Nganampa Health Council As A Multi Purpose Service

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Introductory Welcome

Apologies for the absence of our Director, Dean Coulthard. An advantage of being Director is you can tell people who work for you to do the things you don't want to do. Dean doesn't like conferences. The Pitjantjatjara word for talk is 'wangka', and Dean says at conferences all they do is - wangka wangka wangka.

Nganampa Health is Aboriginal-controlled, and although I'm non-Aboriginal, the things I'm going to say have been worked through and approved by the Nganampa Health Committee. In this presentation I will use the word Anangu - which is the Pitjantjatjara word for person.

Explanation

I'm going to talk about Nganampa Health, what we want from a multi-purpose service, and let you know some of the things we have been thinking about, particularly some of the problems and the services we want. Anangu would say "Ngayulu wangkaringinyi pampaku tjilpiku tjukurpa."

We have some slides which are more of a travelogue through the Anangu Pitjantjatjara Lands - and they will give you an idea of the country and the people. Mandy Pusmucans who works at Umuwa with policy formulation, recruitment and systems analysis is going to push the buttons for me.

Multi Purpose Service

We haven't signed up or finished negotiations on an MPS as yet, but are hoping that the program will start from July 1 this year (1995).

We didn't know what an MPS was when we first started talking. We wanted funding to replace run down Clinics and staff houses, and someone put us onto the Commonwealth and said an MPS would be ideal.

Since that happened we have had additional capital funding from ATSIC, and we will be able to upgrade all our Clinics and staff houses over the next three years - so an MPS is a bit of icing on the cake in terms of improving our services.

I guess because we get no funding whatsoever for aged care, that it is easy to see that an MPS on the Anangu Pitjantjatjara Lands will have a significant aged care focus,
but the flexibility behind the program to fill other health service gaps, makes us wonder how a bureaucrat actually thought up this progressive program.

Another reason we are negotiating an MPS is to lock ATSIC into three year funding. Any money going into Aboriginal services is always under extreme scrutiny, and the Health Committee feel we have been disadvantaged by parochial decisions of ATSIC, and decisions have been made to reduce funding, based on inadequate awareness of the consequences on Anangu health.

Nganampa Health

I need to tell you about Nganampa Health and Anangu tjuta. Nganampa Health is an Aboriginal Controlled Community Health Service that started twelve years ago. We provide all health services on the Anangu Pitjantjatjara Lands in the north west of South Australia.

There are about three thousand people living there - 2,500 Anangu and 500 non Anangu. Anangu have only had regular non-Aboriginal contact for about 70 years. They could still be described as traditional Aborigines in terms of lifestyle.

English is their second or third language. The predominant languages are Pitjantjatjara or Yankunytjatjara. Most Anangu live in six main communities, although there is a growing Homelands movement where about 40 Homelands have been established away from the main communities.

Living conditions are grim, and of course these have a major impact on health status. The climate is harsh - with temperatures reaching 50 in summer and getting below freezing in winter. Water is pumped from bores, and varies in quality. There are not enough houses, which results in significant overcrowding. Family relationships exacerbate this overcrowding. The average income is below the poverty line, and most Anangu work for the dole on CDEP programs.

Many environmental health problems result from poor construction and maintenance of facilities. Simple things like solar hot water systems being fitted on the south side of roofs, or houses not being connected to a bore 100 metres away so the house has no water, make living difficult.

Nganampa has addressed these problems with UPK work. Uwankara Palyanyku Kanyintjaku means "a strategy for well being", and it is a comprehensive public and environmental health program. Recently this has evolved into community development work, addressing Anangu perceptions of whitefellow’s interventions, and what is possible for them in the future.

In six clinics we have an Aboriginal Clinic Manager, generally four Aboriginal Health Workers and two Nurses, and three medical officers look after two clinics each. There is a cleaner in each Clinic, and also a Ngankari - who is a traditional healer. Most Anangu consult traditional medicine and western medicine when they are unwell.
Anangu have a different world view than non Anangu - and place significant value on body, land and spirit. The Land is extremely important to them, and illnesses generally have a spiritual relationship.

