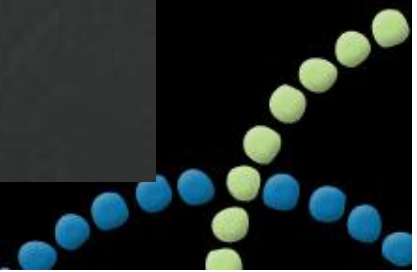
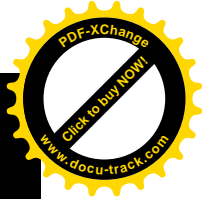


Cooperative Research Centre for  
**Aboriginal Health**





# Indigenous Research Reform Agenda

- Historical experience of cultural and physical anthropology
- Biomedical research co-developed with physical anthropology; health research has grown in its own right significantly over last 2-3 decades
- Focus of research practice
- Indigenous critique of research ethics and relations with Indigenous communities

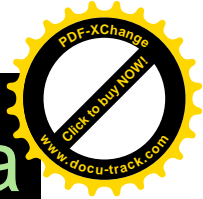
# Indigenous Research Reform Agenda

## Australia

## Original Research

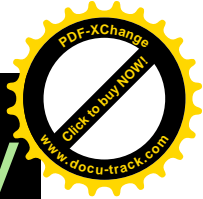
	All	Measurement	Descriptive	Intervention
1987–88	19	2 (11%)	17 (89%)	0
1997–98	80	6 (7%)	60 (75%)	14 (8%)
2001–03	101	9 (9%)	79 (78%)	13 (13%)

Source: Sanson-Fisher et al MJA 2006



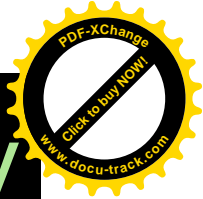
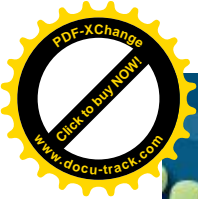
# Indigenous Research Reform Agenda

- **Key aspects of the Indigenous Health Research Reform Agenda:**
  - Priority Setting
  - Collaborative Relationships
    - Research agenda development
    - Research implementation and transfer
  - Capacity building
    - Research infrastructure, method & networks
    - Service, Policy and Community Engagement
    - Indigenous Leadership
    - Ethics



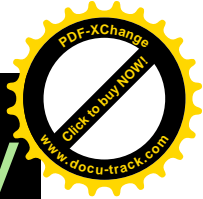
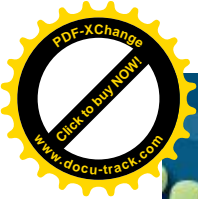
# Burden of Disease and Injury

- Burden of Disease and Injury: 2.5 times that of non-Indigenous Australia
- 18% total - ischaemic heart disease and stroke
- 15% total - mental disorders
- 8% each - chronic lung disease, diabetes and cancers



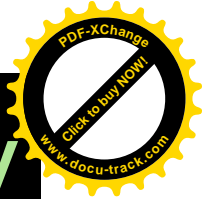
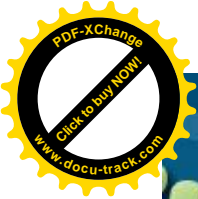
# Burden of Disease and Injury

- In the top seven broad cause categories largest differential was in cardiovascular disease, diabetes mellitus and intentional injuries.
- 10 major risk factors to which the disease burden can be attributed,
  - 10% tobacco smoking causes
  - 9% high body mass
  - 7% physical inactivity
  - 4-3% each high blood cholesterol, alcohol, high blood pressure, low fruit and vegetable intake



# Burden of Disease and Injury

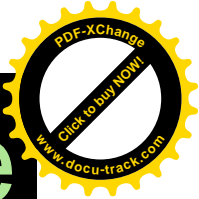
- Indigenous health gap - Indigenous burden of disease would be 59% lower if Indigenous Australians had the same level of mortality and disability as the Australian population. :
- 70% of gap was non-communicable diseases - cardiovascular disease at 23%; diabetes (12%), mental disorders (12%) and chronic respiratory diseases (9%).
- 15% of the gap - Injuries and group I conditions (communicable diseases, maternal and neonatal conditions)



# Burden of Disease and Injury

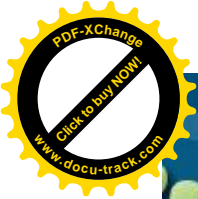
- 11 selected risk factors - total burden would be 29% lower if no health gap accounting for half the overall Indigenous health gap of 59%.
- Tobacco accounted for 17% of the health gap; high body mass 15%; and physical inactivity 12%.





