

Sydney South West Area Health Service Aboriginal Health Plan 2010 - 2014

SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Summary & Strategies Overview



Terminology used within this report reflects the authors understanding of relevant NSW Government policy directives. The term "Aboriginal" is used in preference to "Aboriginal and Torres Strait Islander" in recognition that Aboriginal people are the original inhabitants of NSW (NSW Health Circular 2003/55). The term "Indigenous" has been avoided wherever possible as some Aboriginal people feel that the term diminishes their Aboriginality. The instances where it is used are on quotation from secondary documents which employ this terminology. The practice adopted is consistent with *Communicating positively – A guide to appropriate Aboriginal terminology*, NSW Health 2004.

Story behind the front cover art work:

The art work on the cover is the work of Susan Grant, a well renowned and respected Aboriginal artist. Susan commenced painting in 1991 and since that time has achieved many awards and recognition from her community in the greater western Sydney region. Susan is a descendant of the Wiradjiri people of south-west NSW. Susan's artwork has become more intense over time which she contributes to a special gift handed down by her Aboriginal ancestral.

Susan in her painting has captured the spiritual and cultural meaning inherent in the framework that underpins Aboriginal Health in Sydney South West Area Health Service.

The inner circle represents the camp fire, the giver of warmth that nourishes the family and community connecting the family and community to the earth. The family sitting around the fire are connected to each other by this secure base; this foundation that is important to our mothers and babies and families.

The middle circle represents traditional lore, men's business and women's business, the nurturing of babies by mothers and grandmothers and the passing of cultural knowledge through stories, music, dance and painting. This traditional lore with its spiritual guidance holds communities together and provides connection to land and people. It keeps Aboriginal people strong in body and mind.

Within the outer circle is an Aboriginal man who is disconnected; lost from his traditional way of life and spiritual connectedness. He is on the fringe looking inwards and can reenter with help from his people and services in the community.

This sense of disconnect, powerlessness and not belonging is a result of colonisation and breakdown of traditional life. The lines coming in from each corner represents chaos, those things that have made Aboriginal people unhealthy; racism, discrimination, tobacco, drugs, diseases, alcohol and domestic violence.

The blood is seen running from the camp fire; the blood of the lives of Aboriginal people who are much sicker and die much earlier than non Aboriginal people.

This magnificent artwork with vibrant earthy ochre colours gives us hope like the Aboriginal man looking in lost but able and wanting to become reconnected to land to community; the pink ochre significant for Aboriginal people and their journey back to health.

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For additional hard copies, please contact Vicki Wade, Area Director Aboriginal Health, at the above address

Chief Executive's Message

“ Our challenge for the future is to cross that bridge and, in so doing, to embrace a new partnership between Indigenous and non-Indigenous Australians the core of this partnership for the future is to close the gap between Indigenous and non-Indigenous Australians on life expectancy, educational achievement and employment opportunities.

We need a new beginning – a new beginning which contains real measures of policy success or failure; a new beginning, a new partnership, on closing the gap with sufficient flexibility not to insist on a one-size-fits-all approach but instead allowing flexible, tailored, local approaches a new beginning that draws intelligently on the experiences of new policy settings across the nation.”

Extract from the speech on Apology to the Stolen Generations, 13 February 2008
The Hon Kevin Rudd MP, Prime Minister

During this historical broadcast on Feb 13th 2008, The Hon Kevin Rudd MP, Prime Minister, apologised on behalf of the Australian Government to members of the Stolen Generations. In his speech the Prime Minister pledged the Government to lead a national effort to close the gap between the life opportunities experienced by Indigenous and non Indigenous Australians. Closing the gap is one of the biggest challenges facing contemporary Australia and the health care system.

Sydney South West Area Health Service (SSWAHS) is committed to closing the gap and has a long history of working to improve Aboriginal Health. SSWAHS accords the highest priority to service developments which aim to help close the gap for local Indigenous communities. The challenge is most marked in the many communities within SSWAHS of high socioeconomic disadvantage. Aboriginal and Torres Strait Islander peoples of SSWAHS are disadvantaged across all socioeconomic markers. These differences directly contribute to the poor health outcomes and gap in life expectancy between Aboriginal and non Aboriginal people in SSWAHS.

This comprehensive, detailed and thought provoking plan will guide SSWAHS efforts to close the gap and requires commitment to action by all our services. It is equally responsive to the needs of highly urbanised inner city communities such as Redfern/Waterloo and to those communities on the urban fringe such as Camden. It recognises the impact that spiritual belief and social and cultural context have on access to and engagement with health services; and the importance of placing individuals, families and community at the centre of care. The art work on the cover of the documents dynamically depicts the values and principles within the cultural context of the plan.

The Plan builds on a number of innovative, ground-breaking and successful Aboriginal Health programs in SSWAHS. It is grounded in the cultural values and principles held by local Aboriginal communities, recognising that joint action across services and within communities is necessary to bring about improvements in health.

Aboriginal and Torres Strait Islander people will continue to be at the forefront in shaping SSWAHS services to meet the needs of their local communities. This occurs not only through acting on the advice of Aboriginal community organisations and partnering in service provision, but also through creating employment opportunities for Aboriginal people in the health workforce. SSWAHS is committed to expanding its Aboriginal workforce and to training and nurturing individuals to reach their potential. Aboriginal representation within our health services is the most tangible way to improve access, ensure cultural safety and engage with Aboriginal communities in health improvement. It also makes an important contribution to building the capacity of communities.

This Plan brings together the evidence base, principles of action and the prioritised strategies that are of prime relevance to local Aboriginal communities. It will provide the blue print for services to achieve long term sustainable outcomes in Aboriginal Health.

I thank all those who have contributed to the plan and look forward to a future where its implementation has contributed to closing the gap in our generation.



Mike Wallace
Chief Executive

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1. Preamble

The SSWAHS Aboriginal Health Plan is presented in four documents, including a summary in question and answer format; two supporting papers, covering firstly the population need, policy imperatives and service delivery responses to date and secondly the framework principles upon which services will be provided in the future reflecting community views; and a fourth core document outlining detailed future agendas for action. In total, all four documents provide the schema on how SSWAHS will proceed to improve Aboriginal health over the next five years and make inroads towards closing the gap within our generation.

The approach in providing separate documents reflects both practical considerations in providing accessible and focused exploration of the key health issues for the Aboriginal populations of SSWAHS; and recognition that the diverse target audience for the Plan, including SSWAHS Aboriginal communities, SSWAHS service providers and Aboriginal health workers, managers, policy and planning staff, researchers and those undertaking academic pursuits, may all focus on different aspects of the SSWAHS experience in Aboriginal health.

The Supporting Paper, *Policy and Practice*, surveys the policy environment that has been explored in Aboriginal Health, nationally, statewide and locally, and the impact of these policy directions on the Aboriginal Communities of SSWAHS. Demographic and health status data is presented to profile the characteristics of Aboriginal communities that impact on health. Available data is presented on mainstream services used by Aboriginal people and the range of targeted programs offered in Aboriginal Health is outlined. This Paper identifies the baseline state of play on which future action is built.

The Supporting Paper, *Principles for Progress*, outlines the way in which SSWAHS will proceed to address Aboriginal Health in the future. It reveals the views of Aboriginal communities on needs, gaps and priorities, the principles that will be observed as SSWAHS engages with these communities to improve health and the framework initiatives that will be applied across SSWAHS to ensure that closing the gap remains core organisational business. These initiatives seek to cut through the barriers created by geographic, clinical, craft group or agency silos to develop a shared agenda for progress. It also identifies the rationale for action in priority areas, both corporate and specific to health need. This paper outlines the enabling organisational framework on which future action is built.

The core activities for SSWAHS in closing the gap are outlined in *Agendas for Action* which identifies the specific actions SSWAHS will be taking to improve Aboriginal Health in the future. Building on the evidence presented in the Supporting Papers, it identifies specific initiatives to improve Aboriginal Health and explicitly links these to existing policy and best practice evidence. Lessons from history and the model of care proposed are clearly outlined along with areas of action, responsibilities of partners in action and the projected resources required. The domains for performance indicators and the mechanisms for monitoring and evaluation of programs are also identified. *Agendas for Action* provides the concrete strategies which will shape future action.

Health Services planning processes can be long and involved. Good practice suggests that effective planning requires:

- a sound understanding of the current situation (profiling communities and mapping of services);
- identification of the gaps and deficiencies (listening to communities);
- shared agreement on principles of action (the way to proceed);
- acknowledging boundaries as to what can be done (the role of health services);
- shaping services to be effective (models of care on how to proceed);
- specifying actions that through change, enhancement or redirection lead to improvement (better ways of operating);
- identifying resources, responsibilities and accountabilities for action (committing to action)
- monitoring and review (maintaining and renewing focus).

In Aboriginal Health there has been much policy written, many plans produced, many programs initiated (and curtailed) and ongoing debate as to how Australian society can most effectively engage in improving health. There are many societal factors impacting on the ability of communities to improve their health and a huge range of health services that need to reflect on how best to proceed in meeting community need.

For SSWAHS, producing an Aboriginal Health plan was necessary because amalgamation of previous Health Areas meant that now over 10% of the State's Aboriginal population was estimated to reside within the SSWAHS boundaries and a unified approach was required to address the needs of Aboriginal communities

ranging from highly urbanised inner city communities such as in Redfern/Waterloo to communities on the urban fringe such as in Camden.

Of necessity, the planning process needed to be comprehensive, complex and responsive to community need. Importantly it needed to be grounded in values and principles that are shared with the Aboriginal communities of SSWAHS and that recognise that joint action across services and within communities would be necessary to bring about improvements in health.

This summary document outlines the highlights of the SSWAHS Aboriginal health planning process, the lessons learnt from listening to communities and the headline areas of action that are proposed over the next five years. For simplicity of presentation it follows a question and answer format. Readers are encouraged to refer to the various documents produced as part of the Plan and congruent with the Plan for the details of proposed actions and the policy underpinnings.

