Nyoongar Health Plan

SOUTH WEST / METROPOLITAN REGIONAL ABORIGINAL HEALTH PLAN

DECLARATION

The recommendations in this plan have been identified by the Nyoongar Regional Planning Team as key priorities to address health issues in the region. The recommendations were signed off by the Planning Team on:

.....

Signing off by the Nyoongar Regional Planning Team members signals agreement to support the plan's overall direction, inherent strategies and recommendations.

In the act of signing off, the parties accept that:

- This first planning activity under the State/Commonwealth Framework Agreement 1996 was conducted in the most appropriate manner for the time and resources available; and
- The Plan will be closely monitored and reviewed in order to maintain its relevance in terms of accuracy and focus over its implementation phase.

Signing off does not commit each of the Joint Planning Forum parties to the absolute implementation of each and all of the Plan's recommendations, neither does it restrict development activity of each party to the whole of the recommendations, or particular scope of any. However, it does signal the Nyoongar Health Planning Team's commitment to maintaining open dialogue and working together to achieve the recommendations in the plan.

Signed:

For Derbarl Yerrigan Health Service

For South West Aboriginal Medical Service

For Wheatbelt Aboriginal Corporation

For Albany Family Futures Program

For Swan Health Services

For Office of Aboriginal Health

For Office of Aboriginal and Torres Strait Islander Health

For Aboriginal and Torres Strait Islander Commission

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The word Nyoongar is used in this plan to identify all Aboriginal people living in the Nyoongar region.

List of abbreviations

ACCHO	Aboriginal Community Controlled Health Organisations
AFFP	Aboriginal Family Futures Program
AHOP	Aboriginal Home Ownership Program
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
ARI	Acute Respiratory Infection
ATSIC	Aboriginal and Torres Strait Islander Commission
CFWA	Cancer Foundation of Western Australia
CHL	Chronic Hearing Loss
CVD	Cardiovascular Disease
COPD	Chronic Obstructive Pulmonary Disease
DYHS	Derbarl Yerrigan Health Service
EDWA	Education Department of Western Australia
GP	General Practice
HACC	Home and Community Care
HDWA	Health Department of Western Australia
HFHH	Healthy Families Healthy Homes
IFP	Indigenous Family Program
JPF	Joint Planning Forum
MBS	Medicare Benefits Scheme
MOJ	Ministry of Justice
NACCHO	National Aboriginal Community Controlled Health Organisation
NASAS	Nyoongar Alcohol and Substance Abuse Service
NFP	Nyoongar Family Practices
NHF	National Heart Foundation
NHHRP	Nyoongar Housing and Health Review Project
NMHT	Nyoongar Mental Health Teams
NRAHPT	Nyoongar Regional Aboriginal Health Planning Team
OAH	Office of Aboriginal Health
OATSIH	Office of Aboriginal and Torres Strait Islander Health
OM	Otitis Media
SAC	Southern Aboriginal Corporation
SAHU	State Aboriginal Health Units
SCE	Scaled Central Episodes
SHS	Swan Health Service
SIDS	Sudden Infant Death Syndrome
STD	Sexually Transmitted Disease
SWAMS	South West Aboriginal Medical Service
WA	Western Australia
WAACCHO	Western Australian Aboriginal Community Controlled Health Organisation
WACOH	Western Australian Centre for Oral Health
WAACCT	Western Australian Aboriginal Co-ordinated Care Trial

Executive Summary

The four key areas in this framework are:

- Recognition of the Aboriginal definition of health;
- Commitment to the underlying principles;
- Recognition of the cumulative nature of Nyoongar ill-health and inequity; and
- Targeting of effort to reduce untimely or unnecessary death to establish a rate ratio better than 1.9 by 2010.

In moving to address the state of Nyoongar health outlined in the following sections the Nyoongar Regional Aboriginal Health Planning Team (NRAHPT) believes that strategies need to be framed mindful of these essential elements.

Building Nyoongar Health

Cardiovascular Disease (CVD)
Priorities

- Disseminate heart health care protocols used in the Western Australia Aboriginal Co-ordinated Care Trial (WAACCT) and the provision of training for Aboriginal Health Workers (AHWs) and other primary health care providers;
- Promotion, prevention and education projects among young Nyoongar people in order to promote early behaviour changes;
- Research, develop and implement effective marketing strategies that target Nyoongar smoking;
- Develop innovative partnering arrangements such as Nyoongar Family Practices (NFP) between General Practice, Aboriginal Community Controlled Health Organisations (ACCHOs) and secondary, and tertiary level providers that improves the identification, treatment and ongoing management of high risk individuals;
- Support the decentralisation of Aboriginal Health Services (initially DYHS and SWAMS, then any others as they might emerge) to priority population centres among Nyoongar country, particularly those health districts with significantly higher mortality rates for CVD; and
- Expand co-operation with the National Heart Foundation (NHF) in Western Australia (WA).

Injuries and Poisoning
Priorities

- Targeted road safety campaigns particularly relating to the impact of alcohol;
- Target suicide prevention at Nyoongar children and young people under the age of 25 years;
- Development of suicide prevention training manuals for staff who deal with young Nyoongar people;

- Develop and extend the coverage of emotional and social well-being services to the Nyoongar community;
- Promote services directed at strengthening family and community cohesion; and
- Expand the range and nature of violence prevention programs in Aboriginal communities.

Cancers
Priorities

- Expand health promotion services targeting both men and women;
- Improve the early identification of all forms of cancers for males and females;
- Ensure the effective referral of Nyoongar people to culturally secure treatment services, including secondary and tertiary level services;
- Develop culturally secure support services for Nyoongar people with cancer; and
- Establish research, services and develop linkages with relevant agencies such as the Cancer Foundation of Western Australia (CFWA).

Diabetes and Renal Disease
Priorities

- Improve community-based education and promotion programs to prevent the onset of diabetes and renal disease;
- Improve identification of individuals at risk of diabetes or individuals with undiagnosed diabetes;
- Extend nutrition and exercise programs; and
- Improve the management of patients with Diabetes with particular emphasis on local services.

Digestive Illness
Priorities

- Develop appropriate screening programs for at-risk clients;
- Expand appropriate health education/treatment services;
- Recognise and act upon environmental issues and the relationship to digestive diseases in infants within maternal and child health initiatives; and
- Improve links between primary health care providers and Nyoongar alcohol services.

Respiratory Disease
Priorities

- Develop effective respiratory disease screening in annual health checks for Nyoongars;
- Review and disseminate the respiratory diseases care plan. Western Australian Aboriginal Co-ordinated Care Trial for use by GPs, AHWs and families;
- Expand current self management education initiatives for Nyoongars;
- Link health promotion programs targeting obesity, exercise and other related behaviours with respiratory disease initiatives; and
- Ensure particular emphasis on programs designed to eliminate smoking and other causes of airway infection in the family home.

Special Populations and Programs

Dental Health
Priorities

- Targeted oral health education campaigns;
- Improve access to general oral health services for Nyoongar people;
- Encourage services to elders and older community people, and support family action to improve dental health;
- Establish new contracting arrangements involving dentists in private practice to provide services in small communities; and
- Establish a new partnership with the WA Centre for Oral Health (WACOH).

Alcohol and Substance Abuse
Priorities

- Target prevention programs for all age groups, include the promotion of role models, and the health and social risks associated with excess alcohol consumption and illicit drug taking;
- Increase treatment options such as alcohol and drug counselling, rehabilitation, detoxification and sobering-up shelters;
- Improve training for Aboriginal community workers broadly and AHWs more specifically;
- Improve education of mainstream workers in culturally appropriate ways;
- Monitor underage drinking and restriction of sales or prosecutions where appropriate;
- Educate children and youth in their own traditions and culture, including provision of alternatives to alcohol; and
- Improve communication, particularly between police and Aboriginal people.

Smoking
Priorities

- Expand market research as a tool to assist in the targeting of smoking cessation programs in Nyoongar communities;
- Continue to enhance health promotion activities and disseminate information about the health risks associated with smoking;
- Develop additional strategies to support those Nyoongar people who wish to give up smoking; and
- Develop closer partnerships with relevant agencies such as the CFWA.

Perinatal Period
Priorities

- Improve access to appropriate services that are aware of Nyoongar women's often unspoken needs such as being treated by female doctors, nurses and health workers;
- Increase community education and health awareness and promotion programs aimed at young women. These need to be developed and presented by Nyoongar women and address issues such as sexual health, family planning, nutrition, antenatal and postnatal care;
- Targeted maternal nutrition and breastfeeding programs;

- Targeted smoking and Sudden Infant Death Syndrome (SIDS) campaigns;
- Extend home visiting programs; and
- Improve breast and cervical cancer screening.

Strategies to Improve the Contribution from Other Sectors

Education
Priorities

- Establish a project team to identify the specific priority areas and locations of co-operation between the health and education sectors that will impact on health and well-being including the production of targeted project plans;
- Expand the current co-operation between Office of Aboriginal Health (OAH) and the Education Department of WA (EDWA) around the linking of efforts to manage Chronic Hearing Loss (CHL) and Otitis Media (OM) in Nyoongar school age children; and
- Review current work on the management of transition from school to work in Aboriginal communities to identify appropriate strategies for Nyoongar communities.

Employment and Training
Priorities

- Establish a project team to identify the specific priority areas of co-operation between the health, employment and training sectors that will impact on health and well-being, including the production of targeted project plans;
- Encourage early development of programs targeting the employment and training needs of Nyoongar women; and
- Link the employment and training sector with the Transition from School to Work project recommended in this report.

Housing
Priorities

- Encourage and increase home ownership by Nyoongar families;
- Undertake review as indicated; and
- Ensure that suitable rental and hostel accommodation is available where required.

Justice
Priorities

- Establish new and expanded rehabilitation and sentencing options providing well targeted, carefully structured services that look to the offender's behaviours and perceptions blended with good culturally secure family work and where possible, is situated in the community setting;
- Establish innovative service structures and arrangements providing effective and culturally secure primary health care for prisoners;
- Include sound health care planning for prisoners (based perhaps on the WAACCT protocols);

- Build synergy between the evidence related to childhood health and criminality in latter life with existing Aboriginal Family Futures Program (AFFP) and community based primary health care initiatives; and
- Expand the ability of current service providers to offer comprehensive health services to young families including the provision of community development and other social health services.

Strategies to Protect and Enhance the Social Capital of Nyoongar Communities

Family Violence
Priorities

- Extend family violence prevention programs. Strategies need to include community education and prevention, early intervention, long-term healing and crisis intervention;
- Improve cultural awareness of mainstream services and ensure they are more supportive of community-based initiatives;
- Support and extend existing initiatives such as women's action groups, safe houses, night patrols, community warden schemes and sobering up centres;
- Family violence perpetrator programs provide "cooling off" places with counselling available; and
- Involve Nyoongar people at all levels in addressing family violence. Currently community organisations receive limited resources, support and training.

Men
Priorities

- Develop culturally secure services for Nyoongar men to manage stress and depression and its manifestations in the family and the community in general;
- Develop programs that encourage treatment of the whole person by linking employment, education and training opportunities for Nyoongar men, especially men with families; and
- Develop strategies to improve Nyoongar men's access to and utilisation of health and related human services.

Emotional Social and Cultural Well being
Priorities

- Develop and deploy Nyoongar Mental Health Teams (NMHT) in key locations across the region;
- Promote functional linkages with other service providers such as mental health teams and General Practitioners and
- Establish a Nyoongar Housing and Health Review Project (NHHRP) that identifies the opportunities for health and housing sectors to co-operate to improve Nyoongar health and well being, and to make recommendations about reform to housing and health policy and programs.

Family Formation
Priorities

- Life skills education and role modelling programs to reduce adolescent risk behaviours delivered in supportive environments at times of developmental transitions, eg from primary school to high school;
- Programs that support social, cultural and parenting education for adolescents as they move into womanhood and manhood and as they consider forming families;
- Expansion of the Indigenous Family Program (IFP) and the Healthy Families Healthy Homes (HFHH) programs; and
- Focus attention on innovative educational, training and employment programs for parents in young families as a priority, including part-time work where appropriate for single parent families.

Inter-Generational Issues
Priorities

- Improve access to and appropriateness of Home and Community Care (HACC) and other services for elder Nyoongar people;
- Promote respectful and well-planned health care for elders;
- Establish programs to encourage communication and involvement of Nyoongar elders in the planning of services to ensure appropriate respect for and involvement of Nyoongar beliefs and values, particularly in young families;
- Ensure that hospital care for elders and older community members provides adequate respect for the role and valued position of these community members; and
- Support the development of appropriate accommodation options for older Aboriginal people.

Strategies to Improve the Infrastructure and Performance of the Health System

Accessibility & Appropriateness of Health Services
Priorities

- The Nyoongar Regional Planning Team supports the development of an Aboriginal Medical Service (AMS) in the Wheatbelt area;
- Support the decentralisation of Aboriginal health services priority population centres in Nyoongar country;
- Establish cultural security programs in all hospitals and Health Services in the Metropolitan South West area;
- Establish pilot NFP models for small Aboriginal communities;
- Support the delivery of services closer to where clients live;
- Advocate accreditation of health services as an important indicator that an organisation has the necessary infrastructure, processes and commitment to provide high quality culturally secure health services;
- Establish innovative strategies to improve Nyoongar access to Medicare funded primary health care services;
- Increase Nyoongar representation on mainstream Health Service and Hospital Boards; and

- Support community participation in all levels of decision making.

Aboriginal Health Related Workforce
Priorities

- Address agreed issues raised by the National and State review of AHW training;
- Support appropriate and quality training, employment and professional development of AHWs;
- Encourage training of Aboriginal people in occupations such as doctors, nurses and allied health workers;
- Increase Aboriginal staff across all levels in mainstream services; and
- Improve the skills, knowledge and resources of people already in the health workforce.

New Partnerships
Priorities

- Establish NFP in a number of pilot communities in the South west;
- Establish innovative and appropriate protocols for the sharing of information between GPs, AMSs and relevant State Aboriginal Health Units (SAHU); and
- Provide recognition to and further support for continuing medical education for GPs engaged in the NFP including the development of a relationship; and between this training and Vocational Registration of GPs.

Joint Fund Holding
Priorities

Prior to expansion of community fund holding

- Undertake as a priority, a regional specific analysis of the funds required under a per capita regime;
- The Nyoongar Regional Aboriginal Health Planning Team to establish ground rules for participation in Fund Holding arrangements;
- An information campaign to be undertaken to ensure communities are informed about the risks, responsibilities and understand operational demands;
- The NRAHPT should establish an evaluation framework for fund holding; and
- The NRAHPT will map a phased roll-out of fund holding when deciding implementation strategies.

Service Co-Ordination
Priorities

- Mapping of services available to Nyoongars and the identification of possible synergy between community controlled and other agencies; and
- Expansion of the Indigenous Family Program (IFP) to enable up to 20 families to be recruited.

Cultural Security

Priorities

- Complete phase 1 project at Derbarl Yerrigan Health Service (DYHS);
- Establish agreement on matters relating to cultural property rights;
- Establish the process and content agreement for phase 2, and fund the process;
- Expand the current levels of engagement of appropriate clinicians and health system decision-makers; and
- Extend the process to engage the region.

1. Nyoongar People and Health Today

1.1 NOONGAR WANGKINY (Nyoongar Introduction)

Kaning Australia kulaark mia Nyoongar

Kura kura Nyoongar wort koorl
Ngalla boodja djinaninginy nidja djinaninginy
Aldja garro-djin

1829 Nyoongar moort wedjela baranginy boodjar
yuaaly baldja Nyoongar.

Moorditjer yuttarn boodja

Malajian ngaadom Nyoongar

Nyoongar yorga baalup boodjari Ngalla Koorlangka.

The South West of Australia is the home of the Nyoongar. From time immemorial the Nyoongar have traversed the land (boodja). In so doing they have owned and nurtured the land in a way that no other human being could.

Since 1829 this relationship has been savagely diminished. This dispossession has reached its crescendo and is being challenged by the Nyoongar themselves. The need to re-establish and strengthen cultural ties to the land is growing all the time. Nyoongar rights to good health and a good quality of life is without question. The Nyoongar women know that when they are pregnant they are 'boodjarri' – for our children.

This plan is for our children.

The Nyoongar Health Plan draws on the experience of Aboriginal and non-Aboriginal people. It recognises and is reminded of the valuable work undertaken in the preparation of the National Aboriginal Health Strategy and many other Aboriginal health plans and reports over recent years.

It is also informed by the recent developments in WA. The Health Department of Western Australia (HDWA), principally through the leadership of the OAH has formed new ways of working with Aboriginal communities. A Bilateral Agreement between State and Commonwealth Governments also stands as an example of progress.

Aboriginal communities have reciprocated by co-operating with these new approaches and setting aside the history of mistrust and suspicion that stands as the legacy of some past dealings.

The NRAHPT has taken partnership to mean a reciprocal trust in the individuals and organisations that joined in the development of this Plan and its implementation as well as a

commitment to open, transparent and honest co-operation. All parties accept that in such a partnership it will not always be possible to agree, but all parties do stand ready to continue to work towards a shared vision.

This is a health Plan for Nyoongar people:

> **Nyoongar:** the Nyoongar people are the predominant Aboriginal community and the traditional owners of the land in the South West of Western Australia. The word Nyoongar is used extensively in this report as a way of reflecting this and is to be taken as synonymous with the word Aboriginal and thus be inclusive of those Aboriginal people from other communities who also inhabit the region.
>
> **Nyoongar Region:** refers to the Metro South West Regional planning region. This is a combination of the Perth Metropolitan, South West, Great Southern and Midlands HDWA Health Zones. (See Figure 1.)

1.2 Background

In November 1996, a BA on Aboriginal Health was signed between State and Commonwealth governments, in the presence of the ATSIC and the WAACCHO.

It aims to:

- improve access to and appropriateness of health services;
- increase the level of resources in Aboriginal health; and
- outline joint planning processes including increased Aboriginal participation in decision making, improved co-operation and co-ordination of current services, and regional planning.

The Joint Planning Forum (JPF) on Aboriginal health is a high level strategic planning body that includes representatives from the four agencies involved in the Bilateral Agreement. In the Bilateral Agreement, the State and Commonwealth governments agreed to collaborate in planning and communication to improve Aboriginal health. The JPF agreed that a Regional Planning process would be an effective method of mapping community priorities and health needs in order to resource gaps and guide future directions in Aboriginal health.

Regional Planning Teams were formed in six regions of WA:

- Kimberley;
- Pilbara;
- Mid West Gascoyne;
- Goldfields;
- Ngaanyatjarra Lands; and
- Metropolitan - South West (Nyoongar).

The NRAHPT includes representatives from:

- DYHS;
- South West Aboriginal Medical Service (SWAMS);
- Southern Aboriginal Corporation (SAC);
- Swan Health Service (SHS);
- ATSIC;
- Wheatbelt Aboriginal Corporation (WAC);
- Aboriginal Affairs Department (AAD);
- HDWA - Office of Aboriginal Health (OAH); and
- Commonwealth Department of Health and Aged Care - Office of Aboriginal and Torres Strait Islander Health (OATSIH).

The NRAHPT is under the joint chairmanship of Mr Ted Wilkes (DYHS) and Mr Shane Houston (OAH).

1.3 Aim of the Nyoongar Health Plan

The Nyoongar Health Plan is part of a Statewide planning process to develop collaborative and community based strategic directions for Aboriginal health in WA.
The aim of the NHP is to:

- Identify gaps in service provision and identify priorities;
- Develop options or strategies to address these priorities and gaps;
- Build a framework that deals with Aboriginal health holistically and within culture; and
- Build strategy and commitment that ensures that the Plan is implemented.

The cooperation and communication that was established at a regional level through the NRAHPT has been a positive outcome of the planning process even at this early stage, and it is the intention of all Parties that it will continue beyond the publication of the Plan.
There have been other positive outcomes of the Regional Planning process. These include:

- improved relations between the NRAHPT members and their organisations;
- sharing of skills and information;
- an opportunity for community members to discuss and express their views on health needs in the region; and
- the development of a strategic Nyoongar Health Plan that will ideally attract attention and resources to areas of need.

This NHP has taken into account other health relevant planning processes such as those conducted by the Noongar Country Regional Council, the ATSIC Perth Regional Office, the South West Health Forum and HDWA.

