



Aboriginal Health - Everybody's Business

Diabetes

**A South Australian Strategy for
Aboriginal & Torres Strait Islander People
2005 - 2010**

South Australian Aboriginal Health Partnership

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Aboriginal Health – Everybody’s Business
Regional Resource Package
South Australian Aboriginal Health Partnership

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Department
of Health



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Department of Health and Ageing



Cover design by Terry Stewart

The meaning of the design;

Circles are symbolic of gatherings and pathways symbolise a way of getting there. There are many paths to take in relation to tackling health and wellbeing issues within Aboriginal and Torres Strait Islander communities. The challenge for the South Australian Aboriginal Health Partnership (SAAHP) agencies is to work together on areas of common ground.

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Recognition

'Many Aboriginal and Torres Strait Islander communities and individuals already create and sustain nurturing, healthy and successful families, positive community culture and safe community environments.'

The Executive Committee of South Australian Aboriginal Health Partnership (SAAHP) acknowledges and recognises the existing work within Aboriginal and Torres Strait Islander communities towards their improved social, cultural, economic and health status within the current Australian context.

While the focus of state and national strategy documents such as this is centred on the chronic health issues affecting individuals and communities, much of the achievements of Aboriginal and Torres Strait Islander communities, families, individuals and agencies are largely invisible to the broader Australian community and commonly unacknowledged.

The strength and resilience of a people continuing to maintain and increase their place within an historically hostile, denigrating and imposed culture, is given little public value or recognition and is easily obscured by the pervasive pictures of substance misuse, social and emotional wellbeing, third world health status and generational poverty.

The impact of these social, economic and health issues affect the physical, spiritual, cultural and emotional advancement and growth of all Aboriginal and Torres Strait Islander people.

The SAAHP also acknowledge the value adding of existing efforts and collaborative recognising the essential role of community, family and individual participation in this process.

The SAAHP Executive presents this strategic direction for diabetes in the spirit of collaborative responsibility, to add value to existing efforts and collaborative partnerships towards sustainable change for all Aboriginal and Torres Strait Islander people.

Note:

1. For the remainder of this document reference to Aboriginal and Torres Strait Islander people collectively infers ***communities, families and individuals*** and recognises Aboriginal and Torres Strait Islander ***people*** as two separate groups.

Acknowledgements

The preparation of this State Diabetes Strategy could not have been achieved to this level of quality without significant collaboration and sustained energy, ideas, support, input and guidance from a range of key people.

It is with pride that we acknowledge the involvement of the following key groups and individuals in bringing this project to fruition.

- Aboriginal Health Council of South Australia Inc.
- Aboriginal Torres Strait Islander Commission
- South Australian Department of Health
 - Aboriginal Health Division
 - Population Health Branch
 - Diabetes Strategic Management Group (DSMG)
 - Diabetes Outreach
 - Diabetes Health Promotion Programs – Health Promotion SA
 - Adelaide Central Community Health Services
- Commonwealth Department of Health and Ageing
- Office of Aboriginal Torres Strait Islander Health
- South Australian Aboriginal Health Partnership Secretariat

Background

As far back as 1994 in a survey conducted by ATSIC, Aboriginal communities identified diabetes as a health priority.

South Australia's first set of regional Aboriginal Health Plans "The First Step" (1997) identified diabetes as a priority issue in this state. It was nominated as a South Australian Aboriginal Health Partnership (SAAHP) priority because it was one of five major health issues identified in every Aboriginal community in SA. Others identified were:

- Substance Misuse
- Social and Emotional Wellbeing
- Health Data and Information
- Health Workforce development

SAAHP is comprised of four key agencies involved in efforts to improve health provision to Aboriginal and Torres Strait Islander people and communities throughout South Australia. The Partnership members are the Aboriginal Health Council of South Australia (AHCSA Inc), the Aboriginal and Torres Strait Islander Commission (ATSIC), the State Department of Health (DH) and the Commonwealth Department of Health and Ageing (DoHA).

In 1999, the SAAHP mapped the diabetes service provision gaps across South Australia, making use of existing National and State Diabetes' Strategy's to develop an Aboriginal Statewide Strategy (resulting in "Living with Diabetes an Aboriginal Experience" 2000).

SAAHP Project officers through consultation with workers and communities identified that there was inadequate funding and disjointed approaches around service and workforce development for effective diabetes management, early intervention and prevention.

This comprehensive consultation process built a strong base of credibility and ownership with Aboriginal Health Workers (AHW), (because it focussed on building their capacity in order to address issues from the bottom up). The successful consultation process resulted in the funding and establishment of the Aboriginal Diabetes Educator Regional Network. This network included mainstream workers and thus created a momentum that changed the way mainstream services were working with Aboriginal communities.

