

Cooperative Research Centre for
Aboriginal Health

**SOCIAL DETERMINANTS of
ABORIGINAL HEALTH
RESEARCH PROGRAM**

Report from the Industry Roundtable

Tuesday 6th June 2006

Karna Country

**Lakes Resort Hotel,
141 Brebner Drive, West Lakes
Adelaide**

Contents

ROUNDTABLE	1
BACKGROUND	1
WELCOME.....	1
AGENDA.....	2
CRCAH OVERVIEW	3
AN INTERNATIONAL PERSPECTIVE ON SOCIAL DETERMINANTS OF HEALTH	5
THE RIGHT TO HEALTH CAMPAIGN.....	9
RUMBALARA ABORIGINAL COOPERATIVE HOME OWNERSHIP PROGRAM	11
PARENTING AND CHILD HEALTH IN SA.....	13
OFFICE OF INDIGENOUS POLICY COORDINATION	14
DANILA DILBA HEALTH SERVICE	14
NEWMONT AUSTRALIA	15
AFTERNOON DISCUSSIONS.....	15
CONCLUSIONS / ISSUES TO FOLLOW-UP.....	17
RECOMMENDATIONS:.....	18
STUDENTS COMMENTS/FEEDBACK	18
THE SOCIAL DETERMINANTS OF HEALTH PROGRAM STATEMENT	20
GOAL OF THE SOCIAL DETERMINANTS OF HEALTH PROGRAM:.....	20
1. BACKGROUND	20
2. PROGRAM DEVELOPMENT	21
3. CRCAH SOCIAL DETERMINANTS OF HEALTH PROGRAM SCOPE.....	21
4. OUTCOMES	23
5. WHAT WE DON'T KNOW – KNOWLEDGE AND IMPLEMENTATION GAPS.....	24
6. INDICATIVE RESEARCH QUESTIONS	24
7. DEVELOPMENT AND IMPLEMENTATION OF THE PROGRAM.....	24
8. LINKAGES WITH OTHER PROGRAMS	25
CURRENT SOCIAL DETERMINANTS OF HEALTH PROJECT LIST.....	25
STEPS IN THE FACILITATED DEVELOPMENT PROCESS	26
CONTACT DETAILS FOR THE PROGRAM MANGER AND LEADERS	27
FURTHER INFORMATION.....	28

Roundtable

BACKGROUND

The Industry Roundtable for the Social Determinants Program was held in Adelaide on the 6 June 2006 at the Lakes Resort Hotel at West Lakes in Adelaide.

The Roundtable gave an opportunity for a wide range of State and Federal government departments as well as Community Controlled organisations and research partners to meet and discuss collaborative research and evaluation outcomes for the program.

As part of the capacity development priorities of the Social Determinants Program, a number of students from various partner Universities also took part in the Roundtable.

The aim of the Roundtable was to identify potential partnerships and evaluations which the Cooperative Research Centre for Aboriginal Health (CRAH) might support to help build the evidence-based interventions that improve health through action in the area of social determinants.

WELCOME

The Roundtable was opened with a Welcome by Kaurna Elder Uncle Lewis O'Brien.

The CRAH welcomed participants to the roundtable discussion on the development of its Social Determinants of Health Research Program.

The aim of the roundtable meeting was to examine current CRAH activities within the Social Determinants of Health Program and then produce a list of further research questions and/or other activities that are priorities for the Community Controlled Health Sector and other organisations servicing Aboriginal and Torres Strait Islander peoples. Other activities within the Program include education and training at various levels, capacity exchange, and research transfer & brokerage activities. The generated list of activities will go to the CRAH Board who will then direct the further development of the Social Determinants of Health Program.

An overview of the day and the Agenda were introduced by Jenny Brands, Research and Development Manager, CRAH.

Agenda

Time:	Tuesday 6 June	notes
8:30 – 9:00am	Tea & Coffee available in function room foyer	Tea/coffee
9:00 – 9:15am	Welcome & Introductions Agenda & Purpose of Meeting	15 mins: Welcome from local Elder, Roundtable introductions (Jenny or Mick)
9:15 – 9:30am	Introduction to CRC for Aboriginal Health & facilitated program development approach.	30 mins: Mick or Jenny & Program Leaders?
10:00 – 10:15am	Morning Tea	15 mins
10:15 – 11:30am	Introduction to Social Determinants of Health Program & current research activities	1hr 30 mins
11:30 – 12:00pm	Facilitated discussion to identify knowledge & practice gaps in current activities	30 mins
12:30 – 1:00pm	LUNCH	1 hour
1:00 - 1:15pm	Facilitated discussion continued	15 mins (break into groups)
1:15 – 1:30pm	Afternoon Tea	15 mins
1:30 - 2:00pm	Facilitated discussion continued	30 mins (then as one big group)
2:00 - 4:00pm	Wrap up, Next steps, Close	1 hour

CRAH OVERVIEW

The Cooperative Research Centre for Aboriginal Health

Jenny Brands, Research and Development Manager, CRAH websites:

www.craha.org.au & www.craha.org.au/index.cfm?attributes.fuseaction=links

Jenny gave an overview of the CRAH and the facilitated approach to research development. The CRAH web site gives further information and has links to all the Core Partners.

- *Formerly the Cooperative Research Centre for Tropical and Aboriginal Health*
- *In year 3 of a 7 year funding cycle from the Department of Education, Science & Training (DEST) under the CRC Program*
- *12 Core Partners*
- *7 Associate or Supporting Partners*

The **CRC Program Objectives** are to:

- *Enhance the contribution of long-term scientific and technological research and innovation to Australia's sustainable economic and social development*
- *Enhance the transfer of research outputs into commercial or other outcomes of economic, environmental or social benefit to Australia*
- *Enhance the value to Australia of graduate researchers; and*
- *Enhance the collaboration among researchers, between researchers and industry or other users, and to improve efficiency in the use of intellectual and other research resources*

(At present there are about 72 CRCs funded across Australia)

CRAH PARTICIPANTS

The CRAH is made up of Participants (Core Partners) which are organisations representing either the Health Industry (Industry) or Research Institutions or Universities (Researchers):

INDUSTRY

- *Central Australian Aboriginal Congress (Congress)*
- *Danila Dilba Butji Binnilutlum Medical Service (Danila Dilba)*
- *Commonwealth Department of Health & Aging (DoHA)*
- *Northern Territory Department of Health & Community Services (DoHCS)*

RESEARCHERS

- *Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)*
- *Flinders University (FU)*
- *La Trobe University (La Trobe)*
- *Menzies School of Health Research (MSHR)*
- *Melbourne University (MU)*
- *Charles Darwin University (CDU)*
- *University of Queensland (UM)*
- *Queensland Institute of Medical Research (QIMR)*

CRAH GOVERNANCE

The CRAH is governed by a Board, the majority of which are Aboriginal.

It consists of at least 12 Members who are either Independent or representatives of Industry or Researchers

The Independent Members can only be Aboriginal and includes the Chair and at least 2 other Members

Our Vision

Sustained improvement in Aboriginal Health through strategic research and development

Our Objectives

To ensure highest quality research is carried out with greatest impact on Aboriginal health outcomes through improved partnerships, greater Aboriginal participation and control and better ethical practices.

