This conference monograph has been produced by the Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH), and is the sixth in the series of Aboriginal and Torres Strait Islander environmental health conference monographs. As with previous conference monographs, the report aims to contribute to the debate around, and increase the understanding and awareness of environmental health issues, with a key focus on Aboriginal and Torres Strait Islander Environmental Health Workers (EHWs).

National Aboriginal and Torres Strait Islander Environmental Health conferences are held regularly in order to provide a national forum for discussion and to raise the profile of Aboriginal and Torres Strait Islander environmental health issues.

The first Aboriginal and Torres Strait Islander Environmental Health Conference was held in Cairns in 1998 with the aim of providing an opportunity for people working in and with Aboriginal and Torres Strait Islander communities to discuss common concerns, issues and strategies for improving Aboriginal and Torres Strait Islander environmental health.

The second conference was held in Broome in 1999. The resulting recommendations were used to inform the final development of the Implementation Plan for the National Environmental Health Strategy, and to further develop collaborative projects and strategies for progress on a national basis through the then enHealth Council. A key recommendation from this conference was to establish a national Indigenous Advisory Committee.

The third conference was held in Alice Springs in 2000, and was facilitated by members of the newly established National Indigenous Environmental Health Forum (NIEHF) which comprised Environmental Health practitioners from each State and Territory, and a subcommittee of the then enHealth Council. Each NIEHF member gave a presentation at the conference.

The fourth conference was held in Adelaide in November 2002. The themes of presentations and discussions reaffirmed the importance of a well-trained Aboriginal and Torres Strait Islander environmental health workforce. The conference emphasised that Aboriginal and Torres Strait Islander environmental health workers and officers should be accorded status reflecting the importance of their role, and their training should be provided at accredited and recognised levels.

The fifth conference was held in Terrigal, NSW, in 2004 and brought together environmental health practitioners from across Australia and New Zealand who showcased their projects and programs, successes and challenges. It was anticipated that delegates armed with this knowledge would consider adapting these programs within their own communities.

The sixth conference was held at the Cairns Convention Centre in May 2007 and showcased some new Aboriginal and Torres Strait Islander Environmental Health initiatives targeting improvements to the built environment; workforce development; food safety and nutrition; water quality; waste management; pest and animal control and climate change. The recommendations of this conference have been included in the five-year WGATSIEH Work Plan. Progress on these recommendations will be monitored and the results will be presented at the seventh National Aboriginal and Torres Strait Islander Environmental Health Conference in 2009 to be held in Western Australia.
Acknowledgements

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- Queensland Health
- Australian Government Department of Health and Ageing
- Department of Health and Community Services, Northern Territory
- Department of Human Services, South Australia
- Department of Human Services, Victoria
- Department of Health and Human Services, Tasmania
- New South Wales Health
- Western Australian Department of Health
- Australian Institute of Environmental Health
- Department of Local Government, Planning, Sport and Recreation
- Environmental Protection Agency
- Department of Natural Resources and Water

There has also been considerable assistance from around the country, and delegates are acknowledged for their efforts. Special thanks, in particular to members of the National Aboriginal and Torres Strait Islander Environmental Health Conference Organising Group and the Queensland Local Organising committee and Conference Management Solutions, who provided oversight in expertly guiding the organisation of this successful event:

- Clayton Abreu, Aboriginal and Torres Strait Islander Environmental Health Coordinator, Tropical Population Health Unit, Queensland Health
- Owen Ashby, Manager, Aboriginal Health Unit, Western Australian Department of Health
- Alan Blackman, Project Officer, Environmental Health, Southern Population Health Unit, Queensland Health
- Eddie Bobongie, District Aboriginal and Torres Strait Islander Environmental Health Coordinator, Cape York, Tropical Population Health Unit, Queensland Health
- Sonja Carmichael, Senior Policy Officer, Aboriginal and Torres Strait Islander Environmental Health, Environmental Health Unit, Queensland Health
- Dallas Einsiedel – Project Officer, Environmental Health, Southern Population Health Unit
- Chris Gyemore, Aboriginal and Torres Strait Islander Environmental Health Coordinator, Southern Population Health Unit, Queensland Health
- Zane Hughes, Theme Leader, Regional, Remote and Indigenous Programs, Charles Darwin University, Darwin NT 0909
- Adam McEwen, Environmental Health Officer, Central Coast Public Health Unit, New South Wales Health
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- Merle O’Donnell, Aboriginal and Torres Strait Islander Environmental Health Coordinator, Central Population Health Unit Network, Queensland
- Xavier Schobben, Director, Environmental Health, Department of Health and Community Services, Northern Territory
- Nicola Slavin, Senior Policy Officer, Environmental Health, Department of Health and Community Services, Northern Territory
- Jeff Standen, Manager, Aboriginal Environmental Health Unit, New South Wales Health
- Craig Steel, Acting Director, Environmental Health, Regional Services Branch, Department of Human Services, South Australia
- Nicholas Thompson – Program Coordinator, Environmental Health and Vector Control Unit, Primary Health Care Centre, Thursday Island
- Richard Turnbull – District Environmental Health Worker, Mt Isa, Tropical Population Health Unit, Queensland Health

CONFERENCE MANAGEMENT SOLUTIONS

- Adam Druce, Conference Manager, Conference Management Solutions
- James Paterson, Registration and Operations, Conference Management Solutions
FOREWORD BY THE WGATSIEH

The WGATSIEH is pleased to present the proceedings of the 6th National Aboriginal and Torres Strait Islander Environmental Health Conference, held in Cairns, Queensland, in May 2007. WGATSIEH acknowledges the Irukandji People, the traditional owners of the country visited by all conference delegates.

Our special thanks to the National Aboriginal and Torres Strait Islander Environmental Health Conference Organising Group, CMS Conference Manager and Queensland Health who have all been particularly active in guiding the organisation of the conference.

One of the roles of WGATSIEH is to organise each national conference. Another role is to provide coordinated advice to the Environmental Health Committee (enHealth) and other key stakeholders on national Aboriginal and Torres Strait Islander environmental health policies and associated environmental health issues.

WGATSIEH consider the following as key priority areas to be progressed:

- Environmental Health Promotion
- Aboriginal and Torres Strait Islander Environmental Health Workforce
- National Aboriginal and Torres Strait Islander Environmental Health Information systems
- National Aboriginal and Torres Strait Islander Environmental Health Strategy
- Child health
- Housing and Environmental Health Infrastructure

Environmental health is a challenge. Aboriginal and Torres Strait Islander Environmental Health is an even bigger challenge. This conference continued to showcase the challenges in Aboriginal and Torres Strait Islander environmental health. The presentations in this monograph also highlight Aboriginal and Torres Strait Islander environmental health programs and new initiatives targeting improved housing and infrastructure; workforce development; food safety and nutrition; water quality and sustainability; waste management; and pest and animal control.

WGATSIEH would like to thank the conference sponsors, as this successful conference would not have been possible without their ongoing support and contributions. We would also like to thank the presenters for contributing to such an exciting program, and for highlighting the many positive actions occurring in Aboriginal and Torres Strait Islander communities. Finally, thank you to the conference delegates for attending. You are all urged to continue making positive change through taking on the challenge of Aboriginal and Torres Strait Islander environmental health.

Xavier Schobben
Chair
enHealth Working Group on Aboriginal and Torres Strait Islander Environmental Health
Environmental Health Committee (enHealth) of the Australian Health Protection Committee acknowledges the Traditional Owners of the country visited by conference delegates, and takes great pleasure in presenting the proceedings of the 6th National Aboriginal and Torres Strait Islander Environmental Health Conference. The conference was kindly hosted by Queensland Health on behalf of the WGATSIEH at the Cairns Convention Centre in May 2007.

By holding National Aboriginal and Torres Strait Islander Environmental Health Conferences, enHealth and WGATSIEH aim to raise the profile of Aboriginal and Torres Strait Islander environmental health, and to provide a forum for discussion of priority Aboriginal and Torres Strait Islander environmental health issues.

As in the past, this year’s conference is built upon the achievements of the previous five conferences by reflecting on areas where improvements have been made and by examining those in which there is still work to be done. The Steering Committee for the Review of Government Service Provision titled, Overcoming Indigenous Disadvantage: Key Indicators 2007, confirms our understanding that poor environmental health conditions contribute to poor health outcomes within the Aboriginal and Torres Strait Islander population. Effective environmental health systems are listed as a strategic area for action in the report, which covers some of the key environmental influences on health, which potentially have a significant impact in reducing Indigenous disadvantage and its suitability for policy action.

While it is important to realise that it will take some time before improvements in environmental health lead to improved health outcomes for Aboriginal and Torres Strait Islander Australians, the WGATSIEH will continue to support and provide advice on Aboriginal and Torres Strait Islander environmental health policies and associated environmental health issues through a range of activities, including the release of these proceedings.

I would like to acknowledge, on behalf of enHealth, the significant effort of the National Aboriginal and Torres Strait Islander Environmental Health Conference Organising Group in expertly guiding the organisation of this successful event. I would also like to thank the presenters for contributing to such an exciting program and the sponsors and supporters, without whose assistance this conference would not have been possible.

Dr Roscoe Taylor
Chair, Environmental Health Committee (enHealth)

The following five recommendations have been endorsed by the Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH) and are included in the five year WGATSIEH Work Plan:

- enHealth advocate for further funding to assist with the rollout of the Remote Community Water Project including the development of resource kits and training sessions to assist jurisdictions in the management of water and sewerage.
- enHealth advocate to relevant federal Ministers for the establishment of a training program for Aboriginal and Torres Strait Islander Environmental Health Officers, which could be a matched partnership agreement with State health agencies and assistance with academic and supervision support.
- Establish an Aboriginal and Torres Strait Islander Environmental Health Association to be named ‘The Aboriginal and Torres Strait Islander Environmental Health Practitioners’ Association’.
- The Working Group on Aboriginal and Torres Strait Islander Environmental Health and enHealth co-sponsor the development of the ‘Conducting Dog Health Programs’ for Environmental Health Workers publication with Animal Management in Rural and Remote Indigenous Communities (AMRRIC).
- Obtain enHealth endorsement of the AMRRIC Manual and promote its purchase and use by public health units and local government.
Stephen Canendo has been employed for over twenty-five years with newly-named Yarrabah Aboriginal Shire Council (YASC). For the first twenty years at YASC, he was one of their Hygiene Officers but in 1998 became the Council’s first Environmental Health Worker (EHW). This makes him the longest serving community-based EHW in Queensland.

Prior to commencing in that latter role, Stephen enrolled in the very first intake of students who studied for their Diploma of Health Science (Indigenous Primary Health Care – Environmental Health) at the Tropical North Queensland Institute of TAFE, Cairns. He graduated in 1997 and went on to gain his Advanced Diploma of Health Science. He has since studied as an external student of the Batchelor Institute of Indigenous Tertiary Education near Darwin, working towards his environmental health degree.

During the last 8 years he has actively advocated for environmental health in his community and embraced a very holistic approach. There is no question that the general community awareness and standard of environmental health has significantly increased in Yarrabah during this time, and it has led to a commensurate reduction in disease. This simply would not have happened before the EHW program was introduced. It is a credit to the performance of Stephen Canendo in that time and his ability to achieve considerable gains across a diverse range of environmental health issues. He is well respected in the community for being – ‘true to his words’ and a ‘man of action’.
TUESDAY 22 MAY 2007

CONFERENCE OPENING

Shane Nichols, Deputy Chair, enHealth Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH)

Shane Nichols welcomed conference delegates to the Sixth National Aboriginal and Torres Strait Islander Environmental Health Conference and acknowledged the traditional owners, the Irukandji People. He then paid respect to their Elders and to any other Aboriginal and Torres Strait Elders who were present. Shane then invited Xavier Schobben, Chair of the Working Group on Aboriginal and Torres Strait Islander Environmental Health and Director of Environmental Health in the Northern Territory, to the stage.

Xavier Schobben, Chair, enHealth Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH)

Xavier Schobben welcomed everyone to the Sixth National Aboriginal and Torres Strait Islander Environmental Health Conference. He stated that the location of the conference had come back full-circle to Cairns, which had hosted the very first conference in 1998, and that ironically he felt even more at home, as he and other Northern Territory colleagues were staying at that original venue. Xavier then invited Warren Singleton, an Irukandji traditional owner, to the stage to give a welcome to country.

TRADITIONAL WELCOME TO COUNTRY

Warren Singleton and the Irukandji Traditional Owners & Dancers

Warren Singleton, an Elder of the Irukandji People gave a welcome to country on behalf of the Irukandji People. He thanked Xavier Schobben and Clayton Abreu from the Tropical Population Health Unit and his department, for inviting him and the Irukandji dancers to appear at the conference in recognition of the old people who roamed the land which they claimed as their own from Cairns and Port Douglas. He then introduced the Irukandji Dancers.

CONFERENCE OFFICIAL OPENING

Sophie Dwyer, Senior Director of Environmental Health Unit Queensland Health and Queensland representative of enHealth

Ms Dwyer thanked Mr Nichols and noted on behalf of Queensland Health that she was very pleased to be able to assist in organising the conference with the support of all our colleagues, adding that she would say more about this later. She said that it was with great pleasure she would like to introduce Dr Jeannette Young, Queensland’s Chief Health Officer and currently Acting Director-General Queensland Health. Ms Dwyer thanked Dr Young for bringing a message from the Minister, and for taking time out from her busy schedule to officially open the conference.

Dr Jeannette Young, Queensland’s Chief Health Officer and currently Acting Director-General Queensland Health

“Thank you very much, Sophie. This is one of the best parts of doing my job. I love coming and doing these things and talking to people and hearing what’s going on, and often I learn so much from doing these things as people give me ‘dot points’ to put a speech together and I learn things. I think wow, people have done that, so this is a really great opportunity, and thank you so much for the invitation Sophie, and to the organising committee.

I’d like to start with some acknowledgements. First, of course, to the traditional owners, whose land we meet on for the next couple of days, the Irukandji People. I think that was a great start and a great opening to the next couple of days. Also to Xavier Schobben, the Chair, and to Shane Nichols, Deputy Chair, WGATSIEH on Aboriginal and Torres Strait Islander Environmental Health, Dr Roscoe Taylor, a colleague of mine on the Australian Health Protection Committee and Chair of the enHealth Sub-committee, other conference speakers, guests, including if there are any Elders of the people who lived here, ladies and gentlemen.

As I said, I am delighted to be here today. I am here to represent Queensland’s Minister for Health, The Honourable Stephen Robertson, and to open this very important conference. It is unfortunate Mr Robertson is unable to join us because Queensland parliament is sitting this week, and of course he has to be there for that responsibility. He is also participating in a number of reconciliation events that are being held in Brisbane. I do know he is disappointed about not being here because Indigenous health issues are of particular interest to him, and he regards events such as these over the next few days as crucial for collaboration and relationship-building. As Queensland’s Chief Health Officer, I very much share that view, and being here today as I alluded to before is extra special, as I shall be talking about several initiatives that my own staff have been involved in, and those that I believe embody the spirit of reconciliation.

For those of you not from Cairns, I would like to welcome you to tropical North Queensland. Wherever you have travelled from I hope you have a thoroughly enjoyable stay, and maybe those of you from the south-east corner could have an extra minute in the shower.

I would like to begin my address today by describing the larger health picture for Indigenous Queenslanders. This year Queensland Health has embarked on an exciting new direction in Aboriginal and Torres Strait Islander health. We endeavour to look at Indigenous health issues in a new way, and change how we do business to get better outcomes.

We want to inject more vitality into the way we do business, and focus more on results. In order to ensure that our organisation addresses Indigenous health from a clinical as well as a policy and program perspective, the Director-General engaged a consultant, Robert Griew. I think that Northern Territory’s loss is very much our gain, as Robert was of course the former CEO of the Northern Territory’s Department of Health, and has a wealth of experience. Fortunately for us, he has agreed to join Queensland Health in a...
part-time capacity for the next two years to work with our Aboriginal and Torres Strait Islander Health Strategy Unit to help implement some recommendations he has made during his review. Robert and the unit will implement strategies to ensure that Aboriginal and Torres Strait Islander health is enmeshed in all areas of the Department’s business. They will identify and seek to ensure better Indigenous outcomes from other government departments including the Commonwealth, and also work closely with community-controlled health services. Robert, I know, will be a leader, champion, scrutineer and mentor, helping to keep Queensland Health forward-focused so that Indigenous health issues don’t get bogged down or lost in bureaucracy.

So what are some of the areas of concern? Late last year some of you may be aware that I released the first in a series of two-yearly reports on the state of Queenslanders’ health. I am sure it won’t come as a surprise to any of you that the report identified a number of inequities in comparing the health status of Indigenous and non-Indigenous Queenslanders. Currently the expected average life span for an Indigenous Queenslander is about 20 years less than for a non-Indigenous person, equating to about 60 years for an Aboriginal and Torres Strait Islander man, and 64 years for women. However, we have also to remember that the Indigenous population is a much younger one. It’s estimated that about 50% of our Indigenous population is under the age of 20, and it seems that socio-economic disadvantage rather than location plays a role in the overall state of Indigenous Queenslanders’ health. Sadly, it’s again a fact that death rates in Indigenous populations are estimated to be much greater for conditions such as heart disease, diabetes, chronic respiratory disease, pneumonia and injury. For example, Aboriginal and Torres Strait Islander adults are three times more likely to be admitted to hospital for chronic disease than their non-Indigenous peers.

So all of this highlights the need for action and careful consideration when developing strategies for the future. Much needs to be done – significantly more than we think, and the processes need to be ongoing. I believe the foundation has already been laid and there is some very, very, good work going on, which brings me to the focus of this conference, Environmental Health.

Environmental Health is a strongly emerging area, and one in which we are seeing how community engagement and capacity building can reap great rewards. In a way I believe Environmental Health is the precursor to ensuring overall better health outcomes, so it plays a critical role in laying the foundations to improving Aboriginal and Torres Strait Islanders’ quality of life.

It was noted from 2002 that the government called upon Aboriginal and Torres Strait Islander communities to take up the challenge to manage environmental health issues in their own communities, with communities as pilot tests for environmental health challenges such as mosquito control, food handling practices and animal management. Such pilot tests are employing and educating local people to advise on local issues, while bridging cultural gaps and communicating local issues and needs.

Back in 2002 Queensland Health was recognised as the main advisory body for environmental health in Cape York. The same year the Queensland Government’s Meeting Challenges, Making Choices Strategy was launched to implement the recommendations of the Cape York Justice Study. It called for the active participation of Aboriginal and Torres Strait Islander people to take up the challenge of building the capabilities to manage the environmental health needs within their own communities. As a result, Cape York became a testing ground for a pilot Environmental Health Work Program to address matters such as mosquito control, waste management and food handling practices. It proved an enormous success by increasing the level of Indigenous employment within the community, and providing local people to advise on local issues. The qualified Environmental Health Workers were able to bridge cultural gaps by communicating their local issues and needs, which also resulted in the community valuing the positions and the people in them.

Then in 2005 the Queensland Government agreed to expand the program to include all Aboriginal and Torres Strait Islander Councils. I am proud to say - and we had a bit of a debate, so if I am wrong here please correct me - I believe that Queensland's program is now the biggest Indigenous Environmental Health Program of any State. So I leave you to work that one out over the next few days. There are now approximately 30 Environmental Health Workers employed in 34 communities across the State. While Queensland Health provides the funds, the training and the support, it is important to note that these workers are employed by their own community councils to manage their own community health needs at the local level. This has become a remarkably successful program, and I firmly believe that there are two words that sum up why that is so - community engagement. These workers are now at the centre of their community’s life. Some of these workers are taking up further study, seeing their present positions as a springboard to new career opportunities. I congratulate all the Queensland health staff, some of whom are sitting here today, who have been involved in the development of that program.

Building on from this success is news of a second exciting program now being implemented. In December last year 34 Aboriginal Local Governments and Island Councils were invited to apply for funding to develop and implement animal management programs for their communities. The program is the first of its kind in Australia, and integrates normal animal management with animal welfare, pest and weed control. The program is funded by Queensland Health, the Department of Primary Industries and Fisheries, and the Department of Local Government, Planning, Sport and Recreation. This united effort is indicative of the Queensland Government’s commitment towards working collaboratively to improve the lives of Aboriginal and Torres Strait Islander communities.
A number of Aboriginal Local Governments and Island Councils applied for funding, with some making joint submissions. I am delighted to announce that just this month Queensland Health has approved the applications of 21 councils, and they will receive total funding of $1.16M to participate in the program. This funding will enable councils to employ an animal management worker, purchase equipment and develop programs which may include engaging veterinary services. You might wonder why - although I am sure you don’t - Queensland Health is involved in animal management, but we only have to look to the situation overseas and indeed in our own country to see how sick animals can lead to the spread of disease and infection. Education enforcement is the key to managing the problem.

Of course another important aspect of these plans relates to the problem of feral animals. Whilst these may not impact directly on human health, it is important to recognise that across Queensland the economic costs attributed to feral pigs and wild dogs are estimated to be $45M. Upon completing the course, the workers will have obtained skills in both feral and domestic animal management, as well as animal health and welfare. The program will also provide opportunities for those involved to develop career paths like those who have gone on to hold positions in their communities as chairmen, councillors and community leaders after being EHWs.

Queensland Health’s Indigenous Environmental Health Coordinators will also provide support in partnership with Environment Health Officers. Because this program involves other government departments, the new workers will also be provided with advice and support by specialists from those agencies. As I have said, this is a very exciting program which meshes well with the successful Indigenous Environmental Health Worker program.

Finally, I would like to leave you with one thought. The breadths and complexity of indigenous health issues can at times seem overwhelming. There’s no doubt that there’s much to be done. However, I suggest you walk away today and try looking at some of these issues in a different light. Maybe try something new and see where you can individually add energy, expertise and commitment, to really make a difference. So thank you, and I now declare the 2007 National Aboriginal and Torres Strait Islander Environmental Health Conference officially open”.

Sophie Dwyer, Senior Director of the Environmental Health Unit, Queensland Health, and Queensland representative on the enHealth Council

“Thank you very much, Jeannette, for your support – it will give Zac and I something to debate till the end of the conference. Firstly, I would like to say a few words, but before I do I would like to acknowledge the traditional owners, the Irukandji People, and the Elders who are present. It is very exciting for us to be involved in this conference and it wouldn’t have happened without a lot of support. Clearly there’s the support of the organisational group, and particularly the forum, the Aboriginal and Torres Strait Islander Environmental Health forum as part of enHealth. But the support is more widespread, and if you look at your programs you will see there are a lot of logos on the back of the program, and actual recognition of the amount of support that has come from a lot of places to make this conference possible. Queensland Health would not have been able to put it on without all that support.

Firstly, enHealth itself. You will be hearing from Roscoe soon and Zac, with their support. You’ll also hear from the Forum and the Australian Government representatives, who have also been a great support. My colleagues across all jurisdictions Australia-wide have also contributed to making the conference possible - so that’s an indication of how important this conference is to enHealth. In Queensland we have also had a lot of support. You will also see quite a few of the Queensland Government logos. We call them “Beatie burgers” but in fact if you look at it you will see there is support from quite a few agencies - we have a steering committee in Queensland, a cross-government agency group that looks at environmental health, and we have had Housing and Primary Industries, Environmental Protection, Treasury and other agencies involved.

Three of those agencies have also contributed to this conference, and that I think is very special for us - the Department of Local Government, Planning, Sport and Recreation, which is providing administrative support in both programs, the Environmental Protection Agency and the Department of Primary Industries which are really close partners on the animal management program. So my thanks to them. It is really good to see that cross-agency support which is probably what environmental health is all about - it is not just a health agency business. The conference has also received support from the Australian Institute of Environmental Health, Trovan Microchips and the Batchelor Institute of Indigenous Tertiary Education. So thank you to all the supporters because I think it is through that energy and commitment and financial commitment (where people put their money where their mouth is), that the conference was made possible. It made it easier for us and my staff - in particular I would like to acknowledge Sonja Carmichael, who has been particularly active. Sonja has been the ‘glue’ to hold this project together, and made sure we got to this point. We also received support from within Queensland Health from the Aboriginal and Torres Strait Islander Health Unit, and Sheryl Sandy, the Senior Director, is here today. I am sure you will meet her during the course of the conference.

So you can see that many players have come together. My task now is to introduce Dr Roscoe Taylor, an old colleague of mine, friend, and also the Chair of enHealth. Roscoe has been a member of enHealth Council (now known as the Environmental Health Committee), to give its formal name) in various capacities since 1997. He is currently the Chair, and does a wonderful job. Roscoe has been Director of Public Health in Tasmania since 2002 after spending nine years working as a public health physician in central Queensland. He has over 17 years’ experience in environmental health at both a state and federal level, and is also active in a range of other public health areas such as chronic disease and prevention. So I would like to hand over to Roscoe”.

Sonja has been the ‘glue’ to hold this project together, and made sure we got to this point. We also received support from within Queensland Health from the Aboriginal and Torres Strait Islander Health Unit, and Sheryl Sandy, the Senior Director, is here today.
ENHEALTH REPORT ON PREVIOUS CONFERENCE RECOMMENDATIONS

Dr Roscoe Taylor, Member of Australian Health Protection Committee and Chair Environmental Health Committee (enHealth)

“Thanks everyone, it’s tremendous to be here and as Chair of enHealth I would like to acknowledge the traditional owners of this land and thank the Irukandji People for that really great welcome. It’s a tremendous thing for me to be here.

Basically I became Chair of enHealth by accident really. I’d only been there for a couple of years and I acknowledge the work of my predecessor, Michael Jackson, from Western Australia. I really want to congratulate the organisers, particularly the National Organising Committee, the local organising group and to Queensland Health for organising all this. Thanks to all of you. I understand the turnout today is about twice what it was for the first national conference back in 1998, here in Cairns. So that’s just indicative of the growth that is going on, and to hear Jeannette and Sophie talk about the way Queensland is starting to get the intersectoral collaboration going around environmental health, really, I think is a tremendous step forward. One of the issues I think in the past has been that environmental health has been a bit of a ‘Cinderella’ and tends to fall between some of the cracks between the different departments. However, now you start to see this integrated ownership of it as an issue, and I think that really augers very well. So congratulations to those initiatives that have been announced here.

Communication is an extremely important concern to environmental health at all levels of the system. This event we are having this week is a great opportunity to come together and hear the presentations, give each other food for thought, and see how many of the issues we are all facing are the same in different ways. However, we are all working together on different aspects of what are often the same types of issues. This gives people an opportunity to talk with others from across all levels of the system - from grass roots people, to those advocating for increased funding, and those seeking strategic directions.

I encourage you to use this opportunity over the next few days to meet new people and swap contact details, so you can keep in touch with each other and also to renew old friendships.

Networking and the sharing of ideas are a big theme. We will hear lots of stories and there will be a common theme, I think, about partnership being a major focus of how we actually reach good environmental health outcomes. I also want to acknowledge the work and thank the members of the Working Group for Aboriginal and Torres Strait Islander Environmental Health (whose precursor was the National Indigenous Environmental Health Form, but this is the new name), and Xavier will come back to that in his presentation and talk about how that has evolved, and the new structure in which we find ourselves, together with implications for Indigenous environmental health in Australia.

The partnership you would be very familiar with is the one between government, non-government and the community. Environmental health is something not any one party can do on its own, and it really does behove us all to be players. So we are all responsible. I should stop and dwell a moment on the restructure that has occurred under the Australian Health Minister’s Advisory Council. After 2005 there was a review of the AHMAC structures including the National Public Health Partnership, and enHealth. A new entity called the Australian Health Protection Committee was formed as a principal subcommittee of AHMAC, and there was also a range of other committees. One of them was a Population Health Development Committee. Under the Australian Health Protection Committee were brought several existing subcommittees, including enHealth. Under en-health in turn is the Working Group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH). In addition, under enHealth is the Water Working Group, the Air Working Group and the Toxicology Working Group at this point in time, totalling four key foundation working groups that do a lot of the actual work for enHealth.

The members of enHealth include the Directors of Environmental Health from each State and Territory, Australian Government Department of Health and Ageing, Environment and Water Resources, Australian Institute of Environmental Health, Australian Local Government Association, the Public Health Association of Australia, the Australian Consumers’ Association or “Choice” as it is called now, the National Health and Medical Research Council, and we also have Shane Nichols as Deputy Chair of WGATSIEH. Thanks Shane.

The Terms of Reference - I won’t dwell on these in great detail - but they were reframed in the context of the AHMAC restructure to:

• Provide nationally-agreed environmental health policy advice.
• Coordinate implementation of nationally-agreed environmental health policies and approaches.
• Provide environmental health expertise and support for AHPC’s emergency management role, which was one of the drivers of the establishment of the Health Protection Committee in response to issues such as SARS, pandemic influenza and bioterrorism concerns - all of those things which have caused a national look at how we manage those from a health policy perspective. Mass casualties issue is another one. We, too, need to feed into that work.
• Provide expert, and where nationally-agreed, health advice in environmental policy forums.
• Consult with stakeholders as appropriate in developing and implementing environmental health policy.
• Contribute to international collaboration on environmental health issues.
• Coordinate research, share information and develop practical environmental health resources.
enHealth these days reports through that structure right up to
Health Ministers. The domain of our work is very much driven by
what Health Ministers can influence as well. We still work using the
same principles that we have always had and the membership is
much the same as it was before, and that includes the principles of
consultation and collaboration. If you need to know more go to the

Our strengths include expertise, and commitment – and that’s
true of a number of members on enHealth who are a tremendous
group to work with. With the new structure we now have a centrally
located Secretariat in the Australian Government Department
of Health and Ageing, which gives us a more robust secretariat
arrangement.

enHealth’s work includes identifying where national approaches are
needed, and where indicated go on to develop national policies,
guidelines and models - things that we believe will be useful to
people in their specific field, or in conducting specific projects. We
now form part of a communication system to Health CEOs and
Health Ministers, and we can help share the information, skills,
experience and expertise of others, and people like you. We can
also advocate to a degree.

What we can’t do, unfortunately, is guarantee funding. There
isn’t a particular bucket of funding that enHealth itself controls.
Like others, we have to stand in the queue and advocate for the
purposes of a particular funded project. We can’t take action
without consultation and collaboration. We must work with AHPC
and our colleagues. We can’t undertake projects outside our terms
of reference. This becomes important when you come to look at
the conference recommendations over the years.

I see a key role of the Working Group on Aboriginal and Torres Strait
Islander Environmental Health is to inform and to help drive these
things through enHealth and with enHealth.

The challenges we face (and I am sure you know these so well):

• Isolation – both geographically and professionally.
• Being on your own – limited support, status and poor
  infrastructure.
• Competing demands – where do you start when you are
  confronted with so much to do?
• An inadequate pay structure – the wheels are turning in the right
direction here now.
• Not enough ‘hands on deck’.
• Inadequate funding for resources and equipment.

To governments and communities the value of investing in enHealth
is pretty clear once they start to understand the linkages to people’s
wellbeing and health. To quote a government report from Western
Australia in 1998

‘Improvement of environmental health conditions, particularly in
remote communities, (must) be treated as the single highest priority
for the government’s program’.

Let’s take a look at progress over the past 10 years:

• Establishment of more Environmental Health Worker positions.
  (WA: 50+, Qld: 30+, NT: 10+, NSW-HHWs).
• Better sharing of successes and failings.
• Greater awareness of issues among all levels of government.
• Improved training for EHWs.
• More opportunities to become EHOs.
• Improved promotion of EHWs as a valued profession.

We have seen since 1998 a number of recommendations made at
each national conference like this one - very valuable bits of work –
a consensus of opinions coming forward. It was decided at the last
conference to get a group together to look at the themes arising
from those, and to do a stocktake on progress. The themes that
have emerged from all of the conference recommendations fell into
the following groups:

• Firstly, the value and merit of having conferences such as this –
  these were seen as worthy of continuation.
• Secondly, a whole range of things that fall under the headings of
  • Policy and process.
  • Management and support.
  • Training.
  • Models of working.
  • Advocacy.
  • Food.
  • Housing and infrastructure.

I am not going to go back into the previous four national
conferences, because I understand that the previous chair, Chair
Michael Jackson, at Terrigal, provided a recap of how we have been
implementing those recommendations. Today I will just have a look
at the recommendations from the Fifth National Conference:

• EH input, third edition National Indigenous Housing Guide –
  actioned and completed.
• Advocate for Indigenous communities to be listed as special
  areas under Building Codes of Australia – being progressed.
• Develop an industrial award for EHWs – found not to be feasible
  to have a specific award with current numbers of EHWs. Local
  Government awards are being utilised by some communities.
  This is one that is more of a jurisdictional issue rather than one
  that can be progressed nationally.
• Provide scholarships or cadetships for Indigenous EH
  practitioners – being progressed by jurisdictions to variable
  degree. This is something very valuable to continue working on.
• Update the enHealth website – this is included in WGATSIEH
  Work plan.
• Conduct a national review of the status of Indigenous EH every
  four years – currently being explored.
• Development of a National Indigenous Environmental Health
  Strategy – in the WGATSIEH Work plan. An interesting issue
  here is about the integration into a national EH strategy and how
  that best be pursued.
Subject all Indigenous community water supplies to appraisal under the Framework for Management of Drinking Water Quality – Community Water Planner: A Tool for Small Communities to Develop Drinking Water Management Plans.

So what’s the future? So much has been done when you look back on it, which is encouraging, but there’s so much more work to be done. We must still work together, with Environmental Health being a cornerstone to health improvement. I think one of the key things for the future is the rollout of the Population Health Training Package for Indigenous Environmental Health. Fundamentally though, Indigenous Environmental Health must remain a major priority for enHealth. Thank you everyone for your time, and I hope you have a good conference”.

FOR FURTHER INFORMATION
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WORKING GROUP ON ABORIGINAL AND TORRES STRAIT ISLANDER ENHEALTH
Xavier Schobben, Chair, en-Health Working group on Aboriginal and Torres Strait Islander Environmental Health (WGATSIEH)

“On behalf of the WGATSIEH, we’d like to acknowledge the Iukandjii People on whose land in Cairns we are meeting. It is indeed a beautiful part of Australia. We have certainly come full-circle in hosting these national conferences. We had 112 delegates at our very first 1998 national Aboriginal and Torres Strait Islander Environmental Health Conference in Cairns, and now we have close to 300. While that very first conference was organised very quickly, it achieved what we had planned. That was quite simply to get those people who worked in Indigenous environmental health together to share information, and identify and discuss the issues that had national significance.

At that time, the conference was organised and funded by the National Environmental Health Forum, which was a committee made up of the Commonwealth and State/Territory Directors of Environmental Health. The Forum later became enHealth Council in 1999 and the national conferences were organised by the Conference organisng committee and from 2000 onwards by the National Indigenous Environmental Health Forum, which has now become the Working Group on Aboriginal and Torres Strait Islander Environmental Health, known as WGATSIEH.

I would like to touch very briefly on the background to AHMAC sub-committee review. In 2005 AHMAC directed that the committees reporting to it be reviewed, as it intended to tighten its reporting mechanisms. The guiding principle for the sub-committee review was that a national committee should only exist if its major focus was on national policy development with a view to trying to achieve national consistency. EnHealth Council, which at the time reported to the National Health Partnership, was considered in the Population Health committee component of the AHMAC review. The review’s recommendations and its endorsement by AHMAC resulted in the establishment of the Australian Health Protection Committee and the Population Health Development Principal Committee.

The review also recommended that the enHealth Council be replaced by the Environmental Health Committee (enHealth). AHMAC also directed that all of its sub-committees review their sub-structures, including the National Indigenous Environmental Health Forum, and place a higher priority on national policy development. enHealth endorsed a working group structure to concentrate on air, water, toxicology and Aboriginal and Torres Strait Islander environmental health. AHMAC’s re-emphasis on national policy development required that people with jurisdictional responsibility for Indigenous environmental health policy were now also invited to become members of the new WGATSIEH.

WGATSIEH is comprised of the following members:

- New South Wales : Adam McEwen, Jeff Standen.
- Northern Territory : Zane Hughes, Nicola Slavin, Xavier Schobben (Chair).
- Queensland : Clayton Abreu, Sonja Carmichael.
- South Australia : Craig Steele.
- Victoria : Shane Nichols (Deputy Chair).
- Tasmania : Stuart Heggie.
- Western Australia : Owen Ashby.
- Commonwealth : Jenni Paradowski.
- Secretariat : Commonwealth.

WGATSIEH first met by teleconference on 19 December 2006, and later got together in this beautiful city on 2 February 2007 to finalise preparations for this Conference.

The role of WGATSIEH is to provide coordinated advice to enHealth and other key stakeholders on national environmental health policies and associated environmental enHealth issues.

The Working Group’s terms of reference are to:

- Advise enHealth on Aboriginal and Torres Strait Islander environmental health issues.
- Support the review and development of national Aboriginal and Torres Strait Islander environmental health policy.
- Act as focal group for enHealth in promoting Aboriginal and Torres Strait Islander environmental health with relevant stakeholders.
- Also provide input and direction into enHealth Aboriginal and Torres Strait Islander environmental health conferences and other mainstream conferences relating to environmental health.

The National Indigenous Environmental Health Forum was the predecessor to WGATSIEH, and worked very hard since its inception in May 2000 through to mid-2006. Fortunately there are
a number of members from the Forum still present on WGATSIEH, and I would also like to pay tribute to the Forum members and thank them for their achievements.

WGATSIEH has developed a major work plan to be progressed over the next five years that we hope will achieve some good outputs and outcomes for Aboriginal and Torres Strait Islander communities and environmental health practitioners.

After this conference, WGATSIEH members will also meet to evaluate this Conference and identify any areas for improvement for the benefit of the next Conference to be held in Western Australia.

This Conference provided the opportunity for environmental health practitioners at all levels to network, share ideas and adapt solutions to their local context. The keynote addresses and the 18 presentations should also help you in continuing to take on the important challenge of improving Aboriginal and Torres Strait Islander environmental health.

FOR MORE INFORMATION
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GUEST SPEAKER
Cleveland Fagan, CEO Apunipima Cape York Health Council

“Good afternoon, and thank you for the invitation to come and talk to you guys at the Environmental Health Conference. Before we start I would like to acknowledge the traditional owners, the Irukandji People and also the Elders from Cairns, Cape York, Torres Strait and other parts of Australia. I am here today not to talk specifically about environmental health, but more so around the wider health reforms happening in Cape York.

What I want to cover today is just a bit of background behind Cape York, and then I want to talk a bit about the concept behind what we use at Apunipima. I’d like to talk about the Cape York health reforms, a bit about my organisation, and then talk about the continuum of care which is something we have developed within Apunipima to try and get our thinking right about how we are going to address Indigenous health in Cape York. Last is a very brief talk around what I see are the linkages in health reforms in Cape York, the other reforms that are happening and also the linkages to environmental health.

