personnel (and including, possibly, the "nurse practitioner"), better antenatal care and education, reduction in specific diseases, including lifestyle diseases and illnesses, and improved socio-economic conditions are considered by College members to be significant means to achieve health improvements for women and infants.

Further the College considers that:

> "The early detection and prevention of cancer among Aboriginal and Islander women is of concern to the College and the role of appropriately trained Aboriginal nurse practitioners is seen as a positive step in developing screening programmes. The treatment of Aboriginal cancer patients, including the provision of support during hospitalisation, family support and the follow-up and referral of patients to local doctors needs to be properly managed and developed."

The Family Planning Federation of Australia Inc. (FPF) identified the following areas of concern - contraception, including support for the individual's right to choose the number and spacing of children; the need for Aboriginal women and men to receive information and education about reproduction and contraception; culturally appropriate clinical services; and information about injectable contraception, infertility, and sexually transmitted diseases.

Birthing is viewed by the Federation as a major life event in its widest sense. The submission highlighted a major difficulty

> "In the remoter areas of Australia there is a practice of sending women into town possibly weeks before the birth of their child. This practice is apparently necessary due to the inability to assess accurately the expected time of birth whilst still in the communities. As a consequence, considerable stress in terms of accommodation, care of their children, cost, isolation, etc. is felt by the women. Many health care givers feel that the appropriate technology in the actual communities could help make more accurate judgements possible".

The need for prevention and culturally acceptable and appropriate breast and cervical cancer screening programs, as expressed by the FPF, was raised in several other submissions. Various submissions pointed to the impact of, for example, poverty, violence, poor nutrition and obesity on the overall health status of women.

Both the FPF and Maternity Alliance, a consumers' co-operative, support the Congress Alukra as a means of promoting traditional health practices.

Older Aboriginal People

The Australian Council on the Ageing points out the lack of attention to the needs of older Aboriginal people and the limited knowledge of their needs and circumstances.

> "Indeed, though it may be a facile suggestion, it is probable that the host community would wonder how their needs might be different from the majority.
>
> Such a view represents one of the many paradoxes that bedevil attempts to redress the neglect and injustice experienced by the Aboriginal people".

Several papers which were submitted in place of or to support submissions, emphasised the sad fact that the common definition of old age in non-Aboriginal society does not apply to Aborigines whose life expectancy is considerably less.

Geriaction expressed the following view:

> "We would ask that 'old age' is not fixed in the committees' mind at 60 or 65, and that many 'younger' people in the Aboriginal community may need services which would parallel those of aged services in non-Aboriginal communities. As far as we know there is no research into the specific ageing pattern of the Aboriginal people, and therefore their changing clinical pattern is measured by research inappropriately undertaken by totally different cultural groups".

The paucity of accessible, culturally appropriate, acceptable aged care facilities, services, and places of accommodation was brought to the attention of Working Party members. This includes education programs for staff on Aboriginal culture and issues where care is provided presumably by non-Aboriginal staff.

Health Education & Promotion Programs

Many submissions noted the paucity of culturally appropriate and acceptable health education and promotion programs. Rarely do health advancement and preventative programs take priority over curative services and facilities.

SUBMISSIONS RECEIVED FROM ABORIGINAL ORGANISATIONS

General Comments

Although submissions were invited from Aboriginal groups and organisations throughout Australia, very few formal submissions were received. This was possibly due to the fact that many organisations see submissions as the means for seeking funding rather than a vehicle for expressing concern or need. Additionally Aboriginal people expressed their preference to talk to Working Party members directly rather than preparing written submissions. Letters, position papers and other documents which were forwarded to the Working Party were subsequently considered by Working Party members in the preparation of the report.

Generally philosophical, political and public health issues were raised rather than specific disease problems although details of various programs which were considered to be effective and culturally appropriate in combatting community concerns were described.

Relevant excerpts from some submissions follow:

Kalano Health Service, Northern Territory, discussed the health problems of Aborigines in the Katherine region of the Northern Territory in considerable detail, taking a problem-solving approach to each issue. Similarly Tharawal Corporation, NSW, provided extensive reports, including relevant findings.

Redfern Medical Service, New South Wales, offered wide-ranging recommendations aimed at improving Aboriginal health and wellbeing.

Tangentyere Council, Northern Territory supported a long-term and multi-faceted approach to public health which include:

> "increasing control over our own lives
>
> retaining cultural integrity

regaining collective self-esteem

providing facilities for water supply, waste removal, housing, water heating, electricity, dog control and land management

providing employment and training in socially useful work."

Land management strategies are also seen to have a positive impact on Aboriginal Health.

> "The primary way in which illiterate and unskilled people can have a positive impact on their health is through their own involvement in the creation and maintenance of their environment as a healthy environment."
>
> "It is vastly underestimated the impact land management programs have in negating the alienation people have with their environment and in providing an avenue for socially useful work on a mass scale."

Bugcolman Airways Aboriginal Corporation, Palm Island, Queensland stated:

> "We feel that because we live on a community, we are, more often than not, forgotten when it comes down to benefitting from any health service. We are not saying this lightly, because we have real and chronic health problems here on Palm Island."

Eastern Goldfields Aboriginal Corporation Resource Agency Inc., Western Australia, pointed out that, as a resource agency covering the majority of the Eastern Goldfields communities with the benefit of hands on experience, what the agency had to say was important and may add information from a wider point of view.

Health was seen in its broadest sense, dependent on good public health, sound infrastrcutre, and housing.

Ongoing problems were listed as:

- housing;
- services to houses;
- gas heating and cooking;
- sewage and effluent disposal; and
- heating of water and houses during winter.

Recommendations for improvements included:

- good basic houses;
- sewage and effluent, and rubbish disposal system;
- services such as water and gas; and
- instruction in house maintainance and hygiene.

Koonibba Aboriginal Community Council Inc. at Koonibba, via Ceduna noted that the community now had a much needed, well staffed and facilitated clinic.

One area of need which was identified was the requirement for education programs to assist in the Mothers and Babies area:

> "Generally the Council felt that the immediate health needs were being covered, although concerns were raised that the West Coast region does not have Drug and Alcohol Rehabilitation facilities."

Milingimbi, Northern Territory, health problems were listed as:

- kava
- malnutrition
- STD's
- chest infection
- tropical ear infection
- diabetes
- hygiene
- housing
- dogs and pigs
- drug intake

Milikapiti Community Government Council, Melville Island, via Darwin, stated that the community was generally able to cope with health problems.

> "As we have very capable health workers ...
>
> we think that it needs to be highlighted that health workers in isolated communities, such as ours, need to have access to information and assistance that would be readily available in larger non-isolated centres."

Mooraridqi Community Advancement Co-operative Society Ltd., Mareeba, pointed to the problem of extreme overcrowding and its relationship to alcohol consumption and gambling.

> "...alcoholism is something that we deal with every day. Many of the homes in Mareeba are extremely overcrowded. Mostly this is because there are just not enough houses in Mareeba, but frequently it is because there is insufficient money left over after drinking and gambling to pay for rent. Therefore, these people board with relatives or friends. We have had as many as 18 adults living in a 2 bedroom house. The children in these homes suffer the most. e.g. Insufficient money for food. Insufficient amentities. No place to do homework. Unable to sleep because of noise.
>
> On several occassions, I have talked with people who would like to stop drinking, but while there are others in the house drinking day and night, it is just about impossible, as access to alcohol is too easy. This is also true of the teenagers. Where many underage children would not be able to purchase alcohol, there is a plentiful supply in their own homes.
>
> More housing is needed for families.
>
> The single men and women boarding with these families does not help this situation. Many of the single people collapse because they have been drinking for several days and have neglected to eat. A hostel for the single people, providing cheap accommodation and meals would help overcome these problems."

The submission goes on to discuss the problems of women and children in the homes of alcoholics.

> "Women and children living with an alcoholic are often subjected to severe beatings and verbal abuse. Having nowhere else to go, they stay home and take this abuse night after night."

If a women's shelter (perhaps attached to the hostel) the women could leave their homes at times when the abuse was particularly bad.

There was also concern at the effect of imprisonment:

> "Many men from Mareeba are sent to Townsville for minor offences e.g. failing to pay fines. This can have a devastating affect on their self esteem. They come home angry and unwilling to look for work. Prisoners doing community work seem to have more self confidence in looking for work. In some cases the work they have done while on community work has gained them enough work experience to help them find employment."

Nalkanbuy Health Centre, Elcho Island, Northern Territory forwarded the concerns expressed by a number of Galiwinku women.

They felt that the standard of housing contributes to ill health due to overcrowding, poor plumbing, especially leaking pipes and sewerage, and expressed a desire for more housing and better maintenance.

The lack of employment and the subsequent effects also caused concern, particularly as they considered that there were jobs around the community which needed to be done.

The women considered that people were not eating the right food.

> "They expressed concern that people were not eating the right food. They said they would like more fresh food that could be supplied by a community garden. They felt people relied too heavily on store food. They felt there was a need for more education round the community about nutrition, especially infant and children nutrition - what foods to introduce when etc."
>
> "They also expressed a desire for education in lifestyle, i.e. how to look after their houses properly."

Additional concerns focussed on youth, the problems of early pregnancy and a lack of things to do. Increased sport and recreation programs were seen as one answer:

> "They said that often it was the older women who looked after the children belonging to young mothers. One lady suggested that the older women get together and spend time teaching the younger ones about parentcraft."

Overall there was some dissatisfaction expressed with existing health services and the treatment that Aboriginal people receive.

"This is due to a number of factors:

a) sometimes people are too shy or scared to tell the health centre staff what is really wrong with them.

b) sometimes the health centre staff do not correctly diagnose what is wrong with them.

c) it is sometimes a lifestyle problem which is causing the illness and health centre staff can only treat symptoms and not get to the real cause of the problem. An example of this is when health centre staff treat a child for diarrhoea and dehydration but not fix the leaking pipe or sewerage or overcrowding that is causing the child to develop diarrhoea in the first place."

Pika Wiya Health Service, Port Augusta, South Australia mentioned specific health problems, i.e., malnutrition, ear, chest and skin infections, lifestyles - and diseases such as obesity, hypertension and diabetes which reflect a change in lifestyle - trachoma, sexually transmitted diseases, women's diseases, trauma, and family illnesses.

In offering strategies such as involvement of Aboriginal people in all stages of care, wide education, cultural advancement, community decision making, and health education, the submission states:

"The poor status of health on Aboriginal people is well documented. However, the way to overcome the problem is not so easy. Any plan to overcome the poor state of health must reverse so much of what has happened over the last years including poverty, the hopelessness and the depression. In general the health problems are related to the style of living, whether in towns or bush from poor quality food, too many people in the dwelling no water, etc. Most of the problems are infective with an unknown effect or poor immunity, which may or may not be related to the poor nutrition. These diseases affect the respiratory system, the skin, eyes, bowels, ears, and growth of all types of people...

Basically better health for Aboriginal people will only be obtained when Aboriginal cultures are recognised e.g. with Land Rights etc., Aboriginal people are given hope for the future and poverty and depression are corrected. Health service delivery must be planned and implemented by Aboriginal people, with advice from other people sought when needed."

APPENDIX II

OTHER SERVICES PROVIDED BY THE DEPARTMENT OF COMMUNITY SERVICES AND HEALTH

Home and Community Care

The Home and Community Care program includes such services as home help, home maintenance, respite care, special transport, community nursing, and community day care services such as delivered meals. The aim is to maintain independent living and defer institutionalisation.

Aboriginals are a group targeted for special assistance. However, the current guidelines allow for special programs only if existing services cannot be modified to meet Aboriginal needs.

Disability Programs

The DC&S states that Aboriginals under-utilise disability services funded by the Disability Programs Division, given the high prevalence of disability in the Aboriginal population.

Hearing Services and the National Acoustics Laboratory

The NAL screens Aboriginal children in several parts of the country and assists in the development of technology for hearing loss.

For example, FM radio hearing aid units are being tested to assist in schools.

Emergency Relief

This program provides emergency cash relief payments and the issuing of food vouchers in temporary financial crisis in 1987/88. There was a specific Aboriginal and Torres Strait Island component totalling $0.5million in 1987/88.

APPENDIX III

FUNDING THROUGH THE COMMONWEALTH DEPARTMENT OF COMMUNITY SERVICES AND HEALTH

There is an allocation from the Commonwealth Department of Community Services and Health which, in 1987/88, had a marked bearing on Aboriginal Health and amounted to $82.272 million. The following are the actual amounts:

Office of Child Care Family Support Services Scheme	.900
Children's Services Programs	10.828
Supported Accommodation & Homeless Persons Assistance	4.238
Emergency Relief	.546
Home & Community Care Program	.822
Disability Programs	.480
Residential Care	2.050
Australian Institute of Health	.140
Various Health Projects	2.199
Commonwealth-State Housing Agreement	60.069
	$82.272m

APPENDIX IV

DETAILS OF THE OTHER PROGRAMS INCLUDED IN AHP, QUEENSLAND

Programs for Improving the Health for Aboriginal Children

Childrens Health Screenings - There are comprehensive health assessments of children, conducted only after consultation with the community and only with the full permission of the children's parents.

Such health screenings are conducted by specially trained Public Health Nurses, reviewed, where necessary, by Regional Medical Officers.

The health screenings concentrate on accurate assessments for acute and chronic malnutrition, anaemia, and a range of infections and infestations to which Aboriginal and Islander children are especially prone.

Special attention is given to the synergistic relationship between malnutrition and infection in order to prevent serious consequences for the child.

Children who are found to be suffering from any of these conditions are either referred to the appropriate services or managed by the Health Team.

Child Health Clinics - remote and isolated communities: Weipa, Cooktown, Laura, Coen, Bloomfield, Hopevale, Doomadgee, Aurukun. Under 5 Years - baby clinics, regular surveillance, education and support.

Immunisation - education, follow-up, support and active participation.

The Trichuris Control Program - 12 weekly mass treatments have been conducted at Palm Island and Lockhart River where significant morbidity due to Trichuris was found. This has resulted in significant reduction in worm burdens and eliminated morbidity due to Trichuris in these communities.

The Hepatitis B Program - a State-wide vaccination campaign of children at risk from Hepatitis B has been in progress for two years and was the first comprehensive program of this kind in Australia. The campaign also includes serological testing and follow-up/referral of carriers to detect early evidence of chronic active hepatitis and hepatocellular carcinoma. This campaign is achieving high compliance rates for full courses of vaccine and high seroconversion rates.

Programs for Improving the Health of Aboriginal Adults

In recent years, the AHP has expanded its activities into the adult health area.

Based on proven effectiveness of the techniques of child health screening, referral and management, screening programs for adults are being developed.

Such programs concentrate on those diseases known to cause excess morbidity and mortality in Aboriginal and Torres Strait Islander adults, and include blood pressure, diabetes, assessment of obesity, respiratory function, hearing, vision, infectious and parastitic diseases.

In addition, teams concentrate on the following matters with regard to adults:

Diabetes - screening, surveillance, education and support groups;

Hypertension - screening, referral, follow-up and education groups;

STD - contact tracing, education, support, and referral.

AIDS - education, counselling, and support.

AIDS - the AHP has continued to train and involve its staff in AIDS prevention activities. The AHP is developing an AIDS Health Worker Training Manual and has finalised Teaching Kits on Sexually Transmitted Diseases (including AIDS). The AHP is forming an AIDS Unit which will be composed of five Aboriginal and Torres Strait Islander Community Workers (AIDS).

Infectious Diseases Control Nurse, Torres Strait - detection, treatment, referral, follow-up and education for Hepatitis B, Hansen's Disease, STD's, TB. This Unit has been expanded to include a Health Assistant and a Field Officer.

Daily Living Aids and Home Help - assessments and supply as agents of the Division of Community Medicine.

PROGRAMMES WHICH HAVE IMPACT ON THE HEALTH OF BOTH CHILDREN AND ADULTS.

The Self-Help Health Care Program.

This program was adapted from a program developed by Griffith University. Aboriginal Health Assistants are taught medical and health information and education/self-help health care group methods.

Health Assistants are then primarily responsible for communicating health information and health improvement techniques to their own communities.

Special Projects Unit.

This Unit is responsible for health promotion activities. These activities include the production of culturally appropriate written and audio-visual material and the organisation of group activities which promote health and behavioural change.

The Dietary-Nutrition Unit (DNU).

This unit is composed of two Dietitian-Nutritionists and three Aboriginal and/or Islander Nutrition Field Officers, two of the latter being based in Cairns. The Dietary-Nutrition Unit's major objective is to increase the Queensland Aboriginal and Islander population's awareness of the role of nutrition in health and disease. This task is approached from two different directions:

- provision of practical nutrition education programs to AHP Health Teams who then disseminate this information to their local community, and

- provision of practical nutrition education sessions directly to individuals and groups in the general community.

Hearing Conservation Unit (HCU)

This unit is composed of one Audiologist, 1 Senior Aboriginal Audiometrist (Brisbane) and 2 Aboriginal Audoimetrists (Cairns) who continued to conduct field work to test Aboriginal and Islander children for ear disease and hearing loss. All data compiled from screenings is organised and collated by the three Aboriginal Audiometrists. Summary reports for each community screened are then distributed to all relevant agencies, including the community Council, Schools, AHP Teams, Medical Staff, National Acoustic Laboratories and Visiting Teachers for the Hearing Impaired. The activities of the HCU has resulted in the better management of the hearing disorders and disuse such as chronic serious otitis media.