2. What has been produced?

The SSWAHS Aboriginal Health Plan 2008-2012 is presented in three documents, covering:

- **Policy and Practice** - surveys the policy environment that has been explored in Aboriginal Health, nationally, statewide and locally, and the impact of these policy directions on the Aboriginal Communities of SSWAHS. Demographic and health status data is presented to profile the characteristics of Aboriginal communities that impact on health. Available data is presented on mainstream services used by Aboriginal people and the range of targeted programs offered in Aboriginal Health is outlined. This document presents the baseline state of play on which future action is built.
- **Principles for Progress**, outlines the way in which SSWAHS will proceed to address Aboriginal Health in the future. It reveals the views of Aboriginal communities on needs, gaps and priorities, the principles that will be observed as SSWAHS engages with these communities to improve health and the framework initiatives that will be applied across SSWAHS to ensure that closing the gap remains core organisational business. These initiatives seek to cut through the barriers created by geographic, clinical, craft group or agency silos to develop a shared agenda for progress. It also identifies the rationale for action in priority areas, both corporate and specific to health need. This document outlines the enabling organisational framework on which future action is built.
- **Agendas for Action**, outlines the specific actions SSWAHS will be taking to improve Aboriginal Health in the future. Building on the evidence presented in the volumes above, it identifies specific initiatives to improve Aboriginal Health and explicitly links these to existing policy and best practice evidence. Lessons from history and the model of care proposed are clearly outlined along with areas of action, responsibilities of partners in action and the projected resources required. The domains for performance indicators and the mechanisms for monitoring and evaluation of programs are also identified. This document incorporates the concrete strategies which will shape future action.

These three documents bring together the evidence base, principles of action and specific action strategies that SSWAHS will be focussing on in Aboriginal Health. However, they cannot provide a detailed analysis of all the issues impacting on the health of Aboriginal communities in SSWAHS and have prioritised areas of attention to services that are considered to be of prime relevance to these communities. There are also many other detailed plans and strategies addressing specific areas of Aboriginal Health.

3. What was the process?

The Director Population, Planning and Performance chaired a Steering Committee formed in late 2006 to oversight the process of developing a Plan and the background planning work proceeded through 2007. Planning was undertaken in-house utilising the resources of the Aboriginal Health Unit (AHU) and the Health Services Planning Unit (HSPU) to facilitate the process.

Steering Committee members were chosen on the basis of their ability to bring to the table experience and knowledge of Aboriginal Health issues, as clinical leaders in health areas of high priority for Aboriginal communities, as representatives of key stakeholders in Aboriginal Health service provision or as leaders who can drive key corporate/infrastructural changes within the AHS to benefit Aboriginal populations.

There was extensive representation on the steering committee from across the Aboriginal communities of SSWAHS with invitations to senior Aboriginal Health managers and workers within SSWAHS and each of the two Aboriginal Community Controlled Health Services (ACCHS) at Redfern and Tharawal. There were also representatives from mainstream clinical services within SSWAHS of particular relevance to Aboriginal Health

and the Divisions of General Practice (DGP) within SSWAHS. Other members, including from Aboriginal communities, were co-opted to the committee over the period of its deliberations.

The steering committee established eight Priority Area Working Groups (PAWG), in what were considered to be the major focus areas where improvements in Aboriginal Health could be achieved:

- Early Years, Children and Young People
- Chronic Diseases and Ageing
- Corporate Initiatives
- Cross-Cutting Themes
- Mental Health;
- Drug Health;
- Infectious Diseases and Sexual Health;
- Oral Health.

Policy and planning frameworks at National, State and local levels were reviewed. This included initiatives in the context of COAG, Closing the Gap, bilateral Commonwealth/State agreements, NSW whole of Government initiatives including Two Ways Together, NSW Health Partnership Agreement initiatives, Australian and NSW policy and plans in specific clinical areas and SSWAHS local partnership initiatives.

Relevant data on the demography, determinants of health and health status of the Aboriginal communities of SSWAHS was synthesised. Where accurate data could be sourced the usage of health services by those identifying as Aboriginal was included. In particular the range of programs provided by SSWAHS which are specifically targeted to Aboriginal communities was profiled.

The views of the Aboriginal communities of SSWAHS on their health care needs, gaps in service provision by SSWAHS and the priority areas for action were gathered from a number of sources:

- involvement of the Aboriginal health worker staff of SSWAHS on the steering committee and the working groups established as part of the Plan;
- consultation processes undertaken by the PAWGs;
- views expressed through established Partnership meetings with the Aboriginal communities of SSWAHS inc. the Partnership Arrangement with AMS' Redfern and Tharawal;
- consultations undertaken with Aboriginal communities in the context of other service planning activities in SSWAHS e.g. Aboriginal Men's health, HIV/AIDS and Related Programs, Maternity, Aged Care and Rehabilitation, Youth Health;
- a specially convened **Yarn-Up Forum** canvassing Aboriginal Health issues of strengthening communities, holistic care, working in partnership and improving access.

Four **Framework Principles** were developed to guide the way SSWAHS acts to enhance the health of Aboriginal communities and contribute to the process of closing the gap in health outcomes and addressing health disadvantage. The principles were a synthesis of foundation principles of indigenous health identified internationally, nationally and in NSW and what was identified at the Yarn-Up forum.

The four principles for engaging with Aboriginal communities to improve health were then reflected in eleven **Framework Initiatives** which aim to strengthen the clinical and corporate structures of SSWAHS so that specific initiatives identified by PAWGs in health priority areas are supported and have the opportunity to succeed.

The rationale for program development in each of the health priority areas that were examined by the PAWGs were then identified. This delineated the key elements that policy and the evidence base suggested needed to be reflected in the proposed initiatives for each health priority area.

Then, for each priority health area a summary page was prepared outlining:

- **Principles of Action** – what policy and listening to communities indicates are the important attributes of service delivery;
- **Model of Care** – up to ten main points summarising the way services will be delivered;
- **Action Initiatives** – the headline areas of action (specific actions are identified in templates for each).

For each **Action Initiative** a self-explanatory template format is used to identify the **goals** (target groups, benefits and performance indicator domains), **rationale** (history, data and best practice evidence), **responsibility** (roles of leaders and partners), specific **actions** (inc. timeframes and resource requirements) and the **links** to state and local policy.

The templates clearly outline the accountability for taking action and provide a clear picture on:

- **why** action is required (history, policy and health need);
- **who** will benefit (goals, target population, expected benefits, measures of success);
- **how** services will be provided (model of care, best practice, actions); and
- **responsibility** for action (leads, partners, timeframes and resource contingencies).

Finally the Plan outlines the mechanisms by which SSWAHS will monitor and review progress in implementation and evaluate success of the Plan.

4. What do we know of the demography of Aboriginal communities in SSWAHS?

The total Aboriginal and Torres Strait Islander population in Australia is estimated at 517,174 (2.5% of Australian population), for NSW the estimate is 148,178 (2.2% of total population) and 2006 Census data indicates 14,080 for SSWAHS (1.12% of total population). It is known that the Sydney metropolitan region has a lower concentration of Aboriginal population compared to regions outside Sydney and that within Sydney the concentration of the Aboriginal population is higher in the Southwest and Western region compared to the coastal Sydney region.

The concentration of the Aboriginal population varies across SSWAHS LGAs, with the highest concentration in Campbelltown at 3,833 or 2.68%, followed by Wollondilly at 762 or 1.89%, Marrickville at 1,078 or 1.50% and Liverpool at 2,194 or 1.33%. The lowest concentrations are at Strathfield at 85 or 0.27%, followed by Canada Bay at 215 or 0.33%, Burwood at 120 or 0.39% and Ashfield at 194 or 0.49%. Overall, 72% of the Aboriginal population resides in South Western LGAs i.e. 10,206 people or 1.29% of the total South West population. Inner West LGAs account for 28% of the Aboriginal population i.e. 3,874 people or 0.76% of the total Inner West population.

Aboriginal communities exhibit a younger age profile than non-Aboriginal communities across Australia and in SSWAHS. The percentage of the SSWAHS population aged 0-14 identifying as Aboriginal is around double that of the average for the total SSWAHS population and remains higher than the average through the age cohorts to age 24. In the older age cohorts particularly aged 60+, the % of population identifying as Aboriginal is half or less than the average for the total population. A corollary of these differences is the shorter life expectancy of Aboriginal compared to non-Aboriginal people. In NSW, this gap is 16.4 years for males and 16.8 years for females.

The demographic data indicates that Aboriginal children and youth need to be a high priority for service attention.

Across SSWAHS, there are 2,190 children identifying as Aboriginal in infants/primary school (2.2% of school population), 1,474 in secondary school (1.8% of school population), 418 in TAFE (1.2% of school population) and 336 in University and Tertiary education (0.6% of University population). A significantly lower proportion of the Aboriginal population aged over 15 years report having completed school at greater than Year 10 compared to the non-Aboriginal population.

Across NSW the labour force participation rate of the Aboriginal population aged 15+ years is around 12% less than that of the total NSW population (55.6% compared to 63.0%). Aboriginal males resident in SSWAHS are more likely to be employed in public administration and safety, transport, postal and warehousing, health care and social assistance. Aboriginal males are not strongly represented in professional, scientific and technical services or financial and insurance services and also have less % representation in retail and manufacturing. Aboriginal females resident in SSWAHS are more likely to be employed in health care and social assistance, public administration and safety and education and training. Aboriginal females are not strongly represented in professional, scientific and technical services, financial and insurance services or information media and telecommunications and also have less % representation in retail and manufacturing.

The unemployment rate for the Aboriginal population of SSWAHS is around 2½ times more than that of the non-Aboriginal population. The highest unemployment rates for the Aboriginal population are evident in the LGAs of Fairfield (22.3%), Campbelltown (19.5%), Sydney (19.0%), Bankstown (17.0%) and Wingecarribee (16.9%). Depending on the LGA, the average household income for non-Aboriginal households is between 22% to 46% higher than for Aboriginal households. The lowest average household incomes for the Aboriginal populations are reported in Sydney (\$598), Fairfield (\$739), Campbelltown (\$743), Wingecarribee (\$750) and Leichhardt (\$793). The Plan recognises that enhancing the employment opportunities for Aboriginal people within SSWAHS will be an important initiative to help address economic and health disadvantage.