Goals And Strategies Program

In the mid 1980s Nganampa Health got involved in strategic planning before the term was even widely known in Australia. In respect to the delivery of a comprehensive primary health care program, it was agreed that several major programs, if they were sustained, could improve the health of Anangu.

Another major reason for these programs was to ensure continuity of care and targeted programs to reduce the impact of high staff turnover, with new staff trying to change the world, or becoming overwhelmed with primary clinical care. These programs have been in operation for eight years and by any measure can be shown to have been successful.

The programs are:

**Population Register** - this is maintained consistently and one difficulty in doing this is the mobility of people. We need to know who we are dealing with, and what the baseline health status is.

**Ante natal program** - encourages regular health monitoring and education of the mother. Last year 60% of women had between 6 - 10 visits and 83% had an ultrasound in Alice Springs at some stage in their pregnancy. Maternal age is much lower than the rest of Australia, with 30% of mothers less than 18 years of age.

**Immunisation** - we have the aim of immunising 100% of kids and this is largely successful. In the last few years it has been around 90% in the month it is evaluated, and we catch up on other kids later as soon as we can.

**Growth monitoring** - because minor loss of weight can cause severe problems with kids in a desert environment, together with poor nutrition and disease, protocols have been developed to regularly monitor the growth of kids and intervene as necessary.

**STD Screening** - STDs and HIV are a major worry for Anangu, and an annual screening program allows identification of new cases. The target group is between 12 and 40 years of age. There have been no positive HIV cases found on the Lands, although Anangu say AIDS is like a big eagle hovering on the edge of the Lands waiting to pounce. When it comes it will be like a bushfire.

**Chronic Disease register** - this is maintained in each Clinic to provide proper management of chronic disease such as diabetes, renal failure and childhood haematuria.

One indicator we use in the evaluation of programs is the number of emergency evacuations, and in the last ten years this has been reduced by two thirds. I should also say that we use standard treatment protocols in each clinic for general health.
issues and for women's business, and these protocols are in use throughout Central Australia.

**Aged Care**

Anangu grow old, but age is not an illness, and we have to ensure that any services we establish don't take people away from their community, and we shouldn't implement services that suggest that old people are ill. Our first priority has to be support services, and any residential services must continue to be part of the community. Anangu say that they want to stay in their own country when they grow old, and they want to die in their own country.

Anangu over 65 years comprise about 4% of the population, which compares with about 11% in mainstream Australia. There are a number of Anangu in their 80s. Many remember the first explorers coming through the country. I listen with incredulity at stories of them seeing their first camel, or first motor car.

One problem we have with this data analysis is the estimation of age - there were no records when these people were born. Like racehorses, older Anangu were given birthdates by whitefellows, and most seem to have been born on January 1, and the year has also been estimated.

Old people as we know the term used to be relatively rare in the earlier life of Anangu. In those days I am told they did not need a lot of care. The higher proportion of people living into old age has had an impact on the social and cultural status of communities. They are a very important part of Anangu life, as they are the custodians of traditional Aboriginal Law, but the romanticism as elders and traditional owners is not necessarily correct.

In the same way as with non-Aboriginal society, there is a rhetoric in respect to any individual's feelings about old people's care and well being. When the drudgery and effort involved in daily living in a harsh environment is examined, who wants to look after old people?

Anangu culture has evolved over maybe 40,000 years to give respect to, and maintain old people. When kangaroo is killed and distributed it must be to a sacred protocol, and the old people receive the choicest and tenderest cuts of meat which are easier for them to digest.

Dementia is not seen as an abnormality. Basic necessities such as firewood are provided for them. Sons in Law must show respect and do what is asked of them. The extended families are so large there is always someone to sit with them, to listen to their stories, and to help provide for them.

