

2007-2008
CONGRESS
ANNUAL
REPORT

ABORIGINAL HEALTH IN ABORIGINAL HANDS

CENTRAL AUSTRALIAN ABORIGINAL CONGRESS



To be Australia's leading
Aboriginal community-
controlled provider of
comprehensive health care.

**THE VISION - OUR DREAMING FOR THE FUTURE
CENTRAL AUSTRALIAN ABORIGINAL CONGRESS
2007-2008 ANNUAL REPORT**



President's Report



From Helen Kantawarra, Congress President

Throughout 2007/08, Congress Cabinet remained strong and focussed on ensuring that we provided good health care and services to the community, in addition to continuing our longstanding advocacy role across Aboriginal affairs.

The main issue during this period was the NT Emergency Response Intervention, which brought heavy demands, challenges and confusion with the changes it introduced.

While Congress worked hard to achieve a broad and balanced policy position, the Intervention's racially discriminatory aspects caused much anger and hardship.

We did not support the Government's suspension of the Racial Discrimination Act, nor did we support the forced prohibition of alcohol, extended police powers to enter any house without a warrant or the quarantining of welfare payments to all people.

We did support the substantially increased investment into police and housing, along with new primary health care and 2000 CDEP positions for real jobs.

Congress played a vital role in providing Child Health Checks for the 400 children in our health service area. The Child Health Check was an aspect of the Intervention that Congress chose to support as we believe that our children's health should always be a top priority. To make sure we continue to address our children's health needs, our health staff are working with the families.

Congress also felt it was important to consult the Tangentyere Council Executive on the Child Health Checks service. As a result of some concerns raised, we agreed to set up an advisory committee. This committee held four meetings where regular reports and data on the child health assessments was provided.

This year the Cabinet reviewed the Cabinet's Dreaming Strategic Plan document. "Our Dreaming for the Future" is a 5 year plan from 2008 to 2013.

Cabinet's Dreaming was written in September 2004 and became the Strategic Plan. Cabinet decided that the Dreaming should remain largely unchanged. The minor changes to the vision and aspiration are based on the ongoing development of Congress. The plan consists of:

- The Vision - to be Australia's leading Aboriginal community controlled provider of comprehensive health care.
- The Aspirations (AIMS) that will realise the Cabinet's Dreaming, are described within a set of 9 Aims.
- A set of 18 key result areas.

The 18 key result areas will be used to measure if we are achieving the outcomes, which make it clearer for the Cabinet to judge our progress towards achieving the Dreaming. Cabinet reviews the business plan report every six months.

Cabinet remains an active high profile advocate on key Aboriginal health policy and health service needs of our community. Attendance at the joint AMSANT and QLD Aboriginal and Islander Health Council Governance and Business Improvement Conference, GARMA Festival, AMSANT General meeting, NACCHO AGM Meetings and other relevant local, regional or NT meetings as required.

Policies approved, included organisational;

- Remote Health Services Exclusion
- Pharmacy service
- Use of TASERs by NT police.

A Constitutional Sub Committee was endorsed to review and update Congress's constitution in order to bring it into line with corporate governance best practice.

The Remote Health auspiced health services Branch continued to expand. Currently we are providing service to WAHAC, Utju and WYN. The contract for Mutijulu commenced effective from 1/1/2008. A Health Board is now established by the community and the health service is fully operational.

In closing, I would like to acknowledge the community for their support and confidence in Congress and to acknowledge the Congress Board for its leadership role and support. I would like to offer my special thanks to the Director and the staff for their commitment and hard work during the 07/08 year.

OUR ASPIRATIONS

- To be Australia's leading Aboriginal community-controlled provider of comprehensive health care.
- To improve the health of our community.
- To provide the highest quality services to our community.
- To assist communities who wish to establish their own community-controlled health service.
- To be Australia's leading Aboriginal community-controlled provider of comprehensive health care.
- To remain a community-controlled organisation.
- To provide opportunities for Aboriginal people to train in all areas relevant to Congress.
- To maintain self-determination.
- To secure the financial resources to continue Cabinet's dreaming.
- To expand the services offered by Congress consistent with community needs.



Cabinet

As the key decision-making body for Congress, Cabinet meets every six weeks to oversee the organisation's many activities. Congress Cabinet is made up of four executive positions, two Native Title Holder positions and seven ordinary positions.

Cabinet is elected biennially by members of the Central Australian Aboriginal community at an Annual General Meeting.

Out of thirteen Cabinet positions ten were filled and three General Cabinet Vacancies remained vacant until the AGM that was held on 18 January 2008. All thirteen positions were then filled. On average, ten members attended each meeting and seven meetings were held in the 2007/08 year.

Congress held the AGM on 18 January 2008. Elections were held for all positions. All positions filled.

Executive

Helen Kantawara *President*

Margaret Liddle *Vice-President*

Donna McMasters *Secretary*

Heather Campbell *Treasurer*

Vanessa Davis

Betty Campbell

Betty Carter

Joe Hayes

Margaret Orr

Robert Le Rossignol

Tahnia Edwards

Native Title Holder positions (nominated by Lhere Artepe)

Brian Stirling

Darryl Pearce

Back Row, L-R: Brian Stirling, Robert Le Rossignol, Joe Hayes, Darryl Pearce
 Front Row L-R: Vanessa Davis, Betty Carter, Helen Kantawara, Margaret Liddle
 & Margaret Orr. Front: Donna McMasters
 Not present: Tahnia Edwards

Director's Report



From Stephanie Bell, Congress Director

2007/08 was the year in which the new Rudd Government committed itself to Closing the Gap for Aboriginal people: this was a welcome development.

The current life expectancy gap between N.T. Aboriginal Australians and non-Aboriginal Australians is 18 years for males (59 years) and 15 years for women (68 years). That there has been a steady increase in life expectancy for both Aboriginal and non-Aboriginal people is undermined by the fact that the gap is only narrowing for women - not for men.

Today's Aboriginal people have a life expectancy that is comparable to those of the non-Aboriginal population a hundred years ago. Aboriginal Australians life expectancy also is lower than other Indigenous populations in comparable countries, such as Canada, Aotearoa/New Zealand and the USA.

The 2007/08 Annual Report will be different in format from previous reports.

In this report, I want to explain to you the causes of the life expectancy gap, what Congress is doing to help to close this gap and how we are measuring our performance using Key Performance Indicators (KPIs).

This is a complex story of overlapping health issues and in order for Congress to address many health issues simultaneously, it must coordinate a wide range of different health services.

The 19 Northern Territory Aboriginal Health Key Performance Indicators are used here to give a glimpse of how those services interact.

What makes up this life expectancy gap?

- 77% of the gap is due to people dying too young, mainly from chronic disease, especially heart disease
- 13% of the gap is due to babies dying from infections, not being fed properly, birthing and other problems
- 10% of the gap is due to young people dying from drug-related injuries.

Why are children dying below the age of 5?

