Palya: good. Acknowledging achievements in Aboriginal health and welfare in central Australia

Stewart Roper

Nganampa Health Council

Improving the poor state of Aboriginal health and welfare must remain a national priority. However, coverage of only the most dire health and social problems sometimes afflicting communities risks generating disillusionment.

Introduction

The presentation draws on years working with some noteworthy central Australian Aboriginal-controlled organisations to highlight historical and direct experience of some significant achievements:

- The Pitjantjatjara Council was formed in Amata in 1976 to fight for land rights, their efforts culminating in the granting of inalienable freehold title in 1981. This important achievement assures input into developments such as mining to protect areas of cultural or environmental significance and determine appropriate remuneration. Without freehold title it is highly likely that much of the traditional lands would have been bought up at a fraction of the current value.

  The council has been responsible for delivery of a wide variety of vital services over vast areas in an environmentally challenging setting.

- The Ngaanyatjara Pitjantjatjara Yankunytjatjara Womens’ Council (NPYWC) has supported families and communities since formation in 1980. The council has grown from an advocacy service into a major Anangu-directed organisation. It delivers a wide range of health, social and cultural services across 28 member communities on the NPY lands across central Australia (covering Western Australia, South Australia and the Northern Territory). Initiatives include programs to improve child nutrition, combat domestic violence, alcohol and drug abuse and support community-based initiatives in youth development, family support, aged care and the arts.

- Nganampa Health Council was formed in 1980 to improve health and living conditions on the Anangu Pitjantjatjara Yankunytjatjara Lands. Despite the difficulties associated with such a remote setting, rates of infant mortality and infectious disease have decreased dramatically and child immunisation rates are above the national average. In addition, Nganampa provides 24 hour emergency care and a comprehensive service covering antenatal care, child growth and development, adult and sexual health, chronic disease management, and aged care.

Housing

In the early 1990’s many Anangu in Amata lived in unlined tin sheds or tents. Sometimes elders chose to camp out but there was little choice anyway. Housing has improved dramatically, especially in recent years. As in many other areas, however, the current situation could be much better with a little more attention to the experiences of those who have lived and worked in the area.

The environmental arm of Nganampa Health Council has developed extensive guidelines for appropriate and environmentally friendly housing, paying particular attention to low maintenance drainage systems and insulation. Unfortunately, even recent developments have neglected this valuable information gathered over the years.

I lived in a transportable cabin with poor insulation for 10 years after arriving at Amata in 1990. Even at that time, however, the cabin had an extra corrugated iron roof built over the top, a bit like a carport. This absorbed much of the direct heat from the sun, substantially reducing air conditioning costs. Only as recently as two years ago I have seen housing cabins built for visiting service staff that consisted of
two rows of insulated shipping containers, each of the dozen or so units with its own air conditioner and a shade cloth outside but nothing over the roofs to protect from direct sunlight.

**Education**

When I first arrived in Amata in 1990 the school buildings had already seen better days. Those same buildings were still in place over fifteen years later and had become completely dilapidated with very noisy, inefficient air conditioning and poor heating. The teaching and learning conditions would have been extremely difficult. To make matters worse, many students were experimenting with petrol sniffing and it was rare to see any young people, especially boys, over twelve years of age at school.

The school was rebuilt in 2006/2007 and the effects of supportive infrastructure on staff and student morale are apparent. Artworks and furniture made by students now adorn the grounds and there are many older students there with an obvious interest in the school and learning. The school has also developed programs interacting with businesses to assist students find employment and support them through training and mentoring.

**Petrol sniffing**

Petrol sniffing had a devastating impact on communities and a particularly high media profile for over twenty years from around 1980. Some communities had up to sixty of their young children and youths sniffing. During the last five years to 2012 I have seen only one person trying to sniff in my regular travels to all communities, a situation I would have thought impossible when I first started work in the area in 1990.

The reason usually given for this is that there is now a fuel throughout central Australia that cannot be sniffed. Opal is a variety of low-aromatic petrol developed in 2005 to combat the rising use of petrol as an inhalant in remote Indigenous Australian communities. In reality, however, communities persevered for decades with rehabilitation programs to try to save their children. The framework for the success of the intervention was laid through the extensive collaboration, research and advocacy of all of the previously mentioned Anangu-controlled organisations, Aboriginal communities, health and education services throughout central Australia and the Northern Territory, state and federal government bodies and businesses.

**Health services**

**Immunisation**

Nganampa Health Council continues to consistently perform above the 90% national benchmark criteria for childhood (up to 7 years of age) immunisation coverage rates, as shown in Figure 1 below.

**Hepatitis B vaccine**

A universal newborn hepatitis B (HBV) vaccination program was introduced in the Northern Territory of Australia in 1990, followed by a school-based catch-up program. A recent study by the Kirby Institute in collaboration with CDC (Liu et al 2012) evaluated the prevalence of hepatitis B infection in birthing women up to 20 years after vaccination and compared this to women born before the programs commenced. Compared to unvaccinated women, an 80% reduction in hepatitis B was found in women vaccinated as newborns. A smaller but significant reduction was found in women vaccinated in catch-up programs.
Figure 1

**NHC Childhood Immunisation Coverage Rates**
(Source: GPII Immunisation Statement)

<table>
<thead>
<tr>
<th>Month</th>
<th>Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-11</td>
<td>95.9%</td>
</tr>
<tr>
<td>Nov-11</td>
<td>98.1%</td>
</tr>
<tr>
<td>Feb-12</td>
<td>97.5%</td>
</tr>
<tr>
<td>May-12</td>
<td>97.4%</td>
</tr>
<tr>
<td>Aug-12</td>
<td>100%</td>
</tr>
<tr>
<td>Nov-12</td>
<td>98.3%</td>
</tr>
</tbody>
</table>

Source: Nganampa Health Council, 2011

**Pneumococcal vaccine**

S. pneumoniae is responsible for such a significant proportion of community acquired pneumonia, bacteremia and bacterial meningitis that it has been mandatory to notify all confirmed cases to the National Notifiable Diseases Surveillance System since 2001.