For those who don’t know Cape York or aren’t from Cairns or Queensland, Cape York is the northern tip of Queensland and runs from Mossman Gorge, which is about an hour north of Cairns. It runs right up to the NPA which takes in Horn Island and then down the western side of Cape York back to Kowanyama. Cape York itself is roughly the size of Victoria, so it is a big area we cover. There are roughly 13 Aboriginal communities, four townships of Weipa, Laura, Coen and Cooktown. It has a population of 14,628 of which approximately 50% are Indigenous. Cape York comprises mostly remote communities that are difficult to access for approximately five months of the year, when it is wet and difficult to access by vehicle. Primary health care is provided by the Royal Flying Doctors and Queensland Health, with further specialist care needs requiring people to fly to Cairns, Townsville or Brisbane.

This diagram (life expectancy diagram) is something we always provide when we talk about Indigenous health. I suppose it is one of the reasons why I work in Apunipima, why people work in Queensland Health, the Royal Flying Doctor Service or any of the other health service employers across Australia. There’s been a lot of talk about Indigenous health and about the life expectancies of Indigenous people over the couple of years. But we know as Aboriginal people that the health of our people is very bad. In Queensland, for example, state-wide the average life expectancies for Indigenous males is 56, and for females is 63, whereas non-Indigenous people as you can see from that graph is up to 76 and 82. So really Aboriginal and Torres Strait Islander people are expected to live 20 years less than our non-Indigenous counterparts.

One of the things I did when I first came into Apunipima was to look at trying to provide a simple diagram where people in my organisation and community could look at and understand what we are doing to improve Indigenous health. This is something that we came up with, which tries to link what is happening in the social environment to what we are doing in the health environment, and to work towards the overall aim of reducing the differences in life expectancies. We know up in the north here that our main aim is to improve Indigenous health, so we need to look at and address the reasons why our people are hospitalised, or die. We know these range from things like diabetes, to cancer, to cardio-vascular, to mental health or injury, and the way that we will address these are by dealing with two issues. One is dealing with the health environment, and that’s the area that health service providers plan. Organisations like Apunipima, Queensland Health, Royal Flying Doctor Service, Divisions of GP – these are the areas that we are responsible for. What we look to do in the health environment is to make sure that services we deliver are actually aligned with whatever the health issues are at the community level. At the same time we need to understand that there are a lot of social issues that impact on what we do. Housing, employment, education, land, culture - all of these social issues impact on our ability of what we do in the health arena. The only way we can really get health gains is to deal and address both of those environments together.
When we talk about Indigenous health, we look at what happens overseas. We have looked extensively at what happens in Canada, and you can see in both Canada and New Zealand that life expectancies are considerably higher than what we have in Australia. The figures are anywhere between 13-15 years higher. Indigenous people in those countries live a lot longer. Imagine what we could do as Indigenous people if we had an extra 13-15 years of living, and what we could do with our families and our communities? The interesting thing is that 30 years ago the health status of these communities had the same health status as our communities do now. So they did things back then 30 years ago that actually led to improvements of overall health. Basically what they did is they transferred responsibility from government over to community people. So what we are looking at here is moving from what we currently have, which are poor services. These poor services are directly aligned with community health issues - poor responsibilities in the sense that these are individual, family and community responsibilities around health - to a service where we have the programs that align with community issues that are delivered in an appropriate way for our communities. There is also an individual responsibility to look after yourself.

One of the questions that we asked ourselves was how were these improvements made? We looked at a lot of the literature out there and it came down to three basic things:

- Government-provided resources to Aboriginal health at a level that matches the level of need. It should not be that departments fund according to how much they have allocated to Indigenous health, or how much they have allocated according to a population level - we need funding based on the level of need.
- The other thing they did overseas is that they enabled a lot more Indigenous control over the health services. This ranges from health service planning and management through to the delivery of appropriate health programs and services, monitoring and evaluation.
- Government supported and enabled a holistic approach to health, recognising the impact that broader social and economic factors have on health.

So if this can happen overseas, and if they can improve the health of their Indigenous people over a 30-year period, then the question is, ‘What are the key things we can take out of those learnings and apply to Cape York so that hopefully in 30 years’ time we can look at the same levels of success’?

Around 2005 the Commonwealth and the State funded the Cape York Institute for Policy and Leadership to undertake a report into Cape York - the Health Reform Report - which identified the following key reforms (which mirrored overseas experiences) The recommendations that came out of the Report were:

- Development of the Cape York Health Board.
- Appropriate levels of funding based on need.
- Community control of primary health care services.

This is what we are talking about when we refer to health reforms in Cape York. Apunipima has been given the responsibility to undertake this type of planning, and to identify how we as an organisation in a regional area can move to greater control of health services in Cape York.

A bit about my organisation – we were established in 1994 by Cape York people, and it came out of a meeting at Pajinka (which is right up on top of the Cape of the NPA). Cape York people came together and asked what they could do to improve the health of their people. One of the key messages coming out is that we need to control what we do, and what happens in our community concerning health. The name that they gave our organisation is a name from that area up there - Apunipima means United all in one. They recognised as a group that if we want to improve our health, then we need to start pulling together in addressing these issues in a way that’s appropriate for our communities. We are a community-controlled health organisation, but not in the same sense of some of the Aboriginal medical services around Australia. Our main role is to advocate on behalf of the health needs of Cape York people. This means we don’t deliver straight medical services, but we identify what are the problems with existing services to people of Cape York. We then advocate to the relevant agencies to improve these services, and also to take the higher level policies and funding issues to a national and state level. At the moment we employ about 16 staff but we know with movement over to community control that this number will increase significantly into other professions of the health services. Our staff at the moment focus more around project management and administration, but we know that as we move to a true community organisation we will have to employ doctors and nurses, allied health, environmental health officers and truly become a community-controlled health organisation that’s delivering services.

The vision for our organisation reflects what we hope to achieve under the Health Reforms. Our vision is around Cape York communities owning solutions to live long, healthy, lives through strengthening our culture and regaining our spirits. The way we aim to achieve this is through eliminating health inequalities, strengthening community control of health outcomes, increasing access to culturally-appropriate services, educating better, advocating for communities and influencing social issues that impact on health. This is the vision and these are the aims of the organisation that I’ve been given responsibility to actually achieve.
When we looked at how our health would be improved – I spoke before around the 20-year difference in life expectancy, around how our people die a lot sooner - we have the concept diagram there that spoke around how we will address these issues dealing with health and social issues. It’s good to have those concept diagrams there, but the question that we need to ask ourselves is how do we take that diagram and turn it into services on the ground. What we have started to do is to talk with all our stakeholders, Queensland Health, the Commonwealth, and communities about trying to put in place a continuum of care. This continuum of care is around making sure that when we deal with specific issues across Cape York, we deal with everyone on the same page - that we don’t have certain stakeholders going off and doing different things in each community.

This continuum of care has three levels - community, family and the individual, because there are things that you do differently at different levels. The other key parts of this continuum of care are the upstream issues including for example housing, education, food supply, domestic violence, economic development and behavioural changes. The challenge is how do we deal with these issues in a coordinated way. Unless we start dealing with the ‘upstream’ issues, people will come into the health system, get fixed up and go straight back into the same social environment - the same health problem will reoccur. One of the other key things we need to do is how we get people into the health system. There are many communities up in Cape York (as in other parts of Australia), that have a very, very, low access rate to the health system.

One community, for example, has a population of 1400 yet has only 400 on the primary health care centre books. So what happens to the other 1000 people in that community? There needs to be ways of getting people to access the health system. We can’t get an effective health system working until we actually know what the health system issues are that are being faced in a particular community. In the health services this is the key part of the whole continuum of care, because this is where your health care gains are going to be made. Health gains aren’t going to be made by what I do or what my board of directors do - health gains are going to be achieved through what the nurses, the health workers, the doctors, the environmental health workers, and the allied health professionals do within the community. In the health services we have broken it down into four key areas that are based on a Chronic Disease Strategy for North Queensland that came out of the work that was done in a diabetes trial in the Torres Strait. The work that was done in the Torres Strait was through simple education, detection and management of diabetes. They were actually able to reduce the diabetes rates up there, so if it worked up there then there’s no reason why it can’t work in other parts of Cape York.

Therefore, the key areas are health promotion and education, early detection, management, and then links into specialist care. What we do in these areas is to look at who delivers what services around health promotion and education. Now we know with one application that was done over a year ago for Healthy for Life, that out of 17 communities across Cape York, only one community delivered health promotion and education programs around child and maternal health. So how will mothers know how to look after their kids or how to access antenatal care if you don’t have programs being delivered out into the communities in an appropriate way? Then you look at health promotion and education across the other major health issues of chronic disease, social and emotional wellbeing, mental health, across Cape York - if we are not doing it right in one area, how do we know that we are doing it right in the others?

The second part of the health services is around early detection. How do we know when someone comes into one of the primary health care services in Cape York that their health issues have actually been picked up? How do we know that when it is picked up that they are actually being managed properly, or if they need linkages into specialist care? How do we know if this is actually happening? So the main aim of this is making sure that services that are delivered into Cape York are delivered in a coordinated, collaborative way. We don’t want, for example, current cases of where in one community 20 service providers and mental health people go in to provide services to the same part of the community - the community has a population of only about 1000. It is important to identify which of the current service providers will be better placed to deliver health promotion education programs, which are those that are better placed to do the detection and management, and then determine how we link into specialist care, bearing in mind these aren’t currently available in Cape York.

One of the last parts of this continuum is around the integration back into community. When someone has a baby in Cairns or when they come down here and need an operation on their heart and are told to lose weight or stop smoking, they go back into the community for a two-month period. How do we know that the support is there to help them to do those things? So we are looking at what the support services are for those major health issues those people face, and making sure that they are put in place.

I have spoken about the concept and the continuum of care, and this is the actual model we are going to put in place. It came out of the Cape York Institute Report, and has five levels. The first level is around funding, so it is based on getting the funding mix right. At the moment $30-40M goes into Cape York, but it goes in via four or five different organisations. Therefore, what we are looking at here is to develop a funds pool where the money goes in, and we have contracts and agreements with the State and Commonwealth about the outcomes that we will achieve for that amount of money. That’s ongoing and that’s not going to be achieved in the next 18 months. The second level is around board and governance. Our organisation has a two-tier governance system. The first one is around our Governing Committee which is two representatives, a male and a female, from each community. The Governing Committee is made up of 34 members, and out of the 34 members we select 10 members to sit on our Executive. When we move to a greater organisation with more responsibility we recognise that...
we need expert advice being provided to our Executive Committee in order to make informed decisions. We are now in the process of establishing a group of experts that are pooled with a certain skill. These experts will sit down with our Executive Committee, and provide the advice that our Board needs.

The third level is then around identifying and determining the services that we can provide, and what services that we will purchase from the existing service providers. As I said, that part of it won’t happen over night – it will be a long, drawn out process. However, at the end of the day there are things that we can do to enhance current services out to the communities. The fourth level is around the community clusters. We have identified that we need more staff in certain areas around Cape York that will go in and assist and provide extra services to staff on the ground. At the moment that’s happening through the Commonwealth initiatives of improving primary health care, which is about getting more allied health professionals out there. They operate on a cluster level, so when they go in to Kowanyama, for example, they provide extra advice around dieticians and physiotherapy. Once we have identified what the community issues are, we will determine which programs are needed and if we can’t get the services on the ground, then we will put those services in at the cluster level. This means looking after about three communities, where teams will go in once or twice every month to assist local staff.

The last is around the Health Action Teams. This is the most important part of community control in the health reforms, because it’s about community people taking greater responsibility for health in their community, making decisions about what programs they want addressed, and how those programs should be delivered in accordance with the needs of their community. In terms of how this will work at a community level, we spent the last eight months developing Health Action Groups. Health Action Groups are a collection of community people that come together, that start to take control of health and decision-making at a community level. These Health Action Groups can be made up of anyone interested in that community. For example, clan and family groups, individuals, justice group members, men’s group, women’s group, youth groups, health workers. In Coen, for example, we also have another group involved which we call ‘they’re the white people that live in that town’. So for the Health Action Groups it doesn’t matter who you are - if you are interested in health in that community then you can be part of the Health Action Group. The link then between the Health Action Group and the Council is there. With changes to the shire councils, a lot of councils are starting to focus on local government responsibilities. This means that where previously Council focused on roads, rates, rubbish, housing, etc, they are not going to be able to continue to do that. What we are now looking at is saying to Council is that the Health Action Groups will assume the health responsibility in the community, that the Council will help and will sit on our Health Action Group, and they’ll be the body responsible for health in that community.

I have spoken very broadly about some of the health reforms in Cape York, though I am not an expert in environmental health. A lot of the things here I see are linkages between the reforms and environmental health, but I say that a lot of the clarification of the linkages between environmental health and what we are doing with the wider health reforms, will start to be clarified when we start to do the more detailed planning. However, the impacts that I can see are a transition of Aboriginal councils under the Local Government Act which is happening in Queensland, and possible amalgamation of boundaries in Queensland at the moment where we have a directive from State government that councils need to look at how they can amalgamate and create bigger shires. That’s a problem for our communities in Cape York, because each of our communities has separate shire councils. So it is going to happen - and how it is going to look - we don’t really know at this stage. The reason I raised this is that a lot of the EHWs in Cape York are employed by Council, so it is an issue of where do they sit, who employs them and if the health responsibility is being taken away from Shire Councils, then who has the responsibility to employ the EHWs? There’s also the issue of what are the health reforms of the greater community into environmental health issues by community Health Action Groups, which is likely to raise the profile of environmental health and the recognition of the impacts between environmental health and a lot of the ‘upstream’ issues services in the health services. Like I said, it’s hard to answer a lot of those questions. I know that at the moment it is an issue, but as we go down the planning process and we start to develop the blueprint for health reforms in Cape York, a lot of those linkages and questions will be answered.

In conclusion, health reforms will occur in Cape York. There will be a staged process to transition of decision-making of services and funding allocation from the current State and Commonwealth government over to community control. There’s an increased capacity of Apunipima to be able to provide or purchase services, management of funds (both State and Commonwealth) and the ability to demonstrate provision of health outcomes.

I have given you the big picture of the view around what we see happening in Cape York, and it all comes back to this slide here, which is around improving the differences in life expectancies for Indigenous people. I hope that with the health reforms and the visions that we have for Cape York, we can look back in five to ten years’ time and see that the work we have done has really started to reduce the gap in life expectancies between Indigenous and non-Indigenous people. Thank you”.

FOR FURTHER INFORMATION
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Guest Speaker

Walter Mackie, TSRA Portfolio Member for Environment and Health and Chairman of Iama (Yam) Island Community Council

“It's good to be here this afternoon. Welcome, everyone, to this conference. I would like to begin by firstly acknowledging the traditional owners of the land, the Irukandji People, Elders who are present, ladies and gentlemen. I represent the Torres Strait Regional Authority (the TSRA) and I am the Portfolio Member for Environment and Health. Today I would like to inform you of the work that has been progressed by the TSRA, to improve environmental health outcomes in the Torres Strait. My presentation will cover three areas. Firstly, I will provide you with a brief overview of the Torres Strait, then inform you of the TSRA, followed by the environmental health initiatives currently being progressed and delivered by the TSRA.

The Torres Strait

The Torres Strait is a diverse and unique part of Australia situated on the tip of the Cape York Peninsula, extending some 150 kms north to the border of Papua New Guinea’s Western Province, and north-west toward Indonesia’s West Irian Jaya Province. The region includes 18 inhabited island communities, and two mainland communities of Seisia Bamaga located on the Northern Peninsula Area. The Torres Strait population is approximately 8,306 of whom 6,168 are Torres Strait and Aboriginal People (2001 ABS Census).

The Torres Strait Regional Authority (TSRA)

The TSRA was established on 1 July 1994 under the Aboriginal and Torres Strait Islander Commission Act 1989, which today is known as the Aboriginal and Torres Strait Islander Act 2005. It is an Australian Government Statutory Authority and is the peak representative body for the Indigenous people of the Torres Strait. It has an annual budget of approximately $56.8M from the Australian Department of Finance and the TSRA formulates and implements programs and services to strengthen the economic, social and cultural development of our region. They aim to do this by working toward our six goals of:

- Gaining recognition of their rights, customs and identity as Indigenous peoples.
- Achieving a better quality of life for all people living in the Torres Strait region.
- Developing a sustainable economic base.
- Achieving better health and community services.
- Ensuring protection of the environment.
- Asserting Torres Strait native title over the lands and waters of the Torres Strait region.

By striving for these goals they aim to improve the lifestyle and wellbeing of Torres Strait Islander and Aboriginal people living in the Torres Strait.

Health in the Torres Strait

Despite being part of a developed country and living an often envied life on beautiful tropical islands, no-one can deny that the Torres Strait people still experience hardships and diseases that are regularly found in third world surroundings. It is well-documented that Indigenous people experience more illness and die at a younger age, compared with non-Indigenous Australians. A Report on health indicators for the Torres Strait and Northern Peninsula Area Health Service District (2001 a publication of the Tropical Public Health Unit Network of Queensland Health) has identified that:

- Rates for all causes of death were higher in the Torres Strait and Northern Peninsula Area Health Service District than the rest of Queensland, with most of these occurring in 40-70 years age group.
- Deaths due to Diabetes Mellitus were more than 10 times higher in the District than in Queensland. (Information on deaths due to Diabetes Mellitus was sourced from Improving Diabetes Self-Care in the Torres Strait: a one-year randomised cluster trial 2002-2003).
- Hospital admission rates for Diabetes Mellitus were 10 times higher in the Torres Strait than the rest of the State over the period 1994-1998.

With figures such as these the TSRA has played a leading role in discussions, establishing partnerships and is taking part in key initiatives that are aimed at improving Indigenous health outcomes. TSRA believes a whole-of-government approach is needed to address the health concerns of the Torres Strait. For example, in 1999 TSRA signed the Torres Strait Health Partnership Agreement with the Australian Department of Health and Ageing, and the Queensland Department of Health, the Island Coordinating Council (ICC) and the District Health Council. As a partner the TSRA provides policy advice, secretariat support and information on a range of health issues to the Partnership, and also ensures that environmental health and community infrastructure programs, including mainstream health programs, are linked and appropriate for regional communities.
On 25 July 2006 the Partnership entered a new five-year Health Framework Agreement. The Australian Government Minister for Health and Ageing, Minister Tony Abbott, Queensland Minister for Health, Minister Stephen Robertson, with the Chairperson of the TSRA, ICC and District Health Council, made a commitment together to work towards:

- Advancing Torres Strait people’s access to relevant health and health-related programs, as well as improving the reporting and sharing of services and programs.
- Increasing health service resources to address the higher level of health needs by Indigenous people.
- Support joint planning processes and include Indigenous participation on decision-making and priority determination, to improve the coordination and delivery of service.

The TSRA hopes that through this Agreement the region will begin to see positive health outcomes being delivered to and experienced by, community members.

**DENGUE PREVENTION**

As mentioned in the previous list of statistics, mosquito-borne diseases reported in the period of 1999 to 2003, were 164 times higher in the Torres Strait and NPA Health District than the rest of Queensland. In addition, Dengue Fever outbreaks resulted in 277 reported cases, and the death of one person. To further complicate the fight against dengue fever, a second mosquito that is also capable of causing Dengue Fever was found in the Torres Strait in 2005.

The TSRA and the Department of Family, Community Services, and Indigenous Affairs have begun to address Dengue Fever by entering a Memorandum of Understanding to fund the ‘Asian Tiger Mosquito Control Project’. This Project is aimed at controlling the Asian Tiger Mosquito population, thereby decreasing the incidence of Dengue fever. This $1.1M program will be managed by the Island Coordinating Council, which will work together with all Island Councils and Queensland Health to take necessary measures in controlling the region’s Asian Tiger Mosquito population.

The TSRA is involved in a number of key initiatives that aim to improve the overall health of the region. However, TSRA recognises the fundamental key to creating good health outcomes is not only for the people to lead an active and healthy lifestyle, but to also live in a healthy and safe environment.

**HOUSING**

A report to the Housing Ministers Advisory Council Multi Measure Modelling of Indigenous Housing Needs in August 2003, reveals that in the Torres Strait:

- 20.7% of those households studied for the Report were overcrowded. This was above the total regional average for all ATSIC regions (18.92%).
- The Torres Strait region was the third highest region, with the highest number of dwellings requiring major repair or replacement. The number of dwellings needing major repair or replacement was 369. This is 19% of the total Queensland figure of 1,916. (Major repairs were defined as repairs of $20,000 to less than $60,000 in low-cost areas, $27,000 to less than $80,000 in medium-cost areas and $33,000 to less than $100,000 in high-cost areas. Replacement was defined as repairs of $60,000 or more in low-cost areas, $80,000 or more in medium-cost areas and $100,000 or more in high-cost areas).
- This figure represented 36.8% of the total number of dwellings surveyed in the Torres Strait, and is above the total regional average for all ATSIC regions of 26.1%.

Housing is a critical issue in the region, and when combined with severe overcrowding and poor conditions, the standard of housing no doubt can have an adverse affect on health in the Torres Strait.

TSRA is working with partner agencies and organisations to investigate and attempt to improve home ownership opportunities, as well as address housing shortages, a dysfunctional housing market, and the abnormally high cost of housing in the region. Associated with housing problems there are the issues of land tenure, community viability and sustainability, waste management, adequate data collection, and the need to adequately plan for population trends. In the case of Thursday and Horn Islands particularly, there is a need to balance the needs of housing with the needs of Government, with the housing needs of the general population.

Recently, the Queensland Department of Housing has undertaken a research project to identify housing issues on Thursday Island. This important project commenced in April of this year, and will consider all aspects of housing provision, including impacts on Indigenous people, non-Indigenous residents and Government and private sector employees. This research will include the land and town planning situation, projected housing supply and demand, and land supply and land tenure. The capacity of surrounding islands on housing demand, supply and capacity may also be considered. TSRA is supporting this project and views it as a significant and necessary step in the process of resolving the serious housing issues that confront the Torres Strait region as a whole.

**MAJOR INFRASTRUCTURE PROGRAM (MIP)**

In 1996, it was identified that the Torres Strait people were living in substandard conditions. It was also estimated that a total capital cost of $318M was required to provide necessary basic infrastructure to begin lifting their living standards. Essential infrastructure such as clean drinking water supplies and water treatment augmentation, reticulated sewerage and treatment, subdivisional development and essential services extensions, roads and stormwater drainage, and solid waste disposal, were just some of the areas that need attention and enhancement.

In 1998 the Australian and Queensland Governments made a $100M commitment to begin improving and upgrading the region’s essential infrastructure. Subsequently the TSRA, representing the Australian Government, and the Department of Local Government and Planning, representing the Queensland Government, jointly created and commenced the Torres Strait MIP. The main objective was to improve the health and well-being of the Torres Strait Indigenous people by providing appropriate and sustainable environmental health infrastructure. Over the last decade close to...
$92.4M has been spent in progressively addressing the region’s infrastructure shortfalls. Close to 10 years on, MIP has delivered over 33 infrastructure projects, with a further 11 projects currently in construction or design phase and due for completion later this year. Some of MIP’s life-changing projects include:

- 19 sewerage and sanitation projects completed ($26.5M).
- 5 reticulated sewerage schemes in progress ($32.1M).
- 17 water supply upgrades/augmentation completed ($14.2M).
- 3 water supply upgrades in progress ($3.4M).
- 6 internal road and stormwater drainage upgrades completed ($3.7M).
- 3 internal road and stormwater drainage projects in progress $1.7M).
- 9 subdivision projects completed ($5.5M).
- 2 regional solid waste projects in progress ($0.9M).
- 2 solid waste projects completed ($0.3M).
- 2 regional solid waste projects in progress ($1.2M).

The success of MIP can be attributed not only to the constant delivery of essential infrastructure, but keeping in line with the policy objectives and priorities of the Australian and Queensland Governments and local community councils. Its Whole-of-Government approach has provided an excellent example of all tiers of government working successfully together. It has also demonstrated flexibility, accountability and leadership, and has implemented the broad government policy objectives of shared responsibility and partnership. Furthermore, with its regional focus, MIP has realised a high level of Indigenous participation and ownership. MIP has laid the foundations for the economic development for the region. Through basic services, such as roads, constant water supply and flushing toilets, it has equipped communities to participate in income-generated ventures such as tourism, enhancing the local economy and increasing employment opportunities. In addition, MIP has supported Indigenous enterprise and the local workforce by engaging local councils to oversee and construct works and at the same time up-skilling community members by the use of accredited training programs attached to, or partnered with, MIP.

ENVIRONMENTAL HEALTH OUTCOMES DELIVERED BY MIP

Despite major difficulties inherent in delivering infrastructure to the remote and isolated islands of the Torres Strait, MIP has successfully begun changing environmental health outcomes in the region. In fact, health statistics have confirmed that improved environmental health infrastructure delivered by MIP are playing a key role in the reduction of water and hygiene-related infectious diseases in the region. For example, indications of water and hygiene associated communicable diseases like Shigellosis, Salmonella and Hepatitis A, have decreased in the 10-year period between 1996 and 2006. The Queensland Notifiable Conditions Database (NOCS) reports that incidences of such environmental health related diseases in the Torres Strait have halved, with close to 40 cases per year in 1996 down to under 20 cases reported in 2006.

Through improved environmental health infrastructure such as improved water quality and sanitation by MIP, such illnesses have receded, especially when combined with health education, immunisation interventions and awareness. It is clear that a community’s living conditions play an important role in the health and wellbeing of individuals, and clean water, good sanitation and improved hygiene practices are important in determining good health outcomes.

Last year the World Health Organisation (WHO) estimated that 24% of the global disease burden and 23% of all deaths can be attributed to environmental factors. According to WHO, global environmental infectious diseases such as diarrhoea were attributable to water, sanitation and hygiene. In fact, 88% of such cases were attributed to these. WHO also revealed that 94% of all cases of diarrhoea around the world were attributable to the environment, resulting in more than 1.5 million deaths annually.

In the Torres Strait, MIP has significantly contributed to improved environmental health outcomes:

- In 1996, 34% of people living in the Torres Strait lived in third world sewerage conditions which were a major health hazard. MIP removed all pan toilets, ensuring that all residents had flushing toilets and hand-washing facilities. MIP has or is progressively constructing reticulated sewerage systems in 11 communities.
- In 1996 only 39% of people living in the Torres Strait lived in third world sewerage conditions which were a major health hazard. MIP removed all pan toilets, ensuring that all residents had flushing toilets and hand-washing facilities. MIP has or is progressively constructing reticulated sewerage systems in 11 communities.
- In 1996 there were dramatic water shortages requiring annual barging of emergency water. By 2000 every person in the Torres Strait had access to 250 litres per day (minimal requirement).
- MIP has implemented appropriate regional planning, allowing for effective delivery of prioritised essential infrastructure to meet the most urgent environmental health needs across the Torres Strait region. Results of this planning include appropriate housing subdivisions rather than haphazard development.
- Steadily upgrading internal roads and storm water drainage in each community, thereby reducing dust and flooding, and improving access to important services such as school and health clinics.
- MIP has completed preliminary solid waste management improvements by providing designated disposal areas away from the immediate town area, and disposing of bulk waste from each island.

In summary in almost a decade of hard work the people of the Torres Strait now have access to clean and safe drinking water, flushing toilets, serviced housing lots, sealed roads and drainage systems. In addition, local community councils are well informed and trained to manage community waste through the provision of sewerage treatment plants and improved refuse control techniques.
It is through programs such as MIP that you can see how much environmental health infrastructure is needed to produce positive health outcomes for people. However, while living standards in the Torres Strait are still not comparable to that of mainstream Australia, it is vital that all levels of government continue to work together and support such programs to continue this life-changing work. Thank you.

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WEDNESDAY 23 MAY 2007

Xavier Schobben, Chair, enHealth Working group on Aboriginal and Torres Strait Islander Environmental Health

TRIBUTE TO PHIL DONOHOE

“Tragically, last December the Environmental Health community lost one of its favourite colleagues in Phil Donohoe. I would like to take a moment to pay tribute to Phil, his work and his life. Phil was in the Environmental Health profession for over 20 years. I met him as a pimply-faced student (like me) at Swinburne University in 1981. He had a penchant for life, a bohemian dress sense and a remarkable way with words.

For those of you who knew him, his cup was always half full. He was an eternal optimist, and a bit of a perfectionist as well. He started to work for local government in the city of Werribee in the mid-1980s, and I was working for the Melbourne City Council in those days. He loved to argue on issues and would often debate public health law - particularly precedent law from past English judgements handed down over a hundred years ago, and how a binding precedent from Lord Denning may affect the latest case he was working on in trying to prosecute a food business owner for trying to sell fly-blown chicken.

After working in local government and unbeknown to many people Phil, with his young wife, Amanda, took over the running and management of a boarding house. It was a boarding house that operated for the benefit of society’s less fortunate. Some boarders were alcoholics, whilst others had mental health problems, etc. Phil, being a devout Christian, took it upon himself and his family to take over the management of that boarding house, and he managed those premises successfully for a number of years. On one occasion a boarder actually bashed him, but he carried on regardless. He then moved to Nhulunbuy, in the East Arnhem region of the Northern Territory in the mid-1990s, where he worked as an Environmental Health Officer extensively in Aboriginal communities. He was involved in many activities that had a public health prevention and promotion focus, and had a penchant for dog health. Phil once organised, with ATSIC funding, a conference called the ‘Big Lick’ and it was very well attended. Such was his devotion to dog health and in trying to improve conditions on Aboriginal communities that he helped form the organisation, ‘Animal Management in Rural and Remote Indigenous Communities’ known as AMRRIC. We’ll hear later from Jennie Churchill, Dr Sam Phelan and Senator Nigel Scullion, Minister for Community Services, on the launch of the AMRRIC manual about work that continues with AMRRIC.

Phil had a great passion for life and was always colourful. In many cultures when people pass on, they don’t celebrate a person’s wealth or fame, they simply ask if the man had passion. Well, Phil had many passions in his life. His first was his wife, Amanda, and their five children, Jeremy, Patrick, Alistair, Grace and Ruby. His work passion was to help improve conditions for Aboriginal communities, particularly remote communities.

On a lighter note, one of the many ‘Phil stories’ that still makes me laugh happened back in 1999, when I seconded Phil to assist in reviewing the NT Public Health Act. For those of you who knew him, you’d remember he loved to wear purple shirts. It must’ve been his favourite colour, because the Public Health Act Review Discussion Paper - all 67 pages of it - was printed in purple font! It still remains the only Northern Territory government publication to be totally purple. Whilst working on that particular document with me, he was a perfectionist. He proofread every page, did the art and page layout, and was as proud as punch one day when he came to see me and gave me one of a thousand printed copies he had sent to stakeholders.

I scanned the document, and looked at the contents page, then started frowning. I told him that it was a fantastic document except for the contents page title, which read ‘Public Health Act’ rather than ‘Public Health Act’. I said that while ‘pubic health’ was an important component of sexual health, nonetheless I considered ‘public health’ to be more important overall. He was absolutely mortified at first, but then his face soon lit up with that big grin of his and we soon broke down into uncontrollable fits of laughter. He had a great sense of humour, which I am sure we’ll all miss.

So on behalf of enHealth, WGATSIEH and our colleagues in the environmental health profession, I’d like to acknowledge the wonderful work done by Phil. He was taken from us too early, and as some would say, only the good die young. It shouldn’t have been the case, but it was. Our thoughts are obviously with his family and indeed he does leave a lasting legacy as well as the good work that continues with AMRRIC.

So, Phil Donohoe, thanks for the memories. Gone but not forgotten, mate”.

Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner and A/Race Discrimination Commissioner, Human Rights and Equal Opportunity Commission

“Senator Scullion, distinguished guests and participants, can I begin by paying my acknowledgement to the Irukandji Peoples, the traditional owners of the land on which we are meeting, and pay my respects to their Elders. I would also like to thank the National Indigenous Environmental Health Forum, the conference organising group and Queensland Health for organising this event and for inviting me to address you. Thank you to Shane for his opening words and introduction.

For those who don’t know in July 2004, I took up my five-year appointment as Aboriginal and Torres Strait Islander Social Justice Commissioner at the Human Rights and Equal Opportunity Commission. This role was created in 1992 to provide an ongoing monitoring agency for the human rights recognition of Indigenous Australians. I am conscious of the relatively short period of time I have here today, so of the various functions that I do, I would like to highlight that I am required to report annually to the Federal Parliament on the status, enjoyment and exercise of human rights by Indigenous Australians, and this is called the Social Justice Report. I also produce a Native Title Report which covers both native...
title and other Indigenous land issues such as economic development and so forth. With that come a lot of EH issues. I was pleased to be offered the chance to address this conference, as it gives Indigenous EHWs and others at the coal face of Indigenous communities, a forum for your voices to be heard, and from which to influence policy and decision-making that touches on the vital issues of EH. Forums such as this one should not be taken for granted in the current post-ATSIC Indigenous affairs era. After four years of tracking these so-called ‘new arrangements’ in Indigenous Affairs through the Social Justice Report, to me there has been no more apparent flaw in the way things are organised now than in relation to the processes for engagement, or more accurately, the absence of these processes with Indigenous peoples at both the national and regional levels - and increasingly at the community level.

Since ATSIC has been dismantled, government has consistently emphasised that engagement with Indigenous peoples is a central requirement for the sustainability of the ‘new arrangements’. Yet there has been little progress to ensure that appropriate forums and mechanisms exist to facilitate this. Policy is being developed in a vacuum at the national level, with no connection to Indigenous peoples’ experiences at the local and regional levels, and without applying what I call ‘the reality test’ that comes with Indigenous peoples’ participation and local engagement in the design of policy and programs that affect them.

So I acknowledge you, the participants of this forum, not only for the vital work that you do in communities, but also your commitment to keeping this channel for engagement open. My acknowledgement also goes to the federal and various state level health departments and the enHealth Council for maintaining their commitment to the Forum over the many years that it has been going, and for publishing the excellent reports from these conferences. These are a valuable resource for anybody interested in, or working in, Indigenous EH or Indigenous health generally.

Indigenous health has been a major focus of my time as the Aboriginal and Torres Strait Islander Social Justice Commissioner. Many of you may know that in the 2005 Social Justice Report I recommended to Australian governments that they commit to a campaign to achieve equality of health status and life expectation between Aboriginal and Torres Strait Islander and non-Indigenous people within 25 years. Further, that this overall commitment be supported by the sub-targets of achieving equality of access to primary health care and health infrastructure within 10 years for Aboriginal and Torres Strait Islander peoples, irrespective of whether we live in urban or remote areas.

It is this health infrastructure aspect of my recommendation that I would like to focus on today.

And I am pleased to tell you that there has been a tremendously positive response to recommendations of the report. A coalition of over 40 Indigenous and non-Indigenous organisations (all the major peak health organisations) have begun working in partnership for Australian governments to adopt the recommendations for Indigenous health equality set out in the Social Justice Report. The health campaign is built around the right to health, which is of direct relevance to the health inequality Indigenous people suffer in Australia today (and hence, the policy environment within which Indigenous EHWs operate in). Therefore, I thought it may be useful to hear what the right to health is, and how it may touch on your work and the recommendations that you feed back from this conference.

So what is the right to health? Well, it is found in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The Australian Government ratified, or signed onto, this treaty in 1966, and it applies to all Australians (not just Indigenous Australians). The right to health is not an abstract right to be healthy. No state can guarantee the health of its citizens in an absolute sense against the forces of old age, personal choice, and so on. What the right to health does say, however, is that the State, meaning Australia, and all the governments of Australia have an obligation to provide opportunities for all their citizens to be as healthy as possible. What this means in practice is that the Australian Government provides or ensures two things.

The first is directly relevant to your work -- What is called ‘health infrastructure’, that which lays the foundations for good health: safe drinking water, hygienic conditions with sewerage and garbage safely disposed of, healthy housing and the supply of healthy food. The right to health requires that these things are both established and effectively maintained at a standard that supports good health. The second are health goods and services, and in particular, primary health care services. I won’t be speaking on this part of the right to health today, apart from noting that it obviously covers a vital part of any overall approach to Indigenous health. You can read more about this if you have a look at my Social Justice Report. And, I will soon be releasing a stand alone publication which extracts Chapter 2 of the 2005 Report, (that contains the Indigenous health equality recommendations) and which will become a good reference guide for everybody working in the health industry.

Further, the right to health obliges the State to ensure that everybody, regardless of sex, race, age, sexuality and so on, has an equal opportunity to be healthy. For health infrastructure this means that communities across Australia - whether Indigenous or non-Indigenous - should enjoy a similar healthy standard of drinking water, can access fresh vegetables, fruits and meat, and have their sewerage and garbage removed. It also means that they enjoy - from a health perspective - the same standard of housing that is in good repair, with functioning sanitation, and is not overcrowded.

We all know that despite some areas where real improvements have occurred - particularly the water supplies in many communities - Indigenous people do not enjoy the same equality of opportunity in relation to health infrastructure. I am not going to list the well-known statistics that highlight the glaring inequalities particularly in relation to housing stock in terms of its condition. And I am sure that we are all aware that it is far too often overcrowded and how this then impacts on sanitation, and so on. I am sure this is something that everybody here would have had some direct experience with.

A key component of the right to health is planning, which requires that if gross inequalities exist (such as exist in relation to health infrastructure) that there should be a plan to reach equality as soon as possible. And this leads to the first point I want to make today -- That there is no overall national plan or strategy for specifically addressing
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the total need in communities in relation to health infrastructure. Programs and policies that deal with parts of this need (such as the Indigenous component of the National Environmental Health Strategy, the Dog Strategy that Senator Scullion will be launching today, the Eat Well Australia Strategy, the Building a Better Future Strategy, and programs such as Community Housing and Infrastructure Program (CHIP), which is soon to be replaced by the new Australian Remote Indigenous Accommodation Program) are welcome in that they address parts of this total need. However, an overarching, coordinated national strategy addressing the totality of health infrastructure needs is yet to be developed.

(Let me also clarify that I am not supporting the government for closing the housing associations, but I am supporting the CHIP program.)

There is still a need for a comprehensive intersectoral and intergovernmental approach that aims to coordinate all these strategies into an overall plan which is clearly stated, time limited, with goals for securing equality of opportunity for Indigenous communities in relation to their health infrastructure. As noted, in my Social Justice Report, I have recommended that this goal be set within a time limit of ten years.

And in relation to this, I welcome that there is a National Indigenous EH House Strategy under development by the EH Forum following a recommendation made at the Fifth National Conference. And I congratulate the conference for making this recommendation. I am pleased to hear that the National Indigenous EH House Strategy aims to be as holistic in its approach as possible in relation to Indigenous EH, and that it looks to integrating as many of these smaller strategies I have referred to into something approaching what I am suggesting here: an overall national strategy. However, such a national, overall strategy is, in a sense, beyond the Forum to initiate. It is ultimately dependent on an agreement at the level of Australian Health Ministers Conference, and the Health Ministers need to take this responsibility on board: the development of a national overall Indigenous health infrastructure strategy should be a priority.

And as I have noted, such a national, overall strategy should be time limited, in terms of when it would secure for Indigenous communities equality of opportunity in relation to health infrastructure: ten years is what I recommend.