- Problems during pregnancy and birth causing death in the first month
- Deaths are also due to poor nutrition and environmental factors resulting in infections such as pneumonia, injuries and poisonings.

How is Congress helping to reduce the death rate of babies (infant mortality) and children under 5?

- By providing good antenatal care
- By achieving good birth weights for new babies
- By providing home visitation, education and support for new mothers
- Through care planning for children with chronic conditions
- Through the Healthy Kids Clinic providing immunisation, nutrition advice and Child Health Checks
- By providing accessible sick care day and night.

How is Congress helping to reduce the death rate of young adults (15-30) from motor vehicle accidents, suicides, homicides, and pneumonia?

- Through youth programs and Social and Emotional Well Being Service which work with young people to support strong attachment to parents, peers and school and the development of clear identity and purpose
- Through working to address petrol sniffing and alcohol
- By providing adult health checks, brief interventions and treatment for alcohol, tobacco and other drugs
- Through the Male Health interpersonal violence program

How is Congress reducing the death rate in middle age (35-50)?

- By achieving good pregnancy and birth weights

- By providing Adult Health checks from 15 years to change lifestyle early and prevent premature death from chronic disease
- Through early diagnosis and good management of chronic diseases e.g. diabetics with good cholesterol results in a 46% reduction in death rate
- Through cancer prevention and early diagnosis.

Shaping the debate

Congress has been involved in the development of a number of new programs and services as well as in helping to shape key policy developments in Aboriginal health.

Congress worked very hard to shape the NT Intervention so that it had a positive impact on Aboriginal health. From the outset we opposed the suspension of the Racial Discrimination Act and the discriminatory aspects of the Intervention. At the same time, we successfully worked on ensuring the Intervention resulted in a bigger health investment.

Specifically, there is now a large new investment in primary health care services of the order of \$50 million per year and Congress, along with other Aboriginal health services, will benefit greatly from this. The Expanded Health Services Initiative followed on from the initial phase of the intervention - the Child Health Checks. Congress completed over 320 child health checks at the time but we always advised the government that there needed to be a more sustained investment in primary health care beyond the child health checks. This is now happening.

New initiatives 07/08

Congress has been successful in advocating for the following new services and social preventative programs:

- **headspace** - a new primary health care service for all young people with a special focus on mental health and alcohol and drug problems
- The Grog Mob alcohol treatment and rehabilitation program
- A second Male Health psychologist along with the development of a juvenile sex offender program in a remote community
- The Male Health Summit was held at Ross River (see Appendix A)
- A new psychologist position for Social & Emotional Wellbeing
- The expansion of our home visiting program under the Nurse Family Partnership Program, enabling us to offer this program to all mothers

- A Renal Case management nurse and a nurse position for Chronic Disease Care Planning
- Congress has taken over the auspicing of the Mutitjulu health service and negotiated to auspice the Amoonguna and Santa Theresa health services.

Action on alcohol

Another key area of action in which Congress has been busy is alcohol reform. Congress has advocated, along with the People's Alcohol Action Coalition, for continued supply and demand reduction measures. Contrary to some publicity, there have been significant improvements in Alice Springs and Central Australia since the alcohol restrictions were introduced. The restrictions, along with additional policing and perhaps more recently, income management, have led to the following outcomes:

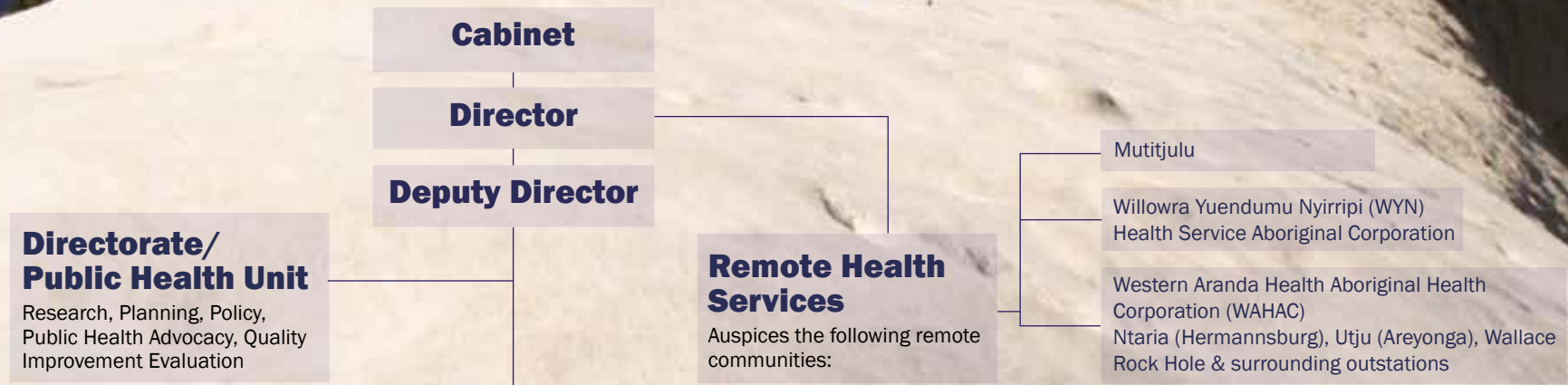
- A 14% reduction in alcohol sales and consumption in Alice Springs. In most parts of NT, alcohol consumption continues to increase but not in Alice Springs – we have turned the corner and things are improving
- A major reduction in the combined murder/manslaughter rate from around 9 per year to 2 in 2008
- A major reduction in the Aboriginal suicide rate from around 7 per year to none in 2008. As suicide is the leading way in which alcohol causes premature death in Aboriginal men, this is a sensitive indicator of success at reducing heavy drinking
- A major reduction in admissions to Alice Springs Hospital for stabbings from 200 to 70 per year
- A 30% reduction in alcohol-caused presentations to the Emergency Department along with reduced admissions especially to the Intensive Care Unit.

These are significant successes but there is still a big alcohol and violence problem. Congress will continue to work with others for action on alcohol.

In closing

The Intervention ensured a very busy year for Congress but I feel we have risen to the challenge - this document provides a snapshot of a very energetic, comprehensive and effective health organisation. Complex it may be but as always the driving motive at the very core of our activities remains *Aboriginal health in Aboriginal hands* .