There were a number of significant project achievements:

- 25 AHW's embarked on and completed the Flinders University Diabetes Educators Training course;
- Regional networks between AHW's and mainstream allied health staff were promoted and initiated;
- Regional links established with Diabetes Outreach, hospitals and health workers;
- Establishment of a project officer position with a special focus on diabetes, in the Diabetes Health Promotion Program located in Health Promotion SA.

During 2001 and 2003, a joint proposal that linked the SAAHP efforts and Health Promotion SA to develop a Diabetes Health Promotion Plan with a special focus on Aboriginal and Torres Strait Islander communities and people was developed.

The most evident gap identified in the “Living with Diabetes” and the strategic plan for diabetes in SA 03-06 was the existence of a comprehensive and decisive Aboriginal diabetes strategic plan to guide and support state, regions and organisations to provide effective and sustainable diabetes initiatives and programs.

Furthermore, it became clear that the long-term sustainability and success of the strategy would be located in its level of accountability, the strength of local community support and the quality of coordination processes across the State’s regional health services boundaries.

This document is the result of collaborative efforts between all four SAAHP organisations, Aboriginal and Torres Strait Islander people, communities and other stakeholders who operate within the sector.

Diabetes – Everybody's Story

Communities, Families and Individuals

The historical and contemporary context within which most Aboriginal and Torres Strait Islander peoples in South Australia has made it difficult for them to live healthy and achieve sustainable wellbeing. It has created widespread social disadvantage and poor physical, social, spiritual and emotional health.

Social disadvantage and poor health simultaneously contribute to, and are a result of, significant diabetes within Aboriginal and Torres Strait Islander communities.

Poorly managed diabetes has an impact on every area of life and limits an individual's participation in employment, educational achievement, and family and community activities.

Community focus on delay and prevention, management and education is central in providing community awareness of effective diabetes care and self-management.

Ineffective diabetes management for Aboriginal and Torres Strait Islander people (for some Aboriginal people the added problems associated with poor nutrition, alcohol misuse and tobacco) have a strong correlation with the main causes of premature death and a comparatively high rate of hospitalisations.

In many Aboriginal and Torres Strait Islander communities more than half of the communities "over 35's" have either diabetes or impaired glucose tolerance. Thus they have a greater risk of heart attacks, high blood pressure and high insulin levels consistent with insulin resistance (O'Dea, 1999).

Diabetes – Everybody's Story

The Facts

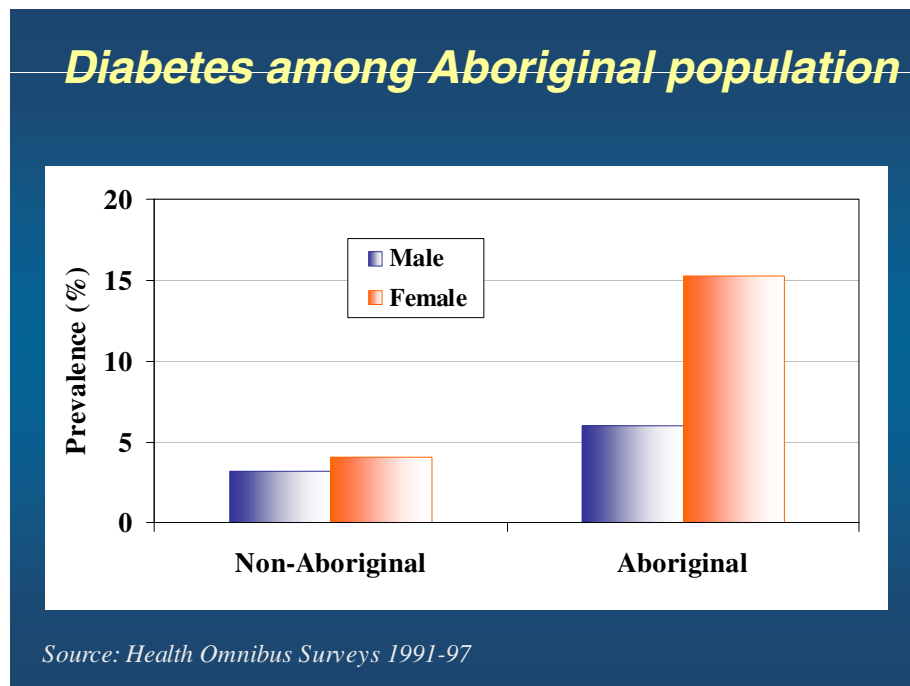
Diabetes is Australia's fifth National Health Priority and within Australia a disproportionate burden of diabetes is borne by Aboriginal and Torres Strait Islander peoples.