It is known that Aboriginal people are between 2.7 times and 5.2 times more likely than residents of NSW as a whole to become victims of violent crime, that Aboriginal people are over-represented generally among persons arrested by police and that the rate of Aboriginal imprisonment in NSW is ten times that of non-Aboriginal people (20% of the adult male prison population and 33% of the adult female prison population identify as Aboriginal). Prison populations have considerable health issues, with data indicating that overall 64% of adult women inmates and 40% of adult men have hepatitis C and over 80% with histories of alcohol or other drugs use. The Plan addresses post release support for the significant number of Aboriginal inmates who gravitate to living arrangements in the Inner and South West of Sydney on release.

Homelessness is also known as having significant impacts in Aboriginal communities with across NSW, 13.5% of male Supported Accommodation Assistance Program (SAAP) clients and 20.9% of female SAAP clients identified as Aboriginal.

Although data specific to SSWAHS residents is not available, it is known for urban communities in Australia, that although 31.2% of Aboriginal people indicate a person or relative had been removed from their natural family, 41.5% continue to identify with a clan, tribal or language group. The Plan includes many initiatives that build on the resilience and cultural strength of Aboriginal identity. Family remains of paramount importance in Aboriginal communities and it is known that the average household size for households with an Aboriginal person resident is 3.3 in the South West (3.0 for non-Aboriginal households) and 2.6 in the Inner West (2.5 for non-Aboriginal households) and that a smaller proportion of Aboriginal people live in lone person households – 11.9% in the South West (17.7% for non-Aboriginal people) and 24.9% in the Inner West (28.0% for non-Aboriginal households). Many initiatives in the plan place the family at the centre of health enhancing actions.

5. What do we know about the health status of Aboriginal communities in SSWAHS?

There is a limited amount of health status information available specific to the Aboriginal populations of SSWAHS; however, it is not considered that the health status of SSWAHS residents would differ significantly from the overall health status of urban Aboriginal populations in NSW. The health status of Aboriginal populations in NSW is generally poorer than their non-Aboriginal counterparts across a range of measures, including evidence that they are:

- more likely to die at younger ages and are more than twice as likely as non-Aboriginal people to die as a result of diabetes or from injuries;
- approximately 1.5 times more likely to be admitted to hospital than non-Aboriginal people with hospitalisation rates 3 to 4 times higher for diabetes, 3 to 5 times higher for chronic respiratory diseases, 4 times higher for alcohol-related conditions.
- More likely to develop lung cancer (accounts for 17.6% of new cancer cases in Aboriginal people, almost twice the non-Aboriginal figure) and cervical cancer (comprises 7.8% of new cancer cases in Aboriginal women, more than 4 times the non-Aboriginal figure).

The health of Aboriginal mothers and babies remains of concern. It is known that the perinatal mortality rate is around 40% higher in Aboriginal communities across NSW and that rates of prematurity and low birth weight are higher. Risk factors for low birth weight and prematurity include smoking in the second half of pregnancy (55.2% of Aboriginal mothers report smoking in the second half of pregnancy, compared with 14.2% of non-Aboriginal mothers) and being a teenage mother (21.4% of Aboriginal mothers are teenagers, compared to 4% of non-Aboriginal mothers) or older mother (9.6% of Aboriginal mothers are aged >35 years, compared to 19.9% of non-Aboriginal mothers). In SSWAHS the proportion of Aboriginal mothers who attended their first antenatal visit before 20 weeks gestation (69.5%) is considerably less than that reported for non-Aboriginal mothers (81.9%). Initiatives in the Plan address these disparities in concert with other work under the NSW Aboriginal Maternal and Infant Health Strategy and SSWAHS Maternity Services Plan 2008-2012.

Childhood immunisation rates are well maintained in the SSWAHS Aboriginal communities with the immunisation coverage rate reported at December 2005 being 89% for both Aboriginal and non-Aboriginal children. However, childhood oral health remains of concern in SSWAHS, with 27.3% of Aboriginal children 5-12 years having no caries experience compared to 53.1% of non-Aboriginal children. The Plan includes initiatives addressing childhood oral health.

Health disadvantage in Aboriginal communities continues into adulthood. However, much of the burden of disease is potentially avoidable. In NSW it is known that of premature deaths (<75 years) in Aboriginal

communities, more than three-quarters (76.4%) were potentially avoidable (i.e. could have been avoided given current understanding of causation, and available disease prevention and health care) compared to just over two-thirds (67.2%) of non-Aboriginal deaths. Rates of hospitalisation for ambulatory care sensitive conditions were consistently more than double those for non-Aboriginal people, both overall and across the vaccine-preventable, acute and chronic categories.

Attention to health risk behaviour will be necessary to have an impact on the disparity in rates of avoidable death e.g. current smoking rates for Aboriginal adults are around double those for the general population across all age groups; while reported rates of risk drinking are around 1.4 times higher across all age groups. In SSWAHS, there is evidence in particular of high risk alcohol drinking and smoking among Aboriginal males and a considerably lower prevalence of adequate physical exercise among females, compared to both their non-Aboriginal counterparts in SSWAHS and across NSW and other Aboriginal populations in NSW.

The impact of continuing high rates of health risk behaviour is reflected in data that suggests hospitalisation rates (in public hospitals) for vascular related conditions (cardiology, stroke, diabetes, renal etc.) among the adult Aboriginal populations of SSWAHS aged 40-65 that are in total, over double that of the comparable non-Aboriginal adult population. For SSWAHS residents 6.5% of Aboriginal people aged 16+ report having diabetes or high blood sugar, compared to an average figure of 6.1% of SSWAHS adults. In Sydney, it is estimated that incidence rates of treated end-stage kidney disease in Aboriginal populations, adjusted for age and sex, are double those of the non-Aboriginal population. In NSW age-adjusted hospitalisation rates for chronic respiratory diseases (cigarette smoking is the most important risk factor for COPD) are around three times higher than for non-Aboriginal people and rates have been reported to be increasing. Also, 23.3% of Aboriginal adults aged 16+ resident in SSWAHS report current asthma, with a much higher rate in females (29.4%) than males (17.6%), this being the highest reported of any AHS and well above the 7.3% reported for the whole population of SSWAHS.

In NSW, age standardised cancer incidence, even with known under-reporting, is higher among Aboriginal males and females for lung cancer, cancers of the mouth and throat, cancer of unknown primary site and less common cancers including liver and gallbladder, pancreatic cancer, cancer of the oesophagus, and, in males only, thyroid cancer. The rates for cervical cancer among Aboriginal women are more than double those for non-Aboriginal women. Incidence is lower among Aboriginal people for colorectal cancer, prostate cancer and lymphomas. High incidence of cancers of the lung, mouth and throat are caused by high rates of smoking earlier in life, while high cervical cancer incidence is preventable by early detection in Pap test screening. High incidence of cancer of unknown primary site is likely to be associated with late diagnosis.

Although for the general population cancer survival in NSW is amongst the highest in the world, it is known that for Aboriginal people, the overall mortality from cancer is 60% higher than that of non-Aboriginal people, reflecting high rates of cigarette use (smoking related cancers generally have a poor prognosis), low participation in population-based cancer screening programs and factors relating to access to culturally appropriate health care.

6. What did the Yarn-Up Forum reveal?

The Yarn-up" workshop (September 2007) had wide ranging representation from Aboriginal communities, including community members working within SSWAHS and ACCHS, and aimed to develop a shared understanding of how SSWAHS could progress in service development around themes of:

- Strengthening communities;
- Holistic care;
- Working in partnership; and
- Improving access.

A World-Café format was used to explore these issues, involving small group discussions enabling participants to discuss in depth each of the themes and plenary sessions that developed consensus views.

For each of the themes Yarn-Up was able to inform the planning process by defining the concept, identifying what was currently holding back progress and recommending actions to make progress. Many ideas came from the small group discussions and these are identified in the plan. A plenary session identified for each theme the main focus of discussions, issues raised and suggestions for action:

- **Strengthening communities** – need cultural centres and meeting places, develop partnerships within SSWAHS, explore 'old ways' solutions, review management perception of role of AHWs, capture data on all the work of AHWs, be mindful of distrust that stems from past experiences, take time for consultation with community groups and to build community participation, build the capacity of all individuals, work with other agencies, work across rural and urban together for a stronger voice;

- **Holistic care** – ensure health professionals recognise that people have more than one health issue, planning to link across all health issues, Aboriginal one-stop shops needed, understand the role of AHWs and collect statistics on all aspects, recognise the AMS is providing holistic care and comprehensive primary health care, clarify and articulate the differentiation in roles between the AMS and the AHS;
- **Working in partnership** – communication between the three levels of partnership i.e. MOU between the AMS and the AHS, middle management/staff and at the ground level, recognise that Individual workers develop their own partnerships which are at risk of collapsing when workers leave, maintain local partnerships, develop local working protocols on who does what, put Aboriginal health on the agenda of new players and partnerships in the game;
- **Improving access** – reorientate services, involve the community in planning, cultural sensitivity training for frontline staff, collaborative effort to address support issues for patients and their families from outside SSWAHS, address confusion about the roles of AHWs, need focus on access to services and not just on delivery of services to achieve equity of outcomes, need equity of access across all the geography of SSWAHS, be proactive to get people to come to services, leadership from management is required, Aboriginal health issues should be included in orientation for all workers.

The plenary session also identified overarching activities for SSWAHS that would help in addressing the issues raised in discussion of the themes. These included:

- Provide health promotion and health education in communities;
- Develop a public affairs strategy;
- Produce an events calendar;
- Progress recruitment of Aboriginal staff;
- Find venues for activities;
- Develop future Aboriginal leaders – identify and promote and support them;
- Increase communication between Elders and other groups and include Elders in planning;
- Increase ways of communicating with Aboriginal Community Controlled services;
- Hold more community social events such as bbqs and participate in community radio;
- Work at breaking down the barriers of geographical boundaries;
- Develop solutions to transport problems;
- Implement cultural awareness/safety programs using community educators –for all staff, including managers, in orientation programs, and included in all business plans;
- Clarify the roles of Aboriginal Health Workers;
- Provide all managers with an Aboriginal Health contact list.