# Role of clinical care

- Significant contribution of mortality and disability as a consequence of disease:
  - Access to health care
  - Quality of health care (treatment protocols, organisation of care, treatment relationships)
  - Effective clinical care, interventions



# Our Vision

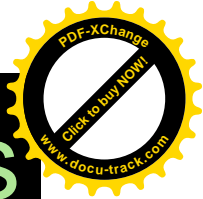
Sustained improvement in Aboriginal Health through strategic research and development





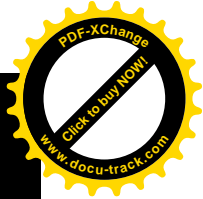
# INDUSTRY

- 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)



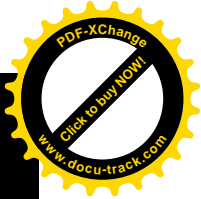
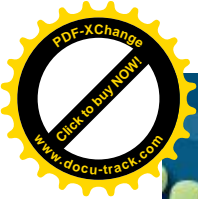
# Research Partners

- Menzies School of Health Research
- Charles Darwin University
- Flinders University
- La Trobe University
- University of Melbourne
- Australian Institute of Aboriginal and Torres Strait Islander Studies
- University of Queensland
- Queensland Institute of Medical Research

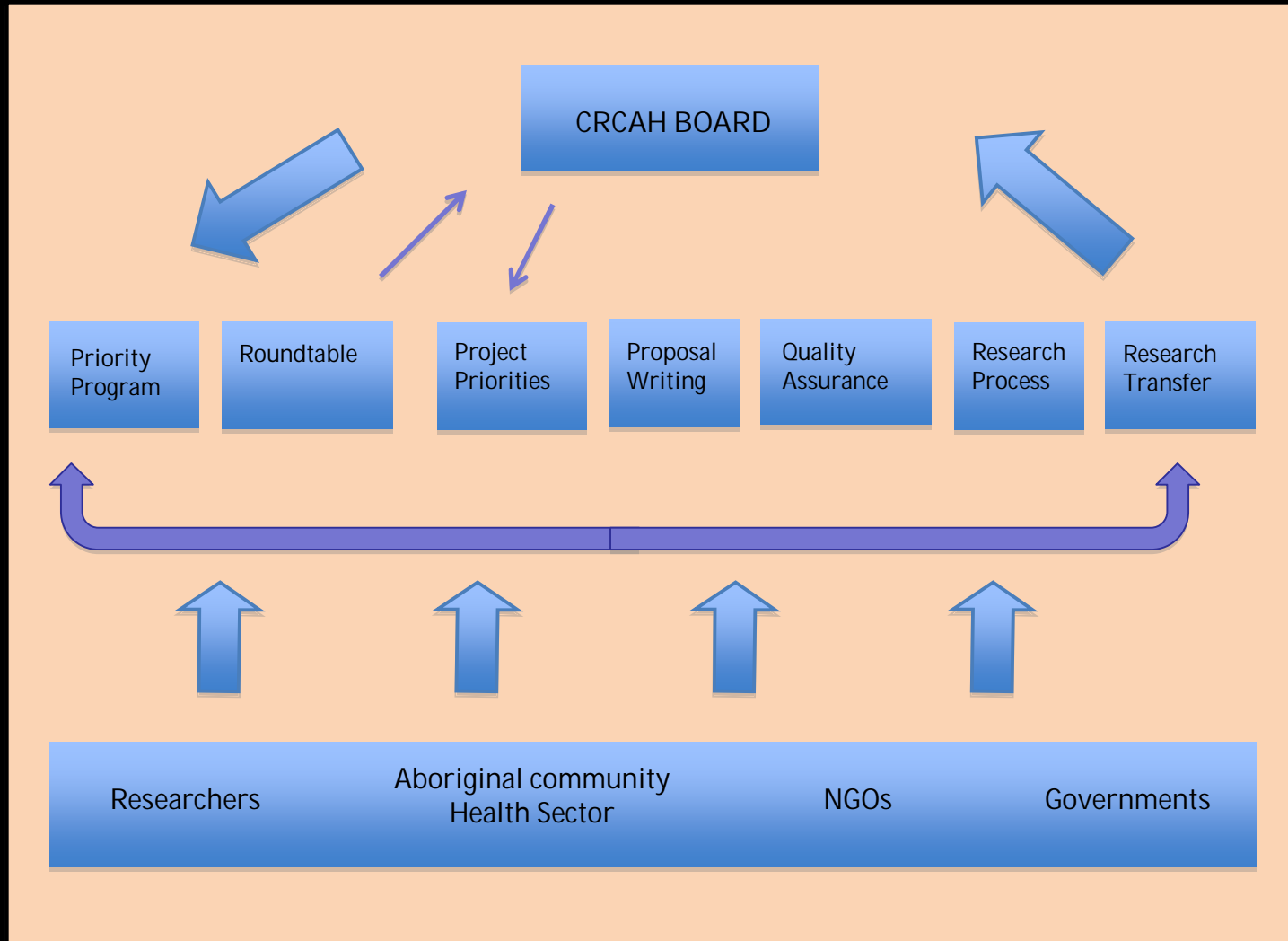


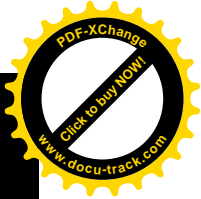
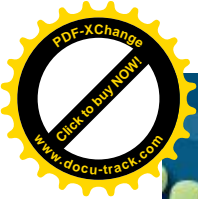
# The Programs

- Primary Health Care, Health Systems and Workforce;
- Chronic Conditions;
- Healthy Skin;
- Social Determinants of Aboriginal Health; and
- Aboriginal Social and Emotional Wellbeing.



