Part A - Building Better Services

Balanced Core Services

We will guarantee that a balanced set of core and targeted primary health care services will be available in all Territory clinics.

Building access to a balanced set of primary health and family wellbeing services is the most important thing a health system can do to improve Aboriginal health and wellbeing. It is essential that a balanced core services platform seeks to protect and promote wellness, prevent illness and trauma, provide diagnosis and treatment and rehabilitation. Core services should be available at any Northern Territory Government clinic to individuals and families within reasonable waiting times. The activities that make up a core services platform include health assessment, illness prevention and health promotion, education for self support and care, diagnosis and treatment of episodic and chronic illness, injuries, primary reproductive care, primary mental health care, co-ordination of referral to other services and centres, support for in home care and advocacy for family, patients and communities.

Aboriginal people make up the best part of the sector's business in the Northern Territory. Finding the right balance of services forces us to think of cultural, social, political and management issues and raises important questions about factors that give rise to inequalities in health and health care. Finding answers requires innovative approaches to the organisation of health care and the careful evaluation of both service delivery models and the performance of health care systems.

Regional pressures or circumstances may demand special attention. Balancing core and regionally specific services requires the system to understand Aboriginal needs well, to have completed the work necessary to support informed decision making and to engage with the community. The other critical element of a balanced core services platform is the responsibilities that individuals, families and communities hold for their own health and wellbeing. Individuals, families and communities and the health system need to define those actions that they can take themselves to improve health and wellbeing.

Five Year Objectives

- Establish best practice standards for core services by appropriately blending scientific and cultural influences.
- Provide balanced core services to agreed standards from all NT clinics including resident and visiting services.
- Establish a core service network at the local level linking with relevant community agencies and other providers.
- Establish systemic monitoring of core service costs, funding, delivery and outcomes.
- Model activity, costs and allocations against core services structure.
- Develop and make available the data and other information to support good decision making at regional level, within the core services framework.

A Lifecourse Approach

We will introduce a Lifecourse approach to the planning and delivery of health and family wellbeing services to Aboriginal people.

How people's lives unfold over time is influenced by whether or not they are born into and live in a family and community that is capable, and whether they have access to health and family development services at the right times throughout their lives. When these positive factors are absent, and access to support and services is limited, people will accumulate a significant burden of ill health and shortened lives. Most importantly they will also deliver to their children a poor start in life.

What are the key transitions or periods in life that impact on health?

Everyone's Lifecourse is a cascading combination of biological and social/environmental influences stretching over time that influence the balance between risk and resilience. This Framework for Action prioritises four key periods in life that impact on Aboriginal health and family wellbeing. They are:

- The Early years
- The Family years
- Adolescence and transition from school
- The Granny years

There is considerable information and evidence that demonstrates the importance to health and wellbeing of each of these periods. Equally, these periods are important because they are times of great importance to Aboriginal people personally, socially and culturally - these years hold a special place. The relationship between these periods is also important. Old people often provide strong cultural and social guidance to families and young people. Children depend on families to keep them safe and grow them up strong, and adolescence is the period for many Aboriginal people where their cultural and social responsibilities are laid before them.

The Lifecourse approach seeks to bring together both the science of health and family wellbeing and the strength and wisdom of Aboriginal culture.

The Early Years - What we know

In Utero

- Alcohol, smoking and other drug use are key determinants in maternal and child health.
- The uptake of sound antenatal care has an important bearing on the outcomes of birth as does the mother's behaviour and environment.

Social Environment

- Infants develop core attachments between about six and eight months and instability in the family structure or environment can result in an insecure basis for bonding. The development of a caring, nurturing family environment has been shown to have a bearing on the health of children in later life.
- Poor socio-economic status has been shown to be a marker of elevated risk. Diet, nutritional status and the physical environment of children are affected by socio-economic status.
- Building coping skills and resources in families builds a buffer against stressors in life. Parenting practices are important determinants in the development of positive behaviours in children in the early years and into adolescent life. The level of antisocial behaviour witnessed or experienced by children has an impact on the level of conduct problems in children, raising the importance of quality in parental and family relationships.

At Birth

- Birth weight and growth in the first year of life has a strong relationship with infant survival, for ill health in later life and for the socio-economic prospects of the individual.

Infancy

- The health of infants and children is at risk through impaired immunity and a number of highly prevalent infections particularly gastro intestinal and respiratory disease. Breastfeeding decreases risks and may contribute to the health of the mother.