So why do I link such plans to time limits or targets? It is because according to the right to health, governments have an obligation to take steps to progressively achieve the full realisation of rights such as the right to health, and to do so without delay. Steps must be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognised in the International Covenant on Economic, Social and Cultural Rights.

Such an approach also uses benchmarks that allow for the monitoring of progress. And targets and benchmarks should be set with the participation of people whose rights are affected, to agree on an adequate rate of progress and prevent the targets from being too slow. Progress should be reassessed independently, with accountability for performance.

And this links to the second point I want to make today, that a National Indigenous Health Infrastructure strategy aside, there is a failure to set targets and benchmarks even within existing sub-strategies: in relation to housing, sanitation, food supplies, and so on. Certainly beyond broad brush goals of equality and EH justice, there are no clear targets in the National EH Strategy, Eat Well Australia or Building a Better Future. Without such benchmarks Australian governments are simply not accountable for progress or lack of progress, because there is nothing against which to measure their commitment.

And as I have advocated, such benchmarks and targets should link in with the indicators set out in the Overcoming Indigenous Disadvantage Framework, and the Aboriginal and Torres Strait Islander Health Performance Framework.

Targets and benchmarks also help ensure that resources needed are devoted to the task. There is no excuse for the shortfalls we have seen year after year in state and federal budgets - there have been enormous surpluses. Recently the Federal Government announced a surplus of over $10 billion dollars, yet the Australian government has not chosen to use this surplus to end the health crises faced by 3% of its citizens.

Finally, referring back to my earlier comments (and this is the last point I want to make today). It is vital that Indigenous people participate in, and are engaged in, the planning and delivery of services that affect them, particularly in the setting of targets and benchmarks. Now this requirement is more than just a nicety. It is the backbone of international human rights law as it relates to Indigenous peoples. It relates to our right of self-determination, non-discrimination and equality before the law, as well as to our rights as cultural minorities to enjoy and practise our culture.

However, the necessity for engagement also comes from practical experience. Bureaucrats and governments can have the best intentions in the world, but if their ideas have not been subjected to the reality test of the life experience of local Indigenous peoples who are intended to benefit from those programs, then government efforts will fail. Specifically in relation to Indigenous peoples, these requirements for participation have been expressed as the principles of ‘free’, ‘prior’ and ‘informed consent’.

In brief, ‘free’ requires no coercion, intimidation or manipulation. ‘Prior’ requires that consent has been sought sufficiently in advance of any authorisation or commencement of activities, and respects the time requirements of Indigenous consultation and consensus building processes.

‘Informed’ requires that information is provided that addresses the purpose, scope, obligations and impact of any proposed activity. ‘Consent’ requires that consultations be undertaken in good faith, on a basis of mutual respect, and with full and equitable participation. It also requires that Indigenous peoples can participate through their own freely-chosen representatives and customary or other institutions, and ultimately must allow the option for Indigenous people to withhold their consent.

And it seems now that what we are seeing at best is the winding back of the potential for Indigenous participation in these planning processes. For example, the federal government’s decision to abolish the CHIP and replace it with the Australian Remote
Indigenous Accommodation Program looks like an attempt to lock Indigenous people out of the planning and management of their own lives and communities, by cutting out communal ownership and getting control of Aboriginal housing.

The recent agreement with the Tiwi People is also of concern. You may have heard that the Tiwi people have bowed to the federal government’s wishes and signed an MOU to give away their right to control their coastal township of Nguiu by granting the government a 99-year head lease over Nguiu; this means they will only have a limited say of what can occur on their land. In return they will get $5M cash, $1M worth of health services, over $13M towards a new school, repairs to an existing school, and some repairs to recreation areas.

I respect the rights of the Tiwi peoples to enter such agreements if they are conducted according to the principles of free, prior and informed consent. However, I visited the Island in January this year and asked the community meeting of over 150 people whether they understood the 99-year lease proposal. Only one person said that they did. Perhaps this is not surprising given that the federal government rushed this plan through in only three months.

However, there is another matter from a human rights perspective that is wrong with this agreement. The provision of health services, schools and so on are rights – And no one should have to trade their land for these citizenship rights.

And these concerns are relevant to the making of Shared Responsibility Agreements (SRAs). I am sure that many of you are aware or may have even been involved with the making of such agreements.

On one hand, SRAs provide a significant opportunity to advance infrastructure provisions and management within communities, and many have proven of benefit to the community, such as the no pool, no school policy. In cases like this, SRAs can be entirely appropriate.

On the other hand, however, SRAs must be negotiated according to the free, prior and informed consent principles and they should not be used to bargain for basic rights, as I noted in last year’s Social Justice Report. This includes health infrastructure (such as water supplies, sanitation and sewerage systems), Such rights subject matters should not be provided on the basis of mutual obligation. Governments remain under an obligation to ensure all its citizens enjoy equal enjoyment of such rights and to take steps to ensure such equal enjoyment at all times, and without conditions attached. Accordingly, programs and services cannot be withdrawn or not offered in the future to a community if a SRA or any other form of agreement does not achieve its stated goals.

Governments must also ensure that they provide the core minimum of entitlement of rights at all times. The following are examples of core minimum obligations that would not be appropriate for inclusion with SRAs or any other such agreements:

- Access to the essential minimum amounts of water, that is, efficient and safe for personal and domestic use to prevent disease.
- Physical access to water facilities and services that provide sufficient safe and regular drinking water.
- Measures to treat and prevent diseases linked to water, in particular ensuring access to adequate sanitation.
- The minimum essential food which is nutritional, adequate and safe to ensure freedom from hunger for everyone.
- Basic shelter, housing and sanitation, and essential medications and medicinal drugs.

This doesn’t mean that SRAs have no place in some aspects of these matters, but you have to look at the detail to determine whether the SRA is acceptable from a human rights perspective.

For example, a SRA or another form of an agreement would be appropriate to ensure that there is appropriate health education in communities concerning the hygienic use of water, the protection of water sources and methods to minimise water wastage. But it would not be appropriate in relation to the supply of water itself. These distinctions are vital.

Guidelines for making SRAs according to the human rights based framework and principles are set out in the Social Justice Report for 2005. I would recommend that you look at these, particularly if the communities that you are working in are considering entering into a SRA in order to address some of the EH or health infrastructure issues.

I believe that SRAs can be better used, and we should all be looking at maximising the benefits our communities get from all programs and benefits available to them, including though SRAs. But this must not involve compromising our human rights.

In finishing, closing the life expectancy gap of 17 years between Indigenous and non-Indigenous peoples in Australia will not happen without a significant focus on the provision of health infrastructure that supports good health. This is not enjoyed equally by all Indigenous peoples at present, and there is no overall, national plan for when this lack of equality of opportunity will be provided. It will take time to reach a situation of equality. And it will only happen with determined action and commitments from across society and from all governments working together. It also requires Indigenous leadership and participation to ensure that decisions and resources are appropriate and targeted to the areas of greatest need.

Governments cannot do it alone. They should not dictate how services are to be delivered. If they do, the successes will be short-lived and not sustainable. Government’s role should be to assist us through listening, funding, and guidance to develop our capacity to enable us to take control of our lives and our futures.

This is the least that we can expect in the 40th anniversary year when the Australian population voted so overwhelmingly for Indigenous people to be treated equitably.

So again, thank you for the invitation to address the conference. I wish you well in your discussions in identifying pathways forward in relation to EH, and what recommendations come out of this conference. And I look forward to any questions you might have.

Thank you.
Q1. Tom of Wujal Wujal - “As the Human Rights Commissioner can I ask your opinion on the push for the disbanding of Aboriginal Community Councils and the amalgamation of shire councils?”

A1. Mr Calma - “There are two aspects to that question. One is the approach taken by all the mainstream councils and their constituents, and their concerns about the amalgamation. I think governments need to listen to people in relation to that. I think there are some specific issues that relate to us and our communities, the DOGIT communities that recently became shires. The whole process for me is just ridiculously short – the conversion from DOGIT communities to shire communities hasn’t even settled. Most communities are just trying to come to grips with that and now we have a new set of arrangements that will have potentially a very detrimental impact on Indigenous communities and Indigenous peoples. It may also have some good impacts in relation to the utilisation of resources and so forth. However, what we will have to think about is that on some of those communities, what will happen when a major shire takes control of them - what sort of representation does the existing Indigenous Council have on the larger shire (that’s one key issue), and the other is what guarantee is there that services will be provided to the community? There will be a fairly significant cost imposed, I imagine, because if some of our remote communities have to pay the rates that exist in the larger shires, how has that been discussed? How is that going to impact on low income Indigenous peoples? That financial aspect of it hasn’t been considered. The other is what safeguards are in place to ensure Indigenous land lots are not taken over and controlled or sold by larger shires, which have under their current arrangements the capacity to subdivide and sell land? They can do that. This is fine if they do that in their shires, but should that happen to Indigenous communities?”

Q2. Paul Endres (Cairns) – “Just a comment, Tom. You have thrown out a few challenges in your address this morning which we hope to take up in our planning efforts. I am not sure you have the time to see any of the presentations today as I know you are a busy man, but I think you will be pleasantly surprised at some of the reports you will hear today about the work that’s being done in this country and in this area. In our role of planning with the National Environmental Health Strategy we will certainly incorporate your comments, and we already have, using your previous report. It’s a pleasure to hear what you have to say today”.

A2. Tom Calma – “I fully acknowledge your efforts, and the key issue for me is how we ensure other activities in the community are coordinated and synergised so that we do see a way forward. For me that seems to be the biggest shortfall in communities at the moment - that lack of planning and that long-term strategic planning from town planners right through to all the various service infrastructure. To suggest that will all happen overnight if somebody owns their home is only part of the solution. There’s a lot more to it than that. We all need to work collectively and cooperatively, and that is the whole issue. If we go back to what existed prior to the abolition of ATSIC - for good or bad (and I think the opinion differs), but ATSIC Regional Councils were working towards establishing regional plans in a very collaborative process in the communities. That has generally been thrown out, and now we are starting afresh again and from what I hear from a lot of Indigenous peoples is why do we go telling another lot of people what we want, when no-one ever listens? So that’s the key message in planning and engagement”.

Q3. John Wayne, West Australian Local Government Association – “Tom, I was interested to hear your comments regarding local government. Western Australia, as you know, has huge expanses of land between Indigenous communities and local governments, especially the more remote Indigenous communities. Ngaanyatjarra is our only Indigenous Shire Council and hopefully there are more to follow. With regard to local government, how do you see a way forward to get more financial assistance for local government regarding provision of services to remote Indigenous communities, especially where they are particularly remote? I’m thinking of communities like Jigalong, which is some 850 kms from their local government in the Pilbara shire. How do you see a way forward with this”?

A3. Tom Calma – “That’s a very important question for a number of reasons. Firstly, the Feds have a responsibility. In fact, they have made announcements that they are putting more money into shires and into local government areas around Australia, from infrastructure to major infrastructure by the way of roads, and that level of investment. It is a key question that I think government is grappling with in relation to homelands or outstations - is how do you fund those, and how do you fund the bigger communities? That’s the problem I see. At the moment there is a whole range of bureaucrats and maybe Ministers all thinking they know the solutions or different approaches forward, but no-one is engaging with the Indigenous residents.

What we have to do is consider the impact of all of these, and determine the key way forward. As you know, local governments get their funding in part through rates they are able to generate, rather than only through federal or state funding. A lot of us don’t know what questions to ask, so we rely on people to inform us. Once we start to look at things like home ownership we need to be realistic. The cost of rates, insurance and maintenance - all things people don’t have to pay when renting. Mortgage insurance will be significant because everyone says an Indigenous home lasts only 10-15 years. Therefore, what company would insure it for a low premium? You can bet your bottom dollar the premium for mortgage protection and insurance is going to be high when it happens. The thing that irks me most in relation to Tiwi is the suggestion that after 10-15 years all rates that are earned from land, with the exception of operational costs of the entity, will go to the traditional owners. Well firstly, we haven’t defined how much of those rates will
be the on-costs, and secondly, if all the traditional owners are getting all the money through rates, what is the shire council going to survive on? How are the roads going to be built? Does that again become the responsibility of maybe the State or Federal government? Who knows? Otherwise we see degradation of those communities.

There are a lot of issues I believe that - and I have talked to Senator Scullion and others about these - we really need to consider to ensure people are able to make a well-informed decision. I am not against home ownership, nor am I against economic development, but it needs to happen within a person's own frame of reference. As a home owner myself, and all of you who are home owners, know the costs, which are not cheap. These expenses will be in addition to current outlays. We know on communities the issues that you face all the time - people can't get access to good food because it is too expensive - so if your home costs are going to increase, what money are you going to have to rely on to buy the good food and to address these health issues? Therefore, we need to look at this holistically, and we have to look at it from the many different agencies approaches to it.

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AMRRIC/IFAW LAUNCH OF THE ON-LINE RESOURCE MANUAL “CONDUCTING DOG HEALTH PROGRAMS IN INDIGENOUS COMMUNITIES: A VETERINARY GUIDE”

Dr Jennie Churchill
“I would like to first acknowledge the traditional owners, the Iruandji, on whose land we are meeting today. Some of you already know of AMRRIC, which is Animal Management in Rural and Remote Indigenous Communities. I hope that by the end of the conference not only will you know more about us but you will have joined our small organisation. AMRRIC is, I think we can honestly say, the only independent organisation that is dedicated to sustainable animal management programs in Indigenous communities. However, it has some bigger visions as well. It supports research in both areas of animal and public health, and in fact is already a partner in a very significant ARC linkage branch program in these areas. We also have as our third objective, developing and implementing education training programs both for vets who are working in Indigenous communities, as well as for people in the communities who we hope will be able to carry on work, because sustainability is the most important thing to make them work.

Today we are really delighted to have the opportunity to launch an incredibly unique resource, the online manual that Shane mentioned, and it has been written by Dr Samantha Phelan who is a Darwin-based vet, with tremendous hands on experience running public health programs across the Northern Territory. It is especially important to us, and we are very grateful to the organisers that we can be here to launch it to such a relevant and important audience. I want to thank Xavier for the very special words he said about Phil Donohoe. Today is also another special opportunity because we can dedicate the manual to the memory of Phil and to the extraordinary passion and commitment that he had for AMRRIC’s work. It is true that only the good die young and those of you who know him (I didn’t know him personally, but I knew of him and have since certainly found out what a very special person he was). I want to thank IFAW, the International Fund for Animal Welfare. AMRRIC, like all small organisations, is not for profit and we always need funding. IFAW stepped into the breach and very generously funded the writing and production of this online manual. We are very grateful to them for that support. It was really critical, and we are very happy to have them as partners in this project.

AMRRIC received its first ever funding in 2004 from Senator Amanda Vanstone, and our next speaker is the Federal Minister for Community Services, Senator Nigel Scullion, who many of you know. I believe Senator Scullion has been instrumental in maintaining the support through the Federal Department for Family and Community Indigenous Services for AMRRIC. We are small. We have a lot to do. We are just developing. However, we have tremendous potential for doing great work in Indigenous communities, and we are very grateful to Senator Scullion for his ongoing support and commitment. He understands the need, he really does, and we are very grateful. It is there with great pleasure that I invite the Minister to come to the stage”.

Senator Nigel Scullion, The Federal Minister for Community Services
“Thank you, Jennie. I would like to add my acknowledgements to the traditional owners of country and acknowledge everybody who is here. A conference of this nature is really valuable, especially in the networking, and the way you share information is an essential element in ensuring we bridge that gap between mainstream Australia and Indigenous Australia that Tom was referring to. Tom will know that I am a very conservative individual and I will be very restrained in my response to some of his remarks today. Tom and I are actually good mates outside of parliament. We are often found hotly engaging in the middle of the road stopping traffic on one issue or another, but it is the nature of that relationship that we get so much out of it. The guide that we are launching today deals very much with the relationships about communities, and that is a very important element.

I honestly got involved in this particular issue well before I came to parliament. In fact, for those who don’t know, I was a commercial fisherman before I came to parliament, and Phil Donohoe and myself were sitting in a dinghy. It certainly wasn’t on the water. I am just trying remembering exactly where it was, but it was in a dinghy on a trailer. I think it was at Coconut Grove, and we had sent the kids off (they were a bit smaller at that stage) to go and get another bottle of red wine. We were pontificating on a whole range of issues. Phil was a very wide-read individual, and he was particularly passionate about the very close
who might have a couple of dogs. They say that all they really want those dogs give you at night. It's the protection that is sadly but importantly part of everyday life and for some people - and particularly older women in communities, particularly in Central Australia - Cairns doesn’t often have three dog nights, but we certainly do in Central Australia. Therefore, it is not only companionship, it’s the warmth that those dogs give you at night. It’s the protection that is sadly but sometimes needed, and the confidence they have in those animals. Often I have been sitting next to a lady in an Indigenous community, who might have a couple of dogs. They say that all they really want is their painting, their dogs, and a cup of tea. Their needs appear to be very low, but the health of their dogs is of great stress to them. They talk to me about whether their dogs are a bit sick when I ask how they are going. That's the first thing they tell me – it's always if their dogs are a bit crook and they are a bit worried about their dog. In this sense it is an integral part of the community, and their closeness to the dogs and the stress that they feel for the animals connects the animal health with the health of the individual, which in turn affects obviously the health of the community.

I believe that for the first time we have now approached this issue with the frankness that it needs, and the practicality that it deserves. I think that this is one of the principles this actual manual provides. Sam, this is a fantastic contribution, but the only thing I noticed is that you got wrong is that on the front here it says it is a veterinary guide. I have to say that whilst it does deal very much in the context of communities and with dogs, I think this is more about the real things in communities – it is really about people. This guide is a fundamental guide about how to do business in Indigenous communities. Tom Calma talked a little earlier about how we communicate – the fundamental right of actually understanding what you are agreeing with, the fundamental rights of having ownership in what is happening in the community. For those of you who haven’t read this, you must.

This is compulsory reading because it is about doing business in Indigenous communities. It is about empowerment and understanding, and it is leaving a legacy of an increased capacity to do things for themselves. I very much commend that actual aspect of the guide. Whilst this is a first step, we are at a point where we have now recognised now that there is no capacity in communities for such an essential element of community health. I hope - and I have spoken to many others in AMRRIC such as Jennie and Phil about the sort of place we need to end up – an end point where we have so much work to do in communities, so many capable individuals, and yet so many people who are unemployed. This is another area where we must put opportunity with capacity, and I can certainly see through AMRRIC that we can have people in each community where there is a need. There is a need in every community in Australia for people to be responsible - to get up every day and be responsible. We are lifting the capacity for people to understand about the health of their animals and to also be able to physically deal with and provide a veterinary service on the ground. I would see in the next couple of years that we will be in a position where there will be Indigenous AMRRIC officers in communities who are able to provide most of the services that this manual provides us with.

This is the first step, and an essential first step. However, there are other elements in terms of the technical aspects. Again, Phil used to always remind me that there is no unique solution to any Indigenous community as if there was, they would all look the same and they don’t. We need to ensure that in the framework provided in this veterinary guide, we recognise the differences and demographics of all the Indigenous communities. As long as we apply the abiding principles that Tom spoke so passionately about...
and the principal thread of Samantha’s guide, I believe that we will do very well, and we will be able to make a fundamental change. It is very frustrating, not being around non-Indigenous affairs but living around Indigenous communities for so long. The pace of change is frustratingly slow. However, I think the nature of capacity-building that’s a common thread and a single element of not only the document, but also the way AMRRIC is working, is really the way of the future, because it will have an enduring legacy. It won’t be ‘touch and go’ - wherever AMRRIC is, I think the relationships are the basis on which the operations rely - those relationships are enduring relationships. If you move around Arnhem Land you will see that - whether it is Steve Cutter or Phil or Sam’s work - that everybody actually understands what they are there for.

I met a retired police officer by accident in Melbourne the other day. He told me about when he was in an Indigenous community in the Northern Territory and how he fixed the dog - he shot 20 dogs, fixed the problem and it was all better. I didn’t remind him of it as he was an old bloke and he was having a good day so I let him go, but the enduring legacy that is left from those sorts of activities in the communities is an enduring legacy of mistrust. Therefore, I think it is incumbent on all of us to remember in the seemingly continual steps of experimentation in Indigenous communities, no matter what we do we have to start getting the fundamentals right, and that’s about ownership and trust and all these things. I am just delighted to see the veterinary guide that I am so proud to launch today is a fundamental element of that. In closing, thank you all again for participating in this conference – your work in EH is an absolute fundamental about bridging the gap between mainstream Australia and Indigenous Australia. These are probably the most important fundamentals of health and wellbeing. It’s very hard to be a rocket scientist or go to school or build or develop if your fundamental wellbeing is altered. So thank you everybody who’s been involved with this, particularly thanks to Sam Phelan. It’s a bit of a beacon in terms of the process. This is not about a veterinary guide, but about how to do business in communities, how to communicate with communities, how to get ownership in communities, and how to leave an enduring legacy of change that is very much accepted in those communities. So with that it is my very great delight to officially launch Conducting Dog Health Programs in Indigenous Communities: A Veterinary and Community Guide”.

Michael McIntyre, Australian Director, IFAW

“I, too, would like to acknowledge the traditional owners of this country, Minister, colleagues and Jennie from AMRRIC. It is my pleasure to be here as part of this very important launch of this manual. IFAW is an international organisation based in 15 different countries around the world including here in Australia, and we work towards making the world a better place for animals and people - whether that be wild populations of elephants in Africa or companion animals such as dogs and cats. That is why IFAW is so proud to be part of this resource manual. It is written in our mission statement at IFAW that we will promote policies that advance the wellbeing of both animals and people - both are very different from a lot of other conservation groups, because it is very much in our mission that we want to promote the advancement of both animals and people. So they are fundamentally linked in our eyes. We have a track record working across the world on different issues, working with companion animals. Whether it is in our dog program in Johannesburg, South Africa, or in some of the poorest communities of the world in Soweto where we have a program working with the communities on dog health issues, whether it be in China where we have a program in Beijing which is connected to laws of Chinese, or whether it be a mobile vet clinic that we run in Bali – I want to point out that the common theme of all these programs we run around the world in helping with dog health issues is the same - people care about their dogs and cats.

I was listening particularly to the comments of Minister Scullion, when he said (and I support those comments) that if we saw many dogs around the cities of Australia we would question what services are available. These are our findings, as well as in these communities around the world. It is often about the lack of resources, but it is also about the extraordinary successes we have had in the basic understanding of what care is needed. Therefore, it was a perfect fit for us to look at how we can help Indigenous communities in Australia. We knew that there were a number of vets who wanted to do work on these issues in Indigenous communities, but there was such a lack of information of what to do in communities. We were very lucky to find people setting up AMRRIC – in particular Phil Donohoe, and others. We found AMRRIC in its infancy, so it was a perfect opportunity for us to join with AMRRIC to look at ways we could help with this.

Therefore, this has been very much a cooperative effort between us and AMRRIC, and something of which we are very proud. I am very heartened to hear the words from the Minister today for AMRRIC to go to the next step, because this is a fantastic resource and a fantastic guide, but obviously the next step is the implementation of the information in that guide and the resources needed to do that. The other thing that needs to be pointed out is that this is a ‘world first’. I remember Margarite from IFAW telling me this morning that when she was working with Sam (who you are going to hear from after me), they were doing something so new when writing the manual - nothing like this exists anywhere in the world. From an IFAW perspective, we are certainly going to be using this in our other programs around the world. It is unique, and a world-first. There are plenty of people I would like to recognise for the work on this manual, particularly Phil Donohoe and his passion for making a difference in this area, to the Federal government for allowing the process to happen through AMRRIC, and my staff, in particular Margarite Young, who has put in a lot of effort, and was there at the beginning, and Dr Phelan. We hope that more vets will be able to work on this issue and be able to use this resource. We do want to see resources put into taking this to the next level, and thank you everyone at AMRRIC for the opportunity to be here to be part of this very exciting launch”. 
Samantha Phelan, author of AMRRIC/IFAW launch of the on-line resource manual ‘Conducting Dog Health Programs in Indigenous Communities: A Veterinary Guide’

“Thank you. I would like to acknowledge the Irukandji People of this country and thank them for allowing me to stand here today. As you heard, I am a vet and I used to work in the Katherine region. I supplied services for about five years to large areas across to Borroloola. Not all of the work I did was perfect, and I went into it in a relatively naïve form. However, things progressed, and I improved my practice and my methods of communication. I provided sustainable dogs programs to some very large communities in that area, and did so without the violence of culls. I think the take-home message today is that we don’t need to cull dogs to advance dog health. In fact, if you are culling dogs to improve EH, you are not winning – and you won’t win in the long term as it is the perpetuation of violence that has been around this country for the last 200 years. The link between human and animal violence - in some cases it is actually the vets perpetrating the violence - and we need to be very mindful of that when we look at service delivery.

Lajumanu, for example, was one of the places I went to first. This was part of a veterinary team combined with a health team that had gone in and thrown meat off the back of a back of a truck (and we are talking 1993). They shot every dog that came in to get meat, in public view. I know that this also happened in Borroloola the year before last, so the idea that this is a long time ago isn’t the truth, and we need to address that from this point forward. AMRRIC is certainly a vehicle to do that. The problem with that style of program and without planning (Tom, thank you for your comments in terms of planning) is that you can create a really wonderful capacity-led capacity-building program by establishing from the outset a decent planning mechanism, using the community. People know what they want – it’s just a matter of tapping into what they want and a veterinary service provider can help them get what they want. You cannot have a dog problem as a result of that. If you just take out numbers of dogs because they are a problem, what you end up with is just more sick dogs. You are not addressing the health issues of the dogs. You also end up with a lot of puppies, and puppies are the ones from an EH perspective that are shedding worms all the time. Therefore, until they die they are shedding gross numbers of worms into the environment – and that’s where your true EH problems lie - with the pups. If you are always just peeling off the top layer and leaving the cute ones, you are continually contaminating your environment.

Therefore, the way I went about it was mostly with a surgical desexing program (though not always), which leaves a middle-aged dog population, which are usually hairy, happy and friendly - not always friendly, but that can be overcome once you have community participation. I agree with Senator Scullion that the Veterinary Guide was probably a bit of a misnomer. It was called that because in AMRRIC’s vision we will also be developing an EHW guide. From a perspective of how it can be utilised in a community at this point, certainly it has a section on how to plan a dog program, how to engage a community, who should be there and how to sit down and talk this stuff through to get everybody singing from the same hymn page. So from a CEO Council perspective, that’s a very valuable area to come from. For EHWs there is also a section on zoonosis, on population control options, and on drug protocols. A lot of the drugs can be bought from Elders and from stock and station agents, and are not scheduled drugs in the NT. There is different legislation in Queensland but in the NT you have to operate with a vet. However, with adequate training EHWs are quite able to use these drugs safely. So from an EH perspective it is actually a really good resource on what truly are zoonotic diseases that can move from people to animals and vice versa. What are these zoonotic diseases, because there are a lot of myths around them and I think that is probably largely what leads the ‘cull mentality’. In some cases there is a lot of misinformation about what those zoonotic diseases are. Yes, they are there and they do exist, but there are effective ways to manage them without killing dogs. So I hope you all become members and enjoy the manual. Thank you”.

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ANIMAL CONTROL AND WELFARE MANAGEMENT - ANIMAL MANAGEMENT REGISTRATION & MICRO-CHIPPING PROGRAM

Walter Morgan, Environmental Health Worker and Rae-Jon Bunting, Palm Island Aboriginal Shire Council

Walter Morgan

“Like everyone else I would like to acknowledge the traditional owners of this land, the Irukandji People, and their Elders. Our talk today is about the Palm Island Animal Management Team. The team consists of me as supervisor, Rae-Jon as my assistant, and four other workers who do all the hands-on work out in the field. This team started off with no funding; just some left over money from other council projects plus CDEP, and a Queensland health worker who was interested in animal control work.

Our animal control program focuses on all animals kept as pets, because they are the most dangerous with regard to health as they are neglected and not looked after. This leads me to the next part. Since time began, dingoes/dogs were useful to our ancestors for hunting and catching food. His reward for that might have been a piece of bone or meat. Moving forward a few thousand years, the dog is still with us, but the family are flat out feeding themselves, let alone feeding the dog. There are a few who do look after their dogs – who feed and groom them properly, and there are still some good hunting dogs out there that people own. However, the majority of dogs on communities don’t go hunting anymore. Instead, they hunt around the tucker table, and are still living on scraps. They are neglected to the point that they live miserable lives as pets – they are flea-ridden, have worms, scabies and other exotic diseases that are also linked to health problems on communities.
My talk today is on Palm Island. I am talking about my own community, so no-one can get offended. We as EHWs must be compelled to observe and carry out mainstream laws and legislation with regard to animal control and welfare. It is up to us to apply them for the betterment of our people, and it is also up to us to educate and involve the community to make them understand they can’t continue to treat pets badly. Our actual program and presentation covers a lot of what we are going to talk about, such as micro-chipping, registration and how we go about doing our jobs”.

Rae-Jon Bunting

“Thank you for having me here. I was first drawn to Palm Island in 2003, when it was much shamed in the international press about the way the animals were being abused and the way horses were being hurt. I was very fortunate to be invited by friends to come and stay to see what I could do to help. In those days I lived with my friends in a camp that was running the horse carers group. After going to Palm Island a number of times and helping with first aid with the horses, and trying to teach kids better ways of looking after their horses in particular, I came across DPI there on one visit. They saw the work that we were trying to do, and said they didn’t really want to go to Palm Island and do the things that the press was saying, but they had an obligation. They asked me if I could continue my work with the community so they could look after their own problems. Some time after I stopped going there (by the way, DPI just paid my airfare as I am a pensioner), I was picked up by ICB as a volunteer. This is a brilliant organisation. I had a contract between Council and ICB that I work as a Council employee without wages.

When we first started on the animal program there was a direct link between healthy animals that are loved and cared for, and sick animals and community health. In early times on Palm Island there were anywhere between 20 to 25 to 50 dog bites a week that went unreported. Today we might have just one dog bite a month. In the early days there were many reports of scabies through the hospital. The incidence is now very, very low, but there are also very few dogs left on Palm. In the early days there were about 2500 dogs. Now there are around 98% fully-registered, healthy dogs on Palm. To start with, the community didn’t want their dogs touched. Now they ask us to take care of the dogs, and they are very much involved in looking after their own health and welfare by looking after their animals. The community assists in the registration process, and helps keep the dogs as healthy as possible. The horse population has also improved out of sight, together with welfare issues.

This slide show was done eight months ago, and the program had been going long before the slide show was produced. However, when Council decided they were going to do dog registration we started with microchipping, and the concept was to microchip every dog on the island. You might recall that I said there were 2500 dogs on Palm so that process began. I think they had microchipped about 80 dogs at Butler Bay, and in the following weeks animal control had picked up about 20 dogs, and had destroyed them. In the short term we abandoned the microchipping program, and took up the collar and tag registration. We will resume microchipping as soon as the numbers are more practical and it’s financially viable. So that process is really working well and we are resuming microchipping next week. Futuristically, for any dog that is found without a collar or tag (because we can see them at a distance), the animal control fellows will catch those dogs and take them to the pound.

The community then has five days in which to get them released from the pound, and if they are not collected they are forfeited, then destroyed. It is very funny, but we found that lots of people had lots of dogs but only one dog lived at the house. We would ask them which dogs they wanted registered, and they would hand over the other dogs. The community support has been absolutely wonderful. I am mainly involved with teaching the animal control officers their work, workplace health and safety mechanisms, showing them common-sense basic ways to catch dogs. One of the big things was the RSPCA – they taught the animal control officers how to implant a microchip. It is rather interesting – it is one thing to learn how to microchip a dog, but another thing when you go to the houses and come across dogs that try to take your arm off. The animal control officers now wear armour-like gloves and use catching poles. It is a very big job – it is just not that easy to say ‘we will microchip every dog’. However, all of these processes were learned as we went through the mechanisms, and when we hit hard spots we would go back and talk about ways of overcoming them.

It is working very, very well. We now have 20 or so cats registered, and Council is really looking forward to having a feral cat hunt shortly. The horses are being branded and registered for ownership, and Council has a rather wonderful view of community and other outcomes that are now very much possible because of the improved stage of animal control and animal welfare. They now have no reason to be ashamed of the horses, and no reason to be ashamed of the dogs. Should they have a visitor to Palm, that person won’t end up at the hospital because of damage from a dog that rushed them. One of the things we found difficult was that the Council asked for mechanisms to be put in place to enforce bylaws. Council has had bylaws for 30 years, yet they have never been enforced, nor the community educated that those bylaws were even there.

So all we are doing is what council now wants under the bylaws. One of the problems we found is that kids were riding on the road at night. We now have animal control operating a night patrol to stop kids riding at night. I go to the school and explain that horses don’t have head lights or tail lights, therefore they should stay off the road. The kids seem to understand that message pretty well. However, for the children who just don’t listen and say ‘I am going to do what I want’, the Justice Group steps in, and we have had a number of children go through the Justice Group. The really good news is that none of these kids have reoffended. They have never been out again, and there have been a couple who have gone through kids court who were really bad, and of course we are not privy to know who they are. I know there are about three, but I don’t know the outcomes because they are children. However, Palm Island Council is very happy about how the processes are going.

The equipment and mechanisms for microchipping are really simple. I don’t know if I would say go to microchipping the first time, as you have to be able to be able to identify animals at a distance. However, it is a very good process as an end goal to have all your animals microchipped, because it goes back to ownership. It is a very technical process with needles, scanners and muzzles – it can take three people to do the job with ropes, collars and registration tags.
and you will need a vehicle. There’s a lot of infrastructure needed to put this mechanism in place. It may not work for all communities – the simple collar and tag might be more efficient. However, this is where Council wants to go on Palm so we will go there. We just have to work out how to do it for them, but it is working well.

The microchipping program at Butler Bay took so long as the training had been on dead dogs and dogs that had been operated on. Therefore, when it came to the practical task of catching the dogs to do 35-40 houses between 3-4 weeks, for Council it became a very expensive exercise with four men to work between 3-4 weeks to do only 80 dogs. It makes it very, very expensive. There were many problems associated at the beginning of that process. We will certainly resume this and get it done, as it’s become Council policy. With the hard work the animal control workers have to do, we just have to find a way for them to do it safely, and not be injured. Also, one of our bylaws is that there are only two dogs allowed per household and that’s where I am saying we microchipped every dog, then found we had to go back and destroy half of them when the dog owners had to decide how many dogs they wanted. They had to decide what dog they were keeping, and what dog they wanted destroyed. That’s why we actually adjourned the microchipping process, as it got to be too expensive and unrealistic to follow that procedure. When we hit a brick wall, we go back and think about what we can do, what we have got, and how we can get this end result that Council wants”.

Walter Morgan

“We still have a long way to go before we are where we should be. In the near future, Palm Island is looking to move to tourism, but we need to fix this problem first - we can’t have a busload of tourists going through town with a bunch of leatherbacks on the corner. Thank you”.

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IMPLEMENTATION OF THE NSW HEALTH COMPETENCY GUIDE FOR ABORIGINAL TRAINEE EHOs

Robert Barnett and Ronnie Naicker, North Coast Area Health Service NSW Health Service and Paul Williamson, NSW Health

Robert Barnett
“We are here today to discuss the development of the Implementation of the NSW Health Competency Guide for Aboriginal Trainee Environmental Health Officers. Thank you and good morning. Firstly, I would like to acknowledge the traditional owners, the Irukandji people, and the Elders present here today. We will first discuss the development of the guide, and from my perspective as a trainee I will discuss the guide. Ronnie Naicker will give a supervisor’s perspective of the guide, and Paul will give an assessor’s perspective of the guide. We will also discuss some of the challenges of the guide.

INTRODUCTION

• The Guide is to train and provide support for Aboriginal people to become EHOs. In 1997 the NSW Health Aboriginal EHO Training Program was launched.
• Trainee is employed by PHU’s for six years + additional two years in NSW.
• Each trainee has to study the Bachelor of Applied Science (EH degree) through the University of Western Sydney.
• Currently eight Aboriginal Trainee EHOs in the NSW PHU Network.

We have eight area health services in NSW, with two public health units at each area health service. I am employed at the north coast area health service.

As well as having to undertake our studies as trainees, our competency guide has been developed for trainees participating in an Australian program. The reasons for developing the guide are as follows:

• To ensure trainees get a diverse range of workplace skills.
• Continuous improvement tool.
- Assesses trainee support needs.
- Structures their work plans and training plans.
• Clarifies roles and responsibilities of the Public Health Unit, Supervisors and Trainees.

Processes involved in development of the guide are as follows:

• Developed with input from UWS, NSW Health, AIEH (NSW), Trainees and Supervisors.
• The first trial assessments by third party assessor identified some gaps in the original guide.
• Reviewed and amended per eighth Competency area developed (EH Technical Skills).
• Evidence guide is structured on a ‘stepped learning process’ of initial, middle and later year competencies, to take into account the expectation that a trainee’s competency increases as further knowledge and skills are acquired.
• All current trainees are using the guide and are being assessed annually.

Structure of Guide and how it applies

1. Competency Areas.
2. Competency Area Descriptors.
3. Competency Elements.
5. Evidence Guide.
1-3 Competency Areas, the Competency Descriptors and Competency Elements - these three sections locate the competency in terms of professional and work areas. Competency Areas describe the skills and tasks required. Competency Descriptions state the scope and the intent of the competency area, and the Competency Elements are the outcomes that combine to make up the Competency Area. The fourth section is the Performance Criteria which defines the performance area required of the trainee and it also specifies a standard of performance needed to achieve the competency elements. The last section of the Guide is the Evidence Guide, which provides on-the-job related guidance to assist trainee, supervisor and assessor understand the performance criteria. There are two levels of information in the Evidence Guide. One level provides a context for the performance criteria within the EH practice, and secondly it describes minimum standards expected to be met by the trainee before competencies can be considered satisfactory.

Competency Areas of the Guide
1. Professional Practice.
2. Management.
4. Information Management.
5. Communication.
7. Community Engagement.

With reference to the slide presentation, here is an example of the Structure of Guide and How it Applies using Competency 8.2 Environmental Health Technical Skills - Drinking Water Quality Management. This table is a copy of a page from the actual Competency Guide. The first column describes a competency element, in this case, quality management. The second column describes the performance criteria and the third column describes the evidence guide. As you can see, the colour shading changes in the second and third columns. The colour shading white indicates the initial year of the traineeship program which is Year 1 and 2, blue shade is the middle year of 3 and 4, and the orange shaded area 5th and 6th year competency, which are the more complex competencies that trainees must acquire.

Competency Assessment Cycle - trainees need to keep evidence of all competencies achieved in our workplace:
- Assessor assesses the trainee’s progression of the competencies he/she has achieved.
- Assessor and trainee discuss the trainee’s progress with the trainee’s supervisor.
- Assessment review by supervisor and trainee - development of training work plans.
- Training work plans forwarded to Manager of EH Unit.
- Trainee and supervisor implement plans by meeting regularly, and the next cycle starts again.

