Introduction

In Part I of this Report we summarised the BAHHWA research and other information related to Aboriginal heart health. In Part II we address the question of what can be done to respond to the issues raised by this research, and report on recommended strategies for action that were developed through a variety of consultations. These strategies give more detail to the recommendations given at the end of each section in Part I.

Principles for changing the Aboriginal heart health story

As discussed previously, social, economic and environmental factors remain major determinants of health throughout life. These need to be considered when making policy and planning programs and services.

A healthy lifestyle, including regular exercise, smoking cessation, reduced stress and a healthy diet, lowers the chances of developing cardiovascular disease. Similarly, following the occurrence of symptoms or diagnosis of heart problems, there are effective preventive actions including early assessment by a GP, good follow-up care, timely communication between primary care and hospital providers, and appropriate referral for other cardiac rehabilitation including dietary advice.

However, putting strategies into action is complex and challenging. Changing health behaviour is much more complicated than simply giving people information, just as changing healthcare practices is more complicated than producing clinical guidelines. The manner in which information is communicated, the context and the supports for patient change are all important, as reflected in the VicHealth best-practice principles for promoting health in Aboriginal communities (see Box 9). These principles are a useful guide for planning and implementing services and programs. They are most achievable when there are strong intercultural partnerships and co-operation across different government sectors, business and the community.

Best Practice Principles to Promote Health in Aboriginal Communities

- take account of historical, social, economic and cultural contexts
- use an approach that is owned and driven by the community, and builds on strengths to address priorities identified by them
- be flexible and allow for innovation
- be accountable, in particular, build in monitoring and evaluation systems and use interventions that have been shown to work
- develop comprehensive and diverse strategies to address social, economic and environmental disadvantages impacting on health
- ensure sustainable funding, program design and governance
- ensure early prevention and treatment with timely and appropriate care

From Life is Health is Life (VicHealth, 2011)² http://www.vichealth.vic.gov.au/lifeishislife
To improve the Aboriginal heart health story, effective intercultural relationships between organisations and individuals need to be developed and strengthened and trust built. Differences within and between organisations include factors such as:

- the complex and diverse needs of individuals and communities
- different models of care
- differences in funding and reporting between mainstream and Aboriginal Community Controlled Health Services
- organisational capacity for change

All of these factors require integrated strategies, partnerships and good governance in order to provide effective care. Intercultural partnerships are integral to promoting individual, family and community health. The case study below shows how a policy to encourage partnerships between mainstream and Aboriginal services was implemented in Victoria. The policy resulted in substantial sharing of resources and joint planning between organisations that had often not worked collaboratively before.

**Policy support for health promoting partnerships**

The value of working in partnership is well recognised, and as a policy direction has in some cases successfully driven practice. Here we describe an example of how this was achieved through the Aboriginal Health Promotion and Chronic Care partnership (AHPACC) program, funded by the Victorian Health Department.

AHPACC supports Aboriginal Community-Controlled Health Organisations (ACCHOs) and mainstream community health services to work in partnership to develop and deliver local services and programs addressing the high prevalence of chronic disease within Aboriginal communities.

The AHPACC funding model recognises that when funding is directed only towards service delivery, staff are often inadequately supported, and services and programs may not reflect the needs of the local community. Consequently, the funding model specifies that agencies can only use 50% of their funding for direct services, and requires the remaining funds to be used for activities such as working in partnership, community engagement, workforce development, organisational change and looking at new ways to deliver programs. These additional activities are monitored and supported through the use of a CQI Tool ([http://www.health.vic.gov.au/aboriginalhealth/programs/partnership_program](http://www.health.vic.gov.au/aboriginalhealth/programs/partnership_program)) that must have senior management endorsement within all AHPACC partnership organisations.

An example of an outcome from this policy is the resource produced by one of the AHPACC partnerships for mainstream partner organisations, 'Improving employment opportunities for Aboriginal workers in mainstream community health services: an Aboriginal Readiness Checklist'. This resource guides organisations to improve their readiness and ability to recruit and retain Aboriginal staff. It also includes resources to ensure that direct-care staff and administrators have appropriate skills, knowledge and attitudes. The resource includes case studies of practices that are proven to be effective. In addition it provides examples of organisation policies, administrative procedures and management practices that support access to culturally appropriate services and competent personnel.
By changing the nature of the funding contract with these organisations, the policy encouraged innovation, workforce development initiatives and co-operation between organisations.


**CASE STUDY**

**Box 10 cont.**

**Structure of this Report according to levels of action**

Not only do strategies to improve Aboriginal health need to incorporate intercultural principles, they also need action to happen at three levels simultaneously: the individual-family-community level; the organisational level (e.g., health services); and at the government/policy level (Figure 18).

We have structured Part II of the Report according to these three levels. Thus Section 2 reviews actions at the individual-family-community level. Subsequent sections look at the organisational actions to support health workers in delivering programs and services according to the Section 2 recommendations (Section 3), and the necessary government/policy level support (Section 4).

While the strategies for action are given here according to the levels that implement the actions, it is important to ensure that actions at different levels are integrated and all aligned to improve Aboriginal health. ‘Good news stories’ and case studies are presented throughout the Report as a guide to successful actions. Also, in Appendix 5, we include resources to help translate recommendations to practice.