School Readiness

- Higher levels of school readiness, including the positive socialisation of children through happy and healthy relationships with parents and family, a supportive environment and positive experiences appropriate to age and maturity have been shown to have a positive impact on child development, academic attainment and health and wellbeing.

The evidence tells us that our attention should be focused around three major elements of child development, namely physical health, cognitive development and socio-emotional behaviour.

The Early Years

The Current Picture

- In 2001 about 44% of all babies born in the Northern Territory were Aboriginal.
- In 2001 NT Aboriginal infant deaths comprise about 66% of total infant deaths.
- While substantially improved since the 1980's, NT Aboriginal infant death rates in 2000 remain four times higher for males and more than five times higher for females than national averages.
- A 2003 report indicated 13.6% of all NT Aboriginal births have low birthweight, compared with 7.6% for NT non-Aboriginal babies.
- Between 1991 and 1995 as few as 33% of Aboriginal women in Central Australia received appropriate antenatal care.
- NT figures from 1998 show that substantially more Aboriginal women smoke and drink alcohol during their pregnancy than non-Aboriginal women.
- In 2001 the majority of Aboriginal and Torres Strait Islander children across Australia under 7 years of age living in non-remote areas were fully immunised.
- In 1999 about 1.5% of children using childcare services nationally were Aboriginal, although Aboriginal children comprise 37% of all NT children aged between birth and 12 years.
- Between July 1999 and June 2000 in the NT, 1787 children and young people were exposed to domestic violence.
- In 2003/04 Aboriginal children in the NT were 4.7 times more likely than other children to be the subject of a substantiated child protection notification.

Core Service - What we will do

- Ensure that all pregnant Aboriginal women receive technically sound and culturally secure antenatal care.
- Ensure safe birthing options are accessible and sound neonatal and postnatal care is provided to Aboriginal women and babies.
- Ensure an appropriate regime of developmental progress and growth checks are undertaken over the first five years of life of Aboriginal children.
- Promote breast-feeding of infants at least until they turn six months.
- Promote particularly the nutritional health of mother and child during this period.
- Provide parenting, family and social support to parents to improve their knowledge, skills and ability to cope with emotional, economic and other stressors. Reinforce positive parenting and the importance of happy and cohesive families. Foster reduction in family violence and antisocial behaviour.
- Encourage the socialisation of Aboriginal children through appropriate and nurturing community and family based activities.
- Promote the appropriate immersion of Aboriginal children in culture and language development at an early age, focusing particularly on building confidence, communication and positive social interaction.
- Reduce the physical risk to Aboriginal child safety in the family home and in the community through a range of targeted individual and community-based actions.
- Open up community health facilities to programs that prepare children and families for transition to school.

Five Year Objectives

- Improved proportion of pregnant Aboriginal women attending their first antenatal visit at or before 13 weeks and before 20 weeks gestation.
- Improved number and proportion of live born infants weighing more than 2500 grams born to Aboriginal women.
- Increased mean birthweight of live born Aboriginal infants.
- Maintain and further improve the proportion of Aboriginal children fully immunised at one year, two years and six years.
- Improved school readiness of Aboriginal children.
- Improved coping skills of mothers and families.

Adolescence and Transition from School - What we know

Patterns of Risk

- The accumulation of reducing physical activity, poor nutritional patterns, uptake of smoking and drinking, building in some cases on top of low birth weight, increases risk of coronary heart disease and other chronic diseases in later life.
- The coincidence of child abuse and domestic violence is widely recognised.

Social Risk

- Young people experiencing the onset of puberty, start to ask questions about their identity, form peer group relationships and experiment with alcohol, drugs and smoking. Sexuality and sex emerge as important issues.
- The fracturing of social life, poor economic conditions and the erosion of cultural identity impacts on the development of young people and increases risk.
- Not all children in adverse circumstances adapt poorly. The ability of adolescent Aboriginal men and women to bounce back in their twenties from the adversity of youth has been shown to be influenced by the strength of social and family networks.

Mental Health and Self Harm

- Suicide is associated with unemployment, alcohol and substance abuse and mental disorder. Significant numbers of people who suicide have a history of self harm.
- Suicide has been seen to have a clustering effect prompting some to define whole communities as "at risk". Studies suggest that people with a high level of spiritual/cultural orientation have a reduced prevalence of suicide compared with those with a lower level of cultural spirituality.