Parasitology

The Microbiologist continues to examine large numbers of faeces specimens to detect enteric parasites. These are then treated or referred. In many communities, certain parasitic disorders have markedly decreased, and hookworm has been virtually eradicated.

Sexually Transmitted Diseases (STD's).

All AHP Teams conduct STD education programs. The AHP also has a specialist Team for STD control, based in Cairns (Team 4).

This team conducts education activities in towns, communities, high schools and among health care personnel, including AHP and hospital staff.

The Team also co-ordinates STD controls in the Cairns and Cape York area, maintaining a register of cases, performing contact tracing, ensuring compliance with treatment and follow-up.

Funding cuts have resulted in decreased travel by the Team to communities on Cape York and case numbers have increased in some areas.

APPENDIX V

AREAS IDENTIFIED AS NEEDING NEW AHSs

New South Wales

AHS's (Large Clinic)	AHS's (Small clinic)
Nambucca Heads	Karuah
Grafton	Coffs Harbour
Armidale	Bellbrook
Lismore	Tweed Heads
Yamba	Cabbage Tree Island
Casino	Baryulgil
Tamworth	McLean
Inverell	Bowraville
Wee Waa	Ballina
Gilgandra	Tenterfield
Dubbo	Tingha
Wellington	Collarenebri
Orange/Bathurst	Enngonia
Cowra	Goodooga
Wagga Wagga	Coonamble
Narrandera	Coonabarabran
Wilcannia	Peak Hill
Lake Cargelligo	Maitland
	Tumut/Brungle
	Bodalla
	Wallaga Lake
	Eden
	Batemans Bay
	Broken Hill
	Mungindi
	Woodenbong
	Weilmoringle
	La Perouse
	Menindee
	Guyra
	Glen Innes

Western Australia

Narrogin
Albany
Bunbury
Merridin
Northam
Moora
Geraldton
Meekatharra
Kalgoorlie
Leonora/Laverton
Norseman/Esperence
Onslow
Port Hedland
Wyndham
Fitzroy Crossing
Derby
Kimberley Central Station Country (Gibb River region)

Queensland

Atherton
Charleville
Cooktown
Cunnamulla
Hughenden
Mareeba
Maryborough
Mossman
Mount Isa
Nerang
Normanton
Rockhampton
Roma
Toowoomba
Yarrabah

Victoria

Echuca
Warnambool
Horsham
Ballarat
Haywood/Portland
Mildura
Swan Hill (part-time clinic)

South Australia

Port Lincoln
Maralinga
Northern Metropolitan Adelaide/Elizabeth.

Tasmania

Hobart
Launceston
Burnie

ACT

Canberra - one service to serve the ACT and surrounding region.

APPENDIX VI

Current Funding Arrangements for Aboriginal Health Service

Before outlining the three basic ways in which AHS's are funded, it is necessary to describe briefly the range of organisations which are encompassed by the general term "A.H.S.".

The Aboriginal Medical Service Co-operative Ltd., in Redfern is the original community controlled Aboriginal Health Service and commenced operation in 1971 by utilising the voluntary services of doctors, specialists, nurses, field officers, and administrative staff. It operated in this fashion for 18 months until it attracted Commonwealth funding from the the Whitlam Government and was able to appoint 1 full-time doctor, 1 full-time nurse, and 1 field officer. Today the service employs a total of 60 staff including; 3 full-time doctors, 6 part-time specialists, 2 registered nurses, 4 healthworkers, 4 full-time dentists and 8 dental technicians.

Apart from normal clinical services it operates programs for:

General Practice;`

Specialist Clinics;
Womens Health Clinic - Antenatal;
Under 5's;
E.N.T.;
Physicians Clinics;
Podiatrist;
Physio Therapy/Natropath;
Diabetic Clinic;
Mental Health Clinic;
Long Bay Gaol & Mulawa Clinic; and

Dental Clinic: General Practice and Orthodontal Clinic; and

2 Mobile Dental Units.

Public Health Programmes (Education Programme);
Nutrition Programme;
Health Worker Education Programme;
Youth Drug and Alcohol Programme;
Home & Community Care Aged Programme;
Aged Hostel;
Communicable Diseases Programme;
Counselling Services; and
Gaol Support and Follow-up Service;

Significantly, the service attracts funds for this wide range of services from a spectrum of State and Commonwealth sources almost as wide. Major sources of funds are:

- Department of Community Services and Health;
- DEET;
- Aboriginal Hostels;
- NSW Department of Health;
- NSW Department of Family and Community Services; and
- NSW Office of Aboriginal Affairs

In contrast to the Aboriginal Medical Service, Redfern, is the Ceduna Health Service, which employs 1 registered nurse and 4 Aboriginal Health Workers, jointly funded by DAA and SA Health Commission.

Within these two extremes are the multitude of some 64 Aboriginal Health Services funded by the Department of Aboriginal Affairs and 18 organisations funded by the N.T. Department of Health and Community Services under its Grant-in-Aid program.

The three basic methods of obtaining operational funding for AHS's are as follows:

- Commonwealth direct grant funding by the Department of Aboriginal Affairs as the only available source of funding. Murray Valley Aboriginal Co-op in Victoria is a good example of this type of funding;

- the second established method of obtaining funding is that of a joint funding arrangement between the Commonwealth and the State or Territory Government; A good example of this type of program is the NGANAMPA Health Council Incorporated, jointly funded by the Department of Aboriginal Affairs and the South Australian State Government; and

- the third form of funding is that where a State or Territory Government provides the total funding necessary to operate a program.

Adequacy of Funding Levels

Under the present funding arrangements, particularly those relating to DAA Grant-in-Aid funding, the AHS's are required to negotiate on an annual basis for their operational budgets.

To a large extent the level of funding available to meet the existing program commitments, any proposed expansion of programs, the funding of new initiatives or the setting up of new AHS's is set by the Government in the context of its overall budget priorities and strategies.

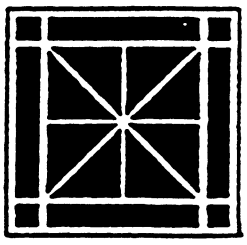
There is not necessarily any link between the level of funds available for health purposes and the actual health needs within any given community. In many cases, funds for expansion and new initiatives are only forthcoming as a result of political pressure on Ministers or as a result of meeting some other politically motivated judgement.

There is no acceptance of a long-term integrated health policy designed to achieve and maintain a significant long-term improvement in Aboriginal Health status.

APPENDIX VII

SEWERAGE AND WATER SUPPLY SYSTEMS

REMOTE ABORIGINAL COMMUNITIES - WESTERN AUSTRALIA



AUSTRALIAN CONSTRUCTION SERVICES
WESTERN AUSTRALIA REGION

NOVEMBER 1988

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APPENDIX

INTRODUCTION

At the request of Mr K. Wanganeen, Secretary of the National Aboriginal Health Strategy Working Party, Mr D. Colley from Australian Construction Services met with members of the Working Party in Perth on the 14 November 1988, and discussed ACS experience with sewerage systems in isolated aboriginal communities in Western Australia.

The first part of this paper describes various sewerage systems installed in isolated aboriginal communities located in the Eastern and Northern parts of the State. It also includes the criteria considered when designing a system and mentions maintenance aspects.

The second part of this paper briefly describes the water supply systems installed in isolated communities in W.A.

STATUTORY AUTHORITIES

In Western Australia the design and construction of aboriginal community water supply and reticulated sewerage systems is carried out in a accordance with the requirements of the Water Authority of WA. Septic tank installations come under the jurisdiction of the State Public Health Department.

The W.A.W.A. has strict guidelines for the design of water supply and reticulated sewerage systems and supervises construction work carried out by Contractors.

The Health Department of W.A. regulations require that permission be obtained from the Department to allow construction of a septic system. The completed installation is inspected by a Health Surveyor.

SEWERAGE SYSTEMS - PART 1

The methods used to collect and treat sewage and domestic waste water in isolated communities located in the Eastern and Northern parts of WA are:-

1. Deep Sewerage System

2. Reticulated Effluent System

3. Septic Tank (Cistern Flush)

4. Septic Tank (Dry Type)

5. Ventilated Improved Pit Latrine (V.I.P.)

6. Absorption Drain

The installation of Dry Type Septic Tanks and V.I.P. Latrines has only occurred in recent times, Dry Type Septic Tanks in 1978 and V.I.P. latrines in 1983.

The areas where the systems are installed are to the East, arid and desert-like, and to the North, arid to semi-arid with a monsoonal type climate characteristically hot and wet in summer (wet season) and warm and dry in winter (dry season).

1. DEEP SEWERAGE SYSTEM (APPENDIX 1 AND 2)

The Deep Sewerage System comprises a drainage reticulation system connected to each house, ablution block etc. to receive sewage for discharge into a single treatment facility of sewerage ponds.

The ponds are large specially formed earth dams of shallow depth designed to utilise the natural processes of algae and bacteria to treat raw sewage and effluent.

Advantages

- Overcomes septic tank and effluent absorption drain problems of blockages, overflow, regular cleanout, cleanout material disposal and limited absorption drain life.

- Areas of non-absorbent ground can be utilised for housing development.

- The ponds are highly effective at treating sewage at low cost with little maintenance.

- The system can be designed to treat sewage from very large communities.

Disadvantages

- Expensive installation.

- Pump stations are generally required because of level sites and the long, drain pipe distances involved.

- Foreign objects can cause blockage and damage to drains and pumps.

- Requires specialist personnel to maintain pumping equipment.

- Requires a reliable adequate water supply.

- Requires a reliable, adequate power supply for pumps.

2. RETICULATED EFFLUENT SYSTEM (APPENDIX 1 AND 2)

The Reticulated Effluent System comprises a drainage reticulation system to receive the effluent from septic tanks and waste water from sinks, troughs, showers, etc. that may by-pass a septic tank. The effluent is discharged into a single treatment facility of ponds, similar to those installed for deep sewerage systems.

Advantages

- As for Deep Sewerage Systems but not as expensive.

- Foreign objects generally remain in the septic tanks reducing the chance of blockage and damage to drains and pumps.

Disadvangates

- As for Deep Sewerage Systems.

- Blockage and damage to drains and pumps from foreign objects could still occur but to a far lesser extent.

- Septic tanks require cleaning out every 2-3 years.

3. SEPTIC TANK (CISTERN FLUSH) (APPENDIX 3)

The Septic Tank (Cistern Flush) system comprises a cistern flush washdown pan connected by a drain pipe to a septic tank. The septic tank is sized according to the number of persons using the facility and whether it receives waste water from sinks, troughs, showers etc.

The standard installation for a house consists of two precast circular concrete tanks connected in series and provides for up to 10 persons.

The effluent from the septic tank discharges either to a Reticulated Effluent System or to an absorption drain such as a leach drain or french drain.

Advantages

- A low cost, clean, odour and insect free method of sewage disposal.

Disadvantages

- Requires a reliable, adequate water supply.
- Cistern and drain pipes must be maintained properly for the proper functioning of the system.
- Proper toilet paper use is essential for efficient operation.
- Septic tank requires cleaning out every 2-3 years.
- Effluent disposal into the ground can be a problem in clay type soils because of the waste water quantities involved.

4. SEPTIC TANK (DRY TYPE) (APPENDIX 4)

The Septic Tank (Dry Type) comprises a superstructure and floor slab mounted over part of a septic tank.

A straight-through type pan with a tank inlet pipe is fixed to the floor slab over the septic tank. Excreta passes directly into the tank without prior discharge through pan traps or drainage pipes.

Effluent from the tank passes into either a reticulated effluent system or an absorption drain such as a leach drain or french drain.

Essential to the effective operation of the septic tank is the necessity to maintain the water seal above the bottom of the pan inlet pipe. Without the seal, significant odour, fly and mosquito problems may occur.

To maintain the water seal the waste pipe from a handbasin or laundry trough is connected directly to the top of the inlet pipe. This may also provide a cleaning effect to the inlet pipe.

The tank requires to be de-sludged every 2-3 years in order to maintain maximum bacterial efficiency and to prevent any undue blockage of the effluent drain or absorption drain.

Advantage

- Requires little water to function.
- Low effluent discharge means extended life or absorption drains.
- Does not require special toilet paper.
- Blockages easily cleared by rodding through the pan.
- Fewer blockages than with a cistern flush septic system.
- One tank has the capacity for use by up to 40 persons.

Disadvantages

- If the water seal is not maintained because of insufficient water entry or tank leakage, then odour fly and mosquito problems will occur.

- Requires regular cleaning of pan fouling to reduce odour and insect attraction.

- Tank requires cleaning out every 2-3 years.

- Not suitable for installation inside a house. Regulations require that the septic tank be located not closer than 6 metres from the house.

- Requires waste water from a basin or a trough to maintain the tank water level.

- Where a washing machine discharges into the trough connected to the pan inlet pipe problems have occurred with smell and the overloading of the absorption drain.

5. VENTILATED IMPROVED PIT LATRINE (V.I.P.) (APPENDIX 5)

The V.I.P. latrine consists of a superstructure and floor slab erected over an unlined excavated pit. A concrete seat is incorporated in the floor structure thereby permitting excerta to be deposited directly into the pit. Sewage disposal therefore does not incorporate discharge of excreta with water or through a P or S trap pan or drainage pipes.

The pit is dug to a diameter of 1.5 metres and a depth of 2.3 metres. The deeper the pit, the longer the life. The top 850 mm is reinforced with a concrete collar to prevent walls subsiding.

The latrine entry generally faces south and the vent pipe north to allow solar radiation to assist in the control of odours.

The walls of the latrine are formed in a spiral shape to promote air flow and strength to the design. The spiral allows the inner part of the toilet to remain dark and provides privacy without requiring a door. The inner walls are painted matt black to cut down on light transmission inside the latrine.

Odour control is assisted by wind entering through the open door and then down through the concrete seat opening into the pit collecting odours which are drawn up the vent pipe to be carried away by the wind. Additionally, solar radiation striking the vent pipe enables the air inside to rise out of the vent pipe. Wind across the top of the vent pipe creates a negative pressure within the pipe which draws air out and replaces it with air from the pit thus further contributing to the circulation.

The vent pipe is covered with fly wire. Any flies in the pit will fly towards the light source at the top of the vent pipe but will be unable to escape.

Where possible the latrine should be sited on the leeward side of any dwelling and in close proximity to a standpipe in order for handwashing to be undertaken.

Where the latrines are regularly washed down and biodegradable materials are used for anal cleansing rather than solid objects, the accumulation rate may rarely exceed .02 m^3 per person per year, giving a pit lifetime of up to 25 years for eight persons.

Advantages

- Does not require water to function.
- Does not require special toilet paper.
- Minimal maintenance required.
- Long life because of low waste accumulation.

Disadvantages

- If not kept clean or the vent fly wire not maintained then odour, fly and mosquito problems will occur.
- Not suitable for installation as part of a house. The latrine is to be at least 6 metres from a house.
- When the pit is full the latrine has to be rebuilt in another location.
- Not suitable to receive waste water from shower, sink, trough etc.

6. ABSORPTION DRAINS (APPENDIX 6)

LEACH DRAINS

The most common method used to dispose of effluent from a septic tank or waste water from a house is with the use of a leach drain.

The leach drain generally consists of precast concrete inverted U sections with small openings in the sides laid end to end in a trench for the required length. On each side of the drain for a width of at least 300 mm and up to the surface coarse sand, crushed rock or gravel is placed. Effluent passes from within the leach drain to this fill material and is absorbed by the soil or evaporated to the atmosphere.

The drain can also be constructed from precast concrete blocks and lids. Fibreglass leach drain sections are also available but are not recommended because earth and vehicle loadings can cause their collapse.

FRENCH DRAINS

The French Drain consists of a slotted PVC pipe laid in a stone or rock filled trench. A french drain would only be used where a source of stone or rock is available and where difficulties would likely occur with the handling and possible transportation breakage of the heavy precast concrete sections. The construction of the drain can be labour intensive with the gathering and placing of the rocks and once blocked cannot be pumped out as is the case with a leach drain.

The length of each leach or french drain is generally established in consultation with the local Health Authority.

Advantages

- A simple, low cost method of effluent disposal.

Disadvantages

- Requires coarse grained soils to be effective.

- Excessive discharges of water, taps left running and large numbers of people contributing can overload the water absorption capacity of the soil.

- Grease and fats from cooking utensils can seal the soil face and reduce absorption.

- Absorption of effluent by the soil is severely reduced during the wet season of the north.

- Requires the regular cleaning out of the septic tank for long life.

SEWERAGE SYSTEM SELECTION CRITERIA

The selection of a sewerage system whether it be deep sewerage, reticulated effluent, flushing or dry type septic, V.I.P. latrine or absorption drain type, is based on the following criteria:-

- Topography or natural features of the area such as hills, rock outcrops, subsurface rock, ground slope, vegetation, water courses and ground water levels.

- Seasonal changes in the ground water level and the absorption capacity of the soil.

- Flood levels.

- The nature of the soil for its suitability to either absorb effluent or to provide water tight treatment ponds.

- The location of community water sources such as bores, creeks and rivers for possible pollution effects.

- Natural resources such as coarse sand, gravel or rock for use in constructing absorption drains.

- The area of land available for treatment ponds.

- Restricted areas due to sites of significance or sacred sites.

- The accessibility of a community for specialist maintenance personnel during the wet.

- The adequacy of existing water and power supply systems.

- Prevailing wind direction for location of treatment ponds and V.I.P. latrines.

- Present and future population numbers.

The decision to install a Cistern Flush or Dry Type septic system or a V.I.P. latrine involves discussions with the Community Chairman and members to determine:-

- The Community's desire for a particular type of system.