Anangu expectations of health care are not high. They are used to racist health attitudes and their marginalisation within the health care system. They are an extremely stoic people - their traditional punishments include spearing and clubbing, and I have seen major trauma where the person bears the pain with only a grimace.
Nganampa Health, being Aboriginal controlled, is attempting to raise expectations and knowledge of health services. The quality of care is exceptional. Anangu Health Workers are the first point of contact in Clinics, and if they cannot handle the problem they seek assistance from Nurses or Doctors. Health Workers act as cultural brokers between Anangu and non Anangu.

**Anangu And Aged Care**

I've spoken fairly generally about aged care and services on the Anangu Pitjantjatjara Lands, and I'd like to concentrate on some of the more unique issues confronting us and what the Health Committee have been considering with implementing an MPS.

- **Complexities - Carer related**
- **Men's Business/Women's Business**

  People lose power in health care institutions, and a major fear of Anangu is being treated by the wrong gender for certain complaints. There are a number of aspects of care that are culturally taboo for the opposite sex to even be aware of, let alone treat.

- **Skin Groups/Avoidance relationships**

  Another cultural complexity for non Anangu are skin groups and avoidance relationships. Some Health Workers cannot treat Anangu from another skin group. With certain family relationships, Anangu cannot speak to, or even be in the same room, as other Anangu. I find moieties extremely difficult to understand, and it reinforces that Aboriginal community control means these considerations are accounted for in the recruitment of staff.

It doesn't make it easier for whitefellows though. I've seen them get really frustrated with Health Workers for not working, or for leaving clinics, but if there is an avoidance relationship, that Health Worker has to get away from the person they have the avoidance relationship with.

- **Language: Pitjantjatjara/Yankunytjatjara**

  Most Anangu understand English, even though it is their second language. Problems with communication are more likely with older Anangu who haven't been to school and haven't had much use for English.
• **Other cultural issues eg wiya**

There are lots of areas that non Aboriginals have little understanding of. It is why we try to attract and retain staff for long periods so they get to understand Anangu way. If you are impolite enough to ask Anangu a direct question, they generally agree with you, even if they don't, or they don't answer the question.

• **Staff Housing for non Anangu workers**

Any non-aboriginal workers we need to employ will require housing. On the AP Lands this means a capital allocation of about $140,000 per employee, together with the lead time to have the housing constructed. Anangu also don't want a lot of whitefellows living on the Lands.

• **Generalist or specialist staff**

Do we employ trained aged care workers, or do we develop existing staff and ensure a generalist focus within Clinics? If we have specialists, what do we do when they take annual leave. How do we ensure a multi-disciplinary team approach?

• **Role of existing staff**

Existing Clinic staff are somewhat scared with the development of aged care facilities. They tend to be over burdened now, and worry about additional workloads. There is no practical career path for staff, nor is there any tangible benefit for personal development in areas such as aged care. We need to have comprehensive consultation with staff to help develop options for the future, and to make sure they are happy with change.

• **Provision of other professional services**

This is in areas such as aged care assessment teams, physiotherapy, occupational therapy and so on. Do we have visiting services - where specialists basically fly in and out and don't get involved with the communities - or do we need to get capital funds for housing for staff? What supervisory and consultative mechanisms do we need to implement? How can a therapeutic service be effective with one or two specialists in an area the size of Tasmania? How can the organisation structure cope with the additional scope of possible professional services?
• **Complexities - Facility related**

• **Old people also care for young children**

  Most old people also care for children. If we establish residential aged care services do we concomitantly establish child care facilities?

• **People used to outdoor living/wiltjas**

  Most people on the Lands use a house as a service centre. They may use the laundries, toilets and bathrooms, but generally socialise, cook and live outside. Currently many old people live in wiltjas, so how do we establish a facility that is culturally acceptable, and can still enable the delivery of high quality care?

• **Heating and Cooling**

  Many old people have said all they want is somewhere cool to go when it is summer, and is warm on those cold winter nights.