Kids Having Kids

- Early school leaving, poor life opportunities and low expectations of life and their future contribute to the level of childbirth to adolescent girls.
- Sex education within a supported program can reduce not only teenage pregnancies but also sexually transmitted infections. There is some evidence indicating that sexual education is associated with the delayed onset of sexual activity.

Physical Activity

- Levels of physical activity are lower in Aboriginal communities and the proportion of Aboriginal people who are overweight or obese is higher. Obesity has been linked to a number of chronic diseases, depression and anxiety.
- Rates of physical activity have been associated with delays in the onset of diabetes and coronary heart disease and with the relief of symptoms of depression and anxiety.

Adolescents are generally healthier than others in their community having survived the perinatal and neonatal periods and the infections of childhood and not yet having developed the chronic ill health of later adult life. But the evidence tells us that they confront a range of risks and challenges and that their health warrants careful attention.

Adolescence and Transition from School

Current Picture

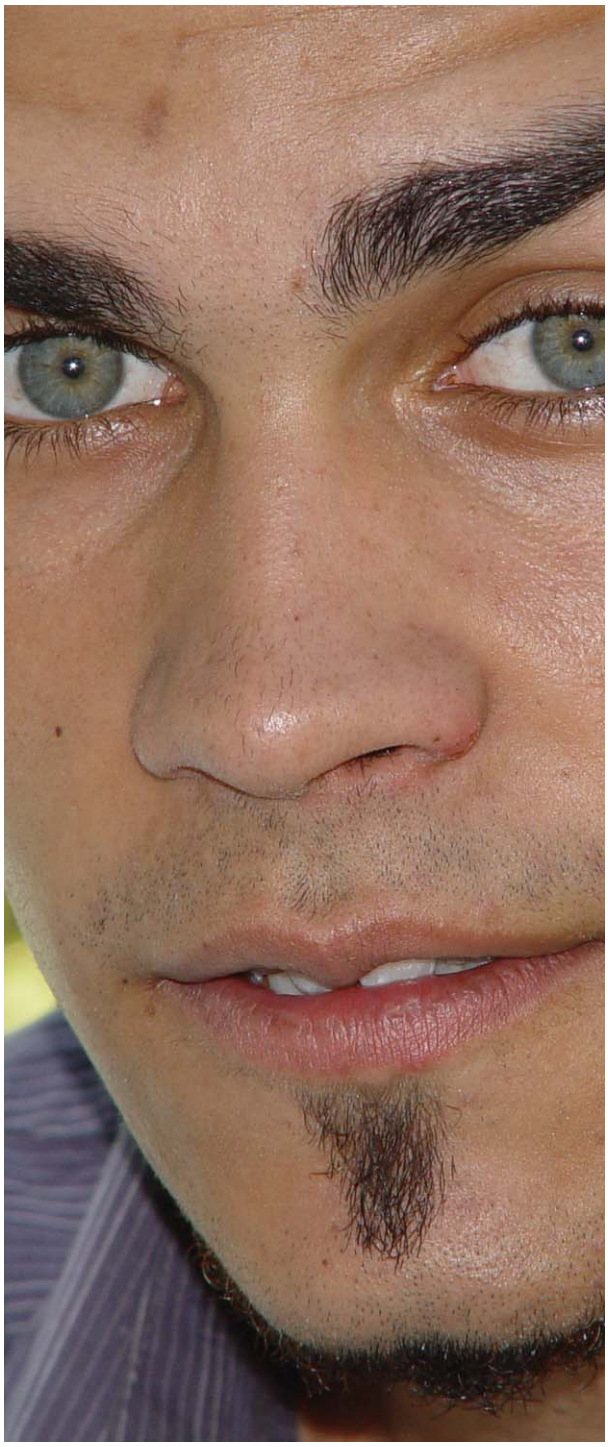
- The age-specific death rates from suicide for Aboriginal males nationally were highest in the 15-24 year age group at 108 per 100,000, some four times higher than for all males in this age group. For Aboriginal females, the rate was again highest in the 15-24 year age group at 18 per 100,000, some three times that for all females.
- Nationally there were about twice as many hospital separations as expected for self-harm, for both Aboriginal males and females.
- National data indicates that undiagnosed mental and social distress brings Aboriginal people into frequent contact with the criminal justice system.
- In 1998/99 nationally, there were about four times as many hospital separations as expected for mental disorders resulting from psychoactive drug use by Aboriginal and Torres Strait Islander people.
- In the NT 1787 children and young people were exposed to domestic violence in 1999/00 with emotional/psychological and physical abuse the most common.
- Of Aboriginal people in the NT aged 15 years and over, 64% of males and 38% of females were current smokers.
- In 2001 10% of Aboriginal people in the NT had never attended school compared with 1% of non-Aboriginal people.
- Nationally 86% of teachers are teaching Aboriginal studies but less than 20% of teachers have had training in Aboriginal studies.
- A much higher proportion of Aboriginal HIV notifications nationally were for women (28%) and more Aboriginal HIV notifications were attributed to heterosexual contact (38%) than in non-Aboriginal notifications.
- In 2002 in the Top End rates of rheumatic heart disease among Aboriginal children accounted for the majority (55%) of all cases. Central Australia had similar rates.