Tragically the incidence of all forms of diabetes in some Aboriginal and Torres Strait Islander communities is 9.6%, compared to 3.7% for the rest of the population.

Type 2 diabetes is a lifestyle disease and is strongly associated with high blood pressure, high cholesterol and the classic 'apple shape' body where there is extra weight around the waist. It is by far the most common form, affecting 85-90% of all people with diabetes. While it usually affects mature adults, more and more younger people, even children, are getting Type 2 diabetes.

The complications of diabetes include heart attacks, strokes, kidney damage, skin ulcers, blindness, limb amputations and erectile dysfunction.

Diabetes occurs at a much younger age in Aboriginal and Torres Strait Islander people (peak prevalence occurring around 35 years of age, compared to 60 years of age in non-Aboriginal peoples).



- Overall prevalence of diabetes was 3.7% in non-Aboriginal population, 9.6% in Aboriginal population.
- Prevalence of diabetes is significantly higher among Aboriginal population, particularly females.

Diabetes – Everybody’s Business

Purpose

The purpose of this section is to guide the strategic direction for key stakeholders towards the development of state, regional and organisational implementation plans to address diabetes within Aboriginal and Torres Strait Islander communities.

This State Diabetes strategy should be read in conjunction with SAAHP’s Substance Misuse, Social and Emotional Wellbeing, Data and Information, Workforce Development State strategy documents towards a greater understanding of other health issues and their link with diabetes.

Commitment

The SAAHP believe that the extensive work currently occurring throughout South Australia requires a more supportive and coordinated response from State and Commonwealth stakeholders to ensure consistency and sustainability of approaches as well as ensuring ‘real’ change in the health status of Aboriginal and Torres Strait Islander peoples and communities.

The SAAHP through its partnerships will actively lobby for service agreements that enhance the achievement of strategic outcomes and the provision of effective responses to planning, medical and clinical service, research and data collection, Aboriginal and mainstream workforce management for diabetes to Aboriginal and Torres Strait Islander communities, families and peoples across South Australia.

Guiding Principles

These principles are evident within this strategy and are consistent with the

- National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003);
- National Strategic Framework for Aboriginal and Torres Strait Islander Mental Health and Social and Emotional Wellbeing 2004 – 2009;
- National Drug Strategy: Aboriginal and Torres Strait Islander People Complementary Action Plan (2003 – 2006);
- Living with Diabetes, The South Australian Aboriginal Experience, A State Strategy and Action Plan for Aboriginal Diabetes July 2000; and
- Iga Warta Principles, arising from the Department of Health 2000, Renal Summit.

Cultural Respect

- Respecting cultural diversity, views, values and expectations of Aboriginal and Torres Strait Islander people within planning and development of health and wellbeing programs and services

Community Control

- Acknowledging Aboriginal and Torres Strait Islander communities' right to control the health and wellbeing approaches and services in their local community and/or region

Holistic Approach

- Attending to the physical, spiritual, mental, cultural, emotional and social wellbeing and their role in contributing to health outcomes for Aboriginal and Torres Strait Islander peoples
- Including the environmental determinants of health such as food, water, housing and unemployment
- Including the social determinants of health and wellbeing, such as racism, marginalisation, history of - dispossession and loss of land and heritage

Local Planning

- Aboriginal and Torres Strait Islander people's central involvement in planning, development and implementation of strategies for better health and wellbeing
- Planning takes place at the local level to develop local responses to local needs and priorities as determined by the local Aboriginal and Torres Strait Islander population/community

Partnerships

- Combining the efforts of government, non-government and community controlled sectors, and working in partnership with communities to provide the best method in improving the broader determinants of health

Recognition of Diversity

- Recognising the diversity within and between Aboriginal communities in the development of programs and services
- Supporting the provision of differing approaches according to region, age and gender

Resources

- Ensuring that resources are sufficient to improve the health and wellbeing of Aboriginal and Torres Strait Islander people
- Sustainable resource building for communities through strengthening community expertise and capacity building of health services and communities

