Aboriginal Health Council
of South Australia Ltd.

ANNUAL REPORT

AHCSA THE HEALTH VOICE FOR ABORIGINAL PEOPLE ACROSS SOUTH AUSTRALIA 2016-2017

ABOUT AHCSA

Aboriginal Health Council of South Australia Limited (AHCSA) is the peak body representing Aboriginal community controlled health and substance misuse services in South Australia at a state and national level.

Our primary role is to be the 'health voice' for all Aboriginal people in South Australia. We achieve this by advocating for the community and supporting workers with appropriate Aboriginal health programs based on a holistic perspective of health.

AHCSA is a membership-based peak body with a leadership, watchdog, advocacy and sector support role, and a commitment to Aboriginal self-determination.

The Board of Directors and the Secretariat collectively form AHCSA. The role of the Secretariat is to undertake work directed by the Council on which all Member organisations are represented.

AHCSA's 36 year history includes:

1981 Incorporated health unit under the South Australian Health Commission Act.

1999 Commissioned a review that recommended reincorporation under the Associations Incorporation Act, SA 1985, to increase effectiveness and representation.

2001 Reincorporated in October as an Aboriginal community controlled organisation, governed by a Board of Directors whose members represent Aboriginal Community Controlled Health and Substance Misuse Services and Aboriginal Health Advisory Committees/Groups (AHACs/AHAGs) throughout South Australia.

2011 AHCSA celebrated its 10th anniversary as an independent Aboriginal Community Controlled Health Organisation.

2014 AHCSA Inc. purchases land and building at 220 Franklin Street, Adelaide, South Australia.

2015 AHCSA Inc. submits an application for exemption to incorporate under the Corporations (Aboriginal and Torres Strait Islander) Act 2006 with the Minister for Indigenous Affairs, the Honourable Nigel Scullion.

2016 Exemption is granted in February, and paperwork is completed for AHCSA to incorporate under the Australian Securities and Investments Commission (ASIC). AHCSA's Board of Directors updated its Constitution to meet ASIC requirements. In August, a Special General Meeting was held with AHCSA Members to endorse the revised Constitution for AHCSA Limited. Paperwork was submitted to ASIC to register as a company.

2017 In January, the Aboriginal Health Council of South Australia Incorporated became the Aboriginal Health Council of South Australia Limited. As such, it became a registered company under the Corporations Act 2001 and is a company limited by guarantee. This is an exciting new phase for the Aboriginal Health Organisation and we work towards becoming a sustainable organisation for Aboriginal people across South Australia into the future.

AHCSA MEMBERS

Aboriginal Health Council of South Australia Ltd.

PIKA WIYA HEALTH SERVICE ABORIGINAL CORPORATION

Established as Pika Wiya Health Services Inc. in the early 1970s to provide a medical service to the Aboriginal population in Port Augusta and Davenport, the organisation was incorporated in 1984 under the SA Health Commission (now Country Health SA Local Health Network Inc.). On 1 July 2011, the service transitioned to Aboriginal community control under the CATSI Act.

Now known as Pika Wiya Health Service Aboriginal Corporation, the organisation operates from premises in Port Augusta and also has clinics at Davenport, Copley and Nepabunna communities as well as provides services to the communities of Quorn, Hawker, Marree, Lyndhurst and Beltana.

NGANAMPA HEALTH COUNCIL

Established in 1983, Nganampa Health Council is an Aboriginal owned and controlled health service operating on the Anangu Pitjantjatjara Yankunytjatjara Lands in the far north west of South Australia. Covering more than105,000 square kilometres, Nganampa Health operates nine clinics, a 16 bed aged care respite facility and assorted health related programs including aged care, sexual health, environmental health, health worker training, dental, women's health, male health, children's health and substance abuse prevention.

The main clinics are located at Iwantja (Indulkana), Mimili, Fregon, Pukatja (Ernabella), Amata, and Pipalyatjara, while smaller clinics are located at Yunyarinyi (Kenmore Park), Nyapari and Watarru. The aged care respite facility is located at Pukatja and administration offices at Umuwa and Alice Springs.

PORT LINCOLN ABORIGINAL HEALTH SERVICE INC.