Core Service - What we will do

- Work with schools to develop and deliver appropriate health and wellbeing prevention and promotion programs to Aboriginal children.
- Provide brief health promotion interventions on appropriate occasions of clinic based service delivery for clients in the relevant age groups.
- Support community leadership and contribute to the development of alcohol, inhalant and drug abuse action in communities including efforts to reduce anti-social behaviour particularly in youth.
- Integrate health promotion into appropriate family, peer and community level opportunities for example through school and peer group activity.
- Develop and deliver Aboriginal Health Worker/nurse based, community-level depression/stress interventions.
- Deliver short and long individual and community interventions aimed at improving communication skills, self-esteem, family problem solving and coping skills.
- Improve health service use of appropriate tools for the identification of individuals at risk of child sexual assault and the strengthening of referral to appropriate services.
- Deliver risk assessment strategies within local populations so that individuals and families with multiple risk factors are identified and provide appropriate intervention services.
- Work with communities and schools to develop agreed plans to manage the impact of suicide and self harm and ensure the development of improved skills and support systems for the community within such plans.
- Support other local initiatives that seek to build a positive self-image and coping skills for Aboriginal youth and young people.
- Develop programs that increase the rate of physical activity for young people particularly during the transition from school and during early adulthood.
- Develop programs with local stores and councils to promote the availability of affordable nutritious foods.
- Deliver sexual health programs including the provision of sensitive contraception services preceding the onset of sexual activity combined with other life skills education initiatives.

Five Year Objectives

- Increased rate of physical activity in youth and young people.
- Reduced number and proportion of resident clients aged 15 and over with Body Mass Index in the overweight and obese range by age and gender.
- Reduced uptake of risk behaviours (smoking, drinking, drug and inhalant abuse) by youth and young people.
- Increased age at which women have their first child.
- Increased proportion of resident clients aged five and 10 years who have been screened according to the guidelines for Healthy School Aged Kids in the previous 12 months, by gender.
- Improved identification and management of preventable chronic disease in resident Aboriginal people aged 15 and over, by age and gender.
- Increased proportion of resident clients aged 15 and over who were screened for chronic disease in the past 12 months, by gender and age group.
- Reduced hospitalisation of Aboriginal adolescents due to injury.
- Improved level of coping/mental health skills in Aboriginal youth and young people.
- Improved management of services to children who have been abused.



The Family Years - What we know

Family Formation

- Instability in family structure or cohesion, family discord, patterns of parental drinking and poor social situation can lead to a poor child-rearing environment that can contribute to poor health in later life.
- Babies born to young girls tend to have lower birth weights contributing to increased risk of coronary heart disease in the child's later life.

Stressors and Coping

- Stress, as an absence of capability to control the Lifecourse including physical environment, health and wellbeing, has been associated with poor health.
- Short-term personal support has been shown to provide benefit including during pregnancy and birth. Supported women tended to have better birth outcomes, less analgesia, and babies tend to be healthier.
- Mental disorders, particularly depression, generally run a chronic or remitting/relapsing course with men less likely to use mental health services than women.

Social Support

- Social support for families has been shown to affect health and wellbeing, for example by reducing cardiovascular mortality.
- Parental networks and the level of family support are important enablers for parents and children to overcome family problems.
- Family cohesion contributes to family and community health.

Nutrition

- The level of education and health of young mothers contributes to the health of children and families.
- Poor families are less likely to have healthy diets contributing to the risk of obesity, high blood pressure and heart disease. Factors during adult life, rather than early life, may be more important in the development of hypertension.

Poverty

- Poverty, lack of education and poor self-esteem affects the health of both parents and children. Families living in poverty are more likely to use coercive parenting which in turn is associated with higher levels of mental ill health in children.
- Job insecurity, unemployment, and type of job is linked to the prevalence of ill health and excess mortality. Disparity in income within society is associated with increased mortality and ill health.