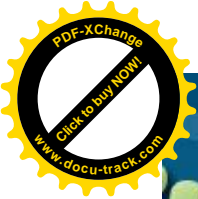
# Research development





# Changing how clinical services are organised: ABCD project



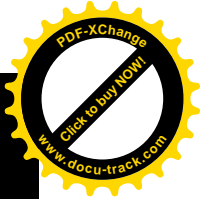


# ABCD project

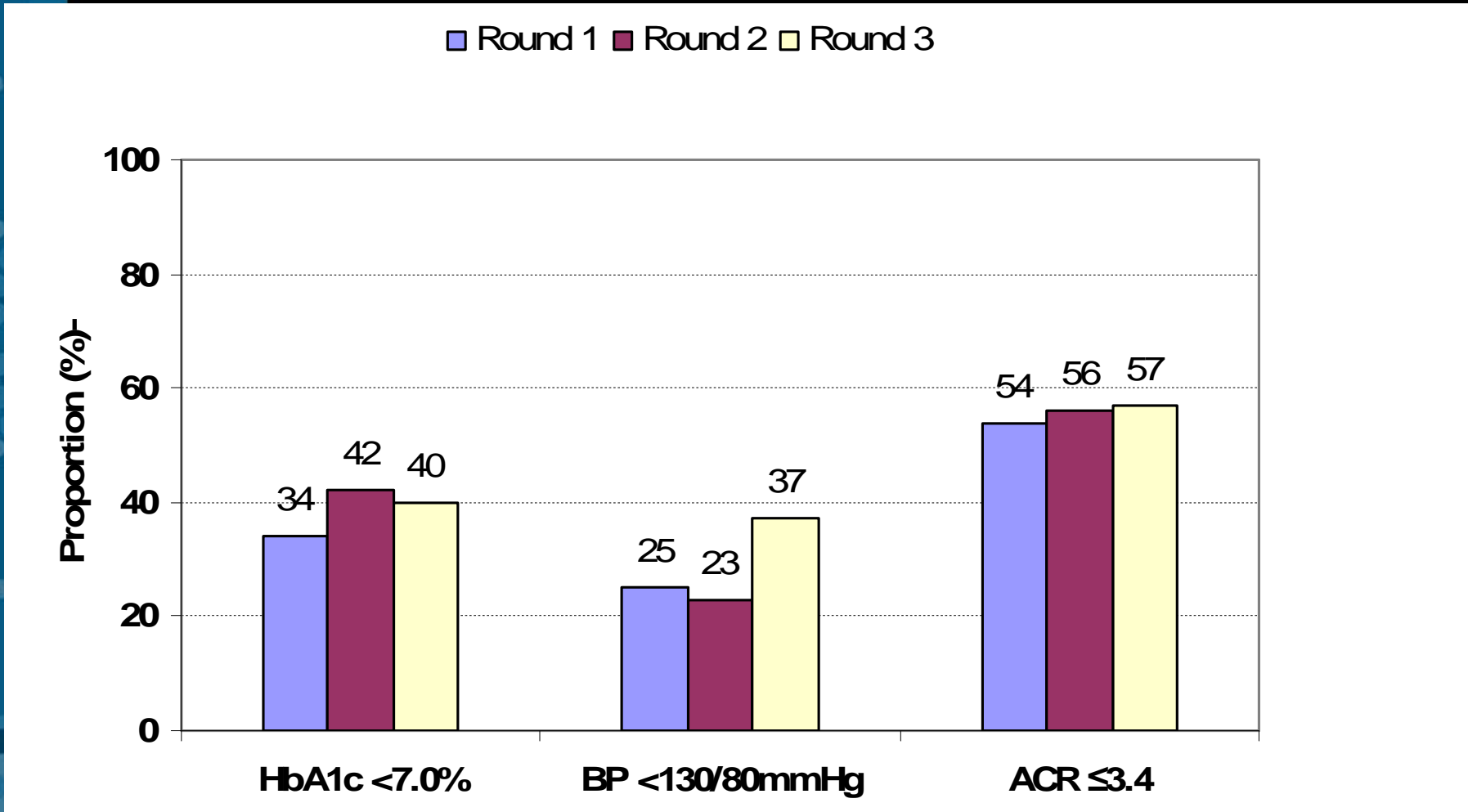
- **Continuous quality improvement**
- **Enthusiastic uptake from staff, services and jurisdictions**
- **Simple organisational changes**
- **Impact on care**
- **Improvements in health indicators**

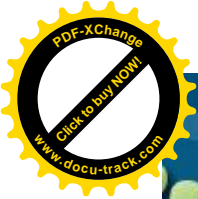
**Project leader: Ross Bailie, Menzies  
School of Health Research**





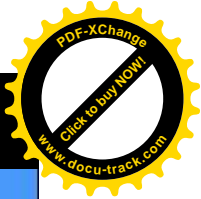
# Changes in intermediate patient outcomes – ABCD sites