- Their reasons for the acceptance or rejection of a type previously used.

- Their understanding of the need to upgrade a present system to one more efficient.

- The suitability of a particular type for the Community and their understanding of its proper method of use and maintenance.

- The number of persons who will use each proposed installation.

- The location of the proposed installation.

MAINTENANCE ASPECTS

Although the Water Authority of W.A. supervise the design and construction of reticulation sewerage and water supply systems they do not take over ownership of the system as is the case in towns and cities. The Authority therefore does not have the responsibility to maintain a system, although they do assume the responsibility for maintaining water supply disinfection systems.

Arrangements are currently being made for the Authority to be fully funded for all maintenance requirements, but in the meantime only essential maintenance is carried out by them within the limits of available funds.

The Authority is planning to set up a Water Supply and Sewerage Operators Course to train selected community members in the basics of operating and maintaining a water supply and sewerage system. The training would also prepare a person to accurately report to a district office of the Authority on matters requiring particular spare parts or the services of an Authority maintenance specialist.

The Health Department of W.A. assist in a training course currently being held at the Peedamulla College in Port Hedland. This course instructs selected community members in the basic repair and maintenance of small water supply installations, septic systems and drains.

In Kununurra an aboriginal Work Task Force has been set up to provide a maintenance service to communities in the region. Two Communities in the Kimberley Region each have a portable sludge pump/tank unit for loading onto a utility vehicle for the purpose of cleaning out septic systems.

Apart from those communities serviced by their own trained people, the Kununurra Work Task Force or the Water Authority virtually no preventative maintenance is carried out. Serious health risks regularly occur when drains become blocked and leach drains overflow.

A particular problem that frequently occurs is when an attempt, often unsuccessful, is made to clear a drain blockage and the screw-on drain access caps are not replaced. This allows soil or other foreign matter to enter the drain causing blockage and the ponding of sewage.

A simple open drain system has been developed to overcome blockages but is suitable only for shower and trough waste water (Appendix 7).

A shallow channel is formed in the concrete floor slab between the shower and laundry. Waste water from the shower drains into the channel and from the wash trough is piped directly into the channel. A grate covered shallow concrete box located immediately outside the shower and laundry is connected to the channel and distributes the waste water into a shallow french drain.

Although this method has the advantage of being virtually blockage free it does have the disadvantages of being suitable only for a single shower and laundry trough and as a source of odour and insect breeding from the french drain. (It is generally installed in conjunction with a V.I.P. latrine).

The use of pipes in drainage systems is the only known method to safely and efficiently convey sewage and providing they are kept free of foreign matter will function without problem. Through the training programmes it is hoped that when a problem arises each community will be able to quickly obtain the services of a person who is skilled in the servicing of plumbing and drainage systems.

WATER SUPPLY SYSTEMS - PART 2

The water supply system in small remote aboriginal communities of up to say 50 people generally consists of two bores, a pump or pumps, an elevated storage tank and a pipeline to standpipes, houses and ablutions.

The predominant source of water is underground. A small number of Communities pump from springs or a river, but in the absence of chlorination this is generally undesirable due to the difficulty of preventing pollution by humans, stock and feral animals.

The quantity of water required for a community is based on the Water Authority of W.A. figure of 400 litres/per/day. Ideally bores are equipped to provide the daily requirement of the community in 12 hours.

PUMPING

Pumping systems installed included:

A combination windmill and diesel operating a single piston pump installed in the one bore, the other bore being capped on standby. This requires the disconnection of pump rods to enable either the windmill or the diesel to operate the pump.

A diesel helical pump in one bore and a windmill pump in the other bore.

A combination diesel and solar powered helical pump requiring the change over of pulley belts from one system to the other.

Electric submersible pumps in each bore where a reliable S.E.C. power supply system is available.

STORAGE

Water is pumped into a 22.5 kl (5000 gallons) tank supported on a six or nine metre tank stand.

In larger communities ground level concrete tanks are installed to provide up to three days storage. Transfer pumps lift this water to a high level tank from where it is supplied to the community.

DISINFECTION

Disinfection of water is carried out by the use of either chlorine gas, solutions or tablets or ultra violet radiation. Chlorine gas and solutions are very effective and are used on large installations, but require expert personnel to monitor and maintain the gas and solution mechanisms. For small communities chlorine tablets have been used in automatic feeders with limited success. Variable flows and tablet jamming have affected the reliability of this method.

Ultra violet disinfection is becoming popular as a low maintenance economical method, but requires a reliable power supply and does not have the residual killing effect of chlorine. Solar power units are being developed for use in isolated areas but have the disadvantage of battery backup.

PIPE

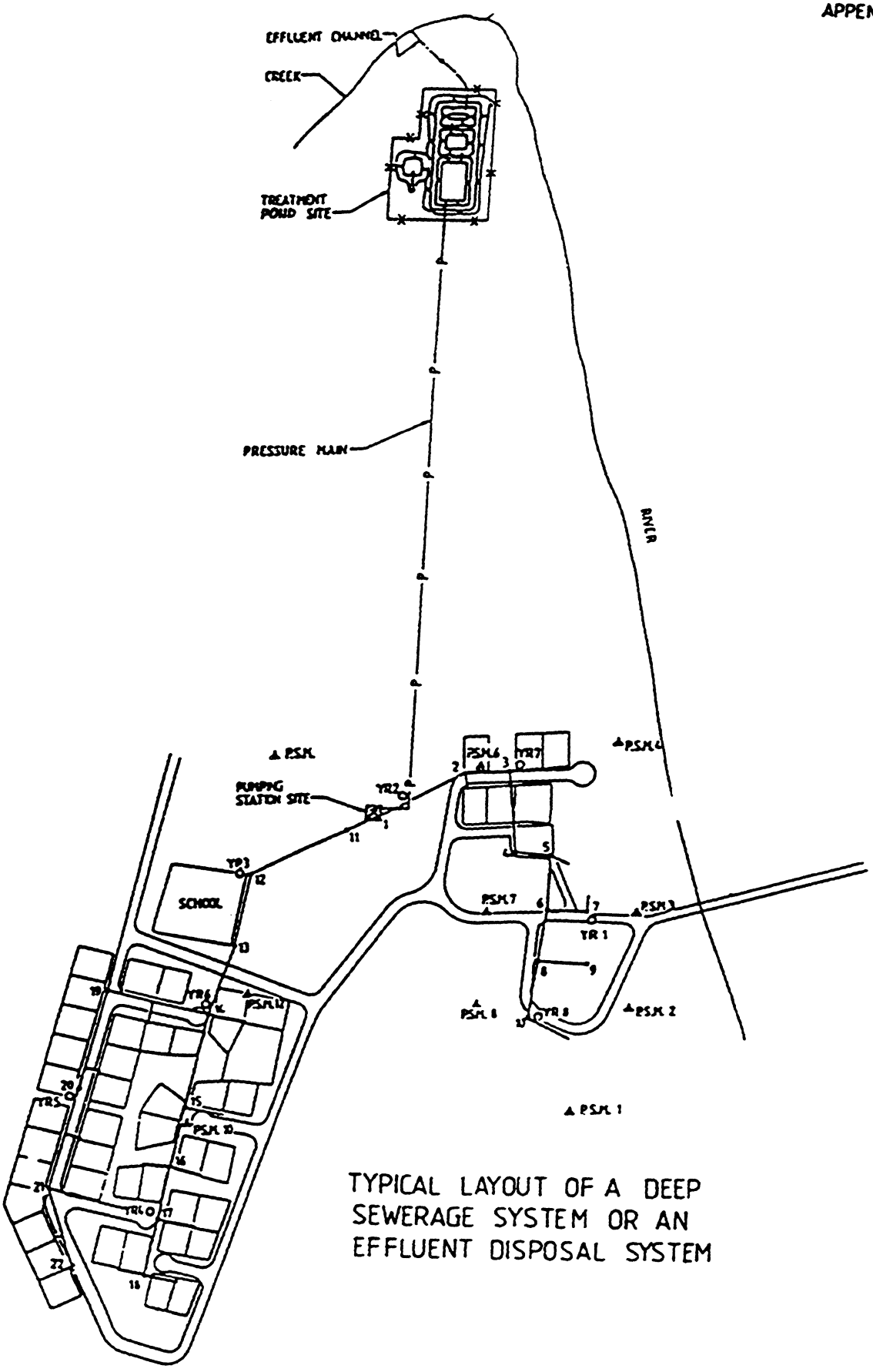
Underground pipelines are generally of P.V.C. or polythene and are laid at least 450 mm of cover for protection. Above ground pipework associated with pumps and tanks is either of galvanised steel or copper.

REFERENCES

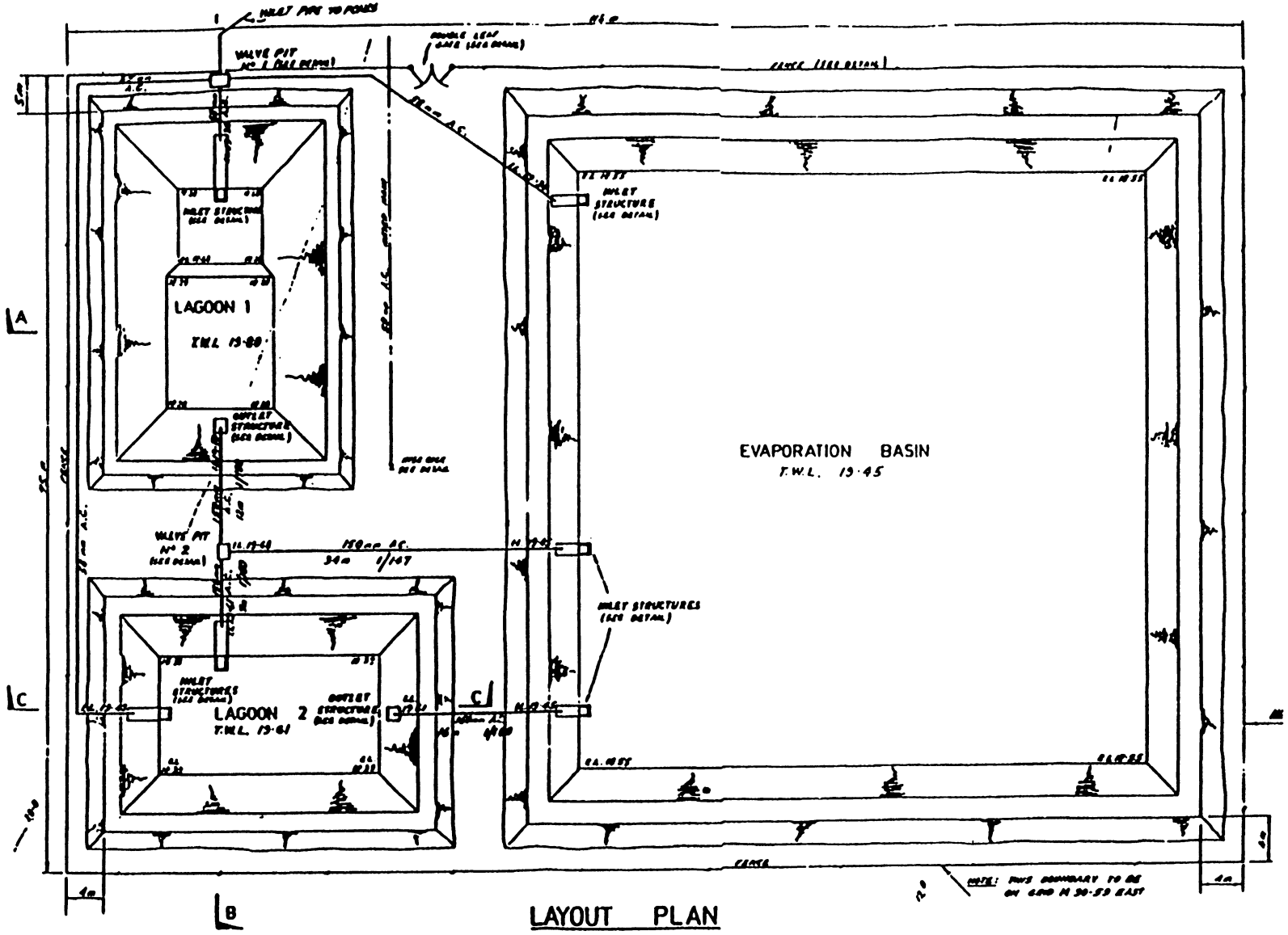
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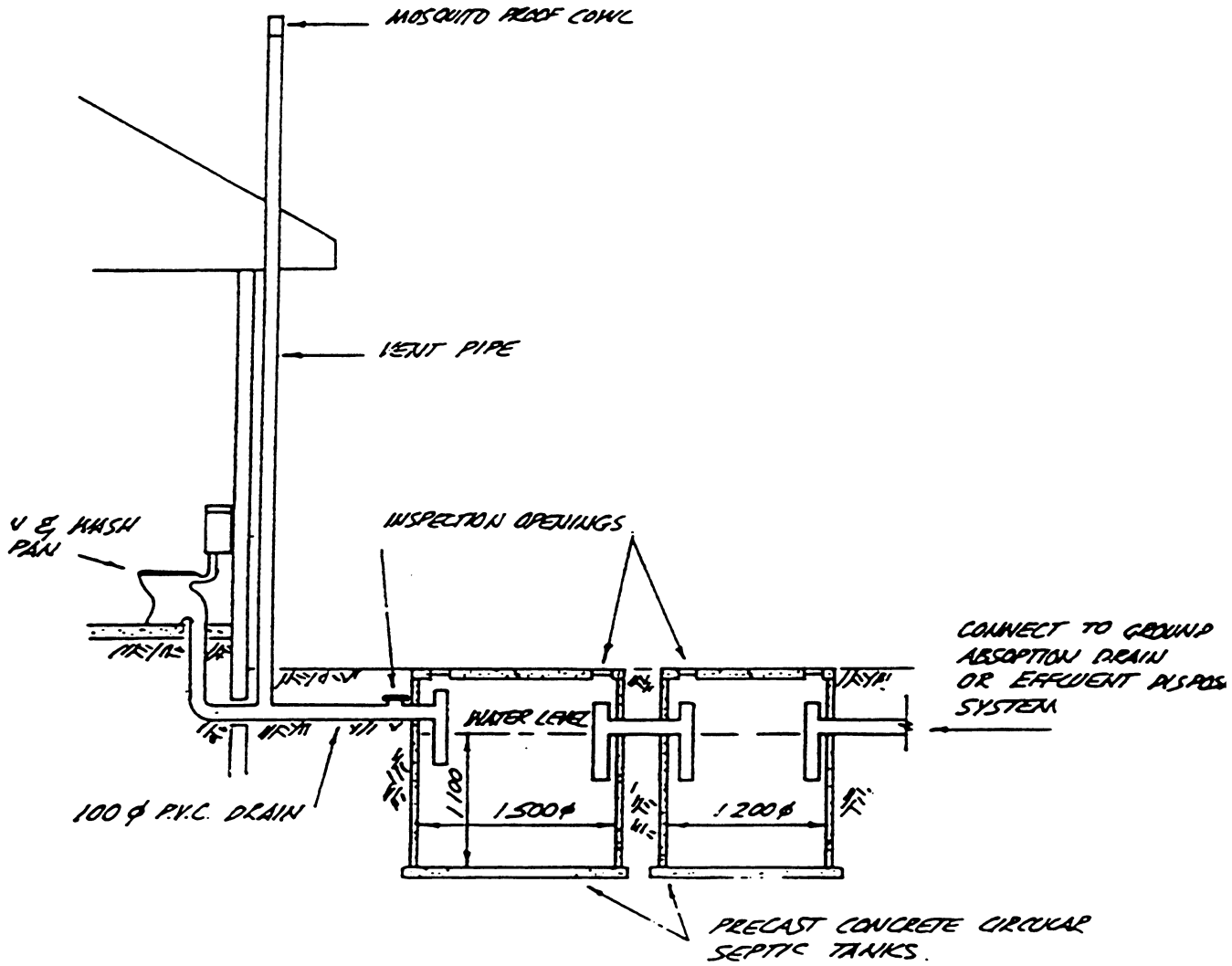
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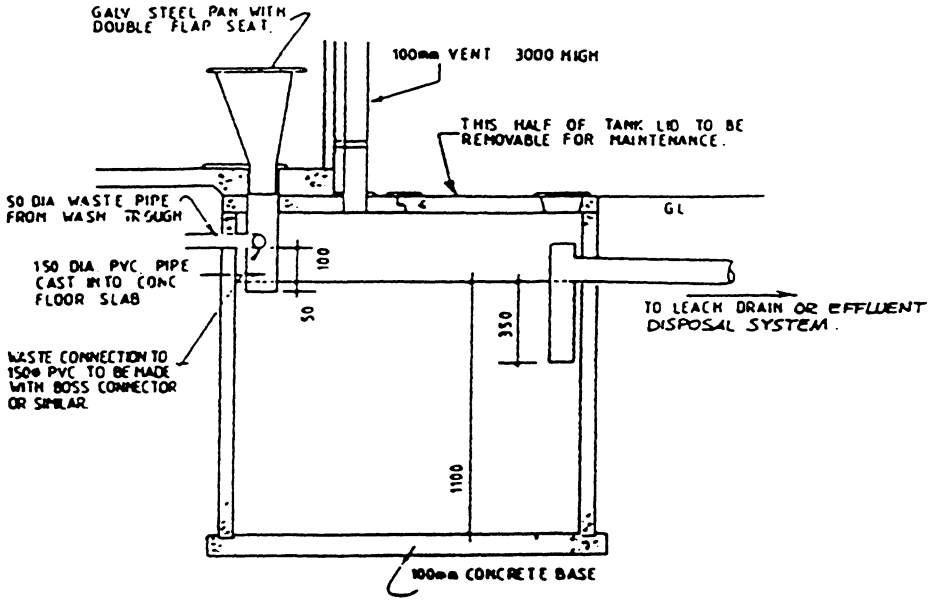
TYPICAL LAYOUT OF A DEEP SEWERAGE SYSTEM OR AN EFFLUENT DISPOSAL SYSTEM