Participants were also encouraged to provide their number one priority, message or action for SSWAHS to take forward from the day and these are also outlined in the Plan.

7. What are the Framework principles?

SSWAHS has developed Framework Principles to guide its actions to enhance the health of Aboriginal communities. These principles reflect essential prerequisites that need to be in place to ensure that action on Aboriginal Health has the best chance of making a real impact. The principles are drawn from foundation principles of indigenous health identified internationally, nationally and in NSW and the framework principles identified at Yarn-Up.

The principles are:

- Provision of services within a **holistic health** paradigm;
- Demonstrating **relationships** between SSWAHS clinical services and with the services provided by other public funded human service agencies that are consistent with an **integrated response** to holistic health principles;
- Demonstrating **partnerships** with Aboriginal communities that reflect both involvement in the development of programs that reflect the **communities' views** of priority areas of need; and an intent to **empower communities** to increase their capacity to address health issues;
- Providing services that are **complementary, supportive and non-duplicative** of services best provided through Aboriginal Medical Services.

The Plan outlines in detail why these principles need to underlie all SSWAHS actions in Aboriginal Health.

8. What are the Framework initiatives?

The four principles for engaging with Aboriginal communities to improve health need to be firmly embedded within the organisational framework of SSWAHS service provision for optimal impact to be achieved on closing

the gap in health disadvantage. To achieve this, key initiatives are identified to strengthen the capability of the clinical and corporate structures of SSWAHS to address Aboriginal health and support the specific initiatives in each health priority area. They will strengthen the focus of the organisation on Aboriginal Health and build the organisational capabilities to make an impact on closing the gap.

These framework initiatives were developed with the active involvement of the SSWAHS Aboriginal Health Unit and the relevant Aboriginal Health Worker staff within SSWAHS. The following table specifies the initiatives and gives examples of the strategic focus over the next five years in these areas. The Plan also documents good practice examples and the partners that will be engaged in this work.

Framework Initiative	Examples of Strategic Focus → 5 years
SSWAHS support of capacity building in Aboriginal communities	<ul style="list-style-type: none"> ▪ Strengthening the capacity of AHWs to undertake community development; ▪ culturally appropriate info on healthy living, damaging behaviours, signs of ill health. ▪ Supporting the development of community support groups. ▪ Increasing the capacity of communities to self manage chronic disease. ▪ Empowering the community to access mainstream health and social welfare services. ▪ Simpler, improved service directories, integrated with community directories; ▪ Assisting communities in developing economic independence, ensuring Aboriginal participation in all Health funded infrastructure development; ▪ Supporting training and management development sought by Aboriginal communities.
Shaping health promotion agendas to work within Aboriginal communities	<ul style="list-style-type: none"> ▪ Implement the SSWAHS Aboriginal Health Promotion Action Plan 2007-2011. ▪ Placement of Aboriginal Health Promotion Officers within Clinical Streams; ▪ Active engagement with State wide committees established by NSW Health. ▪ Adoption of good practice locally, including piloting of innovative approaches. ▪ Include Aboriginal perspectives in mainstream Health Promotion planning; ▪ Aboriginal specific modules within mainstream health promotion programs.
Partnering with Aboriginal Community Controlled Organisations	<ul style="list-style-type: none"> ▪ Consolidate and ensure sustainable formal Partnership arrangements with ACCHS; ▪ Expand clinical service level agreements with ACCHS; ▪ Explore potential to undertake joint research projects.
Partnering with Primary Care Providers	<ul style="list-style-type: none"> ▪ Joint projects with GP Divisions; ▪ Strengthen general practice links to targeted programs inc. Miller Clinic; ▪ Engage with GPs in chronic care prevention and management programs; ▪ Engage with GPs in Aboriginal targeted programs in chronic care self management. ▪ Develop and expand diabetes prevention projects within Aboriginal communities.
Partnering with other Agencies in Whole of Government/Whole of Human Services activities	<ul style="list-style-type: none"> ▪ Fully participate in implementation of local TWT initiatives through REGs; ▪ Participate in regional initiatives in the Workplans of Human Services & Justice SOGs. ▪ Encourage participation of SSWAHS AHWs in relevant Koori Interagency processes. ▪ Full participation in Statewide cross-agency strategies including ACYFS ▪ Cooperate with other Human Services agencies addressing determinants of Aboriginal Health disadvantage in areas such as numeracy and literacy rates and school readiness. ▪ Encourage in-reach of partner agencies to SSWAHS services e.g. Miller holistic day care.
SSWAHS contribution to community renewal agendas	<ul style="list-style-type: none"> ▪ Ensure urban design and planning recognises particular needs of Aboriginal communities; ▪ Include Aboriginal Health representation on planning committees; ▪ Ensure AHWs and ALOs are supported to undertake a community capacity building role. ▪ Support AHWs and ALOs in work with partner agencies on policy development.
Working with clinicians on awareness raising of the principles of holistic care provision	<ul style="list-style-type: none"> ▪ Ensure clinician leadership in developing clinical services targeted to Aboriginal communities in priority areas e.g. chronic care; mental, drug, sexual and oral health. ▪ Expand clinical specialist involvement in Aboriginal health programs operating within a holistic care framework e.g. Miller clinic. ▪ Integrate AHWs and Aboriginal Health Programs within the Clinical Stream structure; ▪ Ensure use of AHIS process within Clinical Streams servicing Aboriginal communities. ▪ Train clinical staff on Aboriginal cultural perspectives on health, wellness and healing. ▪ Explore possibility of preparing clinician toolkit for mainstream clinical providers. ▪ Increase mainstream clinician referral to Aboriginal self management of disease support. ▪ Increase exposure to Aboriginal health perspectives in clinical training programs.
Developing an Area Charter of Commitment to Advancing Aboriginal Health affirming cultural identity and richness	<ul style="list-style-type: none"> • Develop a formal Charter of Commitment to Aboriginal communities addressing - respect for relationship to land; celebration of culture; inclusion in planning and development of mainstream services; respect for identity, experiences and rights; access to mainstream services; making the business practices (inc. clinical care) of mainstream services culturally appropriate; support and nurturing of the SSWAHS Aboriginal workforce. • Maintain Cultural Committee arrangements for celebration of significant cultural events;

Framework Initiative	Examples of Strategic Focus → 5 years
	<ul style="list-style-type: none"> • Recognise Aboriginal country within the entry spaces of all major SSWAHS facilities; ▪ Training/education on culturally respectful communication with Aboriginal communities.
Supporting Aboriginal communities in addressing “men’s business” in health	<ul style="list-style-type: none"> ▪ Use the SSWAHS Aboriginal Men’s Health Implementation Plan (2008-2011) to increase - culturally appropriate activities for men; programs on men’s health; discussion groups on social & emotional issues for local men; access to a range of health services; culturally specific male health services. ▪ Strengthen partnerships with an Aboriginal men’s group network to improve - pathways to SSWAHS services; primary care health checks for men; health education and group discussion; cultural restoration; skill enhancement - literacy, numeracy, leadership and computer literacy; management of conflict, anger, grief and loss; social, recreational and craft training opportunities; access to group and individual counselling.
Supporting Aboriginal communities in addressing “women’s business” in health	<ul style="list-style-type: none"> ▪ Develop a strategic framework or Women’s Health Implementation Plan to identify specific programs for Aboriginal women from a gender perspective; ▪ Partner with communities in a cultural healing program to support women of the Stolen Generation in addressing the impacts on families; ▪ Consider employment of Aboriginal Women’s Health Nursing positions to support activities undertaken with Women’s support groups in the community.
Encouragement of research into issues of Aboriginal health of importance to the Aboriginal communities of SSWAHS	<ul style="list-style-type: none"> ▪ Continue to ensure research proposals go to AHMRC Ethics Committee and are developed consistent with the AHMRC Guidelines for Research into Aboriginal Health; ▪ Encourage use of the CRIAH Tools for Collaboration resource; ▪ Consider partnering in research project(s) addressing the impact of early childhood experiences in areas such as out-of-home placement resilience among children; ▪ Develop action research projects on capacity building in Aboriginal communities; ▪ Contribute to the evidence base for good practice through presentation at conferences and contribution to peer-reviewed journals etc.

9. What are the Corporate initiatives?

SSWAHS as an organisation will need to ensure the particular needs of Aboriginal people are at the forefront of its corporate organisational focus across a number of areas. Most corporate services within SSWAHS are increasingly being organised on an Area-wide basis, raising significant opportunities to further orient corporate activity towards Aboriginal Health and make synergistic impacts across all of the communities of SSWAHS. Corporate initiatives focus on:

- Workforce development
- Cultural safety
- Access to health services
- Extended support to patients and family over a course of care;
- Data collection

The Plan outlines the rationale for corporate developments that will be undertaken over the next five years in these areas, which are necessary to support SSWAHS Clinical Streams in providing the care services that are required to make progress on bridging the gap in health disadvantage in our generation.

The Model of Care adopted for the Corporate initiatives is:

- Support expanded job opportunities, professional development, mentoring and networking of the Aboriginal workforce in SSWAHS;
- Expand training opportunities for Aboriginal students across SSWAHS;
- Improve cultural competency and cultural safety of mainstream service provision;
- Embed strengths based perspective in addressing Aboriginal Health;
- Increase outreach service provision to Aboriginal communities;
- Prioritise Aboriginal communities in AHS Transport Implementation Plans ;
- Expand liaison and linkages to social support for people in care without adequate supporting family networks;
- Identify and improve capture of Aboriginality in key data items for Aboriginal Health.

The following table specifies the initiatives and gives examples of the strategic focus over the next five years in these areas.