Chronic disease

- Tobacco, excessive alcohol consumption and a lack of physical activity are associated with disease in adult life and shortened life expectancy. Alcohol abuse is strongly related to blood pressure in both young and middle age adults.
- Mortality from coronary heart and respiratory disease is influenced by social circumstances in both childhood and adulthood.
- Mortality from accidents and violence and from lung cancer is mainly dependent on factors acting in adulthood.
- Control of obesity and smoking may be the most important factors in reducing chronic disease in individuals and families.
- People from a lower socio-economic status have greater risk of injury.

The Family Years

Current Picture

- From 1996-1998, 80% of Aboriginal mothers nationally who had babies were aged 30 or less compared with 54% of non-Aboriginal mothers.
- In the NT there is a greater proportion of Aboriginal single parent families and a smaller proportion of families without children than in non-Aboriginal families, who are younger, and have generally more children.
- In 2001 only 36% of Aboriginal and Torres Strait Islander Territorians were employed or looking for work. Median weekly income of Aboriginal families in the NT is much lower at $490 per family compared with $1390 for non-Aboriginal families.
- In 1994 national figures show that approximately 25% of Aboriginal males and 29% of Aboriginal females aged 18 years and over are obese.
- National figures reported in 1998/99 show Aboriginal use of the Medicare and Pharmaceutical Benefits Scheme was significantly lower (38% and 31%) than that of non-Aboriginal people.
- In the NT 56% of requests for assistance under the Supported Accommodation Assistance Program that were not met were from Aboriginal people.
- In 2001/02 about 34% of all community mental health consumers in the NT were Aboriginal while about 28% of all mental health acute care separations are Aboriginal. Of all Aboriginal acute mental health consumers some 65% are male.
- The 1995 National Health Survey showed 22% of Aboriginal males and 6% of Aboriginal females aged 18 years and over were high and medium level alcohol drinkers, compared with 10% and 6% for non-Aboriginal men and women.
- National figures show that alcohol and other drugs features significantly in instances of domestic violence and child abuse involving Aboriginal people.
- Injury is very significant in the burden of disease for Aboriginal males and females in the NT.
- Nationally 69% of Aboriginal communities were located 100 km or more from the nearest hospital.
- Based on data from NT, SA and WA in 1998/99 Aboriginal people are more likely to suffer from syphilis (20 times), gonorrhoea (19 times) and Chlamydia (8 times).
- National data indicates 44% of all principal procedures in hospital recorded for Aboriginal people in 1998/99 were for haemodialysis.
- In 2001 the greatest relative differences nationally in age-specific death rates (reflected in the rate ratios) occurs among Aboriginal people aged 35-54 years, where the rates are 5-6 times higher than the all-Australian rates.

Core Service - What we will do

- Provide sexual health and family planning support.
- Services will embrace baby and child health clinics and encourage the formation of supervised play spaces and the development of improved parenting skills.
- Pregnant and nursing Aboriginal women will receive regular home visits from an Aboriginal Health Worker or nurse.
- Services will include support for community action to identify and respond to child sexual abuse and domestic violence.
- Improve the identification, management and monitoring of chronic disease in the adult population.
- Improve nutrition, smoking, alcohol and substance abuse interventions including, as appropriate, referral.
- Support family and parenting activity including promotion of personal and family coping skills.
- Provide intensive support for families in crisis and early intervention for other families.

Five Year Objectives

- Reduced prevalence of preventable chronic disease in resident Aboriginal people aged 15 and over, by age and gender.
- Reduced number and proportion of resident clients aged 15 and over with Body Mass Index in the overweight and obese range by age and gender.
- Increased proportion of female clients who have had a pap smear in the previous 24 months.
- Increased proportion of women with abnormal pap smear results who have had appropriate follow up.
- Increased number of clients with preventable chronic disease managed on care plans.
- Improved proportion of residents with diabetes who have had an HbA1c test in the last 12 months.
- Improved targeting and scope of services offered to support Aboriginal families.

The Granny Years - What we know

Population and Service Impacts

- The conditions and needs generally associated with older age affect Aboriginal people at much younger ages.
- Older Aboriginal people are more likely to be living in poverty and deterioration in income of older people has an impact on health and wellbeing.
- Remoteness significantly erodes older Aboriginal people's purchasing power. Measures that improve access to services that raise living standards independent of income will likely contribute to improvements in the health of older Aboriginal Territorians.
- Older Aboriginal people generally tend to place more emphasis on communities and community based services.