The Port Lincoln Aboriginal Health Service (PLAHS) was founded by the local Aboriginal community in 1992, with the assistance of the Aboriginal and Torres Strait Islander Commission and the South Australian Health Commission through the National Aboriginal Health Strategy. The establishment of the service resulted from a number of reports and submissions put to both the Commonwealth and State Government from the mid 1980s onwards.

NUNKUWARRIN YUNTI OF SOUTH AUSTRALIA INC.

Nunkuwarrin Yunti was initiated in the 1960s by the late Mrs Gladys Elphick, who founded the Council of Aboriginal Women of SA, one of the first Aboriginal organisations in South Australia.

Incorporated in 1971, Nunkuwarrin Yunti evolved from the Aboriginal Cultural Centre, the Aboriginal Community Centre of South Australia, and the Aboriginal Community Recreation and Health Services Centre of South Australia, and became known as Nunkuwarrin Yunti of South Australia Inc. in 1994. In 1998, Nunkuwarrin Yunti was awarded NAIDOC Organisation of the Year in South Australia.

The organisation has grown from a welfare agency with three employees to a multi-faceted community controlled organisation with over 70 staff who deliver a diverse range of health care and community support services.

NUNYARA ABORIGINAL HEALTH SERVICE INC.

Prior to 2003, there were only two Aboriginal Health Workers in Whyalla. Due to access and equity issues raised in 1996 and the overall appalling state of health in the broader Aboriginal community, Nunyara Wellbeing Centre was established.

Nunyara integrates Indigenous holistic models of health care with western models, so that the benefits of both may assist the community. The organisation recognises the wide range of factors that impact on wellbeing including poverty, relationships and the environment, and is working to strengthen the community's capacity to manage their health and wellbeing more effectively. The Nunyara Wellbeing Centre Inc. changed their name to the Nunyara Aboriginal Health Service in October 2012.

TULLAWON HEALTH SERVICE INC.

Established in 1982 as the Yalata Maralinga Health Service Inc. (YMHS) following community initiative and lobbying, the health service was not only concerned with looking after people living in Yalata but also older people who had returned to their traditional lands in the north and at Oak Valley, north west of Maralinga.

By the late 1990s, Oak Valley was ready to establish its own health service called Oak Valley (Maralinga) Health Service (OV(M)) based on two principles that the Anangu people of Yalata and Oak Valley are one people, and both YMHS and OV(M) should have cooperative and 'seamless' arrangements for Anangu between the services.

On 31 May 2001, the YMHS Constitution was amended and the name of the organisation changed to Tullawon Health Service Inc. with the importance of the two principles remaining in the Constitution.

UMOONA TJUTAGKU HEALTH SERVICE ABORIGINAL CORPORATION

Umoona Tjutagku Health Service Aboriginal Corporation (UTHSAC) provides primary health care services to Aboriginal people in and around Coober Pedy and also auspices the Dunjiba Substance Misuse Program in Oodnadatta.

Established in 2005, UTHSAC has expanded steadily over the past 10 years to provide a comprehensive range of high quality services including medical, dental and social services for the community as well as an increasing number of transient clients.

ABORIGINAL SOBRIETY GROUP INC.

The Aboriginal Sobriety Group Inc. (ASG) has been operating since 1973 when it commenced as a voluntary self-help group for people wanting to regain their sobriety.

Today, ASG provides a complete alcohol and drug substance misuse recovery pathway including Crisis Intervention – Mobile Assistance Patrol; Substance Misuse Team – establishes clients' needs and provides referrals; Stabilisation – short-term assistance through hostels and the Health and Fitness Centre and referrals for rehabilitation; and Rehabilitation – long-term holistic program provided by Lakalinjeri Tumbetin Waal.

KALPARRIN COMMUNITY INC.

Kalparrin is a Ngarrindjeri word meaning 'helping with a heavy load'. The organisation was established in 1975 by a group of Elders who were looking for something better in their lives besides alcohol and other drugs.

Situated on a property 8kms east of Murray Bridge, some of the programs and services offered are the Substance Use Recovery Program, Bringing Them Home Program, Mobile Assistance Patrol, Spirited Men's Program, and Community and Housing Services.