We do this by

- *Carrying out research that Aboriginal People and Health Services need*
- *Making research meaningful to our people by transferring into practical change*
- *Ensuring specific plans are made and acted upon to promote the transfer of findings into policy and practice including:*
 - *the application of research findings,*
 - *address barriers to uptake,*
 - *advocate change which will enable the use of research findings in policy and service provision*

The Programmatic Approach

The key CRCAH principles include:

- *potential users of research are involved in its planning, conduct and dissemination, both within individual projects and the programs as a whole;*
- *projects/programs are targeted towards specific outcomes and planned to achieve these outcomes;*
- *research is of high quality and credibility;*
- *specific plans are made and acted upon to promote the transfer of findings into policy and practice.*
- *capacity development for those involved in our research*
- *cooperation between different parties, organisations and between different disciplines;*
- *solves identified problems or to show how to break down a structural barrier to health for Aboriginal people.*

The Programs

- *Healthy Skin;*
- *Chronic Conditions;*
- *Primary Health Care, Systems and Workforce;*
- *Social Determinants and the Physical Environment; and*
- *Aboriginal Social and Emotional Wellbeing.*

The CRCAH Budget

- *Is used to articulate the CRCAH priorities;*
- *Provides certainty to develop project proposals;*
- *Is considered a 'work in progress' and is revised at regular intervals; and*
- *Forms the basis for reporting and therefore is a vital element in the accountability process.*

Facilitated Research Development

- *Not a typical 'Expression of Interest' process*
- *Has the Board deciding its priorities as the first step in the process*
- *Facilitates the development of a research proposal around the identified priorities*

- *Aboriginal involvement in each step is non-negotiable*

The Process

- *Development of research concepts*
- *Consultation with the Aboriginal health sector*
- *Board deciding priorities*
- *Program Leaders and Managers identify Project Leaders then jointly develop the research proposal*
- *Quality Assurance*
- *Project approval*

AN INTERNATIONAL PERSPECTIVE ON SOCIAL DETERMINANTS OF HEALTH **Professor Fran Braum, Flinders University & Program Leader, CRCAH.**

An introduction to the Social Determinants of Health Program from both an International and CRCAH perspectives, including current activity in the CRCAH Program, was presented by Fran Baum, Program Leader and supported by Michael Bentley, Program Leader.

Why Emphasise Social Determinants?

- *Social determinants of health have a direct impact on health*
- *Social determinants structure other causes of health:*
 - *Environment*
 - *Behaviour reflect structures*
 - *Access to Services*
 - *The 'causes of the causes'*

Rationale for Social Determinants of Health

- *Modern public history since 19th century has stressed importance of social determinants of health and health inequities have been noticed by public health activists for centuries*
- *McKeown, Szreter, Alma Ata, Ottawa Charter all emphasise that health is about what happens in everyday life and that health service intervention is minor determinant of population health*
- *This message isn't really enshrined in policy and action and should be – CRCAH needs to show policy leadership to put issue on Australian agenda*
- *Basic logic: what good does it do to treat people's illnesses...then give them no choice but to go back to the conditions that made them sick?*
- *Nothing new – Engels on 19th century England, observed that liquor was 'almost their only source of pleasure for workers in large industrial towns' and that: 'The working man comes home from his work tired, exhausted, finds his home comfortless, damp, dirty, repulsive; he has urgent need of recreation, he must have something to make work worth his trouble, to make the prospect of the next day endurable'.*

Current thinking on creation of health

- *Increasingly key thinkers in public health emphasise that health is about what happens in everyday life and in the environments in which we live and that health service intervention is a minor determinant of population health and that behaviour change strategies in isolation are generally not effectivean example...*

TB: Mean annual death rate

What contributed to falling TB rates in UK:

- *Improved sanitation and clean water which meant other infectious diseases declined so people healthier and less susceptible to TB*
- *Housing improvement – less overcrowding*
- *Less poverty so better nutrition*
- *Not sudden change in behaviour from individual*

Why are poorer populations:

- *Two times more likely to have TB?*
- *Three times less likely to access care for TB?*
- *Four times less likely to complete TB treatment?*

- Five (?) times more likely to incur impoverishing payments for TB care?
- Poverty and TB: A Vicious Cycle

World Health Organisation (WHO) Commission on Social Determinants of Health (CSDH) in a nutshell

- Put SDOH on international health agenda and encourage action on them
- Improve health globally
- Reduce health inequities within and between countries
- www.who.int/social_determinants/en/

WHO CSDH Goals

- To support policy change in countries by promoting models and practices that effectively address the social determinants of health.
- To support countries in placing health as a shared goal to which many government departments and sectors of society contribute.
- To help build a sustainable global movement for action on health equity and social determinants, linking governments, international organizations, research institutions, civil society and communities.

Commissioners

- Sir Michael Marmot (Chair)
- 19 others representing academics, politicians, civil society, senior public health bureaucrats

Commission main strategies

- Knowledge networks
- Country examples
- Genuine engagement with civil society
- Engagement with international agencies, governments,
- Changing focus/work of WHO

COUNTRY EXAMPLES

- Working with countries on social determinants of health
- Country examples are bases for scaling up and policy leadership
- Change social & economic policy to improve health

Country Engagement: Iran 2006

CSDH Field Visits, India 2005

Country Example: Brazil

- March 2006 Brazil launched its own CSDH to address health inequities and develop innovative ways to improve the health of populations
- Income of richest 20% of the population is 26 times larger than that of the poorest 20%
- CSDH will meet in Brazil in September, 2006

Engagement with civil society

- Taken serious
- Civil society organisations contracted to do regional consultations
- CS presence at each meeting
- Important reminder to Commissioners of importance of people's voices

Global Initiative

- Advancing the CSDH agenda by engaging global institutions

CSDH & Global Institutions

- Identify key meetings where global/ regional institutions are present to include CSDH messages e.g. UN Economic and Social Council in April 2006, ILO, UNAIDS, World Bank
- Commissioner engagement with global and regional institutions and processes

Reinforcing WHO's position on SDH

- More in touch with people's reality in their everyday life
- Stronger support for social aspects of health & health equity
- Responsive to civil society

- *Revitalisation of Comprehensive CPHC*

WHO ACTION

The Commission will work with WHO to institutionalize social determinants capacities and approaches within WHO global and regional policies and programmes. This will be accomplished by integrating WHO country, regional and global personnel in all activities of the Commission.

Dr. J. W. Lee – World Health Assembly, May 2004

Announced the formation of the Commission and said “The goal is not an academic exercise, but to marshal scientific evidence as a lever for policy change — aiming toward practical uptake among policymakers and stakeholders in countries”.

Are SDH the same for Australian Aboriginal people?

- *Role of racism*
- *Role of culture*
- *Nuanced difference e.g. need for housing basic but type of housing specific – need for education common but need for cultural education crucial*
- *Other differences – extent of inequity about not just health status but factors underlying this – differences in access to the determinants of health*

Example

- *Study of location, social capital & health in Adelaide*
- *Four post code areas in contrasting suburbs of Adelaide – two higher, two lower SES areas*

Health Status of sample

- *Indigenous*
 - *68% report very good or good health*
 - *Non-Indigenous*
 - *81.7% report very good or good health status*
- Differences in Survey in 4 Areas of Adelaide*

Action from CRCAH to date

- *Existing research (funded and in-kind eg. on electricity supply, racism and health)*
- *Funded course (PHERP) on Social Determinants of Indigenous Health*
- *Ran for three years in Darwin*
- *Text book forthcoming*
- *Seminar Flinders University June 2004*
- *Peer Reviewed Research Monograph – 2006*
- *Clear message – research needed on what works not more description*

What works – SDH and health impact

- *Rarely done internationally – US best – but often policy changes before evaluation can be complete e.g. UK Health Action Zones*
- *Prospective designed evaluations of action on SDH – CRCAH will need industry partners and large budgets – not cheap studies*
- *Retrospective studies to understand why changes have improved health/created disease (perhaps education and health changes) – study of stolen generation is e.g.*
- *Need to be creative about research*

CSDH Dreaming?