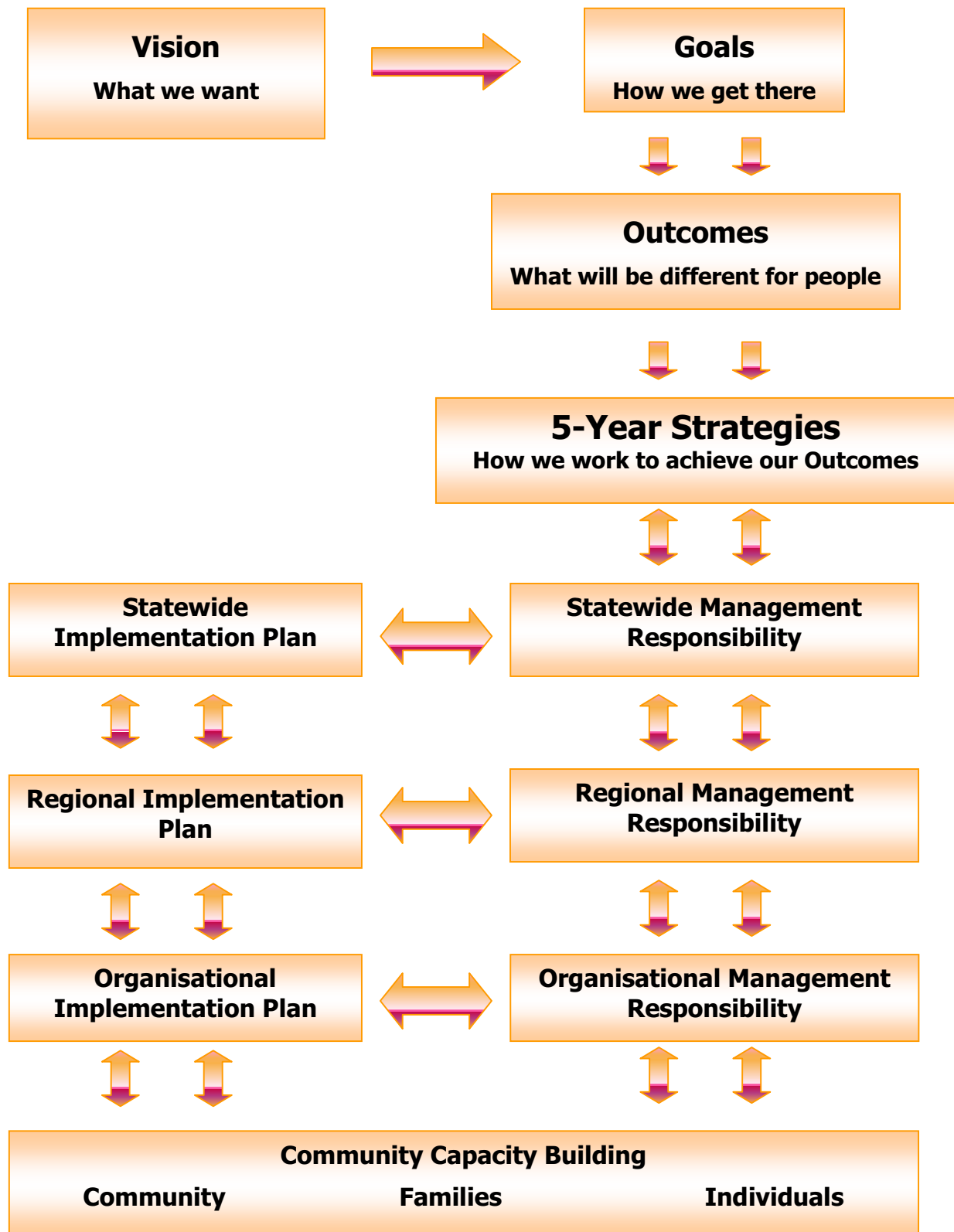
Capacity Building

- Providing information, skills development and/or knowledge acquisition to assist and support individual change
- Building the capacity of a community, families or individuals to manage change and/or maintain resilience

Accountability

- Supporting the effective use of funds by community controlled and mainstream health services and programs
- Ensuring accountability for effective resource application through long-term funding
- Establishing genuine and meaningful planning and services development partnerships with communities
- Government maintaining responsibilities for ensuring all Aboriginal and Torres Strait Islanders have access to appropriate and effective health care

Strategic Planning – Model



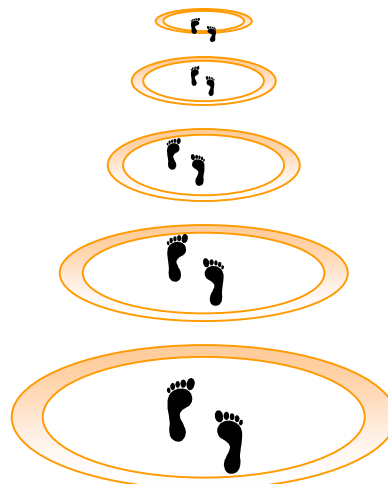
Refer Appendix 1

Strategic Direction - Vision



South Australian Aboriginal and Torres Strait Islander people live healthy lives equal to that of the general population, within well functioning communities that have effective health care and community services that are enriched by a strong living culture, dignity and justice

