National Trachoma Health Promotion Programme

Presented by Laurie Berryman
Program Manager, Ninti One

Assisted by Carol Holden and Steve Fisher

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What is Ninti One?

Ninti One is a not-for-profit company operating at the intersection of research, policy, and best practice to build opportunities for people living in remote Australia.

We specialise in delivering projects informed by research conducted inclusively at the community level.

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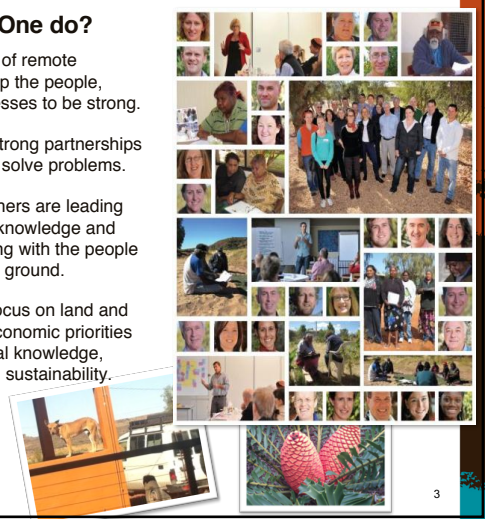
What does Ninti One do?

We work in many areas of remote Australia, working to help the people, environment and businesses to be strong.

We do this by building strong partnerships and working together to solve problems.

Our community researchers are leading the way in gaining new knowledge and understanding by working with the people and communities on the ground.

We work in areas that focus on land and resources, social and economic priorities for remote areas, cultural knowledge, Intellectual property and sustainability.



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Ninti One
Aboriginal Community Researchers (ACRs)

ACRs play an important role in the Researcher team;

- connections with the community,
- ability to speak local language
- Understanding culture and country

These unique skills ensures quality consultation and research.

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ACRs contribute to all phases of the research including the project design, conducting fieldwork in their communities, data analysis and report development.

2015-2017 Trachoma Health Promotion Program (THPP) aims to:

- Support current activities undertaken by jurisdictions by undertaking trachoma health promotion based on Surgery, Antibiotics, Facial Cleanliness, and Environmental Improvements (SAFE) Strategy.
- Increase awareness in endemic communities of the importance of facial cleanliness for trachoma control.
- increase the inclusion of facial cleanliness into other hygiene messages.

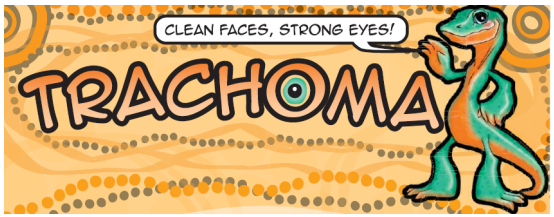
Evaluation

- Insight into community understanding about THPP
- Does knowledge lead to an understanding "that trachoma can be prevented with clean faces"
- How community members have changed their behaviours in respect of "Clean Faces"

Evaluation objective

- The level of awareness of the THPP messages
- The mean by which awareness was achieved
- The actions that people have taken as a result of their awareness

To understand the level of recognition of Milpa, the trachoma goanna, and his messages



Evaluation seeks to:

- Provide evidence of the impact of the THPP
- Capture community members experiences and learnings to enhance future THPP activities.
- Give Aboriginal people a voice to speak about their own eye health.
- Inform how future program activity can build on the success of the current program

Field Methods

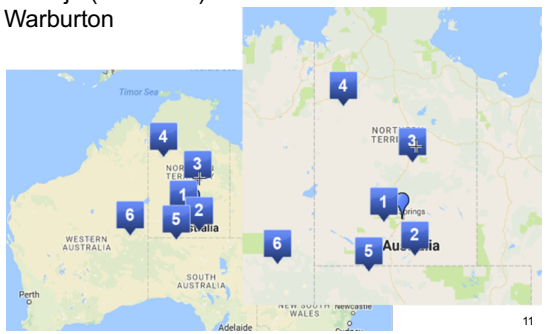
Field methods and survey questions developed through collaboration between IEHU Team and Ninti One Team, including local ACRs.

25 Individual Surveys and 2 Focus groups in each of the six locations

Locations; 6 remote communities across 3 states;

NT: 1. Ntaria (Hermannsburg), 2. Apatula (Finke),
3. Ali Curung 4. Lajamanu.

SA: 5. Pukatja (Ernabella)
WA: 6. Warburton



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What we investigated.

- Are people seeing/hearing the messages
- Where and how are people seeing the messages
- What is the level of understanding of the message?
- Which medium works best?
- Are the messages making any difference?
- What is the level of intention to change behaviour?
- What can be done to ensure the messages are more impactful?

Evaluation Findings

- Community members open and receptive
- Willingness to engage, discuss facial cleanliness and learn about trachoma
- Good recognition of Milpa and the messages

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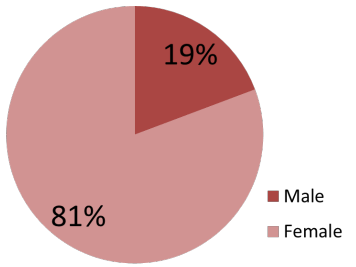
Gender of participants



- Four of every five participants to date have been women
- Imbalance due to cultural factors: female research team & care of children being predominately women's business.

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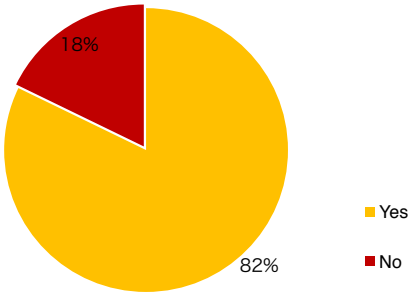
Participants who reported having seen Milpa



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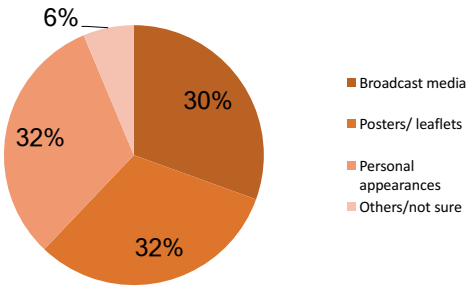
Where have you seen Milpa?



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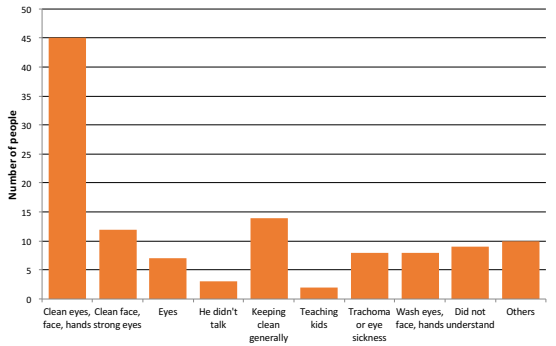
Understanding of Milpa?



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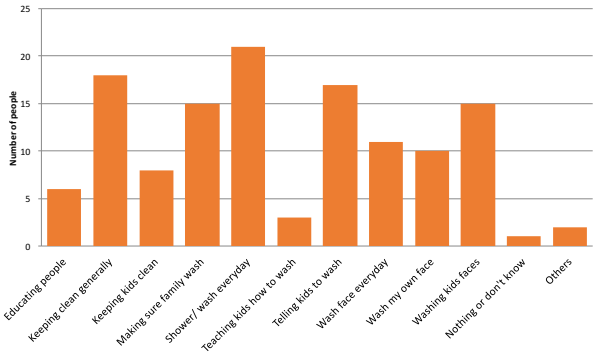
What can you do about clean faces?



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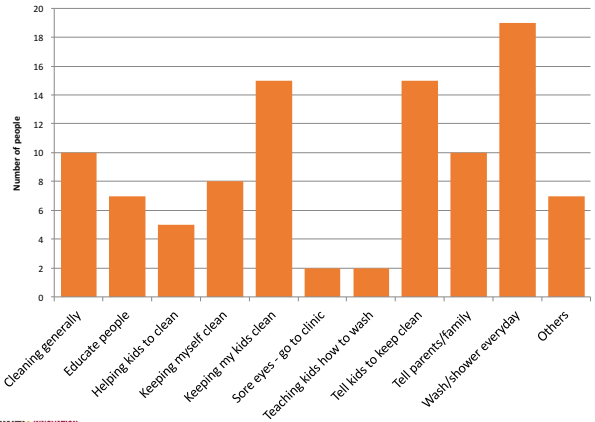
What are you doing about clean faces?