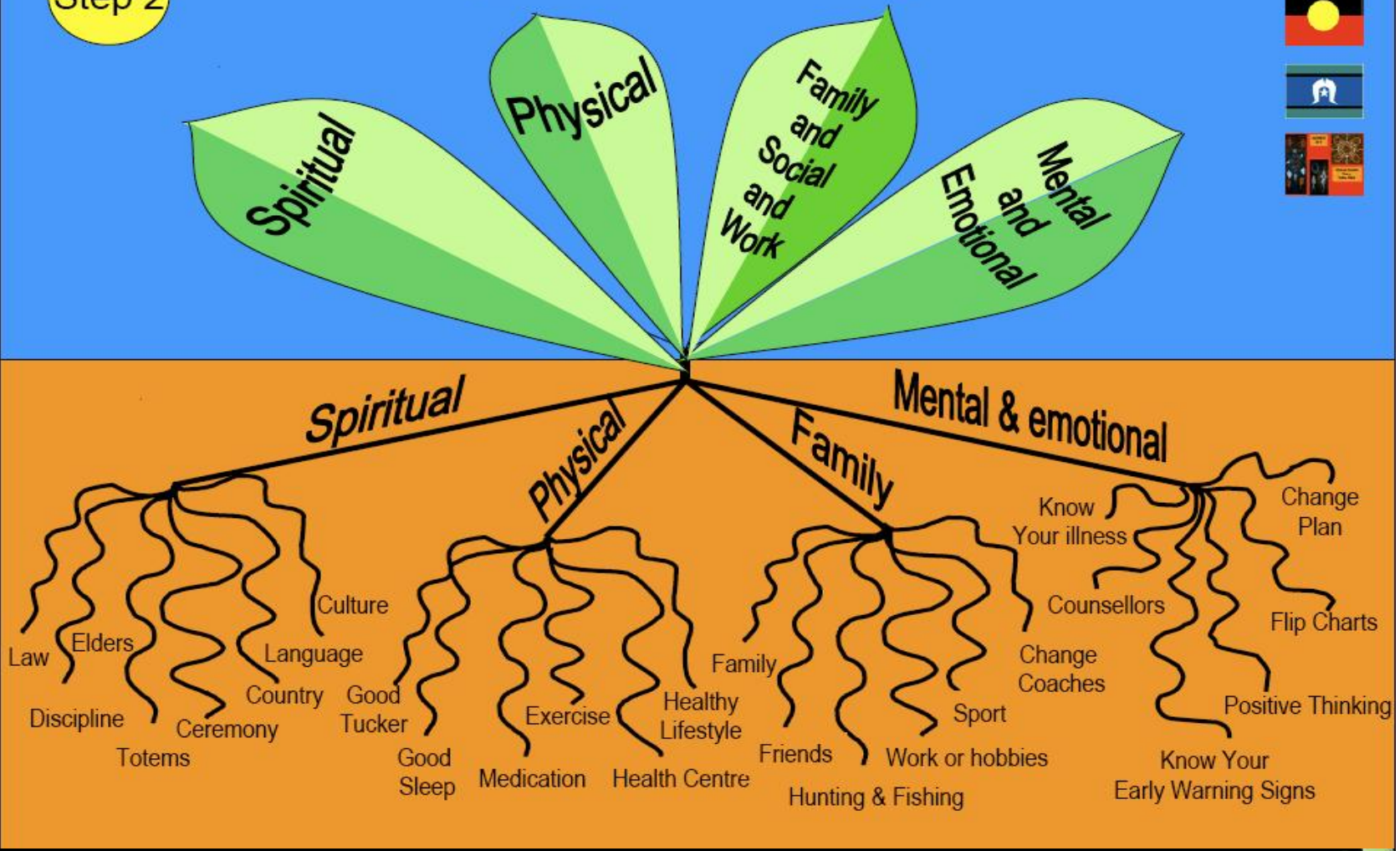
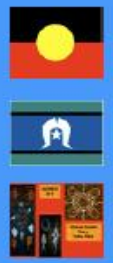
# Better tools for mental health care in primary settings: AIMHI

- Development of appropriate messages and ways of talking about mental health
- Care plans and assessment tools
- Working with workforce agencies and practitioners to increase capacity
- Integration of tools into ABCD systems approach

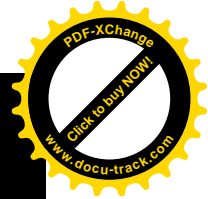


Step 2

# What Keeps Us Strong?



**Project leader: Tricia Nagel, Menzies School of Health Research**



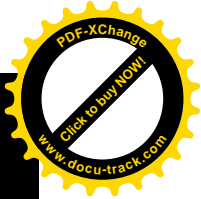
# Skin disease: from the lab to the clinic and beyond





- Skin disease a major cause of illness for Aboriginal children in north Australia
- Emerging resistance to current treatments
- Treatments unpleasant and onerous
- Current clinic practice inadequate
- Environmental factors important

**Project leader: Ross Andrews,  
Menzies School of Health Research**



Cooperative Research Centre for

**Aboriginal Health**

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