1.4 Nyoongar Health Today

1.4.1 Population and Demographics

Of the Aboriginal people living in the Nyoongar region, 69 percent live in the Perth Metropolitan area (Table 1). However, the greatest proportions of Aboriginal people, relative to the total population, live in the Great Southern and Midlands Health Zones.

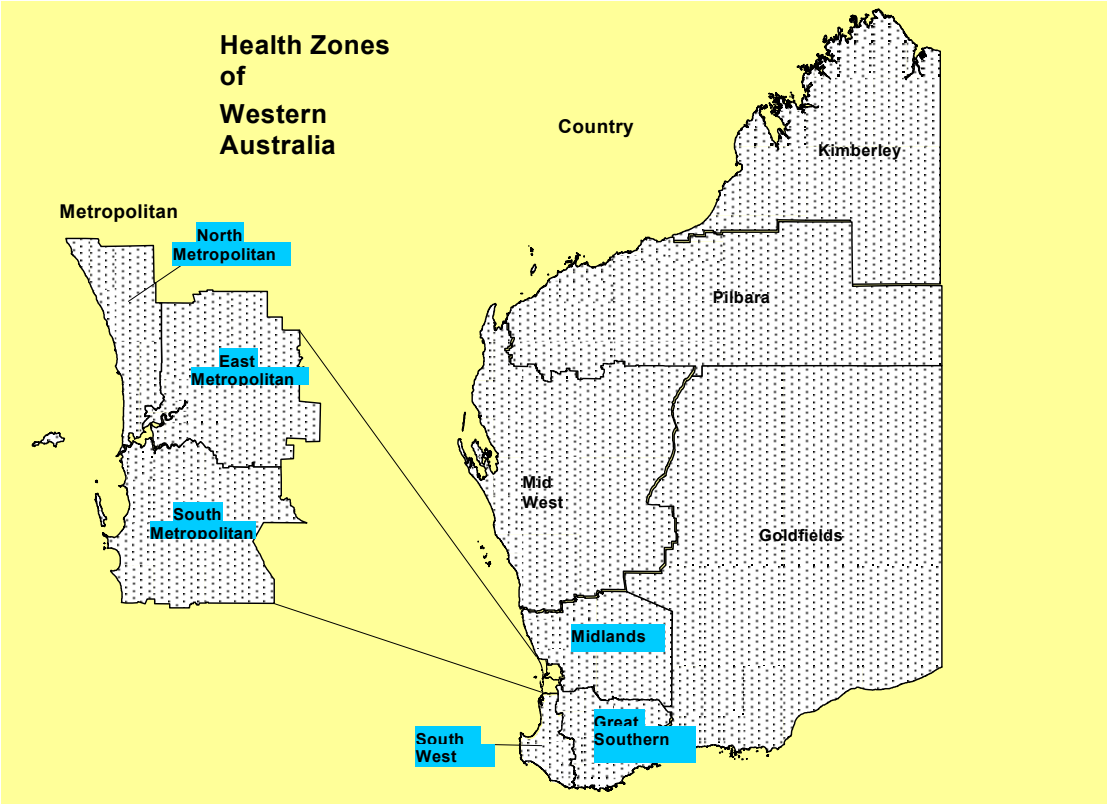
Similar to the rest of the Aboriginal population in WA, the majority (60 percent) of Aboriginal people throughout the Nyoongar region are under 25 years of age.

Table 1. The Estimated Number of Aboriginal People Living in the Perth Metropolitan, South West, Great Southern and Midland Health Zones in 1996.

Health Zone	Estimated 1996 Aboriginal Population	% of Nyoongar people	% of the Total Population
Perth Metropolitan	14,300	69	1.0
South West	1,650	8	1.5
Great Southern	2,650	13	3.8
Midlands	2,100	10	3.9
Total	**20,700**	**100**	**1.3**

Figure 1 is a map of the Nyoongar Health Region showing the HDWA Health Zones.

Figure 1. Health Regions Covered by the Plan (In Blue)



Health Zones covered by this Plan include Metropolitan Zones, Great Southern, Midland and South West Zones. While traditional Nyoongar country varies slightly from this area, these Health zones have been used to ensure accurate reporting.

1.4.2 Births and Infant Mortality

During 1996/97, there were a total of 635 births to Aboriginal mothers in the Nyoongar Regional Planning region. Approximately 12 percent of these babies were low birth-weight ie <2500 grams. This is about twice the rate of low birth-weight babies born in WA.

The major causes of infant mortality in Aboriginal infants in WA are Sudden Infant Death Syndrome, infections, unknown causes and low birth-weight. The SIDS rate for Aboriginal infants is between six and seven times that of non-Aboriginal West Australian babies.

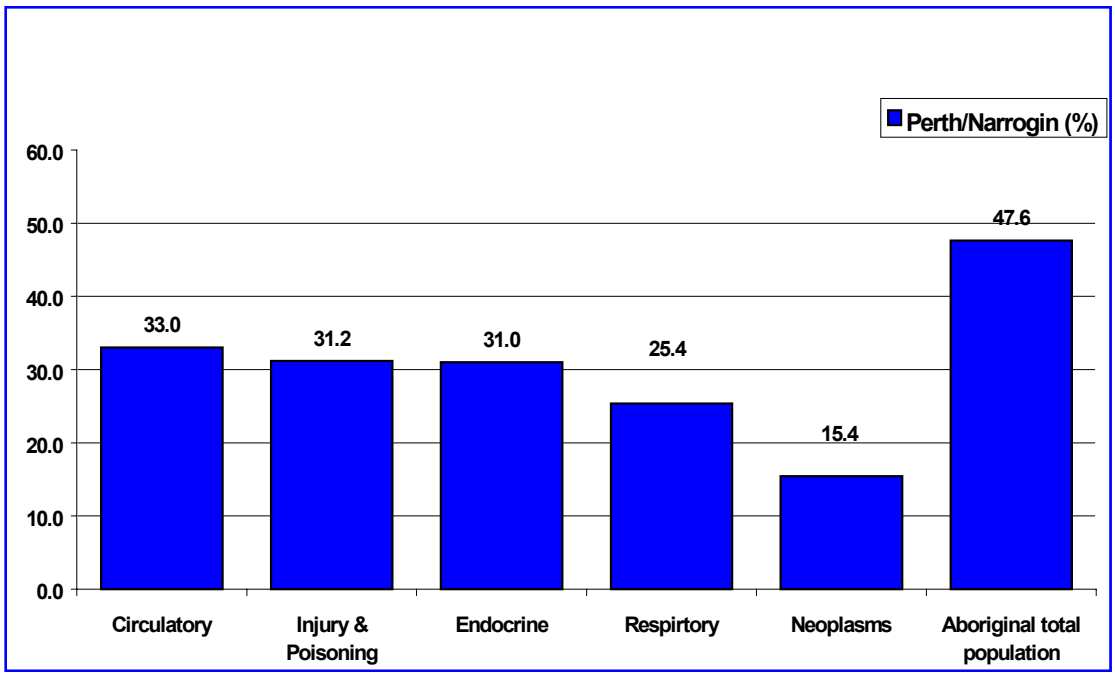
1.4.3 Mortality

In the ten years 1989 - 1998, CVDs were the leading cause of death for both males and females in all health regions. Approximately one third of mortality for the Nyoongar region was due to CVDs. This high mortality rate was mainly due to ischaemic heart disease, heart attack and stroke.

The next group of major causes of death among Nyoongar males and females in the Perth Metropolitan, South West, Great Southern and Midlands Health Zones during 1989-98 were cancers, endocrine diseases (mainly diabetes) and respiratory diseases.

Injuries were also a major cause of death. These include transportation-related incidents, injuries inflicted by another and self-inflicted injuries.

Figure 2. Percentage of State Mortality by Disease Category, Perth and Narrogin ATSIC Regions, 1989 – 98.



1.4.4 Hospitalisation

During 1996/97, the leading cause of hospitalisation for Nyoongar males was infectious, haematological and other disorders, which mostly included scabies and other skin infections and, intestinal infections. CVD, respiratory diseases and injury and poisoning were the next major causes of hospitalisation followed by diseases relating to mobility and the senses which were mainly epilepsy and ear infections.

Among Nyoongar females, pregnancy-related conditions were the leading cause of hospitalisation in 1996/97. Hospitalisation for pregnancy-related conditions were mainly due to births and complications experienced during pregnancy, labour, delivery and after childbirth. The highest hospitalisation rate for pregnancy related conditions were among 18-24 year old females. Respiratory diseases, infectious, haematological and other disorders such as skin and intestinal infections, injury and poisoning and cardiovascular diseases were the next major causes of hospitalisation.

The leading causes of hospitalisation for respiratory diseases among Nyoongar people were bronchitis, pneumonia and asthma. The highest hospitalisation rate for respiratory disease occurred in infants and older adults (65years+).

The highest hospitalisation rates for CVD occurred in mature (45-64 years) and older (65 years+) Nyoongar adults. However, the effects of cardiovascular disease were apparent in the 25-44 year age group, particularly in males. The main causes of hospitalisation for CVD were ischaemic heart disease, angina and heart failure.

1.4.5 Alcohol and Substance Misuse

There are high levels of alcohol-related illness and death among Aboriginal people in the Nyoongar region. In WA, admissions to hospital for alcohol-related problems are eight times higher for Aboriginal men than for non-Aboriginal men and 12 times greater for Aboriginal women. Alcohol misuse is directly responsible for one in ten deaths.

It has been shown that fewer Aboriginal people consume alcohol than non-Aboriginal people. However, those Aboriginal people that do drink are more likely to consume alcohol at harmful levels. A study of Nyoongar people carried out at Perth Aboriginal Medical Service (now DYHS) in 1994 showed that 42 percent of Nyoongar people involved in this research project were non-drinkers. This is a higher percentage than in the general population. However, among the 58 percent of Nyoongar people, who did consume alcohol, 44 percent drank at unsafe levels putting their health at risk. These findings were very similar in a study of 265 Nyoongar people living in the Great Southern Region in 1992.

1.4.6 Communicable Diseases

In 1996, the leading notification rates for communicable diseases among Nyoongar people in the region were for sexually transmitted diseases (STDs). The highest notification rate for STDs occurred in young adults aged 15-34 years.

Vector-borne diseases (such as Ross River Virus) had high notification rates within the Aboriginal people, especially in the South West and Midlands Health Zones. Enteric diseases such as giardia were another leading communicable disease notification among Nyoongar people. Most enteric notifications occurred in children under ten years.

Rates of notification for blood-borne diseases such as Hepatitis B and Hepatitis C were high in the Metropolitan Health Zone. However, testing for blood-borne diseases is more common in Metropolitan areas than in non-Metropolitan areas, and this may impact on notification rates.

1.5 Nyoongar Health in Comparison

Nyoongar people endure ill health that in almost all circumstances is significantly worse than that of non-Aboriginal people living in Nyoongar country. In addition, Nyoongar

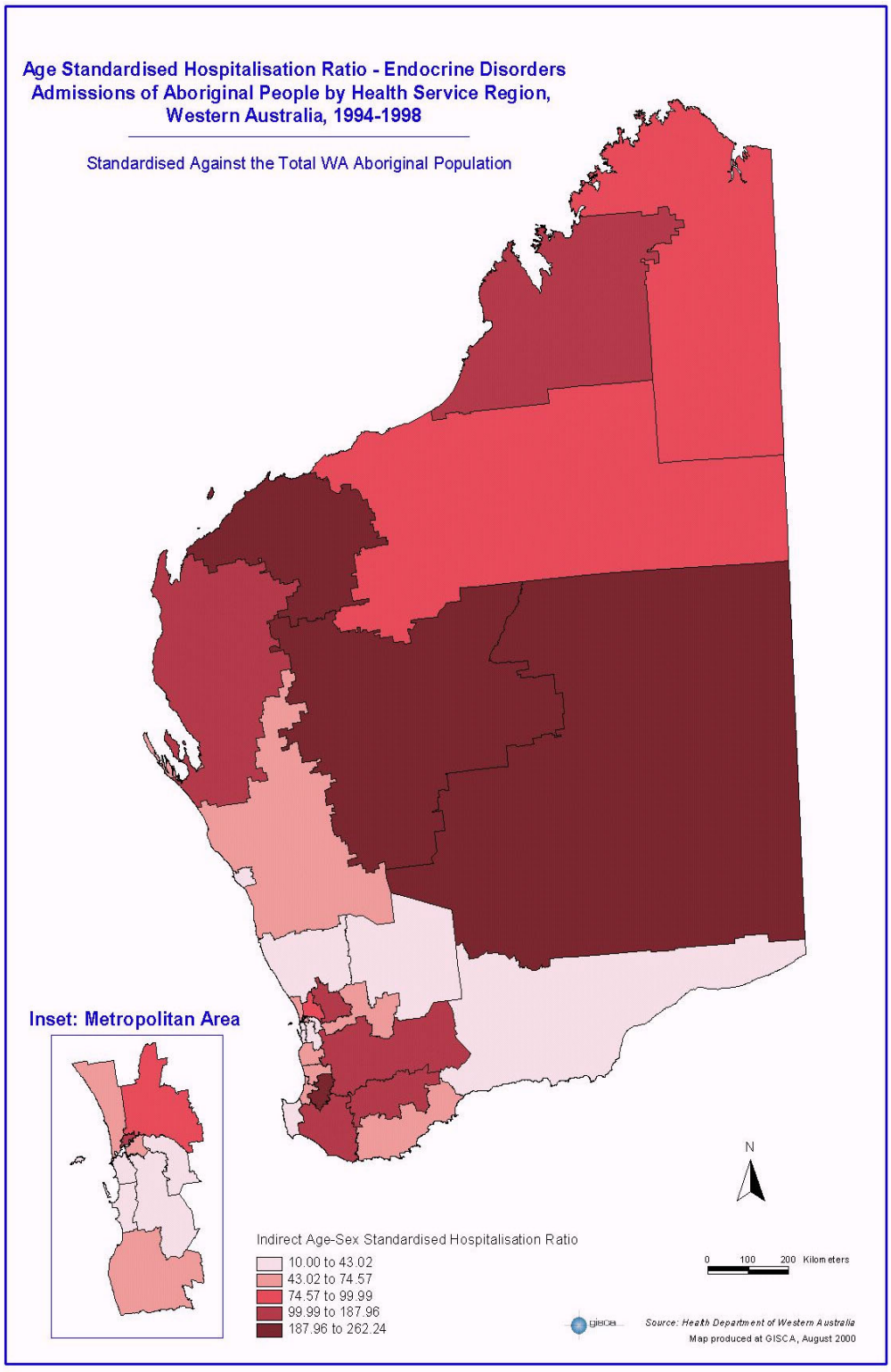
people endure morbidity and mortality rates for certain conditions that are significantly greater than for Aboriginal people living in other parts of WA.

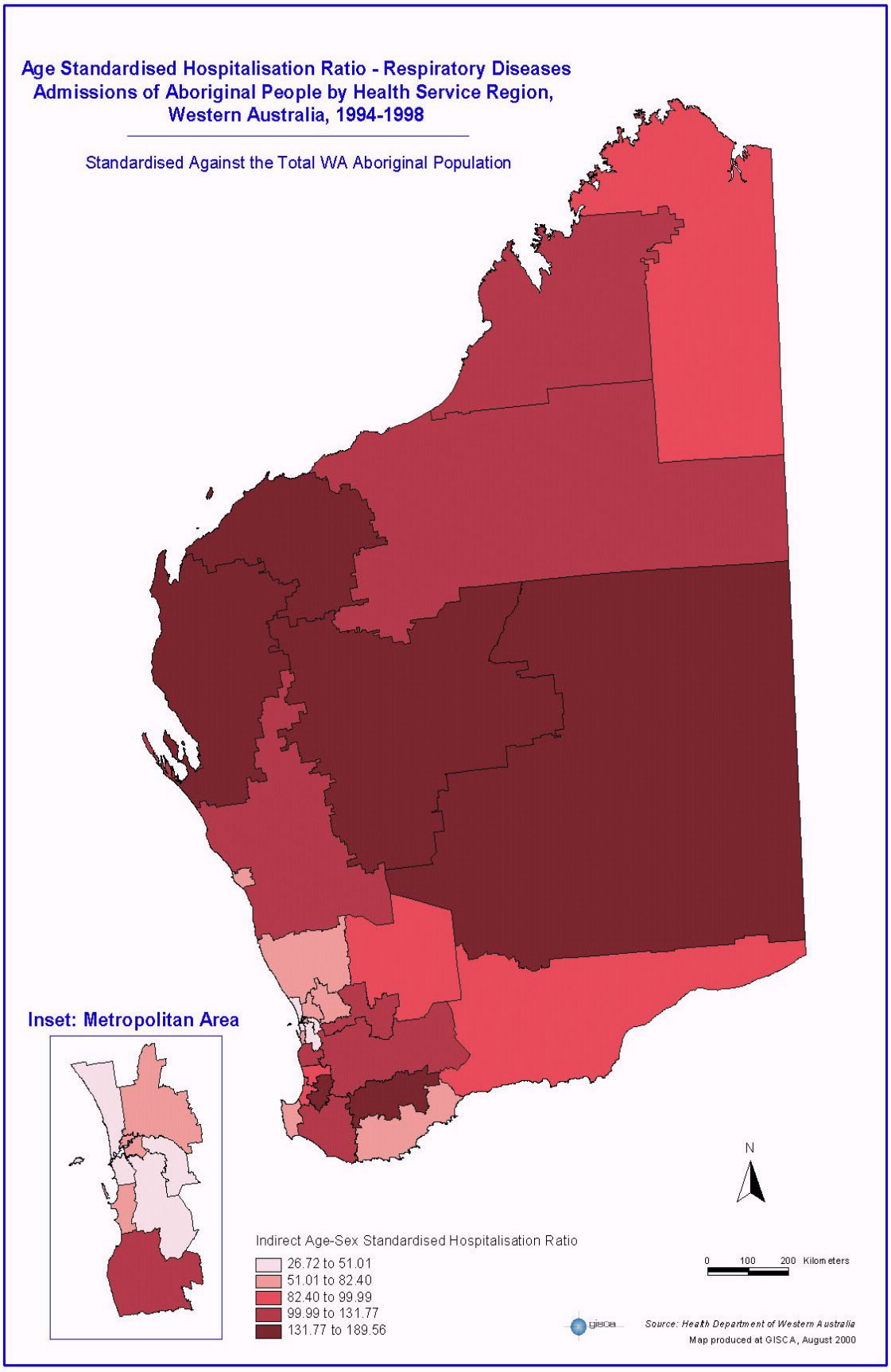
For example:

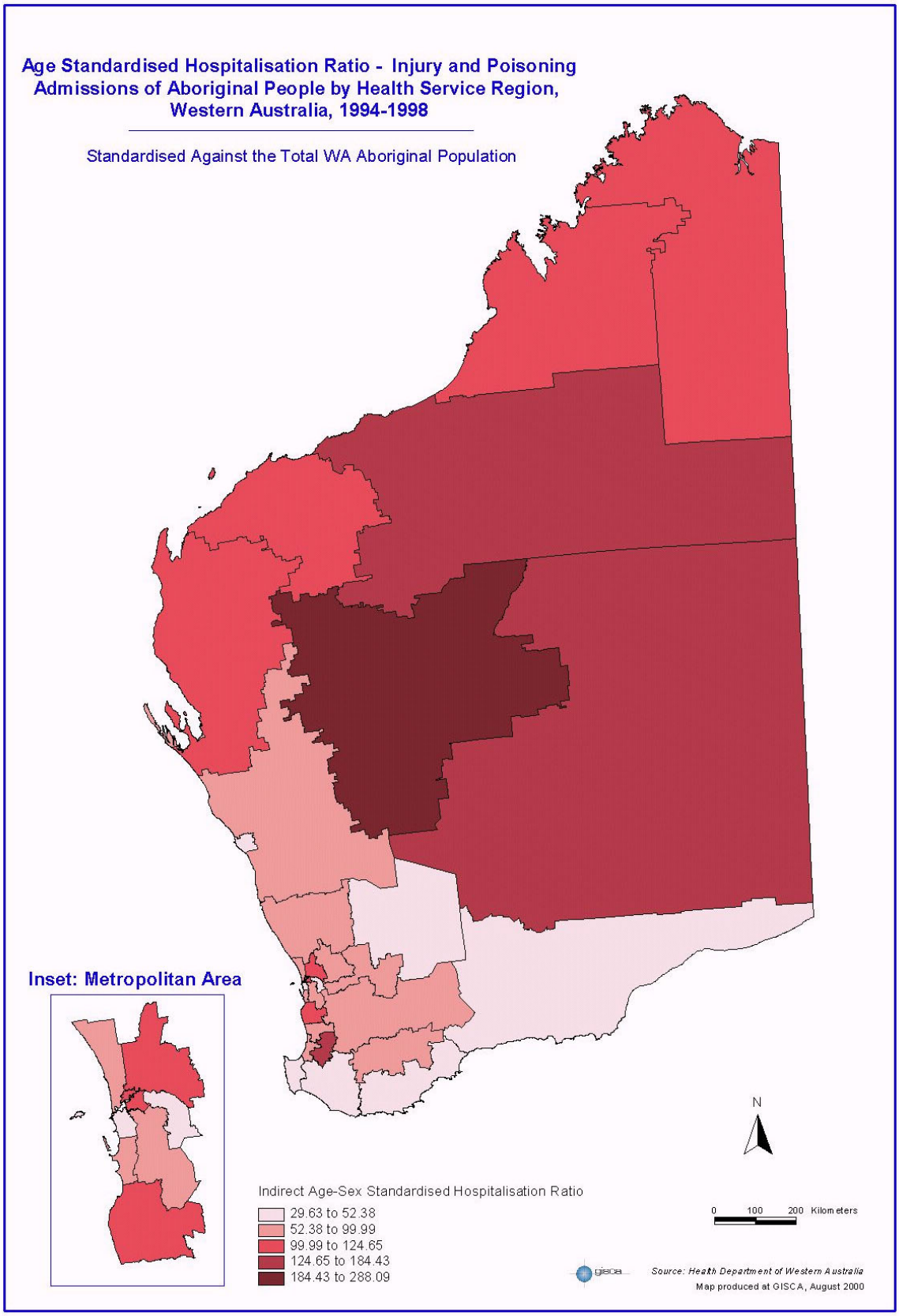
- Almost 300 Nyoongars died between 1987–96 from cardiovascular disease, and mortality rates were significantly higher than state Aboriginal averages for both Aboriginal men and women in four Health Service districts in the region covered by this plan.
- Almost 100 Nyoongars died in the same period from cancers with rates significantly higher than state Aboriginal averages for males in two Health Service districts, and in Health Service district for females.