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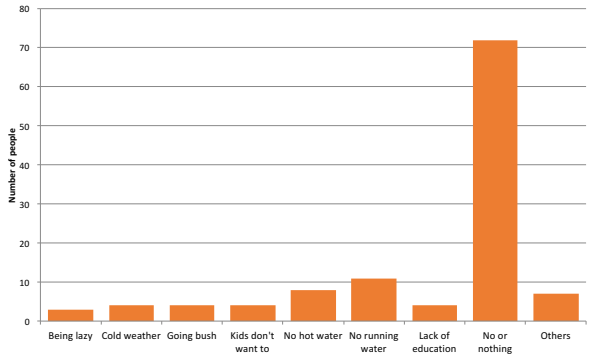
Does anything stop you from keeping faces clean?



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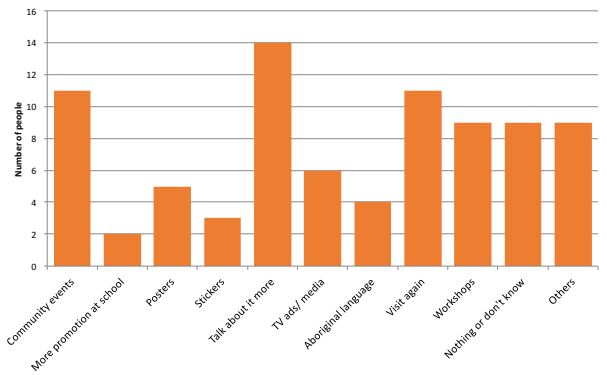
How could a campaign work better for you?



Conclusions to date, *(Evaluation not yet complete)*

- Communities are open and receptive to the messages
- Clean face, strong eyes is generally well recognised
- Broadcast media, paper based media and visits appear to be equally effective
- Interpretation of the message needs development
- Very few participants understand that Trachoma is transmissible
- School and childcare centres are important settings
- Need to target and engage with adults/parents

Improvements to consider

- When Milpa is engaging a school, simultaneously engage the community to reinforce the message
- Community events that engage adults and communicate ways they can support facial cleanliness
- Use local language
- Work with the demographic who still do not understand messages and design alternative engagement strategies.

Indirect benefit of the evaluation

One-to-one health promotion and education through ACRs engaging community individuals and groups throughout the study

Acknowledgements;

Ninti One Research Team:

Senior Aboriginal Research Officers: Tammy Abbott, Sharon Forrester

ACRs: Lena Taylor, Elaine Williams, Maureen Abbott, Samantha Cook, Kelly Swan.

Technical support: Steve Fisher, Teghan Collingwood, Laurie Berryman

Thanks to IEHU
Carol Holden – Preparation of evaluation summary

Thank You

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Trachoma control in Australia

Carleigh Cowling
Kirby Institute
University of New South Wales

Close the Gap for Vision by 2020
National Conference 2017

Acknowledgements

- Communities affected by trachoma
- Contributors to trachoma surveillance and control at state, territory and national level
- Australian Government Department of Health
- Trachoma Surveillance and Control Reference Group

Trachoma

- Eye infection due to *Chlamydia trachomatis*
- Repeat infection leads to in-turned eyelashes which in turn causes corneal damage
- Infections in young children leading to blindness in adults
- Diagnosis of infection is clinical
- Easily treatable with single dose oral antibiotic

Trachoma and global public health

- One of the key Neglected Tropical Diseases
- Globally leading infectious cause of blindness
- Strongly associated with poverty, overcrowding
- World Health Assembly declaration in 1997
- Global elimination targeted for 2020
- Large-scale international control efforts through public/private/NGO partnerships
- Some countries have reached “elimination”

Global Elimination of Trachoma 2020: The SAFE strategy

- **S**urgery for trichiasis
- **A**ntibiotics
- clean **F**aces
- **E**nvironmental improvements

TARGETS

1. Undiscovered trichiasis less than 1 per 1000
2. Trachoma prevalence under 5% in 1-9 year olds

Australia's national trachoma program

- Initiated 10 years ago
- Funding from national government
- Implementation by states and territories
- National guidelines for control 2006, 2014
- Centralised monitoring and evaluation

Australian trachoma program guidelines

- CDNA endorsed 2006, 2014
- Broadly based on WHO SAFE strategy
- Antibiotic component:
  - Screen 5-9 year olds via schools
  - Annual community treatment for 3 years if above 5%
  - Six monthly if above 20%
- Some jurisdictional variation in approach

Trachoma Surveillance and Control Reference Group

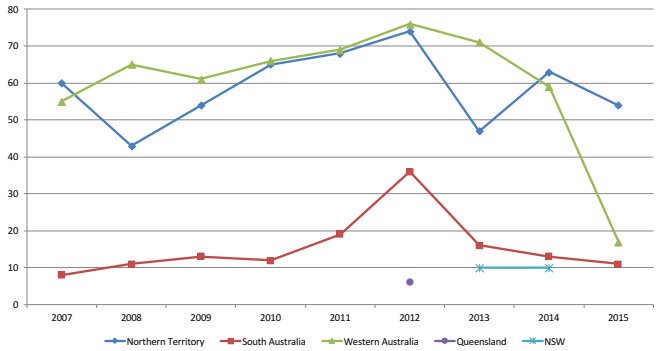
Representatives from:

- Department of Health
- Jurisdiction specific trachoma control team members
- NACCHO
- Expert advisers
- NTSRU

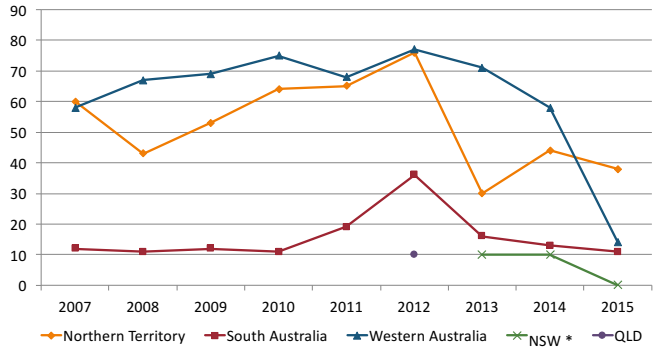
Working groups targeting:

- Meeting 2020 goal
- Facial cleanliness and environmental improvements
- Health promotion messaging
- Coordination and collaboration with PM&C
- Improving social determinants of health

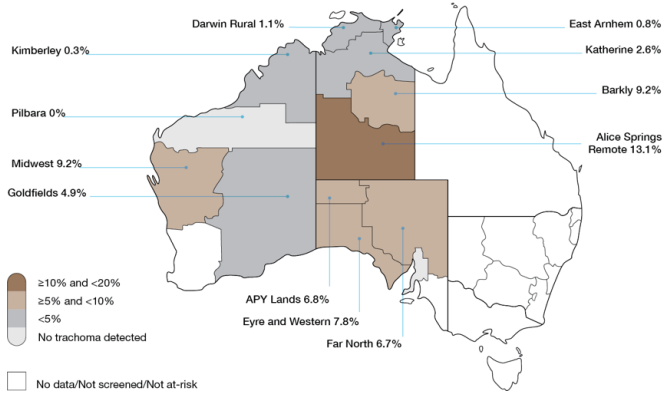
Communities “at risk” that screened and/or treated, Australia



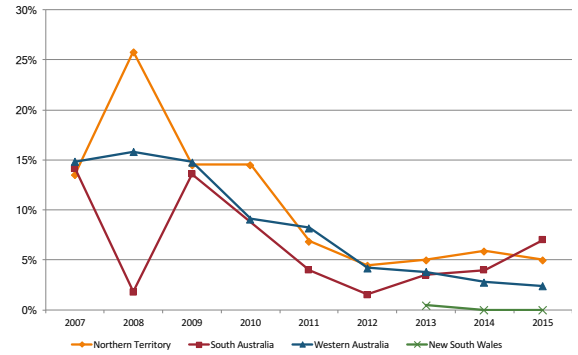
Number of “at risk” communities screened for trachoma, Australia



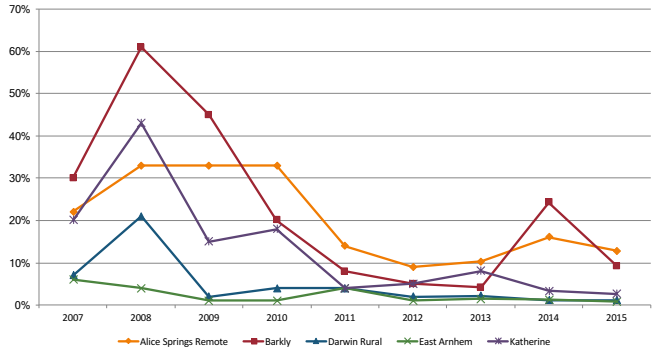
Trachoma prevalence among 5-9 year olds Australia 2015