- *“...the very right to be human is every day denied to hundreds of millions of people as a result of poverty The unavailability of food, jobs, water and shelter, education, health care and a healthy environment”*

It is “not a preordained result of the forces of nature or the product of a curse of the deities. But the consequences of decisions which men and women take or refuse to take.”

Nelson Mandela quoted in Heywood and Altman, 2000, p.173

How can CRCAH help influence those decisions so they promote health???

QUESTION TIME

A general question and discussion followed.

Who's doing what in the social determinants of Aboriginal health?
Workshop participants shared their stories.

THE RIGHT TO HEALTH CAMPAIGN

Bettina King, Senior Policy Officer, Aboriginal and Torres Strait Islander Social Justice Unit, Human Rights and Equal Opportunity Commission.

HREOC website: www.humanrights.gov.au/social_justice/index.html

Partnerships:

- NACCHO
- Australian Doctor (Indigenous) Assistant
- Australian Medical Association
- Reconciliation Australia
- Oxfam
- Royal Australian College of Physicians
- Australian Divisions
- Heart Foundation

Human Rights and Equal Opportunity Commission (HREOC).

Social Justice Report 2005. Chapter 2: Achieving Aboriginal and Torres Strait Islander health equality within a generation – A human rights based approach

Human Rights and health

- *Article 12 of the International Covenant on Economic, Social and Cultural Rights - sets out the right to health*
- *Article 2(i) of International Covenant on Economic, Social and Cultural Rights - non discrimination; progressive realisation*

Building on existing foundations

- *National Strategic Framework*
- *Whole of Government approach*
- *Overcoming Indigenous Disadvantage Framework – COAG commitments*
- *Community Housing and Infrastructure Program*

Ongoing challenges

- *Lack of equality of opportunity to be healthy*
 - ❖ *Access to primary health care and infrastructure*
 - ❖ *The equality gap between Indigenous and non-Indigenous people is not closing*
 - ❖ *Challenges from youthful demographic profile of Indigenous people*
- *Lack of targets and benchmarks*
 - ❖ *Existence of health performance framework*
 - ❖ *Some gaps in data collection*
- *No targeted plan of action to achieve equality of health status*

Campaign for Aboriginal and Torres Strait Islander health equality within a generation

- *Time limited campaign to achieve Indigenous health equality and life expectation within 25 years*

Within 10 years

- *Equality of opportunity in relation to health is established*
 - ❖ *Primary health care*
 - ❖ *Health infrastructure*
 - ❖ *Indigenous health workforce*

How do we achieve this?

- A focus on specific health issues or population groups. For example
 - ❖ Child health
 - ❖ Birth weight
 - ❖ Diabetes/obesity
 - ❖ Chronic diseases

To achieve it in 25 years:

- Requires an address to social determinants of health such as income, education and functional communities; and
- An address to the position of Indigenous peoples in Australian society

Partnerships

- NACCHO
- Australian Indigenous Doctor's Association
- Australian Medical Association
- Reconciliation Australia
- Oxfam Australia
- Royal Australasian College of Physicians
- Australian Divisions of General Practice
- Heart Foundation

Paul Hunt

Special Rapporteur on Health

- Supports the right to health approach to Indigenous health inequality
- Rights based approach is innovative and empowering to the people it serves
- This approach is not popular in Australia because it is not based on a cost benefit argument

Timeline - KEY DATES - 2006

March	Briefing of NGOs
April	Steering Committee established
May	Paul Hunt, Special Rapporteur on health
June	Professor Sir Michael Marmot
November	National Health Summit
November	Federal budget process commences

The campaign

- Ongoing
- Ground up & top down approach
- Correct misinformation [public information campaigns]
- NGOs support other events
- Involved collaboratively on other issues
 - ❖ Violence in Indigenous communities

RUMBALARA ABORIGINAL COOPERATIVE HOME OWNERSHIP PROGRAM

Justin Mohamed, ASHE Director, gave an overview of the Rumbalara services.

RUMBALARA's website: www.raclimited.com.au/index.asp

Rumbalara is a Community controlled service with 7 elected members.

The organisation site was selected in April 1958, the housing project was officially opened and named 'Rumbalara' (meaning rainbow) creating a 50 year relationship with the people in the region.

Other services include –

- An Aboriginal Health
- Dental
- Emotional and wellness programs
- Pre and post natal services
- Housing for the elders/singles
- Rest respite service
- Children at risk / care of children
- Aged Care – cultural and leadership programs

Funding is from State & Federal governments.

Housing – FACS support

- 7 year home ownership program
- accessible for low income families

Shared Responsibility Agreement between FACSIA and FACS that has led to the Rumbalara Home Ownership Program being developed with and include:

- 70-60% home ownership
- 20% reduction to the average home market
- No deposit – use as equity
- Financial counsellor employed to assist families
- Mission Statement
- Affordable housing

Justin highlighted the lack of funding to evaluate the home ownership program and the need for additional resources.

Michael Buckworth, Housing Manager, Rumbalara Home Ownership Program

Rumbalara's Mission Statement

■ *Rumbalara will provide leadership and support community development independence and responsibility through the provision of culturally appropriate world-class services*

Rumbalara's Home Ownership Vision Is...

- *To address the health issues in our community*
- *Provide Employment opportunities*
- *Address Social issues.*
- *Create Economic Independence*
- *Provide Financial Planning*

Home ownership will be a factor in extending the life expectancy of Indigenous people.

FACTS

The Greater City of Shepparton Indigenous population is 6000+.

- *Rumbalara's current housing stock is 55 properties*
- *1 Home Owner of a Rumbalara property*
- *Affordable public housing is an issue*
- *Debt related housing problems*
- *Previous Qualification for formerly an ATSIC home loan*
- *High birth rates*
- *Indigenous migration to the Goulburn Valley*

- Ageing community
- unemployment

Key Stakeholders Role's and Responsibilities

- Rumbalara Aboriginal Co-op
- Rumbalara Tenant's
- Family and Community Services and Indigenous Australia (FACSIA)
- Department of Employment Workplace Relations (DEWR)
- Young's & Co Real Estate Agency

Rumbalara Aboriginal Co-op will...

- Provide access to housing for Rumbalara Community members
- Assist in meeting housing needs for families, single parents, the aged and community members
- Encourage and support home ownership for Rumbalara tenants
- Provide financial counselling

Rumbalara Tenant's will...

- Meet their responsibilities and obligations to pay rent for future maintenance and repairs requirements.
- Provide housing staff with direction and support to enable the team to deliver all aspects of the housing program
- If needed Access the financial counsellor to address money management issues
- Meet their financial obligations with the Financial counsellor

FACT

- If five Aboriginal people bought their homes annually, coupled by the number of homes being built by Rumbalara annually, would result in seven families moving off the waiting list annually.

Family and Community Services and Indigenous Australia (FACSIA) will...

- Establish partnerships and share responsibility for achieving measurable and sustainable improvement for Indigenous people living in Shepparton
- Support and strengthen local governance

Department of Employment Workplace Relations (DEWR) will...

- Provide financial support in Education and Training for housing staff e.g.
- Real Estate Representative Course
- Real Estate License Course

Young's & Co Real Estate Agency will...

- Encourage and support staff in a mentor capacity by providing advice and sharing their expertise.