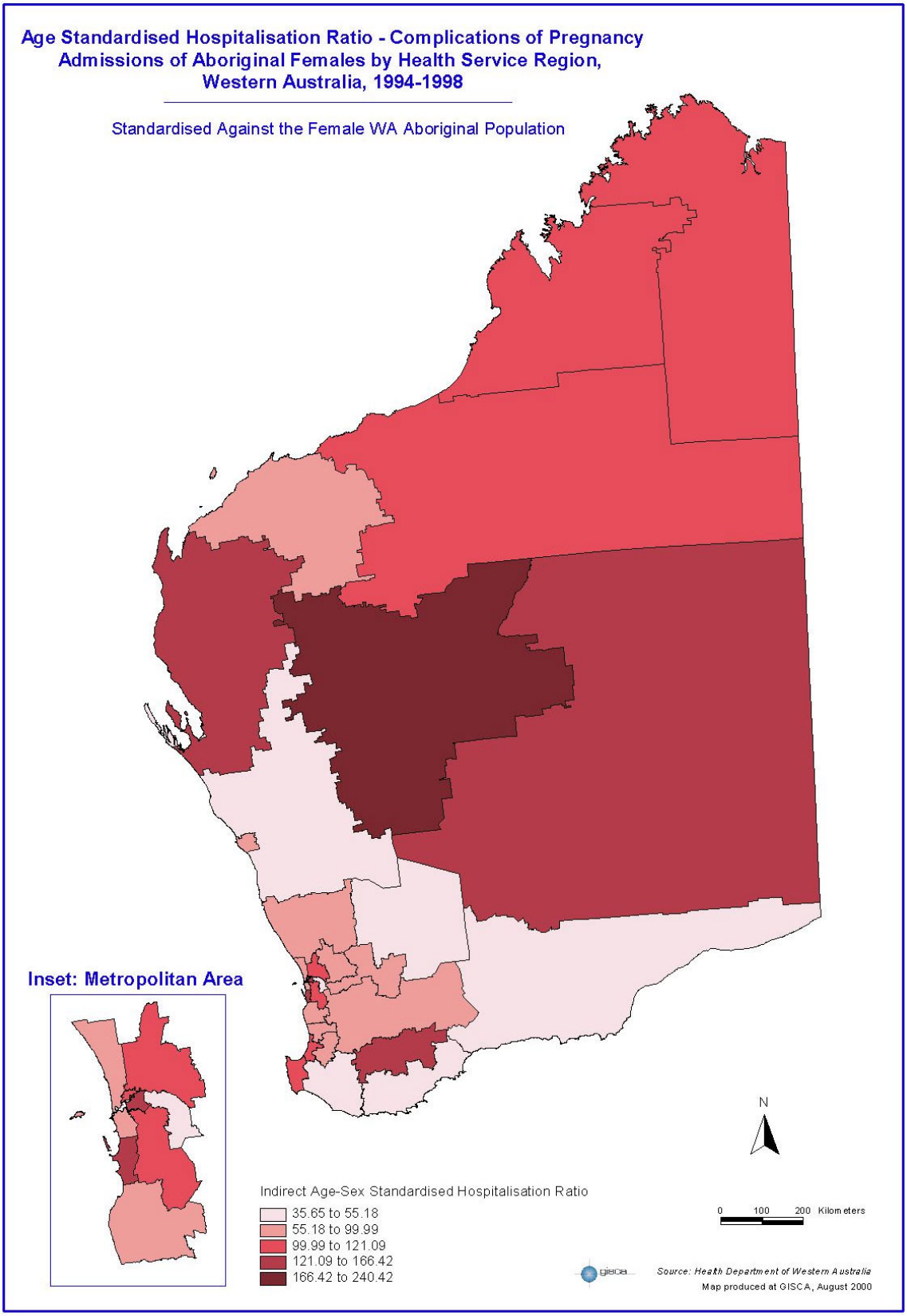
While the size of the Aboriginal population and the absolute number of death is small a careful approach to these statistics is required, Nyoongar mortality rates remain higher than state Aboriginal averages for a number of significant conditions. This fact may challenge decision-makers at state and Federal levels and other Aboriginal communities and requires an equitable response.

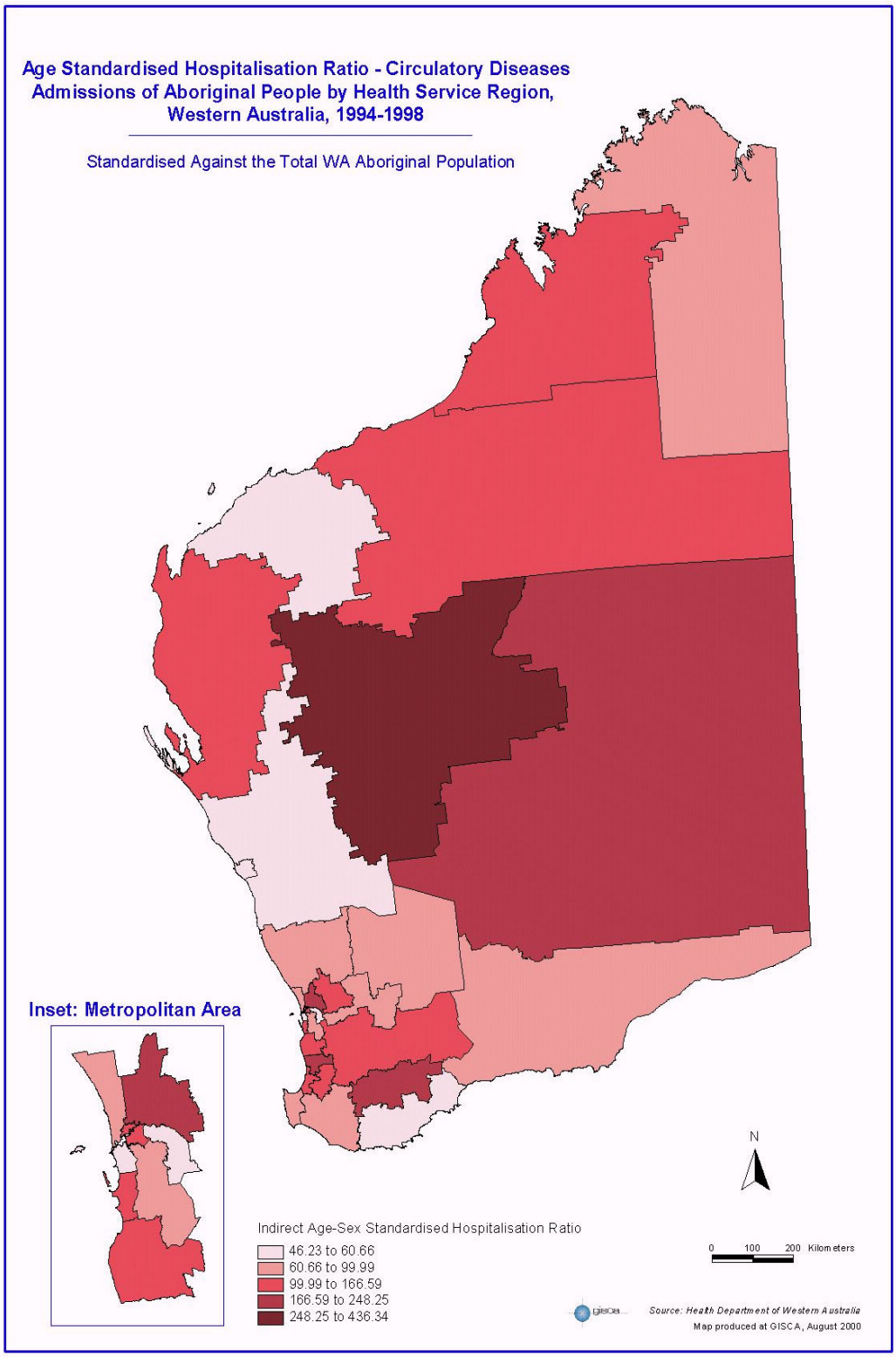
Figure 3. Comparison Maps for Major Causes of Death.




Age Standardised Hospitalisation Ratio - Respiratory Diseases
Admissions of Aboriginal People by Health Service Region,
Western Australia, 1994-1998
Standardised Against the Total WA Aboriginal Population
Inset: Metropolitan Area
N
Indirect Age-Sex Standardised Hospitalisation Ratio
26.72 to 51.01
51.01 to 82.40
82.40 to 99.99
99.99 to 131.77
131.77 to 189.56
0 100 200 Kilometers
Source: Health Department of Western Australia
Map produced at GISCA, August 2000


Age Standardised Hospitalisation Ratio - Injury and Poisoning Admissions of Aboriginal People by Health Service Region, Western Australia, 1994-1998
Standardised Against the Total WA Aboriginal Population
Inset: Metropolitan Area
N
Indirect Age-Sex Standardised Hospitalisation Ratio
29.63 to 52.38
52.38 to 99.99
99.99 to 124.65
124.65 to 184.43
184.43 to 288.09
0 100 200 Kilometers
Source: Health Department of Western Australia
Map produced at GISCA, August 2000


Age Standardised Hospitalisation Ratio - Complications of Pregnancy
Admissions of Aboriginal Females by Health Service Region,
Western Australia, 1994-1998
Standardised Against the Female WA Aboriginal Population
Inset: Metropolitan Area
N
Indirect Age-Sex Standardised Hospitalisation Ratio
35.65 to 55.18
55.18 to 99.99
99.99 to 121.09
121.09 to 166.42
166.42 to 240.42
0 100 200 Kilometers
Source: Health Department of Western Australia
Map produced at GISCA, August 2000


Age Standardised Hospitalisation Ratio - Circulatory Diseases
Admissions of Aboriginal People by Health Service Region,
Western Australia, 1994-1998
Standardised Against the Total WA Aboriginal Population
Inset: Metropolitan Area
N
Indirect Age-Sex Standardised Hospitalisation Ratio
46.23 to 60.66
60.66 to 99.99
99.99 to 166.59
166.59 to 248.25
248.25 to 436.34
0 100 200 Kilometers
Source: Health Department of Western Australia
Map produced at GISCA, August 2000

Each of these comparison maps demonstrate that the pattern of health of Aboriginal people is neither uniform for WA as a whole, nor within the region covered by this Plan.

These comparisons demonstrate the need for careful targeting of Aboriginal health services generally. More specifically they point to areas in which investments should be made in Nyoongar communities.

Comparisons are important because the Nyoongar Regional Aboriginal Health Planning Team believes that health systems need to build a greater degree of flexibility in health funding and program decision-making. This may require Commonwealth and state agencies to rethink the planning and allocative decision-making process. Such rethinking needs to extend beyond the simple extension of information sharing typical of most consultative processes, to a more constructed and transparent outcome-oriented model.

Accurate information about regional and sub-regional variations is important. Commonwealth and state agencies need to ensure that both the absolute level of funding and the purposes to which available funding is applied should reflect the nature of health need within specific Nyoongar communities rather than being applied to generalised or aggregated data. For example, in recent times some health conditions have been funded by Commonwealth agencies in areas where these conditions were not a priority. In these circumstances the question asked by funding agencies needs to change from:

"*we have decided nationally that, condition X needs attention – do you want the share of the money we are making available*"

to

"*we have for this region a fair share of the total funding available, what are the health priorities?"*

2. Foundations for Nyoongar Health

2.1. Underlying Principles

There are several key principles that underpin the Nyoongar Health Plan. These are:

2.1.1 Acknowledgment of the Link between Nyoongar Health and the Land

'Aboriginal medicine and practices are a complex system closely linked to land based cultural beliefs.' Nyoongar people have made it clear that there is a strong connection between their health and the land. For years, Nyoongar culture has been based on relationships with the land, other people and creator beings. Despite the erosion of some forms of Nyoongar culture in some parts of the South West, Aboriginal people maintain a link to their "country", sites of significance and stories about their country.

Many parts of Aboriginal life are "*place oriented*". *Place* where you were born, *place* where your family came from and *places* where significant events in family and community life occurred are common examples of *place orientation.* This orientation sits closely along side sites of significance and other land-based features of Aboriginal cultural and social life. This continuing relationship provides stability and sustenance and is alive in Nyoongar communities and families.

Any Nyoongar Health Plan needs to understand and respect this relationship.

2.1.2 Respecting History

It is vital to take into account the history of Nyoongar people. In the last 200 years, Nyoongar people have survived colonisation by Europeans. While the resulting dislocation, dispossession, disease, and loss of land and language, the imposition of a foreign culture and social system, poverty, racism, and removal of family and identity has impacted on culture, health and social structures, Nyoongar people and culture have survived.

Aboriginal families and communities carry these experiences with them when engaging non-Aboriginal institutions. For many individuals the experiences of racism, dispossession, family separation and mission life are real and personal. Many surviving Nyoongar people have lived these histories. The inter-generational impact of these histories cannot be ignored.

This Plan seeks to recognise these impacts and provide balanced remediation.

2.1.3 Self Determination and Community Participation

Nyoongar people must be involved in all aspects and at all levels of health care delivery including planning and policy development, administration, implementation and evaluation. Community control through AMSs is supported and encouraged by the NRAHPT as a

means of Nyoongar people participating in, and having responsibility for their own primary health care.

The Nynoongar Health Plan also supports the greater involvement of Nyoongar people in other forms and structures of health system activity. Aboriginal involvement in planning, policy and delivery of health services through secondary and tertiary levels of the health system, including at Board level is also supported. The Nyoongar Health Plan supports innovative and expanded Aboriginal involvement in General Practice. All of these approaches lend support to self-determination for Aboriginal people.

2.1.4 Right of Aboriginal People to Choose Different Health Care

Aboriginal people have the right to be different and choose different models of health care. Aboriginal people have significantly different individual and collective life experiences and value systems than do non-Aboriginal people. The socialisation of Aboriginal children, the structure and functioning of Aboriginal families and the history of interaction between Aboriginal and non-Aboriginal peoples all impact on how decisions are made about choice of, and access to health services. Health care services need to take into account the needs of different groups (as identified by that group) and cater for them.

Health plans must respect Nyoongar people's right to be different, to choose different ways of doing things and to not be penalised because of these choices.

2.1.5 Cultural Security

Aboriginal people often have different expectations, attitudes, rights, values and beliefs regarding health and appropriate health care. Cultural Security is about ensuring that health services offered or delivered to Aboriginal people take into account these legitimate expectations. These beliefs and value systems need to be accommodated in the administrative, clinical and other work-place practices of health services and by health professionals.

There has been significant investment in the provision of cultural awareness programs in the health system. While these have assisted by informing individuals about the history and culture of Aboriginal people, it is often difficult to pinpoint the changes in the delivery of health services to Aboriginal people that flow from this increase in knowledge or changes in attitude. Aboriginal people continue to comment unfavourably on the services offered to Aboriginal people saying that they do not respect or incorporate Aboriginal cultural values or Aboriginal community expectations.

The Nyoongar Health Plan includes a clear commitment to and action intended to identify the critical meeting points between Aboriginal cultural expectation, values, attitudes and rights, and the services delivered by health providers. The Plan seeks to engage Aboriginal cultural leaders and clinicians, administrators and others in the health system in efforts to adapt work practice where appropriate to ensure Aboriginal culture is respected including clinical practice.

2.1.6 Accessibility and Appropriateness of Health Care Services

Accessibility and appropriateness are not just simple attributes of geography and staffing. They also relate to issues of user friendliness, ease of access and ease of understanding. Health services may not be geographically accessible for many Aboriginal people who do not have access to transport or finance. In other cases, services may be geographically accessible but do not understand Aboriginal needs or circumstances. In other circumstances physical barriers, uncomfortable surroundings or other practices such as language or lack of privacy may inhibit access to services, whether or not services regardless of the services proximity to populations.

The Nyoongar Health Plan seeks to ensure that health services, including general practice, hospitals, clinics and community health centres are accessible and appropriate to Nyoongar people.

2.1.7 Holistic Health

Holistic health refers to more than just the physical well-being of the individual, but the individual's, family's and community's social, emotional, cultural and spiritual well-being. Health is directly affected by social determinants such as social status, education, employment, poverty, justice, housing etc. Holistic health refers to an integrated and planned approach to health and human development that take all aspects into account, and also addresses health issues with both traditional and modern means, rather than just focussing on a medical model of care.

Holistic health requires providers to treat clients as whole people and not just the sum of body parts. This will entail providers reorganising the service they offer so that clients are not bounced from one body part operator to another but where possible, related health needs are addressed in one 'sitting'.

2.1.8 Intersectoral Co-ordination of Programs and Approaches

Significant causes and contributors to the patterns and severity of Aboriginal ill health lie outside the health sector's ability to directly manage. Levels of income, educational attainment, unemployment, and housing among others impact on the pattern and risk of ill health for individuals, families and communities. The health sector needs to find innovative ways of engaging other sectors in efforts to address these critical cause and effect linkages.

Aboriginal health requires a holistic approach. It is necessary for many different agencies to be involved and to initiate programs. Health will not always be the lead sector in intersectoral programs.

Care is required to ensure that the selection and introduction of priority intersectoral initiatives is well planned and that the cause and effect relationship is clearly understood by intersectoral partners.

2.1.9 Increased and Secure Resources

Aboriginal health gain as a long-term activity requires guaranteed and adequate funding. Not only will changes in health outcomes take time to emerge, building service capacity and access will also require some lead-time. This will only occur with a genuine and continuing commitment from all key stakeholders, including government. Access to all health services must be based on need and an equitable allocation of resources related to this need is needed to improve the quality of life for Aboriginal people.

2.2 A Framework for Nyoongar Health

The NRAHPT is concerned about, and will ensure that efforts to improve Nyoongar health proceed mindful of Nyoongar values and expectations.

The greater proportion of mainstream health care in Australia generally focuses on the individual person and specific health problems. This "medical model" is largely based on European social, economic, technological and political experiences and processes.

For more than 30 years Aboriginal communities have sought to modify this paradigm so that Aboriginal cultural and social concepts of health could be recognised and incorporated. Failure to incorporate legitimate Aboriginal cultural values, rights and expectations into the health system may breech existing international and domestic standards relating to the protection of fundamental rights and freedoms.