Trachoma prevalence among 5-9 year olds in at risk communities, Australia

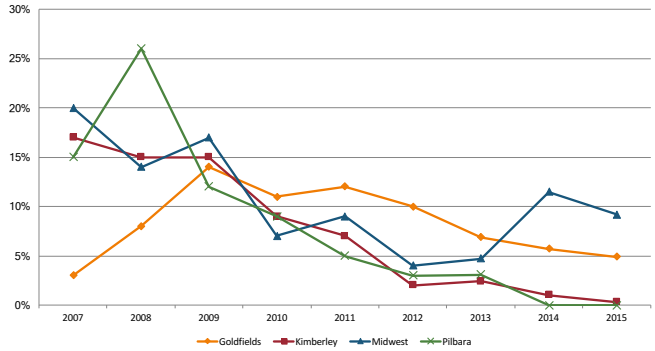


Trachoma prevalence in the Northern Territory (5-9 years)

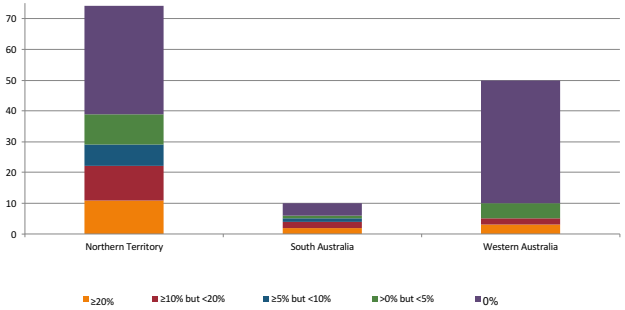


Trachoma prevalence in South Australia (5-9 years)

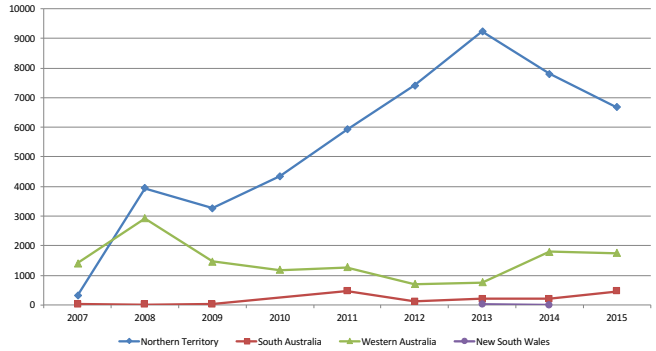
Trachoma prevalence in Western Australia (5-9 years)



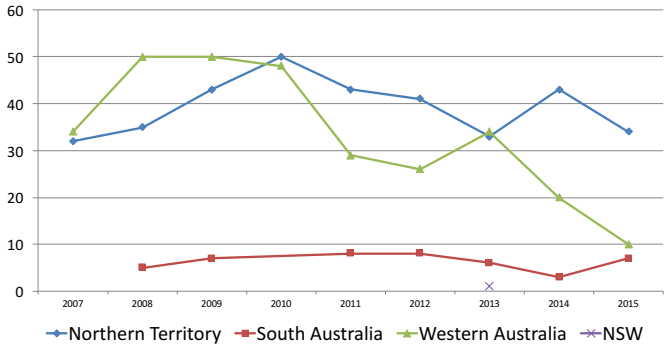
Number of communities by trachoma prevalence in 5-9 year olds, Australia 2015



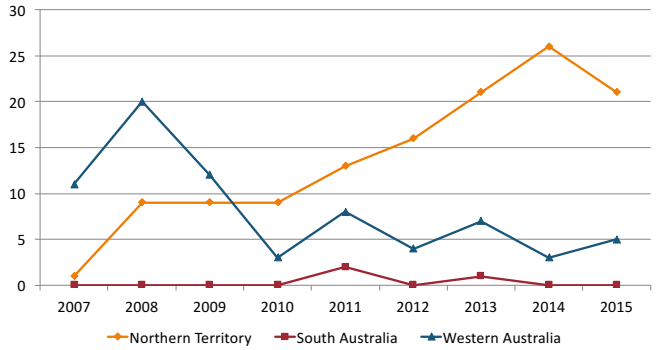
Azithromycin for control of trachoma, Australia



Number of communities treated for trachoma, Australia



Number of communities that undertook MDA



2015 Trichiasis data

	Northern Territory		South Australia		Western Australia		Total		
Number of communities screened for trichiasis	67		11		25		103		
Age groups	15-39	40 +	15-39	40 +	15-39	40 +	15-39	40 +	15+
Estimated population in region*	14310	8108	2895	2000	6057	3586	23262	13694	36956
Adults examined †	2638	2470	700	1264	474	810	3812	4544	8356
With trichiasis (% of adults examined)	4 (0.2%)	25 (1%)	3 (0.4%)	9 (0.7%)	0	7 (0.9%)	7 (0.2%)	41 (0.9%)	48 (0.5%)
Offered ophthalmic consultation	0	8	3	9	0	8	3	25	28
Declined ophthalmic consultation	0	6	0	0	0	2	0	8	8
Surgery in past 12 months	0	6	3	1	0	6	3	11	14

Information gaps for trachoma control in Australia

- Trachoma in younger children
- Trichiasis prevalence and surgery
- Health promotion measures
- **Environmental measures**

Reaching targets in Australia

- Keep on track with programs/funding
- Stronger linkages between sectors
- Local eradication

Aiming for zero?

Close the Gap for Vision by 2020 National Conference 2017

Lessons from the first 7 years of Victoria's Aboriginal spectacle scheme

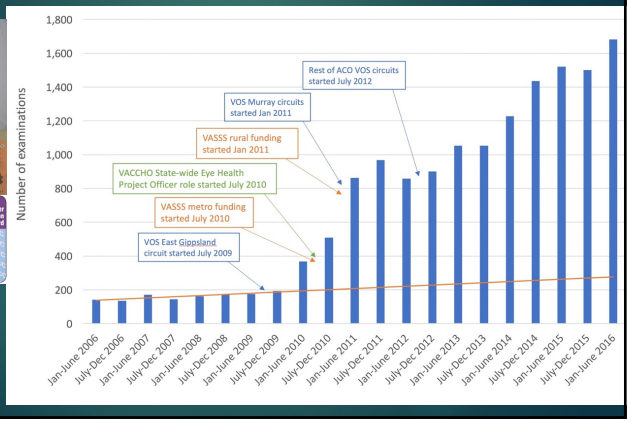
TIM FRICKE

NO CURRENT DISCLOSURES, BUT HAVE PREVIOUSLY MANAGED THE VASSS AT ACO

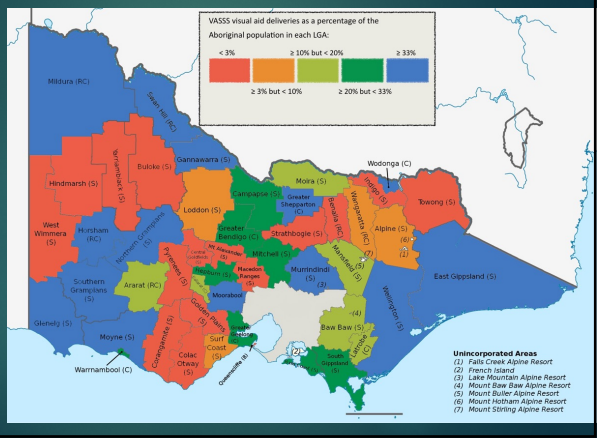
VASSS evaluation 2016

- Reviewed data from the 6.5 years of of the scheme, plus some additional data back to 10 years
- Interviewed people (clients, Aboriginal communities, partner organisations, policy people, practitioners, etc) around the state
- Found the scheme:
  - Is successfully contributing to improved equity of access to visual aids and comprehensive eye examinations by Aboriginal Victorians
  - Has generated direct and indirect benefits to health, Aboriginal health, productivity and quality of life
  - There are some adjustments that can be made to assist targeting of vision impairment and sustainability

Comprehensive eye exam numbers



Spread of visual aid deliveries



Lessons

- There is no one-size-fits-all service delivery model
  - Be flexible to the opportunities and challenges of each place
  - "I used to go to the local (VES Rural) practice – it was okay, but it's much more comfortable coming to the ACCHO. It's easier to pick up the phone and ask for an appointment – I feel more confident, happy, free, less anxious coming here" (ACCHO Client)
- VES rural practices join the VASSS to contribute to Aboriginal eye and vision health, however other stressors impact
  - Sustainability will require engagement, support and funding flexibility

Lessons cont'd

- There is room for more selective targeting
  - Improve access by Aboriginal Victorians at highest risk of VI
- The support of ACCHO's & other agencies that host/assist services is critical to achieving eye care access, particularly for the most complex clients
  - "The Scheme is a game changer – it changed the conversation I have with clients from a real battle to get them to agree to make an appointment to a positive discussion about taking care of themselves" (ACCHO Care Coordinator)
- Eye disease detection and management can be improved further
  - Slit lamps in ACCHOs
  - Funding of eye disease diagnostic procedures conducted in VES Rural practices
  - Address the challenges in attending ophthalmology services