The rates of disease caused by serotypes in the 7-valent pneumococcal conjugate vaccine (7vPCV) decreased between 2002 and 2006 by 78% in children aged under two years as a result of the introduction of a universal childhood 7vPCV immunisation program. Significant decreases in IPD caused by 7vPCV serotypes also occurred in the 2–14 years and 65 years or over age groups. Rates of disease caused by non-7vPCV in the same periods were little changed (Department of health and Ageing, 2008). Rates in indigenous children, however, remained more than 3 times greater than in non indigenous children. Hopefully, this will improve with the introduction of the 14 valent vaccine (covering more strains affecting indigenous populations) in 2012.

It is difficult to accurately assess the impact in remote communities since isolation of the organism is rarely possible and diagnoses are based on clinical symptoms. However, personal experience of health staff in clinics suggest that the incidence of pneumonia requiring antibiotic treatment has reduced dramatically since the introduction of comprehensive pneumococcal immunisation programs in central Australia. I remember often having 10 or more people in a week, adults and children, requiring intramuscular injections of penicillin over 5 days to treat clinically diagnosed pneumonia. In recent years I have rarely come across more than 2 or 3 people in a week requiring such treatment.

**Trends in mortality rates**

As shown in Figure 2 below, over the period 2001 to 2010, the gap between Indigenous and non-Indigenous infant mortality rates has been gradually closing.
These are national figures and some critics rightly point out that the Australian Indigenous population is not homogeneous and that health and conditions in remote settings are often much worse than in urban areas. Again, however, personal experience and discussions with other health staff would support the conclusion that infant mortality and morbidity are decreasing. Infant mortality is indeed so rare that I worked as a nurse in the remote setting full time for ten years and another ten years part time and did not experience one infant death. In addition infectious disease such as pneumonia (as noted previously) have declined markedly.

The observed continuing decline in infant mortality supports the suggestion of the positive impact of interventions such as improved housing, immunisation, antenatal and postnatal care. To keep these achievements in perspective, it is still a relatively common experience for health staff to be called at night to a sick child on a sheet of foam for a mattress in a house with no furniture and bare cupboards. Such poverty severely curtails chances for improving health and education outcomes.

Unfortunately, the statistics the for adult health are less promising as can be seen from the comparative mortality rates in Figure 3 below. Whilst the gap in Indigenous/non-Indigenous infant mortality rates has gradually closed from 2001-2010, the age standardised death rate for Indigenous people has remained at twice that of the non-Indigenous population.
Between 2004 and 2008, 66% of Indigenous deaths occurred before the age of 65 years compared with 20% of non-Indigenous deaths and Indigenous life expectancy for the 2005-2007 period was 11.5 years less for males and 9.7 years less for females compared with all Australians (Australian Bureau of Statistics, 2011). About 80% of the mortality gap (in terms of potential years of life lost) could be attributed to chronic disease. In the 35-54 year age group the prevalence of diabetes in Indigenous peoples is 5 times that in other Australians, clearly increasing rapidly from age 35 years onwards (Hee, 2010).

Increasing rates of chronic conditions such as diabetes, obesity, cardiovascular, renal and liver disease are becoming problematic throughout the whole Australian population and the world. The recognised major contributing risk factors to chronic disease are smoking, excessive alcohol consumption, poor diet and inadequate exercise. All of these can be expected to have proportionately greater health impacts in Aboriginal communities as a result of poverty and isolation:

- In 2004-05, the rate of regular smoking among Indigenous men was around twice that of non-Indigenous men (51% compared with 24%) and the rate for Indigenous women was around two-and-a-half times that of non-Indigenous women (49% compared with 18%) (Australian Bureau of Statistics, ABS, 2006).
- In the NT, per capita alcohol consumption among Aboriginal people is approximately 1.97 times, and among non-Aboriginal people about 1.43 times, the national average. (Gray and Chikritzhs 2007)
- In my personal experience in remote communities the price of food in general is at least twice that in urban areas with fruit and vegetables, often of dubious quality, being up to five times as expensive.
- With external temperatures in excess of thirty degrees Celsius for at least two thirds of the year, exercise regimes are less attractive than in more favourable climates and there are no air-conditioned gymnasiums to entice recruits in remote communities.
These risk factors are strongly associated with social and economic disadvantage and Indigenous Australians have lower incomes, higher rates of unemployment, lower educational attainment and more overcrowded houses than other Australians (Australian bureau of Statistics, 2011). There is a real risk that the positive impacts on Indigenous health such as lower infant mortality and less infectious disease could be swamped by the tide of increasing chronic disease in later years unless socio-economic risk factors are addressed and prevention, treatment and management improved.

References

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