OAK VALLEY HEALTH SERVICE

Oak Valley Health Service was established in 1985 as a community outstation for Anangu people displaced from the Maralinga Lands for the British atomic tests. Oak Valley (Maralinga) Inc. managed the establishment of the community including housing, roads and other infrastructure. Now serviced with a store, mechanics garage, health clinic, aged care centre, a new school and an airstrip, a CDEP program and arts workshop is also available.

The health clinic provides primary health care to the community, monitoring ongoing health issues such as diabetes, hypertension, ante-natal and post-natal care, child and school health. Their main role is health education, hosting visiting specialists and referrals for the Royal Flying Doctor Service (RFDS).

PANGULA MANNAMURNA ABORIGINAL CORPORATION

Pangula Mannamurna Aboriginal Corporation was established from the South East Aboriginal Partnership which comprised Members from the SE Nungas' Club and community Members whose focus was to form a 'one stop shop' for Aboriginal people in the south east.

The organisation strives to build on the vision of the founding Members who wanted to create a place for Aboriginal people to access health and wellbeing services, gather to discuss and address community identified issues, and to be a place to celebrate achievements and culture.

CEDUNA KOONIBBA ABORIGINAL HEALTH SERVICE ABORIGINAL CORPORATION

First established as the Ceduna Koonibba Aboriginal Health Service, the organisation was designed to meet the health needs of Aboriginal people within the Ceduna district of South Australia including Scotdesco, Koonibba, Tia Tuckia, Munda and Wanna Mar homelands. Incorporated in 1986 under the SAHC Act, on 1 July 2011 the organisation transitioned from the SA Government to Aboriginal community control and became known as Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation.

OUR MEMBERS

Aboriginal Health Council of South Australia Ltd.

Key

- Aboriginal Community Controlled Substance Misuse Service
- Aboriginal Community Controlled Health Service

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Throughout this document, the terms 'program' and 'programme' are used. 'Program' relates to State-funded initiatives, while 'programme' refers to Commonwealth-funded initiatives.

CHAIRPERSON'S REPORT PREPARING OUR MEMBERS FOR THE CHALLENGES AHEAD

The past year has been a busy time of change. The Aboriginal Health Council of South Australia Limited (AHCSA) Secretariat, Board of Directors, and I have worked hard to ensure that the organisation remains true to its vision, mission and Constitutional Objectives. I have endeavoured to visit as many of our Members as possible to support them in ensuring that AHCSA is visible out in the community.

In January this year, the Aboriginal Health Council of South Australia Incorporated became the Aboriginal Health Council of South Australia Limited, which is a major milestone for the organisation and its Members. It marked the beginning of a new chapter of working towards the sustainability of AHCSA into the future. This important transition provides AHCSA with the potential to generate income direct to Member organisations. The progress it provides within AHCSA will further support our communities. With leaner funding available for Aboriginal health, we need to be creative to ensure that we can continue to create healthy communities for future generations.

In this respect, AHCSA has entered into a new partnership with the Institute of Urban Indigenous Health (IUIH) and the Port Power Football Club. IUIH has developed the Deadly Choices Program, which AHCSA has acquired from them. Deadly Choices aims to empower Aboriginal and Torres Strait Islander people to make healthy choices for themselves and their families. Deadly Choices also encourages our community members to access their local Aboriginal Community Controlled Health Service (ACCHS) and complete their annual health checks.

The Deadly Choices Program will commence in South Australia at the Nganampa Health Council and its clinics, in partnership with the South Australian Education Department. Education is a priority for our youth and the Deadly Choices Program encourages making Deadly Choices about health, while preparing our young people for the future. AHCSA's ultimate aim is to develop our emerging leaders. The launch kicked off at the Ernabella (Pukatja) school sports carnival.

In my role as Chairperson, one of the most significant pieces of work I have been involved with has been supporting the Chief Executive Officer with Member meetings and discussions regarding the outcomes from the NOUS Group review on the National Aboriginal Community Controlled Health Service and the State Peaks, commissioned by the Department of Health.

The Department has decided that the Agreement under the Indigenous Australians Health Programme should be administered via the National Aboriginal Community Controlled Health Organisation (NACCHO) for each State Peak body. Extensive meetings have been held throughout this period to discuss and negotiate the new Agreement, which was signed by AHCSA in late June, and lasts for three years with a further two years being offered after that time. This will enable many of AHCSA's key positions, which provide invaluable Member support, to continue.