The National Aboriginal and Islander Health Organisation (NAIHO) and its successor, the National Aboriginal Community Controlled Health Organisation (NACCHO) define "Health" for Aboriginal people as:

> "Health does not just mean the physical well-being of the individual but refers to the social, emotional and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.

Critical to this definition is the interplay between Aboriginal individuals, their social organisation and the physical and economic environment in which they live. The considerable emphasis in Western health systems on the individual and individual episodes of hospital or clinical care largely ignores the holistic nature of Aboriginal health, and while they may treat the immediate consequences of ill health, they almost always fail to address causal factors outside the clinical domain.

The Aboriginal community's approach recognises that:

A person is constituted by three separate, though integrated parts:

a body that is required to cope with the physical world we live in and functions normally; ie: has a balanced diet, is well exercised, is cleaned and clothed adequately, and is protected from an often harsh physical environment;

a mind that is required to help us relate with one another in a way that enables meaningful relationships to be developed and maintained. The "mind" of a person is made up of that person's "thoughts" and "feelings". These can be positive or negative (for/against, love/hate); and

a spirit that is required to give meaning to our life, to facilitate an acceptance of the cycle of birth-death-life, is strong, able to reaffirm and guide, and provide security in a world full of challenges.

Aboriginal people have long held that the nature of ill health and disadvantage is linked and cumulative. The impacts of colonisation and past government policies continues to be felt today. This is a theme that is increasingly gaining recognition in the broader community. There is a considerable body of international literature and study that increasingly supports this view:

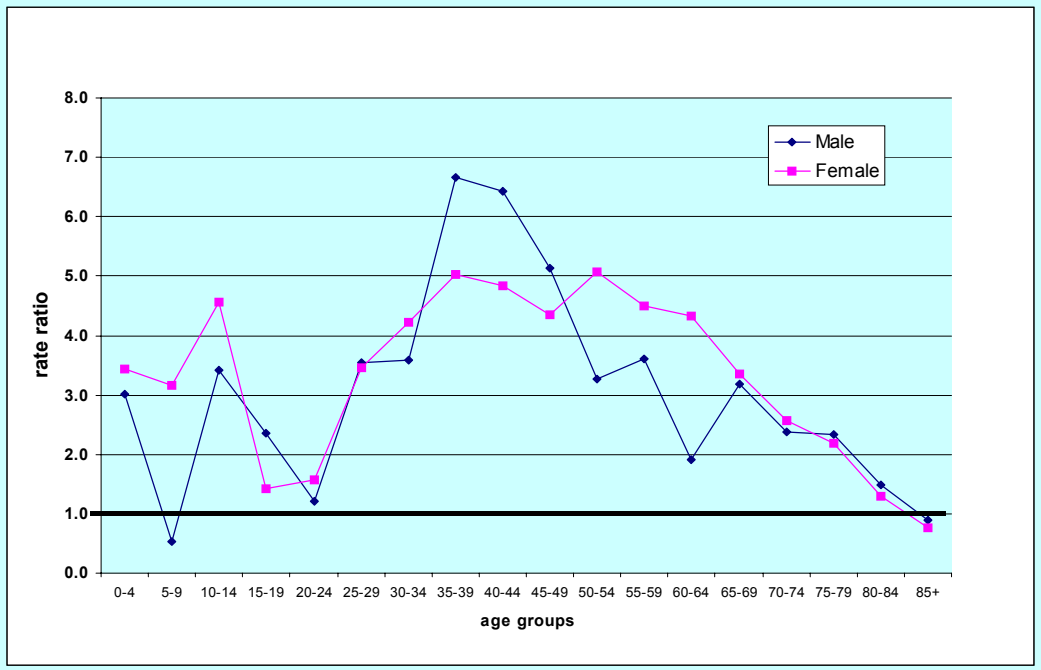
- 🕮 The health and social status of parents is a strong predictor of the health of newborns and children;
- 🕮 The health of the mother, particularly maternal nutrition during pregnancy is an important determinant in key health outcomes of birth including birth-weight, where smoking during pregnancy disrupts foetal growth;
- 🕮 Low birth-weight and maternal ill-health contribute to patterns of ill-health later in life;
- 🕮 Poverty and poor environment impact on growth and development, which in turn impacts on cognitive skills and levels of educational attainment;
- 🕮 Parental social and economic status relates strongly to the educational attainment of children;
- 🕮 Failure to successfully navigate school and the transition to work is a predictor of mortality and chronic morbidity later in life;
- 🕮 Individual social and economic status both impact on and act as a predictor of mortality and morbidity in middle age, and of family dysfunction;
- 🕮 Poor environment, including housing, contributes to chronic ill-health;
- 🕮 Premature death disrupts the inter-generational flow of culture, values and behaviours underpinning social function and cohesion; and
- 🕮 Family function has a relationship to the health of children.

Each of these events impacts on the chances of survival of Nyoongar people in a way that compounds or creates ill-health and inequity. The difference in mortality rates of

Aboriginal and non-Aboriginal West Australians is one measure of the level of inequity endured by Nyoongar communities.

Based on deaths that occurred between 1989 and 1998 (last ten years of available data), the age-standardised mortality rate was 2.5 times higher in Aboriginal males and 2.3 times higher in Aboriginal females than that for the non-Aboriginal community. However, this summary of statistics hides the fact that there are considerable differences in the age standardised mortality rates for different age groups in the Nyoongar community. As shown in the figure below, some age groups show greater disparity in their rates of death than for other ages.

Figure 4: Age Specific Rate Ratios (All-Causes of Death)



Although gender differences are apparent, in general there are three age groups within the Aboriginal population where 'gaps' in the death rate are most apparent. These are:

(1) 0-14 years;
(2) 30-49 years; and
(3) 50-69 years.

As shown in the table below, the major cause of death in these age groups varies. For the 0-14 and 30-49 year old age groups, the rate ratio of deaths due to diseases of the respiratory system is amongst the largest for both males and females. Only for males in the 30-49 year old age group does diseases of the genito-urinary system exceed deaths due to respiratory disease. In the oldest age group, the rate ratio for diseases of blood, mental disorders as well as symptoms, signs and ill-defined conditions and endocrinal diseases are the greatest for females.

Table 2: Age-Specific Rate Ratios by Major Causes of Death (1989-98)

ICD-9 Chapters	0-14 years		30-49 years		50-69 years	
	M	F	M	F	M	F
Infectious disease	6.0	6.2	3.8	6.2	0.0	0.0
Neoplasms	0.0	1.2	1.6	1.2	1.1	1.5
Endocrine disorders	0.0	6.2	7.7	6.2	6.0	17.9
Diseases of blood	0.0	9.3	0.0	9.3	32.1	13.3
Mental disorders	0.0	0.0	5.1	0.0	16.9	16.7
Diseases of nervous system	2.6	2.8	6.1	2.8	5.7	1.4
Diseases of circulatory system	0.0	8.3	8.7	8.3	2.9	6.0
Diseases of respiratory system	11.6	24.9	27.0	24.9	3.5	4.7
Diseases of digestive system	0.0	0.0	15.6	0.0	6.6	8.1
Diseases of genitourinary system	0.0	0.0	48.1	0.0	0.0	3.5
Complications of pregnancy	0.0	0.0	0.0	0.0	0.0	0.0
Diseases of skin	0.0	0.0	0.0	0.0	0.0	0.0
Diseases of musculoskeletal system	0.0	0.0	0.0	0.0	0.0	0.0
Congenital abnormalities	1.6	2.0	0.0	2.0	0.0	0.0
Conditions of perinatal period	2.2	2.1	0.0	2.1	0.0	0.0
Symptoms, signs & ill-defined conditions	8.1	6.8	9.0	6.8	0.0	15.4
Injury and poisoning	3.7	3.9	2.9	3.9	1.8	1.8
Total	**3.2**	**3.8**	**5.1**	**3.8**	**2.5**	**3.7**

Any program aimed at reducing the impact of premature death in the Nyoongar population must also consider the actual number of deaths rather than just focus on those conditions where the largest age-specific rate ratios exist. In addition, caution should be used in those cases where large rate ratios are calculated based on only a few deaths, as the chance of error may be large.

As shown in Table 3 below, the significant causes of death differ between the age groups. In many cases, the cause of death with the largest rate ratio is not the cause that is responsible for the greatest number of deaths in Nyoongar people.

For the 0-14 year old group, death due to respiratory disease, disorders due to low birth-weight or short gestation, SIDS and deaths due to injury and poisoning accounted for 60 deaths or 46 percent of all deaths in this age group in the ten years to 1989.

In the 30-49 year old group, major specific causes of death included cancers (females), diabetes, ischaemic heart disease and stroke, pneumonia and influenza, motor vehicle accidents, suicide and homicide. This group accounted for 169 deaths in total between 1989-98 or 73 percent of all deaths in this age group.

In the 50-69 year old group, the most common causes of death were lung and digestive system cancers, diabetes, ischaemic heart disease and stroke, chronic obstructive airway disease, acute alcoholic hepatitis and alcoholic cirrhosis of the liver. Some 211 deaths were caused by these conditions in this age group in the ten-year period to 1989. Ninety percent of all deaths in this age group were caused by these conditions.

Table 3: Actual Number of Aboriginal Deaths (1989-98) by Major Cause

Number of deaths	0-14 years		30-49 years		50-69 years	
	M	**F**	**M**	**F**	**M**	**F**
Infectious disease	2	2	2	0	0	0
Neoplasms	0	1	11	11	*22*	*26*
Endocrine disorders	0	2	11	6	8	*20*
Diseases of blood	0	1	0	1	2	1
Mental disorders	0	0	5	2	5	3
Diseases of nervous system	3	2	4	2	4	1
Diseases of circulatory system	0	2	*45*	*19*	*48*	*48*
Diseases of respiratory system	5	*10*	13	7	10	9
Diseases of digestive system	0	0	15	9	11	9
Diseases of genitourinary system	0	0	3	3	0	1
Complications of pregnancy	0	0	0	0	0	0
Diseases of skin	0	0	0	0	0	0
Diseases of musculoskeletal system	0	0	0	0	0	0
Congenital abnormalities	8	8	0	1	0	0
Conditions of perinatal period	*13*	*10*	0	0	0	0
Symptoms, signs & ill-defined conditions	*24*	*14*	2	0	0	1
Injury and poisoning	*14*	*8*	*30*	*17*	4	2
Total	**69**	**60**	**141**	**78**	**114**	**121**

These major causes accounted for 75 percent of all deaths in the three age priority groups described above.

Although annual numbers of specific causes of death are too low to enable trends to be accurately determined in this population cohort, most of the differences in the rates of deaths between Aboriginal and non-Aboriginal people are statistically significant. The age-specific analysis of the major causes of death in the Aboriginal population highlights that while there is overlap, each age group has a range of age related conditions that account for most of the deaths within that age group.

2.3 Predicting the future

WA and all other States and Territories have agreed to a set of National Performance Indicators in Aboriginal and Torres Strait Islander Health. WA has already produced two annual reports addressing these indicators. One of the principle measures of performance is the achievement of a 20 percent reduction in all cause age-standardised mortality rate ratios by 2010.

Based on 1989-98 death data, the mortality rate for Aboriginal males and females is 2.5 and 2.3 times higher than for non-Aboriginals who live in the region covered by this Plan. If a 20 percent reduction is to be made over the next ten years relative to the non-Aboriginal population, then the rate ratio will need to diminish to approximately 1.9 and 1.8 respectively.

Translating this to a number of deaths that need to be "saved" is not straightforward. During this time, the Aboriginal and non-Aboriginal population will grow in size and age (possibly at different rates) and the annual rate of death in the non-Aboriginal population is expected to continue on its current downward trend.

Central to the estimation is the availability of reliable future population estimates for the area. The Ministry of Planning recently released annual population estimates by Local Government Area up to the year 2016. Unfortunately these are only for the total population and a breakdown by Aboriginality is not available.

However, using another tool available at the Epidemiology Branch, HDWA can estimate future population figures based on historical numbers. Comparison of the two sets of figures reveals the latter method slightly overestimates the 2010 population, but only by 0.35 percent. Thus, these figures can be used with some degree of confidence.

2.4 Trends in the age-standardised mortality rates

Since 1983, the number of deaths in the region covered by the Nyoongar Health Plan has increased from 56 Aboriginal and 6800 non-Aboriginal to 88 and 8460 people respectively. Despite the increasing number of deaths, the age-standardised mortality rates have decreased by an annual average of – 1 percent and – 2.7 percent for Aboriginals and non-Aboriginals respectively. This is as a result of increased life expectancy. The final rates 1998 were 1260 per 100,000 per year for Aboriginals and 550 per 100,000 per year for non-Aboriginals.

While the reduction in the mortality rate is pleasing, the fact that the non-Aboriginal community death rate is reducing at a greater rate than the Aboriginal community, means that a 20 per cent reduction in the rate ratio will require a larger change in the Aboriginal mortality rate.

2.5 Setting the Target for 2010

2.5.1 Estimating the 2010 Non-Aboriginal Age-Standardised Mortality Rate

Due to larger numbers it is more accurate to estimate the non-Aboriginal mortality rate than the Aboriginal figure. Based on annual death data between 1989 and 1998, the projected total number of non-Aboriginal deaths in 2010 is expected to be 10,931 (± 200). This produces an age-standardised rate of 519 (± 5) per 100,000 per year.

2.5.2 Estimating the 2010 Aboriginal Age-Standardised Mortality Rate

Using a similar method to that used for the non-Aboriginal population, the future number of deaths and mortality rates for the Aboriginal population were estimated to be 139 (± 23) and 1,367 (± 145) per 100,000 per year respectively. This figure yields a rate ratio of 2.6 (compared to a current figure of 2.3 and a desired figure of 1.9). This increase in the rate ratio reflects the widening gap in death rates due to the different annual percentage decrease mentioned above.

What number of deaths needs to be reached to achieve a mortality rate ratio of less than 1.9?

If a target of a 20 percent reduction in the mortality rate ratio is required by the year 2010 and the estimated age standardised mortality rate for the non-Aboriginal population is 519 per 100,000 person years, then an Aboriginal mortality rate of approximately 990 per 100,000person years is required. If the number of deaths can be reduced to only 104 in the year 2010, then; depending upon the actual ages of death, the mortality rate will fall into the range of 960–1010 per 100,000 person years. This will yield a rate ratio of the required size.

2.5.3 The Bottom Line

Thus, based on the estimates shown above, 35 deaths (139–104, a 25 per cent reduction in the actual number of deaths) must be prevented by any intervention or combination of interventions.

2.6 Foundations for Nyoongar Health - Summary

The four key areas in this framework are:

- Recognition of the Aboriginal definition of health;
- Commitment to the underlying principles;
- Recognition of the cumulative nature of Nyoongar ill-health and inequity; and
- Targeting of effort to reduce untimely or unnecessary death to establish a rate ratio better than 1.9 by 2010.

In moving to address the state of Nyoongar health outlined in the following sections the NRAHPT believes that strategies need to be mindful of these essential elements.

3. Building Nyoongar Health

This section contains four groups of linked strategies that the Nyoongar Regional Aboriginal Health Planning Team believes will reduce the levels of ill-health in Nyoongar communities consistent with the Nyoongar foundations described in the previous section. The four groups of strategies are:

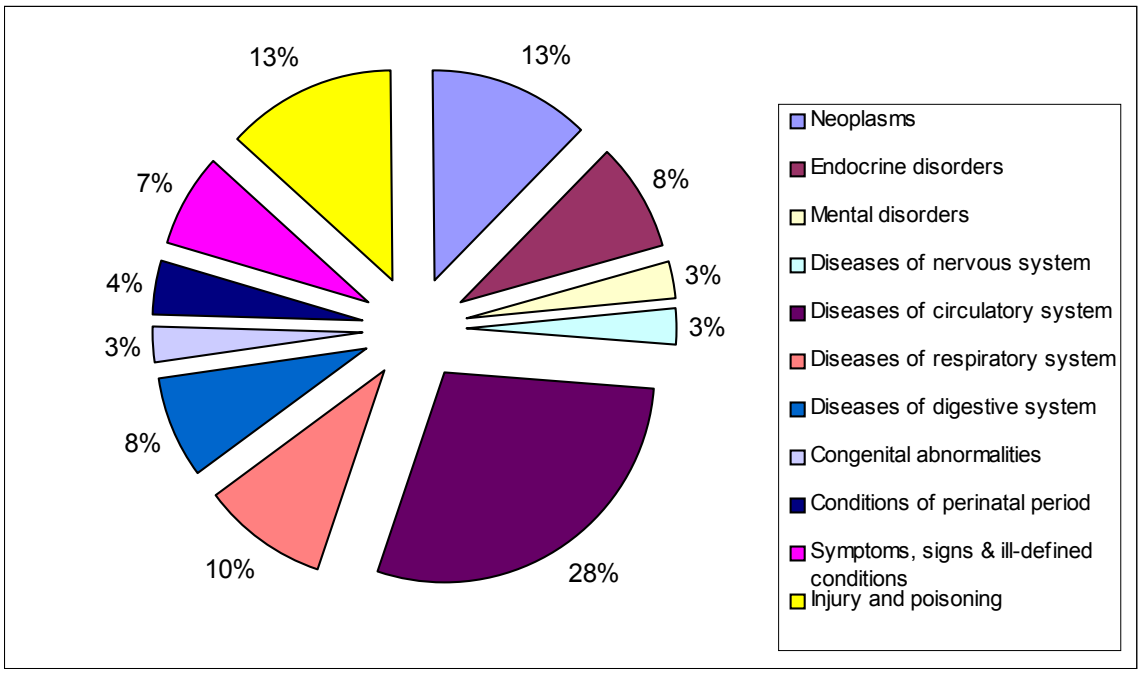
- Strategies to reduce death from ***Specific Conditions;***
- Strategies to improve the contribution from ***Other Sectors;***
- Strategies to protect and enhance the ***Social Capital*** of Nyoongar communities; and
- Strategies to improve the ***Infrastructure and Performance*** of the health system.

This section builds on the work in the previous section, particularly the priority age groups.

3.1 Strategies to Reduce Death from Specific Conditions

Aboriginal people suffer from the same health problems as non-Aboriginal people. However, Aboriginal people tend to suffer from these problems more frequently and more severely. The distribution of deaths in the Nyoongar community in the priority age groups is demonstrated in Figure 5.

Figure 5. Cause of Death – Selected Age Groups in the Nyoongar Community.



The top six causes of death in the priority age groups identified earlier in this Plan accounted for 80 per cent of all deaths in the period under review.

Table 4 Percent of Deaths in Selected Age Groups in the Nyoongar Community

Condition	% of Deaths
Cardiovascular	28.7
Injury and Poisoning	13.3
Neoplasms	12.5
Respiratory	9.6
Endocrine	8.3
Digestive	7.8

Aboriginal people suffer from a range of chronic diseases that are preventable, manageable or curable.

Dealing effectively with these conditions will require a reasoned mix of innovative primary and secondary health services. Health promotion, risk reduction and effective primary medical care provided by teams involving AHWs, doctors, nurses and other practitioners in locations close to where families reside is proposed by this Plan.

Action to address Nyoongar access to secondary and tertiary care services is also required. Analysis of the 39,000 admissions to WA hospitals identified as Aboriginal in 1998/99 has shown:

- 10,606 episodes (27%) were for Aboriginal people living in the metropolitan area, accounting for 21,345 (19%) nights of stay, including 2861 (15%) excess nights of stay. A significant proportion, 8,299 or 78% of all admissions were to a teaching hospital, 1564 or 15% to a metropolitan non-teaching hospital with the balance occurring in private or country hospitals. 7288 (21%) of all Scaled Central Episodes (SCE98) were attributed to Aboriginal people living in the metropolitan area with 1,172 (16%) exceptional episodes.

- 2321 episodes (6%) were for Aboriginal people living in the Great Southern and South West regions, accounting for 7358 (6%) nights of stay, including 879 (5%) excess nights of stay. Most admissions (85%) for Aboriginal people living in the Great Southern and South West were to hospitals within these regions. Admissions from these regions to teaching hospitals accounted for 6% of all Aboriginal admissions for 98/99 with admissions to private and metropolitan non-teaching hospitals accounting for about 1% of admissions from those regions. 2045 (6%) of all SCE 98s were attributed to Aboriginal people living in these regions with 350 (5%) exceptional episodes attributed.