Chronic Disease

- Chronic disease, more commonly associated with older age, is found in middle age in Aboriginal men and women. The premature onset of many disease characteristics of the aged result from a variety of earlier life experiences.

Housing and Mobility

- The quality of housing for older people and their attachment to it has been shown to correlate with health outcomes. The similarities between Aboriginal relationships to country and the attachment to homes have been made on more than one occasion. Aboriginal people without access to home country feel physically unprotected and vulnerable.
- Maintaining mobility, independence and social networks is important. Daily cleaning, bathing, meals, visiting health services and shopping, in the main rely on mobility, sight and hearing. Rates of disability in Aboriginal communities in these areas are higher than in non-Aboriginal communities.

Service Issues

- More than 20% of residential age care residents in the NT prefer to use Aboriginal languages compared to about 0.1% nationally, while 47% of respite users prefer to use Aboriginal languages compared to 0.7% nationally.

Isolation

- Exploitation, abuse and marginalisation of older Aboriginal people occur in some communities, leading to further health and wellbeing consequences.

Current Picture

- For the five year period 1996-2000 life expectancy for Aboriginal males and females in the NT was 59.4 and 65 years respectively.
- In 2001 the median age at death in the Northern Territory is 55.6 years for Aboriginal males and 61.4 years for Aboriginal females.
- Some 7% of Aboriginal people on community aged care packages were younger than 50 compared with about 1% for non-Aboriginal people. About 66% of packages are in remote areas.
- 43% of NT HACC clients were Aboriginal and of these 41.4% were aged over 50 and 26.8% over 70.
- 41% of all Aged Care Assessment Team assessments (including reassessments) were for Aboriginal clients. The NT recorded an assessment rate of 68.2 assessments per 1000 in the 50+ Aboriginal population, which was almost double the national average.
- Intellectual and physical disability rank equally (31%) as the primary disabilities amongst NT Aboriginal disability service clients. Of the clients who identified as Aboriginal, 50% reported having an informal carer compared to 64% of non-Aboriginal clients.

The Granny Years

Core Service - What we will do

The underlying goal of action in this period of life is to make sure that older Aboriginal people can age positively, are highly valued and are recognised as an integral part of the life of Aboriginal communities.

Core services in this area are focused on:

- Promotion of healthy lifestyle
- Early intervention to avoid or delay ill health and disability
- Focus on wellness and quality of life
- Emphasis on rehabilitation and maintaining community engagement and personal capability.

Achieving this requires the health system to deliver services that at a minimum:

- Provide best practice assessment and monitoring of the health of Aboriginal people over 50 including chronic disease and functional impairment and frailty
- Support older people's choices about where they want to live through the provision of appropriate levels of HACC and other accommodation support services
- Support community activities that involve older Aboriginal people in community life and which maintain engagement with social and cultural networks
- Provide appropriate support for and access to culturally secure and technically sound palliative and respite services
- Provide primary, acute and specialist services to help people achieve these ends.

Five Year Objectives

- Improved proportion of resident clients aged 50 and over who were immunised for influenza in the previous 12 months, by age and gender.
- Improved proportion of residents 50 years and over who have had an annual health review, including medications, by gender and age.
- Improved proportion of the resident population aged 50 and above that receives at least two home visits a year.
- Improved access to and quality of end of life care for older Aboriginal Territorians.

Gender and Culture

The particular needs of Aboriginal women and men will be recognised in how services are delivered.

We should approach Aboriginal women's and men's health differently for a number of reasons. Firstly there are biological reasons, the obvious difference that women bear children and men do not. Secondly there are the non-biological reasons, for example the higher rates of death and hospitalisation among Aboriginal males from injury and accidents. Thirdly there are reasons related to the social environment, for example the impact on the self-esteem of men who, notwithstanding society's expectations, are unable to provide for their families because of unemployment. Lastly there are particular cultural expectations specific to gender.

The levels of unemployment in Aboriginal communities have compounded the effects of lost traditional roles for many men. Such changes have been associated with increased levels of mental illness, drinking and violence. Suicide is a major public health issue for Aboriginal men in the Territory and its impact on a family is likely to intensify grief reactions including guilt, feelings of responsibility, shame, social rejection and blame.