Framework Initiative	Examples of Strategic Focus → 5 years
Audit protocol and checklist for mainstream services to assess access issues.	<ul style="list-style-type: none"> ▪ Identify the key factors impacting on accessibility to mainstream services; ▪ Develop audit tool for self assessment of accessibility by mainstream services; ▪ Pilot process in targeted mainstream services e.g. ACAT, CAPAC, cardiology, oncology, diabetes, rehabilitation, community health etc. ▪ Incorporate self assessment process into quality improvement cycles. ▪ Monitor, review and evaluate cost-benefit aspects of the process.
Embed cultural safety across services.	<ul style="list-style-type: none"> ▪ Establish Cultural Safety Framework Working Group; ▪ Develop framework with involvement of top and middle management administrators, front line staff, consumers and/or their families, and community stakeholders; ▪ Plan to integrate ongoing training and staff development into Cultural Safety Framework
Embed use of Aboriginal Health Impact Statements (AHIS) across SSWAHS.	<ul style="list-style-type: none"> ▪ Develop local guidelines for AHIS use; ▪ Develop and conduct AHIS education forums; ▪ Provide ongoing advice and assistance to staff that are required to undertake an AHIS; ▪ Audit check of AHIS registry to assess compliance rates; ▪ Survey of AHIS users to identify scope for quality improvement.
Implement the SSWAHS Aboriginal Workforce Strategy.	<ul style="list-style-type: none"> ▪ Implement the SSWAHS Aboriginal Workforce Strategy, including - employing Aboriginal people into vacancies, traineeships, apprenticeships and cadetships; advertising vacancies through local Aboriginal organisations and events and Aboriginal media; meeting recruitment targets; ensuring Aboriginal workforce distribution matches Aboriginal community health needs; establishing support infrastructure for all Aboriginal recruits; improving transition from traineeship to employment; encouraging identification; development of an Aboriginal employment website; conducting Healthwise career fairs for schools with high Aboriginal student populations using career ambassadors; training for existing AHWs and Aboriginal staff, including skills development, career coaching and mentoring; cultural awareness program and training for line managers.
Enhancing mentoring frameworks and succession planning for SSWAHS Aboriginal staff.	<ul style="list-style-type: none"> ▪ establish a SAOG in SSWAHS ▪ identify mentors from within SSWAHS and develop an Aboriginal mentoring package; ▪ Undertake training need analysis for the SAOG and the AHET ▪ Develop training program for the SAOG and the AHET ▪ Implement training program for the SAOG and the AHET
Supporting and developing Aboriginal Health Worker networks across SSWAHS.	<ul style="list-style-type: none"> ▪ Continued nurturing of the existing AHW Network that comprises over 50 designated Aboriginal health Workers across SSWAHS ▪ Develop the Aboriginal Health Worker Forum yearly calendar
Ensure availability of transport does not impede the access of Aboriginal communities to SSWAHS services.	<ul style="list-style-type: none"> • Review the provision of health related transport by Aboriginal health staff, identifying the ongoing transport demand that should be provided through SSWAHS Transport Services. • Develop an Aboriginal TAG for SSWAHS South West hospitals • Develop IPTAAS information for rural and remote Aboriginal patients; ▪ Develop strategies to improve patient access to services e.g. outreach clinics, improved public transport routes, coordinated group transport.
Coordinating extended support and social assistance to patients of SSWAHS facilities and their families over an episode of care.	<ul style="list-style-type: none"> ▪ Identify the level of support demand and resources in meeting accommodation needs. ▪ Identify degree to which needs will be met by newly constructed patient accommodation and develop a transition strategy till then. ▪ Consult with rural AHS on needs of rural and remote people; ▪ Improve IPTAAS packaging and communication with primary care providers; ▪ Improve partnerships with Govt welfare agencies and emergency and temporary accommodation providers; ▪ Develop clear protocols and pathways for addressing common support issues. ▪ Develop interagency MOU to address short term accommodation needs.
Addressing data collection issues, gaps and opportunities to enhance research agendas.	<ul style="list-style-type: none"> ▪ Audit Patient Information Systems to ascertain level of identification of Aboriginality; ▪ Incorporate a minimum data set across all streams of the Area Health service ▪ Establish data / research working group to develop strategies; ▪ Implementation of a data management and research agenda.

10. What are the initiatives for the Early Years, Children and Young People?

The Model of Care adopted for the Early Years, Children and Young People initiatives is:

- Target Aboriginal families with children in gestation and up to 5 years, Aboriginal young people in school aged 8-18 and Aboriginal youth aged 15-24 with high and complex needs;
- Provide services within the context of community capacity building, fostering role modelling and leadership development;
- Provide services to strengthen connectedness of extended families;
- Early support and primary prevention focus in formative infant years;
- Early intervention and support to ameliorate emerging health impact issues
- Strengthen community knowledge and acceptability of, access to and supported navigation across mainstream services;

- Enhance the Aboriginal workforce within services for families, children and young people;
- Strengthen partnerships with ACCHS, NGOs and human services agencies;
- Expand culturally appropriate educational and health promotion programs;
- Engage with target populations in developing programs that reflect community needs and desires.

The following table specifies the initiatives developed for the Early Years, Children and Young People and examples of actions that will be taken over the next five years.

Initiative	Examples of Actions → 5 years
Enhanced targeted support through pregnancy and during infant years (0-5) for Aboriginal children, their mothers and family units.	<ul style="list-style-type: none"> ▪ Continue the joint home visiting program first two years of life. ▪ Establish an Early Literacy Program. ▪ Offer smoking cessation and passive smoking education program ▪ Develop a “Healthy and Happy Living Education Strategy” for Aboriginal parents on nutrition, breastfeeding immunisation, lifestyle and life skills. ▪ “Transition to School” programs to increase Aboriginal pre-schoolers enrolment in childcare, parental involvement in childcare activities, camps for young parents and babies. ▪ With the NSW Housing Department, implement the Pathways Project and Aboriginal Maternal Infant Health Strategy.
Integrated pathways – enhancing referral to mainstream services and providing supportive environments to ensure access and navigation across services.	<ul style="list-style-type: none"> ▪ Develop guidelines/charter making Aboriginal children a “high” priority, requiring services implement practices responsive to Aboriginal families needs, covering intake, waiting list management, service location etc. ▪ Ensure priority in provision of low cost/ loan equipment by all clinical services. ▪ Audit and service redesign process to make all services more responsive to Aboriginal families needs and cultural identity. ▪ Increase availability of Aboriginal support workers in clinical services e.g. in EDs. ▪ Pathways development within and between services/agencies inc. DoCS. ▪ Develop directory and maps of local service availability ▪ Provide cultural appropriate resources in waiting rooms for Koori kids.
Provide health education, health promotion, case management and streamlined referral pathways through an intersectoral youth worker model outreaching to youth gathering places.	<ul style="list-style-type: none"> ▪ Establish referral links to “Schools as Community Centres” programs Increase intra-service consultation for AYCHN strategic planning ▪ Health promotion campaign (what’s available for youth within SSWAHS) ▪ Establish Working Group including youth reps to develop youth plan ▪ Develop community programs/strategies based on needs analysis ▪ Distribute Aboriginal appropriate resources to service providers ▪ Partnership work with JJ to strengthen access to information and referral ▪ Partnership work with NGO Youth Services to reach AYHCN population ▪ Partnership work to develop Youth Aboriginal Cultural Arts/Music program
Support Aboriginal young people in schools, their families and broader communities through an intersectoral model for health education and promotion in high needs schools and at community venues for children and youth.	<ul style="list-style-type: none"> ▪ Partnering with DET to address school connectedness in areas of: ▪ School environment and connectedness to the school eg: Gatehouse Project ▪ Access to on job training and job skills – with TAFEs, Unis and NGO’s ▪ School education PDHPE programs through AHEOs and other AHWs ▪ Develop and extend social skills ▪ Young mothers completing education e.g. provide accessible child care ▪ Review curricula on life skills, relationship issues etc. ▪ Develop culturally specific information for young boys and girls ▪ Consider ways of providing free contraception

11. What are the initiatives in Chronic Diseases and Ageing?

The Model of Care adopted for the Chronic Diseases and Ageing initiatives is:

- Implement, consolidate and enhance spread of Walgan Tilly solutions, consistent with ACCAHSS.
- Enhance availability of screening for chronic disease and precursors in the community.
- Improve support to primary care providers in screening and disease management.
- Enhance community capacity to create healthy living environments and individual skills in chronic disease self management.
- Improve inter agency and inter sectoral coordination in continuity of care provision.
- Improve access to mainstream Aged Care support services in the community.

The following table specifies the initiatives developed for Chronic Diseases and Ageing and examples of actions that will be taken over the next five years.