- 938 episodes (2.5%) were for Nyoongar people living in the Midlands region, accounting for 2676 nights of stay, including 342 excess nights of stay. Most admissions (74%) for Aboriginal people from the Midlands, were to country hospitals with 22% of episodes for Aboriginal people from the Midlands occurring in teaching hospitals. Episodes in metropolitan non-teaching hospitals accounted for 3% while only 1% of episodes occurred in a private hospital. Some 2% of all Scaled Central Episodes were attributed to episodes from Midlands' residents with 149 (2%) of exceptional episodes attributed.

The way in which many Nyoongar people respond or don't respond to the natural progression of disease leads many to an entry point to care often well into the pattern of progression. Nyoongar people tend not to present early and consequently the burden of ill-health is high for most at presentation. Continuous examination of acute care sector activity can provide useful information on the levels of access to services offered (mindful of the prevalence and incidence of disease) and more importantly where gaps or deficiencies in quality of care and type of care exist. This would be particularly relevant when coupled with prevalence and incidence data from the primary health care setting.

In considering the following group of priority conditions, the NRAHPT believes that well organised processes need to be established to bring together planning, service enhancement and monitoring and data analysis across primary, secondary and tertiary levels of care.

3.1.1 Cardiovascular Disease

CVDs remain among the leading causes of death among Nyoongar people and contribute substantially to the excess mortality experienced by Nyoongar people in middle age and latter life. Heart attacks, ischaemic health disease and stroke account for the majority of cardiovascular disease among Nyoongar people.

Data provided earlier indicates that more than 50 per cent of all deaths from CVD in the Nyoongar community in the ten years to 1998 were found in the 30-49 and 50-65 year age groups. While perhaps not surprising, these numbers are nevertheless important. Ongoing investigations suggest that attention to Aboriginal access to and service utilisation patterns in the secondary and tertiary level CVD services is required.

Analyses of the patterns of admission for Aboriginal people born in the 1940s suggest that they receive a level of service more typical of end-of-life care. This analysis suggests that Aboriginal people in this age cohort do not generally access high cost medical care at levels that might otherwise be expected. Improved co-ordination of services is essential to provide for timely access to CVD secondary and tertiary care for Aboriginal people identified at high risk is essential.

Reductions in the number of deaths from CVD can be achieved by ensuring access to quality clinical services, however a balanced strategy also requires investment in effective and well targeted prevention and promotion initiatives.

Risk factors that contribute to the high incidence of CVD among Nyoongar people include obesity, a sedentary lifestyle and smoking. All of these risk factors could be modified to realise a large improvement in the health of Nyoongar people. Strategies to change the diet of Aboriginal families must engage not only the at-risk individual but also the family member who purchases and prepares food. Smoking in Aboriginal communities has remained a significant challenge for many years. Reductions in the number of smokers in the non-Aboriginal community have not been mirrored in the Nyoongar community. Careful analysis of Nyoongar attitudes to smoking is required to ensure that health promotion messages are relevant and that programs to reduce smoking are well targeted.

In Nyoongar country, heart health programs are run at DYHS and SWAMS. These programs aim to screen clients, identify at-risk individuals and provide prevention and/or management programs to individuals and families. Both the WAACCT and the AFFP in Albany focus on identification of at risk individuals and the development of suitable client care programs.

There are however a significant number of Nyoongar communities not serviced by specific CVD programs. The current heart health effort needs to be supplemented with new operational arrangements that expand the range and coverage of primary and secondary prevention services to Nyoongar families. Such expanded services may well be achieved by improving relationships between General Practice, ACCHOs, the NHF and secondary/tertiary level services.

The NRAHPT believes that a new pilot "Nyoongar Family Practice" program, based in General Practice, should be established.

This pilot would be based around improved utilisation of AHWs in General Practice. Such strategies would provide an effective means of improving coverage in a culturally secure and cost-effective manner. Clearly though these arrangements will need to be premised on innovative partnerships with ACCHOs and local Nyoongar communities.

In the metropolitan and regional areas, there has been decentralisation of Aboriginal health service (Initially DYHS and SWAMS, then any others as they might emerge) to suburban population centres, with the establishment of the Mirrabooka and Maddington sites. Where Aboriginal Health Service clinics are decentralised, it is imperative that appropriate funding is provided to ensure an adequate health service is provided. Improved services for the metropolitan community contemplated in this, and other sections of this Plan, is predicated on the successful decentralisation of DYHS services. These new arrangements are discussed in more detail later in this document.

Priorities

- Disseminate heart health care protocols used in the WAACCT and the provision of training for AHWs and other primary health care providers;
- Promotion, prevention and education projects among young Nyoongar people in order to promote early behaviour changes;
- Research, develop and implement effective marketing strategies that target Nyoongar smoking;

- Develop innovative partnering arrangements such as (NFPs) between General Practice, ACCHOs, secondary and, tertiary level providers that improve the identification, treatment and ongoing management of high risk individuals;
- Establishment of core funding for decentralised clinics for Aboriginal health services including provision of new and enhanced health service infrastructure in rural Nyoongar population centres particularly those health districts with significantly higher mortality rates for CVD; and
- Expand co-operation with the NHF services.

3.1.2 Injuries and Poisoning

Rates of death and hospitalisation from injuries are very high among Aboriginal people. Between 1989-98, twenty-two deaths were recorded in the 0-14 age group in Nyoongar communities. Forty-seven deaths were recorded in the 30-49 year age group.

Transport related injury and death account for the majority of non-intentional injuries. Most of these involve motor vehicle crashes. About half of all crashes involving Aboriginal people involved a single vehicle and almost 80 per cent of crashes occurred in rural areas. Living in rural areas and travelling on rural roads at higher speeds is another risk factor. Alcohol remains a feature in road crashes involving Aboriginal people.

Expansion and intensification of existing pilot road safety as well as youth support and development programs currently operating in the metropolitan area and in some country areas is required. The targeting of campaigns intended to reduce at-risk behaviours needs to be tailored to a Nyoongar perspective. Efforts to validate the relevance of current non-Aboriginal prevention and promotion messages (ie shock ads) are required.

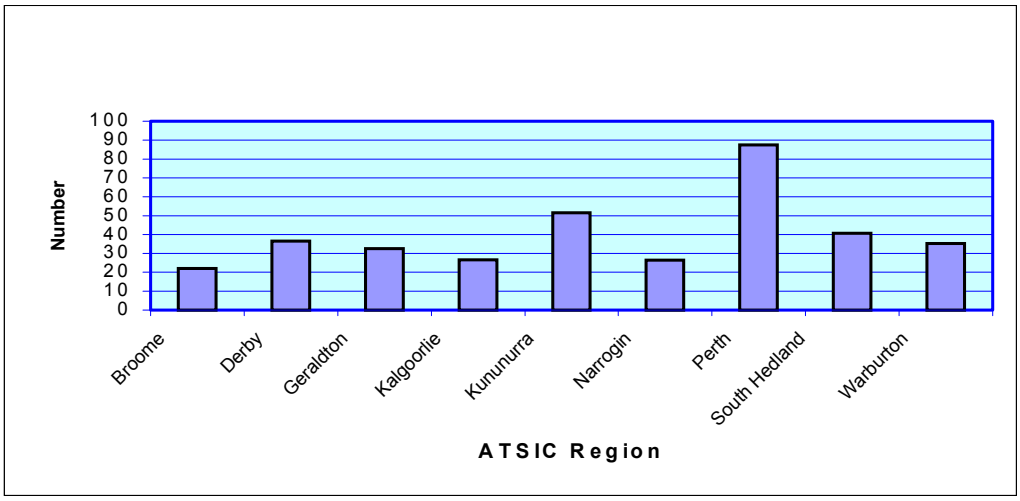
Suicide and self-harm are a major cause of intentional injury. There is a high incidence of suicide and deliberate self-harm amongst Aboriginal youth. The rate of suicide among WA Aboriginal youth is double that of their non-Aboriginal counterparts. Homicide is also a significant cause of intentional injury and communities have expressed concern at the levels of internal violence in Aboriginal families and communities. Domestic violence is of particular concern.

Recent discussion of intentional harm in Aboriginal communities has demonstrated strong support for the development of family and community centred services. These services should endeavour to strengthen:

- the capacity of families, communities and health service decision makers to understand the genesis of intentional self-harm from an Aboriginal perspective;
- recognition of the importance of consistent and culturally secure primary and secondary intervention at a family and community level; and
- support for a balanced combination of clinical and non-clinical strategies.

Death from injury and poisoning is often overlooked when developing strategies to improve Aboriginal health.

Figure 6. Distribution of Observed Deaths by ATSIC Region – Injury and Poisoning.



Addressing injury and poisoning in Nyoongar communities should be given greater weight than it has in the past. Figure 6 above maps the distribution of death across ATSIC regions. Across the state, over the past 10 years, more than twice the number of Aboriginal people died from car crashes than from homicide/violence or a death in custody combined. A significant number of deaths are caused by injury and poisoning and the NRAHPT believes that more attention should be devoted to this issue.

Priorities

- Targeted road safety campaigns particularly relating to the impact of alcohol;
- Target suicide prevention at Nyoongar children and young people under the age of 25 years;
- Development of suicide prevention training manuals for staff who deal with young Nyoongar people;
- Develop and extend the coverage of emotional and social well-being services to the Nyoongar community;
- Promote services directed at strengthening family and community cohesion; and
- Expand the range and nature of violence prevention programs directed at Aboriginal communities.

3.1.3. Cancers

There were 121 deaths in Nyoongar men and women in the period 1989-98. Across the state 41% of all deaths from cancer amongst Aboriginal people in WA were recorded in the Nyoongar community. In the period 1989-98 the standardised mortality ratio in the Perth ATSIC region attributed to cancer exceeded 80/100,000 person years.

During 1998/99 hospitalisations for Nyoongar people in the metropolitan South West regions for neoplasms were:

- 50% of admissions were for males;

- Leukemia was the most common diagnosis for males followed by brain and mouth cancers;
- Uterine leiomyoma and breast/cervical cancer were the most common for females; and
- There were only three episodes with a principal diagnosis for lung cancer in the year.

While it is responsible for a significant number of deaths, particularly in latter years neoplasms do not rank in the top six causes of hospitalisation for Nyoongar males or females.

The OAH has recently engaged the CFWA to conduct market research in Aboriginal communities to determine the attitudes to and motivational issues involved in taking up or ceasing smoking. This will be of particular relevance to new campaigns dealing with this form of risk behaviour. Continuing co-operation between Nyoongar health services and the CFWA should be encouraged.

Priorities

- Expand health promotion services targeting both men and women
- Improve the early identification of all forms of cancers for males and females
- Ensure the effective referral of Nyoongar people to culturally secure treatment services including secondary and tertiary level services
- Develop culturally secure support services for Nyoongar people with cancer
- Establish research, services and develop linkages with relevant agencies such as the CFWA.

3.1.4 Diabetes and Renal Disease

Non-Insulin Dependent Diabetes Mellitus (Type 2 Diabetes) is more prevalent and has an earlier age of onset in Aboriginal people than for the general Australian population. In addition to having a major impact on general quality of life, the long term effects of diabetes include a greater risk of heart attack, stroke, blindness, kidney problems, lower limb amputations and reduced life expectancy. In the Nyoongar community here were 80 deaths from endocrinal disease (mainly diabetes) in the ten years to 1998. This accounts for 31% of all deaths from this cause in Aboriginal Western Australians.

The risk factors for the development of diabetes are the same for cardiovascular disease. Therefore, the impact of diabetes on Nyoongar people can be lessened with modification of these risk factors. DYHS and SWAMS provide community based prevention and education programs and diabetes screening programs. Diabetes in Nyoongar families can be corrected with the adoption of improved nutritional behaviours.

Evidence has suggested that the use of traditional foods and the associated improvement in physical activity can reduce the level of diabetes in Aboriginal families. The conduct of more general family screening or health planning initiatives at the family level have revealed significant numbers of Aboriginal people with undiagnosed diabetes in the metropolitan area. Such initiatives should be extended to the broader Nyoongar community. Effective support and case management structures will be required to ensure Nyoongars identified with diabetes are able to access appropriate services.

A recent survey of the capacity of ACCHOs to effectively deal with diabetes has shown a considerable variation across the state. Initiatives to address diabetes are hampered by the lack of skilled staff, promotion resources and equipment. Efforts are required to ensure a consistent quality and capacity to service client needs at the community level.

Kidney disease is a major contributor to ill-health among Aboriginal people. The high incidence of kidney problems is partly based on lifestyle characteristics such as infections, as well as nutritional and alcohol-related problems. Diabetes is a predisposing factor to the development of kidney disease.

Reviewing data for 98/99 the Nyoongar Regional Aboriginal Health Planning Team found that hospitalisation for renal failure in men in the Nyoongar community occurred from about the mid thirties but mostly in latter life, 55 years plus. There was one death in the Nyoongar community from renal causes in 1998.

Priorities

- Improve community based education and promotion programs to prevent the onset of diabetes and renal disease;
- Improve identification of individuals at risk of diabetes or individuals with undiagnosed diabetes, including through optic retinal screening;
- Extend nutrition and exercise programs; and
- Improve the management of patient diabetes with particular emphasis on local services.

3.1.5 Digestive Illness

Digestive and nutritional diseases, which include disorders of the mouth, oesophagus, stomach, small and large intestines, liver and pancreas are among the most prominent causes of death and hospitalisation for Nyoongars. There were some 63 deaths from digestive diseases in Nyoongar men and women in the ten years to 1998.

For Nyoongar males hospitalisation for digestive disease appears to rise from the late 20's through to the late 50's with similar patterns for Nyoongar women. Interestingly hospitalisation of Nyoongar infants (0-4 years) for these causes is also a notable feature.

Earlier works examining digestive disease in Aboriginal adults in WA found that alcohol-related illness were prominent as a cause of hospitalisation. This included cirrhosis of the liver, pancreatitis and gall bladder infections. For Aboriginal infants environmental factors including gastrointestinal infections appeared as a feature.

Priorities

- Develop appropriate screening programs for at risk clients;
- Expand appropriate health education/treatment services;
- Inclusion of environmental issues and its relationship to digestive diseases in infants within maternal and child health initiatives; and
- Improve links between primary health care providers and Nyoongar alcohol services.

3.1.6 Respiratory Disease

Chronic Obstructive Pulmonary Disease (COPD) accounts for the greatest number of male deaths in the Nyoongar community for respiratory disease. There were 23 male deaths in the Nyoongar community during 1998 from this cause. In addition there were 15 deaths from this cause in Nyoongar women. Deaths in males seem to start in mid-life whereas for women deaths occur mainly later in life.

For Nyoongar males Acute Respiratory Infection (ARI) accounted for the largest number of admissions to hospital in this category in 1998. This was followed by COPD. More than 77% of all admissions of Nyoongar men for respiratory disease in 1998 fell into these two causes. Similarly for Nyoongar women 76% of admissions were attributed to these two causes.

Greater use of self-management of asthma based on sound education and training for Nyoongars may improve not only hospital outcomes but also quality of life and mortality. A number of studies have shown that self-management education reduced:

- hospitalisations;
- emergency room visits;
- unscheduled visits to the doctor;
- days off work or school; and
- nocturnal asthma.

Self-management programs for asthmatics that involved a written action plan have resulted in a greater reduction in hospitalisation than for those clients without written plans. People who managed their asthma by self-adjustment of their medications using an individualised written plan also had better lung function than those whose medications were adjusted by a doctor. The partnering of regular medical review and self management programs however appears to offer the best result. The WAACCT has proven the value of sound care planning for Nyoongars. Application of an WAACCT style of operations may well assist in the management of COPD.

Strategies that help management of COPD in the home are also useful programs which involve the family in prevention initiatives and therapy, may be of value. There are some indications that family therapy may be a useful adjunct to medication for children with asthma.

Smoking is a major contributor to COPD. Elimination of smoking by sufferers and in the family home is a valuable first step. Good nutrition and reductions in obesity and improved exercise can also help the management of COPD. Importantly, each of these strategies involves families.

In the broader approach of this Plan, spirometric screening of high-risk patients may be useful for the early prevention of chronic bronchitis. Annual screening during a health check-up for smokers, patients with recurrent or chronic respiratory symptoms and those with a family history of pulmonary disease can easily be integrated into the life course and family base adopted by this Plan.

Priorities

- Develop effective respiratory disease screening in annual health checks for Nyoongars;
- Review and disseminate the respiratory diseases care plan. Western Australian Aboriginal Co-ordinated Care Trial for use by GPs, AHWs and families;
- Expand current self management education initiatives for Nyoongars;
- Link health promotion programs targeting obesity, exercise and other related behaviours with respiratory disease initiatives; and
- Ensure particular emphasis on programs designed to eliminate smoking and other causes of airways infection in the family home.

Summary

These six causes accounted for more than 760 Nyoongar deaths in the ten years to 1998.

3.2 Special Populations and Programs

In addition to the above priority conditions Nyoongar communities identified a range of issues that are considered to be important additional services required to ensure early and sustainable improvements in their health and well-being.

3.2.1 Dental Health

Nyoongar health workers throughout the region have identified dental health as a major problem. Limited access to dental services, high costs, lack of awareness and fear lead to poor oral health among Nyoongar people.

The consequences of poor oral health may include pain, impaired speech, infection and trouble with eating. There is little data and research in this field. However, it is known that Nyoongar people seek emergency dental services more often than they seek preventative care. Pain management appears to be a very common factor driving Nyoongars to seek dental services. Conversely when pain is absent attention is not sought even though dental needs remain. Primary school dental services cover most small children for general but not specialist services.

The WAACCT operating at DYHS and SWAMS have both found significant demand for dental services while assessing client needs and preparing health care plans for their enrolled populations.

Dental treatment is available at the DYHS on site and SWAMS has contracted dental services from local providers. Both DYHS and SWAMS services began essentially as emergency treatment, but have now had to extend those to more complex work including orthodontic and prosthodontic services. Lengthy waiting time for services in both locations is common.

Interestingly ACCHOs have balanced the traditional child focussed services with the social importance of prosthodontic work for parents and Elders. Attention to the latter has had the impact of encouraging family groups to approach dental health with a new perspective. Experience has shown that by improving the dental health of Elders and older community people this group then take on a role of encouraging younger people, particularly grandchildren to address their dental health needs.

Improved access to care is needed to encourage people to have check-ups. Improved access to general oral health services should result in less emergency care and more planned care, shorter waiting times for non-emergency care and fewer extractions.

The recent decisions by the WA Government to establish the Western Australian Centre for Oral Health and include expanded access to state funded dental services are welcomed. These new initiatives provide a worthwhile basis for Nyoongar health stakeholders to explore new alliances.

Priorities

- Targeted oral health education campaigns;
- Improve access to general oral health services for Nyoongar people;
- Encourage services to Elders and older community people, and support family action to improve dental health;
- Establish new contracting arrangements involving dentists in private practice to provide services in small communities; and
- Establish a new partnership with the WACOH.

3.2.2 Alcohol and Substance Abuse

Alcohol and substance abuse is a risk factor common to a number of the principal causes of death and hospitalisation of Nyoongar people. Earlier evidence in this plan highlights the importance of targeting programs in this area. Of the 58% of Nyoongars who drink approximately 44% do so at levels harmful to their health.

The Noongar Alcohol and Substance Abuse Service (NASAS) provides some support programs including counselling services, as well as education on the dangers of drug and alcohol use, safe sex practice, STDs, personal hygiene, self-esteem and respect for self and others. In addition, NASAS has held workshops at Longmore Detention Centre and Lake Jasper as well as the Swan Valley Nyoongar Community. Similar projects are soon to commence in Bunbury.

The Commonwealth Office of Aboriginal and Torres Strait Islander Health (OATSIH) has recently undertaken a national review of their substance misuse programs and are in the process of implementing the recommendations from this review.

While there are some resources and effective services for Nyoongar people in the Metropolitan area, there are significantly fewer resources and services available to Nyoongars in rural and regional areas covered by this Plan.

Research conducted jointly between Curtin University and Albany Aboriginal Corporation found that use of alcohol, cannabis, and volatile substances begins at about age thirteen, which coincides with the beginning of secondary school. In older age groups, being unemployed was closely linked to higher levels of alcohol consumption. The same study also reported that the majority of Nyoongar youth had a sound general knowledge of the adverse health effects of both smoking and alcohol consumption. However, this did not necessarily prevent youth from smoking and drinking.