**How the actions were developed**

An ‘Information for Action’ workshop was held in November 2013, initiated by the BAHHWA group. Representatives from diverse sectors, including research, policy, and health service provision, came together with representatives of Aboriginal health organisations and the Aboriginal community to discuss ideas and share their knowledge and experience. Their responses were organised into a framework that reflects the multi-level approach needed to implement strategies for action, that is, the three-level approach shown above (Figure 18). Many of the workshop participants subsequently joined the ‘Information for Action’ Reference Group and have continued to have input into these recommended actions.

In addition to the ‘Information for Action’ workshop, we have drawn on other sources, including recommendations made by the authors of the research reported on in Part I. Policy level strategies discussed here are informed by the work of a Victorian Aboriginal health partnership project (AHPACC), and recommendations from a national consultation process, the ‘Better Cardiac Care for Aboriginal and Torres Strait Islander People’ forum, an initiative of the Australian Health Ministers’ Advisory Council (AHMAC).
The work of the AHMAC ‘Better Cardiac Care’ forum occurred concurrently with the development of the BAHHWA ‘Information for Action’ Report. The AHMAC forum undertook extensive expert consultation in 2013-2014, but only considered gaps in cardiac care for Aboriginal people that were within the remit of the health system. Through this process, participants identified priority areas for intervention and corresponding strategies, aligned with current national and relevant international guidelines of best practice. They also drew on previously implemented, successful or promising programs of care. The AHMAC work also emphasises the importance of integrating actions across all levels, recognising the needs and capacities of individuals and families as well as differences between health service providers. The ‘Better Cardiac Care’ forum priorities are expressed as policy level actions; consequently, they have been included in the Government Level section of this Report.

In setting policy direction, in particular where it influences resourcing, ‘Better Cardiac Care for Aboriginal and Torres Strait Islander People’ will significantly contribute to the successful programs and organisational changes described in the first two sections of Part II of this Report.
CASE STUDY

Box 11

Getting Started, Leading By Example and the Power of Ripples

Kathy* was an experienced communicator and educator working for an Aboriginal organisation. Her job involved a lot of travel and liaising with Aboriginal primary health care services for the purposes of training, support and encouragement to improve health service delivery, including management. For many years, she had been unhappy with being overweight.

Kathy’s brother was a diabetic who, following a foot injury, developed an ulcer that became infected, eventually resulting in foot amputation. Kathy was deeply affected by this, being aware of her own risk factors: lack of regular physical activity and being overweight, as well as the family history. She was conscious that her New Year’s resolutions for each of the last 3 years had been to ‘lose 20 kg … exercise more’. She was also experiencing problems with aching joints and difficulty getting up out of chairs. Reflecting on this, she realised that if she genuinely wanted to exercise more and lose weight, she would need to make a commitment and act upon it immediately.

She sought a sustainable lifestyle change rather than a short term ‘diet’. Her strategy for eating was to focus on the ‘Great Australian Diet’ she had read about: a variety of fresh and unrefined foods, predominantly plant-based (grains, fruits, vegetables, nuts and legumes) with the addition of lean meat. This strategy was simple and readily achievable even when she was travelling. She committed to walking every morning and night; if the weather was bad she used a cross trainer or gym. She had a frank conversation with her partner (who also had many chronic disease risk factors) about how important this change was to her, and sought his help and support. His previous resistance to walking with Kathy had made it difficult for her to exercise, but hearing her concerns and aware of what had occurred to her brother, he agreed to exercise with her, although not every day.

Kathy managed to maintain the lifestyle changes to which she had committed. She stopped drinking alcohol regularly, saving it for special occasions only, and avoided drinks containing sugar and calories, instead drinking diet cola or soda water with lime. She lost 10 kg over several months, and, as her figure and fitness improved, this became obvious to others around her. The old aches and pains she had been feeling, one of her main reasons for not exercising, lessened.

Her work colleagues, both Aboriginal and non-Aboriginal, couldn’t help but notice the change in Kathy as the kilograms were progressively shed. She was open about sharing her new lifestyle strategy when anyone asked, but there was no sense of her pushing it down others’ throats or of being a health promotion zealot. Co-workers sometimes came with her on lunchtime walks. Her organisation even started to have the occasional walking meeting, and put more emphasis on healthy catering. Kathy’s relatives were also aware of her success and made changes in their own lives. Her partner regularly responded to her requests to walk the dogs with her. His fitness improved so he was no longer puffing just getting up off the couch as he had done before. Without her having imposed lifestyle changes on anyone (other than her partner), the benefits of the changes she had made became obvious, not only to Kathy’s siblings, work colleagues and friends, but also to the much wider group of people that she interacted with through her work and all the travel this involved.

Kathy was feeling better physically, and her new sense of wellbeing reinforced the value of—and her commitment to—a healthier lifestyle. She enjoyed looking and feeling better, had a greater sense of control in her life, and appreciated the support from her partner and additional opportunities for communication with him.

Kathy’s changes have served as a source of inspiration for others, and in turn, their changes have influenced those around them. That’s a ripple to be proud of.

Source: Anonymous account told to a BAHHWA researcher (*not her real name)