Share Responsibility Agreement What This Means

- Recognises and respects each of the partners right and responsibilities and,
- Provides a basis for cooperation between the partners

Long Term Outcomes

- Provide a secure and stable environment in which to raise children
- Provide families with an asset base that enables them to make choices in life, e.g. retirement
- Long term – disposable income, enabling to pursuit a better lifestyle choice including better educational opportunities for children
- Improve mental and physical health that result from self esteem and personal satisfaction, as the capacity of individuals invariably increased when they enjoyed the benefits of regular employment

Conclusion

- 'Aboriginal health is not just the physical well being of an individual but is the social, emotional and cultural well being of the whole community in which each individual is able to achieve their full potential thereby bringing about the total well being of their community. It is a whole-of-life view and includes the cyclical concept of life-death-life.' (NAHS, 1989).
- The solution to address the ill health of Aboriginal people can only be achieved by local Aboriginal people controlling the process of health care delivery. Local Aboriginal community control in health is

essential to the definition of Aboriginal holistic health and allows Aboriginal communities to determine their own affairs, protocols and procedures.

PARENTING AND CHILD HEALTH IN SA

Bob Volker – Executive Director, Children, Youth and Women’s Health Service, SA Government was asked to outline their current services.

PARENTING AND CHILD HEALTH IN SOUTH AUSTRALIA, website:

www.cyh.com/subcontent.aspx?p=134

- *Mainstream program with Parenting and Child Health Services*
- *17 births per annum.*
- *Assessment and sustained home visits over a 12 month to 2 years period increases access to long term benefits with a gap until school.*
- *Metropolitan and Rural with intention to include Remote and eventually go State wide.*
- *1,600 families*
- *200 Aboriginal families*
- *Population health approach*
- *All teenage mothers and primary health carer.*
- *Vulnerable families*
- *High uptake of Aboriginal Nurse Indigenous Cross Cultural consultants*
- *Early contacts and building relationships*
- *Agreements with*
 - *Centrelink person*
 - *Public Housing Authority*
 - *Evaluation Program*
 - *Evidence Base Program*

Two years ago with the Aboriginal Health Council of SA (AHC) research was done to evaluate Aboriginal families in the Regional areas.

AHC contracted a Researcher to do qualitative work with vulnerable families in the Metropolitan area of Adelaide.

FACCSIA have completed qualitative and quantitative research through the Dorothy Scott Research Fellowship from the University of SA and a second Research Fellowship through FACCSIA.

Children, Youth and Women’s Health Service is currently evaluating the Healthy Ways project as well as working with the Port Augusta Grandma’s Reference Group Program and a Primary Health Care outreach service regarding access to anti natal services with an emphasis on program development on

- *low birth weight*
- *poor birthing*
- *caesareans*

The outcomes evaluation is due after July 2006.

An overview of the Children, Youth and Women’s Health Service, Parenting and Child Health from the internet follows. The Universal Home Visiting Program is part of the Government's commitment to early intervention for a broad range of health issues of public health significance.

Nurses offer a home visit to all new mothers shortly after discharge from hospital. Nurses do the first recommended health check and determine those families requiring additional support.

The Family Home Visiting Program has been funded by the Government as part of the "Every Chance for Every Child" initiative and provides ongoing home visits and support over a 2 year period. Nurses are supported by a multidisciplinary team including social workers, psychologists, and Aboriginal health staff. All Child and Youth Health services are free and statewide. They are provided by qualified nurses, medical staff, social workers, physiotherapists and Indigenous Cultural Consultants.

Child and Youth Health have a number of Indigenous Cultural Consultants whose roles include:

- *Supporting Aboriginal and Torres Strait Islander children and families in gaining access to Child and Youth Health services, eg.*
 - *home visiting*
 - *health checks (pre-school, medical assessments, immunisation)*
- *hearing assessment*
- *Family and Baby Program*
- *parent education*
- *linking families to local community supports and referral services in South Australia;*
- *supporting non-Aboriginal staff to*
- *develop trusting relationships with Aboriginal families*
- *facilitate communication with Aboriginal families*
- *provide culturally sensitive services to Aboriginal children and families.*

Contact details:

The Indigenous Cultural Consultants are Aboriginal workers who are accessible at various times at the following Child and Youth Health clinic locations:

- *Elizabeth, Salisbury, Enfield, Woodville, Marion, Noarlunga, Murray Bridge, Port Augusta and Whyalla.*

General contact numbers for Child and Youth Health services:

- *during business hours (Monday – Friday, 9am – 5pm): 1300 733 606*
- *after hours via the Parent Helpline: 1300 364 100.*

All Child and Youth Health services are free and State wide. They are provided by qualified nurses, medical staff, social workers, physiotherapists and Indigenous Cultural Consultants.

OFFICE OF INDIGENOUS POLICY COORDINATION

Ross McDougall, OIPC gave an overview on a Whole of Government approach to Aboriginal Affairs.

OIPC website:

www.oipc.gov.au/programs/default.asp

Secretaries to set performance agreement with their contracts

Shared responsibility agreement – MOU not legal document:- funding attached

Empowered to Communities

Discretionary monies from the Government are not pensions and main funding is not part and PHC as part of the SRAs

Bunya Community – NT

Local store - mining lease managed by non-Indigenous couple

Discussion about ownership of the store

Discussion about children within the community

- *Government to build a new store*
- *Partners to have kids to school*
- *90% attendance*
- *Regular check-ups with the clinic*

DANILA DILBA HEALTH SERVICE

Barbara Henry, Danila Dilba gave a short overview of Danila Dilba's health services. **Website:**

danila.dilba@org.au

- *From 1 July 06 Evaluation of Programs through Transferral development of research, Development Indicators for health outcomes*
- Evaluation for the areas of Health Care Planning and Health Care Planning Management Support including*
- Develop partnerships with other areas with core partners*

NEWMONT AUSTRALIA

Christine Charles, Newmont Australia Limited

Principles of engagement of engagement of Indigenous people

Stainable development

Desert Knowledge Partnership

How do we measure the partnership between mining and communities?

AFTERNOON DISCUSSIONS

People broke into groups to discuss and explore possible research partnerships.

The 3 suggested groups were:

- **Education, employment and childhood**
- **Understanding Social Determinants Of Health**
- **Racism**
- **Housing and the physical environment.**

GROUP DISCUSSION NOTES

Group 1

EDUCATION, EMPLOYMENT AND CHILDHOOD

Presenters:- Bob Volkner (Children, Youth and Women's Health Service)
Kim Morey (SA Health Dept.)
Merridy Malin (Aboriginal Health Council)
Wendy Edmonson (Flinders)
Kim O'Donnell (Link person at Flinders)
Arwen Pratt (Program Manager, CRCAH)

DISCUSSED:

- ✘ Potential Partners
- ✘ Funding
- ✘ Evaluation

Home visiting is proven to benefit long term health prevention of chronic conditions from 0 – 2 years

Gap between 2 years and 3 years of life (children start kindy at 3) – eg NUNGA specific

Link between educational readiness and health / wellbeing but gap in literature and evidence

Current partnerships with Housing / Centrelink

Potential partnership – Health and Education

Willingness from Education to do funding bid.

- ✘ What is the best way forward to meet this gap?
- ✘ What research is needed?

*Important to use past reports or research that have done community consultations – eg Virtual village report

✘ Need for models that are linked between Education and Health – working with the same parents and engaging with the same families. Potential collaboration.

Similar model in Enfield: Café Enfield an example of successful model – Allison King (across Education and Health)

Other similar models that aren't successful

Gilles Plains Neighbourhood House – also successful

THEMES

- Family / Community driven / SAHP model
- One stop shop
- Transport – to and from services (research link to Kim O'Donnell's Project)
- Being close to country
- Support form extended family

ANTE NATAL

Need for focus on low birth

- Weights / poor birthing outcomes / rates of C sections
- Need for ongoing funding

- Bringing together models / research
- Potential partnership with CRC and Health
- Evaluation and recording stories – current successful models
- Need to involve demographers – Professor Graham Hugo, ABS, Adelaide Uni
- Population changes
- Employment / etc
- Migration patterns
- Data to make links between low socio-economic areas and transport

*Use data to inform specific?'s around Health

*Where is obesity issues and the steady rise and why?