Congress Organisation Chart 2007/08



**Directorate/
Public Health Unit**
Research, Planning, Policy,
Public Health Advocacy, Quality
Improvement Evaluation

**Remote Health
Services**
Auspices the following remote
communities:

Mutitjulu

Willowra Yuendumu Nyirripi (WYN)
Health Service Aboriginal Corporation

Western Aranda Health Aboriginal Health
Corporation (WAHAC)
Ntaria (Hermannsburg), Utju (Areyonga), Wallace
Rock Hole & surrounding outstations

Services
Health Appointments
General Practitioners
Registered Nurses
Healthy Kids Clinic
Visiting Specialists
Aboriginal Health Workers
Pharmacy
Hearing Program
Chronic Disease Program
Frail Aged & Disabled
Dental Clinic
Transport

**Corporate
Services**
Finance
Human Resources
Asset Management
Information Technology
Records Management
Communications
General Administration

Alukura
Women's Health Clinic
Antenatal, Birthing & Post-
natal care
Young Women's Community
Health & Education Program
Nurse Family Partnerships
(Home Visitation Program)

Male Health
Adult Health Checks
Sexual Health Screening
Behavioural Change
Counselling
Ceremony Support Services
Violence Intervention
Program

Childcare
PALS Social Skills
Program

**Education &
Training**
Certificate IV in Aboriginal &
Torres Strait Islander Primary
Health Care

**Social & Emotional
Wellbeing**
Counselling Services
Youth Outreach Program
After Hours Youth Services
Positive Parenting Program
Family Wellbeing Program
Alcohol & Other Drugs Treatment
Program

Why do we need Key Performance Indicators?

- To ensure a common set of core services is available to all Aboriginal people across the NT - wherever they live - and to be delivered by an integrated primary health care system
- To help focus our operational effort in the areas where evidence tells us we will have the greatest impact on “Closing the Gap”
- To give Congress data that will enable us to demonstrate our effectiveness and drive quality improvement
- To simplify reporting requirements.

Under Congress’s funding agreements, we must work to meet these 19 indicators. The KPIs are also integrated into Congress’s Business Plan, which includes around 100 other indicators.

KPIs

Key Performance Indicators (KPIs) for NT Aboriginal Primary Health Care Services

Domain 1: Health Services

1. Number of episodes of health care and client contacts.
2. Timing of first antenatal visit for regular clients delivering Indigenous babies.
3. Number and proportion of low, normal and high birth weight Indigenous babies.
4. Number and proportion of Indigenous children fully immunised at 1, 2 and 6 years of age
5. Number and proportion of children less than 5 years of age who are underweight.
6. Number and proportion of children between 6 months and 5 years of age who are anaemic.
7. Number and proportion of clients aged 15 years and over with Type II Diabetes and/or Coronary Heart Disease who have a chronic disease management plan.
8. Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbA1c test in the last 6 months.
9. Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB.
10. Number and proportion of Indigenous clients aged 15 to 55 years who have had a full adult health check.
11. Number and proportion of Indigenous clients aged 55 years and over who have had a full adult health check in the past 12 months.
12. Number and proportion of women who have had at least one PAP test during reporting period.

Domain 2: Management and Support Services

13. Report on unplanned staff turnover (where possible by occupation) over each 12 month period.
14. Report on recruits (excluding locums) completing an orientation and induction program, including cultural awareness.
15. Report on overtime workload.
16. Report on quality improvement systems including the use of best practice guidelines; eg CARPA.

Domain 3: Linkages, Policy and Advocacy

17. Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research).

Domain 4: Community Involvement

18. Report on community involvement in determining health priorities and strategic directions through any of the following: health boards; steering committees; advisory committees; community councils; health councils.
19. Show evidence of appropriate reporting to community on progress against core PIs.



“Congress is always there for me”

EASY LIDDLE, CLINIC CLIENT, WITH CHIQUITA BICKNELL, ABORIGINAL HEALTH WORKER

Services Branch

Number of episodes of health care and client contacts.

54,465 episodes of care provided to 6700 resident patients and 1700 visitors.

OVERVIEW

Providing more than 54,000 episodes of care a year requires considerable organisation, especially as Congress is striving to improve its services.

The development of a flexible system with both appointments and ‘walk-ins’ has enabled greater choice by the community on how they want to access Congress. Although there were some teething problems with the new appointment system, it has reduced waiting times at Congress to their lowest level for many years with less than 8% of patients now

waiting more than 1 hour. Along with most people now waiting less than 15 minutes we are also seeing more individual patients are coming more often. This is a big achievement for Congress.

Congress has also introduced a free 1800 number to access our services and extended our transport services for specialist clinics.

Congress continues to provide free health care and medicines through our on-site pharmacy along with extended hours of operation.

ANALYSIS

This number has been steadily increasing for some years. Last year’s figures: 51646.

Behind this number, which represents around 2,000 episodes of care per week, lies the vast majority of Congress’s activities.

By locality of patient, the number of episodes break down into 65.2% lived in town houses, 21.5% lived in town camps and 3.8% lived in outstations.

Ease of access has improved partly as a result of an upgraded appointment system.



“Knowing I have the support of the women at Alukura is important to me.”

ALUKURA CLIENT

Congress Alukura

Timing of first antenatal visit for regular clients delivering Indigenous babies.

37 & 56%

OVERVIEW

Staff at Congress Alukura have gone to great lengths to create a caring atmosphere at Alukura. In order to build the trust necessary to forge a close bond between prospective mum and health worker, reassurance and continuity is vital, even if it is sometimes only a phone call.

The aim of antenatal care is to maximise the health outcomes of the mother, baby and wider family. It aims to identify and manage risk factors (such as smoking) or complications early and to monitor progress with information and support throughout pregnancy.

ANALYSIS

37 and 56% are the number and proportion of current patients who have given birth in the period and attended for the first antenatal visit before 13 weeks. There was a decline in early access for antenatal care primarily due to a lack of midwives. All positions are now filled and access is again improving. This is critical as good birth weights follow on from early antenatal care.



“Good birth weights are fundamental to good health across the span of life.”

OVERVIEW

The Healthy Start to Life Program recognised good birth weights as fundamental to the potential for good health across the whole span of life.

A clear link has been established between very low birth weights and preventable chronic disease such as coronary disease, diabetes and renal disease.

As these later diseases are major contributors to the life expectancy gap, achieving good birth weights will ultimately decrease the rate of some of these preventable deaths.

Early antenatal care is also important for establishing the conditions for good birth weights.

ANALYSIS

Services Branch & Congress Alukura

Number and proportion of low, normal and high birth weight Indigenous babies.

Low: 18 (16%)

Normal: 91 (81.2%)

High: 3 (2.6%)

While the 16% figure is equivalent to the Territory average, in the recent period the proportion of low birth weight babies has more than doubled: this is a cause for concern to Congress.

These results correlated with the decline in early access to antenatal care and action is being taken to correct this situation. As a consequence, there should be a return to the 7% figure that has been previously achieved.



“Our immunisation program was successful because we built strong relationships between clinic and community.”

SARAH GALLAGHER, ABORIGINAL HEALTH WORKER

Services Branch

Proportion of children fully immunised at 1,2 and 6 years of age.

72.3%, 88.7% and 82.9%

OVERVIEW

The Utju/Areyonga Clinic, although not a direct Congress service, is auspiced by Congress’s Remote Health Services as part of the Western Aranda Health Aboriginal Corporation. Areyonga is a small community 180 kms west of Alice Springs of around 200 people. The Utju/Areyonga Clinic’s record and method of immunisation deserves wider recognition. They recently ran a special Health Week in order to maximise

Influenza vaccinations before the start of the flu season. To maximise the effect of the campaign all necessary patient data was drawn together and updated. Local artists designed a noticeboard and a number of events during the week were arranged such as a healthy community breakfast and a movie night. The resulting uptake of the flu vaccine resulted in a 97% coverage for the community.