In the Albany study, Nyoongar parents made it clear that they wanted more information on both drugs and alcohol for themselves and their children. Most people thought that AHWs and teachers were the best people to provide drug and alcohol education. They also suggested that "ex-users" get involved in programs to offer a different perspective. Family oriented activities, and sport and recreation targeted specifically at teenagers, but also involving both parents and children were recommended as positive ways to reduce abuse.

The 1994 Summit on Alcohol Abuse held in Perth and regional workshops identified several approaches to dealing with alcohol problems in WA that were based on a holistic approach. It stressed that alcohol abuse cannot be seen in isolation and other critical factors that impact on Aboriginal lives, including housing, general health programs, employment, education and family violence need to be addressed.

In recent times Nyoongar community leaders and organisations have been concerned about the level of 'acceptance' some drug use and alcohol abuse has gained in Nyoongar communities. In some sectors of the community, illicit drug use and/or alcohol abuse is seen as part of an acceptable social environment for Aboriginal families and people. The NRAHPT rejects the notion that illicit drug use or alcohol abuse should be part of any Nyoongar family life.

There is a need for a range of services including:

- culturally secure detoxification services for alcohol and other substances;
- appropriate treatment and rehabilitation programs for clients and families;
- intensive family support, training and employment support and counselling particularly where children are involved; and
- strong community and family level action to eliminate drug use and alcohol abuse as "acceptable" social activities.

Priorities

- Target prevention programs at all age groups, include the promotion of role models, and the health and social risks associated with excess alcohol consumption and illicit drug taking;
- Increase treatment options such as alcohol and drug counselling, rehabilitation, detoxification and sobering-up shelters;
- Improve training for Aboriginal community workers broadly AHWs more specifically;
- Improve education of mainstream workers in culturally appropriate ways;
- Monitor underage drinking and restriction of sales or prosecutions where appropriate;
- Educate children and youth in their own traditions and culture including provision of alternatives to alcohol; and
- Improve communication, particularly between police and Aboriginal people.

3.2.3 Smoking

Smoking is a major contributing factor to the development of heart disease, and adds to complications with many other illnesses such as diabetes, respiratory problems, high blood pressure and stroke. In addition to this, children of parents that smoke often have lower birth-weight and are more likely to suffer from asthma, respiratory problems and health problems in general.

The National Aboriginal and Torres Strait Islander Survey found that approximately 50% of Aboriginal people smoked, which is double the proportion found in the general population. In the Perth ATSIC Region – 50.2% of Nyoongar males and 49.5% of Nyoongar females aged 13 years or more stated that they smoked. In the Kaata-Wangkinyiny ATSIC Region, the rates were 38.1% for females and 57.2% for males.

Aboriginal males die from tobacco-caused conditions 2.4 times as frequently as non-Aboriginal males, and Aboriginal females 3.7 times as often as non-Aboriginal females. Aboriginal males are admitted to hospital for tobacco-caused conditions at 2.6 times the rate of non-Aboriginal males, and Aboriginal females at 4.7 times the rate of non-Aboriginal females.

There are a number of anti-smoking education initiatives targeted at Nyoongar people. The most prominent of these initiatives is the "Say No to Smokes" campaign. In addition, AHWs and other health professionals provide health promotion services on a one-to-one basis. The Nyoongar community generally has a sound knowledge of the health risks associated with smoking.

In the general community targeted health promotion strategies have made a significant contribution to the reduction of smoking. Recently the OAH and CFWA embarked on market research that identifies Aboriginal views towards as well as the motivating factors leading to cessation of smoking. This research will lead to the development of well-targeted and highly relevant health promotion initiatives encouraging smoking cessation in the Aboriginal community.

Priorities

- Expand market research as a tool to assist in the targeting of smoking cessation programs in Nyoongar communities;
- Continue to enhance health promotion activities and disseminate information about the health risks associated with smoking;
- Develop additional strategies to support those Nyoongar people who wish to give up smoking; and
- Develop closer partnerships with relevant agencies such as the CFWA.

3.2.4 Perinatal Period

Aboriginal women tend to be younger when they give birth and have more children than non-Aboriginal women. Rates of complications such as anaemia and urinary tract infections and rates of diabetes in pregnancy tend to be higher among Aboriginal women. Nyoongar women also tend to present to health services later in their pregnancy than non-Aboriginal women. This is for a variety of reasons including lack of access to appropriate health care services.

Aboriginal mothers are about twice as likely as non-Aboriginal women to give birth to babies of low birth-weight. SIDS was the major cause of death among babies born to Aboriginal mothers in recent years. In addition, the infant mortality rate is higher among babies born to Aboriginal women.

Table 5 below details the distribution of birth-weights of Nyoongar babies. About 13% of all Nyoongar babies are born weighing less than 2500 grams. This rate is about twice that of the non-Aboriginal community in WA. Attention to the causes of low birth-weights is required in Nyoongar communities.

Establishing a sound birth-weight provides a contribution to reductions in ill-health later in life. Services that target the transition of girls to womanhood and their health during pregnancy are important to efforts to improve birth-weights. Parallel programs that support the strength of family units can also have a positive impact on maternal and child health. As noted elsewhere improving the economic standing of Nyoongar families will contribute to improved outcomes for babies both in the short and long term

.

Table 5 Distribution of Low Birth-Weight Babies in the Nyoongar Community

	Aboriginal births				**Non-Aboriginal births**			
	LBW <2500g	non LBW >2500g	Total	LBW % of total	LBW <2500g	non LBW >2500g	Total	LBW % of total
E metro	14	122	136	10.3	228	3414	3642	6.3
N metro	22	102	124	17.7	372	5696	6068	6.1
SE metro	18	153	171	10.5	257	3909	4166	6.2
SW metro	21	101	122	17.2	253	3922	4175	6.1
South West	8	55	63	12.7	106	1591	1697	6.2
Gt. Sthn	7	55	62	11.3	59	972	1031	5.7
Midlands	3	41	44	6.8	41	682	723	5.7
Total	93	629	722	12.9	1316	20186	21502	6.1

Aboriginal infants and young children are more likely to have high rates of infections particularly of the respiratory system, gastrointestinal system, ears, nose and throat. These recurrent infections are often linked to the nutrition of both mothers and children. Maternal nutrition and foetal and infant growth can affect the risk of CVD and other important health issues in adulthood.

Maternal and child health services are generally provided through local general practitioners and child health centres. Child health centres and child health programs conducted through DYHS and SWAMS monitor factors such as growth and immunisations and provide advice and information where necessary.

The Bibbulung Gnarneep "Solid Kid" study is a collaborative research project involving DYHS and the TVW Telethon Institute for Child Health Research. It aims to identify key factors that assist mothers and families to rear healthy children. It provides support during pregnancy and afterwards, promotes breastfeeding, examines the effects of smoking on children and aims to decrease the risk of SIDS. The results of this study will provide important information about the needs of this group. The incorporation of the results into program and operational frameworks will require specific attention to ensure the integration of knowledge and operational issues in the health service infrastructure currently in place.

Priorities

- Improve access to appropriate services that are aware of Nyoongar women's often unspoken needs such as being treated by female doctors, nurses and health workers;
- Increase community education and health awareness and promotion programs aimed at young women. These need to be developed and presented by Nyoongar women and address issues such as sexual health, family planning, nutrition, antenatal and postnatal care;
- Targeted maternal nutrition and breastfeeding programs;
- Targeted smoking and SIDS campaigns;
- Extend home visiting programs; and
- Improve breast and cervical cancer screening.

4. Strategies to Improve the Contribution from Other Sectors

Evidence has long shown that many of the causes of ill-health are found in sectors of human development, other than health. The aetiology of a significant proportion of Aboriginal health need can be traced to the housing, employment, justice and family services sectors. These are areas which health has traditionally had little opportunity to influence.

The NRAHPT is conscious that Aboriginal people consider these other sectors to be an important part of the holistic paradigm embraced by them. These sectors are included in Aboriginal descriptions of health need and form part of Nyoongar people's expectations for a healthy future. However, benefits arising from cooperation between health and other sectors have generally been unplanned and ad hoc. The ill-health underpinned by these elements of need is therefore being inadequately addressed.

While there have been some advances in recent years in WA for example, the Environmental Health Needs Co-ordinating Committee these benefits have largely been confined to remote and rural areas outside the region covered by this Plan. Therefore strategies to bring non-health sectors into a co-ordinated and well-targeted program of collaboration need to be determined.

International evidence demonstrates that the engagement of other sectors in well-targeted intersectoral programs does not simply deliver health gain, but also offers improvements to other domains of operation. For example, cooperation between health and education providers in the formative years of a child's life can have a significant impact on the levels of educational attainment in the short to medium term, and the health of the individual in the medium to long term.

Caution however is well advised. The key to successful intersectoral programs appears to rest in the quality of targeting undertaken when linking the various sectors, and in developing inclusive and defined mechanisms for their prosecution. The Planning Team recommends that state, Commonwealth and community sectors establish jurisdictionally-based policy frameworks to promote intersectoral collaboration. The work commissioned by the OAH on *Intersectoral Collaboration: critical success factors*, is a useful starting point for planning intersectoral strategies that form part of this Plan.

Long-term improvement in the health of Nyoongar people will be significantly influenced by sound and well-supported intersectoral collaboration. Below are some of the social factors the NRAHPT has identified as essential to the improvement of Nyoongar health.

4.1 Education

Education plays a number of roles in influencing health and vice versa. This is the nature of the opportunity for cooperative gain. A recent UK report highlighted four major areas where education can assist in improving health. These are:

- helping build better socio-economic status;
- equipping children with practical, social and emotional knowledge and skills;
- providing children with skills to play an active part in society; and
- promoting and protecting the health of children.

While the NRAHPT supports these conclusions, it believes that more work is required at a regional level involving a cohort of government and non-government agencies including health, education, housing and AMSs to identify the detailed priorities for the education-health nexus specifically for Nyoongar people. The NRAHPT is concerned to ensure that the impact of education on health is well targeted and carefully planned. Clearly areas of significant Aboriginal population, overlaid with details of Nyoongar health and economic status will produce a snapshot of locations in which we would most likely also find poor levels of educational attainment.

It is in these areas that the NRAHPT believes close attention should be paid in the first instance. The NRAHPT believes that the task should be to develop a more specific understanding of how these domains of impact play out in the Nyoongar community, and most importantly, what the priorities for action are.

However, while this work is underway, it is appropriate for a small number of projects to commence based on what we already know about the heath-education nexus. The ability to engage both systems early by demonstrating "the art of the possible" would better prime players for future more comprehensive co-operation.

There are a number of areas where the health-education nexus has been well understood for some years. These include the impact of Otitis Media and Chronic Hearing Loss on educational attainment. Chronic nasal and ear discharges are common among Aboriginal children and start to occur in the first few months of life. Disproportionately high proportions of Aboriginal children suffer from chronic OM. The conductive hearing loss produced as a consequence of ear disease occurs at a critical time for learning and language development.

The impact of ear ill-heath on the ability of children to participate and benefit from early childhood education has consequences long into the school career of the child. CHL manifests itself in communication problems that flow on to contribute to learning problems, behavioural problems and poor attendance. Between 1995 and 1999 there were some 1370 admissions of Nyoongar children to hospital for OM or related conditions or procedures.

Health services that provide appropriate levels of support during childhood to reduce the onset and chronic nature of ear infection in Nyoongar children is a worthwhile preventative measure. The partnering of case-finding and treatment services with the ability of teachers and schools to identify children exhibiting behaviours suggestive of hearing loss would add considerably to the efforts to minimise the impact of OM and CHL on the health and educational opportunities of Nyoongar children.

The school participation rate for WA Aboriginal youth aged between 13 and 17 years in 1996 was 61.9 per cent compared to 87.4 per cent for non-Aboriginal youth. Young Aboriginal people are more likely to leave school earlier than young people in the general population. Post-compulsory education rates are substantially lower for Aboriginal people than for non-Aboriginal people of the same age.

Studies have suggested that the successful management of the transition from school to work can have implications for the medium and long-term health of the individual. The EDWA, in co-operation with the Northern Territory and Queensland counterparts has undertaken some work in the development of transition from school to work projects in rural and remote communities. This work may provide a useful basis on which to develop specific initiatives for Nyoongar adolescents.

Priorities

- Establish a project team to identify the specific priority areas and locations of co-operation between the health and education sectors that will impact on health and well-being including the production of targeted project plans;
- Expand the current co-operation between OAH and EDWA around the linking of efforts to manage CHL and OM in Nyoongar school age children; and
- Review current work on the management of transition from school to work in Aboriginal communities to identify appropriate strategies for Nyoongar communities.

4.2 Employment and Training

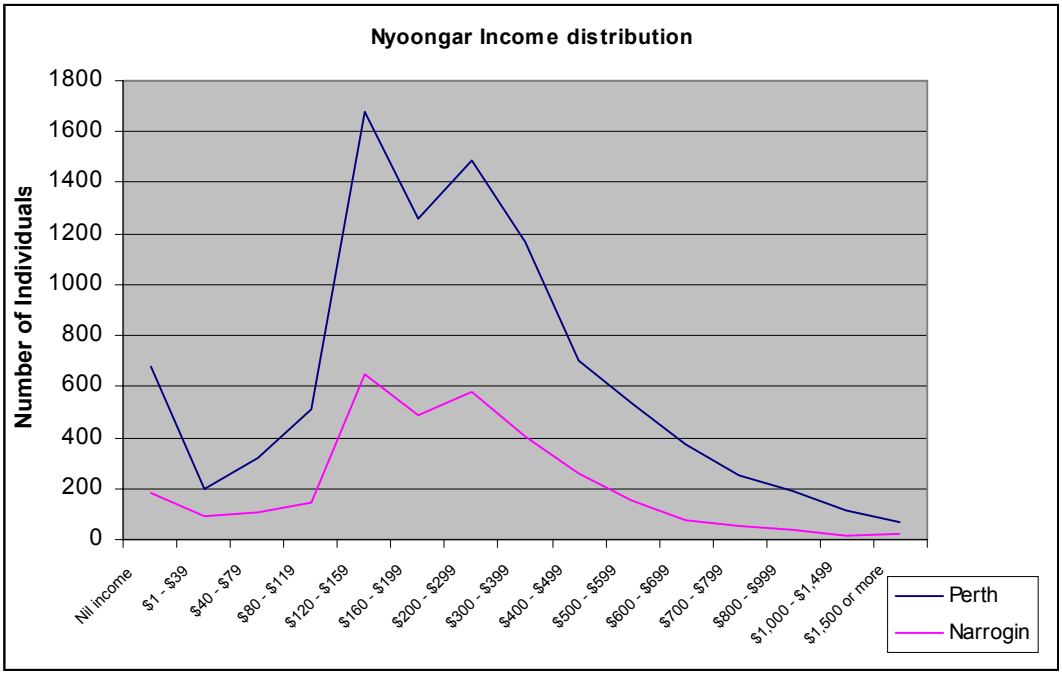
The impact of unemployment and income levels on health is well established. For example, economically inactive men have three times the risk of premature death observed for employed men. There are however some particular periods where employment or the absence of it takes on crucial meaning. The transition from school to work has found correlation in some overseas studies where the individual does not move to employment successfully in poorer levels of health.

Further studies have shown that individuals who suffer chronic unemployment are less likely to recover from bouts of illness than are people who are employed or people who have had shorter periods of unemployment.

Unemployment rates in Nyoongar communities have been high for many years. The 1996 census found unemployment rates of 27.5 per cent in the Perth ATSIC region and 20.6 per cent in the Narrogin ATSIC region. These figures may well be an underestimate Figure 7 below details the distribution of income for Nyoongar communities grouped in ATSIC

regions. This figure shows the relatively low levels of average income for Nyoongars. Income per week peaks at $120-150.

Figure 7 Income Distribution in the Nyoongar Community



The average length of time that Aboriginal people stay in a position is five years. Half stay for less than two-and-a-half years and three-quarters for less than eight years. This implies that Aboriginal people change jobs more often than non-Aboriginal people, and it also indicates a need to improve the alignment of career opportunities and skills development. It is necessary to enhance Aboriginal participation in training, and to develop strategies for certification and recognition of the range of unofficial, "on-the-job" training that occurs.

Similarly, the provision of training, particularly post-secondary needs to be seen in the light of a contributor to health. The general case seems to be that employment and training is offered to the broader Aboriginal community and that other than youth programs, there is little specific targeting of initiatives. The NRAHPT has reviewed studies that show that improving the access to skills training and other forms of formal education, for mothers for example, can have a positive impact on the health of families. The team believes that improved targeting of employment and training programs for Nyoongars in a manner evidenced in a number of these studies should be seen as a priority.

Previous strategies aimed at improving Aboriginal employment have had more success in increasing rates of recruitment rather than training and skills development. Permanent and meaningful employment and training opportunities for Aboriginal people are still scarce, especially for Aboriginal people in rural areas. In addition, it is of great concern that few Aboriginal people are represented at the higher management levels.

As with the education section above, effort is required to define the relationship among employment, training and health more specifically for Nyoongars. The NRAHPT believes that where new programs are seen to closely follow the specific needs of Nyoongars, they

are more likely to be successful for Nyoongar people. Subsequent efforts to tailor programs to match this work will provide a sound basis for the engagement of the employment and training sector.

Priorities

- Establish a project team to identify the specific priority areas of co-operation between the health, employment and training sectors that will impact on health and well-being, including the production of targeted project plans;
- Encourage early development of programs targeting the employment and training needs of Nyoongar women; and
- Link the employment and training sector with the Transition from School to Work project as recommended in this plan.

4.3 Housing

According to 1996 Census data, 6.2 per cent of Aboriginal and Torres Strait Islander households included more than one family, compared with 1.1 per cent of other Australian households. Overcrowding leads to faster deterioration of housing and exacerbates environmental health problems. A total of 64 per cent of Aboriginal and Torres Strait Islander households are in rental accommodation compared with the overall Australian rate of 24 per cent.

Aboriginal and Torres Strait Islander's average household size, as shown in Census results, has decreased to 3.7 persons per dwelling in 1996, compared with 4.6 persons per dwelling in 1991. However, the overall Australian household size in 1996 was 2.7 persons per dwelling. According to 1996 Census figures, an additional 34,527 bedrooms were needed to adequately house Aboriginal and Torres Strait Islander people compared with a shortfall of 35,205 bedrooms in 1991. Australia's Aboriginal and Torres Strait Islander population increased by 33 per cent between 1991 and 1996.

Housing continues to be a major issue for Nyoongar people.

Figures from the 1996 Census show that approximately 30 per cent of Aboriginal households in the Nyoongar region own, or are purchasing, their own homes compared to about 75 per cent of non-Aboriginal people. Evidence suggests that despite their geographic proximity to services, many Nyoongar families nevertheless live in sub-standard or overcrowded housing.

Nyoongar service providers in the Upper, Central and Lower Great Southern and the South West Region reveal that housing for Nyoongar people is overcrowded, in high demand with small supply, waiting lists are long, inappropriately designed and often in need of repair and maintenance. Many of the houses in these communities are now 60 years old and

replacement is slow. Where new housing is being constructed, there is no Nyoongar input into the design of the dwellings. Homeswest are reported to be "extremely inflexible".

Opportunities for private rental are minimal. Nyoongar people are not generally accepted as tenants, "unless you know somebody". While the Aboriginal Housing Directorate Urban Program (Ministry of Housing) makes significant provision for the construction or purchase of Aboriginal rental housing properties in metropolitan and country locations, concern has been expressed at the number and standard of housing available to Aboriginal families. Many Aboriginal homes remain overcrowded and, as such, pose a risk to the health of residents. However, perhaps the most contentious element of the public housing sector activity relates to section 60 evictions.

There are a number of issues related to overcrowding and evictions. Some of these relate to Nyoongar choices about family circumstances, structures and responsibilities while others relate to the economic status of family groups and the attitude of neighbours and housing authorities. Each of these often creates *heat* in the community. The NRAHPT recommends that a structured review of housing as an impact on health and well being in the Nyoongar community is required. The review should pay particular attention to:

- individuals with a critical health need for which housing is an important issue; and
- allocation policy where proposed allocations reduce the capacity of families to maintain cohesion.

Both of these areas impact on health and well-being.

Home ownership in some studies is related to improved health outcomes. The Aboriginal Home Ownership Program (AHOP) within the Ministry of Housing provides a local and flexible opportunity for a many Nyoongar families. The NRAHPT believes that the AHOP should be expanded and that further promotion of the initiative should be undertaken.