Broader benefits

- Commonly described that the simple, positive outcome (getting glasses, seeing better) from having an eye examination, improves self-agency, engagement with culture and community, and broad aspects of Aboriginal health
  - The $10 co-payment is reported as fair and reasonable, and appears to assist developing a sense of self-agency in approaching health care that could have wider benefits
  - The Scheme may return far more value to Victoria than what it has cost - standard health economics estimate suggests annual productivity gains resulting from VASSS of up to $6.6 million
  - Future: consider options to train a group of AHWs to deliver glasses (frame adjustments and vision check) and do some minor repairs, and support them to fulfil the role of delivering glasses at their ACCHO

Summary

- "The Scheme has been good – people ask for it. People say they haven't had an eye test in ages… or forever. But the scheme gives them confidence to ask for a test" (ACCHO Clinic Coordinator)
- "Seeing better with glasses is an easy fix – clients can see an optometrist, get glasses, and see better. Achieving this makes people feel better – they realise that things can be *done*, things can be *fixed*. There is value in a person realizing a positive outcome from having an eye examination. It helps people *own their health*, which changes their approach to solving health problems." (ACCHO staff)
- "You may never know what results come of your actions, but if you do nothing, there will be no results." (Ghandi)

Reference

- Fricke T. Evaluation of the Victorian Aboriginal Spectacles Subsidy Scheme – 2016 Report. Minne-Merri Consultants, Melbourne 2017

Close the Gap for Vision by 2020
National Conference 2017

Indigenous Diabetic Eye Disease Screening and Treatment

Dr Rowan Porter

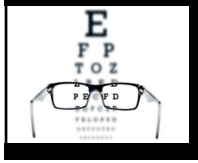
17.3.17

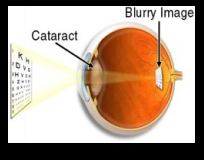
NEHS 2016

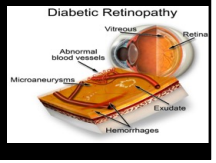
Table 12. Main causes of bilateral presenting vision impairment and blindness in the NEHS

	Indigenous		non-Indigenous	
Main cause of vision impairment (<6/12-6/60)	**n (%)**	**95% CI (%)**	**n (%)**	**95% CI (%)**
Refractive error	116 (63.39%)	55.96, 70.37	124 (61.69%)	54.59, 68.44
Cataract	37 (20.22%)	14.65, 26.77	28 (13.93%)	9.46, 19.50
Age-related macular degeneration	2 (1.09%)	0.13, 3.89	18 (8.96%)	5.39, 13.78
Diabetic retinopathy	10 (5.46%)	2.65, 9.82	3 (1.49%)	0.31, 4.30
Glaucoma	1 (0.55%)	0.01, 3.01	3 (1.49%)	0.31, 4.30
Combined mechanisms[1]	3 (1.64%)	3.39, 4.72	1 (0.50%)	0.01, 27.40
Other[2]	2 (1.09%)	1.32, 3.89	8 (3.98%)	1.73, 7.69
Not determinable[3]	12 (6.56%)	3.43, 11.17	16 (7.96%)	4.62, 12.61
Total n	183		201	
Main cause of blindness (<6/60)				
Refractive error	0		0	
Cataract	2 (40%)	5.27, 85.34	0	
Age-related macular degeneration	0		5, 71.42%	29.04, 96.33
Diabetic retinopathy	1 (20%)	0.51, 71.64	0	
Glaucoma	0		0	
Combined mechanisms	1 (20%)	0.51, 71.64	0	
Optic atrophy	1 (20%)	0.51, 71.64	1 (14.29%)	0.36, 57.87
Not determinable[3]	0		1 (14.29 %)	0.36, 57.87
Total n	5		7	

Ocular complications of Diabetes







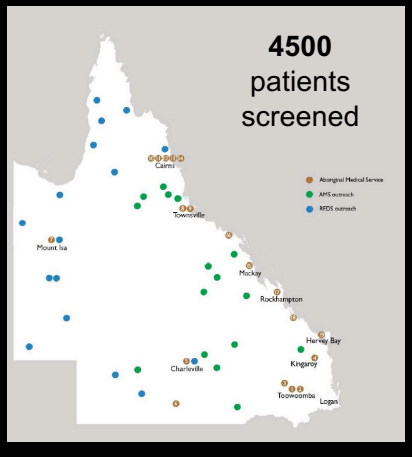
The Ideas Van Initiative 2013-

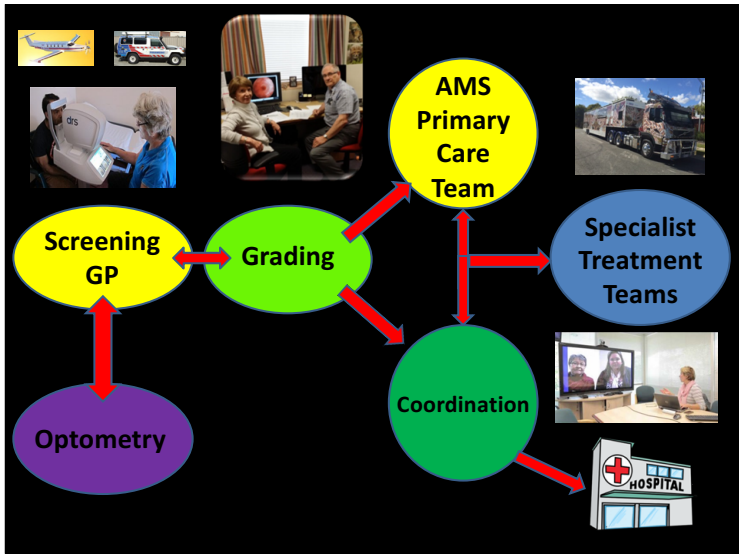
Screening

27 cameras shared across 51 communities

Boxed and delivered Automated Non mydriatic Cameras

RFDS for isolated communities





NOV 2016

MBS Item number for Diabetic photo-screening in Indigenous and Torres Strait Islanders

Aboriginal and Torres Strait Islander Peoples Assessment of visual acuity and bilateral retinal photography with a non-mydriatic retinal camera, including analysis and reporting of the image/s for initial or repeat assessment for presence or absence of diabetic retinopathy in a person of Aboriginal and Torres Strait Islander descent with medically diagnosed diabetes if performed:

a) By the medical practitioner providing the primary glycaemic management of the patient with diabetes (excluding optometrists and ophthalmologists); and,

b) 12 months after the previous retinal photograph.

This service is not available to patients with:

a) An existing diagnosis of diabetic retinopathy; or

b) Visual acuity of less than 6/12 in either eye or a difference of more than two lines of vision between the two eyes at the time of presentation.

Fee: $50.00

Explanatory notes:

This service is separated into two items, MBS item X and MBS item Y, in line with NHMRC guidelines' recommended frequency of repeat testing in persons of Aboriginal and Torres Strait Islander descent and the general population.

This item is intended for the provision of retinal photography with a non-mydriatic retinal camera. Mydriasis is permitted if adequate photographs cannot be obtained through an undilated pupil.

Presenting distance vision means unaided distance vision or the vision obtained with the current spectacles or contact lenses, if normally worn for distance vision.

Detection of any diabetic retinopathy should be followed by referral to an optometrist or ophthalmologist in accordance with the NHMRC guidelines.

Where images are of inadequate quality for detection of diabetic retinopathy, referral to an optometrist or ophthalmologist for further assessment is indicated.

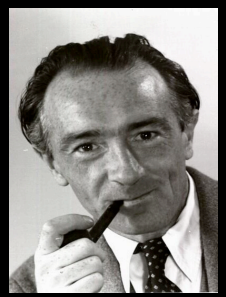
Screening - Item No 11219

Primary care is the home of the patient record

- 1. "Picture" for patient education
- 2. "Window" showing systemic microangiopathy
- 3. "Gateway" to specialist services
- 4. Now "like an ECG" separate item number
- 5. National Grading centre- education, quality assurance and patient safety.