(Adapted from the National Strategic Framework for Aboriginal and Torres Strait Islander Health 2004 – 2009)

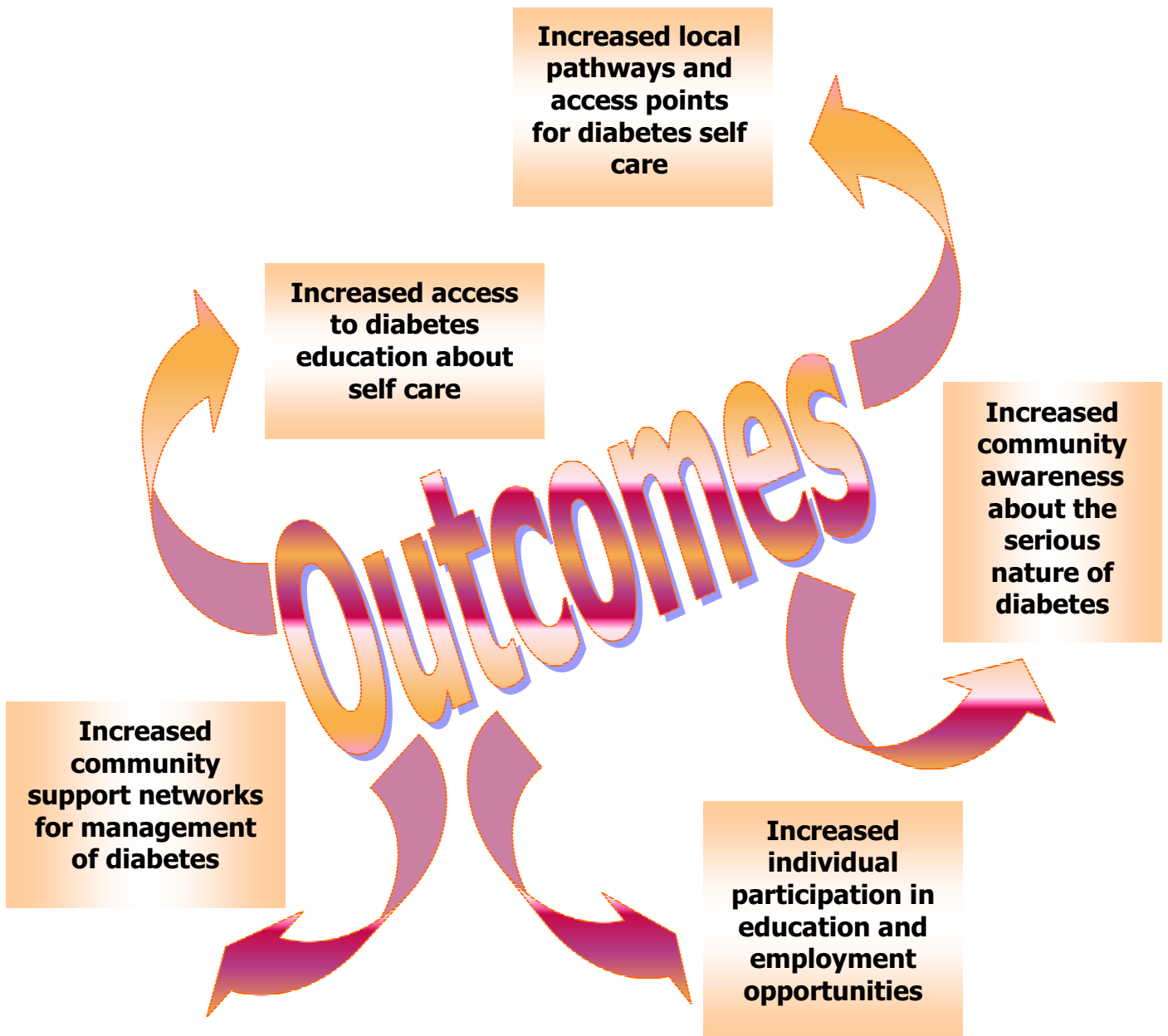


GOAL

To reduce the impact of diabetes on Aboriginal and Torres Strait Islander people throughout South Australia

Strategic Direction - Outcomes

These outcomes are intended to be measurable within the 5-year time frame of this plan.