Priorities

- Encourage and increase home ownership by Nyoongar families;
- Undertake review as indicated; and
- Ensure that suitable rental and hostel accommodation is available where required.

4.4.1 Justice

The common thought in the community at large is that prisons are used as a deterrent to potential offending. That is, the fear of being caught and being sentenced to a term of imprisonment is meant to make people think twice about committing a crime. What is interesting is that there is a growing evidence base to suggest that "the sentence of the Court had no obvious bearing on the outcome". That is, the sentence has little impact on latter offending. On the other side of the coin prisons are used to keep offenders away from the community, and hence, reduce the risk to the community.

Aboriginal people are over represented in their contact with the justice system. The nature of Aboriginal participation in the criminal justice system has bearing on the nature of the strategies to be deployed. Aboriginal people are five times more likely to be a victim of

crime than are non-Aboriginal people, and are ten times more likely to be apprehended, have juvenile detention rates 38 times that of non-Aboriginal youth and make up one third of all prisoners. Almost half (46%) of women in prison for non-payment of fines are Aboriginal. Incarceration and deaths in custody continue to have a profound impact on Nyoongar families in Perth and the South West. There is a growing body of work that links health with criminality later in life. There is also a body of work that suggests that prisoners are less healthy than are members of the general community.

Evidence from the UK indicates that prisoners:

- were less likely than men in the general population to say their health was good or very good;
- had higher than expected rates of smoking;
- are more likely to describe themselves as either drinking quite a lot or drinking heavily; and
- had less than expected lung function.

Recent work in WA has also suggested that Aboriginal prisoners also suffer from elevated health risk and ill-health.

Two objectives for the Nyoongar Regional Aboriginal Health Planning Team emerge:

- promote, restore or treat illness of prisoners; and
- reduce the health risk factors that may contribute to criminality.

The management of health services to offenders in custody is a responsibility of the Ministry of Justice (MOJ) and not the HDWA. Service contracts with the MOJ form the basis for health service provision in privatised prisons.

A mixture of *in situ* (MOJ and primary health care), public (eg hospitals) and private sector services are provided to offenders in custody. Offenders undergoing community supervision orders (eg probation, parole) are required to provide for their own health needs. Medicare does not cover prisoners. A Joint Health-Justice Interdepartmental Committee provides oversight of health services to prisoners.

The development of innovative service structures and arrangements providing effective and culturally secure primary health care for prisoners is considered a priority. The scope of primary level services should reflect a holistic approach in-keeping with an Aboriginal perspective of health and well-being. The continuity of care when people are released from prison is another important issue and new arrangements should be established to ensure seamless provision of care to Aboriginal people. The development of sound health care planning for prisoners (based perhaps on the WAACCT protocols) could not only provide the basis of care while in prison, but also provide an effective foundation for services on and after release.

The other side of the Health-Justice nexus involves the reduction of those health conditions that may impact on criminality. Evidence has shown that elements of early childhood health and well-being may impact of the risk of criminality later in life. Earlier parts of this Plan have already pointed to the relationship between poor health in early childhood and

ill-health later in life. Other studies have also shown that latter life experiences also contribute to the potential for criminality.

Increasingly we are coming to understand the cumulative nature of these early childhood and latter life experiences on the health of individuals and also on their risk of criminality. Some of the risk factors that may be associated with criminality include low birth-weight, poor parental health and socio-economic status, family dysfunction, family stress and conflict.

Preventative and risk reduction strategies are required to deal with these associations. There are some successful examples of programs in the United States. Immediate benefits in maternal and child health outcomes, ensuring long-term benefits in social functioning (including less dependence on welfare services has been achieved through the provision of intensive home visiting services) starting from the antenatal period through to two years of age.

A similar approach has been established as a pilot program in Midland and Albany. It is too early to determine it's impact, but the NRAHPT believes that enhancement to existing services, such as the AFFP and other community-based activity through the marriage of this evidence with the reach of these community-based initiatives, offers great potential for health gain and reduction in criminality later in life.

The NRAHPT believes that building synergy at the community or regional level between new initiatives such as the pilot program and existing programs such as the AFFP and other community-based primary health care services can provide an efficient and evidenced-based approach to Aboriginal health gain. This will in turn provide the best opportunity to reduce the risk of offending later in life.

There is perhaps a third consideration in this section. If incarceration is associated with poorer health outcomes, then reducing recidivism and thereby reducing exposure to the risks should also be considered. While not necessarily a health task, the NRAHPT believes that the MOJ should explore new strategies that provide greater emphasis on reduction of recidivism.

The development of new and expanded options are required that provide a sound basis for reductions in incarceration in the short to medium term. These options will include well targeted, carefully structured services, that look to the offender's behaviours and perceptions, blended with good culturally secure family work and which are, as far as possible, situated in the community setting. Experience in the US and UK demonstrates that such an approach is "successful in the criminogenic effects (not merely their personal development or feel-good effects)". While the adaptation of these experiences to a Nyoongar setting is required, the basis on which they are premised appears sound and of use. The NRAHPT is supportive of such efforts.

The work of Marwarnkarra Aboriginal Health Service in delivering anger management services to residents of the Roebourne Regional Prison is instructive as an example of tackling the drivers of recidivism. Such work should be further encouraged both as a health and as a justice initiative.

Priorities

- Establish new and expanded rehabilitation and sentencing options providing well targeted, carefully structured services that look to the offender's behaviours and perceptions, blended with good culturally secure family work, where possible is situated in the community setting;
- Establish innovative service structures and arrangements providing effective and culturally secure primary health care for prisoners;
- Include sound health care planning for prisoners (based perhaps on the WAACCT protocols);
- Build synergy between the evidence related to childhood health and criminality in latter life with existing AFFP and community-based primary health care initiatives; and
- Expand the ability of current service providers to offer comprehensive health services to young families, including the provision of community development and other social health services.

5. Strategies to Protect and Enhance the Social Capital of Nyoongar communities

Social capital has been defined as "trust, norms and networks that facilitate cooperation for mutual benefit" (Putnman, 1993). Social capital therefore relates to how people stick together, support each other and work co-operatively towards successful collective action. For Nyoongar communities, three significant fields of interaction affect social capital:

- the family;
- the community; and
- Australian social and civic life.

Typically, Nyoongar communities have rested much of their striving for change on the importance of the extended Aboriginal family. The family has stood as the bedrock of culture and in Nyoongar communities is closely aligned to land and other religious and social resources and structures. Nyoongar families have long asserted that the retention of, and participation in, family life forms the basis for the passing down of Aboriginal values, culture and experiences. The demonstrated importance of family reunion and return to the country as part of the "Stolen Generations" movement reinforces this reality.

Over the past 20 years non-Aboriginal social commentators and social scientists have increasingly recognised the role of family in the advancement of health and well-being (Bourdieu, 1993; Putnam, 1995; Newton, 1997; Fukuyama 1999).

Nyoongars, as communities, have drawn on their collective experiences, values and social structures to realise achievements carried forward from common goals, aspirations and needs. Demonstration of this community action can be found in the various Aboriginal rights movements dating from the early 1900s. More recently and perhaps more coherently, social capital in Aboriginal communities resourced the establishment of AMSs in Perth and Bunbury and the AFFP in Albany. Other examples from other sectors can be found in other parts of the Metropolitan South West region.

These two elements of social capital in Nyoongar life have contributed to the establishment of family and community-based action that has successfully contributed to significant reform and important improvements in Aboriginal life. However, the reserves of social capital that resourced these changes have been eroded by ill-health and social injury inflicted on Nyoongar communities since colonisation. Remedial strategies are therefore required.

The third field of interaction that impacts on the strength and extent of social capital in Nyoongar communities is interaction between Nyoongar and non-Aboriginal social and civic worlds. There seems to be two facets to this relationship. Firstly, interactions typical of that found in the Reconciliation and the Federal Council for Advancement of Aboriginal and Torres Strait Islanders, movements appear to have contributed to a convergence of perspectives around moral and other belief-based systems. The other facet to this domain is that which is characterised by the erosion and denuding of social interactions of all things Aboriginal. The elimination of Aboriginal language and cultural practice from the social organisation of WA life stands as examples of this facet. Another example may be when

economic or social development comes at a cost of remaining Nyoongar values or beliefs. These latter examples stand as a drain on reserves of Aboriginal social capital while the former can replenish it.

Strategies are required to protect the social capital that remains, and to find ways of replenishing it. The ingredients of these strategies should include:

1. promoting both formal and non-formal engagements between Nyoongars and other West Australians;
2. creating diversity by protecting against hidden erosion of Nyoongar rights, values and beliefs from intended or unintended outcomes;
3. building bonds of trust and reciprocity between individuals and families, and between Nyoongar and broader societal institutions and groups; and
4. valuing both short-term allegiances and long-term bonds as important to the goal.

The NRAHPT has identified a number of strategies that serve to improve social capital in Nyoongar communities and families.

5.1 Family Violence

Family violence involves not only the immediate family but also the entire community. It can take many forms including physical violence and emotional, sexual, social and economic abuse. There is a lack of culturally secure family violence services across the region for victims and perpetrators who are prepared to take responsibility for their behaviour.

The current focus on spousal relationships, male domination and reliance on the criminal justice system does not address the underlying issues, as well as the needs of family and community for education and healing. Many Aboriginal people feel punishment alone does not solve the problems of family violence but only further destroys family and culture.

Many people see family violence as a part of everyday life and so available services may not be accessed. Abuse may not be reported due to fear of retribution either by the perpetrator or their family. Many Aboriginal women return to relationships after abuse. More work is required to understand the family and other dynamics working in these situations in Nyoongar communities.

Addressing family violence has generally been about providing support services for victims. Future strategies need to be about dealing with the 'whole' issue, as the family unit is paramount within Nyoongar communities. Maintenance of the community (in the majority of cases) is vital to the preservation of our Aboriginal culture.

Priorities

- Extend family violence prevention programs. Strategies need to include community education and prevention, early intervention, long-term healing and crisis intervention;
- Improve cultural awareness of mainstream services and ensure they are more supportive of community-based initiatives;

- Support and extend existing initiatives such as women's action groups, safe houses, night patrols, community warden schemes and sobering-up centres;
- Family violence perpetrator programs provide "cooling off" places with counselling available; and
- Involve Nyoongar people in addressing family violence. Currently, community organisations receive limited resources, support and training.

5.2 Nyoongar Men

Over the last five years, there have been a number of Nyoongar men's gatherings, health conferences and camps. At these gatherings, Nyoongar men have come from all over the region to discuss men's business. These include: Wandering, April 1996; Mogumber, October 1996; Albany, March 1997 and the State Indigenous Youth and Men's Health Conference October, 1997. This is a starting point for Nyoongar men to discuss their stories, help make changes and to take control over their future action.

Interestingly, some studies indicate that men feature prominently in mortality rates for reasons other than just declining access to health services or changes in the environment. Changes in economic and social roles can, it seems from these studies, have an impact on the health of men in particular.

Commentators argue that the psycho-social stress arising from social and economic change is the key factor for men. Unemployment or long hours of work, breadwinner responsibilities in a difficult economic environment, illegal activity, risk behaviour related to stress and social dislocation are seriously affecting health (Wilkinson, 1996).

Many of the discussions have pointed to these circumstances for Nyoongar men. According to many Nyoongar men, the erosion of culture, the removal of roles in the family and community, and the shifting economic environment in the South West over the past 100 years has created behaviours and stresses that manifests itself into mortality and morbidity and in inappropriate social behaviours.

Programs for men that are focussed on these matters are required. By lifting levels of employment, active community participation, recreation and other role modelling in the Nyoongar community for men, the NRAHPT believes that the levels of psychosocial stress and ill-health will reduce, and that the health of individuals, families and communities will improve. This will require the contribution of a number of sectors.

Priorities

- Develop culturally secure services for Nyoongar men to manage stress and depression and its manifestations in the family and the community in generally;
- Develop programs that encourage treatment of the whole person by linking employment, education and training opportunities for Nyoongar men especially men with families; and
- Development of strategies to improve Nyoongar men's access to and utilisation of health and related human services.

5.3 Emotional, Social and Cultural Well-being

Nyoongar emotional and social well-being includes a wide range of factors. It is not only concerned with mental illness but also the social, spiritual and emotional well-being of an individual, his/her family and the wider community. The history and consequences of colonisation, including the removal of Nyoongar people from their land and separation of children from families, continues to have a devastating effect on the lives of Nyoongar people today.

The extent to which individuals are able to have confidence in the social interaction between members of the community has an impact on their physical and mental. It is important members are able to trust the values and other underpinning of these interactions, understand the reciprocity and draw on social organisation to support community interaction and individual participation.

Where Aboriginal people are in a minority, they are less able to make regular contact with members of their social network and are not confident of the underpinning of the social structure around them. They are more likely to suffer from doubts of self-worth and lack trust to engage. Under such circumstances the mental and physical health of individuals and of families may suffer.

Strategies that strengthen the fabric of families and communities are required. Such strategies could, for example, include reform to the housing and neighbourhood design of public housing estates, the policies that inform housing allocation and the availability of local human and other services in these neighbourhoods. The team believes that the provision of services locally, the promotion of Nyoongar families as the target of service planning; and consideration of the need for familiar, social and cultural networks in the design and allocation of housing would make a significant contribution to the well-being of Aboriginal people.

To a large extent, mental health problems have been under-diagnosed and untreated among Nyoongar people. The symptoms of alcohol and substance abuse, self-inflicted injury, family and domestic violence, and child abuse show the seriousness of emotional and social distress among the Nyoongar community. Studies have also shown that a significant proportion of Aboriginal people suffered from chronic stress and depression. These are important issues for the whole community and demonstrate a high level of need for mental health support and services in the Nyoongar community.

Currently, OATSIH funds DYHS, SWAMS and Southern Aboriginal Corporation to deliver mental health support services to Nyoongar people. In addition, Marr Mooditj delivers mental health training for AHWs in conjunction with the Metropolitan Regional Centre. However, Nyoongar people's access to mental health services is generally poor. This is particularly true in rural regions.

The NRAHPT believes that the development and deployment of Nyoongar mental health teams across the region covered by this report is important. These teams would need to be deployed mindful of familiar, community and cultural needs, and they should also provide

support to other generalist mental health service providers who may sometimes have Nyoongar clients.

Priorities

- Develop and deploy Nyoongar Mental Health teams in key locations across the region;
- Promote functional linkages with other services providers such as mental health teams and GPs; and
- Establish a Nyoongar Housing and Health Review Project that identifies the opportunities for health and housing sectors to co-operate to improve Nyoongar health and well-being, and to make recommendations about reform to housing and health policy and program.

5.4 Family Formation

The nature of family life for children impacts on how they grow and develop. This is not only an issue of the physical environment but also the emotional and other social circumstance of the family unit in which they are raised.

A striking feature of the Aboriginal population is its youth. In WA, about 49 per cent of Aboriginal people are aged less than 20 years of age compared to only 28 per cent of the total population. Family formation in Nyoongar communities occurs at much younger ages than in non-Aboriginal life.

Young Aboriginal people are far more likely to leave home by the age of 19 (64% compared with 36% of the total youth population). By 25 years the number of young Aboriginal people living at home is only marginally smaller than in the general youth population (11% and 15% respectively).

More Aboriginal youth form independent families than other young people in WA. The formation of family units in early years of life parallels the high birth rates in these age groups. The significant number of Aboriginal youth living with other relatives is a striking feature of Aboriginal family life in these years. Figure 8 below describes the changes in arrangements relating to Nyoongar youth living at home.

Figure 8. Young People Living with Their Parent(s) as Dependent Offspring.

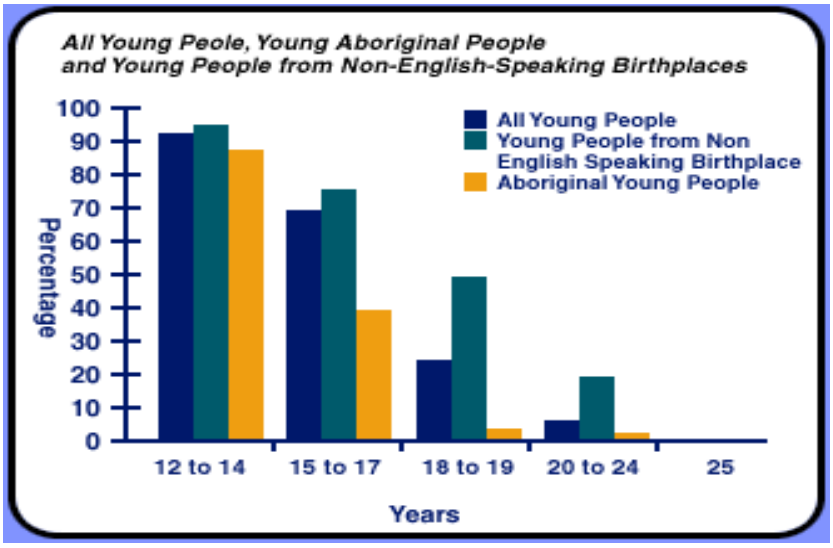
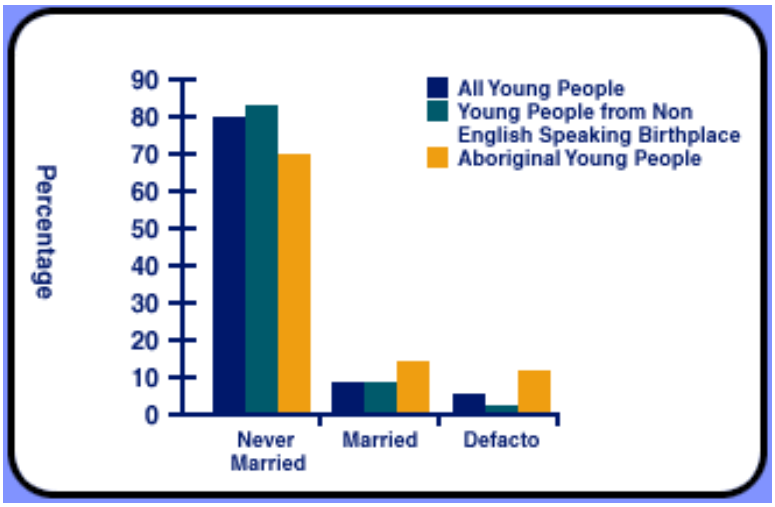


Figure nine below shows that young Aboriginal people are more likely to be married (15% compared to 12%) and twice as likely to be living in de facto relationships (13% compared with 7%) than all 15 to 25 year olds.

Figure 9. Marriage Status of Young People Comparing the Total Population with Young People from Non-English Speaking Birthplaces and with Young Aboriginal People.



Family troubles are most common in poorer families and unemployment in Aboriginal communities has been estimated at five times that of the general community. Income levels discussed in other parts of this Plan indicate the generally poor economic status of many young Aboriginal families.

Parenting that is nurturing, consistent and supportive of the needs of children will contribute to health and well-being, not only during childhood, but also in adulthood.

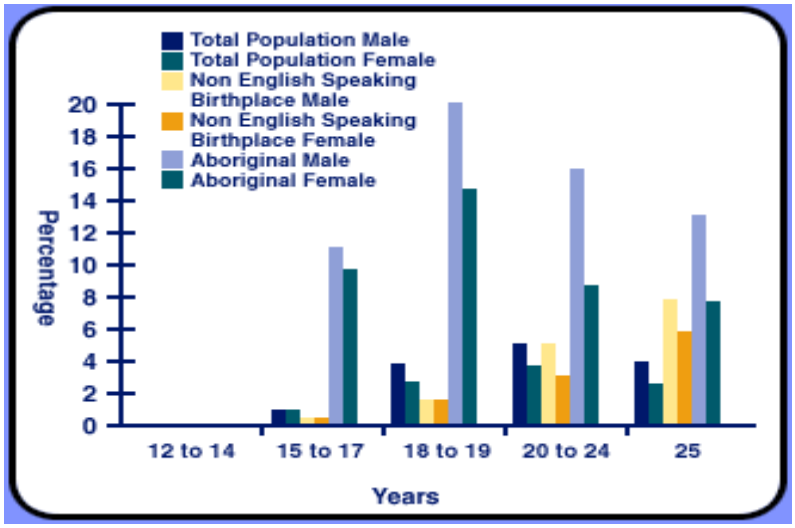
Raising children is not easy and most families look to draw on the experience of grandparents and more experienced family members.