ANALYSIS

Immunisation is provided to patients opportunistically (with the parents consent) and on request. These results indicate both the coverage and timeliness of immunisation. Under Australian Childhood Immunisation Register criteria for coverage, the figure would rise to 95.3%. The slightly lower figure for the 6 years of age marker is a result of the fact that it is harder to get children to willingly undergo immunisation from the age of 4 years onwards.

**BABY MATARNA EATS BABY RICE FOR THE FIRST TIME
- A GOOD START TO EATING HEALTHY FOOD**



Congress Alukura

Number and proportion of children less than 5 years of age who are underweight.

31 -3.5%

OVERVIEW

Congress's Intensive Home Visiting Program has been running for some 8 years. Since 2008, nurses now visit mothers and their newly-born infants regularly, building a close rapport whilst educating and supporting mothers in the benefits of healthy feeding such as iron-rich foods as well as avoiding and treating health problems such as "failure to thrive" syndrome. That intensive home visitation is a recipe for better health outcomes later in life is not just a theory.

Congress has built a good working relationship with Professor David Olds at the University of Colorado Health Sciences Centre. Olds' 27 year US study found that children going through intensive Nurse Home Visitation programs have benefited in significant ways far beyond the toddler years in behaviour and health outcomes. A recent \$2 million grant from the Federal government will see Nurse Family Partnerships expanding to more families in Alice Springs in 2009.

ANALYSIS

Of the 539 children who were weighed, 31 were found to be underweight. Underweight is defined as children in the bottom 3% of a normal population and weight distribution curve. In a normal population of children under 5, 3% would be found to be underweight because they are naturally small - and not due to poor nutrition or poor social environment. Consequently, on this indicator, which is a severe measure of poor growth, there are very few underweight children in the community.



“Above all kids need energy to think, to learn and to create the right pathways for their lives.”

REBEKAH FRENCH, PAEDIATRIC CARE PLANNER

Services Branch

Number and proportion of children between 6 months and 5 years of age who are anaemic.

103 - 12%

OVERVIEW

Tackling anaemia is a top priority because of the complications that result when children do not have sufficient energy.

Fatigued and lethargic children are less likely to be able to learn and to develop in the way that will give them the best chances in life.

The critical risk period for anaemia is in the 6, 12 and 18 months of age period, when the child is usually transiting to solid food.

“If children are not getting enough of an iron-rich diet, or are not able to sustain iron levels in their system then they won’t have the energy to reach the milestones they need to achieve step by step development,” says Congress Paediatric Care Planner Rebekah French.

“Above all kids need the energy to think, to learn and to create the right pathways for their lives.”

ANALYSIS

Congress provided services to 872 children in that year. During this period, the Child Health Check Initiative enabled us a substantial sample - more than 50% were tested for haemoglobin levels.

Haemoglobin levels are an indicator of nutritional status: results are obtained instantly using a haemoglobinometer. A haemoglobin level of less than 110 g/litre is defined as anaemic.



“The right choices about food and diet will make a big difference in fighting chronic disease.”

Services Branch

Number and proportion of clients aged 15 years and over with Type II Diabetes and/or Coronary Heart Disease who have a Chronic Disease Management Plan.

67 (7.3%) & 18 (9.3%)

OVERVIEW

According to Congress Chronic Disease Care Planner Lea Davidson, a big part of the solution is about goal setting.

“It’s important that the patient understand that he or she has the potential to control the disease, that decisions made as part of a care plan will make a big difference.”

Care plans can focus on small changes in lifestyle rather than dramatic medical overnight solutions. These include changes to food choices for both the individual and the family.

ANALYSIS

7.3% of Type II Diabetes patients have a care plan whilst 9.3% of Coronary Heart Disease patients have a Chronic Disease Management Plan.

More care planning nurses are needed to complete care plans as GPs do not always have the time necessary to undertake care plans.

Preventable chronic diseases impose a heavy burden on Aboriginal people: care plans are the basis for long term care aimed at lessening hospitalisation, complications and health care costs.



“The HbA1c level governs how a whole collection of health conditions are to be managed.”

**CHERYL SANDERSON,
CONGRESS DIABETES
CO-ORDINATOR**

Services Branch

Number and proportion of resident clients aged 15 years and over with Type II Diabetes who have had an HbA1c test in the last 12 months.

538 - 57%

OVERVIEW

The HbA1c test has significant implications for a wide range of diabetic complications such as eye disease, circulatory disease and kidney disease.

It is also important to assess blood cholesterol and blood pressure. Getting the average sugar level under control is not easy and requires a commitment to both a more healthy lifestyle and medicines.

As Cheryl Sanderson, Congress’s Diabetes Coordinator says: “The HbA1c level governs how a whole collection of health conditions are to be managed. Getting blood sugar levels under control means we can help people make a difference to their lives, leading to longer, happier and healthier lives.”

ANALYSIS

Glycosylated haemoglobin (HbA1c) indicates average blood glucose level for the previous 2 or 3 months and is a good overall indicator for increased risk of heart attacks, strokes, cataracts, circulation problems and other health issues.

For the first time, an Aboriginal Registered Nurse was employed to focus on completing the annual diabetic cycle of care: this should increase the coverage rate for HbA1c.



“If we can be confident all of our diabetic patients are on these medications, it will delay or even prevent end-stage renal disease.”

OVERVIEW

We treat patients with diabetes to prevent the onset of complications of the disease: kidney disease is a major complication. Sometimes there are medical interventions that in and of themselves make a big difference to outcomes. Putting diabetic patients with early evidence of kidney disease on these medications is one such example.

If we can be confident all of our diabetic patients are on these medications, it will delay or even prevent end-stage renal disease.

We really want to keep our mob off dialysis where we can and that's what this treatment is doing.

Services Branch

Number and proportion of diabetic patients with albuminuria who are on ACE inhibitor and/or ARB.

222 - 71.8%

ANALYSIS

The presence of protein in the urine (albuminuria) is a reliable indicator of renal disease. Control of high blood pressure is significant in slowing the progress of the disease and use of Angiotension Converting Enzyme (ACE) inhibitor or Angiotension Receptor Blocker (ARB) can significantly improve blood pressure control and renal deterioration.

This indicator is still only able to measure ACE inhibitors and not ARB. This will be rectified; however, a comprehensive file audit of patients has revealed that almost 84% of patients use one or other of these medicines.



“Clients come here to do their washing, get a bit of tucker and to get their health looked at...”