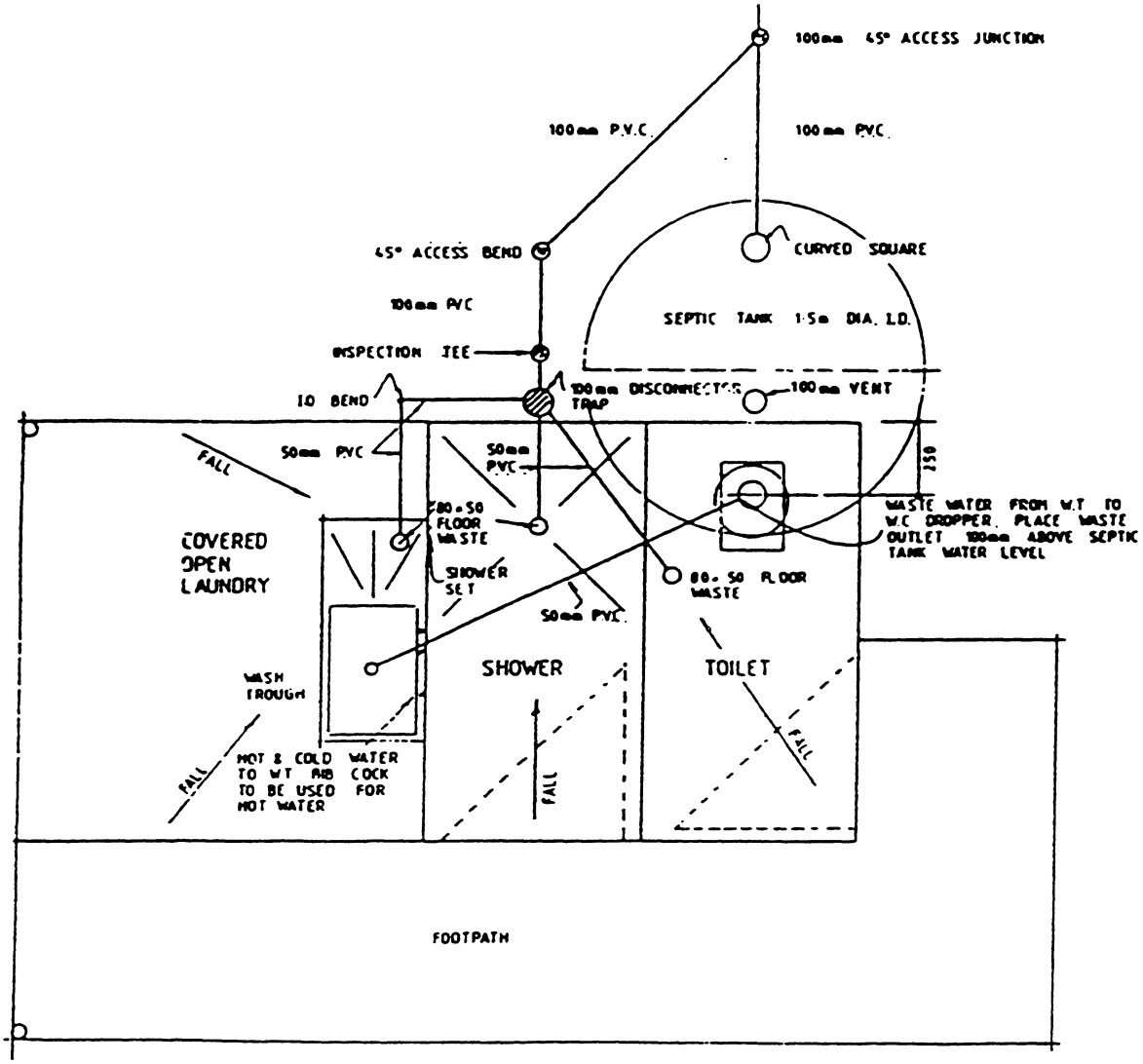
TYPICAL SEWERAGE TREATMENT PONDS



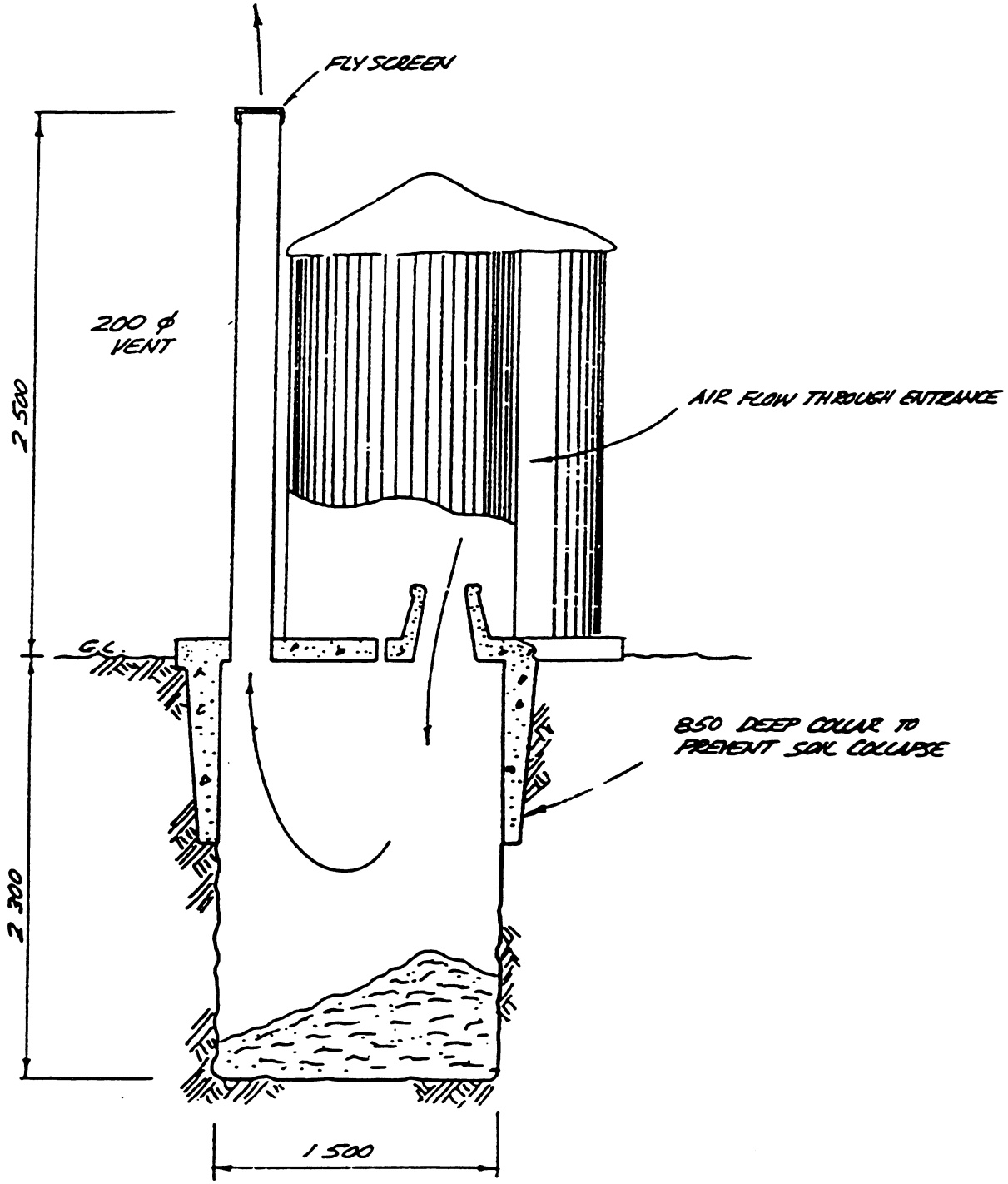
SEPTIC TANK (CISTERN FLUSH)



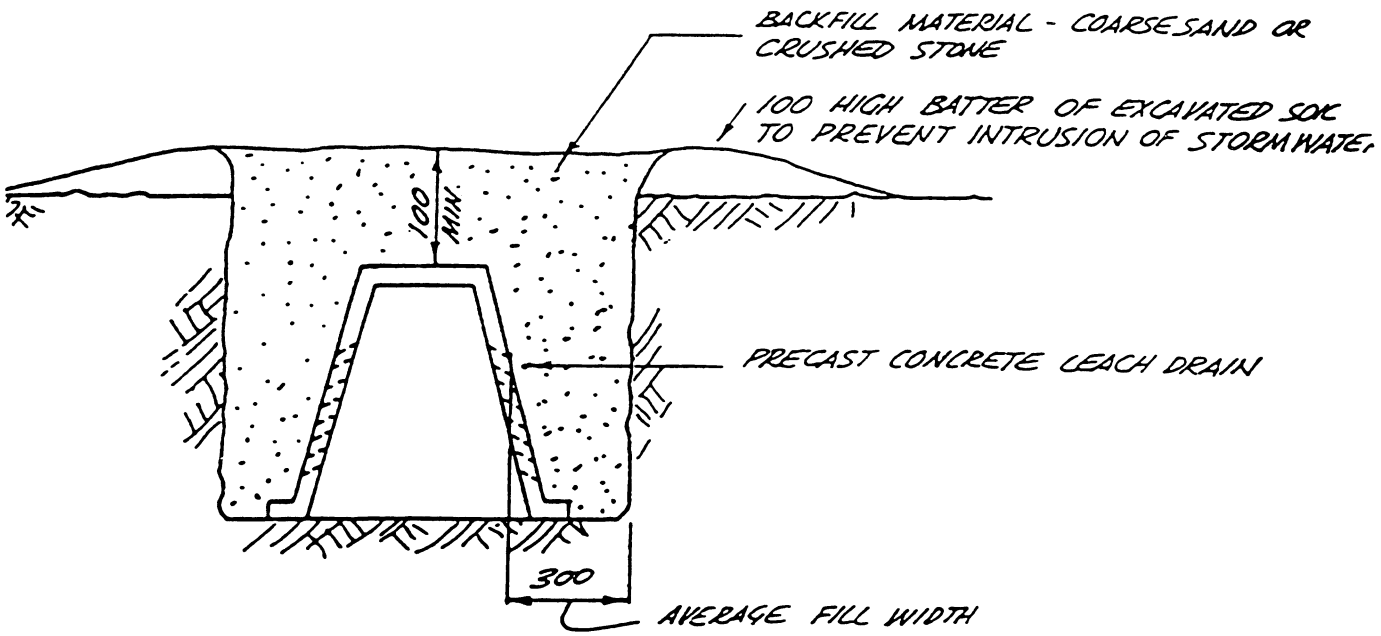
SECTION - SEPTIC TANK (DRY TYPE)



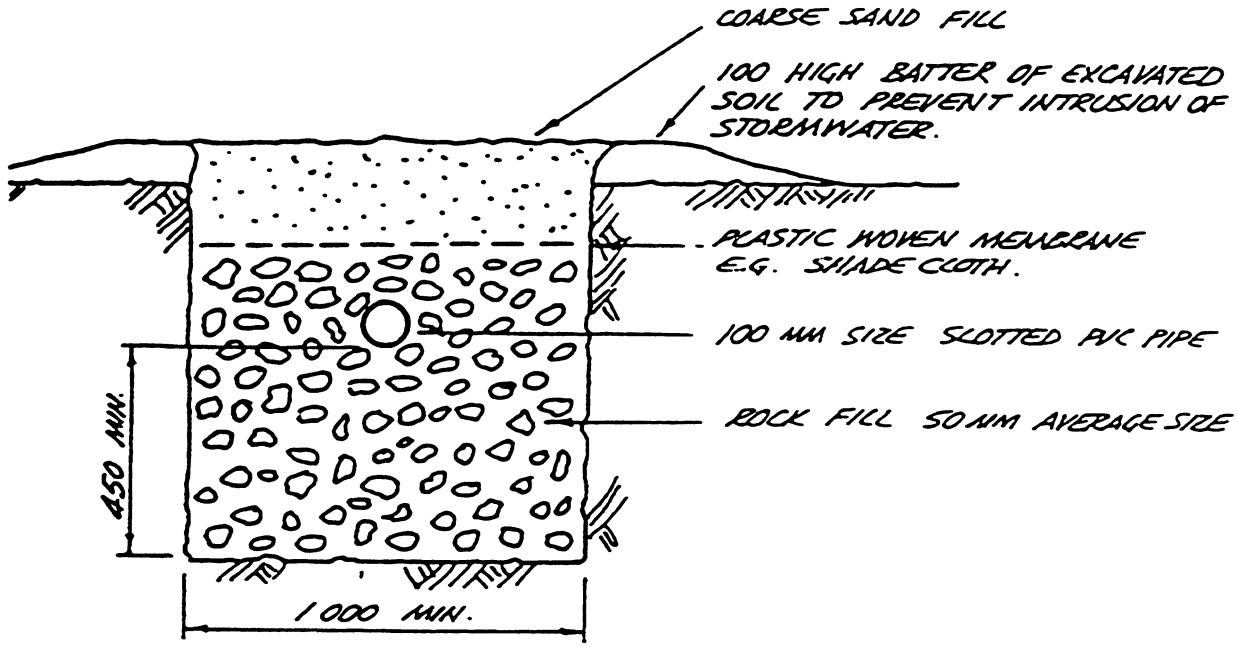
PLAN OF A TYPICAL TOILET BLOCK WITH A DRY TYPE SEPTIC TANK.



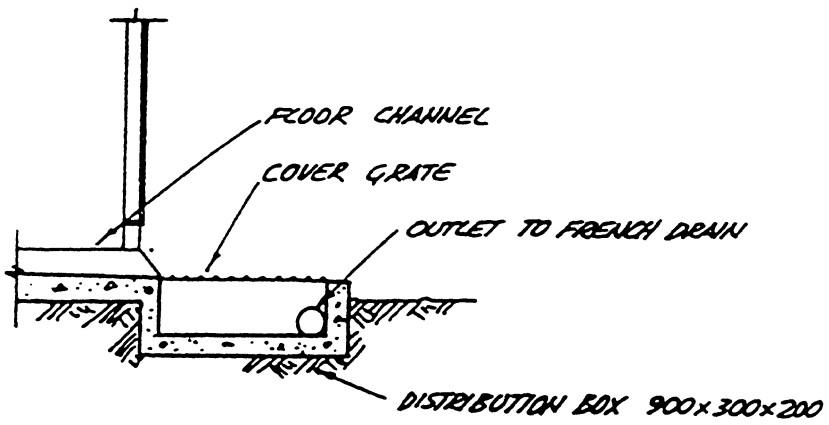
VENTILATED IMPROVED PIT LATRINE (V.I.P.)



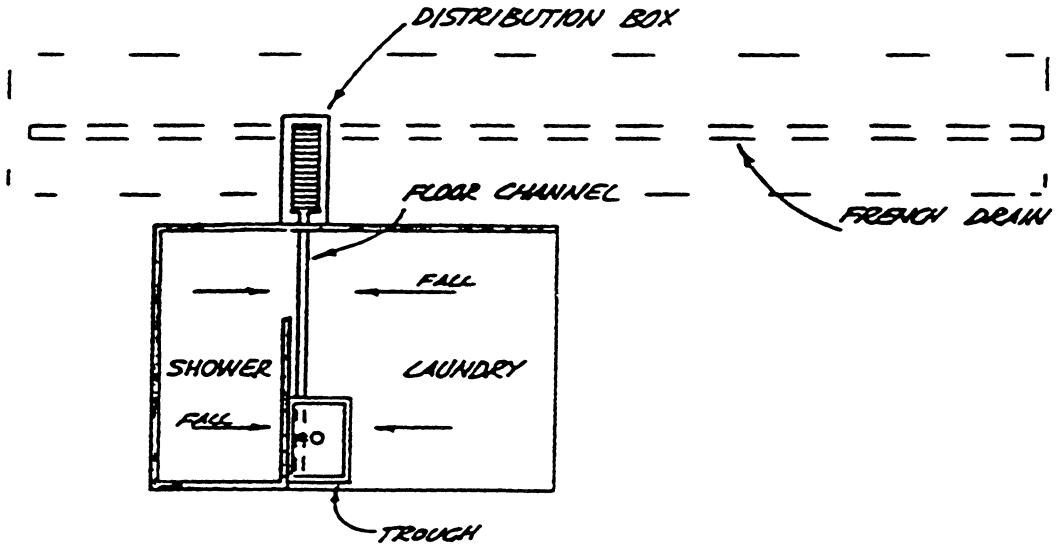
LEACH DRAIN - SECTION



FRENCH DRAIN - SECTION



SECTION - DISTRIBUTION BOX



PLAN - SHOWER / LAUNDRY BLOCK

TOILET AND WATER SUPPLY SYSTEMS

COMMUNITY AWARENESS AND SYSTEM MAINTENANCE

The improvement of sanitation in a community cannot be completely achieved by the construction of a toilet, a disposal system and a water supply system. It is essential that the community be made aware of the proper use of a facility and its maintenance requirements. An on-going follow-up programme involving visiting medical personnel, health workers, health surveyor and the community is required to ensure that a facility is properly used, kept clean and maintained.