Strategic Direction - Strategies

These describe the broader 'big picture' of work to be undertaken across the state during the next 5 years to realise the outcomes.

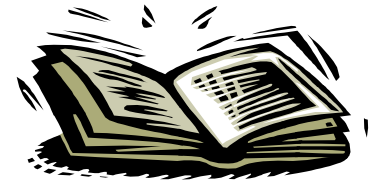
Strategies



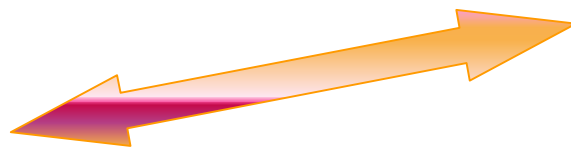
Strategic Planning – Coordinated Approach

- The SAAHP Executive has responsibility to ensure that the actions within this framework are implemented, resourced and monitored
- The Partnership members will undertake actions that facilitate an increased collaborative and coordinated statewide approach in addressing diabetes and its associated problems

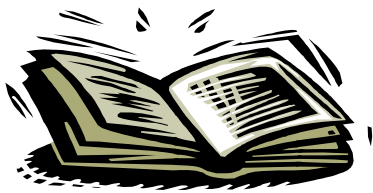
Statewide



Action

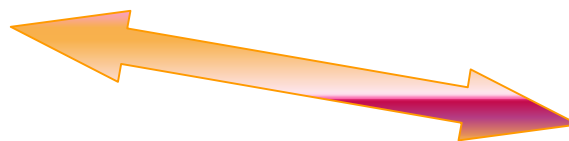


Regional



Action

- Each state health region is supported to develop regional implementation plans consistent with the statewide strategic direction
- Regional plans will facilitate the provision of services, programs, projects and resources consistent with the needs of the region
- Regional planning will support collaborative and coordinated regional partnerships inclusive of open and accountable reporting processes



- Organisations, Services and Agencies will utilise the regional plans to further describe the detailed actions needed to address diabetes issues relevant to local needs and priorities
- Once developed, action plans will illustrate the local picture of diabetes issues, priorities and initiatives

Organisational



Action

Statewide Management Responsibilities

Effective and collaborative coordination, monitoring and review are crucial to the achievement of the strategic outcomes and sustained change. Without this, change will continue to be slow, exhaustive and of greater cost both socially and economically.

Statewide

Develop organisational service agreements which support the achievement of strategic diabetes outcomes

Ensure collaborative regional planning and development process

Facilitate collaborative regional monitoring, review and reporting processes

Support inter-regional information exchange opportunities

Develop regionally coordinated knowledge management processes

Coordinate strategic partnerships between, and collaborative participation of, relevant community controlled, public and private sector agencies, services and organisations

Action

Regional Management Responsibilities

Regional collaboration with state and organisation partners enhances ongoing effectiveness and supports current and future regional planning. The approach also strengthens regional health intelligence and workforce capacity and supports effective and equitable service responses to meet the needs of communities, families and individuals.

Regional

Attend to annual reporting requirements consistent with regional-state partnership agreement

Implement regionally coordinated knowledge management processes

Develop collaborative regional diabetes implementation plans

Advocate and lobby public, private and community sources to strengthen regional resources

Action

Organisational Management Responsibilities

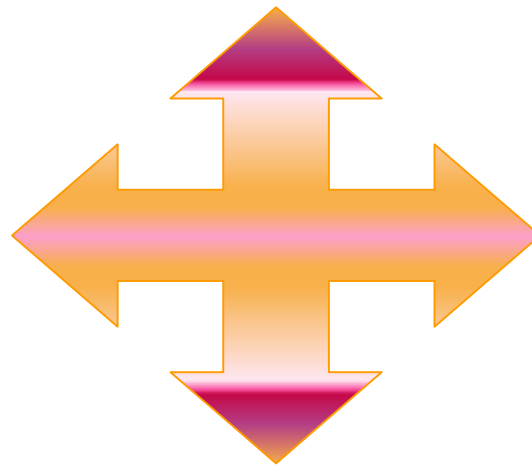
The effectiveness of service provision is determined by the existence of connected, credible and accountable organisations, with efficient organisational management and a workforce equipped to respond and resolve health related issues.

organisational

Implement monitoring and review protocols and practices consistent with regional plans

Develop, and implement effective organisational capacity building initiatives

Provide coordinated ongoing workforce development programs



Establish and maintain existing community, public and private sector linkages and collaborative partnerships