Aboriginal women's health is an area that requires specific attention, not the least being the level of family violence. The reproductive health of Aboriginal women is highlighted by the rates of childbirth at early ages and a lower than desirable uptake of antenatal care. Over the Lifecourse, the timing of family formation and child-bearing impacts on health and family wellbeing. Aboriginal women take prime responsibility for parenting in many Aboriginal families and generally head up most sole parent families. Violence, often associated with alcohol and drugs, has a frightening impact on Aboriginal women.

Aboriginal men are not well represented as users of health and family wellbeing services while Aboriginal women are considerably more engaged. Evidence has demonstrated however that rather than relying on general service models the engagement of Aboriginal men and women in the development of gender specific service enhancements at a local level can lead to improved service uptake.

Women's and Men's Health

Current Picture

Women

- Nationally, Aboriginal and Torres Strait Islander women give birth at younger ages than non Aboriginal women, with over 80% of Aboriginal mothers having babies before the age of 30 compared to 54% for non-Aboriginal mothers.
- 35% of all mothers who gave birth in the NT during 1996-1998 were Aboriginal. Among those, 20% were under 20 years of age.
- Pregnancy and childbirth accounted for 17% of hospital separations nationally among Aboriginal and Torres Strait Islander women.
- Age adjusted death rates for Aboriginal women in the NT are 2.8 times that of non-Aboriginal women with cardiovascular disease, respiratory illness, cancers and injury ranked highest.
- Hospitalisation of Aboriginal women nationally from injury and violence was 20 times that of non-Aboriginal women with rates highest in the 25-34 age group.
- Nationally, Aboriginal women are the least likely to be in the work force but more likely than Aboriginal men to hold a university qualification. Aboriginal women in the workforce are more likely to be employed in human services or government administration.

Current Picture

Men

- Age adjusted death rates for Aboriginal men are 2.4 times higher than for non-Aboriginal men with cardiovascular, injury, respiratory and cancer ranked highest.
- Counting Community Development Employment Program as unemployment, Aboriginal jobless rates in the NT reach to between 53%-57%.
- Nationally, Aboriginal and Torres Strait Islander clients had lower mean hourly rates of pay ($9.80 per hour compared with $10.13 per hour), a lower mean number of hours of work per week (15.4hrs compared with 17.9hrs) and a lower mean weekly income ($141 per week compared with $179) than the general population.
- Aboriginal men in the NT are more likely to drink at harmful or hazardous levels than Aboriginal women.
- According to national figures from the Aboriginal community controlled health sector Aboriginal men are less likely to seek services from a health centre than Aboriginal women.
- Injury is a significant cause of hospitalisation and death for Aboriginal men in the NT.

Core Service - What we will do

- Provide comprehensive primary health services for young Aboriginal women concentrating on:
  - Contraception
  - Pregnancy
  - Pap smears
  - Sexually transmitted and other infections
  - Tobacco and alcohol use
  - Domestic violence and sexual violence
  - Nutrition, including the importance of folate for women
- Local services will engage with local communities on the structure and operation of gender specific service models and their implementation.
- Well men and well women checks will be provided on an annual basis from community health centres including:
  - Immunisations
  - Sexual health
  - Cancer screening
  - Prevalence of risk factors - weight, smoking, diet, blood pressure, diabetes, alcohol consumption
  - Chronic disease screening and treatment
  - As a minimum, gender specific health and wellbeing clinics will be offered every two months in community health centres providing opportunities for health consultations and support around key gender specific health and wellbeing needs
  - Family support and wellbeing needs will be included in well women and men health checks
  - Cervical cancer screening for Aboriginal women and cancer checks for men.

Five Year Objectives

- Existence of specific men's and women's health service strategies in each health centre.
- Improvements in the identification and management of gender specific conditions.
- Incorporation of the different biological, environmental, social and cultural needs of men and women in the delivery of health and wellbeing services.

Cultural Security

We will recognise and incorporate Aboriginal culture into the design and delivery of services.

Culture as a social function creates obligations and responsibilities and establishes an order that binds individuals, families and communities together. Culture and identity is central to health and ill health. How Aboriginal people view wellness and illness is in part based on cultural beliefs and values. At the service interface these perceptions and the social interaction surrounding them influence when and why Aboriginal communities access services, their acceptance or rejection of treatment, the likelihood of compliance and follow up, the likely success of prevention and health promotion strategies, the client's assessment of the quality of care and views of health care providers and personnel.