Initiative	Examples of Actions → 5 years
Implement Walgan Tilly solutions – culturally sensitive and effective discharge planning for Aboriginal patients 15+ years with chronic disease.	<ul style="list-style-type: none"> ▪ Consult with key stakeholders and develop implementation plan ▪ Undertake a literature review on other models (e.g. COACH study) ▪ Develop form for 24hr phone follow up, discharge packages, list of Koori friendly GPs ▪ Review existing discharge planning frameworks and strategies ▪ Develop Koori information pamphlet for all larger hospitals, distribute with TAGs to Aboriginal primary care providers across NSW. ▪ Implement preadmission, admission, discharge and post-discharge.
Implement the Aboriginal Chronic care Program, including multidisciplinary, holistic chronic disease assessment, treatment and management through clinical outreach to primary care settings.	<ul style="list-style-type: none"> ▪ Recruit workforce required to implement program ▪ Review feasibility of replicating current chronic care model at Miller CHC. ▪ Literature review on good practice in outreach health care models. ▪ Strategic plan to guide roll out of Miller model elsewhere. ▪ Detailed audit/mapping of services to be offered at outreach sites. ▪ Assess financial impact and cost-benefit potential. ▪ Business plan for roll-out of outreach packages to community settings ▪ Ensure proposal is reflective of community needs through use of AHIS process, establish advisory committees with community representation. ▪ Encourage improved links with primary care providers, uptake of Medicare EPC opportunities and use of AHP services, quality improvements in medication management. ▪ Ensure continuing engagement of SSWAHS specialist service providers e.g. pop health, cardiac, dietetics, diabetes, renal, respiratory, cancer.
Health Promotion activities for Aboriginal people with or at risk of chronic disease.	<ul style="list-style-type: none"> ▪ To implement the Aboriginal health promotion funds statement of intent 2007/2008 in coordination with the Aboriginal chronic disease priority area working group and other Aboriginal priority area working groups and committees and relevant strategic plans internal to SSWAHS. ▪ To implement plan in partnership with relevant organisations such as government and non-government organisations.
Implement the SSWAHS Aboriginal Renal Health Project.	<ul style="list-style-type: none"> ▪ Project steering committee established ▪ Establish partnership with other primary health care providers, such as ACCHS', Divisions of General Practice, and/or others; ▪ Link proposal to complementary actions under existing NSW Health and Commonwealth investments in chronic disease prevention and management for Aboriginal people inc. the Healthy for Life program; ▪ Participation in Statewide evaluation process, inc. baseline and follow up audits of clinician activity and patient health status – process likely to be led by an external provider with appropriate cultural and renal expertise; ▪ Provision to the Centre for Aboriginal Health, NSW Health, of a project implementation plan within one month of receipt of funds.
Develop an electronic risk assessment and decision support tool for use in primary care settings with Aboriginal people at risk of developing cardiovascular disease.	<ul style="list-style-type: none"> ▪ Identify partners / stakeholders ▪ Establish the reference group, draft the TOR, scope the project ▪ Secure ethics committee approvals ▪ Develop / adapt Electronic Risk Assessment Tool ▪ Develop / adapt performance indicators ▪ Provide training to users of the tool ▪ Roll out tool as a pilot ▪ Evaluate pilot ▪ Provide recommendations to the reference group re the appropriateness of the tool ▪ Implement tool area wide
Improving access of Aboriginal people to Aged Care Programs including TACP, ComPacks, CAPACS & ACATs - to optimise opportunities for their continued living at home within local communities.	<ul style="list-style-type: none"> ▪ Develop & implement appropriate publicity for Aboriginal older community & appropriate facility assessors/discharge planners/social workers etc. ▪ Work with NSW Health to develop appropriate model for TACP across NSW to meet needs of Aboriginal older community ▪ Investigate need for Aboriginal Transitional Aged Care worker dependent on NSW Model developed ▪ Increase numbers of Aboriginal older people access to TACP.
Enhancing Healthy Ageing initiatives – improve access to health and human services and support for clients of Aboriginal day care centres.	<ul style="list-style-type: none"> ▪ Increase client numbers at existing day care centres. ▪ Feasibility study on potential to increase Aboriginal day care centres across SSWAHS inc. in the Inner West. ▪ Work with primary care providers to Increase the proportion of clients with EPC care plans. ▪ Assess feasibility of expanding access to Medicare funded private allied health services ▪ Expand medical, nursing and allied health clinical service inreach to centres in areas such as chronic care management. ▪ Expand training and education in chronic care self-management for day centre clients ▪ Expand access to service provision by partner human services agencies e.g. DADHC, Centrelink, and to NGO and other community support.
Improved employment and training opportunities for Aboriginal people in	<ul style="list-style-type: none"> ▪ Form joint working group with representatives from Aged Care, Aboriginal Health and CEWD to progress three strategies ▪ Identify positions within Aged Care & Rehabilitation (particularly Jane Evans Day Centre)

Initiative	Examples of Actions → 5 years
Aged Care & Rehabilitation services in SSWAHS.	<ul style="list-style-type: none"> ▪ suitable for Aboriginal Health traineeship positions, and work with Aboriginal Workforce Development Officer to progress ▪ Identify positions within Aged Care & Rehabilitation that when vacant may be appropriate for the SSWAHS Aboriginal Employment Coordinator's involvement in recruitment ▪ Increase training opportunities for existing and future Aboriginal Health Workers in Aged Care & Rehabilitation
Implement the Sydney Diabetes Prevention Study (Aboriginal cohort) – lifestyle modification program for at risk people.	<ul style="list-style-type: none"> ▪ Provide a culturally appropriate lifestyle modification support program including group and individual contact, follow up and support. ▪ Train and support General Practitioners in delivering the program. ▪ Recruit, evaluate and work to improve the health of Aboriginal people referred to the SDPP.

12. What are the initiatives in Drug Health?

The Model of Care adopted for the Drug Health initiatives is:

- Multifaceted interventions involving use of prevention, early intervention, treatment and harm reduction.
- Incorporate drug health promotion within broader initiatives enhancing culture, community empowerment and sense of belonging.
- Focus interventions on whole families or whole communities rather than one-to-one psychotherapy or behavioural interventions.
- Emphasis on outreach services building trust with clients and ensuring client retention through extensive use of Aboriginal health workers.
- Focus on shared care with primary care providers and inter-agency partnership approaches.
- Supporting peer education approaches, life skills programs and addressing drug health issues in the context of broader social and recreational activities for youth.
- Strengthened drug health activities within parenting and life skills programs for children and young people.
- Strengthening culturally appropriate approaches to drug detoxification, screening tools and brief interventions.
- Improved networking within the health sector e.g. with mental health in dual diagnosis and with external agencies e.g. law enforcement and prisoners post-release.
- Improved action research on culturally appropriate interventions in Aboriginal communities.

The following table specifies the initiatives developed for Drug Health and examples of actions that will be taken over the next five years.

Initiative	Examples of Actions → 5 years
Prevention, health promotion and early intervention for Aboriginal people with substance use issues.	<ul style="list-style-type: none"> ▪ Identify and/or develop, distribute relevant resources to Aboriginal agencies and communities ▪ Develop and deliver overdose education training for key stakeholders in the community ▪ Implement alcohol brief intervention program ▪ Participate in Aboriginal community activities (i.e. NAIDOC week) ▪ Participate in youth health prevention initiatives ▪ Facilitate community service visits to DHS clinical sites to increase understanding of treatment options ▪ Provide new injecting equipment to 'at risk' communities ▪ Provide brief intervention and referral in community settings ▪ Establish DHS Primary Health Care services/clinics to at-risk communities.
Develop and support partnerships between Drug Health Services (DHS), Aboriginal services and Aboriginal communities and other services within SSWAHS.	<p>Develop, implement and review:</p> <ul style="list-style-type: none"> ▪ Intake and assessment processes; ▪ clinical pathways and service agreements between key services; and ▪ a care coordination model ▪ Continue regular meetings between DHS, ACCHS', Aboriginal Health Services and Aboriginal community services.
Enhance availability of clinical services for Aboriginal people with drug health issues.	<ul style="list-style-type: none"> ▪ Develop an Aboriginal Clinical Support Team to work directly with clients and DHS staff across primary, secondary and tertiary settings ▪ Review intake and assessment procedures for Aboriginal people ▪ Develop individual treatment plans with an emphasis on flexibility ▪ Maintain and improve clinical pathways and service agreements within and between DHS and identified partner services ▪ Provide appropriate training to all Drug Health staff ▪ Review DHS models of care to support Aboriginal clients

Initiative	Examples of Actions → 5 years
Enhance the availability, skills level and organisational support for Aboriginal health workers in Drug Health Services (DHS).	<ul style="list-style-type: none"> ▪ Establish an Aboriginal Drug Health clinical support team. ▪ Develop and implement targeted recruitment strategies for Aboriginal staff across all streams. ▪ Increase awareness of Aboriginal cultural issues among DHS staff. ▪ Develop and deliver Drug Health related training for the Aboriginal Health workforce of SSWAHS. ▪ Establish traineeships and cadetships for Aboriginal staff within DHS. ▪ Provide clinical training and education for Aboriginal DHS staff. ▪ Provide supervision for Aboriginal Health staff (both DHS and SSWAHS Aboriginal Health staff). ▪ Provide opportunities for Aboriginal staff rotations within DHS and SSWAHS. ▪ Provide student placement options for Aboriginal students.

13. What are the initiatives in Mental Health?

The Model of Care adopted for the Mental Health initiatives is:

- In partnership provide outreach specialist medical services to Tharawal and Redfern ACCHS;
- Improve knowledge, assessment protocols and links to specialist care among primary care providers to Aboriginal communities;
- Interagency work improving inreach of mental health expertise to educational facilities, early childhood and family services, community services, housing, justice services etc.
- Work with Aboriginal communities to improve capacity to recognise precursors and early signs of mental health issues and initiate pathways to specialist care;
- Improve the interaction and relationships between AMHS and Drug health services through informal networking and formal joint protocol development and partnership action;
- Increase employment of AHMWs to levels mandated in State policy and provide a supportive workforce development structure for recruitment, training, mentoring, peer support and competency development.

The following table specifies the initiatives developed for Mental Health and examples of actions that will be taken over the next five years.

Initiative	Examples of Actions → 5 years
Expand partnerships and develop strong working relationships.	<p>In establishing partnership relationships with ACCHS:</p> <ul style="list-style-type: none"> ▪ Cooperatively plan and scope services to be provided at ACCHS ▪ Pilot service provision arrangements ▪ After piloting stage determine requirements for service expansion and additional resources required ▪ Establish formal MOUs between SSWAHS AMHS and AMS' <p>In establishing partnerships with NGOs and government authorities:</p> <ul style="list-style-type: none"> ▪ Ensure housing issues are addressed at local JGOS meetings ▪ Expand HASI program subject to funding availability ▪ Engagement of Commonwealth and COAG funded NGOs into working with Aboriginal communities ▪ Expand mental health promotion work with Aboriginal men's and women's groups ▪ Expand provision of AMH First Aid Training programs to partner organisations ▪ Expand input to school based programs such as school-link and MindMatters to ensure focus on Aboriginal students ▪ Establish broadly representative Aboriginal Mental Health and Well Being steering committee
Develop accessible and responsive services.	<ul style="list-style-type: none"> ▪ Strengthen Aboriginal mental health as a specialised component of general AMHS programs ▪ Support clinical supervision and mentoring program for trainee AMHWs ▪ Support a family centred approach to delivery of services ▪ Train staff to deliver Aboriginal Mental Health First Aid (AMHFA) ▪ Develop culturally appropriate Aboriginal health promotion material ▪ Develop Aboriginal friendly and supportive environments in AMHS ▪ Expand services to meet identified needs of Aboriginal communities in: <ul style="list-style-type: none"> · The link between social and emotional wellbeing and physical health · Assessment and care planning for substance misuse · Isolation, depression and dementia for Elders · Camp programs for children and adolescents · Circle of security programs for families · Adolescent programs linked with "headspace" services · Other emerging needs utilising an early intervention care framework.