• **Mobility aids in desert area**

  Four wheel drive wheelchairs sound amusing, but special consideration has to be given to where old people want to go. Most areas are very sandy, and mobility aids must take account of this. We have already had some special aids constructed for old and disabled Anangu, but they are also very expensive.

• **Provision of space for extended families**

  When people are sick and are taken to Clinics or to Hospital, the family goes as well. In any residential facility we need to make provision for additional people who are well, but who may also be able to contribute to the care plan. This may also impact adversely on budgets because of additional meals, washing and provision of sleeping facilities.

• **Central/decentralised residential care**

  Because of cost we have initially thought about establishing one residential aged care facility, but will old people from other areas of the country be prepared to use it? With no public transport on the Lands will we be potentially separating residents from families, and promoting lack of independent living?
• **Various types of community care**

We need to negotiate with communities on services they can provide to old people. Perhaps we allocate an agreed amount to communities for meals, providing firewood, maintaining shelters, and helping with transport. A potential problem is the differing management infrastructure in communities, and their interest and expertise in human services. Perhaps we have to have significant developmental programs to address management, more so than directly providing services.

• **Maintenance of facilities**

It is our experience that it is relatively easy to obtain capital funds to construct a building, but nearly impossible to get recurrent funds for maintenance. In the harsh environment, with mineralised water quality problems, lack of skilled maintenance staff and sometimes vandalism, will any new facilities be falling down in five years’ time?

• **Complexities - General**

• **Cross Border areas and extended families**

Anangu don’t recognise the State borders that are so important for Government funding. People are very mobile, and cross borders frequently and live in other communities for various periods of time. Families have relations throughout this cross border area. Will funding be flexible enough to cater for other government jurisdictions?

• **Transport for families**

I have already said there is no public transport. How do we ensure the really isolated older people have access to services, and how can we promote an independence and continuing family relationships if we only have one residential facility for the frailer Anangu?

• **Acceptable meals**

Dietitians would be horrified with the current intake of sugar and meat, and old people's nutrition needs to be examined carefully with consideration for their culture. Should we employ people to catch kangaroo, rabbit, emu and goannas - which have been the mainstay of Anangu diet?
• New service in an untested area

I'm not sure whether this is a positive challenge for the MPS people, or whether the permutations of delivery that are possible, are actually seen as a negative and that an MPS will not work.

• Funding based on aged over 45 years

The negotiations we are going through have been positive in recognising that you don't need to be 65 years of age to require special care and support, and we will use the number of Anangu above the age of 45 years of age in funding formulas.

• Burden of disease - amputation, diabetes, dementia, renal failure, skin problems, respiratory, blindness, deafness.

  • Many old people are not a burden on anyone and live independently and resourcefully, however it can be suggested that the burden within Aboriginal communities is horrifying. We have a number of people on the Lands who have all these problems, and on top of that they look after several children under five years of age, live in wiltjas made of corrugated iron, branches and weldmesh, and have little support except that provided by Clinic staff.

Funding

The normal question about now is “What is it going to cost?”

At present we receive $4.9 million dollars a year in recurrent funds. This is sometimes criticised as too high, but there are no other health services whatever on the Anangu Pitjantjatjara Lands. In taking on an MPS, we are negotiating for an additional $1 million capital, and $500,000 a year recurrent for three years.

It is important to note that if we do sign up as an MPS, all our recurrent funds are pooled - we lose a lot of the bureaucratic restrictions and line budgets, and we can redraw our budget to meet the health needs of Anangu as agreed between the Communities, Nganampa Health, and funding bodies.

Conclusion

I have tried to give you an idea of some of the complexities that the Health Committee have been talking about, although these issues are perhaps only the tip of the iceberg. Clearly a lot of the issues we need to resolve are not only health related, but are also social and economic. Anangu are pleased that they are being asked to design the MPS service for Anangu, as they are very concerned about the care of old people. At present we are impressed with the flexibility of the MPS guidelines, as quite clearly any new service on the Anangu Pitjantjatjara Lands has to be extremely flexible.
References