Because of the isolation and remoteness of many communities from town centres, health information services and plumbing maintenance services are often unavailable when needed. It is therefore suggested that selected community members be trained to advise on matters relating to hygiene, proper toilet use, sewage disposal and water supplies and to carry out repair and maintenance work.

Any scheme to provide training would require a substantial commitment in persons and funds. It would need to be on-going, have an effective advertising/information programme to encourage support from community leaders and have the support of the Education and Health Departments, the Water Authority and Local Authorities.

The following is an outline of some factors to be considered in a Training Scheme:-

SCOPE: Topics covered in a training course should include:-

- the importance of hygiene;
- knowledge of toilet types and their correct usage;
- knowledge of sewerage disposal methods and their need for maintenance;
- knowledge of water supply systems and how pollution occurs;
- the importance of imparting this knowledge to communities;
- instruction and practical training on repairs and maintenance of community sewerage and water supply systems;
- to know when and who to call if maintenance is required to complex equipment.
- garbage disposal methods could also be included because of its importance to a community's level of sanitation.

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Indicative Costs of Various Sewage Disposal Systems

The following costs are indicative only and are based on installations carried out by contractors in the Northern region of Western Australia.

1. Deep Sewerage System - $175,000

   This figure is based on a community with 50 houses requiring connection to the new system and demolition of septic tanks and leach drains. The new system comprises drainage pipelines, manholes, pump stations and treatment ponds.

2. Effluent Disposal System - $150,000

   As for the Deep Sewerage System but with smaller pumps and treatment ponds and connection to the existing septic tanks.

3. Septic Tank (Cistern Flush) - $ 4,000

   This figure covers the cost of the septic system for a single toilet block with a washbasin and shower. It allows for 6 metres of PVC drain pipe, two standard size precast septic tanks and a 15 metre leach drain. It does not include the cost of the toilet block, any internal fittings or the water supply.

4. Septic Tank (Dry Type) - $ 2,500

   This figure covers the cost of the septic system for a toilet block similar to the cistern flush type mentioned above. It allows for 6 metres of PVC drain pipe, a single precast concrete septic tank and a 9 metre length of leach drain.

5. Leach Drain - $180/metre

APPENDIX VIII

COMMUNITY INFRASTRUCTURE ASSESSMENT
ABORIGINAL SETTLEMENTS (NSW)

Queanbeyan Region

NAME	POPULATION	REQUIRED FUNDING
Wallaga Lake	260-300	$ 224 600
Orient Point	270-300	$ 313 600
		$ 538 200

Bourke Region

Namoi	100-120	$2 465 000
Collarenebri	80-100	$ 57 000
Goodooga	40-50	$ 61 000
Gingie	80-100	$ 233 800
Weilmoringle	80-100	$ 241 500
Enngonia	100-130	$ 210 000
Bourke	140-160	$ 514 500
Brewarrina West	140-160	
Barwon Four	120-130	$4 000 000
	880-1050	$7 782 800

Less Funds Committed

$4 892 000

Funds needed to complete works for which there is no commitment $2 892 800

NAME	POPULATION	REQUIRED FUNDING

Inverell Region

Stanley Village	250-260	$ 176 000
Mehi Crescent	500-550	$ 166 000
Walhallow	180-200	$ 265 000
		$ 607 000

Wagga Wagga Region

Brungle	80	$ 520 000
Cummeragunja	100-110	$ 480 000
Erambie	150-200	$ 950 000
Murrin Bridge	166	$1 155 000
Three Ways	90	$ 735 000
Willow Bend	30	$1 500 000
	616-676	$5 340 000

Dubbo Region

Gunnedah Hill	16	$ 500 000
Bottom (northwest)	10	$ 10 000
Top (south)	60	$1 100 000
Cooma Street	60	$ 500 000
Nanima	120	$1 390 710
	250-270	$3 500 710
Less Funds committed		$ 340 000
Funds needed to complete works where there is no commitment		$3 160 710

Broken Hill Region

Mallee	200	$ 774 000
Mission	80-100	$ 710 000
Namatjira Avenue	80	
Camp Area	120	$1 613 000
Merinee	60	
	540-560	$3 097 000
Less funds committed		$1 768 000
Funds needed to complete works for which there is no commitment		$1 329 000

Lismore Region

Tabulam	300-500	$3 600 000
Cabbage Tree Island	300	$2 360 000
Muli Muli (Woodenbong)	100-110	$ 329 000
Baryulgil Square	80-90	$ 570 000
Box Ridge (Coraki)	80	$1 170 000
Corindi Beach	30	$ 20 000
Hillcrest (Maclean)	80	$ 400 000
Bellwood	100	$ 215 000
Fig Tree (South West Rocks)	30	$ 470 000
Green Hills (Kempsey)	300	$1 049 500
Bellbrook	120	$ 760 000

NAME	POPULATION	REQUIRED FUNDING
Purfleet (Taree)	300	$1 780 000
Karuah	150	$ 170 000
Walcha	40	$ 80 000
		$12 973 500

TOTAL: $26 393 010

Source: Infrastructure Needs on Former Aboriginal Reserves in NSW.

APPENDIX IX

CURRENT APPROVED DEPARTMENT OF ABORIGINAL AFFAIRS SUBSTANCE ABUSE PAPER

The term "substance abuse" refers to harmful, excessive, or non-medical use of any mood-altering substance or drug which results in physical, psychological, and/or social damage to the user and or those closely associated with the user.

Substances seen to be of danger to the Aboriginal population of Australia include alcohol, volatile substances such as petrol, glue and aerosol propellants, kava, prescribed drugs such as valium, serepax and other tranquillisers, analgaesics and tobacco, and such illicit drugs as heroin, cannabis, cocaine and amphetamines. All of these substances represent a potential health threat to the Aboriginal population.

Policy Objectives

To minimise the harmful consequences of substance abuse to the Aboriginal population.

Strategic Goals

(1) The creation of an environment in which Aboriginal people are able to make fully informed decisions about the use of substances, including alcohol and other drugs.

(2) The elimination of all social, educational, and economic inequalities that are conducive to substance abuse.

(3) To ensure, in co-operation with State and Territory Governments and other agencies, the availability of acceptable and appropriate services for the assessment, treatment and rehabilitation of Aboriginal substance abusers. The adaptation of services to Aboriginal need rather than duplication of services should be encouraged, particularly in regard to State-backed residential care programs.

Program Strategies

(1) Support the development of appropriate community based awareness and preventative programs against substance abuse.

(2) Support the establishment and operation of community based non-residential counselling, referral and support services to assist in the treatment and rehabilitation of Aboriginal substance abusers.

(3) Liaise and co-operate with State and Territory Health Departments, Drug and Alcohol Authorities, and other relevant agencies to ensure that Aborigines have access to residential detoxification, treatment and rehabilitation programs and, where necessary, fund special projects to meet Aboriginal needs.

(4) Encourage and support initiatives that will lead to the availability to the Aboriginal population of positive alternatives to substance abuse. Such initiatives should encourage self responsibility and self management and include improved opportunities for formal and informal education, trade and professional training, and recreational, sporting and cultural activities that will promote a fulfilling and satisfying lifestyle that does not require substance abuse as a means of escape from reality.

(5) Selective encouragement of research which will provide base line data on the extent and nature of substance abuse by Aborigines, identify appropriate interventions, and measure the success of prevention, treatment and rehabilitation services.

Project Instructions

In selecting projects for support, preference should be given to those which:

. provide logical and attainable aims and objectives.

. are community initiatives under community control;

. are staffed by suitable Aborigines with suitable training and experience in substance abuse services, a criteria is that employees are sober and that Aboriginal ex addicts are given a high priority for employment;

. plan for Aboriginal staff to be trained to take over executive administrative, training and counselling positions presently filled by non-Aboriginal staff;

. have an educative prevention role;

. are directed towards the young;

. complement rather than duplicate existing services;

- encourage responsible attitudes and behaviour towards substance abuse;
- provide non-residential services at community level rather than residential care in institutions;
- are linked to the development of youth, sport and recreational programs where possible;
- encourage the use of residential treatment and rehabilitation services provided for the general community; and
- are willing to provide to the Department such data as are required to allow assessment of the effectiveness of the project.

Performance Indicators

(1) Macro Indictors (Outcomes) - Statistics on national incidence of alcoholism and other forms of substance abuse by age and sex to be provided by the Department's Statistical Unit from State and Federal epidemiological and sociological research sources.

(2) Project Indicators

Program Title .....

Location ..... Aboriginal Population .....

Nearest Detoxification Service (Name & Location .....)

Service Provided (underline)	Treatment, Rehabilitation, Halfway House, Community Counselling, Support Service, Other (Specify)
Type of Service (underline)	Residential/Non-residential
Staff Employed (M/F)	Classification - Qualification held

No. of Clients Treated | Males | Females

- Daily Average .....
- Shortest Stay .....
- Longest Stay .....

No. of Clients Admitted to Program ....

No. of Clients Completing Program ....

No. of Group Counselling Sessions .... Per Week

No. of Individual Counselling .... Sessions Per Week

No. of Referrals to Program .....

No. of Referrals from Program .....

No. of AA Meetings Per Week .....

No. of Clients Retaining Sobriety ..... for 3 months.

No. of Clients Retaining Sobriety ..... for 6 months

No. of Clients Retaining Sobriety ..... for 12 months

No. of Clients who have dramatically .. reduced their alcohol intake since involvement with this program

Other Activities

List of associated Agencies with whom regular contact maintained.

Brief description of weekly program activities.

APPENDIX X

THE ABORIGINAL MEDICAL SERVICE REDFERN

YOUTH DRUG AND ALCOHOL PROGRAM

SUBMISSION

OCTOBER, 1986

IN THIS SUBMISSION

1. The Aboriginal Medical Service (AMS) Redfern will describe the situation which confronts the inner city Aboriginal Community with regard to intravenous (IV) drug use (especially heroin) and alcohol.

2. We will document the Community's response to this, especially the development of the Youth, Drug and Alcohol Program.

3. We will explain the specific proposals that comprise the Youth, Drug and Alcohol Program, and for which funds are required.

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YOUTH CENTRE BUDGET

INTRODUCTION

In the Aboriginal community of Redfern and the inner city there has been a long felt need for Aboriginal designed, controlled and staffed Drug and Alcohol Services to help people afflicted with alcohol and other drug addiction.

It has been shown and is widely accepted that those health services designed, controlled and staffed by Aboriginal community people for Aboriginal people, are the services that the Aboriginal Community find the most acceptable and useful.

Drug and alcohol rehabilitation is a difficult task - in the best of circumstances and in any community. The services available now to Aboriginal people in the inner city are inadequate and inappropriate. They are "White" services, about which Aboriginal people have always felt sceptical and consequently, have great difficulty in using to their advantage. If we hope to have any significant success in the attempt to intervene therapeutically in the vicious cycle that constitutes an addict's life, Drug and Alcohol Services must be designed for the needs of Aboriginal people. They must be more accessible and culturally appropriate. They must be Aboriginal.

At present the Aboriginal addict bounces between binging, goal? detox, too the streets again. There are few who find their way out of the morass - there are few avenues open to people that enable their addiction to be confronted and their lives restored.

We believe that through the implementation of the proposals in the Youth, Drug and Alcohol Program we can begin to change this. Much can be done to help current Aboriginal drug and alcohol users and to prevent the emergence of ever larger generations of young Aboriginal addicts.

SECTION A: HEROIN

Over the last eighteen months the Aboriginal Community of metropolitan Sydney has become increasingly alarmed at the influx of heroin into the Redfern Community, and the news of its spread into NSW country areas.

Heroin has been around for a decade or more, but Aboriginal users were few in Redfern. They came from somewhere else, passing through the Community, not usually passing their habit on to the Community. This situation has dramatically altered. Now, deals are done in Redfern streets and now, users are recruited daily. Heroin use is affecting not only the health of the individual user, but it is threatening the fabric of Aboriginal society in Redfern, already stressed by chronic poverty and unemployment. Theft is common, dirty needless lie around the streets, violence has increased, users hang around and occupy empty houses. It is the adolescents and the young unemployed who are the new users and they and their families are suffering.

Users steal, deal and/or prostitute themselves to support their habit. They have a dangerous and demanding career. Their health suffers from neglect and from exposure to a spectrum of diseases caught from dirty needles or caused by contaminated "dope". Their children are neglected.

The Community expressed its growing concern over twelve months ago, and the Redfern A.M.S. responded by establishing a Sub-committee for the Proposed Program for Users of Narcotics and Barbiturates. This Sub-committee included representatives from the Drug and Alcohol Authority, the Aboriginal Educational Consultative Group, A.M.S., Aboriginal Arts Board (A.A.B.), Aboriginal legal Service (A.L.S.) and interested individuals from the local community, including users and ex-users.

In addition, the AMS acquired C.E.P. funds to employ three drug counsellors. C.E.P. funding recently ceased so we no longer have drug counsellors. These moves constituted the beginnings of The Youth , Drug and Alcohol Programs.

The A.M.S. Sub-committee, with the invaluable help of the counsellors, has researched the extent of the problem in the Community, examined the treatment options available, canvassed the experts' opinions, and established an appropriate course of action.

They have concluded that at least 0.5% of the Aboriginal population of inner Sydney are i.v. drug users. The use of heroin and i.v. use of other drugs (for example speed) in Sydney has grown so quickly since 1982 that, in the absence of any intervention, the number of addicts will probably double within one to two years.

Heroin has caused a substantial change in the workload of the A.LS. and the A.M.S. in this period. Now about 20% of court appearances for Aborigines in Sydney directly relate to heroin, while in August 1986 at least 2% of the medical consultations at the Redfern A.M.S. were known to directly relate to heroin. This latter figure is significant. Heroin related presentations to the A.M.S. Doctors were rare three years ago. Users are often wary of using the A.M.S. - considering its proximity to the Police Station, the shame many feel in presenting with drug-related illness, and considering that most users ignore symptoms until illness is well established.

The devastating impact of heroin on the individual user and on the Community in Redfern is apparent. So we know we must intervene immediately, and in order to do so we propose the following:

1. INFORMATION/DROP-IN CENTRE

It is proposed that an Information/Drop-in Centre be established where current users can visit for information or a "chat", in a safe environment. The Centre will provide a contact point for users, and Counsellors will be available for life crisis intervention, counselling and appropriate referral if desired.

By this means the beginnings of a therapeutic relationship can be established.

Requirements:

- Two bedroom house
- Two full-time Counsellors
- Operating Costs.

COUNSELLOR: JOB DESCRIPTION:

It is envisaged that the Counsellor will provide the initial contact between the user and the avenues of treatment that will be open to him/her.

a) The Counsellor will promote drug and general health education among the users.

b) The Counsellor will provide information and support to the families of users.

c) The Counsellor will be involved in crisis intervention.

d) The Counsellor will liaise with and refer to relevant agencies and treatment facilities eg A.M.S. Medical clinic, C.E.S., A.L.S., A.M.S. Detox, and Rehab. Centre, when appropriate and acceptable to the user.

COUNSELLOR: JOB DESCRIPTION: (CONT)

e) The Counsellor may commence the individual counselling process with users - by telephone and/or "face to face".

f) The Counsellor will liaise with users in prison.

g) The Counsellor will initiate and maintain contact with the agencies of referral.

h) The Counsellor will follow-up and maintain contact with users, whenever possible.

The Counsellors will be responsible to the Board of Directors of the A.M.S., Redfern.

2. <u>DETOXIFICATION AND REHABILITATION UNIT/THERAPEUTIC COMMUNITY</u>

All the Detox. and Rehab. Centres in Sydney have been assessed by A.M.S. staff. None were suitable. It is difficult to get Aboriginal addicts to go to existing treatment Centres, and impossible to persuade them to stay. Occasionally, a user will complete detox., but then, at that crucial point, is left without further help because there are no Aboriginal Centres for long term rehabilitation.

Thus, we propose to establish a Detoxification and Rehabilitation Unit.

PREMISES:

It is envisaged that at least two large buildings with outdoor facilities will be needed - geographically separated from, but accessible to, the inner city. Accommodation will be provided for fifteen to twenty residents including space for small family groups.

DETOXIFICATION:

Detox. may take up to ten days. Those in Detox. will have separate accommodation within the Unit.

We wish to provide a range of Detox. options:

- Medicated
- Non-Medicated

The Detox. Unit, working closely with Redfern A.M.S., will provide a safe and culturally appropriate treatment facility for "drying out". It will also provide the supportive environment necessary in the immediate post-withdrawal period for the crucial decision-making process to begin.

REHABILITATION

It is essential that in conjunction (but not necessarily at the same place and definitely not in the same building) with the Detox. Unit, a Rehab. Unit be established to provide a culturally appropriate therapeutic community for those patients who need residential Rehab. to enable personal and lifestyle change. Such a Therapeutic Community could be effective for younger, short-term users and poly-drug abusers, of whom there is a relatively high proportion in the Community. Rehab. may take one to twelve months.

Half-way Houses will be established to accommodate those who have completed rehab but who need additional support or a place to stay on their return to the community.

STAFFING

The Unit will be staffed, where possible, by Aboriginal people. Non-Aboriginal people acceptable to the Community and with expertise not readily found in the Community will be employed when necessary.

Administrator/Co-ordinator:

One Administrator/Co-ordinator will oversee the Programs, liaise with other Services, manage the staff and the "household", attend to rosters and ensure culturally appropriate service is maintained. He/she will be responsible to the Board of Directors of the A.M.S., Redfern, as will all the Unit staff.