CONGRESS NURSE JAMIE ALVEA TALKING WITH TERENCE LONG

OVERVIEW

The Congress Male Health Centre undertakes regular full adult health checks, not just in their Gap Rd Centre but in pubs, sporting events and remote areas. Blood pressure, blood sugar levels, height and weight measurement, STIs, kidney disease, hepatitis are all checked. Other parts of Congress that actively undertake full adult health checks as part of their overall programs include Alukura Women’s Health, the Frail, Aged and Disabled Section and, of course, the main Congress Clinic.

A key part of Closing the Gap lies in dealing with preventable chronic conditions. The development of these conditions is linked to lifestyle choices made in early adult life. Adult health checks provide an opportunity to talk to patients - especially young people - about unhealthy lifestyle choices such as smoking, diet, lack of exercise and alcohol. Awareness of unhealthy choices is the first step towards reducing the mid-life death peak. The next best thing is early detection of signs such as high blood pressure or diabetes.

Congress overall

Number and proportion of Indigenous clients aged 15 to 55 years who have had a full adult health checks.

1147 - 27.7%

ANALYSIS

Nationally, only about 3% of Aboriginal people between 15 and 55 have undertaken one of these health checks and Congress is pleased that the proportion of those undertaking checks is slowly improving.

Congress will continue to strive to better this and to offer improved initiatives to support lifestyle changes.



“Adult Health Checks provide a way for the Congress clinic to move beyond treating sick people on the day to also trying to prevent people becoming sick in the first place.”

ABORIGINAL HEALTH WORKER TERRY BRAUN

OVERVIEW

Adult health checks provide a way to assess patient lifestyle and encourage healthy behaviour such as exercise, good diet, low alcohol and quitting cigarettes.

The checks also help us diagnose key chronic conditions such as high blood pressure, diabetes and kidney disease early so that these conditions can be treated effectively.

Adult health checks are a critical component of preventative health care as they are used to prevent the development of disease before it has even begun (primary prevention) or prevent the progression of established disease (secondary prevention).

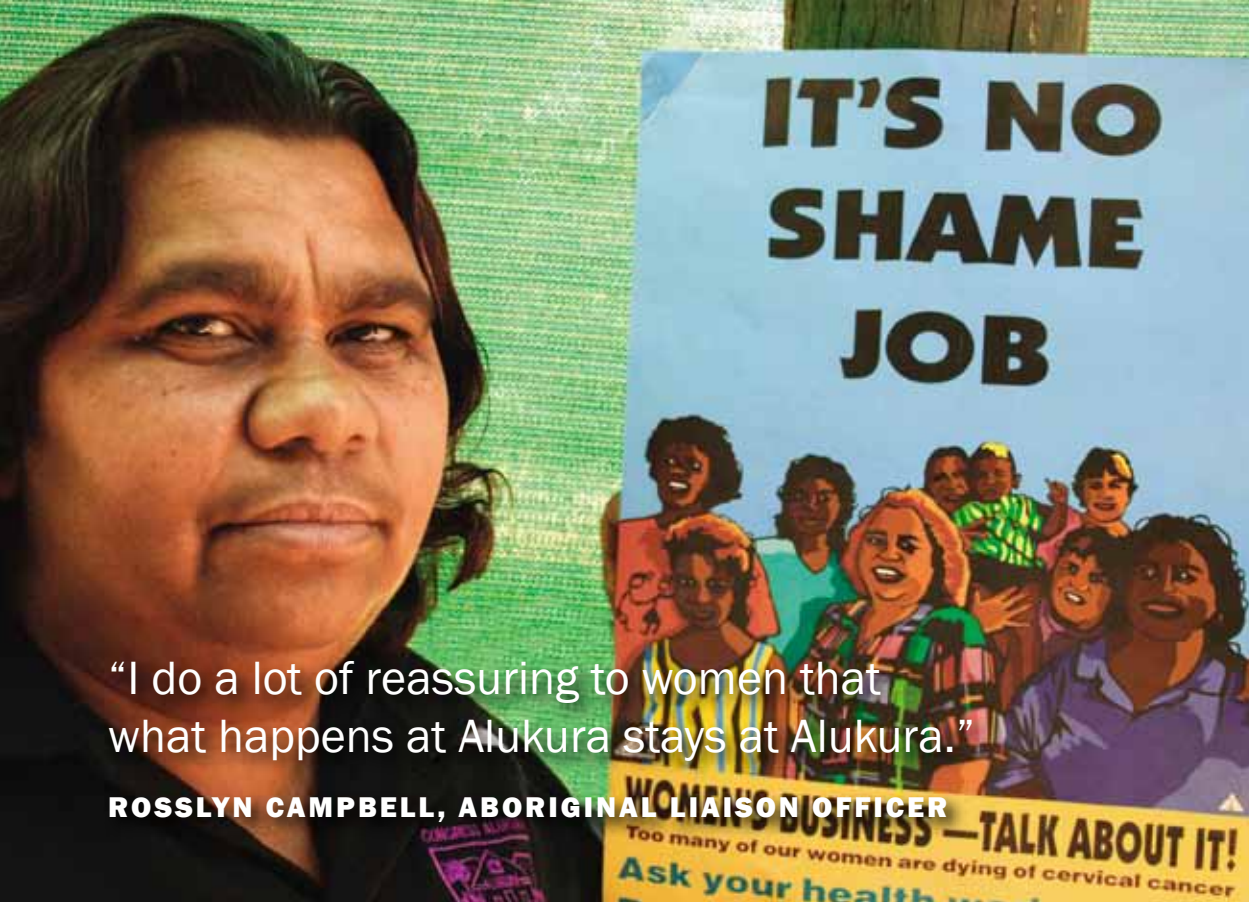
ANALYSIS

Screening people for disease encourages detection at an early stage and allows for good clinical management with the aim of reducing and preventing complications.

Congress overall

Number and proportion of Indigenous clients aged 55 years and over who have had a full adult health check in the past 12 months.

175 & 23%



“I do a lot of reassuring to women that what happens at Alukura stays at Alukura.”

ROSSLYN CAMPBELL, ABORIGINAL LIAISON OFFICER

OVERVIEW

Rossllyn Campbell works at Congress Alukura as an Aboriginal Liaison Officer. She plays a pivotal role in gaining the confidence of local women about PAP tests. A good deal of her role involves picking up women to take them to checkups, reminding them of when tests are due, and counselling - often in the car as they are being taken to the clinic.

“Some women are afraid to have the tests done or to come back to the doctor. They often don't know that things can be fixed up before they get worse and that's a better way to do things. I let them know that this test is picking up stuff before it becomes cancer.”

Congress Alukura & Services Branch

Number and proportion of women who have had at least one PAP test during the reporting period.

789 & 38%

ANALYSIS

Congress Alukura has been through a period of understaffing during which the capacity to see women has been significantly reduced. In addition, although women present often to the main clinic, these checks are often not their priority.

Although the outcome of 38% over 2 years is somewhat disappointing, over time Congress does better with 2711 women or 68% of all women having had a PAP smear at 5 years. The national average at 5 years is around 85%.