Group 2

UNDERSTANDING SOCIAL DETERMINANTS OF HEALTH

WHOLE OF GOVERNMENT RESPONSIBILITY

POLITICAL LEVEL – BUDGETS WITHIN GOVERNMENTS

Not wanting and 'either / or' approach around PHC versus community infrastructure.

- Programs that have impacted on Community wellbeing – look at what has impacted and long term benefits.
 - Consultation process - community control
 - successful programs with stainable long term benefits
 - Partnerships - power bases.
 - models of sustainability.
 - building evidence.
- Knowledge and evidence already done.
 - How do we bring to the attention of Ministers and Governments to effect change?
 - How do we influence governments for change?
- Funding directions are from different areas and gaps form and no meeting point.
- Political determinants within Government Ministers.
 - Qualifications, research and knowledge.
 - Ideological ideas.
 - Not necessary from a level of qualifications and understanding.
- Life expectancy – mortality (infant) gaps still exist.
- SA whole of government strategy with links to strategic planning – ARD

DRIVERS

COAG – how do we link drivers with outcomes?

- Values within a society and a blaming culture.
- How do we better present the areas around Aboriginal Health within changing political environments?
- Complexities within knowledge and evidence based information.
- Rights of Indigenous people within the Health arena – individual verse – whole of community.

Group 3

RACISM (Key Social Issues)

Institutionalism of racism

Overt behaviour

Internalised racism

IMPACT ON HEALTH

ISSUE: When racism is expressed in behaviours and practices and organisational cultures.

Addressed through

- WR issue (unacceptable behaviours)
- Culturally competency

ISSUE: Need to change mind sets.

- What does change mind sets?
 - Cultural awareness – thinking
 - Cultural competency – performance
 - Assessment (?) – but how to assess change – what evaluative ????

Methods and methodologies need to reflect contingent nature of determinants / acknowledging effects of racism.

E.G.

- Remote kids
 - Access issue (delicate)
 - Culture and identity (strong)

- Urban kids
 - Access (strong)
 - Culture and identity (delicate)

ACCOUNTABILITY FOR OUTCOMES

Challenge – how do you define what to be accountable for?

1. Unity – coalition for change.
2. Capacity for Aboriginal people to ‘defend’ themselves – how do we build Aboriginal empowerment in negative environments?
3. Ways to deal constructively with internalised racism.
4. Need to support Aboriginal governance structures to deal with racism effects.

Support for appropriate Indigenous leadership to lead.

Group 4

HOUSING

Rumbalara – Community Housing model

- Uncertainty of long term funding
- Range of stake holders being involved could be a potential barrier?
- Only one provider of housing

NT Government has 2 housing programs under the same umbrella.

Indigenous Housing Authority with 72 communities and 580 outstations with about 1/3 not being used regularly.

There are currently 91 Indigenous Community Housing organisations with currently \$1700 per house for maintenance programs which is increasing to \$2200.

The Integrity of housing “Green Book”

- What should be built?
- Appropriate?
- Tenancy Management.

GENERAL DISCUSSION

At the end of the group discussion there was a general discussion covering all topics and offering suggestions for future directions.

CONCLUSIONS / ISSUES TO FOLLOW-UP

- Three areas were identified that were not sufficiently represented at the Roundtable: Education, Law and Justice and Culture/Land. It is proposed to hold further small industry focus groups around these areas of social determinants.

- One clear potential partnership emerged. Rumbalara Aboriginal Cooperative in Victoria has developed a program to focus on building home ownership within the Aboriginal community in the Shepparton region. The program is strongly supported by the Commonwealth Government. Rumbalara is keen to include an evaluation of the program that would look at the impact on health outcomes. It is proposed that the CRAH support the development of an evaluation plan and support Rumbalara in negotiating long-term funding.

- Further discussions and meetings have been held with the research unit of the NSW Justice Health through our Link people within Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS).

RECOMMENDATIONS:

A proposal went to the Board on 14 June 2006 recommending funding to support the development of an evaluation plan for Rumbalara Aboriginal Cooperative's home ownership program.

STUDENTS COMMENTS/FEEDBACK

STUDENT 1

The roundtable was useful for me in stimulating my thinking on social determinants, meeting a number of different people in different fields, providing a snap-shot of government attitudes and gaining more understanding of Aboriginal views.

I was surprised by the government positions that were expressed on SRAs (that they do not affect basic services and are not discriminatory) although I suppose I shouldn't have been. It seemed to me that the government and the private sector placed more weight on their own views than those of Indigenous representatives. I suppose this reflected my overall impression of the intransigence of the government position.

As you are aware, my mention of human rights and the National Aboriginal Health Strategy were not well received in the working group I was in. This was quite disillusioning and I wondered if the government was seriously looking for input or had already made up its mind. The description of the conclusions of the workshop that a rights approach was deemed inappropriate was of course inaccurate given my comments and the fact that a HREOC representative had presented. I was a little overwhelmed by this opposition but next time may take the opportunity to contribute to the overview of the discussion. There is an enduring division between public health and human rights people on this issue. I have since been studying up on the case law which was cited as an example of a failure of a rights approach. I think that my presentation at the International Society for Equity in Health Conference in September will show more clearly the value that can be derived from a rights approach in the area of Aboriginal health. I am also however critically examining a rights approach in my doctoral thesis.

It is beyond doubt to me that the most relevant and valuable information on Indigenous issues comes from Indigenous peoples themselves. I also think that Indigenous concepts of health and health determinants are superior to Western concepts and that it would be great to have a forum where Indigenous people impart their wisdom on these issues to non-Indigenous people. I thought the Rumbalara presentations were very interesting and would like to know more about their work.

It seems that the shift to the right on Aboriginal issues has made talk of self-determination and discrimination appear dated but was heartened by one suggestion that Indigenous peoples should take their concerns about their health to international fora.

I was also very interested in one of the statistics in Fran Baum's presentation showing that Indigenous people considered themselves better off than non-Indigenous people despite their inadequate access to health care and other services and comparatively poor health status. This seems to reflect the failure to consult Indigenous people and a lack of understanding of their concepts of health and well-being. I think this could be an interesting and perhaps key area of discussion between Aboriginal and non-Aboriginal peoples. In conclusion, there seem to be so many issues that separate roundtables could be held on Aboriginal housing, health care, food, and other social determinants. As I mentioned in the working group, I think that social determinants covers such a huge range of determinants that there is considerable scope for breaking them down into different areas of study. In the area of participation in decision-making as a social determinant, the impact of allowing private interests undue influence in political decision-making while excluding Aboriginal people from decision-making could be addressed. This begins to address some of the underlying structural determinants that ultimately need to be addressed.

I hope these comments are of some use.

Kind regards.

Clancy Kelly (Law Student, Melbourne University)

STUDENT 2

I recently attended a round table in Adelaide regarding Indigenous health and the social determinants. As I was a student and had never experienced a roundtable before I found this is experience to be both rewarding and educational. It allowed me to meet other professionals associated with Indigenous health and other areas of interest. Throughout this experience it allowed me to gain a better idea of where I wanted to go in my career from listening to the passion that the professionals felt in their area. It was also interesting to see how a roundtable was ran and the value of a roundtable for the Indigenous community.

I would recommend this as a wonderful and rewarding experience which helped me to gain a lot of information and experience.

Layla Scott (Queensland University)

STUDENT 3

I enjoyed the round table discussion very much. I didn't however get enough time to meet some of the people with their projects.