Nursing/Health Worker Staff

Eight Registered Nurses will be required to staff the Unit providing twenty four hour, seven day per week nursing cover, while eight Aboriginal Health Workers will support the nursing staff and be closely involved in patient care, counselling and follow-up.

Medical and Counselling Staff:

Access to the Services of a part-time Physician will allow a thorough initial medical assessment of all in-patients, most of whom will have complicating medical problems. This physician will also provide a part-time service to the Alcohol Detox. and Rehab. Unit and a consultant service to the A.M.S, Redfern.

A Doctor from the A.M.S., Redfern, will be available to visit the Unit when necessary, and dental health care will be provided through the A.M.S.

The services of a part-time Psychiatrist will be needed.

In addition, at least three of the Aboriginal Health Workers must be fully trained and experienced Drug and Alcohol Counsellors. They will act as resource people for the other Aboriginal Health Workers and will oversee group therapy and other aspects of the program.

One Welfare Officer (W.O.) will be required to be responsible for liaison with families and agencies that may assist the ex-user in his/her new life in the community. The W.O. will also be responsible for follow-up and on-going support for the ex-user.

Other Staff

One Handyperson/Craftworker/Gardener will be required to develop and manage suitable craft and gardening activities, as well as being responsible for the Unit's general maintenance.

Two Cooks/Housekeepers will be responsible for shopping, cooking, cleaning and general housekeeping.

The services of a part-time Accountant will be needed.

While Heroin has created an acute crisis in the Community, Alcohol continues to be the drug that wreaks the greatest on-going havoc on Aboriginal health, and, because of the violence and neglect that so often accompanies its abuse, on the social fabric of urban Aboriginal society.

At present there are no Aboriginal controlled and staffed Proclaimed Places nor Detox. Centres in Sydney. There is one Rehab. Centre - Bennelong's Haven. The latter uses the Alcoholics Anonymous Program, which, while successful for a few is inappropriate for many.

In the light of this, it is proposed that we establish:

1. A PROCLAIMED PLACE

The aim of a Proclaimed Place is not to detox. nor to reform alcoholics, but to give the homeless, chronic alcoholic a respite from the streets. It will provide people with a clean bed overnight and a nutritious meal.

If appropriate, residents will be referred to the Alcohol Detox. and Rehab. Unit.

Requirements:

- A large four bedroom house in the inner-city area providing accommodation for about 10 adults, both male and female.

- A Manager and a Housekeeper (two people living-in full-time).

- Operating Costs.

STAFFING

The Manager and the Housekeeper will be responsible to the Board of Directors at the A.M.S., Redfern.

They will shop and cook to provide an evening meal and breakfast for those staying the night. They will clean and maintain the house.

They will have access to the services of a Welfare Officer, Cousellors, the Doctors at the A.M.S. and any other relevant agencies.

DETOXIFICATION UNIT:

Detoxification from alcohol can pose some dangers for the patient.

An Alcohol Detox. Unit, staffed by Aboriginal people, under Aboriginal control, and with ready access to emergency medical care when necessary, is the requirement. It is yet to be decided whether this should be a Ward within an established hospital eg Rachel Forster Hospital, or a separate Unit.

The Unit should accommodate six to eight people and allow for a stay of seven to ten days.

STAFFING:

24 hour nursing cover
24 hour on-call medical cover
Drug and Alcohol Cousellors
Welfare Officer

3. REHABILITATION UNITS

It is proposed that we establish two Rehabilitation Units:

- A Suburban Unit with residential accommodation were a maximum of twenty residents, including space for small family groups.

- A country based residential rehabilitation unit.

PREMISES:

Both these premises are to be negotiated.

STAFFING (FOR EACH REHAB. UNIT)

The same principle of Aboriginalisation of staff, where possible, will apply.

Administrator/Co-ordinator:

One Administrator/Co-ordinator will oversee the Programs, liaise with other Services, manage the staff and the "household", and ensure culturally appropriate service is maintained. He/she will be responsible to the Board of Directors of the A.M.S., Redfern, as will all the Unit staff.

Medical Staff:

A part time Physician will be required. He/she will service both Alcohol and Heroin Detox. and Rehab. Units.

THE REHABILITATION PROGRAM

a) Aboriginal Studies:

A cornerstone in the Rehabilitation Program for Aboriginal addicts will be Aboriginal Studies. An addict often suffers from lack of identity, low self-esteem and no direction. An understanding of Aboriginal heritage and culture, a comprehension of our place in Australian history and a consciousness of the struggle - past and present, will help. In addition, Aboriginal Studies will encourage a sense of belonging in contemporary Aboriginal community life.

b) Living Skills Program

- Self and home management
- Budgeting
- Home safety for children
- Cooking/Nutrition
- Health Issues
- Literacy Skills
- How to use the resources the System does provide.

c) Activities Program:

An Activities Program will encourage resocialisation, the enjoyment of healthy activities and the acquisition of new skills.

- Sports
- Gardening
- Crafts

d) Counselling:

- Individual
- Group
- Relationship and Family Counselling

e) Personal Development Program:

- Relaxation Classes
- Behaviour Self-Management Techniques
- Assertiveness Training
- Self-Help Groups

f) Outreach Programs:

It is envisaged that Aboriginal Community Organisations eg Aboriginal Dance Theatre, Redfern, Tranby College, Eora Centre, National Aboriginal and Islander Dance Theatre, A.A.B., will be of assistance to the Rehab. Program, in that they will provide opportunities for training, employment and education, to those on the Program.

g) Narcotics Anonymous (N.A.)/NAR-ANON:

N.A. and NAR-ANON Support meetings will be available for those who are interested.

METHADONE PROGRAM:

Rehabilitation will include a suitable methadone maintenance program for those who need it.

3. EXTENDED REHABILITATION PROGRAM

For some of those who complete detox. and rehab. it is proposed that funds be made available for short (and in a selected number more long-term) visits to traditional communities. This opportunity will be therapeutic and therefore important, as it will enable the reaffirmation of Aboriginality and traditional values, which is integral to our treatment strategy.

SECTION B: ALCOHOL

Aboriginal alcohol addiction is often quite different from non-Aboriginal addiction. Aboriginal addiction is a legacy of colonisation and frequently has its roots in the hopelessness, lack of confidence and damaged self-esteem generated by the loss of Land and Cultural Identity, and compounded by the extreme soci-economic disadvantage that has been the lot of Aboriginal Communities for the last two hundred years.

While Culture and the means of livelihood were lost, one thing was given in return - Alcohol. Alcohol allows one to forget; it allows one to experience an albeit transient sense of potency. It alleviates the boredom, and sometimes hunger, and sometimes pain for which one is too shy or frightened to seek medical help.

Where there has been little else to share, there has always been "the grog" - and so alcohol has become an important ingredient in the social life of urban and fringe communities. However, prior to 1788, alcohol was unknown to Aboriginal people and they were not given the time necessary to integrate its use into their community and cultural life.

It will provide a place for children to go and to meet with friends. It will have recreational and sporting facilities, and a health food snack bar. Regular classes in various crafts will be held, using Outreach Workers from TAFE.

Youth Workers will be employed at the Centre, and as well as assisting the children in whatever way is necessary, they will be a source of accurate information and advice about drugs and alcohol.

In association with the Youth Centre, drug and alcohol free activities can be organised.

- Bush/Holiday camps:

  Bush Camps were organised by the A.M.S. for the youth of the area, in 1985/86. Their aim is to instill pride in the Aboriginal Culture by caring and sharing, and to show the young people that there are alternatives to a lifestyle of drugs and alcohol.

- Disco:

  In order to provide entertainment for the youth and children in a safe, drug-free environment, the A.M.S. in conjunction with the Sydney University Settlement and the local Community, conducted a Disco every Saturday night, in 1985.

  Funds are needed to recommence this Disco.

*** See Aboriginal Medical Service Youth Support Program Submission, 1986.

EMERGENCY HOSTEL ACCOMMODATION FOR ADOLESCENTS: ***

There is a desperate need for crisis accommodation for adolescents and homeless young people in the inner-city.

*** See Submission to Youth and Community Services from Redfern Aboriginal Community Youth Support Committee, 1986.

EDUCATION PROGRAM:

A Drug and Alcohol Education Program based on the home, the school and the Community, and directed towards youth and adults alike, but with special emphasis on the needs of the Youth, is essential.

The School:

The encouragement of drug education and of Aboriginal Studies is important.

The Home/The Community

Radio Redfern:

Radio Redfern has a powerful influence on community attitude formation, and this influence can be used in the fight against Drug and Alcohol abuse.

- drug education programs
- talk-back programs on the issues.

The Youth Centre:

The Youth Centre will provide a drug and alcohol - free venue that is fun, and information on Drugs and Alcohol will be available to the children, there.

- Posters, videos, comics and T-shirts can all be successfully used to give a message.

- the Youth Workers will be a source of accurate information and couselling, and will prompt discussion on the subject.

Other Aboriginal Organisations, the A.M.S, Eora Centre, The Eloura Centre can be used as venues for discussion and/or outlets for drug education information

MEDIA CAMPAIGN:

We see the Media Campaign as an important facet of the Education Program.

The concepts must be expressed in appropriate language and the presentation must be suitable for Aboriginal Youth. The distribution of this material must be done through channels that will reach the Youth of the Aboriginal Community.

The kinds of media which are appropriate include Radio Redfern, Posters, Videos (shown at the Youth Centre, A.M.S. waiting room), T-shirts and Comics.

A well advertised Aboriginal Drug Information (and/or Counselling) Telephone Service would be useful.

The services of a part time Psychiatrist will be needed.

General Dental and Health Care will be available from the A.M.S., Redfern.

Aboriginal Health Workers/Counsellors:

Four Aboriginal Health Workers who have had Drug and Alcohol Counsellor training will be required to organise the self-help groups, conduct group therapy and run counselling sessions.

Other Staff

One housekeeper who will be responsible for shopping, budgeting and the stores, is needed. He/she will organise the residents' cooking and cleaning rosters as part of the Living Skills Program.

One Welfare Officer will be responsible for liaison with families and agencies that may assist the ex-alcoholic in his/her new life in the community. This W.O. will service the Proclaimed Place, the Alcoholic Detoxification Unit and both Alcoholic Rehabilitation Units.

THE REHABILITATION PROGRAM

The Rehabiliation Program will be similar to that described in Section A. However, we recognise that the "Alcoholic" population is different from the "Using" population, and that their needs may differ.

a) Aboriginal Studies will be incorporated into the Program.

b) Living Skills Program

c) Activities Program

d) Counselling

- individual
- group
- family and relationship counselling

e) Personal Development Programs

f) Outreach and Work Oriented Program

g) Alcoholics Anonymous/AL-ANON/ALA-TEEN Support Meetings will be available.

Special Housing for rehabilitated clients will be needed on return to the Community, with continuing counselling and A.A. meetings and support from the Welfare Officer and the Aboriginal Health Workers. Those who complete the Alcohol Detoxification and Rehabilitation Program will be eligible for the Extended Rehabilitation Program as described on page 9.

SECTION C : YOUTH PROGRAM

While it is mandatory that we do all that we can to assist the users and ex-users and the alcoholics, the A.M.S. feels that its primary aim and responsibility is to curb and spread of heroin and other drug addiction among Aboriginal youth.

In general Aboriginal children are severely disadvantaged. They are disadvantaged by poverty, over-crowding, poor environmental facilities and inequality of opportunity from the time of their birth. They are exposed to drug and alcohol abuse from an early age.

Early school-leaving, unemployment, no expectation of job training nor much hope of any secure employment, is the rule for many of the young people. At present, there is little for the adolescents and youth of the inner-city to do, and nowhere, that is drug and alcohol free, to go. In addition, there is widespread ignorance about drugs and the health issues associated with their use.

While this situation persists, the excitement and intrigue that surrounds drug use is particularly irresistible.

So we propose to establish a Youth Program aimed at education and the prevention of addiction among the Aboriginal youth in the Community. The proposals contained within this Program are described in this Section.

1. YOUTH CENTRE: ***

It is proposed that we establish a Youth Centre for the Aboriginal youth of the inner-city. It is to be situated away from the adult social venues where drugs and alcohol are available.

APPENDIX XI

AMENDED DRAFT SUBSTANCE ABUSE POLICY PAPER PREPARED BY THE NATIONAL ABORIGINAL AND ISLANDER SUBSTANCE ABUSE COUNCIL

The term "substance abuse" refers to harmful, excessive or non-medical use of any mood altering substance or drug which results in physical, psychological and spiritual or social damage to the user and or/those closely associated with the user.

Substances seen to be of danger to the Aboriginal and Torres Strait Islander population of Australia include alcohol, volatile substances such as petrol, glue and aerosol propellants, kava, prescribed drugs such as valium serepax and other tranquillisers, analgesics and tobacco and such illicit drugs as heroin, cannabis, cocaine and amphetamines. All of these substances represent a potential health threat to the Aboriginal population.

Policy Objectives

To identify and restrict the harmful consequences of substance abuse in Aboriginal and Torres Strait Islander communities. Assist Aboriginal and Torres Strait Islander communities to remain free of Substance Abuse.

Strategic Goals

(1) Encourage and assist by education and prevention program, the development of an environment in which Aboriginal and Torres Strait Islander people are able to make fully informed decisions about the use and abuse of substance's including alcohol and other drugs.

(2) To address all social, educational, economic and environmental inequalities which are conducive to substance abuse.

(3) Special emphasis must be given to Aboriginal and Torres Strait Islanders community initiated and managed alcohol and substance abuse projects and programs.

(4) Co-operation with other State and Federal Departments and Agencies to improve and develop the availability of appropriate services and programs aimed at the prevention, assessment, treatment and rehabilitation of Aboriginal and Torres Strait Islander people with substance abuse problems.

Program Strategies:

(1) Support the development of appropriate Aboriginal and Torres Strait Islanders community based awareness and preventive programs against substance abuse.

(2) Support the establishment of Aboriginal and Torres Strait Islanders residential and community based non-residential counselling referral, rehabilitation and support services to assist in the rehabilitation of Aboriginal and Torres Strait Islander clients in urban, rural and remote area communities.

(2A) Encourage and support the establishment, improvement and accessability of community based residential and non-residential services providing intervention and prevention strategies.

(3) Liaise and co-operate with State and Territory Health Departments, Drug and Alcohol Authorities and other relevant agencies to ensure that Aboriginal and Torres Strait Islanders have access to residential detoxification treatment and rehabilitation programs, and educate people employed in these services of the unique needs of Aboriginal and Torres Strait Islander people.

(3A) That funding agencies support the establishment, development, enhancement and accessibility of Aboriginal and Torres Strait Islander residential detoxification services dealing with alcohol and substance abuse problems.

(4) Encourage State drug and alcohol authorities to have Aboriginal and Torres Strait Islander representatives on their board who are selected by Aboriginal and Torres Strait Islanders substance abuse workers.

(5) Encourage and support the availability to the Aboriginal and Torres Strait Islander population of positive alternatives to substance abuse. Such initiatives should encourage self responsibility and self management and include improved opportunities for formal and informal education, trade and professional training, recreational, sporting and cultural activities that will promote a fulfilling and satisfying lifestyle.

(6) Promote selective research which will provide baseline data on the extent and nature of substance abuse by Aboriginal and Torres Strait Islanders, identify appropriate interventions and measure the success of prevention treatment and rehabilitation services in consultation with appropriate Aboriginal and Torres Strait Islanders substance abuse workers.

Project Instructions

In selecting projects for support, preference should be given to those which

- provide logical and attainable aims and objectives;
- are Aboriginal and Torres Strait Islander community initiatives under Aboriginal and Torres Strait Islander community control;
- are staffed by Aboriginal and Torres Strait Islanders with suitable training and experience in substance abuse services, a criteria is that employees are sober and that Aboriginal and Torres Strait Islander ex-addicts are given a high priority for employment;
- plan for Aboriginal and Torres Strait Islander staff to be trained to take over executive administrative, training and counselling positions on programs which are presently filled by non-Aboriginal/Islander people;
- plan for Administration Staff from Departments and agencies both Commonwealth and State to be Aboriginal and Torres Strait Islanders with an appreciation of alcohol and substance abuse issues;
- have an educative and preventive role;
- provide intervention, prevention and education that are directed to the young;
- complement rather than duplicate existing services;
- encourage responsible attitudes and behaviour towards mood altering substances;
- provide non-residential services and follow up programs at community level and residential care in Aboriginal and Torres Strait Islander substance abuse programs;

- are linked to the development of youth, sport, cultural and recreational programs where possible;

- encourage the use of residential treatment and rehabilitation services provided for the Aboriginal and Torres Strait Islander and the general community;

- are willing to provide to the Department such statistics as are required to allow assessment of the effectiveness of the project, provided it does not breach confidentiality - this data to be provided 6 monthly.

A. Specific emphasis should be given to Aboriginal and Torres Strait Islander women issues.

B. Specific emphasis should be given to Aboriginal and Torres Strait Islander aged and disabled people with substance abuse related problems.

C. Specific emphasis to existing and co-dependency programs dealing with substance abuse related problems.

D. Specific emphasis to pre and post prisoners programs with substance abuse related problems.

E. Specific emphasis to Aboriginal and Torres Strait Islander with mental health problems caused by substance abuse.

(14) Appropriate accredited training programs for alcohol and substance abuse workers, using an accredited training programs as a model.