Strategies try to improve this coverage include the employment of a new Aboriginal Liaison Officer outreaching to women.



Come to our place.

If you're interested in an exciting career challenge, Central Australian Aboriginal Congress is looking for **Registered Nurses, Midwives and Child Health Nurses** to deliver comprehensive primary health care in Alice Springs.

“Health staff are at a premium around the world so we have to go the extra mile”

DARRELLE WINDSOR, CONGRESS RECRUITMENT OFFICER

Congress Corporate Services

Report on unplanned staff turnover in permanent positions (where possible by occupation) over each 12 month period.

- General Practitioners 8%**
- Aboriginal Health Workers 0%**
- Registered nurses 5%**
- Managers 22%**
- Child Care Workers 14%.**

OVERVIEW

As at June 30 2008, Congress employed 141 staff in positions for its Alice Springs operations and a further 18 staff in the auspiced remote health clinics.

This does not include casual staff. In this time, Congress experienced significant growth, especially in the program area of mental health.

Congress also employed numerous people on short-term arrangements as a result of the Emergency Response. Unplanned turnover is defined as turnover that results from an employee leaving their employment from a permanent position which is a position funded for 2 years or more.

ANALYSIS

These turnover figures are not unusual for Central Australia or for remote employment generally. The employment market in Alice Springs is particularly fluid across many occupations and organisations. In our professional categories, Congress employs many people from outside the NT.

Historically, they tend to stay for short periods of time before returning to their home state. In lower paid occupations, employees tend to work for short periods before moving to higher paid employment as they gain experience and/or qualifications.

Congress does particularly well in attracting staff, with an average vacancy rate below 5%. Retention rates have benefitted from improved orientation in the workplace context and by offering competitive salaries and working conditions.



“When people understand where they stand and what their rights and obligations are, then they can build well-being.”

KEN LECHLEITNER

Congress Corporate Services

Report on recruits (excluding locums) completing an orientation and induction program.

90%

OVERVIEW

Congress staff are required to complete an Orientation Program within 3 to 6 months of their commencement date. The Orientation program comprises 4 steps, some of which are run with the participation of Central Australian Remote Health Development Service (CARHDS). Ranging from a broad historical examination of the impact of white settlement of Central Australia to local cultural traditions, the training also includes Congress’s own unique history.

Ken Lechleitner (above) is one of a number of people who contribute to the Orientation Program, usually giving a brief outline of the Dreaming Tracks around Alice Springs as viewed from Anzac Hill. Behind his talk, Ken is keen to get across the idea that within both European and Indigenous cultures, rules are given - rules on conduct and rules on how to live together- and it is by following those rules we learn to move forward together. “At their core, both cultures believe that man should respect fellow man.”

ANALYSIS

Orientation that includes cultural awareness is a necessary element for new recruits, many of whom are from urban or overseas backgrounds. As some recruits come to Congress with only the vaguest notions of the complexity of indigenous culture, the potential for misunderstanding is high. As medical procedures, of necessity, involve intimate dealings with the patient’s physical and mental self, it is vital that new staff have a good grasp of where they stand culturally.



As part of Congress's commitment to a comprehensive health service, some out of hours work will be inevitable: the challenge is to manage that workload effectively.

OVERVIEW

Congress rosters medical staff on for evening, weekend and public holiday clinics which provided 5203 episodes of care which is 10% of total episodes of care.

In addition, an on call GP service after these clinics have closed saw a further 1497 patients or 3% of total episodes of care.

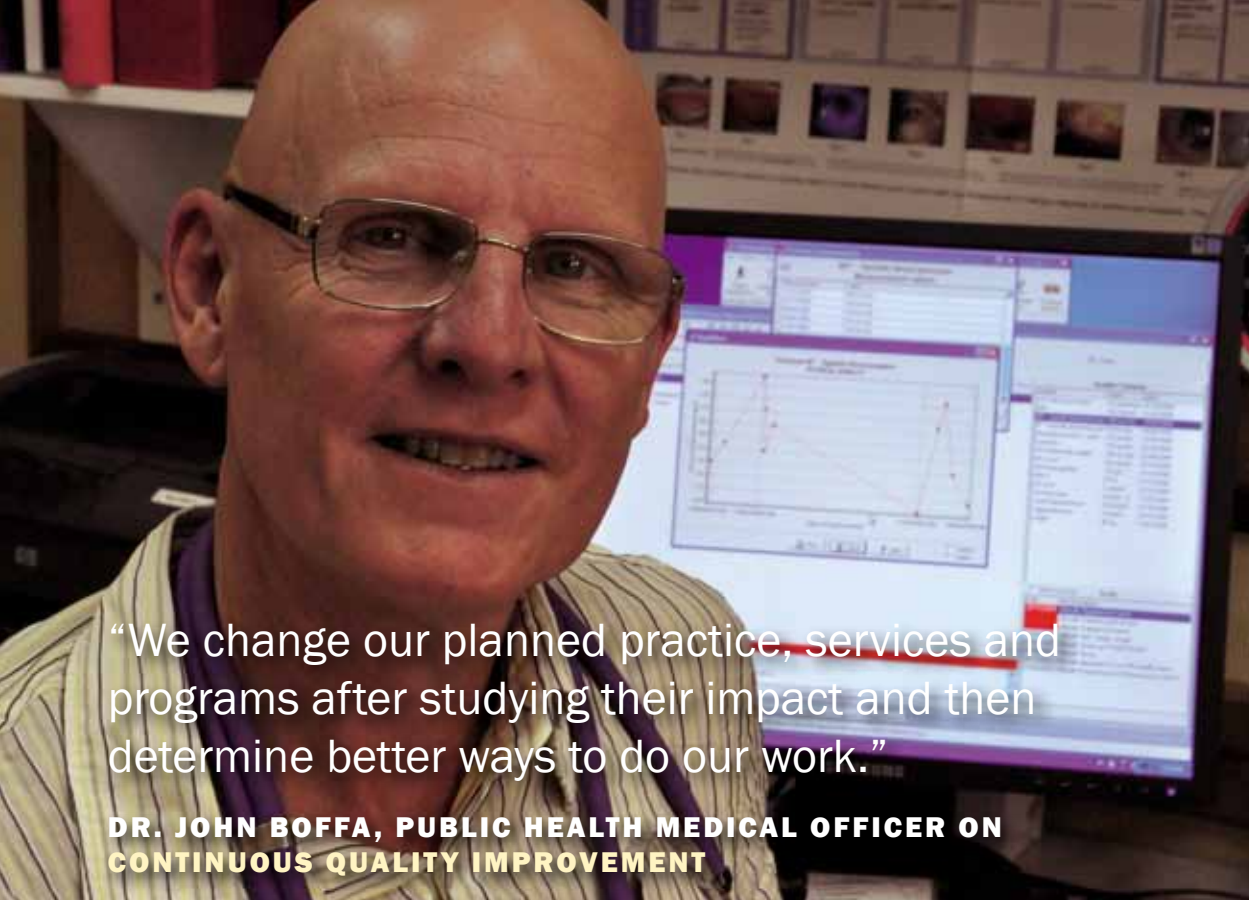
Services Branch & Corporate Services

Report on overtime workload

1%

ANALYSIS

Congress keeps overtime to a minimum and provides it after hours services through non-overtime remuneration arrangements to avoid increased costs and "burning out" staff. However, because of unfilled positions or recruitment difficulties in specific skill areas, some staff can be asked to work overtime. This has only been the case in this reporting period for receptionists and Aboriginal health workers and represents only a very small component of the recurrent salary budget. Overtime at Congress accounts for about 1% of the overall salary budget each year.