Action

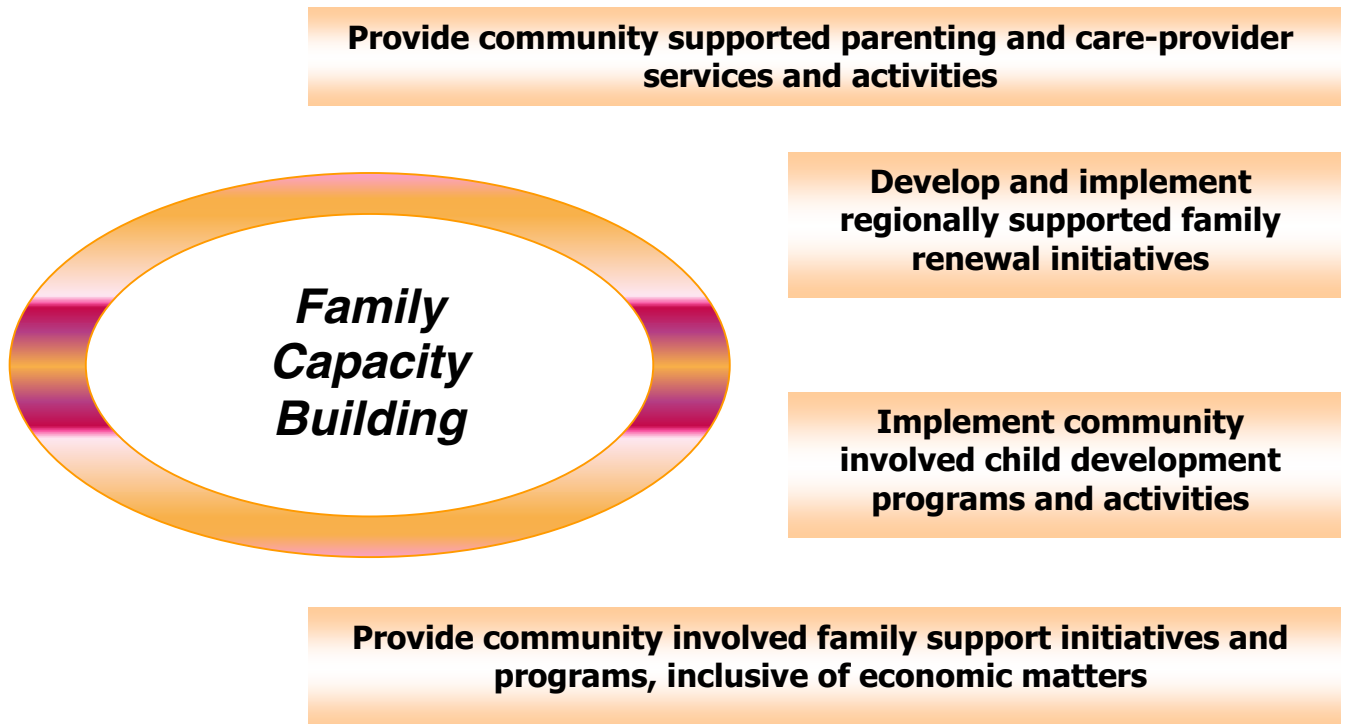
Statewide Service Provision - Communities

Sustainable change for communities hinges on building their capacity to accommodate and manage change. Planning should be broad and adopt a whole of government and community sector approach to build their capacity to support families and individuals.



Statewide Service Provision - Families

Sustainable change for families hinges on building their capacity to access culturally specific and relevant community and public primary and clinical health care services that are accessible and used by families and individuals.



Statewide Service Provision - Individuals

Sustainable change for individuals hinges on building their capacity to accommodate and manage change. Building capacity of individuals requires a diverse approach that is not only health focussed. Addressing social, economic and environmental determinants are additional factors that will assist the achievement of meaningful wellbeing for individuals, family and community.

Provide information, education and skill development sessions, programs and activities

Ensure the provision of community supported diabetes education to Primary and secondary students

Implement community supported school retention programs and activities

Ensure young people are supported with accessible primary health care services

Develop community supported diversion activities for young people

Provide substance free spaces and activities for young people

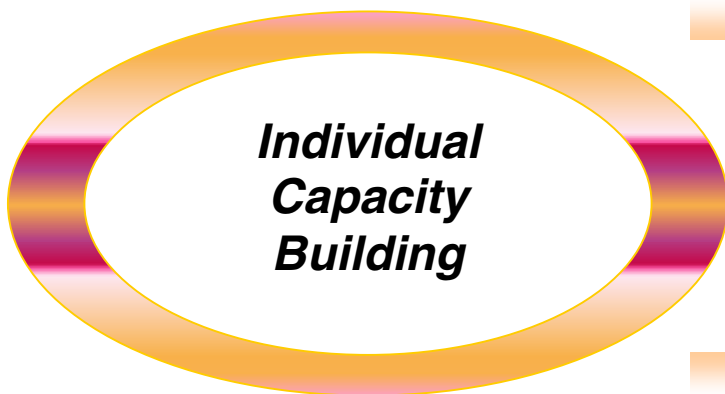
Implement community supported early intervention programs and projects