Trainee’s Perspective
- The Guide provides trainees with a guide regarding the EH skills that are to be acquired in their field of work.
- Flexibility to acquire skills that assist with personal development through on-the-job training and courses - also gives opportunity to undertake studies in areas such as onsite management and tobacco compliance training.
- Gives trainees and supervisors a guide to develop a trainee’s annual work plan.
- Links work experience to academic study, eg, when studying food, able to undertake work experience with local government to conduct public food inspections (which is not able to be done in the public health unit).
- Challenges and pressures to meet all competency areas, eg, balance the needs of my family along with study and work commitments.
- With good support from family, friends and fellow trainees, self management, good time management and self motivation, the Competency Guide is a useful tool.
- The guide may assist in future employment, as it shows evidence of competencies worked towards, and work experience undertaken.

The next slides show trainees in action undertaking some EH activities. This is a picture of Trevor identifying adult mosquitoes with the aid of a microscope. This type of activity may assist Trevor to obtain skills to meet competency elements of competency areas in EH risk management and EH technical skills. This is a picture of Wendy grabbing a chicken for a blood sample to be taken as part of the NSW Health Sentinel Parvo Virus Program, which is a training course. Wendy, during this training course, may have met competency elements under competency areas of professional.
Day One

practice, EH risk management, communication, policy and legislation and EH technical skills. On your right-hand side is a picture of me dressed up in the Mr Germ costume at the Kempsey Croc Festival, as part of the Mr Germ Wash Hygiene Program. The other character is the Germinator, a new addition to the Mr Germ Program.

During this type of activity I would have achieved skills under professional practice, management, communication, community engagement and EH technical skills. This is a picture of Ed replacing a shower rose in a bathroom during a Housing for Health program. A program like this may allow a trainee to gain skills in all competency areas. This is a picture of Louise setting a mosquito trap during a mosquito training course. Again, Louise would have met a number of competencies during her training. This last picture shows Aunty Mim, a community water sampler, taking a water sample, checking for E.coli. I have been involved in training community water samplers like Aunty Mim, and coordinating the program. Work activities like this have assisted me and other trainees to meet a number of competency areas. For additional information on the trainee program and competencies guide there is a picture story board out in the foyer, and I invite you all to go and have a look at it”.

Ronnie Naiker

“Thank you Robert. I will talk about the Supervisor’s perspective:

• Supervisor’s primary role is to deliver the training outcomes expected of the AEHO Program.
• It is important to implement the guide within the period of the traineeship, eg, in Robert’s case, five years.
• A trainee’s annual work plan and monthly operational plan all need to be implemented in the work environment.
• Progression of competency element and performance criteria is written into work plans, and based on feedback and reviews.
• Ensure ample opportunity for trainees to gain technical skills internally and externally, and with a variety of activities.
• Ensuring objective competency skills are met is difficult, eg, conflict management and legislation interpretation.
• There are limitations with competency areas.

• Funding is adequate but is limited to core PHU activities which are public health protection focused, and as Robert mentioned, we don’t have a food inspection role. Therefore, that is one area where Robert needs external training.
• Team effort to ensure trainees get the required workplace skills support in order to achieve goals and meet competencies.

The next slide is a photograph of a supervisor and trainee attending to a damaged water pipe in a community. This activity will cover a number of competencies when the activity is done”.

Paul Williamson

“My role in this process is to work with Ronnie and Robert in their workplace; to sit with Robert and look at documentation that will form part of his assessment, and to undertake the assessment itself. In this case, Robert’s first assessment was undertaken during his fourth or fifth year, so we had a lot to cover in terms of the guide. Other assessments have been done with other trainees who are only in their first year. The Guide is structured to try and cater for a wide range in terms of assessment situations, ie, to reflect the position of trainees with respect of their traineeship progression. As Robert said, it is meant to help trainees manage the process with their supervisors throughout their traineeship.

As an assessor it is a wonderful opportunity to work with the trainee - to gather the evidence they wish and need to present to their employer, and through me deliver the evidence to their employer so they may let them know how they feel their traineeship is going. In some cases I have also been able to facilitate ongoing discussions with their manager and the Area Health Service as they move through their traineeship.

Whilst the Guide has been developed to assist trainees as part of their employment within the NSW Aboriginal EH Training Program, the Aboriginal EH Unit recognises that trainees are not just training for EH inside NSW Health, but also for the wider EH profession. They may find future work in another environment, such as in local government, private consulting places or maybe inside community organisations. So the scope of competencies goes much broader as it does for other places. So it is important to implement the Guide within the period of the traineeship.

The assessment guide is evidence-based, and the process we have used provides trainees with the opportunity to document, explain and talk, take me (as assessor) out into the field, or take me to other people they work with. These activities are extremely valuable in the process. My role in the process is to document and to assist them put this evidence into a form that can be used through the other points of the assessment cycle we showed in the diagram earlier.
One of the things we have learned from the assessments is that the workplace may need to gain external assistance in order for a trainee to get through some competency areas. For example, a short-term job placement at another public health unit or in a local government or external agency office may be needed. Some trainees have already done this in areas such as septic tank inspections out in local government areas in their region, in order to see how these are regulated by local government. Some of the area health services have a very strong relationship with their local government areas while others have a very weak relationship - so there are different ways and challenges ahead.

Another major learning is that the management of competency-based training is a new process for many of the supervisors of trainees. This means that the development of the traineeship programme will need to be monitored and driven by the workplace manager. However, it is also clear that there are instances where some managers don’t have the skills to manage the implementation of the competency-based assessment process. The various PHU’s have significantly different management systems and operational focus as well. For example, the Far West AHS has a very different focus to many city-based public health units. As such, the NSW Health Aboriginal EH unit needs to identify where those gaps exist and work with the Area Health Services to roll out the Guide. This may need to involve training of Managers and Supervisors in competency-based management skills.

The assessment criteria included in the Guide focuses on skills and knowledge, not on subjective analysis. Therefore, from an assessor’s point of view, the Guide is very easy to use. The Guide structure recognises there will be a number of stages of development in knowledge and skills, as Robert pointed out earlier. It recognises that over time the trainees’ skills will develop, and as such the document must be used over a six-years or so year process. It doesn’t expect people to just rush straight off into the whole thing. My final point highlighted through the assessments I have carried out with trainees is that the organisations rolling out this performance-based and quality management based guide may not have management systems that follow such processes. Therefore, there is a certain level of development also needed in the area health services.

This is the feedback from me as an assessor. With this next slide, Robert has asked me to continue the general presentation. The challenges that have been recognised are that the implementation of competency guides may need to be extended for a further two years. Robert pointed out that the traineeship includes the degree course, which is for six years. They do have their option there of an extra two years in the workplace, and I think that’s where this point is being targeted. That is, it’s about extending the competency guide into areas when they have become qualified, so it’s a point about bridging between the traineeship and their professional practice. For example, some skills require formal EHO authorisation before they can be gained. In some competency areas the bar may be high, but it is a work in progress and there is a mechanism through the Aboriginal EH Unit in Sydney to continue to review the guide. So these points may be taken up by them.

In conclusion training Indigenous people is about getting people to make a difference in improving EH in their communities, and in the areas of health services in which they are working.

The guide:

- Aims to ensure consistency, and provide a mechanism of fairness in terms of the development of their skills.
- Provide a “blue-print of what is required by all parties (the trainee, the assessor and anybody else they relate to or from where they are getting their training), and it should not be underestimated that part of the training may need to be provided by third parties.
- Is a continuous improvement tool with steps and stages.
- Assists with employability for trainees.
- May increase job satisfaction and EH retention.

Before we finish, we would like to make the following acknowledgements to:

- NSW Health Aboriginal Environmental Health Unit.
- Project Officer, Paul Williamson.
- NSW Health Aboriginal Trainee Environmental Health Officer Network
- NSW Health Public Health Unit Network.
- University of Western Sydney.
- Australian Institute for Environmental Health (NSW Div)

QUESTIONS

Q1. Pat Nichol, Wujal Wujal - “Regarding the receiving of the program in the Far West areas like areas out here, how well is it received? Do you get a lot of trainees in those types of areas”?

A1. Paul Williamson - “Correct me, but are you asking whether there are trainees in the Far West”?

Q2. Pat Nichol - “Yes. How well is it received in remote communities”?

A2. Paul Williamson - “In my other work with the area health service out there, I am based in the greater western area which is basically Dubbo west. I have involvement with Thadd Naga, who is the trainee out in that area, and also with another group of people called Healthy Housing Workers who are working out there. These are not at the degree level, but are VET level trained. I believe it has been well received in terms of their interface with the communities, but we could ask Thadd, too, in that regard and how well it’s received. He probably has a stronger perspective on that”.

PG 33
Thadd Nagas - “I am a trainee similar to Robert. I am out in the far west and there’s another trainee by the name of Trevor Robinson also working based in Dubbo. The Competency Guide itself is accepted by both of us trainees out there. There is also an EHW (Healthy Housing Worker program out there which has been part of the COAG trial). It’s been a long process and it’s been accepted in communities. We have been able to get a lot of work done in communities that wouldn’t even get touched by an EHW, so it is working well”.

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IDENTIFYING APPROPRIATE ENVIRONMENTAL HEALTH INTERVENTIONS TO REDUCE THE TRANSMISSION OF PATHOGENIC ORGANISMS THAT CAUSE DIARRHOEA, SKIN AND RESPIRATORY INFECTIONS: HAND WASHING PROJECT
Nicola Slavin and Annette Fuller, NT Department of Health and Community Services

IMPACT OF CHILDHOOD INFECTIONS
Infectious diseases such as respiratory and intestinal infections are the leading causes of hospitalisation for Aboriginal infants and children in the NT, with rates many times higher than in the non-Indigenous population. Skin infections are also a major contributor to the burden of illness experienced by Aboriginal babies and children in the NT.

These infections impact not only on the health of children in the short term but may also contribute to chronic disease in adulthood. Research indicates that repeated infections during infancy and early childhood can also result in impaired growth, which may lead to long-term health repercussions. Growth in the first year of life, as well as in utero, has been shown to impact not only on somatic growth but also on the development and function of specific organs which in turn has been found to have direct consequences for adult chronic disease particularly cardiovascular disease and hypertension (Barker: 1991; Maguire: 2004).

PREVENTATIVE INTERVENTIONS
Primary barriers such as sanitation and hand washing after faecal contact have been found to be the most effective means of reducing diarrhoeal disease. Curtis and Cairncross’ (2003) recent systematic review of the effect of hand washing with soap indicated that hand washing with soap can reduce the incidence of diarrhoeal disease by 42-47%.

Whilst it has long been accepted that hand washing provides an important means of preventing the spread of diarrhoeal disease, it is only relatively recently that the connection between hand washing and respiratory infections has been recognised. Several studies have shown that hand washing is effective at reducing the rate of respiratory infections in a range of populations. The Karachi Soap Health study found that children younger than five living in households which had received intensive hand washing promotion and who where provided with free soap had a 50% lower incidence of diarrhoea and pneumonia than controls (Luby et al 2005). The same study also found that children younger than 15 had a 35% lower incidence of impetigo.

A number of international studies conducted in a variety of settings including childcare centres and in the homes of urban families in the UK (Curtis et al: 2003), have shown that people often do not adequately wash their hands after key junctures such as going to the toilet and cleaning up after children who have defecated.

GLOBAL FOCUS ON HANDWASHING
The determinants of hygiene behaviours such as hand washing are complex and research indicates that simply teaching people about the health benefits of hand washing does not result in substantial behavioural change. Internationally there is an increasing awareness that in order to change handwashing behaviour on a large scale, the principles of industrial marketing need to be applied.

The Public Private Partnerships for handwashing with soap is a global initiative developed by a number of government and non-government organisations including the World Bank, the Water and Sanitation Program, the London School of Hygiene and Tropical Medicine, USAID, UNICEF, Unilever and Colgate Palmolive. The aim of the initiative is to foster productive partnerships between private industry and the public sector, utilising the unique skills and expertise that each sector has to offer. In particular, the private sector has a wealth of marketing expertise which can be utilised to promote hand washing with soap to the public, and increase the likelihood of hand washing becoming a habitual practice.

The underlying belief behind the Public Private Partnership for hand washing with soap is that hand washing needs to be tackled on the scale of vaccination programs where population coverage in any given area is almost total (Curtis 2002). The Public Private Partnership model was first trialled in Ghana and in Kerala, India. Since then the model has been successfully applied in a number of countries including Senegal, Peru and Indonesia.

PROJECT DESCRIPTION
The long term goal of the project is to reduce the person-to-person, and environment-to-person, transmission of pathogenic organisms which cause diarrhoea, skin sores and respiratory disease. The project is being trialled on an Indigenous community in both Central Australia and in the Top End of the NT. There is also a designated comparison community in both regions.

We hope to implement the project divided into three stages, each to be run over approximately a year. The focus of stage one is on identifying effective means of promoting hygiene in Indigenous communities. The second stage of the project will involve the development and implementation of a repair and a maintenance strategy for essential plumbing, and the third stage will reinforce key health messages. We are currently in the process of implementing stage one of the project.
One of the key strategies of stage one is the development of a social marketing campaign, central to which is the target audience’s identification of the perceived barriers to, and benefits of, the desired behaviour. The function of a social marketing program is to change the ratio of benefits and barriers so that the target behaviour becomes more attractive.

**BASELINE DATA**
The following baseline data was collected at the trial and comparison communities:

- Housing surveys were conducted to identify the maintenance needs of community-managed houses.
- Administered questionnaires were delivered to each household. The questionnaires were aimed at identifying the current knowledge, attitude and behaviour in relation to washing hands with soap.

**QUESTIONNAIRE FINDINGS**
Many respondents in the Top End community said that they usually used soap when washing hands. However, most homes did not have soap at the time of doing the questionnaire. In Central Australia, nearly all homes did not have soap at the time of doing the questionnaire. Several respondents stated that they did not believe it was important to wash your hands.

In the Top End trial community, many respondents understood the importance of washing hands and nominated key times to wash hands as being after going to the toilet and before preparing or eating food. Many understood that washing hands could stop germs from spreading. However, in Central Australia, respondents had a limited understanding of germ theory.

**FOCUS GROUPS**
A social market research company was engaged to research the primary barriers and motivators to washing hands with soap. The researcher used focus groups and in-depth stakeholder interviews to explore what are the barriers to people washing hands with soap as a routine behaviour, and what sorts of things would motivate people to adopt that behaviour.

The focus groups explored:

- What current opinions and attitudes exist towards handwashing?
- What are the existing handwashing behaviours?
- What influences people’s opinions generally?
- Channels of communication within the community.
- General media consumption habits.

**BARRIERS TO WASHING HANDS WITH SOAP**
Primary barriers and motivators to washing hands with soap that were identified through the focus group discussions included:

- Handwashing is not a social norm. Washing hands with soap is not a routine behaviour, and there is no social expectation of one another in terms of washing hands.
- Soap is not available in homes. Most of the households we talked with did not have soap, although some households said that they sometimes used alternatives such as dishwashing detergent and shampoo.
- Handwashing is not seen as useful. Many people didn’t understand the link between washing hands and stopping the spread of germs. Hence, there is limited belief about the benefit of routinely washing hands.
- Health hardware is not maintained. While structurally many of the houses have appropriate health hardware, at the time of doing the housing surveys, many houses needed routine plumbing maintenance.
- Low self efficacy. Sometimes people don’t believe that they have control of their own situation and events that affect their lives.

**MOTIVATORS/DRIVERS**
Factors that motivate people include:

- Overall, people expressed a positive attitude towards washing hands with soap.
- People did not consider that soap was expensive to buy.
- Nurturing and wellbeing. Keeping children healthy is considered important.
- Image and appearance are cited as important with men and women taking care to present themselves, wearing clean clothes, combing and dying hair, etc.
- People are keen players and spectators in many sports.

**CREATIVE CONCEPTS**
An advertising agency was engaged to develop concepts based around motivating factors identified through the social market research. These are currently being tested.

**COMMUNITY ACTIVITIES**
Community activities will be developed and run on communities to coincide with a possible media campaign. To date we have run educational activities within the schools highlighting how, when and why to wash hands. A major activity planned is the engagement of professional Hip Hop artists to develop hip hop music that incorporates the hygiene message. The music will be professionally produced and will also feature on community service announcement ads on Imparja Television. Other activities will include soap making, t-shirt printing and possibly home hygiene activities in conjunction with homemaker and housing maintenance programs.

**LESSONS LEARNT**
While the project is not yet completed, a number of lessons have already been learnt including:

- The need to allow adequate time for the ethics approval process in project timeframes.
- The importance of providing consultants with very detailed briefs.
- Recognising that the timeframe of the project and project milestones will not always coincide with community priorities.
REFERENCES

QUESTIONS:
Q1. “What if people are allergic to soap? What can they use, because a lot of them suffer from allergies”?
A1. Nicola Slavin - “We haven’t explored that one much yet. In central Australia there were issues around not liking to wash their hands because soap irritated their skin. We will now look into alternative soap such as soap-free washes that work the same as soap, but don’t have the same sort of allergens as soap. We will also look at alternatives for soaps that are good for hard water, because that is a bit of a problem down in Central Australia where soap won’t lather nicely for people. If that’s an issue we will explore the sort of stuff around allergies, but I don’t think anyone has raised that as a big point so far”.
Q2. “Another point I noticed was you said it would take 12 months to implement. Why will it take so long when people should be told now about washing their hands”?
A2. Nicola Slavin - “The first stage will run for 12 months, where we focus on promoting hand washing. For the whole 12 months Annette will be out in the bush talking with people. We will have the ads on TV and all the other stuff that goes with it - it just takes time to get things up and running”.
Q3 Craig Steel – “Good presentation, ladies. Central Australia also includes a lot of our remote areas. If I heard you right, you said that the majority of your households do not have soap in them and nor do a lot of impoverished communities in Central Australia. From our point of view, how are you going to get soap into households? Could perhaps some of the funds you spend on advertising and social marketing not have gone to actually providing the soap into the households so they could have at least had the opportunity to wash their hands whilst you go through your 12 months, which is largely project-oriented for consideration”?
A3. Nicola Slavin - “As Annette highlighted a little when she did the questionnaire, one of the questions was did people think soap was expensive. The majority of people said that they didn’t find soap expensive to purchase, so I am not sure cost was a major factor. Nonetheless, we are trying to get soap out there but we didn’t just want to provide free soap to all households because the project was meant to be sustainable in that in the long-term nobody would be providing free soap - the idea was that we would also be marketing soap more intensively in the shops. Annette was going to explore with the shops that maybe if you buy a certain amount of groceries you get a bonus bar of soap with grocery purchases in some ways that potentially could be sustainable. We have been talking to the community and looking at ways that they can keep this going in the long-term. Also, with the community activities there are giveaways, competitions, workshops, the prizes and ‘thank yous’ that are toiletries and soap products. We are trying to get more soap out there as well, but I’m not sure the cost of soap is a major inhibitor, really.
Q4. “I am interested in your housing survey and the data on the number of houses that had soap. Did the survey record which of those houses had soap holders”?
A4. Nicola Slavin - “No, it didn’t”. Certainly in my house you can’t keep soap - it ends up everywhere but where it should”.
Nicola Slavin - “No, we didn’t specifically identify soap holders. We only looked at hand basins and if people had a hand basin there would be a space to put the soap”.

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SUSTAINING ENVIRONMENTAL HEALTH IN INDIGENOUS COMMUNITIES
John Carleton and Graham Locke, Queensland Department of Local Government, Planning, Sport and Recreation

DEPARTMENT OF LOCAL GOVERNMENT, PLANNING SPORT AND RECREATION
“For people to enjoy and maintain a healthy living standard, it is essential that environmental health infrastructure, such as water supply, sewerage, waste management, drainage systems and sustainable services are adequate. Inadequate essential services in remote Aboriginal and Torres Strait Islander communities can underpin health status. It has been identified that the health status of Aboriginal and Torres Strait Islander people is well below that of the rest of us living in Australia. Recognising that improving a community’s general health and wellbeing can result from effective and sustainable environmental health infrastructure, the Queensland Government established the Indigenous Environmental Health Infrastructure Program (IEHIP). The IEHIP encompasses infrastructure development and sustainability operations of essential environmental health infrastructure to 34 Queensland Aboriginal and Torres Strait Islander Councils.”
Improving the capacity of the community to maintain essential services is a key outcome of the IEHIP. To this end, the program in its present form is making significant progress. Continued progress and improvements to sustaining environmental health infrastructure will require ongoing cooperation among a broad range of stakeholders including all levels of government, the community and other stakeholders.

**KEY WORDS**

Environmental Health Infrastructure
The essential infrastructure systems required for general health and wellbeing, such as water supply, sewerage, waste management, stormwater, roads and serviced lots.

Essential Service Officers (ESOs)
Council staff responsible for the operations and maintenance of essential services such as water, sewerage, waste management services.

Traditional Owners
People who, through membership in a descent group or clan, have responsibility for caring for particular country. Traditional Owners are authorised to speak for country and its heritage.

1. **INTRODUCTION**

In 1987, the Nganampa Health Council published an environmental health report called the 'UPK Report'. The report reached the conclusion that nine healthy living practices are necessary for improved health in the Anangu Pitjantjatjara Lands. These healthy living practices are important to improving the health and wellbeing of all people living in Queensland.

The nine healthy living practices listed according to their likely importance to improving people’s health status are:

1. Washing people.
2. Washing clothes/bedding.
3. Removing waste.
4. Improving nutrition.
5. Reducing crowding.
7. Controlling dust.
8. Temperature control.

These healthy living practices are impacted on by the type and condition of environmental health infrastructure in a community. Likewise, they can be used to identify, plan and prioritise environmental health infrastructure projects and their sustainability.

A 2003 report by Queensland Health reported that the health of Queensland Aboriginal and Torres Strait Islander people remains substantially worse than any other section of the Queensland population. Examples of this disparity between Indigenous people and other Queenslanders are:

- Gap in life expectancy is estimated to be 18-19 years less.
- The age adjusted death rate is estimated to be over three times (3.2) greater.
- Infant mortality rates are still unacceptably high, at two and a half times greater.
- The estimated mortality rates for Queensland Aboriginal and Torres Strait Islander people in middle age (40-64 years) are among the highest recorded in the world.
- Mortality rates in early middle age are estimated to be more than five times greater.
- There has been little improvement in adult mortality over the last 20 years, and this lack of progress is virtually without precedent on a world scale. (Queensland Health, 2003)

The Australian Government Productivity Commission, through its Review of Government Service Provision, issued a report in July 2005 entitled ‘Overcoming Indigenous Disadvantage’, which identified relevant key indicators and strategic areas for action and included effective environmental health systems.

With regard to effective environmental health systems, the relevant indicators identified by the Productivity Commission review were:

- Rates of diseases associated with poor environmental health (including water and food-borne diseases, trachoma, tuberculosis and rheumatic heart disease).
- Access to clean water and functional sewerage.
- Overcrowding in housing.

Each of the identified indicators is related to the type and condition of the environmental health infrastructure.

There is considerable evidence that the health and wellbeing of Indigenous people can be enhanced through:

- A strategic and integrated approach to improving environmental health-related infrastructure and sustainable services.
- Sustainable integrated models of funding addressing whole-of-life costs of infrastructure.

2. **OBJECTIVES**

The primary objective for the IEHIP is to improve the health and wellbeing of Aboriginal and Torres Strait Islander communities by providing an integrated infrastructure development and sustainability program focused on whole of asset life infrastructure provision and management. Other specific objectives are:

1. To improve Aboriginal and Torres Strait Islander environmental health infrastructure systems.
2. To improve asset management.
3. To provide technical training.
4. To assist with legislative compliance.

Allied closely with these operation and maintenance objectives is the requirement to develop and sustain ongoing community employment, training and management capability. Facilitating improved employment, skills transfer and training outcomes will enhance a community’s capacity for the longer term.
3. INFRASTRUCTURE DEVELOPMENT AND SUSTAINABILITY

In 1995, the Queensland Government established what is now referred to as the Indigenous Environmental Health Infrastructure Program (IEHIP) to significantly improve the health and wellbeing of Queensland Aboriginal and Torres Strait Islander communities by improving environmental health infrastructure. Environmental health infrastructure is defined as:

- Improvement and/or augmentation of water supply schemes including reticulation, metering, house connections or water treatment.
- Improvement, augmentation and/or new reticulated sewerage systems or sewage treatment.
- Improvement, relocation of old waste disposal sites or new waste disposal facilities including sealed, all-weather access to such facilities.
- New fully serviced sub-division housing lots.
- Sealing and drainage for internal community roads.
- Improved stormwater drainage and surface infrastructure.
- Preparation of community planning documentation (mapping, community plans, etc).

The IEHIP has its roots in the important ‘National Commitment to Improve Outcomes in the Delivery of Programs and Services for Aboriginal Peoples and Torres Strait Islanders’ which was endorsed by the Council of Australian Governments (COAG) on 7 December 1992.

In addition, the IEHIP seeks to address needs identified by Meeting Challenges Making Choices (COAG 2004), and Queensland Government priorities - improving health care, strengthening services to community, growing a diverse economy and creating jobs through a continued commitment to assist Indigenous communities disadvantaged by location, size and a limited rate base.

Currently the IEHIP is divided into distinct implementation program models for infrastructure development and sustainability, located on mainland Queensland or in the Torres Strait (refer to the maps in Appendix 1).

3.1 INFRASTRUCTURE DEVELOPMENT

Each of the infrastructure development program models employ similar elements for procedures and process for program governance, procurement of Project Managers and construction companies and collaboration with Councils, community and relevant stakeholders.

The IEHIP is managed in partnership with the Queensland and Australian Governments, Aboriginal and Torres Strait Islander Councils, communities and other related agencies.

In 2005 the Queensland Government provided $100 million to address environmental health infrastructure projects in Aboriginal communities on the mainland. This allocation was conditional on matching funding provided by the Australian Government, which to date has provided $30 million. Strategic program management is coordinated by the Queensland Government.

In Torres Strait, the Queensland and Australian Governments have been collaborating since 1998 with matched funding of $92.4 million delivered through the Major Infrastructure Program (MIP). The MIP funds are managed by an independent Fund Manager, and the management and reporting provides assurance that the funds are being appropriated in accordance with an agreement between the funding agencies. Strategic program management is coordinated by the Torres Strait Regional Authority.

3.2 INFRASTRUCTURE SUSTAINABILITY

The mainland sustainability program provides expert technical advice on water supply, sewerage and waste management infrastructure systems to 17 mainland Aboriginal Councils. Funding of this program has been provided by the Queensland Government. However, the mainland infrastructure development program has allocated approximately 15% of appropriated funds to support sustainability activities.

A different program model is employed in the Torres Strait sustainability program, where the primary emphasis is on the provision of technical services and advice to the 17 Island Councils. The infrastructure is managed and operated by a team consisting of management and technical support from officers from the Island Coordinating Council (ICC) and the community provided Essential Service Officers to operate their infrastructure on a day-to-day basis. The program is managed by the ICC, with joint funding from the Queensland and Australian Governments.

Whilst slightly different program models are used in the implementation of sustainability activities, there are close similarities

TECHNICAL SERVICES AND ADVICE

1. Conduct site visits to each community to assess the operational status of the infrastructure systems. Provide technical services and/or advice to enhance the capacity and capability of the systems to sustainable levels of operations and maintenance.

2. Maintain contact with the infrastructure staff.

3. Assist in the development and improvement of an asset management culture for infrastructure systems within the Council and the community.

4. Monitor legislative compliance to ensure that the infrastructure systems are being operated and maintained satisfactorily.

5. Provide advice to the State and Council to help ensure that appropriate technology for the infrastructure systems is considered.

TRAINING

1. Prepare training needs analysis for the infrastructure staff and update as required.

2. Facilitate a training program for the infrastructure staff.

3. Develop orientation, technical training and support materials to strengthen existing knowledge and provide increased skills capacity.
1. Carry out ongoing liaison with infrastructure staff, Council management and relevant stakeholders to encourage acceptance of the infrastructure staff role, facilitation of their responsibilities, and coordination of related projects.

2. Provide information from time to time to update government agencies and other stakeholders on outcomes and status of infrastructure operations and maintenance.

3. Support development of effective communication mechanisms for the infrastructure staff.

4. Provide support and assistance for public awareness activities relating to sustainability of the infrastructure systems.

OTHER
1. Other tasks to support sustainability of the environmental health infrastructure.

4. SUPPORTING INFRASTRUCTURE DEVELOPMENT AND SUSTAINABILITY OPERATIONS

Effective infrastructure development and sustainable environmental health infrastructure requires acknowledgement and attention in the key areas of staff, consultation and communication, partnering and collaboration, and cultural heritage.

ESSENTIAL SERVICE OFFICERS

Essential Service Officers (ESOs) are members of Council’s infrastructure or works teams. They are responsible for the sustainability of environmental health infrastructure. ESOs benefit from the IEHIP through technical advice and specialist training in water industry operations.

ESOs play a vital role in improving a community’s health and wellbeing. They often work closely with Environmental Health Workers and other professionals, who complement and support each other in their respective roles.

CONSULTATION AND COMMUNICATION

Essential to the effectiveness of infrastructure development and sustainability is implementation of close consultation and communication among all parties involved. This ensures that a high level of service is provided at all times.

Consultation with the Council and the community requires development of an open, honest and proactive relationship. In addition to the formal decision-making process, it is also beneficial to engage others such as men’s, women’s and other community groups and the general community, as the effectiveness of environmental health infrastructure affects all those in the communities in some way.

Community consultation also needs to recognise cultural differences between the communities and the interests of Native Title holders. This may require a flexible approach that can focus on multiple issues/interests, whilst respecting the various stakeholders and promoting communal values in achieving sustainable high standard community infrastructure.

An ongoing review of the consultation and collaboration strategy is integral to the sustainability of IEHIP projects.

PARTNERING AND COORDINATION

The IEHIP actively seeks partnering opportunities with other stakeholders with aligned objectives. The partnerships formed during program delivery have dramatically improved outcomes via many avenues, including pooling of funds, capacity-building in communities, and coordination of service delivery. Partnering arrangements employed have been with:

- Queensland Department of Main Roads to jointly fund multiple roads and drainage projects.
- Queensland Environment Protection Agency.
- The Torres Strait Heavy Equipment Management and Training Program to deliver accredited training to over 100 civil earthmoving trainees.
- The Island Coordinating Council Infrastructure Support Unit to deliver appropriate handover training and technical support to ensure ongoing infrastructure sustainability.
- Local Councils to achieve local involvement in construction projects.

The cross-agency cooperation that has been achieved through these forums has meant that the infrastructure development and operational discussions are taken into consideration of each other, which results in sustainable infrastructure delivery.

CULTURAL HERITAGE

Maintaining heritage values and places is a vital part of the community’s ‘sense of place’, cultural identity and well-being. This is particularly true for Indigenous Australians, whose heritage creates and maintains links between ancestors, people and the land (Australian Heritage Commission, 2002).

In recognising the rights and interests of Indigenous peoples in their heritage, all parties concerned with identifying, conserving and managing this heritage should acknowledge, accept and act on the principles that Indigenous people:

- Are the primary source of information on the value of their heritage and how this is best conserved.
- Must have an active role in any Indigenous heritage planning process.
- Must have input into primary decision-making in relation to Indigenous heritage, so they can continue to fulfill their obligations towards this heritage.
- Must control intellectual property and other information relating specifically to their heritage, as this may be an integral aspect of its heritage value.

(Australian Heritage Commission, 2002)

The process of collaboration with Traditional Owners should be considered early in the development of project plans, as this can have an impact of the timely completion of the project.
The Queensland Aboriginal Cultural Heritage Act 2003 and the Torres Strait Islander Cultural Heritage Act 2003 specify that land users are to proactively assess cultural heritage issues prior to undertaking any land use activity, and to negotiate directly with Traditional Owners where cultural heritage is likely to be an issue. The legislation also establishes a duty of care on all land users to take all reasonable and practical measures to ensure their activities do not harm cultural heritage. In addition, guidance and tools to help assess and manage cultural heritage are provided, with assistance also provided by other State agencies such as the Queensland Department of Natural Resources and Water and the Environmental Protection Agency.

There is recognition that Aboriginal and Torres Strait Islander cultural heritage begins by identifying the Traditional Owners to the area, which in the first instance is the registered Native Title Party for the area. If there are no registered Traditional Owners of the area, one should engage the person or other Indigenous persons with an interest in an area in accordance with the local tradition or custom, as being responsible for the area.

Other cultural heritage matters to consider are:

- Cultural heritage monitors.
- Logistics of collaboration with Traditional Owners.
- Cultural heritage management plans.

Cultural heritage monitors can be an invaluable source of assistance to ensuring that projects are successfully completed. Cultural heritage monitors provide assistance in the identification of culturally significant values and places.

The cultural heritage legislation specifies that a cultural heritage management plan is required when an Environmental Impact Statement is specified. Taking a proactive approach to the preparation of a cultural heritage management plan provides a number of beneficial outputs, including early engagement of the community, open communication, identification and resolution of issues, opportunities for employment and training, and a more effectively implemented project.

5. SIGNIFICANT SUSTAINABILITY OUTCOMES

Some significant IEHIP sustainability outcomes are:

- Community Infrastructure Audit - A comprehensive audit has been carried out on the mainland Aboriginal community infrastructure, operations and staff capacity. The audit has identified the current state of the infrastructure, and provided training needs analysis. Ongoing technical assistance and an appropriate site-specific training program is being implemented. The audit identified a large range of issues, from simple items which can be rectified by a change of work practices, to a requirement for new infrastructure. Identified issues were assessed according to criteria of public health, occupational health and safety and compliance. The audits provide a valuable management tool for current and future operational activities, plan future infrastructure, and assist in making appropriate financial decisions.

- Water Demand Management Project - A pilot water demand management project is currently being implemented in the Northern Peninsula Area of Cape York. The pilot project seeks to determine an appropriate delivery methodology, actions and evaluate outcomes of water demand management prior to commencement in the other Aboriginal communities.

The project is using the community-based social marketing (CBSM) approach to bring about behavioural change. When water demand management principles are communicated using a CBSM approach, priorities of different users are considered to ensure that water supplies are used wisely in the public interest.

- Asset Management System - A comprehensive asset management system has been implemented in the Torres Strait sustainability program. The program provides accurate, reliable information on the water service infrastructure located throughout the 17 Island Councils.

- Staff Capacity Building Program - A comprehensive skills enhancement program designed to increase the capacity of infrastructure officers to obtain nationally-recognised competency in water industry operations has been implemented in the Torres Strait Island sustainability program. This assists in giving operators a higher degree of ownership for the valuable work that they perform.

6. COMMUNITY BENEFITS

Outcomes delivered by IEHIP are consistent with relevant policy objectives and priorities of both the Queensland and Australian governments. This includes the whole-of-government approach, where all three levels of Government continue to successfully work together. Likewise, IEHIP has demonstrated flexibility, accountability and leadership, and has continued implementation of the broad Government policy objectives of shared responsibility and partnership.

IEHIP has achieved outstanding impacts on the health and wellbeing of Aboriginal and Torres Strait Islanders. Furthermore, IEHIP has provided multiple flow-on benefits to community capacity building and economic development, by providing employment, training and the necessary skills for community members to enable them to have the capacity and confidence to undertake future activities.

7. CONCLUSION

The Queensland and Australian Governments have made a substantial investment in environmental health infrastructure in Queensland. It is therefore important to allocate resources for the future to optimize the life cycle of the infrastructure, and to provide the service levels that the communities require.

The provision of essential environmental health infrastructure and ongoing support for high quality sustainability services assists to maximise the use and lifespan of the infrastructure in Aboriginal and Torres Strait Islander communities, and helps to mitigate the risk of continued community exposure to unacceptable health and environmental hazards.
Continued progress and improvements to environmental health infrastructure will require ongoing cooperation among the broad range of stakeholders, including all levels of government, the community and other stakeholders.

The scope and methodology of the IEHIP can be replicated in other communities. However, it may require adjustments to account for site-specific conditions, infrastructure and staffing considerations.

REFERENCES

APPENDIX 1 - MAP OF INDIGENOUS COMMUNITIES - MAINLAND QUEENSLAND

MAP OF INDIGENOUS COMMUNITIES – TORRES STRAIT QUEENSLAND

QUESTIONS
Douglas Passi, Mer Island - “Regarding your waste management program - I know some community members support you there because the environment we are keeping is too small to support rubbish. I have a problem with quarantine to recycle. I am very frustrated with the health of my children. Promotion at school. It has been going on for nearly a year - getting waste recycled and coming up from the Torres Strait to Cairns. Is there any infrastructure planning that can sort this issue”?

John Carleton - “I appreciate that and for those of you not familiar with the area, Torres Strait has a significant issue re quarantine zones. In order to move things in or out of the zones we have to comply with AQIS (the customs people). I appreciate that it is a very frustrating experience from a strategic and operational point of view. However, the Major Infrastructure Program that is currently in the Torres Strait has a regional waste management strategy, which looks from a strategic point of view at how we are going to deal with waste. We have a secondary project which we are in the process of doing with EPA on Warraber Island, which is looking at some operational things dealing with recycling and so on. Another project we are about to implement in the Torres Strait looks a little bit further at how we are going to try to access some of the issues we have, particularly with the Quarantine relationships. We need to get AQIS and Australian Customs on board in order to mitigate this. We can’t give you the outcome on that, but we would like to resolve some of these problems right now. It could be that we find other innovative ways to deal with the waste on site where it is, or try to develop some system that Customs will accept on how we can move it through the zones to Cairns or some area of recycling. It is being looked at, and all I can really say is that we are conscious of these issues we have with State government and also particularly with the TSRA. It is a significant issue. We talk about it every time we have management meetings, and this is discussed with them every week. We also talk about waste. I hope I can give you some comfort that we are trying to address it. Thanks”.

Steven of Yarrabah - “You were talking about working in partnership with ICC and TSRA. I just want to know, for mainland communities who are you going to work in partnership with? Would it be our respective councils, or what”?

John Carleton - “Our partnership arrangements when we do capital works, operations and maintenance are directly in partnership with local governments and mainland communities. We are wanting to extend it further to the community itself, but our key partner from the local government area are local councils. In Torres Strait we deal only with ICC, and the local government in the Torres Strait. ICC just talks on behalf of councils in the Torres Strait. On the mainland it is with the council itself”.

Steven of Yarrabah - “You must be taking into account that a lot of mainland communities are in transitional stages - we need clear directions”.

Graham Lock - “Regarding amalgamations, we are in the dark about exactly what is going to happen, too”.
John Carleton - “We appreciate your comment. To give you an example, we did an audit on the mainland. One part looked specifically at the service officers at the infrastructure level or operations, but it also identified particular management issues happening within the councils - dealing with financial management from an infrastructure point of view. This is where we are working with the other branches in state government to get capacity building occurring in the different communities as they go through their transitional periods. We can provide them with training and assistance from a financial management point of view about what is asset management and what is infrastructure. We are trying to do our component of that governance aspect”.