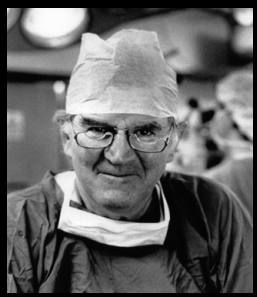
"No Survey without Service"

Professor Archie Cochrane



1909-1988

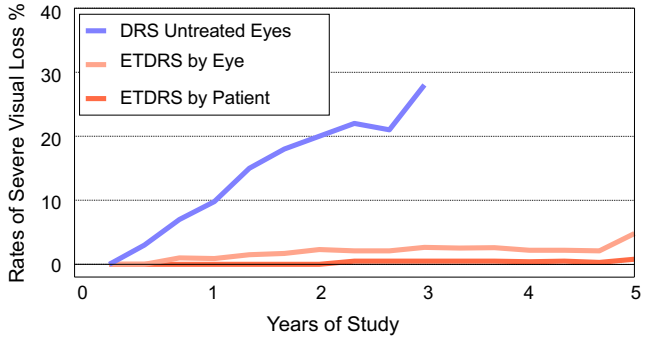
Professor Fred Hollows



1939-1993

Centre for Eye Research Australia

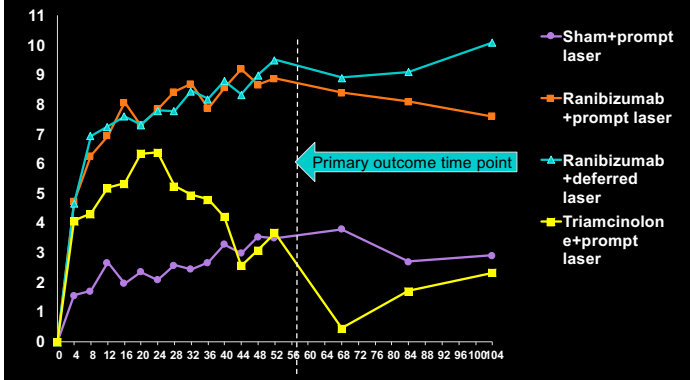
Efficacy of Laser Treatment



Ferris JAMA 1993

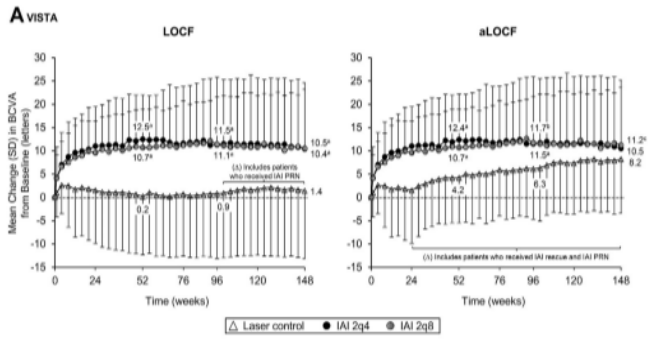
THE UNIVERSITY OF MELBOURNE

The New Paradigm Challenge



*Values that were ±30 letters were assigned a value of 30
P-values for difference in mean change in visual acuity from sham+prompt laser at the 52-week visit: ranibizumab+prompt laser <0.001; ranibizumab+deferred laser <0.001; and triamcinolone+prompt laser=0.31.

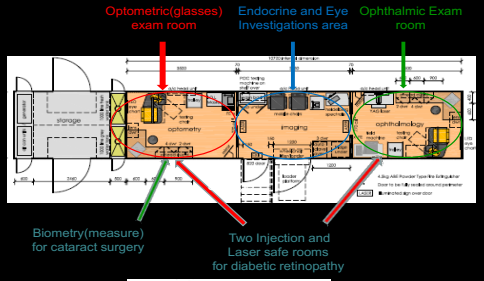
Every Second Month?



New Paradigm,
Treatment Challenges

- Injection interval: workforce and compliance
- Equipment: Cost, weight and resilience
- Drug: Cost, compounding and cold chain
- Clean room, disposables and assistance
- Decentralization: Small remote populations
- Laser: down but not out.

THE IDEAS VAN



V2020 ATSI Position Statement 2016 Access to ANTI VEGF

- 1. Permit fundus photography as documentation for the purpose of Authority approval of anti-VEGF medications until Optical Coherence Tomography (OCT) item number is implemented and is available in rural and remote areas;
- 2. allow for another medical practitioner to obtain Authority approval
- 3. MBS item for Optical Coherence Tomography (as recommended by Medicare Services Advisory Council MSAC);and
- 4. secure funding for Optical Coherence Tomography (OCT) equipment to ensure that anti-VEGF therapy is delivered according to best practice standards.

First OCT Item Number

The item descriptor to commence from 1 November 2016 is as follows:

Category 2 – DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

Group D1 – MISCELLANEOUS DIAGNOSTIC PROCEDURES AND INVESTIGATIONS

Subgroup 2 - OPHTHALMOLOGY

MBS 11219

Optical coherence tomography to determine if the requirements relating to:

a) age related macular degeneration for access to initial treatment with ranibizumab or aflibercept, or

b) diabetic macular oedema for access to initial treatment with ranibizumab, aflibercept or dexamethasone, or

c) central retinal vein occlusion for access to initial treatment with ranibizumab or aflibercept, or

d) branch retinal vein occlusion for access to initial treatment with ranibizumab

under the pharmaceutical benefits scheme are fulfilled.

Maximum of one service in a 12 month period

Fee: $40.00

Please note that the OCT item currently does not include aflibercept for branch retinal vein occlusion or ocriplasmin for vitreomacular traction because these pharmaceuticals are not available on the PBS for these indications.

OCT

- 1. Standard of care for detecting and measuring retinal thickening
- 2. Non invasive and reproducible test
- 3. OCT is now the national standard for accessing restricted PBS intravitreal medications.
- 4. OCT is fragile, for mobile use with care
- 5. Combination of fixed and mobile units needed

2017 Goals Regional and Remote

OCT units

Regular regional Indigenous surgery lists

National Grading Center

Mass Spectacle renewal

Mobile surgical Pod

RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE MEDICAL EYE SPECIALISTS

A Queen Elizabeth Diamond Jubilee Project
Diamond Jubilee Partnerships Ltd

Indigenous Diabetes, Eyes And Screening "IDEAS"

Ophthalmology Clinic Van

Service-Annex to enhance

1. Equipment Costs shared- 3rd highest for any specialty.
2. Delivered to door- Numerous bulky equipment items, secure.
3. Cushioned by air suspension and custom packaged.
4. New Day, New clinic location each morning is possible.
5. Annex to Indigenous health- dedicated space, specialty equipped and stocked, laser safety standards and injection approved space.

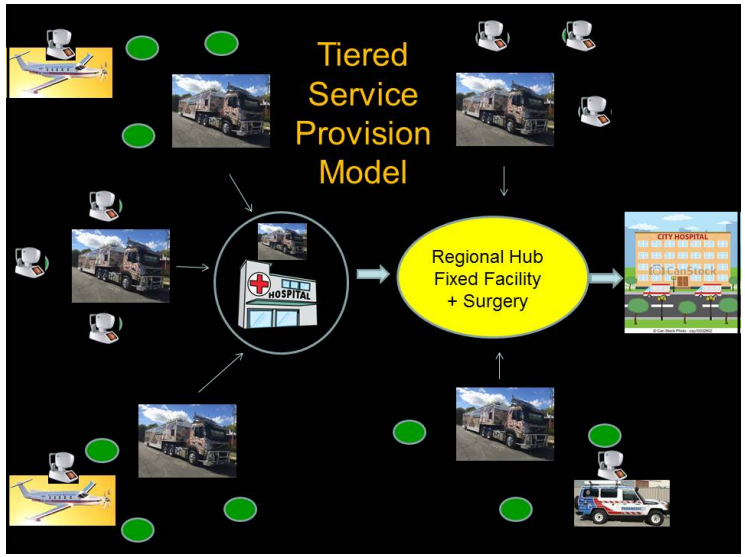
6. Local Team: continuity of care, community members, low transport costs makes sustainable.
7. Multiskilled team: optometrist, orthoptist and Ophthalmologist visit up to every month to provide standard of care injections.
8. Examination and treatment: with measurements for cataracts but no intraocular surgery.
9. Centrally stocked: Anti-VEGF(Drug) monitored and renewed centrally with other stock.
10. Billing: is separate and bulk billed.
11. 15 ophthalmologists appreciate being able to deliver the same standard of care they can provide in there own clinic.