Performance Indicators

(1) Macro Indicators (Outcomes) - Statistics on national evidence of alcoholism, and other forms of substance abuse by age and sex to be provided by the Department's Statistical Unit from State and Federal epidemiological and sociological research sources.

2. Outlined a course of action to promote the positive use of the guidelines in the evaluation of proposals for research funding in Aboriginal health,

3. Identified mechanisms which outline and guarantee the pivotal role of Aboriginal communities in the design, execution and evaluation of research into Aboriginal health,

4. Identified the necessary steps and agencies to which the Guidelines are to be promulgated,

5. Identified the on-going consultation process with Aboriginal communities in respect of the above.

Having completed this task a broader workshop outline was considered and adopted. This approach fostered a sessional format in the Workshop and was based on:

- The role of research in Aboriginal health,
- The relenance of research within the Aboriginal reality,
- Principles, Standards and Rules - benefits and shortfalls,
- What are the right words - a drafting session,
- final review - confirmation of the workshop results.

These five sessions provided the focus for further discussions and development.

THE PROCESS OF CONSULTATION

This National Workshop heard, as the Alice Springs Conference had, of Aboriginal communities disatification with the historical approach of researchers to the need for consultation/negotiation in respect of the subject matter and methodology of research in Aboriginal health. There was considerable discussion on the question of whether the development of "Guidelines" on this matter would be sufficient to bring about the sought of attitudinal and behavioural change Aboriginal communities were seeking.

The was broad agreement that there was a need for some yardstick against which the approach and attitude of researchers would be gauged. This yardstick would be established to reflect what communities thought to be a minimum level and process of consultaion/negotiation necessary to ensure the problems of the past were not repeated. The workshop considered that the term "Guidelines" did not convey the necessary tenor, rather it was suggested that the phrase of Principles, Standards and Rules was a clearer and more appropriate description on content and intent. This phrase was adopted by the workshop as the title of our work.

The Process of Consultation

Research in the past, the workshop discussed had been invasive and conducted with little or no real consultation/negotiation with Aboriginal communities. The workshop agreed that this was not appropriate. The lack of consultation/negotiation had contributed to conflicts within Aboriginal communities and between communities and research agents, misconceptions about Aboriginal culture and communities, inaccuracies in research findings and reinforced Aboriginal communities suspicion of research generally as a tool of health improvement.

The workshop endorsed the principle of Aboriginal self determination as fundamental in any consultation/negotiation process. This was taken to mean that Aboriginal communities have the right to approach any discussion on research from a point responsive to Aboriginal interests and culture. The workshop was anxious to identify a process whcih clearly encompassed this principle. Participants recalled experiences where single communitiy members had been approach for comment on particular proposals in isolation from broader discussion with the community. Similarily, there were cases cited where the cultural regimen was ignored resulting in the wrong people being asked to comment on maters which, in a cultural context were not their perogrative to discuss. Such actions were considered inappropriate and unacceptable.

A process of consultation/negotiation had to be identified which

ensured proper discussion through community mechanisms, control of which was vested in the communities. This was necessary to ensure that communities could have trust in the process. A number of examples were noted in which researchers had sought advice and approval of Aboriginal individuals in Government Departments as a substitute for proper community consulations/negotiations. While this may have been the result of ignorance, the effect was to deny communitites appropriate examination and discussion of the proposals. The workshop was concerned to address these and other difficulties.

Additionally, the process identified had to accommodate the various geographic and cultural circumstances of Aboriginal communities.

That process is outlined below.

A. Where a local Aboriginal community controlled Health Services Exists

That the primary point of contact for researchers shall be the local community controlled Aboriginal Health Service and the National Aboriginal and Islander Health Organisation. Where the subject matter of research has not previously recieved ethical approval from that community, that the matter should be the subject of a community meeting or meetings.

B. Where a local community controlled Aboriginal Health Service does not exist

That the primary point of contact for researchers shall be the local community controlled agencies and the National Aboriginal and Islander Health Organisation. Where the subject matter of research has not previously recieved ethical approval from that community, that the matter should be the subject of community meeting or meetings

C. Where no local community controlled Aboriginal agency exists

that local community structures must be respected and that researchers must firstly seek proper Aboriginal community involvement and approval at the local level and with the National Aboriginal and Islander Health Organisation. Where the subject matter of research has not previously recieved ethical approval from that community, that the matter should be the subject of community meeting or meetings.

The Workshop agreed that Researchers would be required to provide funding agencies and responsible Ethics Committees with appropriate documentation and other such evidence which demonstrated that proper community consultation has occured.

The meeting then addressed the question of "how does a researcher demonstrate that they have consulted/negotiated properly". It was considered appropriate that the workshop should identify a series of benchmarks, compliance with which would demonstrate acceptable consultation/negotiation.

These benchmarks are as follows:

- provide written documentation demonstrating support and consent from communities for the particular research proposals including evidence that shows that information was provided according to the level of comprehension of the community. Such documentation should come from the local community controlled agency.

- provide evidence of meetings with the concerned Aboriginal community, including what specific efforts have been taken to inform the community i.e. translations

- demonstrate that they have considered the benefit to the community, including efforts to promote sharing of research skills

- demonstrate that they have addressed the question of ownership of materials

- demonstrate the degree to which the researcher has addressed social and cultural imperatives within the community.

In formulating these benchmarks the Workshop was concerned that Ethics Committees should carelfully assess the researchers compliance with each of the above. The meeting was careful to identify the most important standards in order to ensure that an acceptable basline of approach was established.

On Going Review and Funding of Research

Within the process outlined above the role of local community controlled agencies was central. This role was not seen as a once off function, the workshop agreed that local community controlled agencies had an on-going function in monitoring the implementation of research projects. In discussing this function the workshop considered a number of options which were intended to maximise community scruitiny and participation in the implementation stages.

The workshop noted that established Research Ethics Committee maintained an overview of projects for which they had granted ethical approval (...to maintain survielance of projects until completion so that the committee may be satisfied that they continue to conform with approved ethical standards - N.H.& M.R.C. SUPPLEMENTARY NOTES, 1985). Should at some time during the implementation of the project a situation arise whereby ethical standards were contravened mechanisms were available to compel researchers to adjust their approach. The workshop accepted that a similar approach should be adopted in the case of research in Aboriginal health.

The workshop considered that control of the funding of research was the most effective way of maintaining appropriate control over the ethical behaviour of research initiatives. Whereas Universities and other such institutions fulfil the role of administering funds, the Workshop agreed that the local Aboriginal Health Service or local

community controlled agencies should likewise administer funds for projects within their communities. The relationship between locally determined ethical standards and the administration of project funding would, in this way be a most effective monitoring mechanism.

The Workshop subsequently endorsed the following position:

- That where Aboriginal Health Services exist they be responsible for the administration of funds for research initiatives

- that where no local community controlled Health Service exists that the local community controlled agency be responsible for the administration of funds

- that where no local community controlled agency exists that funding be administered by an agreed community controlled agency, such as the National Aboriginal and Islander Health Organisation.

A National Perspective

The Workshop had so far considered projects which had a local or limited impact area. In turning to research projects of a national nature, such as a national measles or childhood immunisation research project the workshop again built upon community structures as the most appropriate mechanisms for determining and monitoring ethical standards.

The Workshop agreed that there should be established a National Research and Ethics Committee, auspiced by the National Aboriginal and Islander Health Organisation.

It would be the role of this committee:

- consider ethical approval for research initiatives of a national nature

- imput into the national allocation of research dollars to Aboriginal health

Where this Committee grants ethical approval for an initiative the workshop agreed that the auspice body of the committee, the National Aboriginal and Islander Health Organisation should administer research funds. The meeting was concerned that additional funds be provided to the auspice body to meet costs of the committee's operation.

SOCIAL AND GENDER ISSUES

The Workshop recognised that the most difficult ethical issues related to social and cultural perspectives.

In discussing these issues, participants adopted an approach which recognised the cultural responsibilities and sensativities of "womens" and "mens" business. As a consequence the Workshop divided, following a short introductory session into groups based on these cultural responsibilities and sensetatives.

This report does not go into specific detail on the nature of these discussions only in sofaras is required to describe the necessary standards the Workshop thought were needed in this important area.

The following statement was carefully drafted taking into account the nature and emphasis of these discussions. All participants have agreed to the text.

"The process of research in Aboriginal health presents potential areas of social and cultrual conflict. Researchers must address this potential for conflict. The use by Researchers of assumptions of moral, social or cultural correctness or appropriateness will interfer with community lifeways and denegrate research.

In the development, delivery and evaluation of research proposals Researchers must seek to clarificationa and approval from the community. If this process requires methjodological modification then the community should review and consider its consent of such modifications, to ensure protection of community lifeways.

The local community controlled agency is responsible for assessing and approving such issues.

Researchers should take great care in areas of research that deal with:

1. gender
2. parenting, family and community structures and responsibilities
3. personnal and collective relationships
4. invasions of the body
5. handeling of human specimens and products

In approaching these matters the Reasercher must also be aware that their social status, as determined by the community, as well as gender will be a vital consideration in determining access to sensitive areas.

Specifically, Aboriginal women , as advised by the community must be involved when research deals with womens or childrens health issues. As a consequence Aboriginal women are to monitor all research dealing

with womens and childrens issues.

Likewise Researchers must not ignor the specific cultural and social needs of Aboriginal men in research programs.

The particular issue of post mortem examinations needs close attention and any research of this natire must respect the integrity of the person and relationships with the family, community and nation. For example the removal and withholding of organs presents particular difficulties.

The responsibility of researchers to gard against violation of cultural and social imperatives beyond the primary contact with the community must also be addressed. The Researcher should seek the approval of the community in such instances.

Researchers must provide the community with an understanding of the process of research which includes collection and analysis of data and the drafting and publication of reports.

Researchers must be aware that any breeches of Aboriginal Lore/law may invoke community rebuff and/or punishment.

C O M M U N I C A T I O N

A N D

C O N S E N T.

Communication and cosent were two issues recognised as fundamental to the development of ethical standards in the area of Aboriginal health research. It was recognised that Aboriginal health research touches on many areas which are made more sensative because of uncertanities created by cross cultural influences.

The Workshop saw that some of these uncertainities may be based on a lack of understanding, on the part of researchers about Aboriginal culture and community lifeways. Researchers may unwittingly impugn standards because of a lack of specific knowledge. It was also recognised however that a small number of researchers have used cross cultural barriers in an unscrupolous manner.

In developing standards, the Workshop sought to ensure that Researchers were guided in an approach to the provision of information to communities that avoided misunderstandings.

Participants were conscious to ensure that Standards in this field reflected the fact that the provision of information and the obtaining of consent was not regarded as a once of or superifical excerise. Communities are concerned to know about the entire process of research from initial discussions, through implementation to publication of research reports, and in order that this concern be address Researchers should be prepared to provide information on and obtain consent to each stage of the research process.

The following text was accepted by the Workshop:

"Communities must be provided with all the relevent information and explanations on the intent, process and methodology, evaluation and potential use of any research proposal.

This information must be provided at the level of comprehension of the community and must utalise appropriate Aboriginal educational process and tools.

Researchers must comply with any request for further information from local community controlled agencies.

The obligation of reseachers to comply with this requirement shall remain in force for the duration of any research project.

In meeting the requirement of this document to obtain the consent of communities to research, Investigators must resapect the Aboriginal communities process of decision making. Community processes of

decision making shall reflect varing social and cultural values.

Investigators must address, with care this need ensuring that they do not act in a pre-emtive or impulsive manner. For example Researchers must allow sufficient lead time for the community to consider any proposla nor should they seek to access sub groups or individuals without prior permission.

Having addressed this process however researchers must be aware of the continuing need to obtain the consent of individual Aboriginal people that may either participant or contribute to the execution of any research project."

COMMUNITY BENEFIT

AND

EMPLOYMENT OF LOCAL PEOPLE

Research, above all must be relevant to needs. The Workshop was clear in its support for this concept. In too many instances had researchers embarked on a research initiatives which had little or no relevance to the needs of Aboriginal communities. The Workshop considered that too often research had been used as a vehicle for agrandisement rather than betterment of peoples. It was agreed that measures were required to ensure that research in Aboriginal health contributed to a principle purpose, that of improving the health of Aboriginal Peoples.

This, in the opinion of the Workshop could be achieved in a number of direct and indirect ways. Researchers, in seeking to directly benefit communities could examine a specific health condition in Aboriginal communities and seek to devise strategies intended to address this need. Alternatively, benefit could accrue to communities where Researchers, in the course of their work, shared various research skills with local communities members by employing such people in the research team.

Employment of local community members, however was considered by the Workshop to be of further benefit. Such employment was recognised as a prime means of avoiding the difficulties of past experience. With local people employed research teams would benefit from local knowledge of lore, lifeways and other sensative issues.

The following text was accepted by the Workshop:

"Researchers seeking to work in Aboriginal communitites may confront a variety of unfamiliar environments and circumstances. In many circumstances the employment of community members will aid the Researcher and improve the quality of communication and ultimately strengthen the initiative.

Reseachers, where local community controlled agencies believe it necessary must provide for the employment of local Aboriginal co-investigators

Research needs to address and provides knowledge to an improvement in ABoriginal health and community development.

Researchers must identify the areas and nature of the potential benefit and impact and obtain the concurrance of the local community controlled agencies that such outcomes are of value to the community at large."

O W N E R S H I P

A N D

P U B L I C A T I O N O F M A T E R I A L S

Research material and data shall remain the property of the community. The community retains the right to censor research materials of a sensative nature.

Prior to any publication or other use of research materials or Reports the approval of the LCC agency is required.

In preparing acknowledgement of research attention must be had to the proper accreditation of participation and assistance.

Results of research must not be published in a form that permits identification of individual subjects. Pictorial material should only be made with the consent of the local commmunity and should be handled according to their wishes.

Researchers need to be aware that future utalisation and publication, if contemplated may be jeopardised by the inclusion of such materials examples of which include - inclusion of materials depicting or relating to deceased persons may cause related research material to be withdrawn from use.

EXPLOITATION OF COMMUNITY RESOURCES

Aboriginal community controlled organisations rarely have the financial and other resources necessary to fulfil community needs. Therefore any additional drain on available resources detracts from the potential for achievment of community goals. Researchers must understand that local community controlled agencies are not resourced to accommodate the additional cost burden that research projects may involve.

Researchers must therefore address the question of proper utalisation of communtiy reesources.

In seeking the co-operation of Aboriginal communities and local community controlled agencies they (researchers) must provide reimbursement of any cost incurred which relate directly or indirectly to programs of research. Such costs could include etelphones, transport, freight, gas and water, accommodation, supervision costs and wages of assistants or intepreters.

G O A L S A N D O B J E C T I V E S

O F

T H E W O R K S H O P

The Conference in Alice Springs provided a useful basis for the development of appropriate and achievable Goals and Objectives for the National Workshop. These were to:

1. develop a set of ethical guidelines on research into Aboriginal health

and

2. identify the mechanisms necessary to establish a nexus between the guidelines and the funding of research into Aboriginal health.

These two principle aims were complimented by a number of statements which clarified the direction and nature of the these aims. These were:

- that Aboriginal communities be given a greater say in the distribution of funds, allocation of priorities, the methodologies of research and the implementation and evaluation of research proposals;

- that Aboriginal communites be central to the development and execution of research;

- that communites recieve financial support for research and development training;

- research which reflects the collective nature and needs of Aboriginal communites be given priority over that which is individualistically oriented;

- that priority be given to issues for research that are identified by Aboriginal communities.

The Workshop considered these matters and comments and adopted a set of Goals and Objectives for the Tallimba workshop. These were:-

That by the conclusion of the Workshop we shall have:

1. prepare a draft document which outlines the ethical responsibilities relating to research in Aboriginal health,

That Workshop was convened in August, 1987 and was funded by the N.H. & M.R.C. Held at "Tallimba", near Camden N.S.W. it was attended by some 30 Aboriginal community representatives and other delegates from around Australia. The Workshop met for 3 days. A list of workshop participants is attached at Appendix B.

The Workshop was recorded and minutes have been prepared. The Report which follows is based on the preliminary minutes and convenors notes from the workshop.

APPENDIX XII

REPORT OF THE NATIONAL WORKSHOP ON ETHICS OF RESEARCH IN ABORIGINAL HEALTH

CONVENOR: Shane Houston

No of Clients Treated | Males | Females

- Daily Average
- Shortest Stay
- Longest Stay

No of Clients Admitted to Program
No of Clients Completing Program
No of Group Counselling Sessions Per Week
No of Individual Counselling Sessions Per Week
No of Referrals to Program
No of Referrals from Program
No of AA Meetings Per Week
No of Clients Retaining Sobriety for 3 months
No of Clients Retaining Sobriety for 6 months
No deaths Alcohol related 6 month period
No of clients Retaining Sobriety for 12 months
No of Clients who have dramatically reduced their alcohol intake since involvement with this program

Other activities

List of Associated Agencies with whom regular contact maintained.
Brief description of weekly program activities

Project Indicators

Program Title .....

Location .....Aboriginal Population .....

Nearest Detoxification Service (Name & Location .....)

Service Provided (underline)	Treatment, Rehabilitation, Halfway House, Community Counselling, Support Service, Other (specify)
Type of Service (underline)	Residential/Non-Residential
Staff Employed (M/F)	Classification - Qualifications held

F O R W A R D

In November, 1986 the National Health and Medical Research Council (N.H.& M.R.C.) and the Menzies Foundation convened, in Alice Springs a national conference on "Research Priorities in Aboriginal Health". Emerging from that conference was a series of recommendations which called on the N.H.& M.R.C. to provide resources to Aboriginal communities to convene a further national workshop which was to address the "contentious" issue of ethics, as it relates to Aboriginal health research.