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QUEENSLAND HEALTH TAKES ON THE CHALLENGE: OUR EVOLVING ROLE IN ABORIGINAL & TORRES STRAIT ISLANDER ENVIRONMENTAL HEALTH

Paul Endres, Director Environmental Health Services, Tropical Population Health Services
Sonja Carmichael, Senior Policy Advisor Aboriginal and Torres Strait Islander Environmental Health, Environmental Health Unit

Paul Endres
“I appreciate being on the Irukandji’s land where we are meeting this week, and particularly for the opportunity to speak to all my friends and colleagues in this place. I also pay my respects to the Elders who are here as well. To my friends and colleagues here, I have been really looking forward to this week, and it is fantastic to see some old faces. I have had the privilege of watching you all achieve amazing things over the years and in this wonderful region, and I have really genuinely been looking forward to seeing everyone to talk about how far we have come and to share information about some of the projects that we have been working on. I would like to acknowledge my good mate, colleague and mentor, Stuart Heggie, who is here today from Tasmania. He went to Pundamara in 1990 to the conference, and that pretty much changed all our lives. At the time we were looking for direction, and I know Stuart has presented to you at these conferences and said we weren’t sure and wanted to find our way. We knew there were major problems in these communities, but we didn’t really know how best to tackle them. Our white fella way of thinking wasn’t working. Stuart saw this at the conference that WA had the EHWs, and he thought ‘what’s this’? He then looked around at this new thing and thought that it might be the answer we were looking for.

That was in 1990, and all those people with the government and community working with us helped turn this EHW program around into the success it is now. We have won awards for it, and looking at the program we have today we certainly have come a long way.

I would also like to acknowledge Ross Spark, Director of TPHU. I am sure Ross is known not only to those in this room, but also in the Northern Territory and WA. He is also my mentor and my friend. Ross said that he visited the Kimberley Health Unit when he was on holidays, and people came to him and said they knew Stuart took their idea and that they really appreciated what you have done with it, and where it has gone. Now they want to learn more about it, and I suppose that is why we are here today - to say what we have achieved, and where we can go from here. Are there any people here from the Kimberleys? Good, maybe you know Ross, and can catch up with him later.

I am really pleased to see all the EHWs who have been trained - particularly those people from Queensland - because I know all of those who are speaking to you this week. To see them getting up at a national forums and workshops - getting up and presenting is extremely gratifying to me. I actually asked for the time change which you might have noticed. I was supposed to be on tomorrow with Sonja, and I said we would really like to be on before our colleagues because we wanted to publicly acknowledge how important their contributions have been to their people, and to thank them for their work, because they are really humble people and I am humbled by them. I really do want to thank them for the work they have been doing. I just wanted to say it is nice to be able to get up early. I know Walter has already spoken, but this was the first slot we could do it, and I really want to thank them for the work that they have been doing before you hear about it from the people themselves. Stephen Canendo, you will notice, is a keynote speaker at this conference. He was in the first group of EHWs to graduate many years ago. Eddie Bobongie, Walter Morgan, Clayton Abreu, Ronald Williams, Alan Blackman, Chris Gyemore are all Qld EHWs program graduates who are all presenting this week. I think that is what we have been aiming for in these conferences, and we are now seeing it happen - and I am only talking about Queensland. Aunty Mena David from lama in the Torres Strait and Freddie David from Poruma from the heart of the Torres Strait are here. I will be talking about their communities. Toshi Kris, Chairman of the TSRA, was in the first group of EHW graduates in Queensland, and he has never forgotten us, I can assure you. He is a very strong advocate for EH, and we will be approaching him to get his organisation even more involved in enHealth Council’s Working Group.

As Eddie said, I began my career in 1987, when I transferred to Cairns from Brisbane. Soon after I was driven up to Hope Vale in 1987 with my boss. So coming out of Brisbane and going up to Hopevale was an incredible experience. I can tell you I was shocked, coming from Brisbane - I couldn’t believe people in Australia lived like that. I asked a lot of questions as to why these people were living in these houses. I just knew they were going to get sick if they lived in these houses. It was very unacceptable to me to see those conditions then, and it still is. Those of you who know me, know I like to challenge things even if it means being a bit controversial - so I don’t want to let you down today at this national forum. What I would like you to do is to all stand up in your places...
for me. I am not going to give you a load of statistics, but just read through this slide. You have all seen this before. Tom Calma, the gentleman who spoke this morning, is the bloke who wrote it. I will leave this up while we do this short little exercise. Cleveland Fagan mentioned that this is now 19-20 years - this statistic is from 2002. Now I am looking at that with a lot of concern, as it has gone up, and we are trying to get it to go down!

So what’s going on? I don’t know how it can go up in five years, and that is a big concern to me. So I put it to you - if we don’t have some action, and we don’t action the things out of this conference, then we will continue to see this figure increase. We want it to go down to zero, and that’s what I am after. I want to see that happen in my life time. I want all of you who think the government has done enough about this gap between mainstream and Aboriginal and Torres Strait Islander people, to sit down. Second, do you think the community councils have done enough about this gap? Sit down if you think they have. Hmm, interesting, now think about this really hard and be honest with yourself. Do you think you are doing enough about it? Sit down if you think you are doing enough about it. Well I actually thought that might happen - I didn’t think anyone would sit down. I would be quite happy with that and if you felt that you had done enough, that’s good. There are people here who have, but it’s good to see so many committed people in the room.

I won’t ask you to remain standing for the whole talk, so take a seat. The reason I did that is because what I am saying to you all today is that it is up to all of us. If you can’t believe that we can reduce this gap by improving EH conditions, let’s have a look at what can be done. I just want to show you a few photos. This is Jim Larry, a friend at Poruma, and an EHW. The photos I am showing are from Poruma and lama because you are going to see over the next days other people talking about their communities and what they have done. So I am talking about two communities where the people are here, but they haven’t had the opportunity to speak. I have asked them if they mind, and they both said ‘No, go for it’. This is Jim’s house, and this is what I first saw when I went to Poruma some years ago. We worked a lot with the council, and this council had a really good understanding of what hygiene and improving environmental health conditions can do, because we had workshops there. The TPHU holds workshops twice a year, where all EHWs come together. We don’t have them in Cairns - we have them in the communities and the islands. This island has only 40 houses or so. It is a very small community, but they hosted a workshop for three days. The community cooked, and the council attended for the three days, which was an incredible commitment. They got a very good understanding of what hygiene means, which previously wasn’t there. When I first used to go up there people thought if they had a bad house or a dirty septic or whatever, they just might get sick. They thought they might go to the doctor, then would be right. People didn’t see that if they got rid of the dirty septic they could improve those conditions in those houses, and they wouldn’t have to go to the doctor in the first place.

I think for a long time they just accepted that they get sick and then went to the doctor. They didn’t question why they were getting sick. This slide is the same bathroom area we were looking at in Jim’s house. The council took the limited money they had - and I can tell you it wasn’t enough – then with their knowledge they used local people to make these improvements. They realised that fixing up the shower blocks is going to help Jim’s health, his family and his kids - that they should spend the money there, instead of spending it on an airstrip. They put the money into this as they saw it as a priority. It was a big turning point for us. At Yam Island, Mena brought in a dog program. She asked us what we could do about dogs. I said ‘There’s a lot we can do’. She said ‘The dog is my totem – I want to do something about these dogs’. I said ‘You can register them, and track how many there are and how many people have a dog, and then you can get a vet to help look after it’. She said ‘What’s this registration’? I said ‘Well, you know, they just get them tagged’, so she did. She had it organised in a couple of days. Mena did something really smart - she got a really fancy collar and charged everyone $10 each for one. It only cost her $10, but because everyone got a tag, she was able to keep record of who owned what dog (they were only allowed to have two dogs). She kept track of them, and if they went outside of that she went and talked to the people. Mena said she might have to go and take a couple of the dogs away if they were sick, or whatever. So simple. We have people working in animal management, and we will talk more about that. These were simple things which I wouldn’t have thought of, in that culture, and we learned a lot from it.

(Running through slides) - Hot water systems were a part of the improvement program. Before and after of the grease trap. That is the same grease trap, and I can tell you that kids were playing in it about five minutes after I took the shot. Old houses to new houses. Streets with dust being thrown up and dogs walking about with people getting sick – so they paved the streets. They all did it – they used bricks, and they all did it. It is a very tidy town in the end. Look at the picnic areas – notice the bins. The bins were getting knocked over by dogs, so they secured them. So simple, but look at how clean it is - no litter - and there is a lot of pride on this island now!

I think the way we approached it with proper community engagement was what led to some of the improvements, and you are going to see a lot more over the next couple of days. I think we are using community engagement. I don’t think we use any of the big words you see in all the documents - there is a place for that - but I don’t think we are using that. We are talking to people on the communities, we engage people and have engagement, planning and delivery of services. It’s like Mr Calma said this morning, because it is a right, and it’s the law.

We’ve got limited plans and they are time limited. We are developing one at the moment and the project officer who is doing that is in the room, Andrew D’Addona - in consultation with everybody. We have a one-year plan and a five-year plan, then we are going to have other five-year plans until it is sorted. Rolling plans. We are developing these while listening to the people we
work with in the Cape York and Torres Strait. We take time to listen to these people. We listen to what community people say. We listen in big capitals. I talk a lot but I do listen sometimes. I can do both. We sit with the Elders – at night – whenever – not on our time. We go in for one day for two hours. We sit. We go for days and we wait until they are ready to talk. Some of us use digital recorders to record what they have to say so we can listen to it, and so that the other people in the office can listen to it. We do it on Tj time and community time, not white fella time. I don’t go out in a boat with EHWs to catch a fish, contrary to popular belief. That’s when they tell me about their people. That’s when they tell me things. If I catch a fish that’s great, but I don’t do it for that reason. Some of the best things I’ve heard have been out in a boat or sitting under a tree with someone, because it is comfortable – not sitting in big capital cities or Cairns. People get intimidated. We sit in that community; at that place, and hear about that place.

Other examples of us listening and what it turns into – the EHWs said in the early intakes (of the Diploma course) that they wanted to get together and share their ideas and help their own people. So we held community workshops twice a year (funded by John Scott, TPHU Manager at the time, in Brisbane, but these workshops are now funded by Qld Health). It isn’t much money – just $6,000. We achieve a hell of a lot. And people share their ideas. The EHWs said they wanted to bring back community cleanups. I think Freddie might have said to me in the old days, actually I think it was an Elder said to me that “In the old days when the policeman said ‘You clean this place up’, you cleaned it up - people did it, and people felt pride in their community”.

We wondered how we would do this, so we held a workshop about tidy towns, and that’s what the result is. Look at that. Look at how much rubbish was picked up on that beautiful island by all those kids. Freddie organised it with the council. EHWs organised it with the councils. They understood how important that work was. Grand stuff. Good fun, simple with great healthy outcomes - fewer injuries, no rubbish, no flies, there are so many things I can go into. What that means - and I am not telling you anything you don’t already know - as EH professionals you know what that can lead to.

The coordinators - the IEHIT team – the EHWs – they are our liaison officers who Sonja will talk about. They are the link between the community’s knowledge and our knowledge. They are the interpreters who assist us with understandings between our two cultures. The EHWs are the link between the councils and the communities, and the other agencies who visit the communities. They are translating their cultural ways, white fella cultural ways into the community’s knowledge and our knowledge. They are the link between the councils and the communities. They are learning how best to give the communities an understanding about those links between poor health standards and disease. Brisbane Corporate Office EH Unit is the link to the Ministers of State and Federal - the people who give the money, the funding bodies and produce and ratify the policy decisions that affect the strategic direction we are taking. This collaboration is very powerful. It makes us strong and it makes us one. One vision, one focus. Get rid of that gap!”

Sonja Carmichael
“I would like to acknowledge the traditional owners, the Irukandji people, and pay respects to Elders here today. Before sharing what we do in respect to EH in our communities, I would like to give a bit of an overview of the changes that are currently taking place in communities as a whole. Our conference theme ‘Taking on the Challenge – Aboriginal and Torres Strait Islander environmental health’ is based on the Meeting Challenges Making Choices (MCMC) Strategy. Some of you may be aware that making environmental health a priority was not the only thing that resulted from this strategy. MCMC also had major outcomes which related to community governance - the most important outcome being that our Aboriginal Local Governments and Island Councils are no longer differentiated from mainstream local governments. This signals a major transition in terms of council status under the Community Governments Improvement Strategy. This means that all Aboriginal Councils are now required to comply with the requirements of the Local Government Act 1993. With respect to environmental health, this will include obligations under the Public Health Act 2005 and Food Act 2006, and others that are administered by environmental health units in Local Governments such as the environmental protection and dangerous goods legislation.

Most recently the State Government has announced the amalgamation of all Queensland shire councils. This is still being finalised, and recommendations will not be known until the end of the year. However, it does mean that environmental health must be considered as a key function and responsibility of Councils. It also means that as the lead environmental health agency, Queensland Health will be working more closely with other agencies who are responsible for aspects of environmental health that are outside the jurisdiction of the health portfolio. This includes agencies such as EPA, DES, DPI & F, DLGPSR, for example.

So, what does this mean for the future direction of the Queensland Health Aboriginal and Torres Strait Islander Environmental Health Strategy? Firstly, I’ll briefly mention our existing strategy. This Strategy spanned from 2001 to 2006, and aimed to provide a strategic direction for the development of partnerships with other stakeholders both at a state and local level. It also provided a framework for action to address EH outcomes through a whole-of-government approach. Goals included fostering and supporting active participation of Aboriginal and Torres Strait Islander people in the management of their environmental health needs within communities, and to initiate and enhance Aboriginal and Torres Strait Islander programs that ensure the standard of environmental health in Aboriginal and Torres Strait Islander communities is equal to that of the broader community.
The strategy had six key action areas:

- Community participation.
- Coordination and collaboration between agencies.
- A sustainable environmental health workforce.
- Healthy housing and infrastructure.
- Information networks.
- Optimal environmental health programs.

We have commenced a review and evaluation of the Strategy, and initial feedback indicates that we have made significant progress in meeting the goals and objectives of the Strategy. However, we are also aware that there is a lot more work to be done.

The Strategy: Where to from Here? We have had a number of brainstorming sessions with a number of stakeholders and are in the process of developing draft plans, so that’s a work in progress that Queensland Health is supporting through the appointment of our Senior EH Officer, Andrew D’Addona. This is a new position created to manage the EH-W and Animal Management programs. Andrew will be coordinating the planning, and liaising closely with us. We have learned a lot from the past and we are all working together, as Paul mentioned, to come up with a new plan. That new plan needs to be community-driven, and that’s the key to responding to what the needs are at the local level.

I would also like to draw on the importance of Commissioner Calma’s principles of participation FPIC that he mentioned this morning – free prior informed consent – the basis for consultation and Aboriginal and Torres Strait Islander participation.

The foundations have now been laid, and have provided a base on which we can build and extend. Areas which will be of great importance over the next five-year period will be the introduction of the new Population Health training competencies. As councils take on all the responsibilities expected of Local Governments, this can be expected to be reflected in the level of professionalism of council services. Supporting EH-Ws in their Council’s new responsibilities and role they play will be a major goal. As you may be aware, the Health Training Package has been reviewed and one very exciting outcome is the development of an Indigenous-specific environmental health range of competencies. EH-Ws will be encouraged to view environmental health not only as a job, but as a career path that may lead to other exciting opportunities.

The need for coordination and collaboration between agencies must continue to be strengthened. This is more so now given the broader range of environmental health responsibilities that EH-Ws will be undertaking.

The Environmental Health Unit of Queensland Health provides secretariat support and is represented on a number of stakeholder groups, both within and outside Queensland Health. Internally we have the HIT team - Indigenous Environmental Health Implementation Team (IEHIT), which consists of all our Indigenous environmental health coordinators. Key roles of this group include providing advice to the Population Health Units on environmental health policy, and providing advice and information to community stakeholders.

The HIT team reports up to the SIEHC – Strategic Indigenous Environmental Health Coordination Group. This group consists of the Senior Director EHU, myself, the Directors of EHS of each Population Health Unit and the three Zonal Coordinators. This group drives the implementation, monitoring and review of the Strategy. It also provides collaborative input and direction into existing and future culturally-appropriate Aboriginal and Torres Strait Islander environmental health projects, policies, programs and strategies.

Some issues that arise out of SIEGC meetings may be fed up through the NIEHRF – Northern Indigenous Environmental Health Regional Forum and what is affectionately known as the GAG – Indigenous Environmental Health Government Agencies Group (IEHGAG). The members of IEHGAG represent their respective departmental interests, provide access to appropriate networks and have knowledge of their agency’s interface with Indigenous communities and environmental health-related matters. On a National Level we participate in the Working Group on Aboriginal and Torres Strait Islander environmental health.

Of course, much of the work that has been taking place is due to the valuable input, dedication and passion of our QHealth Indigenous EH Coordinators and EH-Ws. In the area of EH, they are a valuable conduit between QH and communities. I personally would like to say a big thank you to Merle, Clay, Chris, Alan, Richard, Eddie, Nicky and Dallas for their contribution to EH and to QHealth. Thank you”.

Paul Endres

“There are two programs - the EH-W program which has been going since 1990, and the Animal Management Program. We provide support through training and resources. The big thing is - and this is what Stuart drove, and everyone knows that it was not just Stuart - it was a huge group of people involved, who we would train to work in their own communities. We would not just put them in an office, but we would stock that office with everything they would need in order to do their job. There was funding for a position - a $14M grant. There was one position per community, and there are 34 communities in Queensland. Plus resources - vehicle, office, equipment, and all the things they need. There were two key things - we had the resources and we had the position, so we just started off with that. This came in only a couple of years ago. We are always looking at new ways to solve problems. EH-Ws need training and professional mentors. We’ve [Environmental health staff] tried to fill that role but we can’t do it any more. There used to be only a few (EH-Ws) but now there are a lot, and we haven’t enough people to help. We are under-resourced in this area, so we are looking at different ways that we can do it. We can do certain things and I think we do them pretty well. I know that my staff are extremely committed to helping, including putting their family life on hold sometimes to travel up to the communities.”
So we are looking at whether we go outside to get resources. There are still a lot of deficiencies, and we are planning to manage this. The Animal Management Project cultural needs are communicated through our coordinators and our EHOs. The Animal Management Project Officer is actually called a Project Advisor, and has extensive experience working in the NT. He is Scott McIntyre, and I’d say a few people here probably know him. He came to us from northern NT. This is promoting greater governance and promotes more jobs, and that’s the important thing about it. We are not getting the EHWs to do this dog work, as they are too busy. These are extra jobs. It is the first time a project of this scale has been undertaken on this level in Australia. A lot of people talk about it. A lot of ministers said they would solve the problem, but nothing much happened, so Queensland Health is taking it on and we will give it our best shot. It will work because EHWs have been a driving force behind this. I really believe it is going to work - we are learning a lot, and I think we are playing it smart. The best thing about the animal management project is that they allocated a large proportion of the grant to training. We are going to use that money wisely, and that’s why I reckon it will work. It’s not just training when it starts - its ongoing training. When those people finish their course they’re just not going to be left by themselves. They will have mentors, and they will continue to be trained.

To finish up, we have a lot more to do. I think we are on the right track, but we can do better. We are definitely under-resourced but that’s no secret and everyone is under-resourced. You just don’t complain about it do you what you can with the people you’ve got, and work out how to do things better. If we want to attract the type of funding our work will require, we will have to show that we are producing effective and sustainable outcomes - prove it. It is not easy. It is a big challenge and it is up to us. No-one else can do it for us. It is our responsibility. You want to do something about this problem, - you have to do it, I have to do it, we have to do it. We don’t complain and wait for someone else because it ain’t going to happen. Don’t wait around for that. We are the ones setting the direction, and we are lucky that we can. So let’s get on with it. We all need to do it together. You all stood up, and no-one sat down. You don’t think you are doing enough, that’s great. I like seeing that, because everyone’s keen. Excellent stuff!

There’s a lot of talent in this room. We have just seen it. Let’s just get out there and continue that work and finish off the job. If Mr Calma was here I would ask him if he thinks we are passing the reality test. I think we are getting there, but I don’t know if we have got there yet. I really like the way he thinks. He is a pretty smart man. If we are not doing it right, let us know. We will ask Mr Calma later if we are doing it right. We can learn from him and adapt our programs. I think 25 years is way too long. I can’t stand up for that long. I am tired. When that gap gets to zero I will sit down. I will retire and be very happy, but I can’t keep standing up. Let us set a challenge that 25 years is ridiculous. I don’t want to see kids waiting 25 years – let’s pull that gap down in the next … I won’t put a time on it, but let’s make it a lot less than 25 years. Now if anyone in the room might know of anyone who wants to help us with this, or work in this area, we have a job going, so there’s a quick plug. It’s there if you want to go to places like this, and do the sort of work we are doing.

I don’t want to be standing up all my life. I want a rest. Help me out. I will be sitting down looking at things when we close the gap. I will keep standing up until we do. Thanks”.

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INDIGENOUS INVOLVEMENT IN NATURAL RESOURCE MANAGEMENT
Kevin Giles, Swan Catchment Council – Indigenous Cultural Heritage Program, WA

“I would like to acknowledge the traditional owners of the land and thank the Elders present. As time is an issue I will get on with this presentation. As you can see, I have now been promoted to Cultural Heritage Program Manager. Basically, when I finished my university degree with my second application I applied for a job with the Swan Catchment Council. It was everything that had been taught to me in university, so I thought it was timely. When I got there my manager couldn’t tell me exactly what I had to do. At that time it was a requirement of all Catchment Councils to have an Indigenous person on staff as part of the consultation process, which was a good thing as he couldn’t even set me a task. I just started going around talking to people. Firstly, I identified groups like land councils and traditional owners and started going out on consultation, talking to these groups. However, going round and doing this I found there were a whole lot of groups that didn’t get talked to at all. So I started branching out to talk to all the people on the ground. I think in Perth, the Swan region, we have 30,000 people there. Again, I did as many as I could. A lot of these people worked in government agencies and you get talking to these people from this agency and that agency, discovering that a person might be limited in what he can do, so you are transferring this information back out to community. I think it puts you in a good position, because you are actually providing this information back out to community people. So you know what people are doing, and in doing that you are actually going out to those people who
Indigenous Engagement in Strategy Development:

- Vision – present the vision to the community in the Swan region.
- Environmental sustainability is essential in maintaining cultural heritage.
- Aspirational target be developed.
- Regional delivery programming is essential.
- Multiple benefit outcomes.

The Swan Region NRM Strategy was the final document. In that process of development we had to go out and talk to community members and identify assets of the region - land, air, biodiversity, cultural heritage. I came along and talked to my manager, and with the help of the community I identified cultural heritage as an asset of the region. When you look at cultural heritage there are other things that are part of that, like land, air and biodiversity. They all sit under that, so we have actually included them in the NRM Strategy. At the time I was looking around the country to see how many strategies had been written and what had been done with them. I looked at about three of them, with not one picture of an Aboriginal person in any, so we went ahead and put this in there. The CD Rom on the right is written into the document. As soon as you open the strategy, you have the creation story of the south-west. This actually gives meaning behind what they are doing – environmental management. This hasn’t been there in the past. The second one – When The Sea Level Rose - the timing for that is right, as the sea level is actually rising at the moment due to climate change and other issues. The artwork for that cover we put out to the south-sea level is actually rising at the moment due to climate change and one – When The Sea Level Rose - the timing for that is right, as the snow is actually giving meaning behind what they are doing – environmental management. This hasn’t been there in the past. The second one – When The Sea Level Rose - the timing for that is right, as the sea level is actually rising at the moment due to climate change and other issues. The artwork for that cover we put out to the south-sea level is actually rising at the moment due to climate change.

The Cultural Heritage Inspirational Target is to protect, enhance and incorporate cultural heritage values within the region in order to achieve sustainable natural resource management outcomes. They won’t achieve sustainable NRM outcomes if they haven’t got this information in there. Again we have foreseen what we have had to do. We’ve put it in there and now all agencies, local governments, etc, are using this method. The photos at the bottom of the slide – the Advisory group, I will talk about in a minute. They actually asked me to look at some of the environmental projects around Perth. We then organised a site tour consisting of going around looking at some of the environmental restoration projects happening in the Swan region, but again we added the Aboriginal element to it. The Elders were over here telling the stories, while we went around. The main thing I learned was you will have a good outcome - it was a good opportunity to get Aboriginal people and non-Aboriginal people on the bus together – those who would not normally meet with each other and exchange ideas.

To that aspirational target these are the Management Action Targets developed by the Aboriginal community, and again we went through a long planning process for six to twelve months. It was reviewed, and we developed an expert panel made up of Aboriginal people in the Swan region. They sat down and reviewed it. We put the "smart" analysis over it – specific, measurable, achievable, realistic and time bound. There were eight of them, and they all became amalgamated. The first one is to research, record, and publish Nyoongar history of the Swan region by 2009. We are doing that at the moment through the CDs we are producing, books, through our programs and all our information is being accumulated and being put together.

Review and identify opportunities in policy and legislation to include Indigenous cultural heritage by 2009. This is happening in the Swan region and in the state. We are going through the legislation, and while we are trying to do programs this is actually pinpointing some of the flaws in the legislation. However, we can’t do anything, so we are actually picking them up and putting them back to the government agencies responsible. If you can’t help us do this, then your legislation needs to be reviewed.

Increase Indigenous employment and participation in NRM activities locally and regionally by 2009. In the Swan region we have actually increased that by 1300%. The Indigenous Advisory NRM Group is made up of 10 people, myself, two other officers, an Indigenous marine and coastal officer, an Indigenous wetlands officer. Hopefully I will have more officers on board.

Achieve 75% increase in the number of community, local governments and state government agencies involved in NRM incorporating Indigenous cultural heritage included as part of their processes by 2009. We are going a long way to achieving this. In the Swan region we have 37 local government authorities, and nearly all of them are knocking on the door now wanting to be involved with the Advisory Group, seeking advice from them, and state government agencies are knocking on the door.
The next one, to establish partnerships to further incorporate NRM principles into heritage protection by 2008. This is essential, as no program is going to survive by itself unless it is rich. Again you have to develop partnerships. Someone else always has something to offer, and if you can acknowledge that you will go a long way towards achieving it. Quantify investment outcomes – that was added in 2005 by the Advisory Group I established. It is basically a social return on investment matrix. A $100,000 project – we can actually monetise the entire program, and put it into an Excel spreadsheet so that every part of your program gets monitored over a five-year period. Your $100,000 investment actually returns $5M back into the whole community, so it is a good way of justifying what you are doing and cementing what you are doing. At the end of the day you can find economic rationalising principles. That's how the government works, so this is how we can counteract that.

A five-year period. Your $100,000 investment actually returns $5M back into the whole community, so it is a good way of justifying what you are doing and cementing what you are doing. At the end of the day you can find economic rationalising principles. That's how the government works, so this is how we can counteract that by putting these mechanisms in place to actually ensure that we what we are doing continues:

Swan Catchment Strategy: Current Indigenous Involvement:

- Indigenous Land Management Facilitators Network (13 in Australia).
- Indigenous NRM Coordinator Network.
- Indigenous NRM Advisory Group made up of 10 people with 5 subregions in the Swan region.
- Indigenous Marine and Coastal Officer and Indigenous Wetlands Officer are about being a conduit for local government and other agencies, and are in heavy demand, producing cultural heritage plans in the Swan region.

Swan Catchment's current Indigenous involvement:

- Indigenous Stories - we have just had approval to do more - a third CD, and are selling 30-40 CDs a week. Profits go back into Indigenous NRM programs. The success of the stories is great, so it is a saleable mechanism for future management. The CD Rom is popular with about 10 tourists a week ringing up and wanting copies, so it is a good message.
- Indigenous site mapping – everything we do is being documented onto a map. We are upgrading both site information and the Department of Indigenous Affairs Science Registrar.
- Cross-cultural awareness training – we do that with community groups and local government – whoever wants it, we will deliver it.
- Maali Foundation is set up to supplement the shortfall of funds allocated to the Indigenous component in NRM.
- Indigenous Environmental Agreement is an agreement with the Department of Indigenous Affairs, South West Aboriginal Land and Sea Council, to put us in a position where we can approve environmental restoration in the Swan Region.
- NRM Site Tours - programs that teach about the Aboriginal significance of land, learning how to make spears, etc. It doesn’t only have to be kids learning this stuff. We are also trying to incorporate this stuff into the education curriculum – this is where it should be. It will create your environmental engineers of the future.

Swan's Future Indigenous Involvement:

- Indigenous Natural Diversity Officer by next year.
- Indigenous Trails Program.
- Indigenous NRM Traineeships/Rangers.
- Over the last five years we have put in 10 submissions for these, and have received knockbacks on funding. However, we continue to ask for funding.

Of the new arrangements when they closed ATSIC, the first thing they did was recognise regional representative structures. That is what is said in the document, so I am at the doors as soon as they open as we deal with NRM.

Overview of the Regional Representative Structure:

- Swan Catchment Council – one Indigenous representative.
- My position, the Marine Coastal Officer and the Wetlands position - so there are only three plus the advisory group. Again, other agencies are beginning to follow our steps - even the Land Council, which is actually advertising and employing NRM officers now, picking up on this so it is getting bigger. I think you will find this is the case across the country.

Looking at the COAG compendium document last year, I found it confusing. Under COAG there are 42 ministerial councils. The State Ministerial Committee for NRM and Salinity, Minister for Agriculture, Fisheries and Forest, and the Primary Industries Council administer the national heritage trust money, and that’s where the NRM stuff happens. The Ministerial Council and MCATSIA are developing bilateral to better serve us, but again it is not filtering down to the bottom. I have read the bilateral for our state, and communities don’t have a say in that. There’s no mechanism for community.

What this flowchart is actually showing is our representative area. If you go across the bottom of the slide, the work of the Reference Group and the project officers are recognised as a regional structure going back to the OIPC. When that happens, out of that should be a regional partnership agreement, a government strategy developed between government agencies, and out of that should become Indigenous NRM-specific funding arrangements. Underneath that are your shared responsibility agreements or your lever for community.

This is how they said it should be working, and we have put the model before them yet they still haven’t got back to us. On the right there (of the slide) is an advocacy strategy. I basically targeted all those groups, compiled discussion papers and sent copies to every one of them. The Ministerial Council and the National Indigenous Council sat down with the chair of the National Indigenous Council, and actually explained what we are doing. They talked about setting up a 20- year plan and everything underneath that. We have done a 50-year plan, with management targets under that. It is a sort of proven method of how we have gone about it, yet again we
still haven’t received any response. I saw just a couple of weeks ago that they’ve actually indicated that the Indigenous NRM will be allocated $48M next year for regional and remote areas, but I think it is just a mechanism for CDEP.

Going down to the bottom right (slide) shows all the other strategies that I have had input into – Aboriginal Economic Development Strategy, Aboriginal Development Tourism Strategy, etc. Again, having input into them so when it hits the ground like Aboriginal tourism, NRM stuff is actually in there, and it is part of the work plan of the role of the coordinator. We then have all these other links into all these other programs. Again, going back to the COAG, all agencies were supposed to develop an Aboriginal reconciliation action plan. I think I have found about three. I think this is an exercise of how you have input into the ministerial framework.

Ministerial Councils are made up of State and Federal Ministers, Australian Local Government President. It has sort of evolved a bit now. Under the Swan Catchment Council we just call it the Indigenous Cultural Heritage Program. In the middle is the Swan Catchment Council, on the right is the Maali Foundation and on the left (slide) is the Indigenous Advisory Group and other. The Indigenous NRM Advisory Group is the Maali Foundation. It is an actual lever to funds where we can do work, cut through the red tape, and get on with it. The Indigenous Cultural Heritage Policy is underneath (slide), the Indigenous Cultural Heritage Program Manager then we go down to the program itself. The reporting side of it – NAC-funded programs to report under the national cultural heritage indicators in the state environment reporting. On the other side, are those that are agency-funded, overcoming Indigenous national disadvantaged indicators. Again this is all good, and in the middle of all that we have the social return on investment which actually shows the monetisation return on everything we are doing.

I think the logo is good – we sort of borrowed it from the State and reshaped it with red, black and yellow. Maali means ‘black swan’. This is the way we are going to create our autonomy in the Swan region – do what we want to do and not what agencies want to do. The most important thing is to get out and talk to people, as you don’t know what is going on unless you get out there. A lot of agency people don’t see the need to go out to talk to people. They develop plans and then go out there and do it. However, if you go out there and do it to start with, you actually deal with some of the problems before they happen”.

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A TRIAL OF BIOLOGICAL TREATMENT SYSTEM IN AN ABORIGINAL COMMUNITY IN COASTAL NSW

James Allwood, Tim Short and Tait Farram, Aboriginal Environmental Health Branch, NSW Health, Greater Southern Area Health Service Merriman’s LALC, SEC health.

James Allwood

Good afternoon and on behalf of colleagues I would like to acknowledge the traditional owners of the land on which we meet. I would also like to thank the conference organisers and all of you for the opportunity to present today in this beautiful country. I hope to take the rain back to southern NSW when I go as it so green here. This is my first national conference, and it is great to come here to network with new people and particularly catch up with old friends. This afternoon we are going to talk about a trial of biological treatment system in an Aboriginal community in coastal NSW. I will go into the background of the trial and my colleague, Tim, will go into what a biological system is, and a little bit of the methodology of the trial. Tait is going to look at some of the results we got from the trial, and draw some conclusions from there.

Background:

- Discrete Aboriginal community with 32 homes located on the south coast of NSW.
- Currently all homes rely on septic tanks and onsite disposal.
- The community has a known history of poor onsite sewage management due to a number of reasons, such as topography. The community is on a ridge line. The slopes on which the houses are built are extensive, soil quality isn’t conducive to onsite disposal, and there are loadings issues, ie, the community has a reticulated water supply.
- A reticulated sewerage supply has been proposed by government on a number of occasions over the last decade, but it hasn’t come to fruition.

During the Housing for Health Project carried out in the community in 2005 to 2006, it was reaffirmed that the current onsite waste disposal system (which are septic tanks and absorption trenches) were overflowing, and could be contributing to ill health in the community.

While carrying out the Housing for Health Project, three of the worst affected properties were considered for interim solutions using project funds to retain the existing septic tanks, and perhaps renew the land application areas.

A geotechnical report was commissioned, and quotations for the work sought. The report recommended evapotranspiration beds (due to the poor clay soils) to replace the existing failing absorption trenches.

When tenders were received it was found that costs were high, due mainly to the amount of soil that would be required to be imported and contoured. This was unfortunately beyond the Housing for Health budget, and therefore not able to be done.

At this time the local Council and Department of Commerce (DoC) were engaged with the community looking at options for a community-wide scheme that would include offsite treatment and
disposal. One of the options being considered was the installation of a biological Treatment System (installed at each house to replace each existing septic tank, with the waste being pumped to off-site disposal).

In consultation with community, Department of Commerce, NSW Department of Aboriginal Affairs and Council, it was agreed to install a biological treatment system at one of the worst affected houses. This was done. The use of a biological treatment system as a trial would allow an:

- Immediate improvement in treatment and disposal for residents.
- Opportunity for residents of the community to view a biological treatment system first hand, and see how the system works.
- Evaluation of a biological treatment system as an onsite waste water disposal option for Indigenous communities – looking at both treatment and disposal.
- Evaluation of the effectiveness of the system to treat waste water prior to further treatment and disposal off-site – on a community-wide scale. This point was of particular interest to Department of Commerce, NSW Department of Aboriginal Affairs and Council, because one of the disposal options being considered is waste water from the entire community to be reused at a local farm*.

Tim Short

*Good afternoon everybody. I think my wife summed up best what a biological sewerage system is - the poo goes in one end, the worms eat it, and you get waste water out the back end of it, so in the context of that.

What is a Biological Wastewater Treatment System? (Wet Composting Toilet):

- Main components are a tank, filter bed, a sump in the base of the tank and centrally located pump well. It also requires an external pump for distribution to land application area which can have an alarm at the house, or be linked to a telemetry system, which means a phone goes off somewhere if the pump fails.
- You can have further additional treatment such as UV that can allow for the waste water to be used for above ground disposal, or irrigation under the ground which is the case in this presentation.
- What makes them different (and you probably have them in Queensland) is the structured arrangement of layers of geotextile material and media.
- The filter bed is made up of three layers of coco peat filled modular geotextile bags, 250 mm deep, each section laid over with shade cloth. Between each layer there is a further barrier made up of agricultural drainage pipes that helps to support it, and helps to allow air to circulate around it.
- A final geotextile filter moves suspended solids down to about 90 microns, and a sump below that is filled with agricultural drainage pipes, again to support the beds above.

Installation of the system:

- The tank is initially inoculated with worms, beetles, mites and other soil fauna.
- The biological treatment system and evapotranspiration area was installed in July 2006, and approved by the local shire council.
- Design based on AS/NZS 1547.
- LAA System is based on a peak hydraulic load of 1,400 litres per day, requiring evapotranspiration area of 400 m2 and is accredited for use in NSW. The subsurface drip irrigation lines are wrapped in a geotechnical cloth to prevent damage.
- Our particular site, as James mentioned, was on heavy clay soil, with the initial design for up to 1000 sqm, based on a peak load of 1,400 litres per day. After 400 metres was installed we allowed for an increase up to 600 metres of lines for the land application area, and this amount was ultimately signed off by the local Council.
- The system was designed to treat 1600 litres per day, and historic water use data indicated an average daily usage rate of 1,244 litres per day.
- Water-saving devices were also installed throughout the house, which had about eight residents.
- Primary focus of our work was to solve immediate onsite effluent disposal adsorption issues.

These various slides show:

- Tank and external control box.
- Inside the tank - inlet pipe for waste, important not to drown the worms in initial installation.
- Servicing - about once a year, low technology, but lots of parts.
- Not getting the results, though we were hopeful.

This is a photo of the central pump that sits inside the central well. You can see there that it is being serviced, and with this particular system this is required about once a year. As I was saying before, it’s basically coming in this side here, going down and comes back up the well and goes out there. In this particular instance we fitted a flowmeter on the downstream side of the tank, and there was also a flow meter on the house. We were curious as to what sort of difference there would be between the outlet to the house and the outlet to the tank, and initially we actually found the meter readings on the outlet of the tank were actually higher than the house. Part of this was because there’s a valve - a water rotor that splits water effluent across two line areas. Because the system is pressurised initially it comes back up, so there’s actually a valve that’s fitted there. When it reaches a certain pressure, it actually blocks off. However, after the initial installation there were some problems with that valve, and it was causing some effluent to re-enter the tank. This is the first part of the land application - the initial 200 sqm - and you can see here what appears to be effluent actually running down the contour lines. Because it was such a slight grade (which was less than 10%) it shouldn’t have been a problem, but because the system was pressurised, there was equal distribution across that
land application area. The second land application area was initially proposed down here. What actually happened was when it rained this actually created some drainage channels, and ultimately the effluent was escaping down and onto the road. This one down here was ultimately deactivated, and an additional 400 metres of irrigation lines had to be put across the slope at the back of the house.