Cultural security is a commitment that the construct of effective clinical care, public health, health systems administration and the provision of services offered by the health and wellbeing system will not compromise the legitimate cultural rights, views and values of Aboriginal people. The crux of the move to Cultural security is a shift in emphasis from attitude to behaviour, ensuring that the delivery of health services is of such a quality that no one person is afforded a less favourable outcome simply because they hold a different cultural outlook. Cultural security recognises that a more respectful and responsive health system will contribute to improved outcomes and greater efficiency.

Increasingly the medical profession has recognised that 'health care belief systems are critical to the patient's healing process' and overseas studies have shown that the practice and advice of traditional healers is often valued more highly than the advice from western medical practitioners. These themes are repeated in recent decisions of the Australian Health Ministers' Advisory Council.

Cultural security in health service provision is also emerging as a risk minimisation and cost containment issue with some overseas providers adopting this approach in an effort to improve market share, contain costs, improve outcomes and improve quality. Some overseas malpractice insurers offer premium discounts to doctors who take cultural security or competence into their practice. Cultural security enriches the competence of practitioners and administrators in the design, delivery and evaluation of health services.

Core Service - What we will do

- Education of professional and other staff about the importance of Aboriginal culture and values in the delivery of health services.
- Ensure that those health services/events that have significant cultural relevance across the Lifecourse are delivered in a culturally secure manner.
- Incorporate cultural values in the description of best practice in clinical, administrative and management practices.
- Promote community engagement and trust in the development of cultural security in health and wellbeing services.
- Provide targeted staff orientation on the specifics of how culture impacts on the delivery of services locally.
- Improve Aboriginal language programs for staff and use of interpreter services where required.
- Promote NT specific teachings on cultural security in undergraduate training for key occupations within the industry.
- Build the measures and indicators of cultural security and establish valid and reliable collections, establishing feedback loops to clinicians, administrators, government and the public.

Five Year Objectives

- All clinics will have established culturally secure clinical, administrative and employment practices at health service level.
- Improvements in the uptake of services and compliance with treatment.
- Decrease in adverse events.
- Strengthened community trust in services through transparent evaluation of process and impact at health centre level.

Partnerships and Engagement

We will support pathways to community control through the engagement of local Aboriginal communities in the setting of strategic priorities, agreeing non core services and monitoring of performance of all community health centres in the NT.

The history of Aboriginal health has often been polarised and weakened by conflict between differing views about how best to approach the tasks ahead. The Government has signalled its commitment to turning this history around in the Territory by building better ways of working together. It is generally accepted that processes that involve and empower the community can make a real contribution to the outcomes of programs and have been shown to have an impact on mortality. The evidence also suggests that community participation and involvement will help reduce inequities in health. While we generally agree that there is no one model for community participation, what is clear is that it can have a positive impact on a wide range of outcomes including the community's capacity to identify and address their own health and wellbeing concerns.

This Framework for Action is a declaration by the Department of its willingness to engage in an honest two-way relationship with Aboriginal communities. The successful implementation of this Framework for Action requires an effective engagement or partnership between a numbers of key players, particularly the Aboriginal community controlled health sector. Communities expect that the Department and the community controlled sector, as major providers will deliver:

- Consistency in service design and protocols
- Sharing of information and collaborative action
- Complementary workforce structures
- Shared access to relevant, quality health and wellbeing resources outside their sector.

A variety of the outcomes sought by this Framework for Action require reform in a number of domains including the workplace, education and training, and the business of government. This Framework for Action will seek to involve other stakeholders that have a significant role in building the successful implementation including the unions and professional groups.

Five Year Objectives

- Maintain bilateral and multilateral cooperation with the Aboriginal Medical Services Alliance of the NT, service providers and the NGO sector to promote improved services and outcomes.
- Renegotiate and implement the NT Aboriginal Health Framework Agreement.
- Implement a shared core services platform, performance monitoring and information agenda for community-controlled and Departmental health and family wellbeing services, including ongoing review.
- Establish in consultation with unions and professional groups a collaborative workforce development plan involving community-controlled and public sector providers and staff that supports the core services agenda and provides significant opportunities for shared professional and career development.
- Create effective partnerships in research that assist in building better health for Aboriginal Territorians.
- Increase the proportion of Departmental committees and working groups with appropriate Aboriginal participation.
- Support and assist Aboriginal community organisations to develop greater competitiveness in tendering for contracted services.
- Establish Aboriginal community participation mechanisms for all Departmental clinics where none currently exist.
- Build collaboration with the Cooperative Research Centre for Aboriginal Health and Charles Darwin University on appropriate matters outlined within this Framework for Action.