Points from the roundtable discussion include.

- there were some good ideas and projects going on, and some committed people running them, however.
- I would have liked to have seen more discussion and consultation at a grass roots level. (I felt very strong about this)
- I feel that we need to concentrate at the consultation level first before we even look at the programs.
- the programs have to come from a need that the community expresses.
- we need to show evidence of this.
- we need to focus on what is sustainable.
- show evidence on how this could be so
- we need more Indigenous leadership in our partnerships

I hope this might help in some way. Please let me know if I can be of any further assistance.

Luita Casey (Flinders University)

The Social Determinants of Health Program Statement

This statement was approved, in its current form, by the CRCAH Board in 2005. It is intended to be an evolving document which will be further developed through Community and Industry collaboration.

Goal of the Social Determinants of Health Program:

Develop a detailed understanding of the social determinants of Aboriginal health and of the interventions that are effective in improving health status through action on social determinants.

The Cooperative Research Centre for Aboriginal Health (CRCAH) is committed to carrying out research that will improve Aboriginal health. To do this, we will continue to develop strong partnerships between the research community, the Aboriginal health sector, governments, community partners and organisations in the broader community. Our research will be directed towards priorities identified by Aboriginal and Torres Strait Islander people and by those industry partners who can make use of the research. We will also incorporate capacity development and research transfer throughout our work.

The Social Determinants of Health Program is one of five programs through which research development within the CRCAH is organised. Within the Social Determinants of Health Program Statement, other program and administrative areas of the CRCAH are incorporated for a whole CRCAH approach.

1. Background

Public health history demonstrates that improvements in the social and economic determinants of health produce significant gains in life expectancy and quality of life. Clean water, sanitation, education, meaningful employment, good nutrition, appropriate housing, control over life circumstances, supportive communities and networks, peace and freedom from discrimination and racism all make significant contributions to keeping people and their communities healthy. Unfortunately Aboriginal people have not had access to these basic determinants of health to the same degree as non-Aboriginal Australians.

While the CRCAH has been founded on the belief that these social determinants are fundamental to Aboriginal health, developing a research agenda in this area is not an easy task. The social determinants are 'upstream' and change in them will often take some time to show outcomes in 'downstream' health. In the immediacy of the health crisis faced by Aboriginal people in contemporary Australia the provision of 'downstream' services often takes precedence, even though these will not tackle the underlying causes. Yet history shows that if significant gains are to be made across a population, interventions, both upstream and downstream, are essential, otherwise health services will be curing people simply to return them to the conditions that created the illness in the first place. The importance of the social determinants of health has been consistently recognised by the World Health Organisation (WHO) through its Alma Ata Declaration and Health for All 2000 strategy, the Ottawa Charter for Health Promotion and, in 2005, through the formation of a WHO Commission on the Social Determinants of Health which will work for three years to examine evidence on effective strategies to improve health through the underlying determinants (See Appendix A).

The CRCAH's predecessor, the CRC for Aboriginal and Tropical Health, and the CRCAH's Core Partners have already done considerable work to promote a better understanding of the social determinants of health, and particularly, the Aboriginal understandings of the social determinants of health. This work also contributed significantly to developing a research agenda in the Social Determinants of Aboriginal Health.

There are two key components of this pre-existing work:

1. The development of a short course and text book about the social determinants of Aboriginal health which is now to be developed into a semester long unit as part of the Charles Darwin University's Public Health course work program.
2. A substantial body of work carried out through the CRCAH, Menzies School of Health Research and Flinders University about infrastructure and essential services and Aboriginal health.

2. Program Development

In 2004 the CRCAH commissioned a series of papers covering a broad range of topics relating to Social Determinants, Processes and Aboriginal Health. The papers were presented at a two day workshop held at Flinders University in July 2004 where specific themes emerged. These themes were:

- Racism and discrimination and their relationship to health, in particular the impact of the cultures of non-Indigenous health care organisations/ structures on Indigenous health.
- Law and the impact of community justice interventions on health and wellbeing.
- Gaps in Aboriginal understandings of health and social determinants, in particular in interventions that Aboriginal people want and the implications of this for health (and other) services.
- The impact of education, in particular the areas of educational interventions that Aboriginal communities think are important and want.
- The understanding and experience of poverty from an Indigenous perspective.
- The impact of physical environments and infrastructure on health, in particular further research into environmental health in the urban context.
- The lived experience and meaning of work, (un/under) employment for Aboriginal people.
- Preventing problems associated with social and emotional health, in particular the meaning and experiences of resilience.
- What works in community-based strategies, in particular, what works in prevention of illness and how can communities develop sustainable interventions.

The papers (being prepared for publication following a process of peer review) have made a significant contribution to defining a CRCAH Social Determinants research agenda. The CRCAH Board has also emphasised its priorities for the Program. Together, these influences suggest that the need is for:

- Assessment of strategies that have worked in the past in terms of the social and economic changes that affect Aboriginal health status (also drawing on international experiences), and, on the basis of these assessments, determining what can be learnt from these to implement practical strategies in urban, rural and remote Aboriginal communities.
- Evaluation of the health and health determinant impacts of social determinant interventions.
- Further research on the impact of racism on health, particularly in policy and service provision.
- Specific research on rural, remote, regional, suburban and urban Aboriginal health need to be encouraged as the social determinants are likely to operate differently in each of these settings.

A key component of work undertaken in the CRCAH to date has been a pilot audit of social determinants interventions. There is currently no consolidated picture of the types and extent of interventions in Australia that focus on the social determinants of Aboriginal health. The CRCAH undertook a pilot audit of such interventions in South Australia. Information collected in this exercise indicated that current interventions focus on basic infrastructure and health hardware needs. The pilot audit will be used to inform the conduct of a more extensive national audit, which will provide for the first time a picture of Australian social determinants interventions likely to impact on Aboriginal health.

3. CRCAH Social Determinants of Health Program Scope

Social determinants of health are the economic, physical and social conditions that influence the health of individuals, communities and jurisdictions as a whole. Social determinants of health determine whether individuals stay healthy or become ill. Many circumstances are included as social determinants. Some of these are housing, education, social networks and connections, physical infrastructure, racism, employment and law enforcement and the legal and custodial system.

The challenge for the CRCAH in setting the scope of this program is to prioritise funded activity in a way that is focussed enough to achieve outcomes, without narrowing the scope to exclude the encouragement of work by partners across a broader spectrum.

The following diagram is a proposed conceptual framework for the World Health Organization (WHO) Commission on the Social Determinants of Health that identifies two major groups of determinants, structural (social position) and intermediary (social exposure). The WHO Commission on the Social Determinants of Health has proposed the two domains be divided as under:

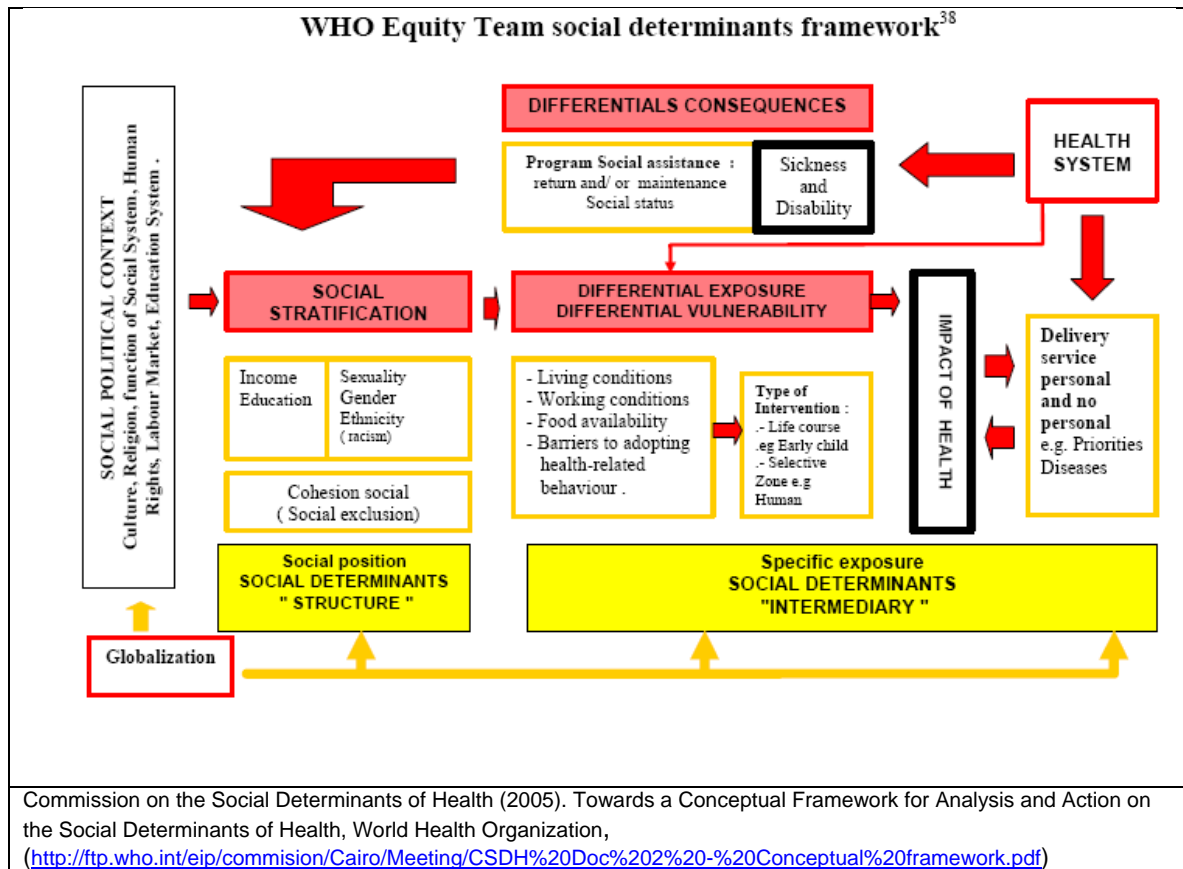
Structural determinants

- Racism

- Social Inclusion/Exclusion (Culture & Gender), and
- Law and Governance

Intermediary determinants

- Aboriginal Health and the Physical Environment, and
- Employment



It is the purpose of this program statement to set a framework that can guide the planning, monitoring and implementation of the Social Determinants program. The scope of the program will include:

- identification of existing Australian interventions that address the social determinants of Aboriginal health;
- evaluation of outcomes of sustainable interventions set up by partner organisations that address the social determinants of health in order to improve Aboriginal health;
- development of collaborative research, and in particular, evaluation of interventions in partnership with government agencies and other service providers;
- identification of current achievements and gaps in research;
- systematic review of existing knowledge, including drawing explicitly on the knowledge generated by the WHO Commission on the Social Determinants of Health (see Appendix A) and its relevance and value in an Australian Aboriginal context;
- how the relative value of resource allocations to health, education and housing for example, can be assessed;
- comprehensive understanding of factors that contribute to the development and onset of social determinants;
- modelling of relevant interactions between different determinants; and,
- identification of gaps and barriers to the uptake of knowledge for change.

The planning and implementation of this program will be closely integrated with the work of other research programs of the CRAH. Improvements in the social determinants of Aboriginal health, for instance, addressing racism and improvements in physical environments and employment, will have long term benefits to the outcomes of the other CRAH program areas.

The focus of the Social Determinants program will be to undertake collaborative research and evaluate outcomes and current sustainable interventions that have been set up by other partner organisations. The negotiation and implementation of these evaluations may be to some extent opportunistic, based on the receptivity and availability of collaborative partners and relevant interventions.

Stakeholders in the work of the Social Determinants Program will be broad ranging. Unlike most CRAH programs, where the key stakeholder groups are within the health sector, this program will largely focus on stakeholders outside the traditional health sector. However, this will not exclude the health sector, which is of vital importance in carrying out the work of the program.

Research design and implementation will be undertaken in ways that recognise Aboriginal authority in framing problems, setting priorities and valuing outcomes.

4. Outcomes

4.1 Health outcomes

Improved health outcomes in Aboriginal communities through:

- better understanding of the social determinants of health; and
- interventions designed to meet the values and needs of Aboriginal Australians and which will have downstream improvements in Aboriginal health.

These health outcomes will be achieved through the combination of research, policy and practice, and capacity development outcomes outlined below.

4.2 Research outcomes

Evaluation of research on the social determinants of Aboriginal health will result in evidence that can be used by policy makers and service providers to:

- focus on interventions that address the social determinants of health and improve health outcomes in Aboriginal communities;
- identify key factors in successful uptake of evidence, barriers to that uptake and evaluation of interventions to improve the uptake of evidence; and
- develop processes that produce sustainable change at community, organisational, practice and policy levels.

4.3 Policy and practice outcomes (research transfer)

Policy and practice outcomes will be achieved through the combined efforts of the CRAH's research and industry partners. These include:

- influencing the development and implementation of strategies and policies to address the social determinants of health in Aboriginal populations at national, state/ territory and local levels;
- using research outcomes to inform policies, guidelines or standards that contribute to the on-going development and use of public health and educational materials and,
- improved access to and uptake of evidence (in policy, service development and practice).

4.4 Capacity development outcomes

Capacity development outcomes are a priority and these will be achieved by:

- identifying and strengthening pathways for Aboriginal practitioners (both within and outside the health sector) to acquire research training in the social determinants area;
- increasing Aboriginal research capacity through scholarships, traineeships, professional development strategies and/or cadetships;
- developing a greater understanding by researchers and government policy makers of the social determinants of health;
- the incorporation of evidence-based practice about the social determinants of Aboriginal health into education and training for both Aboriginal and non-Aboriginal practitioners; and,
- assisting non-Aboriginal researchers to learn to work appropriately and effectively with Aboriginal communities and agencies and building linkages (in language and experience) between researchers and industry, between Aboriginal and non-Aboriginal partners.

5. What we don't know – knowledge and implementation gaps

Further work is needed to identify knowledge and implementation gaps in this program. This will be done by:

- identifying existing interventions that address the social determinants of health in order to improve Aboriginal health;
- developing a more complete description of existing projects, including potential outcomes, indicative research questions, research strategies, research transfer, education and training, capacity development activities (planned or potential);
- identifying other potential in-kind work that might be brought into this program; and,
- developing linkages and collaborations between projects and programs (multidisciplinary research projects have a greater chance of achieving transferable outcomes).

6. Indicative Research Questions

As the Social Determinants of Health has such a broad scope it is anticipated that the program development activity (see 7.4) will help the CRCAH to focus its activity and develop indicative research questions.

7. Development and implementation of the program

7.1 Facilitated collaborative research development

This program will achieve its outcomes by drawing together existing funded and in-kind research projects, and where necessary, undertaking additional research. Developing a robust and productive research plan involves articulating specific questions that can be answered by research, identifying methods of data collection and analysis, negotiating settings and partners. This is commonly a highly iterative process, visiting and revisiting the questions, methods, data and settings until a tight powerful protocol has been developed.

In the context of the CRCAH research this cycle of iterations will also include questions about community involvement, transfer and dissemination, and education and training.