For what is considered a fairly low technology piece of equipment, there are a lot of bits and pieces. A full service was done a couple of months after the initial installation, and another one was done later. Again, at this stage it is probably not providing the results people had hoped for.

When we looked at what to sample for, we thought that because a tank was to be fitted to each house, ultimately the additional treatment that would be required by the Department of Commerce would be things like biological oxygen demand (BOD) and suspended solids. These are obviously important, because if you want to use the effluent above ground UV treatment would need to be fitted, or additional treatment would be required, as well as the normal parameters, E.coli, Ammonia, Nitrogen and Phosphate.

All the results were analysed at a NATA registered laboratory, and our sampling for the first six months of installation. We will continue the bi-monthly sampling for another six months. It is quite easy to take a sample, as you can see it’s just a priming pump and a container to take the sample after you let it run for a while.

Tait Farram

Results:

- E_Coli and water usage results - only one week where the E_Coli is low.
- Suspended solids - only passed the standard once.
- Biochemical Oxygen Demand (BOD) - well over the scale.

Issues encountered:

- Unusually high rainfall events resulted in subsurface water infiltrating the evapotranspiration area.
- Consistent spikes in water usage since installation – for some periods an average daily flow > 2,000 litres per day, which was beyond the tank’s capacity.
- Incorrect installation of drip lines led to seepages and run-off from the initial land application area.
- High readings from test results from samples taken.
- Grass would not grow for some time on land application area.
- Lack of maintenance on land application areas.

Other problems that may arise:

- Land application area may become damaged by vehicles.
- Mowing of land application areas may not occur often enough, resulting in possible saturated areas being created.
- Potential to overload the system as it’s connected to a reticulated water system.
- Plastic top of tank may become damaged.
- Homes may require extra tanks to cope with more people.

Advantages of the system:

- Residents were pleased there where no offensive odours released from the system, in comparison with the previous septic tank.
- Apart from the initial, incorrect installation of the drip lines, no effluent has escaped from the land application area.
- The system has the option of being upgraded to cope with more grey water use.
- Once the system has been studied and tested for some time, it could prove to be a cheaper alternative for the community instead of a Sewage Treatment Plant - it is about half the cost of a sewerage treatment plant, but there are more costs associated with it if it has problems.
- 20-year guarantee for performance and parts and requires only one service per year.
- Manufacturer claims system costs less than $20 a year to operate.
- Greenhouse-friendly, no chemicals and has a robust construction.

Conclusions:

- Sampling – the system is not meeting the NSW Health CoA Standards, particularly for BOD and E.Coli.
- Continued monitoring of tank and disposal areas is needed.
- A system to maintain the land application areas needs to be developed.
- Removal of waste pile to eliminate refuge for snakes.
- Any above ground disposal or reuse will require further treatment.
- It is good it was a trial - a ‘try before you buy’.

I would like to extend thanks to:

- Traditional owners and Elders.
- NATSIEH Conference organisers and sponsors.
- NSW Health.
- BVSC and ESC.
- The Batchelor Institute.
- Indigenous community involved in the trial
- Everybody present today.

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How did we do it?

Andy Irvine

our turf ourselves and put the goal posts up ourselves”. We laid an irrigation system which was designed by Jim Byrne. We laid a drainage system going through one end of the field, and we also put go anywhere as waste. We designed it for the football oval with a pit. We planted trees in them, so the water wouldn’t just run into the creeks. This is how we set all our wetlands up with gravel pits. This is the sewerage system that we got rid of – at flow times water has now got a full-time job. This is one of our Year 2 certificates. Right doing the wetlands has received a certificate out of all this, and the fellow on the right is laying turf on the oval. The young fellow on the right is just 1 km from our community, and we realised we had to stop the run off going into the Clarence River system”.

Alan Boota

SLIDES TO GO IN HERE

“Referring to slides, here are some fellows who have had training to operate machinery, and are working in our community. The young fellow on the right is laying turf on the oval. The young fellow on the right doing the wet lands has received a certificate out of all this, and has now got a full-time job. This is one of our Year 2 certificates. This is the sewerage system that we got rid of – at flow times water would just run into the creeks. This is how we set all our wetlands up with gravel pits. We planted trees in them, so the water wouldn’t go anywhere as waste. We designed it for the football oval with a drainage system going through one end of the field, and we also put in an irrigation system which was designed by Jim Byrne. We laid our turf ourselves and put the goal posts up ourselves”.

Andy Irvine

How did we do it?

• Step 1: Identify all the environmental health problems in our community.
• Step 2: Come up with our own solutions to fix problems and create assets.
• Step 3: Identify who we needed to work with us to fix those problems.
• Steps 4-10: Work hard.

This project was a very long process. It started a large number of years ago, with the Housing for Health Project in Malabugilmah community. The NSW Health Department had a project to go out there, and started to talk to the community about their EH needs. Here’s a day where we were talking about Housing for Health programs, and you can see a box here with all kinds of electrical equipment. We were looking at it and discussing what might, or might not, go right in the community with electricity, so the Housing for Health program was the first step to assess what was there, and what needed to be done. This was a NSW health program which ran HfH/FHBH Program funded by the NSW Department of Aboriginal Affairs and Department of Family and Community Services. These organisations have great relationships with each other, and we work quite closely to deliver these projects across the state.

The project was structured around the following nine healthy living practices:

• Washing people, particularly children under five years of age.
• Washing clothes and bedding.
• Removing waste safely from the living area.
• Improving nutrition - the ability to store, prepare and cook food.
• Reducing crowding and the potential for the spread of infectious diseases.
• Reducing negative contact between people and animals, vermin and insects.
• Reducing the negative impacts of dust.
• Controlling the temperature of the living environment.
• Reducing trauma (or minor injury) around the house and living environment.

First of all we had to identify the many problems with plumbing and drainage in Malabugilmah. Many communities we have been to have had sewerage problems caused by leaking appliances, and not so much by failing sewerage systems. There are just huge amounts of water going into the system.

First of all we had to survey the houses and identify the extent of the problems, and this is what we found in August 2004 - (referring to diagram on slide):

• 0 houses had safe electricity.
• 1 house had a passable shower.
• 1 house had a working bathroom.
• 0 laundries, drainage working.
• Many taps, cisterns and valves were leaking, resulting in high water use and an overloading of the sewerage system.

So Malabugilmah mob started fixing them all – tubs, rebuilt stairs, hand rails and kitchens, bathrooms, toilets, taps. In this second survey you can see a drastic improvement in most of those areas. It’s still not 100%, but there’s certainly a huge improvement. What we did find in detail was that pipes were leaking all over the place, septic tanks were blocking up, and the collection wells, pumps and the sewerage ponds were overflowing into the creek. This was polluting the swimming hole, making kids sick, ruining the country and wasting large amounts of water. When I first started working with Terry and Alan in the early days, the automatic pump system
for Malabugilmah didn’t work. Terry and Alan found themselves, day after day, night after night, sometimes sitting down at the river with manual pumps, pumping enough water up to the community. As the Malabugilmah Community worked on the Housing for Health project, we started to discuss concerns that the sewerage treatment system was not working properly. It was overflowing at the village, the ponds, and the creek where the kids were swimming, and ruining their country, as Terry spoke about before. The Malabugilmah community relies very heavily on the Clarence for a lot of their hunting and gathering, so it was a pretty serious situation.

EXISTING SEWAGE TREATMENT SYSTEM

This was maintained under the Housing for Health program, and you can see it was based on a septic tank with wet patch and leaking pipes all over the place - effluent collection tank which was overflowing, with an overflow box that was full and overflowing. The control box light was flashing constantly, and the pumps weren’t working. The untreated effluent was discharging into the creek, and the swimming hole was just downstream from that. The oxidation ponds were a little way away from the community, but not a long way, because Malabugilmah is quite a steep site and the housing is on slopes, and there isn’t much room to do all this. The overflow ponds were well and truly overflowing. They had also been located when they were originally put in a flood zone, so every time the creek flooded it just scoured out the ponds and sent it all down the river. There were many boggy areas, with lots of mosquito problems. Terry will talk about that in the changes he has noticed. Terry also became an expert screen manufacturer during this process, so he was a bit of a ‘gun’ on all that. Semi-treated effluent was being discharged into the creek. Housing for Health can only do so much in terms of infrastructure, so we cleaned and sealed the septic tanks, serviced the pumps and controls, cleaned the rainwater tanks and resealed them, and put in pressure pumps for the rainwater tanks, but that was as far as Housing for Health could go in terms of infrastructure.

Alan Boota

We approached Robert Vidler, CDEP Manager, who arranged meetings with people from the NSW and Federal Governments to sort out these problems. We had meeting after meeting to discuss how to fix the sewerage. As the discussion about fixing the sewerage continued, other issues facing the community were raised:

- There was nowhere safe for kids to play or for people to exercise, as the houses at Malabugilmah are on steep slopes and the roads are all washed out.
- The rural skills program with TAFE was going really well and they had a very good teacher who wanted projects so that people would get practical experience using the skills they were learning.
- Malabugilmah needed some new opportunities for employment.
- Malabugilmah wanted to work with some people who could see what we were trying to do, and who could help us make it happen.

Through this opportunity our people got a lot of skills, and have managed to get jobs in mainstream such as council work. We came up with a solution of how to fix the problem and this was our plan. We set up the new system from the septic tank into the new tank, and it goes through a UV and then back onto the tank and that would aerate the oval. We also put a drainage system in the oval that went back into the wetlands, and the water would then be pumped back out to the irrigation system. This way we would be using water all the time, and have constant use on the oval to keep it green.

We had many meetings and discussions, and we found people who could assist us to put our solution into practice:

- Coffs Harbour ICC – discussed what was possible using a Shared Responsibility Agreement.
- NSW Department of Aboriginal Affairs – discussed what they were prepared to contribute to the project.
- Yabur Yulgun CDEP – assisted us to negotiate the terms of the SRA and agreements with NSW Government.
- Yabur Yulgun CDEP – agreed to take on the role of contractor with Malabugilmah Community to do the work.

The plan required some specialist knowledge, so we called Dr Keith Bolton from Eco Technology Australia, who came and talked to us about wetlands technology. He agreed to help us build our own, and to fix our sewerage problems by treating our wastewater using gravel beds, melaleuca trees and gravity, with a lot of hard yakka. The community was very much in favour of that. You will see that a lot of people went out on a limb here. Yabur Yulgun, the ICC and CDEP all went out on a limb here. These were not ‘token’ jobs here – these guys welded every piece of pipe and manufactured the whole thing themselves. It was a really big job and was done through really extreme weather conditions. Day after day Alan was the site supervisor, and his job was to get everybody here into their boots, hats and coats. He did an incredible job. This was a huge project. Wetland cells were fabricated on site and were placed in clusters around the village, the idea being that you treat close to the source of the sewerage, and where the sewerage is you treat it there. So if all the pumps and everything else break down, the sewerage is treated. They backfilled the gravel, backfilled and levelled, and finally planted with melaleucas, which are harvested. That is what takes all the stuff out of the sewerage.

Jeff Green, from All Excavations and Environment, provided the equipment and on-site supervision and training for all the earthworks. Under Jeff’s supervision we put in the wetlands, laid the pipes, did the earthworks and levelling, and installed the civil works such as manholes, sub-surface drains, stormwater drains and erosion control. After getting their machinery operator tickets, we found that a few of the crew were ‘naturals’ on excavators and bobcats. There’s further work in operating equipment on offer with local contractors, based on their demonstrated experience. Here you can see the civil works and earthmoving projects, the installation of underground drainage below the irrigation lines so
that the field never becomes waterlogged and no treated water gets to the surface. Jim Byrne, from Irrigation and Water Technology, came and spoke to us about how we could safely reuse the treated wastewater to irrigate underneath our footy field so it would be green all year round. Here you can see ploughing in the sub-surface irrigation lines, connecting the irrigation lines to the mains, and setting up the pump shed, with controls, filters, alarms and UV sterilisation. Here you can see the laying of the turf on top - 9000 rolls of turf were laid. This was a huge job, and the bits that were laid had to be kept moist. Here's Malabugilmah's oval – their waste water treatment system right there.

**QUESTIONS**

Q1. “How often do you need to maintain the Melaleuca”?

A1. Andy Irvine - “It gets harvested as needed, depending on how much water is needed at the time. It gets to a certain height and then it needs to be cut off. The system has to be maintained like any pump system. The system for the community is a fail-safe system, because if anything is washed away for example, the community is safe in the knowledge that the water that escapes into the creek will be treated 100 times better than it was initially without any maintenance”.

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**NO PULGI – URBAN INDIGENOUS HOMELESSNESS AND ITS EFFECT ON HEALTH**

Joan Clark, Dr Katina D’Onise, No Pulgi, Nunkuwarrin Yunti.

Homelessness is a serious population health issue that has been increasing over time in Australia. The extremely poor health experienced by homeless people represents the severe end of the spectrum of poor health from inadequate housing and health hardware.

There is a lot of debate about definitions of homelessness, as a home means different things for different people. What is consistent is that being homeless is not as simple as inadequate or no housing. A home means a person has access to shelter and good, functioning, health hardware. It also includes the security and social connectedness that having a home can provide. Homelessness is a lack of any of these integral aspects of a home.

The concept of homelessness to Indigenous people is broader, and incorporates both spiritual and physical dimensions. Spiritual homelessness can mean a number of different things. It can mean a separation from traditional land, a separation from family and kinship networks, or a crisis of personal identity, wherein one’s understanding or knowledge of how one relates to country and Aboriginal identity systems is confused[1]. People may move around at significant times for important cultural reasons, and due to a lack of accommodation options, may be homeless while in Adelaide.

In the 2001 census, there were 86 homeless Indigenous people, with 48 people sleeping rough (no adequate shelter)[2]. A second study using the capture-recapture technique in 2005 found that Indigenous people made up 35.8% of homeless people sleeping rough in Adelaide, with at least 108 Indigenous people sleeping rough in the city[3].

The Uwankara Palyanyku Kanyintjaku (UPK) 9 Healthy Living Practices provides a set of basic principles required for good health. When any number of these practices fail or are completely absent for homeless people, issues such as lack of shelter, storage facilities, safety, cleaning facilities, cooking facilities or a lack of sense of wellbeing and self control all combine in different ways to contribute to extremely poor health. This extremely poor physical environment, combined with the unhealthy social and cultural environment in homeless communities, results in significant health problems including psychiatric problems, social marginalisation and even early death. Many Indigenous people who are homeless live in more ‘visible’ public places. This can increase the social marginalisation and discrimination that homeless Indigenous people experience from the general community.

Within the different levels of homelessness, there is more ill health seen in those people who have no shelter at all, compared with those with sub-standard shelter. A review of the literature indicates that homeless people are 3-4 times more likely to die than the general population. The average age of death is between 42 and 52 years old[4].

Table 1 outlines the major health issues encountered

<table>
<thead>
<tr>
<th>HEALTHY LIVING PRACTICES</th>
<th>HEALTH OUTCOMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washing people</td>
<td>Skin infections, poor wound healing, respiratory disease, diarrhoea</td>
</tr>
<tr>
<td>Washing clothes</td>
<td>Skin infections, poor wound healing</td>
</tr>
<tr>
<td>Ability to prepare, store and cook nutritious food</td>
<td>Tendency to therefore eat take-away or not at all (poor diabetic control, obesity/ malnutrition, increased risk of certain chronic medical diseases)</td>
</tr>
<tr>
<td>Temperature control</td>
<td>No protection from extreme heat or cold weather, can lead to dehydration, sun burns, inability to rest/sleep, particularly a problem if the person is unwell</td>
</tr>
<tr>
<td>Safety</td>
<td>Often people are victims of violence</td>
</tr>
</tbody>
</table>
The No Pulgi program in Adelaide is an example of a primary health care service specifically set up to address these issues. The program in Adelaide works with homeless people to offer holistic primary health care services that acknowledge the complex environment in which homeless people live. It was developed to address the largely unmet health needs for homeless people in Adelaide, particularly their chronic health care needs. The philosophy of the program is that individuals experiencing homelessness - or at risk of homelessness - have the right to comprehensive primary health care that is accessible, equitable, empowering, encourages inter-sectoral collaboration, and is self-determined.

No Pulgi is a collaborative effort initiated by Nunkuwarrin Yunti, Aboriginal Sobriety Group and RDNS and supported by the South Australian Department of Health and The Central Western Adelaide Aboriginal Primary Health Care Access Program (APHCAP). Other key agencies involved with the service include Drug and Alcohol Services South Australia and the Street to Home service. The partnership was developed to better address the health needs of homeless people, acknowledging that this is a difficult and complex task that would best be tackled by a partnership model.

Services commenced in March 2005. No Pulgi provides outreach primary health care services in a variety of different environmental settings including Day Centres and other places where people live and gather in the city, including the Adelaide city parklands. The service is free, flexible, and has strong links with homeless service providers to ensure integrated, holistic care that also includes social and environmental domains. It considers the whole person and the environment they live in when managing health issues. The team consists of an Aboriginal Health Worker, General Practitioners, an Intra Venous Drug Use Outreach Worker (Nunga HIV Intervention Team), and a Community Health Nurse.

An important learning from the program is that shelter, food and safety are the immediate pressing needs for homeless people, and so all other issues become secondary. In order to be successful, a service for homeless people needs to be easily accessible, including going to people in their own environment, and it needs to consider the whole person and the environment they live in to be effective. Homeless people often need support to attend to their social and physical health needs (transport, accompany people to appointments) and advocacy in dealing with mainstream services.

Structurally, homeless services need to work in partnership with other groups in the sector, including social services, to ensure seamless service delivery and best quality of care.

REFERENCE:

Ms Joan Clarke
Worked for 20 years as a health worker and nurse.
Working as an Aboriginal Health worker for the No Pulgi program since 2005.
Joan is an Adnyamathanha/Nurrunga woman.

Dr Katina D’Onise
MB BS, MPH and TM, FRACGP
Advanced Public Health Registrar
Worked for No Pulgi 2005-2006, and is now working in the South Australian Department of Health

QUESTIONS
Q1. “With homelessness, are there are any centres for them where they can sleep at night”?

A1. Joan Clark - “At the sobering up unit. They are breathalysed on the way in, fed in the morning, and then they can go. There aren’t enough beds (there is only one). It is on a first-in-first-served basis. A lot of people camp just outside the building as it is a little bit safer there because there are workers and stuff around there all the time. A lot of people are just sleeping outside.

Q2. “What is the breathalysing and sobering up for”?

A2. Joan Clark - “They have to be at a certain limit before they can get in. The only way people can get in sober is if we advocate for that to happen. That is pretty hard for us, because we will save those spots for people who are sick. However, they do have a transitional room. When Doc and I go there on a Monday or Friday we can refer clients into that room if they want to start rehab, and they can stay there as long it takes for them to move onto somewhere else”.

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BLACKTOWN ABORIGINAL SAFETY PROMOTION PROGRAM – HOME SAFE HOME PROJECT STREAM

Wendy Bryan-Clothier, Sydney West Are Health Service

“I would like to acknowledge the traditional owners of the land, the Irukandji, and their Elders, past and present, and thank you all for staying for the last session of the day. I am presenting the Blacktown Aboriginal Safety Promotion Program – Home Safe Home project stream. I am representing all the partners in this project, which was unified with a specially designed logo that represented bringing community, government and non-government, Indigenous and non-Indigenous people together. We now have a logo that was designed by one of the youths at a community outreach and we have also taken ‘United We Win’ which is the title of a poem by Oodgeroo Noonuccal (Kath Walker). This was cited at the beginning of the Report that led to the project’s development. Today we will have a quick look at the overview of the project, the background (particularly to all the realms this involves), the objectives of Home Safe Home, how we established the project, Stages 1 and 2 of the project, the challenges and lessons we have learned from that so far, our sustainability challenges, the budget we have worked with to date and for the next 12 months, and other outcomes from the project.

OVERVIEW

As you can see it is a busy flowchart.

The Blacktown Aboriginal Injury Surveillance and Prevention Project Report was commissioned by NSW Health, undertaken by the area health service and published in 2003. It pulled together data from police reports, health data etc, on injury statistics and involved the project worker interviewing people such as those whose families had experienced injuries, and safety was an issue and all the aspects that led to that issue. As the report was released, NSW Health also released the NSW Health Aboriginal Safety Promotion Strategy which was developed, with behind-the-scenes liaison, with the people who put together our report, but additionally with the support of people from Shoalhaven and the Mid North Coast who had done similar local reports.

Then we have the overlay of Two Ways Together, which is the NSW Aboriginal Affairs Strategy to invite all government agencies to work together to address Indigenous needs. Therefore the Department of Housing should be working with Department of Health, should be working with the Department of Planning should be working with the RTA – this would provide a system of cohesion that is bringing people together. We challenged all these people with the Two Ways Together mandate, the local information that we need and NSW Health really wanted someone to pilot a project. We brought everyone together, and provided a lot of evidence, and we basically said the onus is on each of your agencies to work together. You can like it or not, but we think this will be a really great program - come along. From that, we now have all that you can see above. On average we have at least one meeting a week to develop all of those aspects of the project. The Blacktown Aboriginal Safety Promotion Program, multiple agencies working together and working with community. Annual NAIDOC activities for the program are also another way of us engaging with the community to inform and be informed about the project and its direction. As you can see, we have done a lot regarding community forums, and that’s just a small part of it.

Additionally from the Safety Promotion Program we have the three safety Projects:

- KAYS Keeping Aboriginal Youth Safe is indirectly targeted at the incarceration rates, and looks at youth and family safety. They do this by linking with Council, the RTA, TAFE, and Births Deaths and Marriages. What they are doing is improving youth driver licencing through mentoring, and raising awareness of the debt reduction process which is a key barrier to gaining a licence. This is proving to be a very strong program, but unfortunately that is not what I am here to talk about today.
- Safety in the local environment (is also called ‘Ngarra’ which means ‘to listen’ in the Darug language, and we have permission to use that terminology by the Darug people) targets safety improvement in the general environment in pubs and clubs, to reduce the impact of unsafe drinking and driving activities. This is done by working with the Office of Liquor, Gaming and Racing, RTA and Council. It is also anticipated that as that program becomes stronger the phase with pubs and clubs will start to be able to function on its own with feedback and support from Liquor Gaming and Racing and community and RTA with less involvement. However, it will start to have a greater role in the development of the planning strategies and community redevelopment in the Blacktown local government area. Those consultations are still in the infancy stage.
- Thirdly, Home Safe Home – the one I am here to speak to you about today.

HOME SAFE HOME PROJECT

BACKGROUND TO THE PROJECT

The Home Safe Home Project, operating under the Blacktown Aboriginal Safety Promotion Program, is working with partner agencies to seek to reduce the rate of injury in the home. We are aiming to look at issues in the physical environment which can be improved through intervention by housing providers and partner agencies. Our work involves audits of the infrastructure of the home, replacement of some safety products, education and awareness of residents’ safety issues, empowerment to report to the housing provider, support in establishing a response to need in those housing providers, educational activities across partnership agencies, involvement in evaluation procedures for the whole of the program, and the development of strategies to address family violence in the community.

The objectives are basically very broad, and have been developed in consultation with stakeholders to:

- Increase fire safety awareness.
- Highlight the importance of water safety.
• Safer home structure and environment.
• Decrease the likelihood of falls around the home.
• Link to an appropriate Family Violence group.
• Establish an effective community support team regarding safety.

The key point to these is partnership will only get us there. We have to establish that community support team.

To establish the project we held a workshop and it:
• identified three manageable areas of intense need (youth safety, environment safety, and home safety projects),
• Established working parties for the project streams,
• An additional workshop was held to engage more agencies regarding Home Safety, inviting them to partner the project.
• Additionally, some of the key players that stepped forward at the initial meetings offered to be key liaisons between the project, the AMS and the Land Council.

STAGE 1 - PARTNERSHIP
This is where we had people with experience partnering the project, and were able to start moving the project forward. We developed a group of partner agencies to effectively support community. The issue is that in the Blacktown local government area there are about 7,000 members of the community who are Indigenous, and it is also estimated that the Department of Housing has about 10,000 homes. The Aboriginal Housing Office has about 300 homes, the Land Council has about 45 homes and Community Housing is known to have Aboriginal tenants, but they don’t know how many. The Department of Housing also cannot accurately report the number of Indigenous tenants, because their current data system does not allow that. So we are working slowly.

Key partners include:
• Kidsafe house.
• Aboriginal Housing Advisory Committee.
• Aboriginal Elders and Community.
• NSW Health.
• Wirringa Baiya Aboriginal Women’s Legal Centre.
• Department of Housing.
• SWAHS.
• NSW Fire Brigades.
• Gilgai Aboriginal Centre.
• Mlimali Aboriginal Community Association.
• Blacktown City Council.

We have contact with community associations, government bodies, and a complex network whereby we interact with the Elders, either by letter or separate meetings.

PHYSICAL ENVIRONMENT
• The Housing for Health system was seen by Blacktown community representatives as not suitable for them – I am advised it has been removed from the CEO’s KPI for the Area Health Service.
• We developed a Home Safe Home Subcommittee to develop a safety audit tool.
• As community does not want attention drawn to them we had to make sure the audit tool was suitable for Community Support Agency representatives to run on their own.
• That person audits the infrastructure to report ‘only on things that need repair’ to the housing provider. However, in the audit tool all the things introduced to the box by the resident are also assessed, eg, extension leads to see if they are safe, and upskill and talk up these issues in the home. For example, people have trip hazards because they have misused a cord, replacing faulty double adapters with flat ones, check on plumbing, small torch for nighttime emergencies to reduce falls in homes, screwdrivers to facilitate small repairs to things like hinges, small selection of child safety locks for the householder as packed in the shop so later they know what they are looking for and will be able to choose the system appropriate for them, energy-efficient light bulbs that don’t add to power loads in the home.
• Audit reps also carry power point testers and thermometers to test faulty hot water systems (to be at 50 degrees).
• Safety Audit
  – Tool developed by working party.
  – Trial with five families connected to agency support.
  – Further tool development.
  – Project established.
  – Reporting to local Department of Housing Aboriginal Advisory Committee.

WORKFORCE TRAINING
One of the other issues that was identified by our community liaison people, the auditors, is that there are issues with ‘sharps’ in the homes. One of the key barriers to providing services in homes is OH&S restrictions, eg, needles on floors, so workers cannot go in. We developed a training program to minimise this, by developing training on Safe Sharps Collection and Disposal in partnership with the Needle Syringe Program and with Council’s Waste Education Officer. We have also engaged with Diabetes Australia, as not all sharps are for drug use - some of them are medically required. We are now developing an in-service training program for key partners so the whole team can be upskilled to know where to go to get rid of these products. Audit agency representatives are trained in Audit Tool Use and reporting, and there is future in-service training for partner agencies being scoped.

ANNUAL EDUCATION ACTIVITIES
• Ongoing efforts of recognition of community leaders and partners.
• Community Safety Expo due 14 June 2007 - a new project that arose from the Home Safe Home Project regarding fire safety activities, eg, fire escape plans and proper use of fire blankets. The community didn’t like the idea of uniformed persons in the house, so we are hosting an expo including all sorts of agencies such as the police, fire safety, mental health, RSPCA, Council, Department of Housing, TAFE (staff covering food safety, electrical, plumbing and home safety issues).
NAIDOC Week Activities – To increase community awareness of:
- Home fire safety.
- Needles and syringes.
- Waste management.
- Safety across all ages.
- Driveway safety.
- Medicine and chemical safety.

EVALUATION
- BASPP partner ‘The George Institute’, is undertaking evaluation of the whole project, which will also recognise our achievements and our challenges so when we go back to our line managers we can identify barriers and achievements.
- Involves
  - Project group interviews.
  - Individual member interviews.
  - Reviewing community feedback.
- Home Safe Home project evaluation is ongoing.

OUTCOMES TO DATE
- Funding during 2006 to establish this pilot program.
- Partners conducted 16 audits during the 2006-2007 financial year.
- 16 home safety kits installed into homes.
  - Replaced extension leads.
  - Fixed light globes.
  - Checked power points.
  - Falls prevention.
- Two families moved to appropriate housing - one was moved because years ago she had a large number of children and took a rat-infested house on the proviso that another one would be provided as soon as possible. When our people went into the house it was still rat-infested, with kids sleeping on mattresses on the floor, with rats living inside the mattresses. We talked to the Department of Housing. The other house needs repair from damages from other persons who visit the home but the damages are not the only problem. The house has had a huge hole in the floor, right under where their fridge is located. This has been there for over three years, because the floor had rotted from a water leak.
- Improved linkages with Housing providers across the region.
- Moving towards an MOU with the Department of Housing to improve the reporting of audit outcomes and appropriate agency response re HSH Project
- In the last 12 months we have received $10,000 in 2007 from the Aboriginal EH Branch to continue activities for 50 more houses, and to run educational activities which has taken some pressure off us so we can focus on activities.
- Benefit of information not gathered as random anymore, but more comprehensive (a whole set of key questions) which means a more effective service

STAGE 2 - INTERPERSONAL SAFETY
- This is a little more awkward. This is something that is not going to be handled by me as it is not my area, but it is something that is believed to be very much within the scope of HSH. A lot of things happen when you are at home. It was a very strong requirement from the crew, so today some of our friends from the group will be attending another meeting in the community on family violence with a key NGO, and are going to be discussing linkages and appropriate means for the group to move forward. We will wait and see on that one. We hope to have some strategies developed on this before the end of the year, so we can begin to make the appropriate linkages and bring these people to the table. When we run the next Safety Expo and maybe some other community activities, we will be able to bring these people forward as well.

CHALLENGES/LESSONS LEARNED
- Some of our challenges have been about developing partnerships, because they take time to develop.
- Each agency has their own restrictions on funding and activities, and how they prioritise their work.
- We definitely need culturally-appropriate strategies for Sydney, as they are vital to success.
- Require respect and preparedness for different ways of working.

SUSTAINABILITY CHALLENGES
- No dedicated Safety Program in all agencies to link to the project – they don’t connect that what’s happening in the home is connected to work (that’s where the OH&S issue keeps coming back).
- Big project – lots of time needed and faces member limitations.
- We have had some losses in Staff Movement.
  - Rotation intra-agency and inter-agency.
  - Benefits of these movements have been greater than the losses.
  - While that has been saddening, most have left after briefing incoming staff and creating passion, and those who have left have taken their experiences into their new agencies and further developed support in new networks.

BUDGET
- Actual expenses 2005-06 year <$1,500.
- Funds received 2006-07 year $10,000.
- Approximate in-kind 2006-07 year from partners $50,000 (eg, wages, resources, printing).
OTHER OUTCOMES

- Community support continues to grow.
- Support from various levels of Government.
- Support from non-Government organisations.
- Strong interagency partnerships.
- Our group aims to respond to needs of the community, rather than ‘this is what we have money for, what can we do with it’?
- ‘Can do’ attitude from all partners, and when they don’t, we can still link back to the Two Ways Together program”.

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YARRABAH ABORIGINAL COUNCIL WHICH WAY THIS JOB EHW?

Stephen Canendo, Environmental Health Worker

“Thank you, Shane for your introduction. I appreciate that - it is good to know I am so respected in certain areas. I have been sitting listening to my fellow EHWs from all around the country, and it was good to hear about what people are saying, but I sat down and wondered what I am going to talk about. I thought maybe I should talk about some important services – it’s good to deliver those services. However, before I get into this, I would first like to acknowledge the Irukandji People, as this is their country we walk on, and to also acknowledge the Working Group who invited me to come and speak here today, and you mob. It is good to see people turn up, as that is motivation itself. One man cannot solve things by himself, so it is good to see people.

Description of Yarrabah community where I am currently living:

- DCGIT community approximately 60 kms from Cairns, but in a boat only 12 kms (15 minutes to get there).
- Established in June 1892.
- 60 kms in length, confined within False Cape to the north and Palmers Point to the south.
- Traditional owners of that country are the Gungganji mob.

HISTORY AND BACKGROUND

- I am currently employed as Environmental Health Worker at Yarrabah.
- Previously I was in charge of hygiene gang (picking up garbage).
- Current duties.
- Place of birth – Gordonvale.
- Cultural background – I am of Aboriginal heritage - my father was born on Hammond Island, and my Mother is from Torres Strait.

WHAT IS ENVIRONMENTAL HEALTH?

I’ve been to a lot of conferences and workshops, and one of the famous descriptions of environment is ‘a place, be it man made or natural, where we tend to spend a lot of time’. So I’d like to say my description of an environment is one word – country. As we live there, environmental health can be classed as caring for country. For EHW to deliver appropriate health delivery is one word – proper. You need to get the support of your council. Because EH is new on the scene, the more your Council understands, the better your work will be. You must inform the community that you need their input plus their participation, because remember, any plans you bring your people will abide by that, so try to think for the people, by the people. It has to be a team approach, just like last night when Queensland played better as a team - that’s why they won.

You need to get onside with your fellow workers. What if you come in to do the water with your qualifications, yet someone is already in place doing the water. You think about invading that space. In my community, I have an essential services officer who looks after the water, and they know their job well as they have been doing it for so long. I don’t come in and tell them what they should be doing. I adopt a theory of ‘what can I do to help you’? A lot of time they are busy doing manual jobs, so I can help them by doing promotion. Outside organisations will come in, and whether you like it or not, they will think you might not be doing enough in animal control, for example, and they will go over your head. So when they call you to come to the table, you need to be able to talk to them.

I have a brother younger than me, and he came to me one day and said ‘What does 1+1=? 2? No, 1+1 makes whatever you want it to be. I thought he was talking silly, but he was a community member and I looked for motivation and inspiration. So I sat down and thought, 1+1+1+1+1=5, but let’s get outside the box. With that 5 you get the support of your council, input of participation by your community members, and you are working with other staff and organisations. That 5 x 1 will equal a better environmental health service that will consist of safe water, good waste management, good animal control, good promotion, healthy community, good housing - see what I mean, so don’t always think 1+1= only 2, as it can equal anything.

My current duties would be what EHW do – housing inspections, no pest control as I don’t have a licence. But what I concentrate on is promotion, because you need to know what your problems are. You need to know about your enemy before you go on fighting - to look at ways to fix them, studying them and getting in there. For example, housing inspection – you must think ‘What does it do?’ What do the negative issues do? I believe they affect your mind. There is a thing called mind, body and place. If you have a healthy mind, you will have a healthy place but, for example, if you have a leaking tap it will affect your mind such that you can’t sleep. You don’t worry about it because you think that’s where the EHW comes in. But a lot of problems I have found in my community are small things.

Just like in Paul Kelly’s song Wave Hill ‘from little things big things grow’. You get to little problems early to stop them before they grow. Just as in health promotion. That’s why I concentrate a lot on educating the children - as they are little things and they will grow - and while they are at school you just keep adding to this. Then one day they might say ‘That man talked to us about EHW, I want to try and do that, too’. That’s leadership. You can lead from the front but you can also lead from the back. You take your turn and lead first, and then you lead from the back. How do you lead from the back? Encourage. Go along, I am there behind you – I am there for support. Speaking of support, I forgot to mention some important people. I forgot to thank my respective partner - family support is all very important. Just think about it - when you go away to study, you are leaving your partner and children behind. Trust is important too. Also support from your fellow practitioners, and your Indigenous zonal EH coordinators, because they are looking after the government, just like us looking after our issues. If I get a problem I call Clayton as he is my contact with the outside world. He’s done the same sort of training as me but he applied for a job with Queensland Health because he knows somebody. Like other zonal health coordinators, they put themselves there as that
is where they felt their calling was - because that is where they felt they can be of more assistance.

RESOURCES
If you don’t get the support of your council, who will support you? Who pays you? Outside organisations have limited resources. Community members are a resource that doesn’t cost you anything. If you have a community of say 3,000 people like we have, and if I can convince them to help, that’s 6000 extra hands – many hands make light work. Maybe we need to introduce a disease – a major outbreak into our communities. That disease I reckon which has been lost, is pride. Pride is infectious, and if we can get our community feeling good about themselves then that is good. Respect - respect will get us a long way. Respect our country, our fellow man and our people. Respect is good.

CULTURAL ATTACHMENT
Talking about these workshops and travelling here. Let’s think about how can we relate workshops culturally? Our Aboriginal people and Torres Strait people, even if they haven’t been walking about, why did our people hunt for food in canoes? When it was dry and there was no food, if it wasn’t good there, they went somewhere else. So let’s think about education for the community. That’s when you take that step like TAFE and a bit further to university, but you are always going to come back. Warriors always set out to hunt, so look at yourself as hunters, as warriors who are not bringing tucker back, but you are bring back something else - information. You are bringing information back, and educating children. When I visit schools and talk about Mr Germ, Aboriginal and Torres Strait Islander children like to touch, so pat them on the head – praise is good.

I will finish up with this.

I look for motivation. When I feel I am going to chuck it in I look for something that will make me want to keep going. There’s one word we black fellas use, and that is ‘deadly’, which means ‘good’. I have made up seven letters from the word for the following, for a ‘deadly’ EHW

Dedication: To your respective council, your position and to the duties involved.

Enthusiasm: When conducting promotional duties plus also when community residents are reporting problems and concerns.

Adaptability: When attending meetings/workshops/conferences, understand mainstream jargon. Break it down and communicate it on at the community level.

Durability: To possess mental and physical toughness to face any hurdles encountered, as you will take a lot of abuse. Physical toughness means you might have to go and help your fellow workers grab a dog, for example.

Love: As an EHW it is important to not only love the job you’re doing, but display it when working.

Yearning: To seek further qualifications to improve quality of EH service delivery to your respective communities.

It’s not all about me doing my job, but you doing your job in your community.

One bloke yesterday was so nervous when he was talking, but I could see his passion when he was talking as he was doing this for his community. If you have passion about your job, it makes it all worthwhile in the end. Thank you”.

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KEEPING RESEARCH ON TRACK
Dallas Young, Manager, Public Health Field Research Program, James Cook University.

“I would like to begin by acknowledging the traditional owners of the greater Cairns areas, the Indinji, the Tjapukai and the Irukandji Peoples, and would like to also acknowledge any Elders here today. I would like to thank my colleague, Yvonne Cadet-James, who developed the presentation with me, and who usually co-facilitates or co-presents with me at conferences. I would also like to thank the organising committee for inviting me to come along and talk about research today, and in particular Sonjia Carmichael for her support.

I am a member of National Medical Health Research Council’s research panel, which essentially reviews applications that are submitted for funding under the NHMRC’s grant proposal process. What has been noticeable over the last couple of years is the lack of research applications to address EH issues. As an example, for this year our Review Panel looked at 50 applications for funding, and only one of those had an EH focus. I encourage conference participants to consider developing collaborative research partnerships, and applying to funding rounds for research dollars.

Before I started I had a talk with Bully about my presentation, and the one thing that he said was to make it applicable and practical to this audience. So I guess for a lot of people out there the work that you do is a step towards undertaking research. The impact of this and producing results from your work can have an influence on policies and practice not only at a local level, but also at a national level.