RANZCO The Royal Australian and New Zealand College of Ophthalmologists
THE MEDICAL EYE SPECIALISTS

A Queen Elizabeth Diamond Jubilee Project

Diamond Jubilee Partnerships Ltd

Indigenous Diabetes, Eyes and Screening
"IDEAS"



Lions Outback Vision

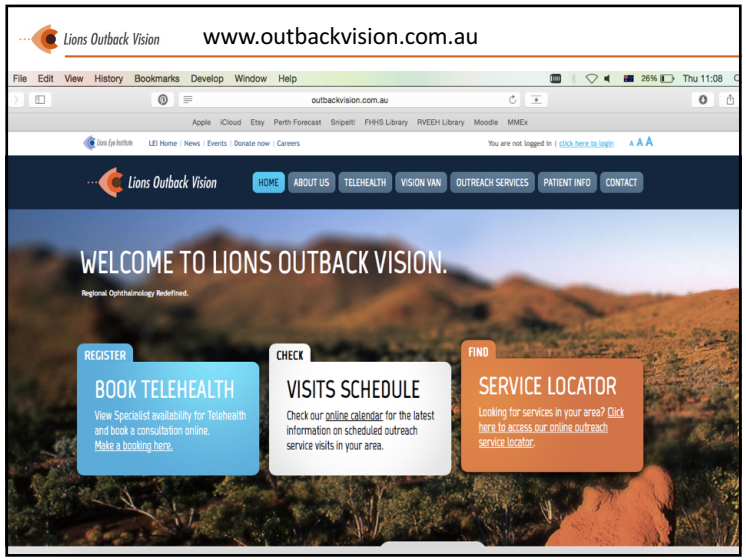
Helen Wright
VOS Coodinator
Lions Outback Vision

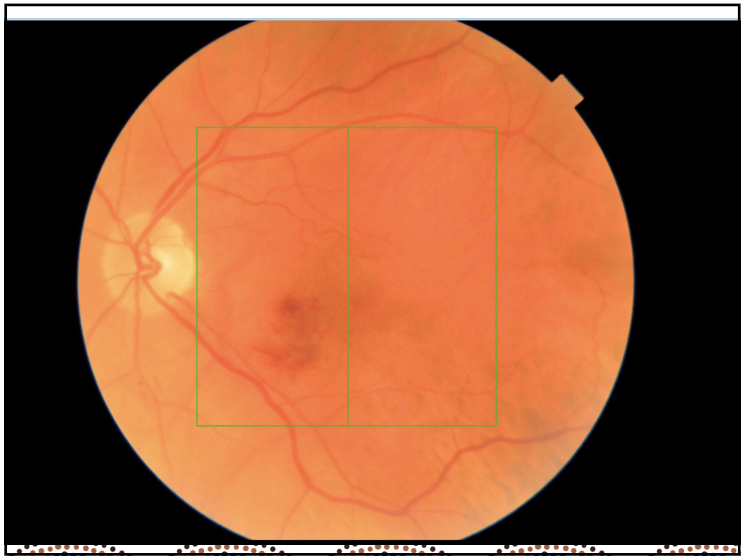
Telehealth for Eyes

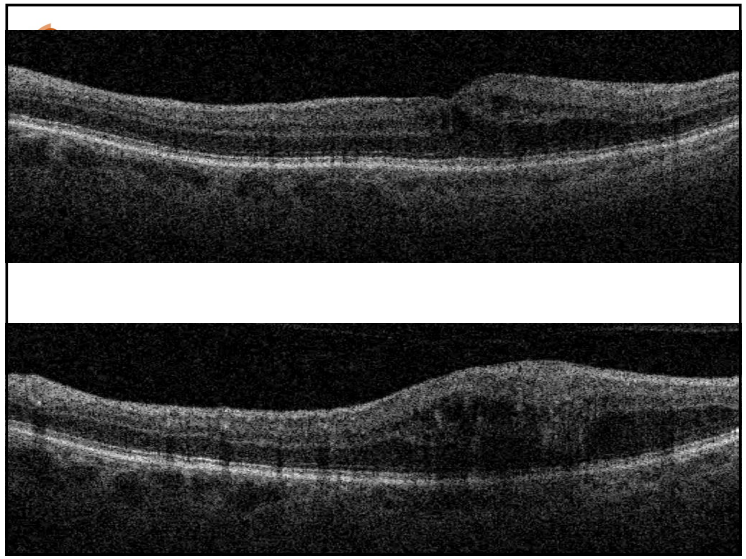
Lions Outback Vision

- 2011.- Medicare changes to allow Telehealth for GPs to contact ophthalomoglists via Videolink.
- 2012. - Audit shows that it was actually the optometrists doing the bulk of the referrals to ophthalmolgists (not GPs) as they had the necessary skills and equipment to help with diagnosis and management.
- 2014 - A further study to model a payment for Optometry involvement.
- 2015- With some advocacy in Canberra and support from the Colleges , new item numbers introduced for optometrists
- 2016 - 800 consults, mainly chronic disease. 50% directly booked for elective surgery and consent over video link (cf 10-20 % for normal ophthalmology clinics.

Lions Outback Vision


Lions Outback Vision
www.outbackvision.com.au
File Edit View History Bookmarks Develop Window Help
outbackvision.com.au
Lions Outback Vision
HOME
ABOUT US
TELEHEALTH
VISION VAN
OUTREACH SERVICES
PATIENT INFO
CONTACT
WELCOME TO LIONS OUTBACK VISION.
Regional Ophthalmology Redefined.
REGISTER
BOOK TELEHEALTH
View Specialist availability for Telehealth and book a consultation online.
Make a booking here.
CHECK
VISITS SCHEDULE
Check our online calendar for the latest information on scheduled outreach service visits in your area.
FIND
SERVICE LOCATOR
Looking for services in your area? Click here to access our online outreach service locator.






drs

Lions Outback Vision

- Mavis's story

Lions Outback Vision

Punmu

Newman

Surgery Hedland

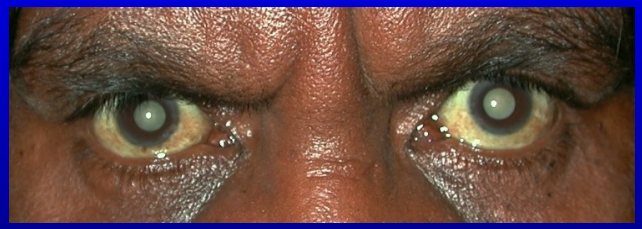
Lions Outback Vision

Lions Outback Vision

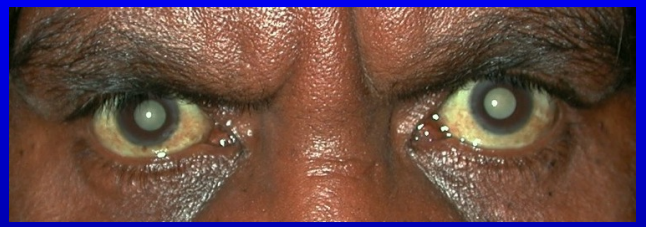
Issues

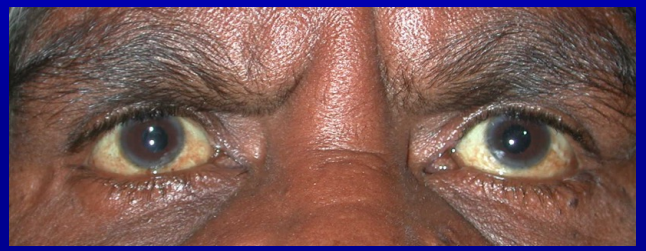
- Not for everyone and not a perfect model
- Not for all applications - Not able to provide treatment but good for consents and providing advice on urgency of referral.
- Only really effective if the ophthal is familiar with the community and pathways and lay of the land.
- Needs committed ophthal and optoms
- Can only ever be as good as the information provided by the optometrist
- Need both the car and the key to make it work.

CATARACT SURGERY in CENTRAL AUSTRALIA



CATARACTS





Before

- ‘bilateral cataract blind’
- All day curled under blanket

After

- Impact (in a Different Patient!)

“getting my manhood back”

Back to shooting, running night patrol and passing on Men’s business

- Eye treatment is preventive medicine
- Retain independence and function at individual, family and community level
  - –Better able to manage own health needs
  - –Comply with driving standards
  - –Hold down job
  - –Fulfil cultural role as elder and leader
  - –Support family health behaviour & compliance
  - –Strengthen community and positive experiences of health services
  - –Reduce dependence on friends, family and services
- SAVES MONEY and ENHANCES QUALITY OF LIFE

Surgery Week

- 1 or 2 per year since 2007
- Targeted 40- 50 patients
- Remote community
- Extra support, travel, accommodation etc
- Extra staff, specialist colleague, scrub staff, liaison & interpreters
- Some patients who would not otherwise access care
- NTG / FHF partnership support

Welcome to Alice Springs Hospital

STAFF

One specialist (2)
One training registrar (1+)
FHF Fellow Av 2 per year (varies)
3 nurses (3+)
1 receptionist shared with ENT (dedicated)
Part-time Aboriginal liaison (FT)
No specialist outreach coordinator (1)
No Eye Unit Manger (1)
Coordination with local optometrists

