Working in partnership

AIHW and the Office for Aboriginal and Torres Strait Islander Health

Almost one year on from the Australian Government's announcement of emergency measures to protect Aboriginal children in the Northern Territory, it is clear that strong partnerships underpin the initiative's progress and its future.

An integral part of the emergency response has been voluntary child health checks and at the time of writing over 8,700 checks had been undertaken in remote communities and outstations across every region in the NT.

The Australian Government Department of Health and Ageing's Office for Aboriginal and Torres Strait Islander Health (OATSIH) has responsibility for planning and mobilizing the resources for the child health checks. This has involved the direct recruitment, training and deployment of child health check teams that include a doctor and up to three nurses, and administrative support staff. Increasingly, Aboriginal Community Controlled Health Services and the Northern Territory Department of Health and Community Services are working with OATSIH on the Child Health Checks and follow-up services.

An important part of the initiative is ongoing examination of its implementation and impact, and in view of that a memorandum of understanding (MoU) to cooperate on an evaluation was signed between OATSIH, the AIHW, the Northern Territory Health and Community Services, and the Aboriginal Medical Services Alliance of the Northern Territory.

OATSIH's Brendan Gibson said the Institute's 'crucial role' is as data custodian and to provide independent analysis.

To support the four-party MoU, another agreement between OATSIH and the AIHW was signed, contracting the Institute to collect the data from the health checks, build a database of information, undertake analysis and produce reports.

Dr Gibson said the AIHW has worked hard to understand the needs of the project and proven to be a responsible and professional partner.

'The Institute's role is professional and expert data collection and analysis. Its independence is also important', he said.

The information gathered from the child health checks is significant in terms of determining the health needs of individuals and communities and planning follow-up health services.

Each child health check takes an age-specific history of medical conditions, including general health, immunisations and development. For children aged 12 to 16 years, questions about alcohol, tobacco, other substances, mood, self-harm and sexual health (if indicated) apply. Social history, such as living conditions, is also covered.

It is a comprehensive examination similar to a thorough check-up by a GP of height, weight, eyes, ears, teeth, skin, heart sounds, lungs and abdomen, as well as other matters such as a finger prick blood test for haemoglobin level (anaemia), and possibly glucose (diabetes) in older children.

De-identified copies of child health checks are sent to the AIHW to enter into a database, after which the Institute analyses the information and provides ongoing reports to OATSIH. The Institute has also been able to provide expert advice on data collection issues.

Dr Gibson said the information received back from the Institute has already been used to coordinate follow-up services and planning in individual communities for health services.

'It is already affecting the implementation of the initiative. It is also a major contributor to the evaluation which will inform future policy making, on the basis of how successful we've been in reaching children with child health checks and follow-up services.' ■