Over the years there has been a lot of research undertaken in our communities into aspects of Aboriginal and Torres Strait Islander health and wellbeing. Sometimes the outcomes of this research have not always benefited our communities. Aboriginal and Torres Strait Islander research conducted in Australia today is guided by ethical principles formulated during the 1980s, and outlined in guidelines produced by the NHMRC of Australia. This presentation will provide you with information in order for you to become familiar with the research process. It will also assist you in understanding that the research journey respects our shared values, priorities, needs and aspirations, and benefits not only Aboriginal and Torres Strait Islander people, but researchers and the wider Australian population.

The two documents that I refer to throughout this presentation are the Values and Ethics Guidelines, and the Keeping Research on Track document.
At the heart of ethical practice of Aboriginal and Torres Strait Islander health research is the question of how research proposals are assessed and monitored by ethics committees, and what level of Indigenous involvement in assessment is desirable, practical and realistic. Although there has been very little Aboriginal and Torres Strait Islander involvement in ethical matters, the reality is that not all jurisdictions within Australia have established or supported this involvement. The NHMRC recognises that Aboriginal and Torres Strait Islanders are overwhelmingly the most disadvantaged group in Australia, and that the health research in this area does not appear to be contributing to an improvement in health status. The Council developed a number of initiatives to engage with Aboriginal and Torres Strait Islander peoples, and encouraged productive research. This includes a commitment to increase its investment into Indigenous health research to at least 5% of its funding, in line with the recommendations of the House of Representatives Inquiry ‘Health is Life’. This includes the development of a Centre for Clinical Excellence in Aboriginal and Torres Strait Islander health, by providing training opportunities for Indigenous scholars, a revision on ethical matters in Aboriginal and Torres Strait Islander research and the establishment of a research agenda working group known as RAWG. The NHMRC signed a five-year collaborative agreement on Indigenous health research with the Canadian Institute’s Health Research, and the Health Research Council of New Zealand. The expected outcomes include information sharing of research methodology, ethical conduct of research, community engagement, transfer of research outcomes and research capacity, as well as encouraging direct links between researchers and organisations for the development of collaborative research programs.

The overall objective of the RAWG Road Map is to support the NHMRC to advise Aboriginal and Torres Strait Islander communities throughout Australia on the achievement and maintenance of the highest practicable standards of individual and public health, and to foster research in the interests of improving those standards. RAWG has outlined six research themes critical to achieving substantial health gains for Aboriginal and Torres Strait Islander people.

While reasonably current data on aspects of risk, disease and deaths in Aboriginal and Torres Strait Islander peoples is available, the quality in some areas remains inadequate. Strategies for health improvement require the clarification of the role of social and other determinants of risk, disease and death.

There are two complementary areas covered in this theme. The first is the focus on research around field development, infancy, childhood and adolescence, and factors which promote resilience and lay the foundations for good health throughout life.

Within these priority areas the theme encompasses research that examines the effectiveness and efficiency of primary health care and related services, whilst recognising factors such as geographical location, community groups, service infrastructure, governance and service mix. This theme also involves the focus on specific causes of death, illness and disability, and the application of preventative diagnostic and treatment- based interventions and health services. Research on effective population health measures would be encompassed by this theme. Many mainstream health programs have an Aboriginal and Torres Strait Islander focus, yet at present there is little reliable data on the uptake of these programs by Aboriginal and Torres Strait Islander peoples, or of their effectiveness.

International research which has taken a broader approach to health status has highlighted the impact of factors such as locus of control, lack of social capital and loss and grief on our health status. Little research has been undertaken in this area in Australia. Associated with this is a need for greater understanding of EH. Other factors that may be the focus of research in this area include food supply, education, employment and economic security, transport, personal and community safety, play sport and recreation.

Gaps remain in understanding the health issues of some Aboriginal and Torres Strait Islander populations and communities. For example, there is a lack of information on the needs of urban communities, Torres Strait Islander communities, young adults and the elderly. Priority needs to be given to research that produces data and knowledge critical for health gain in these populations, or in these communities. This theme includes a focus on the range of options for building the pool and skill base of Aboriginal and Torres Strait Islander researchers. It also encompasses the development of consultation and research practice and protocols including ethical guidelines and specifying the need for mechanisms for disseminating and implementing research outcomes. It also includes a focus on the development and testing of better research tools and treatment for methodologies, for example, research into measurement and treatment of mental health in Aboriginal and Torres Strait Islander communities.

The construction of ethical relationships between Aboriginal and Torres Strait Islander peoples on the one hand and the research community on the other, must take into account the principles and values of Aboriginal and Torres Strait Islander cultures. Within the research process, failing to understand differences in values and culture may be a reckless act that jeopardizes both the ethics and the quality of the research. Working with differences in a research context takes time, care, patience and building of robust relationships. The values and ethics guidelines promote a more flexible approach, and encourage research to reposition itself to incorporate alternative perspectives and exercise judgment as to its ethical implications.

The responsibility for maintaining trust and ethical standards cannot depend solely on rules and regulations. Trustworthiness of both research and researchers is a product of engagement between people. These guidelines are based on the importance of trust, recognition and values. The evolution of the relationships between Aboriginal and Torres Strait Islander communities and the research community has taken a number of twists and turns over the years. These guidelines articulate the meaning to Aboriginal and Torres Strait Islander peoples on each of the six values identified and agreed upon at workshops held throughout the country.
Aboriginal and Torres Strait Islander societies have sustained enormous impacts in the past, to which our cultures have responded. For long periods, both an official and popular view was that this change essentially involved the view of disconnection, of contemporary Aboriginal existence from the values and integrity of a traditional and historic society. However, to the contrary, contemporary Aboriginal and Torres Strait Islander societies draw their strength and existence from the body of knowledge, values and wisdoms that emerged from the interaction of tradition and history. When making judgments about Aboriginal and Torres Strait Islander peoples, Australia and its public institutions must acknowledge our history and bridge the difference in cultural outlooks to find a fair, respectful and ethical way forward. These guidelines, in addition to the National Statement, the authoritative statement on health research involving Aboriginal and Torres Strait Islander peoples, has the same status and authority as the National Statement.

The six core values in this document include reciprocity, respect, equality, responsibility, survival and protection, and spirit and integrity. Discussion during the development of these guidelines emphasised the relationships of these values over time and their importance to identity. An understanding that the present and the future are absolutely bound up in the past and that these cannot be separated from each other when discussing issues where key values are at stake, is shown in this diagram, by indicating that these values are present through time - past present and future. Reciprocity involves exchange, although in the context of research this often involves unequal power relationships. In negotiating the conduct of research, Aboriginal and Torres Strait Islander communities have the right to define the benefits according to their own values and their own priorities.

Contributions to the research enterprise come in a variety of connected forms, and all should be respected. The trust, openness and engagement of participants in communities and individuals are as important as the scientific rigor of the investigation. A respectful relationship is fundamental to a sustainable research partnership. International and domestic studies have increasingly revealed a correlation between social and economic inequality, and poor health. Researchers seek to advance the elimination of inequalities. Historically, Aboriginal and Torres Strait Islander peoples have not received the benefits with them belonging principally to researchers and institutions. When engaging Aboriginal and Torres Strait Islander peoples in the research, enterprise researchers should carry responsibilities in addition to the science of their own inquiry. During 2002 the NHRMC held a series of national workshops and received submissions to consider Aboriginal and Torres Strait Islander health research issues.

Three important messages came out of this process:

1. The need to improve the way researchers work with Aboriginal and Torres Strait Islander peoples.
2. The need for developing the research capabilities of Aboriginal and Torres Strait Islander peoples.
3. The need to improve our awareness of our rights as participants in the research journey.

‘Keeping Research on Track’ is a guide for Aboriginal and Torres Strait Islander peoples about health research processes, and was launched in 2006 by the NHMRC. It is important for Aboriginal and Torres Strait Islander peoples to know their rights in order to participate in research. This includes to commission research that meets our priority needs - to say ‘no’ up front, to say ‘yes’, to negotiate a different focus for the research, to request more time to talk about the proposal, to expect that our cultural values are respected, to have input into the research agenda, to check on the researcher’s track record, to expect that the way we do things in our communities and organisations is respected during the research process, to negotiate a formal research agreement, and to delay and stop the research. Aboriginal and Torres Strait Islander peoples have a right and indeed a responsibility to be involved in all aspects of research undertaken in our communities and our organisations.

This document will assist us to work out whether any proposed research is relevant, ethical, and appropriate by identifying our most important shared values and listing our rights to participate in all stages of the research journey. It also provides a checklist of the steps community members may follow to keep the research on track.

Research partnerships need to be developed from the very beginning. This could mean developing relationships with organisations or communities before even considering undertaking research. For the researcher it would be important to develop rapport before coming up with a proposal and applying for funding, and then seeking an organisation or a community to which to apply it.

The eight steps of the research journey will assist people who are involved in negotiations about research, to ensure that the research is relevant to communities and organisations’ needs and aspirations. Each step of the research process is discussed throughout this document, and lists key questions that may be asked in developing a research partnership.

So, in conclusion is it possible to reconcile the interests of research and researchers with the values, expectations and cultures of Aboriginal and Torres Strait Islander communities? The evidence suggests that it is. Several different models have been used successfully to build trust and recognition of cultural values and principles, while advancing the objectives of the research enterprise. A common feature across all models is the explicit recognition and commitment to respect our cultural values and principles. The model also illustrates important aspects of accountability and transparencies standards processes and structure.

If you would like more information on the two documents about which I have spoken today, please go to the NHMRC website http://www.nhmrc.gov.au/.

You can also download the documents or request hard copies.

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Day Two

AEDES ALBOPICTUS (ASIAN TIGER) ERADICATION PROGRAM

Ronald Williams and Wayne Christian, Tropical Population Health
Unit QHealth

Ronald Williams

“Good morning everyone. Firstly, I would like to talk a little bit about my background, and where I come from. My mother is from Saibai in the Torres Strait, and my father is an Aboriginal from the tip of Cape York. Before we begin we would like to start by recognising the traditional owners of this region for allowing us to speak from their land, thank the chair, EH staff and Queensland Health for inviting us to this get together, EH staff from across the states, ladies and gentlemen. The topic for our presentation this morning will be on Aedes Albopictus Eradication Program across the Torres Strait and the NPA. First up we will look at the project itself. Secondly, we will look at the aim of the project and thirdly, we will look at the results of the project.

The epidemic of dengue fever in the Torres Strait in 2004 caused deaths due to dengue haemorrhagic fever. This outbreak and others have been caused by the container breeding mosquito, the common dengue mosquito, Aedes Aegypti. This mosquito is the only dengue fever mosquito in Australia. The Asian Tiger mosquito Aedes Albopictus causes dengue fever overseas, and it was not here in Australia then. Now the discovery of Aedes Albopictus in the outer islands in 2005 has resulted in the Aedes Albopictus project to cover 12 infected islands. This team conducts routine mosquito monitoring and comprehensive effective mosquito control of 12 islands. It consists of 10 staff members - six in the control team, three in a surveillance team and one is our project manager.

When we are out there controlling and eliminating Aedes Albopictus from Torres Strait, we are also wiping out the dengue mosquito, improving community water storage infrastructure in Torres Strait, increasing knowledge regarding prevention of dengue in general, and increasing community council activity in control of container breeding mosquitoes. The project covers all communities in the Torres Straits, and five communities of the NPA region, the northern tip of Cape York.

The first priority is 12 islands. In 2005 there used to be 10 islands, but the mosquitoes have travelled by wind or boat to other islands. Before visiting any community to do controlling, the community council is contacted and the visit is discussed with the CEO and EHWs. The council then advises the community of the proposed visit, and the EH works with the control team. Before leaving the community, the work carried out is discussed with the council and a written report is left with them to show which house was covered.

There is monitoring of mosquito numbers after the visit of the control team by a second entomology team (which is the surveillance team), to show that our control measures are working and that there are fewer mosquitoes after the treatments. As I stated before, as well as killing the tiger mosquito, there is also less Aedes Aegypti.

Lastly we like to state our claim that the project is very important - it reduces the population of mosquitoes throughout the region, and it also reduces the risk of dengue outbreak throughout the Torres Straits.

Before I finish I would like to thank the councillors, CEOs and EHWs of the Torres Strait for assisting us in performing our duties in the past and for the future. I want to thank each and every one of you for your cooperation this morning”.

Wayne Christian

“I am from Bamaga, and have been with the Aedes Albopictus team since last October. I work mainly with the control side, the eradication team and more recently with the surveillance team.

The dengue mosquito looks like many other species of mosquitoes in Queensland, because of the way they appear, and because of the coloration of their legs. To the average person it is hard to identify, unless you are looking under the microscope. As a rule of thumb, if the mosquitos are biting you indoors and during the day, then it is more than likely a species of the Aedes Aegypti, or the common dengue mosquito, or the Aedes Albopictus. These are mosquitoes that are capable of carrying the dengue virus.

The dengue mosquito can also be identified by its behaviour – it bites people during the day whilst indoors, very hard to catch, very fast, usually darting back and forwards, likes to hide under furniture, likes to bite people around the ankles and feet areas, its bite is usually undetected and painless, and the bite may be mistaken for sandflies or midges. The adult mosquito prefers dark areas to rest, such as under houses and buildings.

Its favoured resting spots are usually places such as under the bed, tables and chairs, wardrobes, closets, on piles of dirty laundry, shoes, and dark, quiet rooms, or even on dark clothing.

The dengue mosquito is in fact a unique mosquito because of its breeding habits. Unlike other mosquitos, the dengue mosquito prefers to breed in manmade containers that are around the house, for example, tiles, discarded rubbish, buckets.

This mosquito is somewhat domesticated. Unlike the Asian Tiger Tale, it is known to also breed in man-made containers, as well as in natural areas such as swamps and natural breeding sites.

Aedes Albopictus (Asian Tiger Tale) is a tree hole mosquito, found in areas such as natural forests, planted forests, scrublands and wetlands. The Asian Tiger Tale also has the ability to breed in man-made containers such as buckets, tyres, food containers and so forth, and in coconuts, palm fronds, tree holes. It is quite an adaptable breed of mosquito.
This particular species is similar to the Aedes Aegypti in that they are aggressive day feeders. The Asian Tiger Tale attacks humans, livestock, and other animals as a food source. Instead of buzzing around, it goes straight in for a feed.

The Asian Tiger Tale is capable of spreading the dengue virus, as well as Japanese encephalitis and West Nile. Like the Aedes Aegypti which usually attack around the leg regions, the Aedes Albopictus will go straight and hard to all parts of the body. Aedes Albopictus has been found in all the islands in the Torres Straits, except for Saibai.

Breeding on some of the islands can be attributed to excessive rubbish in household yards, or rubbish that is stored in council facilities or open land areas such as dumps. Cemeteries, discarded tyres, buckets, plastic tarpaulins and even white goods at the dump or at your house are all great breeding spots. (PowerPoint) Here is an unusual photo of an engine with brake fluid found to be a breeding area - wherever there are containers of water.

AAEP is not a permanent fixture or program within Queensland Health - funding has been approved for the next two years of operation. The program is reliant on funding to keep it alive. Because of the life cycle for the program, Queensland Health is looking at a more strategic approach in delivering services to the island communities in the Torres Straits.

By way of strategic planning, Queensland Health is looking at a more ‘hands on’ approach, promoting capacity building for community councils and community people, as well as providing the current service of eradication and surveillance throughout the island villages. Activities such as spraying, legalities of spraying, and the use of chemicals. At the end of the day, when the program is not funded the information is being passed on to the EHWs, and back to the communities to take responsibility for this.

In our current service delivery to the communities, we are involving the EHWs based in the communities. In doing so we are creating community links, working in partnership, education and training (EHW accreditation), and community involvement. Such involvement is community awareness of knowing where we are on the islands – we are well-known in the Straits as ‘the mossie guys’ – which is an example of education in the communities knowing what we do, and what the issues are. There is also a greater responsibility and care (sustainability), healthier lifestyles, it gives EHWs an opportunity to work up their own development plans and how to work in their own communities, develop ideal planning and management practices, and a safer environment.

To date we have had four rounds of eradication treatments on Mabuiag and Masig Islands, and three rounds of eradication treatments on Erub, Mer, St Pauls, Ugar Gaubudth, Warraber and Poruma. Second round eradication treatments have been held at Kubin, Iama and POW.

Other Islands such as Dauan and Boigu have had positive sites for Aedes Albopictus. However, the number of specimens collected was minimal, and did not require an immediate response at this stage. Saibai Island has proven negative to the Aedes Albopictus mosquito. However, surveillance is still conducted at certain times.

We don’t just discard these communities, and they continue to be monitored by our teams”.

QUESTIONS:
Q1. “When you say that at some of the communities there wasn’t a need for an emerging eradication program, even if there were just a few mosquitoes don’t you think a program should have happened anyway”?
A1. Wayne Christian - “On Saibai they haven’t had it yet. Dauan found a couple of larvae, but it was more significant in outer islands”.
Q2. “I am asking about a preventative rather than a proactive approach, even if there was a small population, to stop it from growing”.
A2. Wayne Christian - “Population has a bit to do with it. The decision-makers are ENT Officers who are more inclined to give a better reason for why they do this community rather than another community”.

FOR FURTHER INFORMATION
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A MODEL FOR THE DELIVERY OF ENVIRONMENTAL HEALTH SERVICES ON A REGIONAL BASIS

Raymond Christophers, Nirrumbuk Aboriginal Corporation; Louie Bin Maarus, Regional EHW; Phillip Augustine, Regional EHW
Kullarri Region EH Services, Nirrumbuk Aboriginal Corporation;
Gerhard Ehlers, Townsville Shire Council

Raymond Christophers
“First of all we would like to acknowledge the traditional owners of this country, and we thank you very much for your welcome. Before I start I would like to take the opportunity to present a bit about the Nirrumbuk Aboriginal Corporation.

Nirrumbuk Aboriginal Corporation is a service provider and is a full corporation. We don’t work for the government, though we do contracts for the government. As you may have heard, our leader says that we have to be mainstream, so what Nirrumbuk Aboriginal Corporation has done has been to try and go in that direction.

Here is a map of the Kimberley showing where we are located. It covers an area 300 kLms south and 220 kLms north of Broome.
There are four major communities and 82 outstations (area of 56,000 sq km) in the Kimberleys.

Some of our stakeholders include the communities, Broome Shire Council, Nirrumbuk employees and Office of Aboriginal Health.

I can’t agree with some things said this morning about monitoring and reporting, because we have done the labouring bit. However, you can only do the labouring bit so far, and I think that education is the way to go - the more people are educated, the quicker our job will be.

**WHAT ARE PART OF OUR SERVICES?**

- Monitoring and reporting on EH matters.
- Minor repairs involving water/wastewater.
- Dog Health Program.
- Pest Control Program (Mosquito Control).
- Assist with community projects/education.
- EH-related community cleanups.
- Pre-cyclone season cleanups are a big one for us.
- Training and development is always what we do.
- Maintaining plant and equipment.
- We assist in the education as part of our role.

**HOW WE DO IT?**

We try to employ a person from the community, who is chosen by the community:

- We employ one AEHW in each major community, and we work with that person, giving him full support.
- We employ a three-man regional crew.
- Work is flexible - planned six months in advance.
- Planning meetings involve all stakeholders.
- All our staff are trained in Certificate 3 (even myself, who was originally trained as a butcher - so I had to learn that one).
- All staff are trained to Certificate 3 level in Aboriginal Environmental Health”.

**Phillip Augustine**

“I would like to acknowledge the traditional owners of this country and thank you for having us here.

**MOST OF OUR JOB IS**

- Monitoring - checking on ponds, a contract to maintain overgrowth and check fences, etc. In one of the communities during a heavy season, the rain cut underneath the fence and made a tunnel. Kids got underneath, were chasing ducks into the ponds, and a small toddler got into the water. A day later it showed up in schools that a few of the kids were affected by the water. What we are doing is interacting with health clinics and schools to keep in touch in order to maintain a good standard of health.
- Reporting – as a regional team we look at water sampling. There are cases in clinics where kids suffer from diarrhoea, and one case showed e-coli. We came across two cases of kids with Giardia, so we had to go to schools and talk about germs.

- Pest control – also EHWs are trained in pesticides in the spraying of cockroaches, dogs and mosquitoes in households. In households we encourage people to empty dog bowls, for example. We encourage them to follow normal safety precautions and the use of cockroach barriers, and how birds and animals can be affected by cockroach spray indirectly.
- Community projects.
- We file weekly timesheets to the office in Broome”.

**Louie Bin Maarus**

“Good morning. I come from north of Broome. I would like to acknowledge the traditional owners for giving me the opportunity to speak on their land.

I do the regional crew of three boys:

- Run the heavy machinery (950 cat) used in the program.
- We visit all 82 outstations at least twice a year around the Broome area.
- The four major communities are visited twice a year with assistance from the local AEHW.
- The major part of regional crew time is spent on - EH-related cleanups.
- Pre and after cyclone cleanups.
- Dog Health Program.
- Travelling – eg, 500 km a day to reach a community.
- Gidanka community is a big community of 600-700 people.
- We also work closely with other teams such as tips”.

**Gerhard Ehlers**

“I had the great privilege of working with Nirrumbuk Aboriginal Corporation for a year and a half. I would like to take this opportunity to acknowledge the traditional owners of the area. I was funded by the Office Aboriginal Health, but was stationed in the shire who gave me administration and office support.

My role was mainly that of a liaison person between the various stakeholders such as government departments providing legislative and technical advice/service of:

- Water sampling.
- Disease investigation.
- Food premises inspections.
- Management of pest/vector control programmes.
- Processes applications for effluent disposal systems.
- Assesses community layout plans.
- Education and training programmes for community and AEHWs (education is a passion of mine, as I believe education is the way to improving things long-time).
- Funded by the Office of Aboriginal Health.
- Administration/office provided by the Shire Council.
- EHO focuses on the 2004 survey findings of the Environmental Health Needs of Indigenous Communities in WA survey. Out of that came some core EH issues that needed to be focused on, such as the inadequacies of the smaller outstations. This is where the Nirrumbuk model really came in, as it also serviced
the outstations on an area of 56,000 sqm, which is a huge area. A lot of the government funding and programs focused on the large communities and neglected the smaller outstations, where Nirrumbuk filled that gap. One example I can give is when that survey was conducted there were no dog programs in 60% of the communities, and during the program we found that 74% of households actually had dogs, so you can imagine the health impact. With Nirrumbuk coming on board and the model they used, there is now 100% dog health programs in all communities, including the outstations.

One of the advantages for me working with Nirrumbuk was that it gave me credibility and acceptance into the communities in a much shorter space of time. We did all our planning together and worked as one, to the extent that I felt I was part of Nirrumbuk. Again it was also the access to local historical knowledge and other things.”

Raymond Christophers

“We are required to give a quarterly financial report and half-yearly service report:

- Six months’ forward planning with our stakeholders.
- Communities are informed prior to regional EHW crew visits.
- We bring the EHWs into Broome and hold a planning meeting and go through allocation sheets to get a summary of data of what our core jobs are for the next six months. We did all our planning together and worked as one, to the extent that I felt I was part of Nirrumbuk. Again it was also the access to local historical knowledge and other things.”

“Referring to diagram - here is the summary sheet, which provides a good overview from which we can plan, and covers all the bases in the contract.

MANAGEMENT INFORMATION
- Three-monthly detailed plans for AEHWs and RC.
- Weekly allocation sheets completed.
- Information from allocation sheets tallied cumulatively.
- Summary % for each crew produced.
- Data used to fine-tune service delivery.

PROGRAM STRENGTHS
In the past the service delivery was better for the workers - structure is to fulfill the contract:

- Central Management
  - Removes politics from service delivery.
  - Ensures a uniform standard of services.
- Program is self-contained for
  - Staff – none have left (they are all good men).
  - Equipment – we are applying all the time for equipment.
  - Maintenance – we are learning as we go with maintenance schedules.
- Everyone knows what is happening, and when.
- Delivery can be integrated with other programs for synergies.

I manage two programs - NS team to outstations. The team comprised six originally, but we joined with another team. The new team members are learning, so we are now covering the areas better with cross-training of both teams.

PROGRAM WEAKNESSES –

- Program continuity under threat from.
  - Changing government policies.
  - Relatively short expiry dates.
- Uncertainty over the future CDEP funds – this is a big one for me, as I have been a chair for this. I’ve talked to ICC and it looks like the money that’s there will only help me to prop up service men, but not the EHWs – may not be CDEP-subsidised in the future.
- No provision for depreciation of capital items - if you are running a real business you need to be able to do that, and we need to continue to work on this to get it - our machine is a $300K value machine. Gone are the days of pick and shovel, and we need to have this sort of machinery.
- Program focuses ‘outside of fence’ – the education part of getting back inside the house and educating people about the small things. The speaker this morning had a good point about the small stuff like leaking taps.

CONCLUSIONS
- Well-trained staff is a most important asset, and it is important to me to make sure that they get the support.
- Refresher training courses are important.
- Model delivers an efficient service.
- Model delivers a cost-effective service.
- Our model can be copied or expanded anywhere.

Our recommendation to government is for government to combine Environmental and Municipal Services under the health umbrella. Their core business is housing, not health, and CHIP funding should go to health which would protect EHW funding. We are happy to talk to anyone about this program and provide advice to help others set one up for a small fee, of course. Thank you.”

CANNING THE DUMP – RECYCLING IN A REMOTE CAPE YORK PENINSULA ABORIGINAL COMMUNITY

Brad Milligan, Eddie Bobongie, Tropical Population Health Unit Queensland Health

“On behalf of Eddie Bobongie and myself I would like to acknowledge the traditional owners, the Irukandji People and Elders, and thank the conference organisers for their invitation to come and address the conference. We are here today to talk to you about our recycling program which we set up in the Cape York Peninsula”.

Eddie Bobongie

“With this program ‘Canning the Dump’, the backbone of this program was the EHW at the community. Like Stephen Canendo said, people like us Indigenous EHWs, we are the leaders in that community. In my position as a District EHW I lead the way and
then let them run with it, but I come from behind and support
and assist it, and provide professional advice. People like Brad
work with me, and are also a driving force. When we go to the
communities we see big mounds of cans at the dump site. So one
day we sat down with a plan and asked where all the cans come
from. They said they came from the canteen, so people must drink
a lot of alcohol to have so many cans in the community.

We then approached the council and talked to them to make them
understand that the program would help the community. We
convinced them to start the program. The next step was to tackle
the people about where the cans were coming from, and we talked
to the canteen manager. We explained that we were going to start
the program and he agreed to it as well. The next step was to
approach the recycling company in Cairns to get resources like wool
bags to put the cans in. Luckily we didn’t have to crush the cans, so
this made things easier”.

Brad Milligan

“Thanks Eddie. As Eddie said, the program evolved after a few
trips to the communities. Over a period of six months we watched
the dump triple in size, with the majority being aluminium and steel
cans. We spoke with the EHW at length, and then with the Council,
and made a commitment. Interestingly, we estimated that about 70% of the dump was aluminium or steel cans, but when we got
down to the ‘nitty gritty’ we determined that the community was
disposing of around 50000 aluminium and steel cans per month - a
huge amount of waste.

This was one of the things that made us look at the dump. There
was poor management, and as we wanted someone to take
ownership of the dump, the EHW put his hand up.

Why choose waste management in the community? There were a
couple of reasons. It was very cheap for us to get a basic program
operational. We actually asked for no money from the council, and
no-one else provided any money to get the project going, which
made it easy for council to support. Council was happy for us to
help try to do something if they didn’t have to put any money in, and
we could achieve a visual difference at the end in the community.
The council had very little knowledge of environmental health, and
didn’t have any EHW working there in the past, so some of the
conditions were pretty bad. As I said, we estimated the dump area
tripled in size from 2004 to 2005. Seventy per cent of waste was
aluminium cans, with no dump management strategies.

HOW DID WE MAKE IT WORK?

- Basically by recycling the cans. Transport and storage were the
  key issues we needed to address.

HOW DID WE DO IT?

- We made an agreement with the recycler in Cairns to supply us
  with some bags. He initially didn’t want to support the program
  as the bags supplied cost them money (they had sent bags out
  in the past which had not been returned). Eventually we were
  able to talk him into it.

  - The wool bags fold down to almost nothing, and contain about
    30 kilos of cans.

- We send 30 bags down at a time, and in fact Eddie is
  constantly chasing the recycling company for more bags for the
  EHW on his behalf.

Of note, the recycler requested that the cans be returned
uncrushed, so that was a bonus for us to try to convince
the community to take the project on. They didn’t need to have
someone sitting there crushing cans. One of the barriers is the wet
season, and transportation of the cans which are moved on a truck.
Another bonus is for trucks carrying loads in can now take bags
of cans out, so they don’t have empty loads. However, with the
wet season we also have had to identify a storage place near the
canteen to store the bags.

COLLECTION

- We struck an agreement with the canteen manager at the
  source to separate the cans, collect them at the end of the
  night, and deposit them into the bags, rather than dump them
  at the tip.

- We have also looked at future expansion to households, but to
date this hasn’t kicked off.

- Council is looking at incentives for kids to be involved for
  collection days such as barbecues and prizes, but this hasn’t
gone forward as yet.

BENEFITS OF RECYCLING CANS

- Money comes back into the community to be used for activities
  for kids and adults.

ACHIEVEMENTS

- 100 bags of cans back to Cairns for recycling, which is a
  massive step forward for the community.

- Now able to control the local dump (reference to a diagram
  in 2003 in comparison to 2006) and got on top of their waste
  management.

- Best thing has been the acceptance of EH by the council of
  how important it is to the community and health.

LESSONS LEARNED

- Many contracts were made verbally (which can go to the side
  sometimes).

- There was an issue with council not being paid their money by
  the recycler, but this has been resolved.

- It is a good project for the community to see the effective work
  of an EHW, and the importance of EH in the community.

- Storage of aluminium cans especially in the wet season is a
  challenge, as aluminium cans are great mosquito-breeding
  containers, and a fair area is needed with dedicated coverage
  for the stored bags which are 1cbm in size.

- Bag alternatives may be needed if they run out or cannot be
  delivered due to the wet seasons – eg, bulk material bags.

COSTS

- Very low costs – just an investment of time by Eddie, the
council, the EHW and the community.

- Obtaining goodwill service providers.
FUTURE
To look at implementing this program at other communities in Cape York.

QUESTIONS
Q1. “Have you considered extending this project of recycling to other products like plastics”?
A1. Brad Milligan - “Yes. This was the first step. However, there is a problem with plastics. As you know, a lot of dumps regularly get burnt so it is an issue, but we can certainly look at it - concentrating on separation of items at the household”.
A1. Eddie Bobongie - “We have introduced into the community brown paper bags at the store to get rid of plastic bags, as they are no good for our land and our sea”.

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WORKING TO IMPROVE WATER AND SEWERAGE PROVISION IN DISCRETE ABORIGINAL COMMUNITIES IN NSW: MURDI PAAKI REGION CASE STUDY
Thaddeus Nagas, David Ferrall and Stephanie Smith,
Greater Western Area Health service

Thaddeus Nagas
“I would like to acknowledge the traditional owners, Irukandji people, and any other Elders present – it is great to see such a great turnout. Our presentation will be covering two parts. It will explain the work being carried out in NSW and within the Murdi Paaki region, which is the area in which David and I work”.

Stephanie Smith
“Public Health Units across NSW have reported ongoing problems with the operations of water and sewerage systems in Aboriginal communities. Project Managers often come to ask for financial assistance with sewerage, for example, as these issues fall outside the Housing for Health program. The Aboriginal Environmental Health Unit has been unable to provide assistance in an ongoing manner, so the Unit has had to sit back and work with government agencies to work out what is the core of the problem. How can we work from a government perspective to assist communities? One of the options that came up was to expand the Colisure drinking water monitoring program, but the issue arises, why monitor if you can’t fix? Across NSW we don’t have a state-wide program to rectify these issues.

COMMON ISSUES
• Outfall from an unmaintained common effluent system (sewerage ponds) discharging to a creek.
• Septic tank damage.
• Waste from trenches overflowing in a back yard.

Stop-gap measures are commonly implemented that are unsustainable – financially, environmentally, and for public health. For example, a sewer well was manually pumped out by one individual for over 12 months before the pump was repaired.

Water supply infrastructure needs to be protected and requires regular maintenance.

Some discrete communities are dependant on rainwater.

Water quality monitoring of community and private water supplies (eg, tanks) is often undertaken on an ad hoc basis.

ACTION TAKEN
• NSW Aboriginal Community Water and Sewerage Working group was formed.
• An issues paper was developed.
• Main aim - that all Aboriginal communities in NSW have access to safe, sustainable drinking water, and functioning sewerage systems.

An example of the number of people around the table - NSW Group Representatives:
• NSW Health.
• Public Health Units (GWAHS and HNEAHS).
• National Indigenous EH Forum (enHealth).
• Department of Aboriginal Affairs.
• Department of Commerce.
• Department of Local Government.
• Department of Energy, Utilities and Sustainability.
• Department of Natural Resources.
• NSW Aboriginal Land Council.
• Public Interest Advocacy Centre.
• Local Government and Shires Associations of NSW.
• NSW Water Directorate (Walgett Shire Council).
• Federal Department of Family Community Services and Indigenous Affairs.
• NSW Aboriginal Housing Office.

The group asked who were the most vulnerable communities that needed their focus. It is very important to involve peak community organisations and the Local Government and Shires Associations.

It was decided to look at discrete Aboriginal communities using the CHINS definition which identifies those discrete communities as geographical locations inhabited mainly by Indigenous communities with housing or infrastructure that is owned or maintained on a community basis.

There are 66 discrete Aboriginal communities in NSW. They receive water in one of two ways - either to the boundary of that community, or by their own water supply, bore or septic tanks. Of the 66, the majority of them received water to their boundaries from utilities, with only about 20% managing their own water. However, in terms of sewerage, over half of the communities have to manage their own sewerage systems.
ISSUES PAPER FINDINGS
Preliminary desk top analysis (that did not involve field work):

- 61 Aboriginal communities are likely to require ongoing assistance with the management of their water supplies.
- 58 communities are likely to require assistance with their sewerage systems.
- Broad costs - $3 to $5 million per year (on operations and routine maintenance only, it does not include capital upgrades).

THE PAPER CONCLUDED THAT

- The roles and responsibilities are unclear amongst government and communities.
- Mainstream Government support services currently have limited capacity to support LALCs.
- Many rural Local Government councils are financially challenged – particularly those rural or remote who struggle to upgrade their capital infrastructures.
- There is a skills shortage in rural communities (health and building, engineering, plumbing, electrical). For example, in Bourke there is only one plumber and no electrician.
- Limited technical and financial capacity within LALCs.

KEY RECOMMENDATIONS OF THE PAPER

- A state-wide recurrent funding program for operation and maintenance.
- A public health risk-management system to improve the monitoring, such as developing site-specific tools.
- An Aboriginal traineeship program to build capacity in the operations and maintenance to reduce skills shortages.
- Improved state government technical support and advice to LALCs in the management of their water and sewerage systems.
- Need to base this on partnerships and the program needs to be flexible”.

Thaddeus Nagas

“Water and Sewerage Operation and Maintenance Program in the Murdi Paaki region is:

- Funded by NSW Department of Aboriginal Affairs under the Two Ways Together initiative.
- Auspiced by Murdi Paaki Housing in partnership with PHU at Broken Hill.
- Program funded over six years.
- Coordinated by a licensed plumber, with operational and strategic support from the Broken Hill Public Health Unit.
- Targets communities on Aboriginal Land Council Land where they are not adequately addressed by local government or similar.
- The plumber works well with the community.

DEMOGRAPHICS

- A huge area covers the former Murdi Paaki ATSIC region (approximately 303,000 sq kims) - impacts on travel time and the size of the team servicing the area.
- 57,680 people live in the region (about one person for every 5 sq kims).
- 7,846 Aboriginal people live in the region (14%). In comparison, the Aboriginal population of NSW is 1.9%.

THE COMMUNITIES

- The Program targets 12 communities on land owned by Local Aboriginal Land Councils.
- Most communities are former missions that have had ownership of the land transferred to them under the NSW Aboriginal Land Rights Act.
- Water and sewerage infrastructure ranges from being connected to local council services, to having independent systems, or a combination of both.

PURPOSE OF THE PROGRAM

- To monitor, maintain and repair water and sewerage services to communities on LALC Land (once it got to the boundary because of money, and Councils thought money was going into the communities - this was a misinformation issue that has now been overcome.
- Not for household plumbing problems (that are normal housing provider responsibilities).

THE TEAM

- The maintenance team comprises the Water and Sewerage Coordinator and two Aboriginal plumbing apprentices (which is fantastic).
- The team covers a lot of distances and therefore spends a lot of time away from home.

MAIN PRIORITIES AT THIS STAGE

- Public Health Unit’s role was engaging with LALCs and Local Government to become a face for people to phone. We are also able to be contacted through the housing provider, Murdi Paaki.
- Three-monthly surveys of communities.
- Rapid response to water and sewerage breakdowns.
- Routine maintenance and modifications in houses in the communities.

SOME OF THE USUAL PROBLEMS

- Infrastructure breaking down.
- Overgrown effluent ponds.
- Burst water pipes (before in most communities there was no expertise to replace or repair, but now people can just contact us).
- Poor water pressure.
**Benefits**

- Provides timely response to community concerns, working for our mob and making our people healthier and stronger.
- Improves health and safety.
- Identifies systemic problems.
- Preventive maintenance.
- Off-sets R+M costs.
- Improved networks and communication*.

David Ferrall

"WHERE ARE WE GOING? WATER QUALITY MONITORING PROGRAM"

**Two Parts to the Program**

- **Colisure Program** for communities with an independent water supply (groundwater). Monthly verification samples taken by the Public Health Unit.
- **NSW Health Drinking Water Monitoring Program** used for communities connected to town supplies.

**Colisure Program**

- Operates in two Murdi Paaki communities, and is a field test.
- Field results which are run by a community person are faxed through to the Public Health Unit every fortnight – there are also visits to the community to take verification samples, which are also sent for analysis to be assessed against the Australian Drinking Guidelines.
- Enables problems to be identified early.

**Access for Water Sampling**

- Sampling points have been installed in communities connected to town water supplies, with the permission of the communities involved.
- Provided easy access point for sampling.
- The results of these are web-based databases, and provide feedback to the community on water quality.

**Recent Upgrade**

- New pump station and gantry has been installed, but with no ongoing maintenance program it may result in it returning to a poor condition.

What we are looking at doing at the moment is

**Current State of Play**

- Signed agreements with Shire Councils, Land Councils and Local Government to maintain the infrastructure on land council land.
- All communities but one have sewerage pumping stations, and are the biggest source of problems as far as breakdowns go, so we are now looking at trialing Telemetry systems to enable rapid responses. This will reduce the risk of environmental harm by sewerage overflows into the environment. We are currently trialing one, and looking at rolling it out to other communities.