“We change our planned practice, services and programs after studying their impact and then determine better ways to do our work.”

DR. JOHN BOFFA, PUBLIC HEALTH MEDICAL OFFICER ON CONTINUOUS QUALITY IMPROVEMENT

OVERVIEW

Quality improvement is vital to meeting our aim of being the best possible service for our community.

QI systems in place include:

- Service and program planning and development
- Regular review and evaluation
- Operational plans with clear goals, activities and performance indicators so services and program can be evaluated
- Analysis of data
- Routine file auditing and feedback to individual practitioners
- Regular group case studies and inservice training sessions

- Continuous professional development
 - Peer review and benchmarking with national mainstream standards and other Aboriginal health services
 - A requirement to follow the CARPA Standard treatment manual & the Women’s Business Manual or document justification for other treatment options
 - External accreditation of clinical services
 - Surveying patient satisfaction as well as a suggestion box.
- The indicators and analysis contained in this report are part of a much larger set of indicators that Congress uses to continuously evaluate and improve all of our services and programs.

Congress Directorate

Report on quality improvement systems including the use of best practice guidelines; eg CARPA.

See overview

ANALYSIS

As Congress has grown there has been a parallel growth in the systems for continuous quality improvement and good clinical governance.

Congress is doing much more in this regard than is the norm within the Australian primary medical care system. Data collection and analysis using key performance indicators has reached a sophisticated level at Congress and there is evidence across most indicators of continuous improvement. For instance, we know that we are providing better chronic disease management for our patients than mainstream general practice. It also means we are able to identify areas where we are not doing as well so there can be a focused effort on improvement.



“Congress has used its policy and advocacy expertise to help shape and influence the Emergency Response so that it will deliver the best possible outcomes for Aboriginal people.”

DONNA AH CHEE, DEPUTY DIRECTOR

OVERVIEW

The policy work Congress does is exemplified by this excerpt from the Congress Cabinet endorsed position paper on the Federal Government’s Emergency Response:

Central Australian Aboriginal Congress believes that there is an urgent need to reform the racially discriminatory aspects of the Emergency Response while continuing to implement the large investment in new services and programs across a broad range of social determinants of health.

There is a need to reform and not roll back the intervention and we believe this latter term creates the impression that all aspects of the Intervention should be reversed and this is not what is needed. For many years Aboriginal people have identified the need for essential services and programs and we have been advocating for governments to act. In this context, Congress welcomes the large increased investment in services and programs that has now emerged from the emergency response.

ANALYSIS

Congress Directorate

Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research).

See Appendix B for complete list

Congress has continued to play a leading role in research, advocacy and policy development in Aboriginal health.

Congress has established and maintained key collaborative networks to enable us to influence the policy agenda in Aboriginal health in ways that we believe will Close the Gap within the next decade.

This is an ongoing struggle but it continues to be a core part of Congress’s activities.



“The Strategic Plan is the blueprint which will guide us as we grow and adapt, keeping our eye firmly on the goal of Aboriginal health in Aboriginal hands”

**HELEN KANTAWARA,
PRESIDENT, CONGRESS**

Congress Directorate

Report on community involvement in determining health priorities and strategic directions through any of the following: health boards; steering committees; advisory committees; community councils; health councils.

76%

OVERVIEW

In the process of defining Cabinet’s Dreaming, Cabinet set a number of criteria that determined what Aboriginal Community Controlled means. Under the banner of community driven services the following aspirations were identified.

- the needs of the community will determine the services Congress seeks to provide

- All at Congress will respect Aboriginal custom
- The Cabinet will determine, through its governance functions, the direction of Congress
- Cabinet will ensure that all Congress practices uphold Aboriginal culture and respects customary law.

ANALYSIS

Community involvement is critical to the success of the Cabinet’s Dreaming, a new Strategic Plan for Congress 2008-2013 was drawn up to provide the direction Congress will take over the next five years to achieve its aspirations.

The Strategic Plan identifies key result areas which will be used to assess the achievement of these aspirations. The above figure of 76% is an average attendance rate at the seven Cabinet meetings across the year.



“With its deep roots as a community organisation, Congress has a strong history of reporting and accounting for itself.”

STEPHANIE BELL

OVERVIEW

When first created in 1973, Congress was intended as a vehicle for change. It was to address injustice and to make life different for Aboriginal people in Central Australia.

Through a community control approach to health care delivery, Congress played a vital part in helping Aboriginal people to take charge of their own lives. Community control means that the people who use the health service, control the health

service via a publicly elected Cabinet.

With this robust tradition of community control and with its deep roots as a community organisation, Congress has a strong history of reporting and accounting for itself.

As a result we embrace new methods and approaches to community accountability, including the methods used in this document - which is an indication of the priority that we give this important task.

Congress Directorate

Show evidence of appropriate reporting to community on progress against core performance indicators.

ANNUAL BUSINESS PLAN

ANALYSIS

Congress develops its annual business plan against the Cabinet’s strategic plan. Cabinet endorses the business plan including the performance indicators that will demonstrate to Cabinet, who represent the community, progress being made by Congress.

A detailed report against the business plan is provided to Cabinet every six months and this includes progress over time on all of the performance indicators.



In late June 2008, around 400 Aboriginal males met for several days on the lands of the Eastern Arrernte people at Ross River outside of Alice Springs. This gathering, the 2008 Aboriginal Male Health Summit, was organised by Congress's Male Health Branch. As a consequence of the pain and confusion arising out of the 'Little Children Are Sacred' report, there was clear need to focus on males understanding their roles as fathers, uncles, brothers and sons in caring for children in a safe family environment that leads to a happier, healthier, longer life.

A number of goals had been set:

1. Acknowledge the hurt caused by a proportion of the male community against family and community members through violent acts, which are not historical cultural practices, which shame many Aboriginal males who are not violent;
2. Acknowledge Aboriginal males who already contribute to providing a safe healthy environment for their family, while reinforcing that pornography, child abuse, sexual abuse, neglect and violence are not acceptable;
3. Provide knowledge to enhance the individual's capacity to make behavioural changes in their community or family environment, to provide adequately for their children;
4. Reinforce the goals of the NT Intervention and the changes that are being implemented to assist them in making their family or community environment safe for their children; and

Appendix A

The Aboriginal Male Health Summit



5. Provide recommendations to government and organisations on changes Aboriginal males believe are required to allow them to reach their true potential and take their place alongside the wider community.