Initiative	Examples of Actions → 5 years
Provide a skilled and supported workforce addressing Aboriginal mental health issues.	<ul style="list-style-type: none"> ▪ Provide Aboriginal Mental Health First Aid Program (all AMHWS trained) ▪ Provide cultural competency training program for general AMHS staff ▪ Develop specialised support for AMHWs e.g. child, adolescent, comorbidity ▪ Establish professional supervision and support framework ▪ Establish AMHW training structure internal to AMHS ▪ Facilitate access to skills development from sources outside AMHS ▪ Establish links with Universities for work experience and placements.

14. What are the initiatives in Infectious Diseases and Sexual Health?

The Model of Care adopted for the Infectious Diseases and Sexual Health initiatives is:

- Target youth aged 16-30;
- Early intervention through “active outreach”;
- Enhance the Aboriginal workforce within sexual health services;
- Strengthen partnerships with ACCHS’;
- Deliver localise State community awareness campaigns;
- Enhance cultural safety aspects of sexual health service provision;
- Enhanced surveillance of STI infection;
- Enhanced voice of Aboriginal people in policy and planning;
- Improve the pathways across primary and specialist care – patient journey and referral mechanisms;
- Improve linkages with general practice – information, education and enhancement of continuity of care.

The following table specifies the initiatives developed for Infectious Diseases and Sexual Health over the next five years.

Initiative	Examples of Actions → 5 years
Improving access for young Aboriginal people (16-24 years) through provision of outreach STI testing (urine only) at key gathering points for Aboriginal youth.	<ul style="list-style-type: none"> ▪ Identify the venues and frequency of attendance for “active outreach” ▪ Prepare health education and information packages tailored to target population ▪ Engage and establish enduring partnerships with partners in service provision ▪ Pilot the process in selected venues ▪ Expand reach and frequency consistent with demonstrated achievements
Provide comprehensive health information and education on sexual health issues to community groups at community based venues and support State & National campaigns at a local level.	<ul style="list-style-type: none"> ▪ Develop an annual calendar of events, to be coordinated across the Area. Ensure that sexual health programs are included at these events. Key events for the calendar will be: NAIDOC Week, Sorry Day, Youth Week, Sexual Health Week & World AIDS Day. ▪ Support recipients of Sexual Health Week grants to implement programs for Aboriginal youth. ▪ Focus on continued partnerships with Glebe Youth Service and Marrickville Youth Resource Centre, building on the Memorandums of Understanding in place with these services. ▪ Develop similar partnerships with youth services in the south west which access large numbers of Aboriginal youth. ▪ Continue to develop locally relevant Aboriginal-specific sexual health resources.
Improve access and pathways to specialist care and associated services for people with Hepatitis C.	<ul style="list-style-type: none"> ▪ Identify outreach opportunities for the Aboriginal sexual health nurse e.g. Miller women’s group, Hoxton Park CHC, Tharawal. ▪ Evaluate success of retreat for Aboriginal people with hepatitis C to be held at Picton Healing Centre, with a view to further retreats being held. ▪ Consult retreat participants about design of a hepatitis C resource. ▪ Community education about hepatitis C to be provided by ASHWs. ▪ Cultural awareness training for hep C treatment providers by ASHWs. ▪ All SSWAHS programs designed to raise awareness of hepatitis C treatment will prioritise Aboriginal communities. ▪ All ASHWs will undertake Mental Health First Aid training, and will train carers of Aboriginal people on hepatitis C treatment. ▪ GPs with high Aboriginal caseloads targeted for ASHM hep C training.
Strengthen the capacity of SSWAHS sexual health services through increased employment of Aboriginal staff and enhancement of their skills.	<ul style="list-style-type: none"> ▪ As Aboriginal outreach clinics are piloted in 2008, identify future staffing needs. ▪ Ensure that the Aboriginal sexual health workers and sexual health nurse are well supported - by management and by a team based approach to their work. ▪ Experienced Aboriginal Sexual Health workers will act as mentors to new staff (this may be part of a broader Aboriginal health mentorship program). ▪ Support Aboriginal sexual health staff to undertake the AHMRC ▪ Diploma of Aboriginal Sexual Health. ▪ Ensure all Aboriginal sexual health staff attend Aboriginal Mental Health First Aid training. ▪ Explore options for establishing an Aboriginal sexual health nurse cadetship or graduate traineeship. This could possibly be done in partnership with another Area Health Service, to guarantee permanent employment at the end of the traineeship.

Initiative	Examples of Actions → 5 years
Enhance the participation of Aboriginal staff in the policy and planning development process for sexual health services in SSWAHS.	<ul style="list-style-type: none"> ▪ Maintain the existing training opportunities available to Aboriginal staff via the Workforce Development Program. ▪ Aboriginal Health Impact Statements will be mandatory for all Sexual Health Service planning, research and program development activities. Key Sexual Health Service staff required to attend workshops on Aboriginal Health Impact Statements (starting Aug/Sept 2008). ▪ Regular meetings of all Aboriginal Sexual Health Workers and their line managers will be established (based on a successful model used by Aboriginal Mental Health Workers). ▪ Cultural management by Bangala will be maintained for Aboriginal Sexual Health Workers. ▪ ASHWs will be represented on the Area-wide Aboriginal Sexual Health Advisory Group. ▪ Updates on Aboriginal Health Plan PAWGs, including Infectious Diseases and Sexual Health, will be on the agenda of all AHWs Forum meetings. ▪ Senior Aboriginal Sexual Health Workers will participate in the Senior Aboriginal Officers Group. ▪ Other actions relevant to this strategy - SH3: Cultural awareness training for hepatitis C treatment services and SH5: Mentoring for Aboriginal Sexual Health Workers.
Advance issues of cultural safety and respect for identity of Aboriginal people within sexual health services.	<ul style="list-style-type: none"> ▪ Audit sexual health services to ensure that they comply with NSW Aboriginal Health Cultural Safety Standards. ▪ Complete an Aboriginal Health Impact Statement for all proposed sexual health clinical and health promotion programs. ▪ Ensure that all sexual health service staff attend annual Aboriginal cultural awareness training. ▪ Ensure that all new sexual health staff meet with senior Aboriginal Sexual Health Workers as part of their orientation. ▪ Ensure that Aboriginal-specific resource material is clearly displayed at sexual health services. ▪ Wherever possible, Aboriginal sexual health staff to be available to support Aboriginal clients at sexual health clinics. ▪ Aboriginal Sexual Health Nurse and Aboriginal Sexual Health Workers will conduct outreach to Aboriginal community venues. ▪ Promote to Aboriginal communities the days that the Aboriginal Sexual Health Nurse works at RPAH and Bigge Park Centre Sexual Health Clinics. ▪ Provide additional clinical services to Aboriginal clients (e.g. Gardasil vaccination, pap smears).
Enhance surveillance of STIs in Aboriginal communities.	<ul style="list-style-type: none"> ▪ Continue enhanced surveillance for syphilis. ▪ Commence enhanced surveillance for gonorrhoea amongst women, area-wide, for a minimum of five years. ▪ Commence enhanced surveillance for gonorrhoea amongst men in Western Zone only (south west). ▪ PHU to continue to liaise with laboratories and GPs regarding inclusion of Aboriginality on notification forms. This issue is being taken up at a national level by the National STI Working Group. ▪ Analyse SSWAHS syphilis and gonorrhoea data from the last five years ▪ RPAH Sexual health service to participate in the "Access" project, a database on Chlamydia risk factors for clients of sexual health services., GPs and Aboriginal Medical Services (this project has AH&MRC approval).
Engage more effectively with primary care providers of significance in Aboriginal communities.	<ul style="list-style-type: none"> ▪ HARP Health Promotion teams will identify GPs with significant Aboriginal caseloads, through consultation with the Australasian Society of HIV Medicine (ASHM), Divisions of General Practice, Aboriginal Medical Services and the Aboriginal community. Work with ASHM to provide 'category 1' training to these GPs, based on the STIGMA GP training project model. ▪ Encourage GPs with high Aboriginal caseload to undertake RPAH Sexual Health Clinic's program of paid clinical attachments. The clinical attachments include work in HIV and sexual health clinics and attract category 1 CME points. ▪ Provide identified GPs with Aboriginal-specific sexual health promotion materials. ▪ Incorporate Aboriginal specific information into existing in-services for public and private pharmacotherapy providers. ▪ Explore possibilities for providing sexual health in-services for SSWAHS Aboriginal mental health and Aboriginal early childhood workers ▪ Provide annual sexual health in-services for Aboriginal medical service GPs and nurses
Engage with Justice Health to provide post-release support on sexual health issues and engagement into treatment for former prisoners.	<ul style="list-style-type: none"> ▪ At a minimum, we will produce a resource for Aboriginal ex-prisoners with information and referrals about sexual health, hepatitis and HIV. ▪ Possibilities for other projects will be explored in collaboration with partners listed above.

15. What are the initiatives in Oral Health?

The Model of Care adopted for the Oral Health initiatives is:

- Population health focus emphasising provision of culturally appropriate oral health promotion and education widely across Aboriginal communities;
- Target population health approaches to children, youth and young families;
- Include an oral health component in broader health promotion and preventative health programs within Aboriginal communities;
- Provide oral health messages and education to Aboriginal community groups;
- Raise the profile and improve service linkages and referral pathways for oral health with other SSWAHS clinical services provided within Aboriginal communities inc. chronic care, drug health, mental health, diabetes etc.
- Strengthen partnerships with ACCHS to facilitate improved access for Aboriginal communities to general and specialist dentistry;
- Tailor Commonwealth initiatives to local environments to ensure optimal impact for initiatives to facilitate access into clinical care;
- Enhance the Aboriginal workforce within oral health services;
- Enhance knowledge of oral health among AHWs and AHEOs working within Aboriginal communities;
- Enhance cultural safety aspects of oral health service provision;
- Enhanced voice of Aboriginal people in oral health policy and planning;
- Improve linkages with general practice – provision of culturally appropriate oral health information, education and enhancement of early detection and referral to clinical care.