I would like to acknowledge our Board of Directors for their good governance, support and commitment to AHCSA, and I thank the staff for their hard work and dedication to supporting and assisting our Members and communities.

The next twelve months will undoubtedly see further changes, particularly with the uncertainty of the current political landscape both at a state and national level. However, AHCSA as well as our National, State and Territory Peaks, are well prepared for whatever lies ahead. We will steadfastly be here to provide leadership and support to our Members, which ultimately benefits our communities.

John Singer
Chairperson

I HAVE ENDEAVOURED TO VISIT AS MANY OF OUR MEMBERS AS POSSIBLE TO SUPPORT THEM IN ENSURING THAT AHCSA IS VISIBLE OUT IN THE COMMUNITY

AHCSA LIMITED THE BEGINNING OF A NEW CHAPTER. INCOME DIRECT TO MEMBER ORGANISATIONS

PROVIDING **LEADERSHIP** IN ADDRESSING HEALTH NEEDS FOR OUR MEMBERS AND **ADVOCATING** FOR OUR COMMUNITY ACROSS SA

CEO'S REPORT A YEAR OF CONTINUED GROWTH AND DEVELOPMENT

Being the Peak Body for Aboriginal health in South Australia, AHCSA as an organisation has been represented across the state and interstate on many and varied forums. The funding landscape has changed dramatically, and AHCSA has held discussions with the Department of Health, Canberra, the National Aboriginal Community Controlled Health Organisation (NACCHO) and other NACCHO Affiliates in order to progress the implementation of the new Sector Support Funding Agreement between AHCSA and NACCHO.

It is anticipated that we will be successful in receiving this agreement on 1 July 2017, ensuring that AHCSA can maintain its commitment to our Members and comprehensive primary health care. There have also been numerous conversations, conferences, and work undertaken alongside our Member services.

AHCSA has continued to maintain critical relationships and ongoing support from key stakeholders. In particular this year, the Wardliparingga Aboriginal Research Unit, the South Australian Health and Medical Research Institute (SAHMRI), Cancer Council SA, Cancer Australia, Close the Gap, the Heart Foundation, the South Australian Council of Social Services (SACOSS), Health Consumers Alliance, Mental Health Coalition, Rural Doctors Workforce Agency (RDWA), GPEx, and the Adelaide and Country South Australia Primary Health Networks.

The launch of the South Australian Deadly Choices Program was held at the Adelaide Oval with John Singer, AHCSA's Chairperson, and Adrian Carson, CEO of the Institute for Urban Indigenous Health (IUIH) being interviewed. The Port Adelaide Football Club (PAFC), along with David Koch, PAFC Chairperson, hosted the event. Since then, further progress has been made on the Deadly Choices Program rollout in South Australia. There has been ongoing engagement with the PAFC and the State Department of Education regarding the Program. Training will soon commence through IUIH for the school Programs. This will include site visits to IUIH with representatives from the PAFC, senior staff from the State Department of Education and Gavin Wanganeen, South Australian Deadly Choices Ambassador.

AHCSA's Registered Training Organisation (RTO) is expanding with continuing progress in discussions for training to be delivered in partnership with Griffith University Queensland and their five sites, to deliver Certificate III and Certificate IV in Clinical and Practice to pre-enrolled students. This will allow the students to gain direct entry into Midwifery and Nursing study. IUIH are also committed to a training model that will see staff and future students undertake Certificate III and Certificate IV Clinical and Practice programs. Locally, we are continuing discussions with the Dean of Health Sciences at the University of South Australia to look at strengthening pathways in higher education for our Aboriginal Health Worker students.

AHCSA and the Royal Doctors Workforce Agency (RDWA) were principal partners for the Australian Medical Students Association (AMSA) SA Global Health Conference 2017. AHCSA sponsored this event to provide support to the young people who will be part of the medical workforce in the future. This event was very well attended with over 500 students participating.

We continue to ensure that the AHCSA Constitution and the Constitutional Objectives are the foundation of our organisation and are embedded in our Strategic Directions, Organisational Plan and the Organisational Structure to drive program delivery.

Looking towards the upcoming year, we will continue to provide strong leadership in addressing Aboriginal health needs for our Members, and advocate for our community across South Australia.

I would like to acknowledge our dedicated AHCSA staff, who have demonstrated their commitment to ensuring our Members are supported in the maximum capacity that is required.