The Summit was a stunning success, providing a powerful sense of inclusion for its participants and culminating in a series of public statements that gathered very positive national publicity and acknowledgement.

Behind this outcome was a process that was aimed at achieving a comprehensive series of summit recommendations, then turning them into a five step action plan:

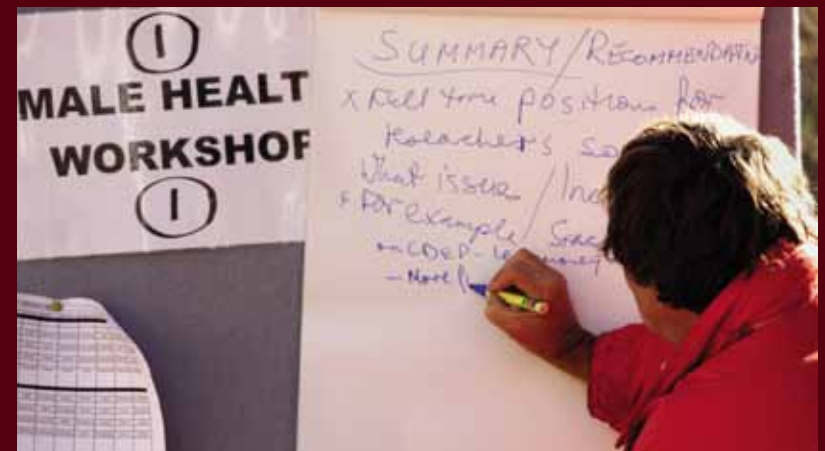
1. Workshop the issues and find solutions.
2. Develop and submit recommendations.
3. Get recommendations implemented
4. Measure the results of government actions.
5. Set up review mechanisms to monitor implementation

The Workshops ranged across many topics, including

1. CHILDREN ARE OUR FUTURE.
2. DOMESTIC VIOLENCE.
3. PORNOGRAPHY/SEXUALITY.
4. HEALTH: MALE WELLBEING.
5. GROG AND OTHER SUBSTANCE ABUSE
6. ENVIRONMENTAL HEALTH.
7. EDUCATION/ EMPLOYMENT.
8. ABORIGINAL CULTURE

The workshops dealt with issues frankly and openly, bringing out a complex mix of feelings, experiences and ideas. To quote from one of the many workshop reports:

The big theme was inclusiveness – bring families back together, work with the whole family, work with the whole community. Males want to be in families, are seeking acknowledgement and inclusion, and are prepared to put a lot of effort into that.



Many males feel that they have done well as fathers and family members – not perfectly, but well – and whilst acknowledging the dangerous, fearful, and distressing actions of some men, most males feel grossly misrepresented when ALL males are labelled with violence and abuse. Males do want to take a role in caring for children and families but don't always know how, and recognise that they need help with this that is positive and inclusive. Community empowerment, men's centres and safe houses, for families as well as males, located within and run by communities were common themes.

We heard of many positive activities and strategies in communities to restore and maintain safety for children and families – some recent, but many of long standing.

Males are struggling with how to deliver discipline that is not violent inside families and communities where some elements are out of control. Many times we heard that males need to ensure that their characters, words, and actions are aligned and consistent – a need to “walk the talk”.

We heard of needs and aspirations that mirror those in the wider Australian community – Aboriginal males want the same things for their families that all fathers do, and a clear need was identified for sustainable long-term investment rather than erratic short-term funding to support this.

Arising out of the workshops and follow-up discussions came 22 key recommendations:

1. Unfinished business - we need action
2. Male Health Programs
3. Community-based prevention programs
4. A National Male Health Day
5. Establish male networks
6. Tax Free Status for community-based professionals
7. Aboriginal education revolution
8. Manpower planning
9. Economic empowerment of aboriginal males
10. Recognise the need for cultural knowledge in all positions





11. Community courts
12. Cultural training for children
13. Long term investment
14. Superannuation
15. Alcohol and other drugs
16. Coordinate national anti-violence awareness campaigns
17. Sexual Health Education
18. Bans on Pornography
19. The Little Children are Sacred Report
20. Human Rights and Equal Opportunities
21. Northern Territory Government's Emergency Response
22. Closing the Gap

The full workshop summaries, the key recommendations and further information are available through Congress's website at www.caac.org.au/malehealthinfo

Congress Male Health Director John Liddle best summarised the Summit's outcome when he said: "This Summit has been about Aboriginal males taking control, not being given it, not having it forced upon them, but willingly taking up the difficult challenges that confront us all."

The historic Inteyerrkwe Statement

"We the Aboriginal males from Central Australia and our visitor brothers from around Australia gathered at Inteyerrkwe in July 2008 to develop strategies to ensure our future roles as husbands, grandfathers, fathers, uncles, nephews, brothers, grandsons and sons in caring for our children in a safe family environment that will lead to a happier, longer life that reflects opportunities experienced by the wider community.

We acknowledge and say sorry for the hurt, pain and suffering caused by Aboriginal males to our wives, to our children, to our mothers, to our grandmothers, to our granddaughters, to our aunties, to our nieces and to our sisters.

We also acknowledge that we need the love and support of our Aboriginal women to help us move forward."

- A position paper on the integration of alcohol and other drug, mental health and primary health care services was finalised with Aboriginal Medical Services Alliance of the Northern Territory (AMSANT)
- A position paper on the Australian and Northern Territory Government's Emergency Response to Child Sexual Abuse in the Northern Territory
- Ongoing participation in the development of the Teasdale Corti international research project on comprehensive primary health care including an international literature review and development of research proposals on the social determinants of health.
- The Director is a board member of the Cooperative Research Centre for Aboriginal Health (CRCAH) which continues to research and advocate for action to address the social determinants of health
- The Director is a board member of the National Aboriginal Community Controlled Health Organisation board
- The Deputy Director is a member of the National Indigenous Drug and Alcohol Advisory Council (NIDAC) as well as the Australian National Council on Drugs (ANCD)
- Participation through AMSANT in the Northern Territory Aboriginal Health Planning Forum
- Participation through AMSANT in senior collaborative meetings to shape the health component of the NT Emergency Response including the Expanded Health Service Delivery Initiative
- Participation, with AMSANT, in meetings with the Australian government Health Minister on the NT Emergency response
- Participation, with AMSANT, in meetings with the NT Minister for health advocating for new policies to address the social determinants of health.
- A peer reviewed paper has been prepared and submitted to the Australian and New Zealand Journal of Public Health based on the literature review done for the National Drug Research Institute alcohol research project.
- An editorial was written for the Medical Journal of Australia on the barriers to effective cancer care for Aboriginal people.

Appendix B

Part of KPI 17

Report on service activities (position papers, collaborative meetings and services, published papers, policy submissions, participative research)



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