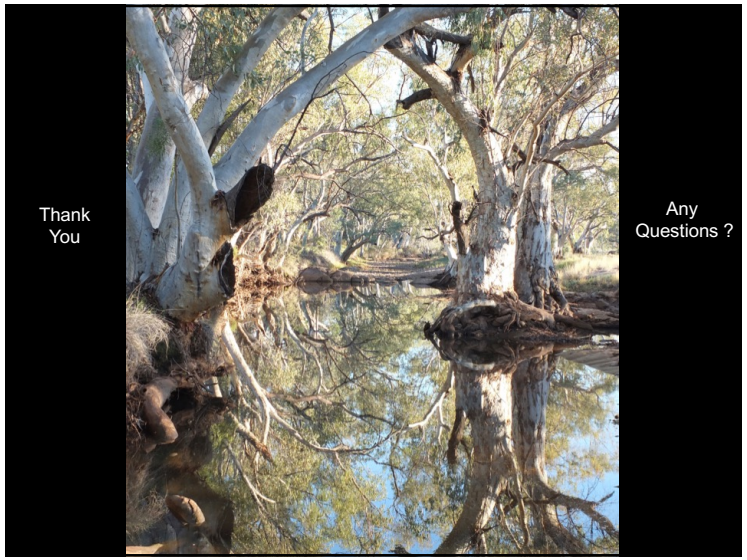
FACILITIES

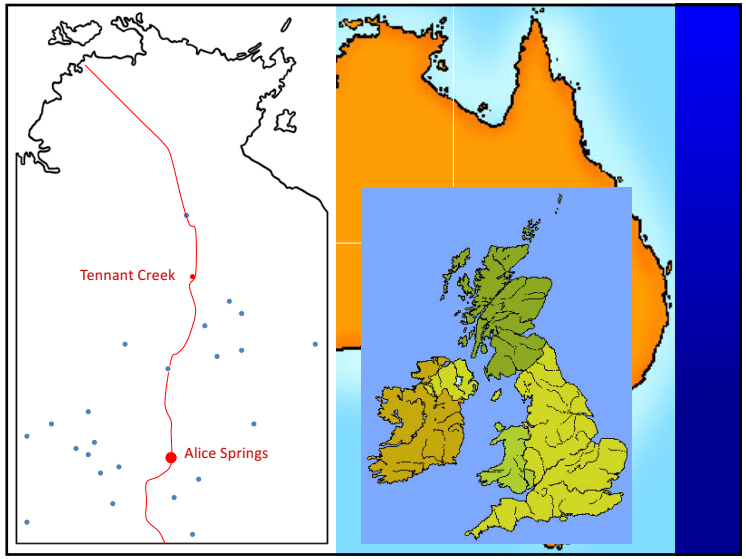
5 rooms (regional unit)
DPU theatre 1.5 days (2 + opportunistic surgery)

SERVICES

Full time on-call (shared on-call)
Outreach 42 visits to 30 communities per year (+)
Theatre 375 – 400 per yr (550 – 600)
Outpatients 3500 per yr (5 -6000)
Tennant Creek 6 x a year (6+)


Dedicated allocated funding
Develop efficient service delivery
• Initial investment for regional centre
• Adequate space
• Sufficient support staff
Co-ordination linking primary / secondary / tertiary
RETURNS GUARANTEED !


Thank You
Any Questions ?


Tennant Creek
Alice Springs


EYE
EYE
10:17 29/OCT/2012

Challenging health environment

- Indigenous Australians life expectancy 10- 20 years less
- Highest rates renal failure in the world
  - Tennant Creek dialysis rates
- High rates cardiac & respiratory disease & diabetes (3x)
- Increasing burden of chronic disease
- Personal health often not able to be a priority
- Cultural Priorities
  - Connection to country / Sorry business
- Taboos and fears – preference to avoid hospitals
  - Delayed presentation
  - Advanced disease processes
  - Sporadic attendance

Pragmatic and Opportunistic patient care

Challenging Eye Health Environment

- Increasing chronic disease workload – lifetime
- Diabetic Retinopathy causes 9% blindness in this population
- Risk of vision loss is 8 x greater in Diabetics
- Blindness rates 3 x non-indigenous Australians
- Trachoma prevalence 21% to 4.6% (2008 – 20016)
- Cataract higher rates of blindness, lower rates of surgery
- 40% population take up 60% time
- Over an area the size of Spain (>1M square Kms)
- 20-25,000 km travel a year

Are your eyes OK?

- Kuru Palya
- Alkgna Mara
- Alkgne Mwerre
- Milpa Ngutchu
- Miyu Kamada
- Ankga Mora
- Napunju Mandatch

Why Bother? – Positives

- Providing a service where it is desperately needed
- Perversely more rewarding when able to succeed despite all the challenges
- Great technically challenging surgery & wide range,
- Excellent and unique training opportunities for eye registrars - ongoing RANZCO support & accreditation
- Remarkable environment – social, cultural and natural

Why Bother? – Negatives

- No Outpatient Private Practice
- On-call and impact on family
- Huge turnover of staff
- Difficult to build continuity yet establishing relationships is crucial for Indigenous patients
- Long-term problems subject to short-term planning / yearly budget cycles
- Emphasis on completing reports/stats taking clinical staff away from delivering clinical care

CATSINaM
CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES

Approaches to embedding cultural safety in individual and organisational practice

Close the Gap for Vision by 2020: National Conference

Melbourne, March 17th 2017

Janine Mohamed, Kathleen Stacey & Ben Gorrie

Unity and Strength through Caring

Who is CATSINaM?

We are:

- the national professional association for Aboriginal and Torres Strait Islander nurses and midwives
- established initially as CATSIN in 1998
- a membership-based organisation with over 900 members at present

The largest numbers of Aboriginal and Torres Strait Islander health professionals are in the nursing and midwifery workforce

Unity and Strength through Caring

CATSINaM

What does CATSINaM strive for?

- Non-Indigenous nurses and midwives receive a good grounding in what cultural safety and respect is, and understand that this as a life-long journey
- Greater numbers of our Members in the health system in all sectors
- Our Members are resilient and connected
- There is increased understanding and shared commitment to cultural safety in the nursing and midwifery professions
- Culturally respectful health systems where Aboriginal and Torres Strait Islander peoples experience cultural safety and have better health outcomes

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Why focus on Cultural Safety?

- Aboriginal and Torres Strait Islander Australians are more likely to seek access to health care, and achieve better health outcomes by accessing services that are respectful and culturally safe places.
- A lack of cultural safety and institutional racism are barriers to recruitment and retention of Aboriginal and Torres Strait Islander students and graduate nurses and midwives.
- Under-representation of Aboriginal and Torres Strait Islander peoples in the health workforce is a contributing factor to the lower rates of Aboriginal and Torres Strait Islander peoples accessing health services comparative to need.

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What does CATSINaM do about Cultural Safety?

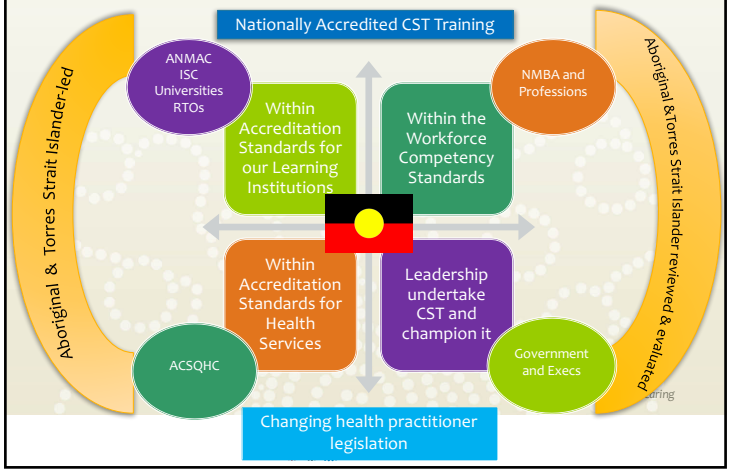
- Promote our Cultural Safety Policy Position Statement – currently being updated as 'Embedding cultural safety across nursing and midwifery'
- Promote our 'Towards a shared understanding of terms & concepts: strengthening nursing and midwifery care for Aboriginal and Torres Strait Islander peoples' paper
- Hold 2-day 'Cultural Safety and Respect Workshop' for key stakeholders (ongoing)
- Run Member workshops on Cultural Safety and Resilience (ongoing)
- Held a National Nursing and Midwifery Cultural Safety Summit (2014)
- Held a 'Cultural Safety in Policy and Practice Summit' (2016)
- Adapted the Aboriginal and Torres Strait Islander Health Curriculum Framework for nursing and midwifery with a core focus on cultural safety (2016-2017)

Just stepping into VET Sector for the same reason with Enrolled Nursing

Unity and

CATSINaM

Where to embed CST/Cultural Respect



National government statements

Unity and Strength through Caring

Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013-2023

- In the section on 'health system effectiveness', Strategy 1B states that:

*"Mainstream health services are supported to provide clinically competent, **culturally safe**, accessible, accountable and responsive services to Aboriginal and Torres Strait Islander peoples in a health system that is free of racism and inequality"*

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Learnings about embedding cultural safety

- Address the confusion regarding terminology and the philosophy of cultural safety –accessing the right training
- Clarify the role of non-Aboriginal people in cultural safety
- Emphasise the importance of organisational and professional leadership
- Take an organisational cultural change approach to shape individual and organisational practices

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A self-reflection exercise on cultural safety

- Who has attended 'cultural **safety** training'?
- What understanding do you have of cultural safety?