Provide opportunities for young people to participate in addressing substance misuse issues

Establish effective and appropriate support networks and services

Establish community involved diabetes delay and or prevention programs and projects

Provide community credible, coordinated care and specialist treatment services



The Next Steps

STATEWIDE LEVEL

- If you have state wide responsibilities, the section on statewide management responsibilities is your starting point. Further assistance can be obtained from the following:- Department of Health/Aboriginal Health Division (DH/AHD), the Department of Health and Ageing (DoHA), Office of Aboriginal & Torres Strait Islander Health (OATSIH), the Aboriginal Health Council of SA (AHCSA) and/or the South Australian Aboriginal Health Partnership (SAAHP) Secretariat

REGIONAL LEVEL

- If you have regional responsibilities, the section on regional management responsibilities is your starting point. Further assistance can be obtained from the following:- DoHA/OATSIH, DH/AHD and or AHCSA when developing an Aboriginal and Torres Strait Islander Health plan that supports the priorities of all health service providers in your region

ORGANISATIONAL LEVEL

- If you have organisational responsibilities, the section on organisational management responsibilities is your starting point. If you are in a mainstream organisation that is developing or updating its Aboriginal and Torres Strait Islander health plan contact the AHCSA and DH/AHD about how planning can be supported and linked to the Aboriginal Community Controlled Health Service (ACCHS) sector strategic plan

INDIVIDUAL LEVEL

- If you are interested as an individual, contact your local Aboriginal Community Controlled Health Service and mainstream health organisation about their Aboriginal and Torres Strait Islander health plans and opportunities to become informed about and/or involved in health service activity

Abbreviations

ACCHS	Aboriginal Community Controlled Health Service
AHAC	Aboriginal Health Advisory Committee
AHCSA	Aboriginal Health Council of South Australia Inc
ATSIC	Aboriginal and Torres Strait Islander Commission
ATSIS	Aboriginal and Torres Strait Islander Services
DH	South Australian Department of Health
DSMG	Diabetes Strategic Management Group
DoHA	Department of Health and Aging
OATSIH	Office of Aboriginal and Torres Strait Islander Health
SAAHP	South Australian Aboriginal Health Partnership

Glossary

Aboriginal Community Controlled Health Service (ACCHS)	<ul style="list-style-type: none">▪ ACCHS are primary health care services initiated by local Aboriginal and Torres Strait Islander communities to deliver holistic and culturally appropriate care to people within their communities. Their board members are elected from the local Aboriginal community (NATSIHC 2002)
Connectedness	<ul style="list-style-type: none">▪ A relationship that links and bonds one with community, family and friends
Partnership Approach	<ul style="list-style-type: none">▪ In the context of national public policy, a partnership approach for the management of Diabetes is defined as a close working relationship among Commonwealth, State and Territory, and local governments; affected communities; business and industry; community-based organisations; professional workers; and research institutions
Prevention	<ul style="list-style-type: none">▪ Broadly defined as an intervention strategy to improve the knowledge in the general community of the serious nature of diabetes and the severity of the risks associated with undiagnosed diabetes, complications associated with diabetes, risk factors for and symptoms of type 2 diabetes
Social and Emotional Wellbeing	<ul style="list-style-type: none">▪ Broadly, a comprehensive term used for the physical, psychological, and cultural welfare and happiness of an individual within his or her community
Knowledge Management Process	<ul style="list-style-type: none">▪ A systematic approach to manage the use of information in order to provide a continuous flow of knowledge to the right people at the right time enabling efficient and effective decision making in their everyday business

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- Stepping Onwards 1997-2002 (South Australian Aboriginal Health Partnership)
- Keeping Them Safe (Department for Families and Communities, May 2004)
- National Diabetes Services Scheme (Diabetes Australia)
- Aboriginal Services Plan (Department of Human Services, January 2004)

Appendix 1 - Defining Terms

The following provides the thinking behind the development of the strategic goals, strategies, outcomes and actions within this current framework.

The defining of these terms is by no means definitive and is intended only to illustrate how the planning of this document arose.