The Alice Springs Conference adopted the following specific recommendations:

- that ethical guidelines for health research involving Aborigines be established,
- that these guidelines be establiahed by a forum of Aboriginal people...within 6 months,
- that this forum use as a basis for these guidelines a number of specific and general guidelines already in existance i.e. Research guidelines of C.A.A.C.,
- that the close relationship between ethical guidelines and criteria for funding of research projects be recognised,
- that the Conference nominate an Aboriginal person to act as Convenor (Shane Houston was subsequently elected),
- that there be Aboriginal representation on the N.H. & M.R.C. Ethics Committee.

(A complete copy of the Alice Springs Conference's recommendations is attached at A.)

It is obivious that the Conference, particularily the Aboriginal participants placed considerable emphasis on the need for action in this field.

Following agreement from the conference a Convenor was elected whose responsibility it would be to draw together Aboriginal community representatives from around Australia in a national workshop with a view to producing a set of guidelines on the Ethical Responsibilities of Research in Aboriginal Health.

C06-0443d

NHMRC SUBMISSION TO THE NATIONAL ABORIGINAL HEALTH STRATEGY WORKING PARTY

1. INTRODUCTION

1.1 The NHMRC, which has a responsibility for identifying national health needs and priorities, recognises that improvement in Aboriginal health must be a major national and NHMRC priority.

1.2 Through its Principal Committees, the NHMRC has:

(a) a record of initiatives in Aboriginal health (Appendix I);

(b) the potential to make substantial contributions to Aboriginal Health (see Section 5) (Appendix I).

1.3 As an organisation, NHMRC could contribute to:

- programs of research and training;
- information gathering services;
- monitoring and evaluation of programs;
- policy and guideline formulation;

through (i) its existing committee structure (Appendix I); and

(ii) its support of Aboriginal Health Research and Training (see Section 5.1).

2. ABORIGINAL HEALTH PROBLEMS

The NHMRC considers that there are a number of categories of Aboriginal health problems which should be assigned a high priority. These are:

2.1 Those diseases which are the major causes of death in Aboriginal adults, including pneumonia and the lifestyle-related diseases of diabetes, hypertension, stroke, ischaemic heart disease, chronic respiratory disease, lung cancer and alcohol-related deaths, as well as infectious diseases and trauma.

2.2 The still high perinatal mortality and low birthweight of Aboriginal children, and the high rates of childhood diseases such as respiratory infections, skin, ear, eye, gut and kidney infections, nephritis, rheumatic fever and enteric parasites. (In general, therefore, while 2.1 indicates the need for an increased emphasis on adult programs, this should not be at the expense of programs directed at children.)

2.3 Those diseases linked with inadequate living conditions, especially with regard to housing, water supply and sanitation. Trachoma is one of the high incidence diseases which are exacerbated by problems in this area.

2.4 The sexually transmitted diseases, with special attention to AIDS.

2.5 The major and over-riding health consequences, both physical and psychological, that come from being a disadvantaged sector of the Australian population. This is a major sociological problem that will need to be addressed in any comprehensive approach to Aboriginal health.

3. ABORIGINAL INVOLVEMENT AND PRIMARY HEALTH CARE

The NHMRC supports the continuous involvement of Aboriginal representatives and community members in all developments and initiatives aimed at improving their health, both at the consultative phase of program design, and in the management and evaluation of specific programs. Self-management may well be a pivotal factor in health improvement.

Primary Health Care is considered to be a key strategy in improving Aboriginal health. As defined by the WHO (1978), it is the universal accessability of essential health care "to individuals and families in the community, through their full participation and at a cost that the community and country can afford". (The essential elements of Primary Health Care are outlined in Section 4).

4. A SYNTHESIS OF THE NHMRC'S VIEWS ABOUT THE DIRECTION OF THE HEALTH STRATEGY FOR ABORIGINAL HEALTH

Health research endeavours are important to the improvement of Aboriginal health. The whole spectrum of methodologies and models within science can be considered. Thus, there is a place for the simplest forms of evaluation of a health promotion or educational endeavour, and for small scale epidemiological studies as well as large scale and very extensive population studies. Clinical studies are fundamentally important where the pattern of illness in the Aboriginal community is different from that in the rest of Australia, for example in conditions such as gastroenteritis

and respiratory disorder, nose and throat disease, eye disease, diabetes, prevalence of cardiovascular disease etc. Finally, there is an important place for basic research whether this be biological or anthropological in nature.

We believe that the full range of health services should be available to Aboriginal people, and that there is a need to consider strategies for improving the efficiency, effectiveness and acceptability of such services for Aboriginal people.

The huge investment in hospital services has been criticised as being irrelevant to Aboriginal people, and the NHMRC acknowledges that hospital and other tertiary services may at times be provided in ways that are not in accord with Aboriginal culture. However, there is evidence that such services have helped in the past to reduce mortality from childhood diarrhoea and other indicator conditions, and there is also evidence that Aboriginal health is poorer where there is limited utilisation of hospital services. Consultation with and involvement of Aboriginal community representatives is essential to ensure that delivery of tertiary services is acceptable to the local community.

In addition, there are differences between Aboriginal communities in the patterns of utilisation of primary health care services, and there is evidence to indicate that child health is worse in communities with lower rates of utilisation of primary care services.

It can therefore be argued that while the provision of tertiary care to the Aboriginal community should not be diminished, there has to be a much more robust and well-resourced thrust in the area of primary health care. The essential elements of the primary health care endeavour include:

- promotion of good nutrition;
- adequate, accessible, safe water;
- basic sanitation;
- appropriate housing;
- maternal and child health care, including family planning;
- immunisation against major infectious diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs;
- promotion of mental health;
- community participation in determining priorities and developing programs.

(World Health Organisation Unicef. Primary Health Care World Health Organisation, Geneva, 1978)

A sound primary health care program would promote self reliance and community development. However, within such a list there are many complex questions and major knowledge gaps that need to be filled.

There are two main kinds of knowledge gap:

(1) areas of knowledge that are exclusive to one or other group within a community:

- the Aboriginal members, for example, have a large store of cultural and personal knowledge which is both relevant to their health behaviours and often misunderstood or dismissed by non-Aboriginal health workers and researchers. Similarly, health scientists have a range of technical and clinical expertise that Aboriginal communities would find extremely useful. Effective methods of exchanging these different types of knowledge need to be developed and utilised so that the health scientists can be educated as to the best ways of working within the context of Aboriginal culture, and ways are developed so that the Aboriginal community can make best use of modern health knowledge.

(2) areas of ignorance shared by all the groups within a community:

- here, research needs to occur in order to discover new information which would help to solve health problems that have been identified.

These problems are not necessarily of a high technology or biomedical variety. They may be as simple as the design of basic health hardware. Projects such as the Uwankara Palyanyku Kanyintjaku (UPK) project may need to be repeated in many centres.

Much of the work that would need to be done is in the health education area and such programs will require research which would best be carried out by combinations of Aboriginal health workers and social scientists working in collaboration with epidemiologists and clinicians. Such programs would advance the concept of self management, which must be fundamental to a sense of self esteem and personal competence. A community sense of its own self worth is an important building block in a capacity to remain healthy.

Methods of training health workers, not only to provide a service but also to conduct research are important to this program. This could be promoted through the NHMRC and through existing organisations such as the Menzies School of Research.

No program of work could be satisfactorily carried out by a single health organisation on its own. Co-operation between the Aboriginal communities and educationalists, social

scientists, lawyers and other experts will be fundamental to any comprehensive strategy.

5. FUTURE ROLES FOR THE NHMRC IN ABORIGINAL HEALTH

The NHMRC is an experienced body in matters of health research and the conduct of research programs.

It could play a part in a total strategy and has expertise to offer. The following areas may be considered as useful contributions.

5.1 The NHMRC would strongly support a formally organised initiative in Aboriginal Health Research and Training. High-level Aboriginal participation is regarded as essential to such an initiative, which should include the following important activities:

(a) curriculum development and training of Aboriginal and non-Aboriginal health workers in:

- research and evaluation techniques;
- self-management approaches;
- remote area nursing and health care;
- public health and preventive medicine.

(b) Continuing research into clinical aspects of major causes of Aboriginal mortality and morbidity, and their control.

(c) The development of health education programs.

(d) Research into and monitoring of intervention programs.

(e) The evaluation of models for the delivery of health services.

A significant objective of this formal initiative would be to use the information collected about Aboriginal health and related social issues when developing intervention programs. These would then be trialled in a manner worked out jointly with the Aboriginal communities involved, and progressively improved.

5.2 The collation of information in order to further develop and monitor specific policies and guidelines could be carried out within the existing frameworks of the major Committees, especially on key topics for which current knowledge is fragmentary.

5.3 The NHMRC could work with the AIH in the establishment of improved data collecting arrangements to monitor Aboriginal health on a national basis.

5.4 The NHMRC could actively support the training of Aboriginal health workers at all levels, both through scholarships and through the support of training facilities. In tandem with such activities it could encourage:

(a) the development of national accreditation standards for particular courses, and;

(b) the promoting of access to professional courses in the areas of medicine, nursing and social work for Aboriginal and Islander students with a demonstrated aptitude for such courses.

5.5 Through the efforts of the Medical Research Committee and the Public Health Research and Development Committee, a significant coordination and monitoring of research could be achieved in order to minimise duplication of effort and ensure the best allocation of the available research funds.

5.6 The NHMRC will continue to monitor and advise on those issues which have particular relevance to Aboriginal health and which are presented through its existing committee processes. A current case in point is the use of kava, which the NHMRC considers should not be encouraged in Australia and which it would like to bring to the attention of the National Aboriginal Health Strategy Working Party as an issue of potential concern. This is a subject which the Public Health Committee, in association with other bodies such as the Ministerial Council on Drug Strategy, will continue to review and advise on as required.

5.7 It is important that ethical guidelines continue to apply to all health related research in Australia. The NHRMC, through the Medical Research Ethics Committee is experienced in producing such guidelines and in guiding the regulation of ethical aspects of research. Having advanced far in consultation about ethics with the Aboriginal people, and having made considerable headway in developing official ethical guidelines following the production of advisory notes, the NHMRC would see itself as continuing to fulfil the role of contributing to the further development and monitoring of activities in the ethical regulatory sphere.

5.8 The NHMRC can also have an informal function, in that it has a very wide established network which may be extremely useful to many bodies working within a comprehensive health strategy. There is a community of research workers already established within NHMRC and funded by them who engage in a wide range of activities. The utilisation of existing networks would be an important goal of a comprehensive health strategy. The NHMRC's ethical guidelines will be very useful in evolving a national health strategy. It is obvious to us that many previous health endeavours, whether they have been orientated around a research program or not, have floundered because of lack of ethical sensitivities.

APPENDIX I

OUTLINE OF ACTIVITIES OF THE NHMRC

The NHMRC has as its major responsibility the identification of national health needs and priorities and in particular the research component of these needs. Having identified these, Council is responsible for promoting research in areas of health need and for establishing fellowships and scholarships which will ensure the orderly development of well-trained scientists in all areas of health care. The NHMRC is also responsible for providing information and advice on policy matters to the Minister for Community Services and Health, the States and Territories and for addressing health priorities of the Australian community.

The NHMRC has five principal committees which have different functions. These are:

1. The Health Care Committee (HCC) is responsible for the identification of problems and issues within health service delivery systems, whether these be at the primary, secondary or tertiary level. It has many subcommittees which meet either regularly or on demand to address situations of national concern. These include committees on women's health, child health, mental health and dental health. In the past these have included aspects of Aboriginal health. HCC's main method of functioning is to produce reports which contain both policy advice to Council and advice to other committees, such as the Medical Research Committee, concerning research needs and research priorities.

2. The Medical Research Committee (MRC) is the major funding body of the NHMRC for health and medical research. It funds institutes, and programs and project grants. Of these, the most important for Aboriginal health are the project grants. These are projects which are competed for across the nation, about 300 being awarded each year and usually for a period of three years. The policy of NHMRC is to fund these projects excluding infrastructure costs.

   Project grants are awarded at the beginning of each year and cover such subjects as epidemiology, public health, clinical sciences, the evaluation of clinical trials and basic biological science, and health care evaluation. The Medical Research Committee (and the Special Purposes Committee of MRC) has funded Aboriginal grants in 1986, 1987 and 1988. It is currently considering 23 new projects in 1988 for support in 1989.

   Currently funded projects in Aboriginal health are listed in Appendix 2.

A subcommittee of MRC is the Special Purposes Committee (SPC). This was developed with a particular aim, i.e. to identify areas of important health need where there was either a dearth of research or of scientists. The task of this subcommittee is then to devise strategies which will increase relevant scientific endeavour in areas of special need. Over the years, these have included alcohol and drug related problems, ageing, rehabilitation, chronic disability, environmental toxicology and public health. Most importantly, since 1985, the SPC has advertised for projects in the area of Aboriginal health. This has proved to be very successful. As one of its priority areas the SPC also organises workshops and the NHMRC was the source of funds for the Alice Springs workshop in 1986, which was organised in conjunction with the Menzies School of Research.

Following the workshop on Aboriginal health held at Alice Springs, the Medical Research Ethics Committee was financially assisted by the Council of the NHMRC to enable it to hold a forum at Camden in order to address issues raised in the first part of the Alice Springs workshop on the ethics of research on Aboriginal health.

As a result of this forum, advisory notes have been drawn up to assist Institutional Ethics Committees and Regional Grants Interviewing Committees in assessing applications for research in Aboriginal health.

3. The Public Health Committee (PHC) considers issues of major significance to Aboriginal health. It enquires into and reports on matters relating to the protection and promotion of the health of the community, develops priorities for public health action in Australia and advises governments in relation to these issues.

Through its expert committees, it develops recommendations and regulations relating to the regulation of food, chemicals, environmental hazards and communicable diseases to prevent unnecessary morbidity and premature mortality and to promote well-being and improvement of the quality of life.

The committee actively promotes the public health philosophy of social action to prevent disease, illness and injury and to promote health. The Public Health Committee produces policies about Aboriginal health care and provides comment on public health research projects that are specifically concerned with Aboriginal health. It also provides advice to MRC and the Special Purposes Committee of MRC about the quality of public health projects in this area.

4. The Public Health Research & Development Committee was formed two years ago. Its functions are to promote research and development within that aspect of public health which is particularly concerned with primary health care and evaluative endeavours. The priorities which it has identified for funding of research grants from its own funds are derived from the recommendations of the Better Health Commission. Since not all of them can be funded in any one year, there is a rolling system of funding whereby 2, 3 or 4 topics are chosen in any one year. For example, in 1987 the areas that were funded, and advertised as priority topics for applications by potential research workers, included the prevention of mental illness, improvements in nutrition, accident and injury prevention and primary prevention of cancer of the breast and cervix.

   Whilst all these areas are obviously relevant to Aboriginal health, it is also the case that Aboriginal health per se is a priority topic within Public Health Research and Development; and it was a major research theme in 1987.

   Another way in which PHRDC aims to meet our national needs is through the Research Fellowship and Scholarship Scheme. These fellowships and scholarships are designed specifically to promote training in research skills for people who are committed to a public health career. This was believed to be a major deficiency in the spectrum of health professionals' skills across the country, and was one of the main driving forces behind establishing PHRDC.

   The Public Health Research and Development Committee currently has six research projects in the area of Aboriginal health and four grants for training, one of which is a fellowship.

5. The Medical Research Ethics Committee (MREC) is responsible for providing ethical guidelines on matters of health and medical research. It has produced the NHMRC Statement on Human Experimentation and Supplementary Notes. These provide guidance on ethical matters bearing on human research and experimentation, for research workers and administrators of institutions in which research on humans is undertaken in Australia. The Supplementary Notes have addressed the structure and function of institutional ethics committees, epidemiology, research on children, etc.

   The first Supplementary Note provides specific guidelines on how ethical aspects of research should be regulated. It lays down that in every institution in which research is undertaken there must be a properly constituted institutional ethics committee, and that no research project may proceed without prior consideration and approval of a written protocol by such a committee. These injunctions apply regardless of the source of funding of the research, NHMRC having resolved that any institution that does not conform in respect of <u>all</u> research on humans conducted by it, (to Supplementary Note 1), shall not be eligible to receive funds for research from the Council.

There is a separate Animal Experimentation Ethics Committee which works in close collaboration with the Medical Research Ethics Committee.

The Medical Research Ethics Committee has already produced a set of Advisory Notes on Ethical Matters in Aboriginal Research derived from the Ethics Workshop in Camden, and the Committee is in the process of preparing formal guidelines to be adopted by the NHMRC. The implications for Aboriginal health of these activities are profound. Not only have the Aboriginal people themselves been alerted to the existence of ethical guidelines that relate to research in all communities including their own but they are also assured that details of ethical principles that are particularly important for them are being spelt out separately. The Advisory Notes on Ethical Matters in Aboriginal Health emphasise consultation with, and participation of, Aboriginal people in any such research. The clear intention of that emphasis is to indicate that Aboriginal communities should have a much greater influence on research in which they are involved than has ever been the case before. They will also, of course, have a powerful influence on the maintenance of standards of ethical conduct.

This is relevant to the present submission because NHMRC, like many other organisations, believes that one of the most important steps that can be taken in connection with health research in Aboriginal people is to amplify existing ethical guidelines to ensure that they are sensitive to the special cultural needs of the Aboriginal community.

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