The CRCAH is keen to encourage the community of researchers and the wider CRCAH community to participate cooperatively, not just in identifying research priorities but also in the shaping of the projects themselves. This is a marked change from customary practice where research planning is often a quite private activity involving a small group of colleagues.

7.2 Integrating research, research transfer and capacity building

Provision for transfer and dissemination will be incorporated into research design from the earliest stages. This will include researcher and CRCAH initiated strategies (offering resources and opportunities), as well as industry and community initiated strategies (responding to and supporting practitioners who are asking questions and looking for better ways of doing things). It will include all avenues from accredited training to outreach programs to the internet.

Opportunities for capacity building, including education and training, will be incorporated into research design. Capacity in this program refers to the capacity to frame research questions on the social determinants of health, design and conduct research, and work to maximise the chances of uptake of the research findings. Capacity building includes organisational development as well as workforce development.

Research transfer and capacity building will be facilitated by building close links with Aboriginal health care organisations and communities in the design and implementation of the research.

7.3 Network of interest

The CRCAH has one network of interest which consists of interested researchers and practitioners from across the CRCAH community. The CRCAH's communications activities, such as Convocation, committees, visits, and emails, contribute towards bringing people together and keeping them updated. The network brings people together to develop and undertake a series of fundable projects and linked groups of projects across all the CRCAH programs ensuring that synergies between the programs are maintained. The network includes:

- researchers and practitioners associated with projects already funded by the CRCAH;
- researchers and practitioners from CRCAH partner organisations (including CRCAH Research Development Group members);
- relevant experts (people from outside the CRCAH may be invited to participate);

- industry representatives including people from the CRCAH Small to Medium Enterprise (SME) forum.

8. Linkages with other programs

The Social Determinants program will have strong linkages with all CRCAH programs although there is a high degree of overlap between the Social Determinants of Health Program and the Social and Emotional Well Being Program which will take responsibility for Early Childhood Development and direct interventions to promote well being.

The Social Determinants Program will also build strong linkages with the other CRCAH program areas, which include:

- Healthy Skin – Housing and overcrowding, appropriate functioning health hardware and access to water for washing;
- Chronic Conditions – Aboriginal understandings of health and whole of community strategies, racism and discrimination and their relationship to health services;
- Comprehensive Primary Health Care, Health Systems and Workforce – Aboriginal health preferences, racism and discrimination and their relationship to health services, intersections between the health and other sectors in comprehensive primary health care.

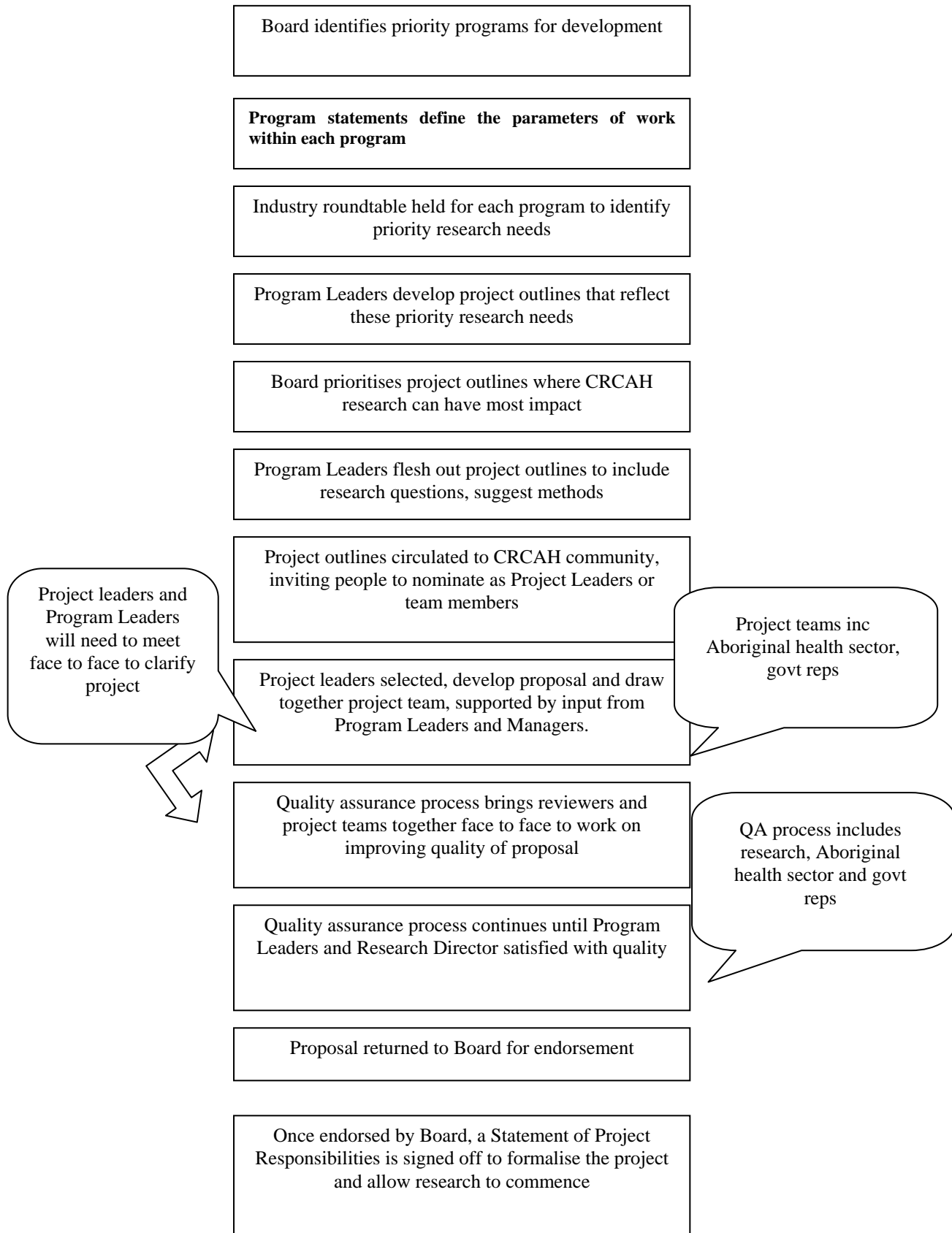
Current Social Determinants of Health Project List

A full list of CRCAH projects within all program areas can be found in the 2005 Annual Report. It is important to note that while CRCAH projects are allocated to a particular program for administrative and reporting purposes cross-program linkages will be developed across all research areas.

January 2006

Project No.	Project Title	Project Leader or Contact person	Administering partner
92	Grandmother's wisdom: Domestic violence and harmful drinking in Aboriginal communities in SA.	Charlotte de Crespigny	Flinders University
115	Identification of access and equity issues governing domestic water changes to Indigenous families SA.	Eileen Willis	Flinders University
136 IK	Water service delivery and Statement and Cwth water reform objectives – a response from Aboriginal communities SA.	Meryl Pearce	Flinders University
142 IK	The compositions and contextual determinants of urban health inequities.	Fran Baum	Flinders University
19	Fluoridation Demonstration Project	Ross Bailie	MSHR
129	(Course) Social Determinants of Indigenous Health Short Course 2004 - 2005.	Ross Bailie	MSHR
162	Housing Improvement and Child Health (HICH) Project.	Ross Bailie	MSHR
13	Socioeconomic and environmental determinants of health in Indigenous communities in the NT.	Ross Bailie & Mathew Stevens	MSHR
156	What is Social Capital for Aboriginal people in the Goulburn Valley and how can we benefit from it?	Petah Atkinson	University of Melbourne

STEPS IN THE FACILITATED DEVELOPMENT PROCESS



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