- With the service agreements we will be able to obtain an estimate of costs to provide repairs and maintenance upkeep. We will be able to inform the Working Groups on how much it does cost to provide these services to the communities.
- Looking to incorporate traineeships in Water and Wastewater Operations into the service agreements. This should develop local capacity such as qualifications in water and waste water infrastructure. Councils are keen to do this as there is a skills shortage in these remote areas, leading to difficulty in retaining or attracting staff.
- Water management plans being developed based on community water planning tool - a resource for community to manage risks that exist.

In summing up, despite various capital upgrades over the years, there has been no routine maintenance of water and sewerage infrastructure undertaken on LALC land in the region. Service agreements with local governments are the most practical option, given there is already an existing workforce and the close proximity of these communities to local council services (in most cases).

This also includes services such as rubbish services, and not just sewerage and water services.

This program is only a stop-gap measure. It is essential that recurrent funding is made available in the longer term to ensure that the gains made to this point are sustained. This gets back to the issues identified by the Working Groups. Hopefully they will develop strategies with long-term solutions and provide infrastructure in these communities to the same standard of those in the mainstream communities*.

**For Further Information**

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FOOD SAFETY, ANIMAL & PEST CONTROL PROJECT

Alan Blackman, Chris Gyemore and Dallas Einsiedel, Southern Population Health Unit Network Queensland Health

Chris Gyemore

“I would like to acknowledge the traditional owners of this country again. For those of you who don’t know Dallas, Dallas used to work for the Brisbane North Population Health Unit, and is now at our Brisbane South Side Population Health Unit, which covers South Brisbane. The area of Southern Area Population’s Health Service covers a wide area which includes:

• Gold Coast.
• Brisbane South.
• West Moreton.
• South Burnett.
• Toowoomba.
• Darling Downs.
• Charleville and Roma HSDs”.

Alan Blackman

“Good afternoon everyone. Welcome to the Sixth National Aboriginal And Torres Strait Islander Environmental Health Conference. I would like to acknowledge the traditional owners of this land, the Irukandji Peoples. The slide you see there shows the areas I service - the Charleville and Roma Health Service Districts - and in particular St George and Mungindi, those that we will be focusing on.

WHY DEVELOP/IMPLEMENT THE PROJECT?

Identified a need through:

• Consultations.
• Local Governments and other relevant services and agencies.
• Health Workers.
• Those employed by Queensland Health and AMSs.
• Community members across the Southern Area Population Health Service.
• EH issues within home environments”.

Chris Gyemore

“The point I want to make is that within the area we have to utilise health workers in the communities, because we have no EHW workforce. HWWs help to advocate on behalf of us and help organise workshops, as contacts in the communities. We put a little of EH in there, as they help advocate for us as well. I know we are healthy workers and overburdened with normal work duties and responsibilities, so we don’t want to impose too much, but they can help out. They know the community as we don’t. We mainly know the service providers. Another difference, too, is that we recently had meetings in Brisbane. The thing that stands out a lot like in communities like Cherbourg is that they have these infrastructure problems. However, it is different working with Councils such as Toowoomba or Roma City, as they are non-Indigenous councils. Therefore, we have to be sensitive as to how we talk and approach them. We have to be professional. Joke with the ones you can joke with.

It takes up a lot of time but I think people generally appreciate you dropping by. Even if the councils or local governments don’t have much to do with the workshops or whatever, you need to be respectful, as you are in their community. Acknowledge that you are in their community trying to do work there.

With other communities you might have infrastructure problems. Most local governments in our area have safe drinking water and essential services taken care of, but most issues are actually in the home environments. If we are going to be promoting or educating people we need to target people in their home environments, and that is therefore harder to access. For example, in Cherbourg you can tap directly into the families through the kids at schools. In Toowoomba there might be three families in one area that don’t talk to another group, so we have to be careful when accessing the different groups without offending people - we need to be sensitive to cultural issues and be fair to everyone.

WHAT/HOW/WHERE DO WE DELIVER?

The area of Roma Health Service District are:

• St George (1700 population) and Mungindi (500 population) (Roma HSD).
• Many indigenous people are also located in metropolitan areas, but are hard to contact.
• Delivered to 10-15 participants x 2 hrs (CDEP).
• Target groups - (HWWs and Community members - CDEP).
• Relies heavily on HWWs and other relevant services like in St George, linking in with the EHO. Let them know if you are in their community out of courtesy.
• Alan and I have reached the stage of developing our own flyers and relevant information sent on to local organiser, so less work for the HWWs. We try to do the flyers, contact numbers of HWWs, and we can send things out to them.
• Provide meals/light refreshments to encourage increased participation.
• Evaluate understanding during or after information delivery.
• With small numbers it is pretty easy to engage with – it is important to take the time to yarn and listen.

Topics/areas covered in these workshops are all very important and include:

• Temperature and food - eg, food left out.
• Safe food shopping – eg, labelling, expiry dates.
• Safe food storage – eg, if bought in the shop, the need to take into account travelling time.
• Food preparation – eg, handwashing, how you prepare food such as raw foods and vegetables.
• Cooking and reheating food.
• Animal and pest control”. 
Dallas Einsiedel
“I would like to acknowledge the traditional owners of country. When we go into the community we also talk about the danger zones regarding germs, temperatures and how to store different kinds of food. Benefits and outcomes range from being able to provide:

- Increased EH services to communities such as running workshops.
- Coordination and collaboration between Services.
- Increased knowledge and awareness of EH to Councils.
- Increased knowledge and awareness of EH to Health Services.
- Increased knowledge and awareness of EH to other relevant organisations/services and agencies.
- Certificate of Participation/Attendance at the end of workshops as self accomplishment.
- Take home resources as reminders/positive messages – eg, flyers, pamphlets.

Our flyers and workshop papers that we have designed can be adapted for other communities’ use”.

Chris Gyemore
“The presentations and flyers we have designed include topics such as food storage and presentation, safe food shopping, and safe food storage. It is good environmental health information for our communities. If people understand more about EH work and what our role is, we will have more support from the community and will be more likely to advocate for EH. We are also working on developing a workshop on nutrition.

So that is our presentation. We have a resource here we use in our area which covers temperature and food, and is valuable information for health workers and services. You can deliver talks to the health teams and inform them of EH and the work we do, discuss how they can work in with us at the different levels, and community members get some benefit out of it as well”.

QUESTIONS

Q1. “When you are working in a major community do you get much involvement with local government EHOs to bridge the gap type service”?

A1. Chris Gyemore - “As we mentioned earlier, we do it on a regular basis anyway and call in and see the local government EHOs as a courtesy as well. We let them know if we are going to be there for a couple of days, and let them know what we are doing, such as workshops. They get an invite to come along as well”.

Q2. “Are they interested in coming along”?

A2. Chris Gyemore - “I think at certain times, yes. It depends on how busy they are, eg, involved in rubbish clean up”.

Q3. “I can see the possibility of EHOs with a busy schedule and lack of services to Indigenous areas; programs like this are good for them to interact with Indigenous communities.”

A3. Alan Blackman - “In Roma Health District we did find a bit of difficulty in communication between the Indigenous community and local government, but through Chris and other people this was overcome and now it is a great success, leaving personalities at the door and getting on and fixing up the community”.

Q4. “Is there a problem with education in black communities? Do they get the information and hold it”?

A4. Chris Gyemore - “That’s what it is about, especially from the home environment and with Indigenous HWs out there. Hopefully they can run with it in schools and the community after we have left. We hope they continue on with it after we have gone.

A4. Alan Blackman - “We have devised a questionnaire post-workshop, to ensure people we talk to know what we have been talking about. With CDEP it was initially difficult to get them to come along, but we have now introduced a certificate to show they have attended the workshop. It is working, and there are no complaints about it, and it definitely benefits them”.

A4. Dallas Einsiedel - “We don’t use the evaluation at the end of the sessions. We prefer to answer questions then and there, so there is an evaluation right through, so it makes it a bit more relaxed”.

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REMOTE COMMUNITY WATER MANAGEMENT PROJECT
Robyn Grey-Gardner, Desert Knowledge Cooperative Research Centre with Families, Community Services and Indigenous Affairs and the Centre for Appropriate Technology

INTRODUCTION
All Aboriginal communities need a water supply that has an adequate amount of good quality water that meets the purpose for which it is utilised. An unreliable or inadequate water supply may lead or contribute to health problems for residents or prevent livelihood opportunities. The most important factor for water provision, however, is maintenance. This paper describes the principles of the risk management approach, and the implementation practices developed during the Desert Knowledge CRC’s Remote Community Water Management Project.

The Australian Government Department of Families, Community Services and Indigenous Affairs and the Centre for Appropriate Technology were partners in the project who engaged five small remote Aboriginal communities to develop their own water management plans. The community water management plans were based on risk management principles, and were designed by and for the communities themselves to carry out. Support materials or resources to assist with ongoing maintenance were developed specific to each community. The paper describes the
resources, which outlines the hazards and risks to each water supply and how often maintenance activities are required. The project’s implementation process provides important lessons for the uptake of similar programs to improve water supplies through better management in remote Indigenous communities.

THE RISK MANAGEMENT PROCESS FOR SMALL SYSTEMS

The risk management approach is the accepted guiding principle now in Australia and around the world for water management (Australian Government 2004, World Health Organisation 2004). The risk-based approach is described in the Australian Drinking Water Guidelines’ Framework for the Management of Drinking Water Quality (Australian Government 2004). It is a comprehensive process with 12 elements, or stages, that is based on the following steps described by Naudebaum et al 2004:

- Understand the water supply system.
- Identify hazards, hazardous events and sources.
- Estimate the level of risk for each identified hazard or event – consider the likelihood and consequence/impact/severity.
- Identify and plan preventive measures for each hazard or event, and implement and monitor preventive measures - (establish critical limits and monitoring systems, corrective action and verification procedures and documentation).

The Framework covers all aspects of the water supply system from the catchment or source (such as a bore), to storage (such as tanks), treatment processes (such as chlorination) and distribution system (such as pipes) to the tap where it is consumed. The approach has the capacity to be applicable to large systems such as a capital city water supply. However, this project found that it is equally applicable to small systems. In the case of small systems, there are generally fewer regulatory procedures and people involved in management because the system is less complex.

MAKING WATER MANAGEMENT RELEVANT

The project worked with five small remote Indigenous communities. The communities were Kanpa (WA), Port Stewart (Qld), Yappala and Worro Downs (SA) and Mpwelare (NT). The communities all had the primary responsibility to manage their own water supply, and as such did not have a water utility or regional area service provider to oversee maintenance and water quality testing. Each community also had a strong purpose or livelihood such as tourism, breeding camels or cattle. The continuity of the community livelihood activities also had a strong purpose or livelihood such as tourism, breeding camels or cattle. The sustainability of the community livelihood activities provided a strong incentive for the communities to keep their water supplies maintained. All communities fulfilled the most important basic principle of the Framework, which is a commitment to the management of the water supply.

The project identified a way of making water management a priority for communities by broadening the risk management approach, which is specific to water quality; to include the management of water quantity and understanding the water required to fulfil community aspirations. Put simply, the project aimed to work with the communities to ensure the water is adequate for the purposes for which it will be used. For example, is there enough high quality water for the residents to drink, and enough lower quality water for stock to drink?

The project also used the risk management resources currently available, and used adaptive strategies to make the process relevant to the Aboriginal community context. The Community Water Planner (CWP) (Australian Government 2005) is a CD which can create a water management template using risk management principles. The CWP is a reliable method to outline the potential risks to a water supply and suggested preventive activities. The CWP can be updated and used as a water plan by itself. However, we found that its format is best suited for people who have computer skills and an understanding of technical terms. The community members involved in the project had a preference for the information to be simplified and targeted to their individual circumstances and needs.

IMPLEMENTATION OF WATER MANAGEMENT STRATEGIES

The risk to a water supply is highest when there is no maintenance. A water supply that is not maintained will, eventually, break down. The risk management approach endorses preventive measures and multiple barriers which, when developing the water management strategies, translated into quite simple monitoring activities. Preventive measures are activities that reduce the hazards. Multiple barriers are points to stop contamination from spreading throughout the water supply and reaching the tap. A preventive measure may be to check that a fence around the catchment or bore site is intact. It is a barrier to stop animals from accessing the catchment area or bore site.

Another barrier further along the water system may be valves installed in the pipeline to prevent backflow. These relatively simple measures can have a big impact on maintaining water quality.

To prevent problems in the future, each community worked to make their own water management plan. The plans were developed over a period of a year during meetings and workshop activities, and involved four steps outlined in Figure 1. The first step was to survey the water supply and take water samples for microbiological, chemical and radiological testing. The water quality and survey results were presented and discussed with each community. The participants then analysed the available information and ranked the hazards and potential risks. The most effective activity was walking along the water supply system, talking about the positive and negative aspects of the supply. This activity created a good atmosphere to demonstrate problems and think through the practicalities of solutions on the spot.

This process of sharing information, ranking and prioritising hazards and making rectifications to the water supply built the capacity in each community about water management practices and principles. This information was matched to the community’s water needs and aspirations. The Sustainable Livelihoods pentagon (IDS 2006) was a useful tool for assessing the community’s available assets and capability to manage the water supply. It enabled community members to identify their available assets (human, financial, social, physical, and natural) that could be harnessed in implementing their water management plans.
The management strategy development included identifying improvements to the water system, and appropriate management responses. Activities to reduce the risk to each water supply were actioned as part of the learning process for participants, and included fencing and concreting around the bore, burying pipes to prevent damage from fire or cars, and cleaning up rubbish.

**Figure 1** The four steps to create a water management plan

### MANAGEMENT AND MONITORING ACTIVITIES

All communities already had a good understanding of the basic operation of their water supply. Developing the water management strategies, however, allowed the community members to identify gaps in their knowledge and what support may be needed for future management. Monitoring activities are clearly outlined in resources such as log books, posters and manuals, and were developed according to the needs of each community. For example, Yappala and Worro Downs wanted step-by-step manuals that showed their water supplies as a schematic or basic map, with photographs of key points and a description of the characteristics of the system. The manuals outlined tasks that should be completed as routine or weekly, and other activities that should be completed six-monthly or annually. The layout is useful because activities are clearly described, and water system points can be easily recognised.

The anticipated recurrent costs for the water supply infrastructure and guidance for asset management was also included in the Yappala and Worro Downs manuals along with contact sheets and directions for emergency procedures. Water quality problems are often triggered by sudden changes such as high rainfall events or equipment failure. It is important to foresee such events, and recognise what procedures are necessary during these times.

There was a range of resources developed during the project. In some communities the resident population changes, so efforts to provide information about how to carry out maintenance procedures or what to do when unexpected situations arise (such as a reduction in water pressure) were described in posters as flow charts or decision trees, with photographs depicting key components such as a power box or a pump. The posters were displayed at key locations around the communities, so they are visible when needed, and act as a reminder at other times.

Early in the project a full suite of water tests were conducted to assess the supply. Apart from any emergencies, it should not be necessary to regularly test the water supplies. It is cost-effective and appropriate to ensure that the risks are reduced and preventive maintenance is carried out. The community residents have been trained to chlorinate dose their tanks, and would be able to send samples off to the laboratory if required. However, this would only be necessary under extreme circumstances – such as if many people have been sick and continue to get sick after the water supply has been treated. Kanpa is using a hand-held kit to test their water quality for parameters such as pH, Total Dissolved Solids and temperature. These tests will enable the community to create a baseline of information to see whether there are any changes in water quality over time. Changes in the water quality should trigger a response from the community since a change in pH, for example, may mean that the water quality is deteriorating or warn that the pipes may corrode.

### WATER USE

All case study communities had no means to accurately measure how much water they used. During the project, some rough measurements were taken by calculating how often a storage tank with a known capacity was refilled. This provided a basic understanding of the water usage patterns. A more comprehensive understanding of water use patterns is needed for sustainable water management. Four of the five communities installed water meters so community members would be able to keep track in future of the amount of water the community was using, and to better understand the seasonal trends. Water meters can also be used to indicate leaks in the water system.

### THE HOLISTIC APPROACH

The Remote Community Water Management Project successfully engaged five Aboriginal communities to understand the principles of risk management and create management plans to maintain the integrity of their water supplies. “What we learned from the project is that little things can turn into big things. Small things need to be fixed because they can have severe consequences sometime later on” project participant, Rex McKenzie, Worro Downs.

The process is not complicated, but is staged. Meetings and water management plan development procedures are well spaced allowing time to ensure that the fundamental principles are well understood by participants. The staged approach proved beneficial because community residents were able to continue with other commitments, and between meetings talk among themselves and generate greater community resident involvement. Early in the project, for example, there was a core group of people in each community who were interested in the project, and driving the process. Once the benefits of the approach and the management strategies were realised there were more and more people in each
of the communities who volunteered to participate in the project. Project participant from Yappala, Leonie McKenzie summed up this experience when she explained “There is pride in having the knowledge about the water supply and everyone is more involved now”.

The holistic approach – incorporating water quality, quantity and the use of the water can provide a basis for communities to make sustainable choices. Project participant, Preston Thomas said that “the information and capacity building has helped the community to understand what aspirations are realistic and the limits to growth for Kanpa”.

The water management plans are the beginning of a regular monitoring and maintenance regime that, combined with an annual review program, will continually improve the water supplies in each of the participating communities. Water risk management cannot eliminate hazardous events, but a methodical approach to planning will certainly reduce the risks and dramatically improve the chances of a timely and appropriate response from community members when needed.

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“TE RIU O HOKIANGA ENVIRONMENTAL HEALTH THROUGH MĀORI COMMUNITY DEVELOPMENT.”

Maria Hepi and Marara Rogers, Institute of Environmental Science and Research Ltd and Hauora Hokianga Health

Marara Rogers
“I would like to acknowledge the traditional peoples of the land and Elders. It is a privilege to stand here with my Elders behind me to meet with you. Thank you to those who organised this conference, and who allowed us to come and share what we do in New Zealand. This project – here is a picture at the back – is a picture of the ocean where we get the fish, seafood, muscles, paua (abalone) - you name it, we have it, but we could lose it with pollution that is flowing into our seabeds.

There are a number people involved in this project from all over New Zealand:

- Te Riu o Hokianga: environmental health through Māori community development research design – (evolving world of kaupapa Māori research);
- Reflections on a bi-cultural partnership.

Our presentation will cover:

- Background and significance.
- Mahinga kai (food gathering) impact.
- Marae onsite waste water management project.

Health Research Council (HRC) three-year research project

- Background and significance.
- Mahinga kai (food gathering) impact on our environment of human wastage going into our water ways.
- Marae onsite waste water management project.

ESR and HHEET Partnership – Contract with HRC Research, Kaupapa Māori, action/participatory

Hokianga Health Organisation service 6,000 people, who are predominantly Māori people. We have community clinics and 36 marae catchment area – this project is about how to keep people safe on the marae. For example, farmers and cows crossing creeks. Māori have a different way of looking at the land - we see our genealogy, the sacred past, ancestors, our marae, ourselves, and it is the living future of our people.

The Project started as a result of the marae people to look at how they could work on their ablution blocks that were no longer able to take the capacity of visitors who came there. We are tribal people, with the Ngā Puhi tribe and Te Rarawa tribe either side of the catchment area. There are 36 marae, most of which are carved.

As Hokianga Health we went to ESR to ask how we could help these people. Together we put a proposal to the Health Council and received funding for three years to look at barriers for Māori people on their marae.

The outline of the project research, community development, relationships and outcomes.
RESEARCH
Marae – “state of the art” – capacity, lay of the land, type soil, system design, health protection, food safety, Auahi Kore, water supply, streams, use of streams, grey matter.

COMMUNITY DEVELOPMENT
Marae project management, informed decision-making, dynamics of whanaungatanga, skills development, maintenance programme, oral histories/preserve historic memories, take responsibility to reject pollution, support restoration.

RELATIONSHIPS
Runanga – Te Rarawa/Ngapuhi, FNDC, Funders – ASB/lotteries/other, system tank design and suppliers, WINZ (Work and Income New Zealand), Marae Committees, Kaumatua tautoko, educators.

OUTCOMES
Population health, capacity building, intersectoral cohesion, Marae project outcomes achieved, sustainability.

This is a Marae - a meeting place for Māori - where we celebrate occasions such as weddings, meetings, etc. It is used in many ways, and has sleeping facilities. Marae can be carved, or modern in design.

Marae site design features dining room, gift room, kitchen block, meeting room, sheds, chiller, outdoor fire places (originally were internal) and an ablation block.

Taumata Kakenga:
• Whānaungatanga (relationship building) with anyone who can help.
• Inter-agency collaboration.
  – Tribes: Ngā Puhi and Te Rarawa (two tribal areas), regional and local council, health provider, funding agencies, government agencies.
• The research supports the goal of improving marae on-site wastewater systems, but is also about the processes of how Māori can work with outside organisations to address environmental health problems.
• It is also about a process we went through, too.
• Built on prime land and belongs to the people, and was built without building consent. However, legislation has now come into place having an effect in terms of building and resource consent. Therefore, if they want a new ablution block, they need to go through Council to comply with regulations such as inspections and design, all of which costs money.
• Therefore, they needed to start fund-raising in order to pay for the engineer, drawing of plans, and we help them by breaking down these barriers with Council.

PROJECT RELATIONSHIP TREE

There was a struggle to meet all these organisations’ requirements, so we have become the ‘in-between negotiator’ so we can support the Marae trust. There are two pricing categories for building consent, and Marae have been classed as ‘commercial’ so they are charged $200 to $300. This is because people in Council have no idea what a marae is or what its needs are. Council sees the marae as a tourist attraction, like a camping ground, but nobody pays to be on the marae - no fees are charged. Therefore, we are working with Council to determine another category for marae and churches. One of the things we have done is to bring the people from the various agencies to talk to the community on to the marae, so they can experience the rituals of encounter, which is led by the marae people, the use of Māori language and their hospitality. The marae has a flat structure, with no dominance in the room when we have a discussion. So we are giving them that experience, and also teaching them about humility, because they don’t hold the trump card after all – we do as a people.

TAUMATA KAKENGA KAHUKURA – THE AIMS
• Self-determination.
• Capacity building.
• Best practice model.
• Multi-agency working together – still breaking down barriers and coping with staff changes.
• Environmental cleanliness – fighting it still, ablation blocks tend to leak and people walk it through into the dining room and spread disease, but we haven’t got evidential information that they got sick - but we know from public perspective it is there. One marae major outcome for us.

The above are the aims of self-determination. For example, we have one marae that received $1M to get more money from government. They had to design a business plan, eg, of self-determination, so they are actually learning about how to do that. The money comes to them and they use the money as wisely as they can to get through the business plan. It is interesting there is no ‘big brother’ person at the top here, handling their money or being their fund-holder. That’s another capacity-building outcome for the people. Many of these people are unemployed, so learning. The funder wanted a good outcome and the people had the ability to do research projects on their own. This project has given us that opportunity to have one community member complete her Masters, and I will complete mine next year. I won’t be likely to leave the community, so the skills will stay in the community.

We are still fighting environmental cleanliness. The marae area themselves want to be sure that people are not picking up the pathogens and the E.coli because the current state of marae ablation blocks is such that they tend to leak and children and adults are walking through it to the dining room and they are carrying these things around on their shoes or their hands so it is spreading. However, we have no evidential data to say that people who go to a marae get sick, because when the party is over the guests go back to wherever, and they will see their own doctors if they are feeling sick. However, we know from a public health
perspective it is there. We have developed a road map for other marae to follow before they begin their projects. Funders require the title of the land, registration documents, records of meeting minutes and AGMs. Marae need to raise money to pay for the engineer and then all of the costs related to the business consents. It was only a few years ago we had just a hole in the ground, then we got flush toilets, and now we have flush toilets with no working pumps as these can’t manage the capacity of the people who come”.

Maria Hepi

Process: tu¯ akana/t¯ eina

- Non-indigenous researchers - critical to have members from the indigenous community as tu¯ akana, for guidance and hosting in relationship-building with the indigenous community.
- Gatekeepers for indigenous community ensured our trustworthiness to be able to work with the community.
- It is impossible to know another culture as you know your own. Do not presume that you do or can. I’ve been involved with M¯ aori culture for over 20 years, but will never know their culture.
- Can be difficult/frustrating working within another culture, not being able ‘to be as loud as in your own’.
- Although sometimes difficult, also very rewarding. Can gain a deeper understanding of issues from dual perspectives.
- When working on issues from/of another culture, it is important to work with people from that culture in true partnership.
- Something done differently in another culture is not wrong, merely different - there will be valid underlying reasons. For example, time.
- Learning about another culture does not happen through a book, rather by hands-on experience.
- Do not aspire to be the ‘knight in shining armour’, rather a resource/support for the other culture’s own aspirations.

I would like to leave with some quotes for people to think about

“How do they (non-indigenous people) think that by looking at us they will find the answers to our problems? Why don’t they look at themselves”? – Wayne Ngata.

“Valid M¯ aori history is ‘history as related by M¯ aori, under the scrutiny of M¯ aori, challenged by M¯ aori and agreed upon by M¯ aori’.” – Mereata Mita.

“Not just history but also the understandings of your research”. “We have a history of people putting M¯ aori under a microscope in the same way as a scientist looks at an insect. The ones doing the looking are giving themselves the power to define” – Mereata Mita.

These are important lessons for non-Indigenous people who work with Indigenous people whether they are researchers, agency workers or council staff”.

Marara Rogers

“One upon a time M¯ aori had one colour, but now we are a mixture - we are changing in colour - we have a different shade but the values, beliefs and traditions we carry with us as we go through life are still there no matter what colour we are. Why do we do it? The future is our children. Thank you”.

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CLIMATE CHANGE AND ENVIRONMENTAL HEALTH

Xavier Schobben
“Dr Donna Green from CSIRO was a late withdrawal from the Conference program, and was to present Climate Change and Health: Impact on Remote Indigenous Communities in Northern Australia. Xavier Schobben subsequently provided a presentation on Climate Change and Environmental Health, which was largely based on a presentation made by Professor Bart Currie, from the Menzies School of Health Research, to the Climate Changes Symposium at Charles Darwin University in 2005. Due to recent changes to some of the data presented and corresponding sensitivities, a fully updated presentation was not available at the time of publication”.

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PLENARY SESSION LED BY MERLE O’DONNELL

“I would like to acknowledge the traditional owners, the Irukandji people and their Elders who are in the room and our past Elders as well. Here is a quick summary of the last few days. What we have seen over the last few days has been good. There is a lot of hard work going on in the communities, and I am sure we can take back to our own communities some of those practices. Out of those presentations there have been a lot of key messages including our keynote speakers, such as Mr Calma.

Some of the keynote messages are partnerships, trust, respect, engagement, real community consultation and community capacity-building. Overarching these is a message to build relationships that are genuine and meaningful - not gammon relationships like over the last 200 years or more. We need to have a genuine and meaningful relationship with the federal, state and local governments, as they are the ones who don’t understand us and they need to take on board our messages and listen to us - such as Tom Calma’s message regarding the Tiwi Islands experience.

Policies - We need to make sure that decision-makers in policies include Aboriginal and Torres Strait Islander EH points of view. My personal experience has been that EH has been a second cousin to the clinical profession, but I am pleased to say it has been
gaining momentum these last few years. However, we still need to continue driving that message home.

Culture - We have links to land and sea and we must not lose sight of that, but we also need to remind decision-makers of these links to the land and sea.

Make sure programs are sustainable and that our communities need to be sustainable – that they have the control.

Funding - We need to have a commitment from funding bodies to continue with programs. It’s all very well that local government intends to amalgamate shires and communities, but our communities aren’t rate-based, and we need to make sure this is recognised and that it does not reduce our funding.

Committees - We need to make sure our Aboriginal and Torres Strait Islander people sit on national committees where we can make a difference, ensuring messages go up at a national level.

Stephen Canendo’s Keynote Address – ‘one plus one makes whatever’ – the more ‘ones’ you put together the easier it will be to solve environmental issues, eg, one person can pick a table up, but if four people get on each side of the table, they can pick the table up together. Therefore, let’s all pick up our wishes together. The other thing that struck me was Stephen’s message of dedication, enthusiasm, adaptability, durability, love and yearning (‘deadly’), and how it ties into our job, our community and our families.

We are going to now talk about suggested statements from the suggestion box. If there is a recommendation or suggestion you would like to discuss, don’t be ashamed. Please get up and let us know what you meant. The conference organising group will work on them and put them into a framework where relevant to each state jurisdiction to action. There are no guarantees, as some may take time. However, with the National Working group of Aboriginal and Torres Strait Islanders we will make sure they will be addressed in one form or another.

SUGGESTIONS BOX – GOVERNMENT RELATED:

* Bind the Crown under the Act, making them accountable to Indigenous communities.
* The Government has a responsibility for both State and Federal.
* Lack of services (what is surplus doing in Government coffers)?
* Fundamental rights - Aboriginal people still don’t trust the Government.
* Promote Policies - The advancement of ‘Truth in Implementation’.
* Currently a CHIP review by the Canberra ICC, within the section called municipal services, can there be a recommendation that this funding be targeted towards Indigenous community councils for EH Services such as dog health and pest control. Funding diminishes as it passes through Government.
* More visits from the Queensland Health coordinators.
* Information gathering for application/registration of guidelines through the local law model.
* WA should have funding for an EHW in each community similar to Queensland.
* Developing a tri-state system in central Australia for an EHW/EH Service System managed locally.
* Issues exist with cross border training and work/expertise/funding.
* This ‘region’ would best be managed by a tri-state approach.

SUGGESTIONS BOX – GENERAL:

* Place a skilled Aboriginal and Torres Strait Islander negotiator in every community across Australia.
* Refresher training for NPA EHW’s on water testing.
* Animal Management Program to include Microchip, Dog Registration Form and Carcass disposal (policies).

SUGGESTIONS BOX – CONFERENCE DELEGATE SUGGESTIONS AND STATEMENTS:

* That a publication be produced that documents case studies of environmental health interventions in Indigenous communities which highlights successes/failures and lessons learnt.
* That more health economic analysis be undertaken of the above cases to build the evidence base.
* That consideration be given to extending the hand washing project to include face washing and ear cleaning. That the project be implemented within Indigenous schools, and that it be evaluated after three years.
* Develop a database of experts in different areas such as effluent disposal, so that practitioners can access their knowledge and advice.
* That WGATSIEH and enHealth co-sponsor the development of the “Conducting Dog Health Programs” for EHWs publication with AMRRIC.
* It would be nice to have PowerPoint presentations and outcomes sent to us.
* The focus of this conference seems to have been mainly on Aboriginal and Torres Strait Islander people living in discrete communities. The majority of Aboriginal and Torres Strait Islander people do not live in discrete communities, and the majority live in urban areas. The five-year plan should recognise and reflect this.
* Rather than spend each day of the workshop on presentations, it would be good if the last part included interactive workshops which could discuss the great ideas heard in the presentations, and consider lessons learnt, information worth sharing, and possibilities for National policy, etc.
* It would be good to have a summary of the talks given by the keynote speakers in the program.
* Policy frameworks in Western Australia - some areas have already been talked about that fall through the gaps such as community food stores not funded by housing authority and no specified funding body. Government to take responsibility to fund food stores in communities without that type of funding.
* Development of clear national standards by WGATSIEH through enHealth with the National Water Commission for public EH in all new water and sewerage infrastructure, and advocate for development of a mechanism for maintenance funds not just for housing, but also for water and sewerage.”
HYGIENE INTERVENTIONS: WHAT EVIDENCE IS AVAILABLE ABOUT THEIR EFFECTIVENESS?

Liz Mc Donald, Ross Bailie, Peter Morris & David Brewster,
Menzies School of Health Research - Charles Darwin University

THEME: ENVIRONMENTAL HEALTH SERVICES IN COMMUNITIES

The slow progress to achieve healthy living environments in many remote Indigenous communities calls for a more considered and evidence-based approach to developing policy and programs to address the current problems. The World Health Organisation recommends that all public health interventions should be based as far as possible on a mix of scientific evidence, expert opinion and practical experience. In choosing what interventions to introduce into communities, environmental health workers need to have the capacity to assess the likely effectiveness of interventions according to the population group to be targeted, the context and vehicle for delivery, and quality of the evidence available. To contribute to meeting the needs of policy makers and others working to achieve improved hygiene and healthy living environments in remote Indigenous communities, a systematic literature review concerning a wide range of hygiene interventions has been completed.

This review looks beyond examining the strength of epidemiological evidence. Only studies that involved Indigenous populations, and populations from developing countries who live in tropical climates, were considered eligible for inclusion. More than one intervention type or one primary outcome measure was eligible. Outcomes measured included the suite of infections that Indigenous Australian children frequently experience, that is upper respiratory tract infections (including Otitis Media), skin infections (including infected scabies), and chronic gastrointestinal disorders caused by pathogenic viral and bacterial agents, and helminths.
NATIONAL INDIGENOUS HOUSING GUIDE 3RD EDITION

Anne Rhodes, Colleen Gibbs & Paul Pholeros, FaCSIA & Healthabitat Pty Ltd

THEME: HOUSING ISSUES AND PLANNING

AIMS/OBJECTIVES
• The National Indigenous Housing Guide provides practical advice about housing design, construction and maintenance to improve the living environment for Indigenous people, with a focus on safety and health
• The guide complements the Building Code of Australia and State/Territory government building standards
• It is distributed across Australia to designers, architects, builders, maintenance workers and environmental health staff

PROJECT/PROGRAM
• The third edition has been expanded to include community planning information and specific instructions for maintenance of health hardware
• Data from housing for health projects has been updated and the differences since 2003 have been analysed and discussed

RESULTS/EVALUATION
• The third edition has been compiled following a review of the second edition by technical experts
• Submissions were invited from over 300 stakeholders
• The contents were decided in a two-day workshop with selected contributors

SUSTAINABILITY
• The third edition of the National Indigenous Housing Guide will be published in hard copy and available on the Internet
• A web-based forum will be established to encourage users to exchange information, designs, ideas and debate about Indigenous housing design, construction and maintenance issues

LESSONS LEARNT
• The guide has been endorsed by the Standing Committee on Indigenous Housing, which comprises the Australian and all state and territory governments
• The data indicates that there have been some improvements in the condition of houses since the second edition was published in 2003.

BUDGET / FUNDING
• The National Indigenous Housing Guide third edition is published by the Australian Government Department of Families, Community Services and Indigenous Affairs

CONTACTS / LINKS / RESOURCES
• Healthabitat Pty Ltd
• Reference and resources are listed in the third edition of the guide
ABORIGINAL ENVIRONMENTAL HEALTH OFFICER TRAINEE PROGRAM

Jeff Standen, Manager Aboriginal Environmental Health Unit, NSW Health
Andrew Reefman, AEHU, NSW Dept. of Health.

THEME: LOCAL REGIONAL AND NATIONAL INITIATIVES

The program aims to train Aboriginal people in the field of environmental health in an effort to develop an Aboriginal workforce with the leadership and technical skills to progress environmental health issues into the future.

In April 1997, NSW Health (with some initial funding support from the Commonwealth government) launched a five-year pilot program to train and provide study support for six Aboriginal people to become Environmental Health Officers.

The initiative has now grown into a continuing training program. It is fully funded by NSW Health with eight trainees employed full-time by an Area Health Service based in urban and regional Public Health Units within NSW.

With supervision by senior staff in the Public Health Unit, the trainee progressively, takes on more responsibilities. The trainee also participates in University studies via distance education to complete a Batchelor of Applied Science (Environmental Health) with the University of Western Sydney.

Trainees study at home (study leave is also part of the conditions of employment) and in the workplace and attend the university campus at least once a semester for on-campus residential workshops (for up to one week at a time) and again for tutorials and exams at the end of the semester (usually a few days).

The program covers the cost of travel and expenses associated with the trainee’s employment or study. Course fees (including HECS) for up to 24 subjects (being the full degree course load), and any other associated costs (including textbooks, technical equipment and graduation costs) are met by NSW Health.

At the completion of their study, trainees are offered two years employment with the Public Health Unit as a graduate EHO to consolidate their skills.

Trainees and graduates are playing an increasing role in ensuring the success of public health projects in communities and also in developing links between the communities and the public health units.

Trainees are also entitled to student membership of the Australian Institute of Environmental Health, the professional body for Environmental Health.
EVALUATING THE NSW HOUSING FOR HEALTH PROGRAM

Darren Mayne, Epidemiologist Aboriginal Environmental Health Unit, NSW Health (now with South Eastern Sydney/Illawarra Area Health Service). Jeff Standen, Manager Aboriginal Environmental Health Unit, NSW Health

THEME: HOUSING ISSUES AND PLANNING
LOCAL, REGIONAL AND NATIONAL INITIATIVES
COMMUNITY ENGAGEMENT/PARTNERSHIP
ENVIRONMENTAL HEALTH SERVICES IN COMMUNITIES

Housing for Health is a repair and maintenance program that focuses on surveying and fixing Aboriginal housing, with all works prioritised to maximise health benefit, particularly for children 0-5 years old.

The Housing for Health process aims to assess, repair or replace health hardware so that houses are safe and the occupants have the ability to carry out healthy living practices (HLPs). All works carried out are prioritised in terms of health benefit. The priorities are:

- Safety - Immediate life threatening dangers are addressed as the highest priority.
- Healthy Living Practices -
  1. Washing people
  2. Washing clothes and bedding
  3. Removing waste safely
  4. Improving nutrition
  5. Reducing the impact of animals, vermin or insects
  6. Reducing dust
  7. Controlling temperature
  8. Reducing trauma
  9. Reducing overcrowding

The program has a philosophy of no survey without service and involves training community members in this area. It is as much a community development project as an asset management project.

In partnership with Department of Aboriginal Affairs, NSW Health has undertaken Housing for Health projects in over 50 communities across NSW since 1997.

NSW Health’s involvement in this program is for a number of reasons:

- The anticipated health benefit particularly in children, by ensuring community housing is equipped to enable residents to undertake healthy living practices.
- Research has shown that improving essential health hardware (fixing a leaking toilet, electrical repairs, having sufficient hot water, having somewhere to wash a baby or child etc.) can lead to improvements in health status;
- Reduce health expenditure through reduction in infectious diseases;
- Reduce social stress by ensuring basic health hardware (toilets, hot water etc) are working in the houses;
- Building a bridge between communities and Public Health Units, across which other health related projects can follow.

NSW Health has been evaluating projects throughout the program in a number of ways including:

- Post-project evaluation. This involved revisiting communities to evaluate the effectiveness and sustainability of the gains initially made in the project. This was done by carrying out the survey and fix process in a community 2-3 years after the completion of the initial project.
- Evaluating the health impacts of the program. This involved an analysis of hospital separations data in an attempt to determine whether an association between the Housing for Health program and a health status could be identified.
- Documenting qualitative benefits that have arisen out of the program including the development of follow on programs with communities (such as asthma reduction, injury prevention, pest control), and employment and training opportunities provided for community members, such as apprenticeships and Healthy Housing Workers.

The presentation will outline some of the results of the program to date as well as results of the health evaluation.