1 = None 2 = Limited 3 = Some 4 = Fair 5 = Good

- What ability do you have to explain the difference between cultural awareness and cultural safety training?

1 = No 2 = Limited 3 = Some 4 = Fair 5 = Good

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What is the focus of Cultural **Safety** Training?

- Recognising, understanding and responding to racism
  - at an individual level
  - at the social-cultural and institutional or systemic level
- Understanding how dominant culture values and beliefs shape health care practice and attitudes – individually and systemically
- Encouraging critical self-reflection for non-Aboriginal people
- Exploring 'whiteness' and white privilege and how it shapes the lives of Aboriginal white people and Aboriginal and Torres Strait Islander Australians
- Learning that cultural safety is the experience of the recipient of care, it is not defined by the caregiver.
- Understanding the impact of colonisation and dispossession, and the historical and ongoing effects in Aboriginal and Torres Strait Islander people's everyday lives

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Examples of feedback from CATSINaM's Cultural Safety Training

Theme: Opportunities provided for personal insight, development and self-reflection

"They were thought-provoking and I had not thought of racism from the point **of *white privilege*** before."

"I was turned to look at myself and deeply examine my thoughts and views about race, racism and whiteness."

"The presentations were directional, probing and confronting in a positive supportive way."

Theme: Challenging and confronting, but essential to moving forward and beyond other learning of this kind

"…enabled the challenging questions to be addressed both internally and with my peers."

"Recognition that the context of my work (and the world) is the dominant paradigm and is not easy for everyone."

Theme: How to identify the impact of institutional racism in practice

"Gave me a much richer and in depth awareness of the stark inequality and unfairness in the health sector for Aboriginal and Torres Strait Islander health workers and patients."

What is the focus of Cultural **Awareness** Training?

- Raising the awareness and knowledge of participants about the experiences of cultures different from their own - in particular, different from dominant culture
- If racism is named the focus is on individual acts of racial prejudice and racial discrimination rather than racism as it is embedded in systems
- Historical overviews may be provided, but the focus is on the individual impact of colonisation, rather than the inherent embedding of colonising practices in contemporary health and human services institutions
- Maintains an 'other' rather than a clear self-reflective focus for participants – people attend to learn about Aboriginal people and culture, not about themselves
- Non-Aboriginal participants are not usually asked to engage in critical self-reflection about:
  - themselves
  - their culture
  - how racism is embedded at an institutional level

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Role of non-Aboriginal people in cultural safety

Why am I here presenting on cultural safety?

Non-Aboriginal, particularly white Australians have a **critical** and **necessary** role

Acknowledge racism's existence then identify, address and dismantle racism

Take leadership and responsibility

Unity and Strength through Caring

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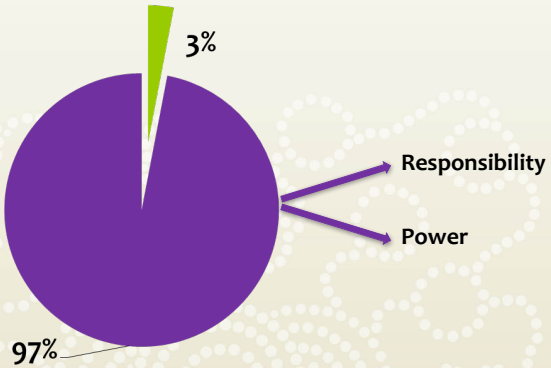
Whose problem? Whose responsibility?



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Organisational and professional leadership

Why is this important?

- Our people are dying too soon, too often and are sick much earlier in life with many years of quality life lost
- Leadership must come from different sources – we cannot rely on government to **consistently** 'walk its talk' despite the national statements, as it has a poor track record
- Cultural safety must be present in the health system itself, if we are to tackle institutional racism, not just cultural safety in individual practice
- "The standard you walk past is the standard you accept" – this can only be addressed through committed organisational **and** professional leadership

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Critical self-reflection – how do I and the organisation operate?

Knowing how you operate in Aboriginal and Torres Strait Islander health:

- Lack of practical knowledge - 'don't know how'
- Have a fear of practice - 'too scared' or 'professional paralysis'
- Aboriginal health is perceived as too difficult - 'too hard'
- Learning to practice regardless - 'barrier breaker'

Your self-reflection about where your experiences, characteristics and confidence lie is important.

It highlights and encourages growth in you as a health professional, rather than Aboriginal clients or workers being the focus for change.

Unity and Strength through Caring

AM Wilson, AM Magarey, M Jones, K O'Donnell, J Kelly (2015)"Attitudes and characteristics of health professionals working in Aboriginal health"

CATSINaM

Barriers and enablers to cultural safety at an organisational level

- Gain leadership commitment to a long-term strategy
- Leadership undertake the training **first**
- Plan an approach that includes cultural safety training and **other strategies**, as well as consider risk management
- Build 'critical mass' among staff to champion change
- Identify structures for people to support each other on the journey, as there can be resistance and language can be difficult
- Have a specific strategy to support Aboriginal and Torres Strait Islander staff - they have unreasonable expectations placed on them to take greater responsibility for cultural safety

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Other organisational strategies – what could they be?

- How is cultural safety identified in strategic and business plans?
- Is racism named in the 'code of conduct'? More importantly, is it **acted** on?
- Is there an anti-racism policy? Again, is it **acted** on?
- What support is there for staff to undertake cultural safety training?
- Is there a strategy to bring cultural safety into the organisation to ensure staff undertake it?
- Does cultural safety get named and identified as a priority during induction/orientation?
- Do you ensure that students on placement have learned about cultural safety and Aboriginal and Torres Strait Islander health before their placement?

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CATSINaM

The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework

An adaptation of and complementary document to the 2014 Aboriginal and Torres Strait Islander Health Curriculum Framework

Version 1.0: 2017 (FINAL DRAFT, January 2017)

Unity and Strength through Caring

Final version will be endorsed by CATSINaM Board in May 2017 and promoted widely

Four curriculum content themes

- **Theme 1:** Cultural safety
- **Theme 2:** History and diversity of Aboriginal and Torres Strait Islander peoples, the post-colonial experience and implications for population health and health care practice
- **Theme 3:** Partnerships with Aboriginal and Torres Strait Islander health professionals, organisations and communities
- **Theme 4:** Clinical practice, service delivery and achieving culturally safe health care systems

Recommended teaching order

Unity and Strength through Caring

CATSINaM

Other organisational strategies – what could they be?

- What employment strategies exist to increase the number of Aboriginal and Torres Strait Islander staff?
- What support strategies are developed and implemented that consider the cultural safety of Aboriginal and Torres Strait Islander staff within the organisation that respond to these needs and help retain staff?
- How do Aboriginal and Torres Strait Islander people (staff, service users, community members and other organisations) play a role in the governance and decision-making processes of your organisation – including program design, delivery, review and evaluation?
- How does your organisation visually and verbally acknowledge Aboriginal and Torres Strait Islander people's presence, i.e. in the building, entrance, waiting rooms, service delivery spaces and at events or forums?

CATSINaM

Questions to address about cultural safety

1. Have I really attended cultural safety training?
2. Are my health service colleagues and leaders attending cultural safety training?
3. What responsibility are **non-Aboriginal people** taking to create cultural safety in my work contexts?
4. What leadership is taken in my **organisation** to be explicit about cultural safety in policy and practice? Who takes it? What part do I play?
5. What leadership is taken in my **profession** to be explicit about cultural safety in professional and accreditation standards?
6. What organisational cultural change strategies are being implemented?

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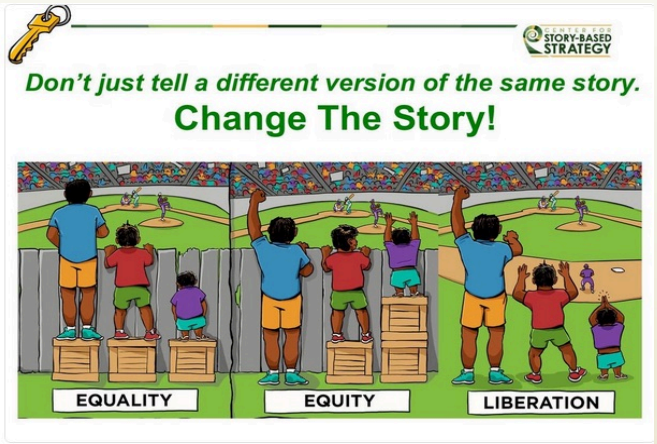

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CONGRESS OF ABORIGINAL AND TORRES STRAIT ISLANDER NURSES AND MIDWIVES

Thank you

"Australians … must constantly test their own institutions, their democracy and their defence of the human rights of minorities by the worlds best standards."

Justice Michael Kirby, 2004