Communities have often expressed concern about 'kids having kids'. Communities are looking to strategies to improve the parenting and relationship skills of young families. Stability of families is related to economic and social pressures. The comparatively poor life expectancy and generally poor socio-economic circumstance of Nyoongars means that young families are often unable to count on parents and grandparents to help create a stable family environment. Parents often live under similar social and economic pressures as do their children. Support for new programs that build capacity in young families in a culturally secure manner are required. Such efforts would ensure a stronger family fabric in these young families and thereby contribute to improvements in health and well-being.

Maintenance of a stable family environment is a very important element in building health in family members. New strategies are required to bring educational services, employment and stronger cohesion to families.

In many Nyoongar communities, changes in the family structure accompanied by economic and social pressures, result in varied family structures. Figure 10 illustrates that a significant number of Aboriginal youth live with relatives.

Figure 10: Young People Living with Relatives



A higher proportion of young Aboriginal people live with relatives (other than parents) compared to young people in the total population (10% and 2% respectively). Young Aboriginal men are the most likely to live with relatives (11%) and young Aboriginal people generally are less likely to be dependent students, or to live alone in a group household.

Role modelling has been highlighted as an area of significant need particularly when traditional family structures are eroding. The HDWA, EDWA and Department of Family and Children's Services have Aboriginal role model programs designed to encourage Aboriginal youth. Sport and recreational programs have been designed by ATSIC and the

Ministry of Sport and Recreation to encourage Aboriginal youth to excel in their chosen sports.

The provision of co-ordinated support programs targeting Nyoongar youth may have the dual effect of improving family formation and lifting youth health.

Priorities

- Life skills education and role modelling programs to reduce adolescent risk behaviours delivered in supportive environments at times of developmental transitions, eg from primary school to high school;
- Programs that support social, cultural and parenting education for adolescents as they move into womanhood and manhood and as they consider forming families;
- Expansion of the IFP and the HFHH program; and
- Focus attention on innovative educational, training and employment programs for parents in young families as a priority, including part-time work where appropriate for single parent families.

5.5 Inter-Generational Issues

Aboriginal Elders and older community members are accorded a special place in Aboriginal life. The impact of colonisation in the Nyoongar world has seen much of our traditional knowledge and practices eroded. It is often the cases that a few Elders and older community members hold much of the traditional memory of Aboriginal life and much of the memory of the past century. These combined elements represent a significant store of Aboriginal identity. There has been some blurring of the traditionally defined roles of Elders. Because we have so few older Aboriginal family members, many families look to their oldest for the stability and teachings previously provided by traditional Elders.

The role of Elders within Aboriginal communities sometimes varies, but generally consists of helping the people, individually and collectively, to gain knowledge of the history, traditions, customs, values, beliefs and the struggle of Nyoongars. Elders play a role of bridging the traditions and beliefs of Nyoongar people and the modern-day influences that Nyoongar women and men confront.

The NRAHPT is concerned to ensure that services offered to Nyoongar Elders and older family members provide the best level of care and support so that these important family and community members can continue their role in Nyoongar life.

This must involve both the promotion and maintenance of a healthy physical life for Elders and older community members, and the opportunity to fulfil their roles by constructively engaging them in the health improvement effort.

Aboriginal people use aged care services at younger ages than do non-Aboriginal people due to a higher incidence of illness and debilitation and lower life expectancies. Aboriginal people prefer to use home and community care services rather than use residential services since these services allow people to remain with their families.

The HACC Program is jointly funded by the Commonwealth and state governments. It provides funding for services to support people, who are frail, aged or have disabilities. HACC coverage for Aboriginal people is variable. In Perth and the South West, Nyoongar health workers have indicated that families and carers often encounter difficulties accessing adequate daily services and respite care.

Additional efforts to plan and monitor the health of Elders and older community members must be incorporated in the services offered to the Nyoongar community. It should be recognised, where appropriate, that support for the development of appropriate accommodation options for older Aboriginal people is needed.

The planning and provision of health and related services would benefit from a planned involvement of Elders. This is particularly important where the erosion of Aboriginal values has contributed to a health deficit, or through the positive reinforcement of values and beliefs as a risk reduction or health promotion strategy. Aboriginal Elders and older family members have for example already played a significant role in helping young Aboriginal families acquire the skills and appreciations necessary to be more successful young parents.

There is an additional need for accommodation for Nyoongar families when relatives are sent to Perth, Albany or Bunbury for care. It is very important, especially for elderly people, to have family support. There needs to be provision of accommodation for the family of patients travelling to Perth or to regional centres for care.

Priorities

- Improve access to, and appropriateness of, HACC and other services for elder Nyoongar people;
- Promote respectful and well-planned health care of Elders;
- Establish programs to encourage communication and involvement of Nyoongar Elders in the planning of services to ensure appropriate respect for, and involvement of, Nyoongar beliefs and values, particularly in young families;
- Ensure that hospital care for Elders and older community members provides adequate respect for the role and valued position of these community members; and
- Support the development of appropriate accommodation options for older Aboriginal people.

6. Strategies to Improve the Infrastructure and Performance of the Health System

6.1 Accessibility & Appropriateness of Health Services

Access is a significant issue for Nyoongar people. There can be many sorts of difficulties in access to services. Factors that may play a part in making access difficult include, when:

- a health service is too far away or there is no way of getting there;
- people running the health service do not understand Nyoongar needs;
- there are problems with understanding and communicating with people providing those services; and
- there is no money to pay if the service does not bulk bill.

Although the full range of high-standard mainstream services may appear to be available to many urban Aboriginal people, there are often barriers to use of those services, including difficulties in access, disempowerment, racism, discrimination, and cultural inappropriateness. Findings of recent local surveys confirm these difficulties experienced by Nyoongar people.

When Perth Aboriginal mothers participating in the Bibbulung Gnarneep "Solid Kid" Study were asked whether they had experienced difficulties accessing care during their pregnancy, 19 per cent reported difficulties. Difficulties accessing care included:

- transport and distance (37%);
- impersonal care, rudeness, ignorance (20%);
- difficulty accessing doctor of choice (12%);
- waiting times, (12%) and
- child care (9%).

Similar results were found in a survey carried out in the Wheatbelt. In this study, 84 Nyoongar people living in the Avon Valley and Wheatbelt were asked about barriers to accessing health services and what would make access easier for them. Although many Aboriginal people reported that many of the staff were helpful, professional and courteous, half of the people interviewed reported feeling uncomfortable in the presence of staff. Participants in the study also made specific complaints about the lack of visits from Community Health workers, and the need for more AHWs.

There is a diverse range of stakeholders involved in delivering health services and programs to Nyoongar people. These include primary health services, secondary and tertiary services, public health and community services, patient transport and accommodation. Each of these services must address the issues associated with access, appropriateness and affordability.

There are few Nyoongar people on Hospital and Health Service Boards. Given that these Boards are responsible for the development of the broad policy and operational frameworks and priorities, Nyoongar representation is important to ensuring the appropriateness of services offered. Additionally Health Services need to review Aboriginal employment

within their establishment. While Nyoongars may represent a small proportion of the total population, in some locations their share of service activity exceeds that which is expected, based on population figures. Health Services also need to consider the use of other special measures to promote Aboriginal employment as a social justice matter.

Medicare is meant to be a universal health insurance program. In reality however, Medicare's universality is compromised for Aboriginal people. In Bunbury it was found that almost 30 per cent of the Aboriginal population was not enrolled in Medicare. The NRAHPT believes that reform to the structure of such "universal" programs is required to ensure that Nyoongars are not disadvantaged further and that they receive their fair share of Medicare-funded programs. The use of alternatives such as a "cashing out" method of accessing Medicare funded primary health care services should be established.

There are two AMSs in the Nyoongar Health Region. These are SWAMS in Bunbury and DYHS in East Perth and Midland, with outreach services in Mirrabooka and Maddington. These services enable Aboriginal people to decide the direction of future initiatives, policy and programs to be delivered to Aboriginal people. Many Aboriginal people feel more comfortable accessing these health services.

DYHS previously operated on a centralised service model. Further decentralisation of Aboriginal health services to Mirrabooka and Maddington has been planned for some time and has commenced. An additional Aboriginal Health Service for Rockingham/Kwinana/Fremantle is also required. Further support for the expansion and decentralisation of Aboriginal health Services (initially DYHS and SWAMS, then others as they might emerge) to priority population centres among Nyoongar country is required.

Both DYHS and SWAMS are sites for the WAACCT. Coordinated Care is a relatively new way of funding and delivering health and community-related services. The WAACCT has provided a new impetus to the provision of planned and coordinated services to Nyoongars. It is more pro-active and concerned with effective management and prevention, to the extent that WAACCT represents an improvement in care to Nyoongars. The lessons learnt from the WAACCT should be shared with other service providers in the Metropolitan South West area.

In addition to DYHS and SWAMS, other ACCHOs such as the Southern Aboriginal Corporation based in Albany and the Wheatbelt Aboriginal Corporation based in Northam also provide some specific health programs. Further services are also provided by Government health industry employees including AHWs.

In the Nyoongar region, the AFFP program is based in Albany, Narrogin and Katanning. It provides an opportunity for Nyoongar people to plan and improve their own health and social services within a family framework. The program is based on strengthening and working with families to develop their social, physical, mental and spiritual health needs.

Additionally, other strategies are required to bridge service gaps in those areas where no AMS exists or is not likely to be established. The Nyoongar Family Practices (section 6.3) proposals outlined below offer a strong basis for improved services and outcomes. Such models are important in small Aboriginal communities.

Priorities

- The NRPT supports the development of an AMS in the Wheatbelt area;
- Support the decentralisation of Aboriginal Health Services to priority population centres among Nyoongar country;
- Establish cultural security programs in all hospitals and Health Services in the Metropolitan South West area;
- Establish pilot NFP models for small Aboriginal communities;
- Support the delivery of services closer to where clients live;
- Advocate accreditation of health services as an important indicator that an organisation has the necessary infrastructure, processes and commitment to provide high-quality and culturally-secure health services;
- Establish innovative strategies to improve Nyoongar access to Medicare-funded primary health care services;
- Increase Nyoongar representation on mainstream Health Service and Hospital Boards; and
- Support community participation in all levels of decision making.

6.2 Aboriginal Health-Related Workforce

The Aboriginal health workforce is a crucial element in the improvement of the health of Nyoongar people. AHWs operate in a broad range of urban and rural settings. They may work alone or as part of a team. However the Aboriginal health workforce is wider than just AHWs. Many more Aboriginal people are required in all parts of the health system in occupations that include doctors, nurses and allied health positions as well as management, policy and decision makers.

A National Review (and a separate WA Review) of AHW training is underway. It is estimated that there are some 200 AHWs employed in WA engaged under many varied conditions. Furthermore, there are an estimated 50 accredited basic courses for health workers nation wide. This review involves a national consultation process to identify priorities of national significance. The WA review will concentrate on more specific issues such as training quality and availability, accreditation, employment opportunities and ongoing professional development. It is difficult to increase the numbers of AHWs while there are unsatisfactory training and employment conditions.

The NRAHPT is concerned to ensure that there are sufficient numbers of AHW available to drive the various strategies outlined in this document. In particular, the Team is anxious to ensure that the training and development of AHW equips them not only for work with individuals but increasingly work with families. Many of the prevention and treatment strategies outlined in the document overlap and many of them highlight the role of the family in treating and preventing illness and death. The Team believes that a considerable amount of effort should be invested in building the capacity of AHWs and other health professions to work in a family setting.

This may well require the Commonwealth as the primary funder of primary health care to rethink funding and other related arrangements to ensure that workers are able to devote an appropriate amount of time in this field of service. Medicare, for example, does not lend itself easily in its present operational structure to such service arrangements.

Priorities

- Address agreed issues raised by the National and State review of AHW training;
- Support appropriate and quality training, employment and professional development of AHWs;
- Encourage training of Aboriginal people in occupations such as doctors, nurses and allied health workers;
- Increase Aboriginal staff across all levels in mainstream services; and
- Improve the skills, knowledge and resources of people already in the health workforce.

6.3 New Partnerships

The NRAHPT believes that in addition to improvements in the number of AHWs and an AMS in the Wheatbelt, other partnerships are required to ensure an effective and culturally-sound health system for Nyoongar communities. New relationships between local GPs, regional AMSs and local communities offer an innovative and exciting new prospect for Aboriginal health gain.

Local GPs in many locations across the Metropolitan South West have a positive relationship with local Nyoongar communities. However, the nature of private practice and the economic imperatives surrounding it can create a climate where health promotion and prevention work, and appropriate social health services are not commonly available to local consumers. This can create a fracture in the continuum of care provided to these communities.

DYHS, SWAMS and the AFFP in Albany have each developed a new generation of relationship over the past two to three years with other non-community controlled health service providers. This Plan contemplates an extension of these successful initiatives by drawing into the network selected GPs in a number of communities across the metropolitan South West region.

The basis of the strategy being proposed is to create small pilot zones where local GPs selected by local communities are partnered with appropriate ACCHOs. The nature of this partnership would see AHWs from the AMS working in the local GP practice. These arrangements would act as the basis of a sharing of the AMS expertise in health promotion and prevention, and social health servicing with the primary medical care offered by the GPs. The outposting of AHWs in this manner will also provide an effective vehicle for secondary prevention and treatment compliance, an area of considerable need in Nyoongar communities.

Increasing the capacity of local GPs to participate in health care planning for local Aboriginal families, supported by AMSs, will provide an effective addition to needs-basis programming. Opportunities flowing from this could include combining local disease prevalence and incidence information with the strategic information available from state health sources as well as regional data from the AMS to form a basis for program decision making for that zone.

Implementation of this arrangement will require the Commonwealth to consider carefully how Medicare Benefit Schedule funding is applied to this model. The NRAHPT believes that a form of joint fund holding that draws a per capita contribution from the Commonwealth in lieu of MBS may be a viable alternative.

Priorities

- Establish NFPs in a number of pilot communities in the South West;
- Establish innovative and appropriate protocols for SAHUs Aboriginal Health Units; and
- Provide recognition to, and further support for, continuing medical education for GPs engaged in the NFP, including the development of a relationship between the training and Vocational Registration of GPs.

6.4 Joint Fund Holding

The WAACCT has offered a unique opportunity for Government, communities and health providers to test the operation of forms of joint community level fund holding. While there have been a number of tangible successes associated with this Trial, experience has given us a good picture of the process and capacity building required on all sides if the notion of joint fund holding is to be effectively introduced.

The simplistic notion of just hand over the money and we'll get on with the job" has been tested from the perspectives of:

- Governments' concerns over financial and political risk;
- the community's ability to effectively understand and respond to their own staff and organisational needs required to handle heightened individual, family and community demands for services;
- the community's transition from being largely a *demand* driven provider of services to a *supply* driven purchaser of services including the management of per capita funding, including the difficult issue of choices of services made available;
- community controlled health services working with other public sector and private sector health care providers in various forms of legally enforceable contractual arrangements; and
- bureaucracy's ability to handle the adoption of new ways of working and to ensure that operational systems are appropriately tuned to these new ways.

These are valuable hard-learned lessons and the progress of the Trial has helped both DYHS and SWAMS position themselves as a combined purchaser and provider of services. The concluding impressions left from this Trial have been that the process can work but that precursors are clear; that is:

- significant organisational growth and development is required in community controlled AMSs (and it isn't as easy as people first think); and
- reform of Governments' approach to management of community fund holding and how outcomes are specified is required.

In association with other strategies outlined in this Plan, fund holding should be further explored and piloted. The rate and location of such pilots should however be decided once

the NRAHPT has established some criteria for participation in fund holding and communities have had an opportunity to consider the risks, responsibilities and operational demands of such an arrangement. These criteria should draw on the experiences of SWAMS and DYHS.

A stand out issue that will require attention at the inter-governmental level are decisions about the level of funding provided to support this initiative. The simple resort to national figures as the basis for establishing per capita levels is in the Team's view, inadequate and a more detailed analysis is required to determine appropriate levels. The work of the Commonwealth Grants Commission and the OAH may be for a useful basis for such an analysis.

Priorities

Prior to expansion of community fund holding:

- Undertake as a priority, a regional specific analysis of the funds required under a per capita regime;
- The Nyoongar Regional Aboriginal Health Planning Team to establish ground rules for participation in Fund Holding arrangements;
- An information campaign to be undertaken to ensure communities are informed about the risks, responsibilities and operational demands;
- The NRAHPT should establish an evaluation framework; and
- That the NRAHPT will map a phased roll-out of fund holding when deciding implementation strategies.

6.5 Service Co-Ordination

There are many Nyoongar agencies across the planning region. The NRAHPT is interested in building greater levels of co-ordination between these agencies. Paralleling the developments around fund holding should be strategies that build a greater degree of co-ordination and product management at the community level to ensure that families in need are better able to access the package of services required to address their health and well-being needs.

The Coalition of Aboriginal Agencies in Perth has recently been formed to identify strategies to better utilise member agency's resources to meet the needs of clients. This work involves building better co-operation across agency's structures and program activity. A corollary of this work is the detailed analysis of service gaps as they currently exist in this cross-agency environment and the planning of reform to existing, and the addition of new and/or rationalisation of existing services.

A practical example of this intention is the creation of the Indigenous Family Program, an across-agency program managing the service requirements of a group of high service need families. This program's current capacity is limited to ten families.

Service agencies should be encouraged to examine ways of building greater efficiency and cohesion between the service and policy platforms of their respective agencies. These developments fit well with the shared fund holding proposals mentioned elsewhere in this document. Managed integration of these proposals may provide an efficient and meaningful way of building improved service infrastructure at the community level.

Priorities

- Mapping of services available to Nyoongars and the identification of possible synergy between community controlled and other agencies; and
- Expansion of the IFP to enable up to 20 families to be recruited.

6.6 Cultural Security

Increasingly, health services are recognising the need to ensure that the service they provide to Nyoongars does not offend the legitimate cultural rights, views, values and expectations of Nyoongar people. Cultural security concentrates on the behaviours of service providers and their compliance with legitimate cultural expectations. Previous efforts to effect change in behaviours by concentrating on the attitude of service provider staff did not take into account the absence of knowledge about the specifics of Aboriginal cultural expectation in the region of service. Nor did it establish well-defined employer expectations of workplace behaviours.

This approach seeks to identify areas where culture and delivery of health services intersect and to map changes in the way in which services are provided to take into account the culture of Nyoongars. Clearly there will be some areas where the clinical imperatives need to take priority, but even arriving at that agreement speaks well for the building of a long-standing partnership between clinicians, communities and administrators on matters of cultural security.

Cultural security of necessity requires Nyoongar communities to talk about culture and in accepting this, non-Aboriginal participants have to understand that Nyoongars do not surrender their cultural property rights, they are agreeing to share information and to participate in a process.

The second stage of the Cultural Security program for Nyoongars is to take agreement between OAH and DHYS sponsored discussions with Elders and others in the Nyoongar community and to start the process of working through priority areas of health services to ensure that culture is taken into account.

This will involved getting key Nyoongar spokespersons, law holders and Elders together with key health decision makers and clinicians to start the process of mapping the modification of clinical and administrative practice. In order to keep the integrity of the process sound, the number of participants in this second stage should only involve those who have a direct role.

The progress through this phase should perhaps be broken into groups:

- General Practice;
- Hospital; and
- Specialists.

A few common participants may be required to ensure consistency, although the need to protect cultural property rights should remain of central concern.

The DYHS has already commenced work to engage Nyoongar leaders and communities in a process that is intended to build a health services environment that is culturally secure for Nyoongars. The OAH has drafted and received WAACCHO support for a Cultural Security policy.

Priorities

- Complete Phase 1 project at DYHS;
- Establish agreement on matters relating to cultural property rights;
- Establish the process and content agreement for Phase 2, and fund the process;
- Expand the current levels of engagement of appropriate clinicians and health system decision-makers; and
- Extend the process to engage the region.

7. Conclusion

This Nyoongar Health Plan is intended to be a shared agenda for all those people concerned with improving the health of Aboriginal people in the Nyoongar region. This includes deliverers of health services, Aboriginal community groups, decision-makers and all government agencies, not just those involved directly in health.

The Plan aims to bring about significant improvements in health services for Nyoongar people in the short to medium term and major improvements in Nyoongar health outcomes in the long term.

The Plan identifies a wide range of recommendations and priorities that need to be addressed. A significant increase in resources is required to address some of these priorities while others require little or no extra resources, just commitment from all the parties involved.

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