The following table specifies the initiatives developed for Oral Health and examples of actions that will be taken over the next five years.

Initiative	Examples of Actions → 5 years
Increased access to mainstream publicly funded oral health services including engagement with the private sector through the Oral Health Fee for Service Scheme, the Pensioners Dental Scheme and the Medicare Enhanced Primary Care Scheme.	<ul style="list-style-type: none"> ▪ Provision of a full range of general and specialist dental services to the Aboriginal people residing in the SSWAHS ▪ Encourage eligible patients to seek care under the Medicare EPC whilst the program remains in operation
Emphasise oral health as an integral component of holistic care provision to Aboriginal communities within the context of preventative health measures (health promotion, education and early intervention).	<ul style="list-style-type: none"> ▪ Increased oral health promotion activity with strategies targeted at specific populations within Aboriginal communities. ▪ Integration into other health promotion activities with particular emphasis on diabetes, cardiovascular disease, tobacco and alcohol, nutrition and drug health. ▪ Targeted focus on integrating oral health into Child and Youth health promotion programs. ▪ Implementation of the NSW Early Childhood Oral Health Program (ECOH – NSW Health PD2008_020) in all Aboriginal communities throughout SSWAHS.
Increase the number of SSWAHS workers and especially oral health professionals who have been trained in meeting the oral health needs of Aboriginal in a culturally sensitive and supportive way.	<ul style="list-style-type: none"> ▪ Increased cultural awareness training for relevant personnel ▪ Publicise and implement ECOH Program with Aboriginal Health Workers

16. What accountability mechanisms are there for implementing the Plan?

There are a number of accountability mechanisms built in to ensure that SSWAHS can continue to monitor the extent to which the initiatives proposed are implemented across SSWAHS. An important aspect of this will include the ongoing mechanisms by which SSWAHS involves the Aboriginal communities of SSWAHS, including its Aboriginal Health workforce in advising on the best means of addressing Aboriginal Health Issues. These mechanisms include use of existing mechanisms such as:

- The Partnership Arrangements with the ACCHS at Redfern and Tharawal;
- The Aboriginal Health Worker Forum within SSWAHS that meets on a regular basis;
- The Senior Aboriginal Officers Group;
- Monitoring arrangements under existing plans and strategies which address Aboriginal health needs including the SSWAHS Aboriginal Employment Strategy;
- Ongoing operations of a fully supported Aboriginal Health Unit (AHU) Bangala and Aboriginal Health Executive Team (AHET).

Higher level monitoring will be continued through performance indicators SSWAHS has committed to in the context of the NSW State Plan, NSW State Health Plan and SSWAHS Health Service Strategic Plan, as reflected in the Area's Performance Agreement with the NSW Health Department and also through indicators developed within the inter-agency plans SSWAHS participates in through multilateral Senior Officers Group and other whole of Government arrangements, including progressing of the *Two Ways Together* agendas.

More specifically, it is proposed that the Priority Area Working Groups (PAWGs) established as part of the planning process continue in a monitoring and review capacity for the life of the Plan. It is expected that these groups would need to meet on a bi-annual basis to ensure that service development is proceeding on track with the directions established through the extensive consultative processes undertaken within the Plan.

Each initiative included within the Plan has clearly identified performance indicators which identify how successful implementation can be measured. They also clearly outline who is responsible for implementation and their role, along with the partners in implementation. PAWGs and others assessing implementation will be able to refer to this information as progress is reviewed over time.

Abbreviations

ABS	Australian Bureau of Statistics	CPITN	Community Periodontal Index of Treatment Needs
ACAT	Aged Care Assessment Team	CRIAH	Coalition for Research to Improve Aboriginal Health
ACCAHSS	Aboriginal Chronic Conditions Area Health Service Standards	CSAHS	Central Sydney Area Health Service (former)
ACE	Adolescents Coping with Emotions	DADHC	Department of Ageing, Disability & Homecare
ACCHO	Aboriginal Community Controlled Health Organisation	DAA	Department of Aboriginal Affairs
ACCHS	Aboriginal Community Controlled Health Service	D&A	Drug & Alcohol
ACYFS	Aboriginal Child Youth and Family Strategy	DHS	Drug Health Services
AHEO	Aboriginal Health Education Officer	DMFT	Decayed, Missing or Filled Teeth
AHET	Aboriginal Health Executive Team	DoCS	Department of Community Services
AHIS	Aboriginal Health Impact Statement	DoH	Department of Housing
AHMAC	Australian Health Ministers' Advisory Council	DoHA	Department of Health and Ageing (Commonwealth)
AHMRC	Aboriginal Health & Medical Research Council of NSW	DV	Domestic Violence
AHO	Aboriginal Housing Office	ECOH	Early Childhood Oral Health
AHP	Allied Health Professional	ED	Emergency Department
AHS	Area Health Service	EDD	Estimated Date of Discharge
AHSM	Aboriginal Health Service Manager	EPC	Enhanced Primary Care
AHU	Aboriginal Health Unit (Bangala)	ESKD	End Stage Kidney Disease
AHW	Aboriginal Health Worker	ESRG	Enhanced Service Related Group
AIDB	AIDS/Infectious Diseases Branch (NSW Health)	FAE	Foetal Alcohol Effects
AIHW	Australian Institute of Health and Welfare	FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs
ALO	Aboriginal Liaison Officer	FAS	Foetal Alcohol Syndrome
AMHS	Area Mental Health Service	G&S	Goods and Services
AMHW	Aboriginal Mental Health Worker	GP	General Practice
AMIHS	Aboriginal Maternal and Infant Health Strategy	HACC	Home & Community Care Program
AMS	Aboriginal Medical Service	HARP	HIV and Related Programs
AN_SNAP	Australian National Sub-Acute and Non-Acute Patient Classification	HASI	Housing & Accommodation Support Initiative
ANTaR	Australians for Native Title and Reconciliation	HCV	Hepatitis C Virus
ANZDATA	Australian & New Zealand Dialysis & Transplant Registry	HIC	Health Insurance Commission
ASHM	Australasian Society for HIV Medicine	HITH	Hospital in the Home
ASHW	Aboriginal Sexual Health Worker	HIV	Human Immunodeficiency Virus
BBV	Blood Borne Virus	HS&JMSRN	Human Services & Justice Metropolitan Sydney Regional Network
CAAH	Centre for the Advancement of Adolescent Health	HS&JSOG	Human Services & Justice Senior Officers Group
CAMHS	Child & Adolescent Mental Health Services	HSNet	Human Services Network
CAPACS	Community Acute & Post Acute Care Service	ICC	Indigenous Coordination Centre(s)
CBT	Cognitive Behavioural Therapy	IDU	Intravenous Drug User
CEWD	Centre for Employment and Workforce Development	IPTASS	Isolated Patient Transport & Accommodation Assistance Scheme
CFHN	Child & Family Health Nurse	JGoS	Joint Guarantee of Service
CHC	Community Health Centre	KPI	Key Performance Indicator
CHETRE	Centre for Health Equity Training, Research & Evaluation	LGA	Local Government Area
CHOCIP	Community Health and Outpatient Care Data Collection	LOS	Length of Stay
CKD	Chronic Kidney Disease	MDS	Minimum Data Set
COAG	Council of Australian Governments	MHDAO	Mental Health and Drug and Alcohol Office
COPD	Chronic Obstructive Pulmonary Disease	MH-OAT	Mental Health Outcomes Assessment Tool
		MOU	Memorandum of Understanding
		N/A	Not Applicable
		NACCHO	National Aboriginal Community Controlled Health Organisation
		NAIDOC	National Aborigines and Islanders Day Observance Committee

NCHECR	National Centre in HIV Epidemiology and Clinical Research	SCATSIH	Standing Committee (to AHMAC) on Aboriginal and Torres Strait Islander Health
NCIRS	National Centre for Immunisation Research & Surveillance of Vaccine Preventable Diseases	SDH	Sydney Dental Hospital
NGO	Non Government Organisation	SDPP	Sydney Diabetes Prevention Program
NSP	Needle & Syringe Program(s)	SHIP	Sexual Health Information Program
NSW Health	NSW Department of Health	SNAP	Sub and Non-Acute Patients Data Collection
OATSIH	Office for Aboriginal & Torres Strait Islander Health	SOG	Senior Officers Group
OHFSS	Oral Health Fee for Service Scheme	SSWAHS	Sydney South West Area Health Service
Oxfam	Oxford Committee for Famine Relief (1942)	SSWOHS	Sydney South West Oral Health Services
PAWG	Priority Area Working Group	STI	Sexually Transmissible Infection
PBS	Pharmaceutical Benefits Scheme	SW	Social Work(er)
PDHPE	Personal Development, Health and Physical Education	SWSAHS	South Western Sydney Area Health Service (former)
PDS	Pensioners Dental Scheme	TACP	Transitional Aged Care Program
PECC	Psychiatric Emergency Care Centre	TAFE	Technical & Further Education
PHU	Public Health Unit	TAG	Transport Access Guide
POA	Principles of Action	TOR	Terms of Reference
RACF	Residential Aged Care Facility	TWT	<i>Two Ways Together</i>
RACGP	Royal Australian College of General Practitioners		
RCMG	Regional Coordination Management Group		
REMS	Research Evidence Management & Surveillance (SSWAHS Unit)		
REG (TWT)	Regional Engagement Group (TWT)		
REPIDU	Resource & Education Program for Injecting Drug Users		
RPAH	Royal Prince Alfred Hospital		
SAAP	Supported Accommodation Assistance Program		
SAOG	Senior Aboriginal Officers Group		

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