Thank you to our funders, which include the Department of Health, SA Health, NACCHO, the Department of Prime Minister and Cabinet, GPEx, the Lowitja Institute, the Department of Social Services, and SAHMRI for their continued support to AHCSA and its Members.

It has been another significant year, and we face many challenges ahead. To all staff, Board and Members, thank you for your continued support. Your dedication and commitment to AHCSA ensures our success as the peak body for Aboriginal health in South Australia – our health, our choice, our way.

Shane Mohor
Chief Executive Officer

DEPUTY CEO'S REPORT PARTNERSHIPS CONTINUE TO GROW AND STRENGTHEN

As AHCSA approaches its second year of being truly established at 220 Franklin Street, it is evident that we have developed a strong foundation for the organisation. Periods of change are often accompanied by growth and the 2016-2017 reporting period has been an exciting time as new projects and ventures have developed, research projects have commenced and existing programs/programmes have been nurtured and evolved. Along with this, our relationships and partnerships have continued to grow and strengthen.

I take this opportunity to celebrate the amazing staff at AHCSA, who continue to give their all to support one another, our Members and our students in the high quality of work they carry out with our key partners and stakeholders. We were able reach the end of the financial year with all of our funding agreements and staff contracts continuing on after July 1, with multiple years being offered on some. This provides the ideal environment for stability and continuity, with the potential for substantial program/programme planning, going forward.

Our research arm has continued to expand, with a number of new initiatives with key partners and Members firmly in place. These include the Male Shedding the Smokes Programme, Building Safe Communities for Women, the Gender Equity Study and a new study planned for later in the year focusing on the Aboriginal Workforce. I would like to acknowledge our funders, which include the Lowitja Institute, the Department of Social Services and the Commonwealth Department of Health for making these projects possible. The research teams are working hard with their respective advisory groups, research partners, our Members and community participants to ensure that all of the research they conduct is appropriate, consultative and respectful. They have achieved great outcomes to date, and I have no doubt that they will continue to do so.

The Quality Systems Team continues to excel in their support of our Members with identification and implementation of continuous quality improvement processes such as clinical governance, Communicare training, their SA Quality Improvement Data (SQID) Cycle webinars, and the development of Medicare manuals and training. With the new funding agreement with NACCHO set for three years, there is ample opportunity for the Team to solidify their work and plans to support our Members over this period, rather than having to carry out short term projects. Continuous quality improvement is an essential element to the growth of every organisation, and AHCSA and our Member services are no exception.

The Public and Primary Health Care Team continues to provide their far-reaching support to our Members and areas without ACCHSs, such as Point Pearce, the Riverland, Oodnadatta, Port Pirie and the newly formed Moorundi Aboriginal Community Controlled Health Service.

The Ear and Hearing Health Programme has continued to evolve as has the Sexual Heath and Blood Borne Virus Programs. The latter has embarked on significant research with the Kirby Institute and James Ward at the South Australian Health and Medical Research Institute (SAHMRI). An environmental approach has seen the Trachoma Elimination Program, the Eye Health Programme and the Rheumatic Heart Disease Program working together, where possible, to both share resources and incorporate a holistic and public health approach.

Our former Chief Executive Officer, the late Mrs Mary Buckskin would have been humbled to have an Aboriginal Health Worker Award named in her honour, and it was rewarding to have the Health Awards, and particularly the Inaugural Mary Buckskin Male and Female Aboriginal Health Worker Awards, incorporated into our first AHCSA NAIDOC ceremony held in the new building. It was an honour to host the Buckskin and Karpany families and have them participate in the presentation. AHCSA will host these awards every two years, with the next one scheduled for July 2018.

In closing, it is a pleasure to work alongside a group of people who are inspirational, dedicated and motivated. We are fortunate that this culture extends to the AHCSA staff, Directors, our Members and our partners. I look forward to working with you all over the next twelve months and to the exciting new ventures to come. Thank you for your continuing support.

Amanda Mitchell
Deputy Chief Executive Officer

AHCSA NAIDOC OPEN DAY 2016

SONGLINES: THE LIVING NARRATIVE OF OUR NATION

For Aboriginal and Torres Strait Islander people, the Dreamtime describes a time when the earth, people and animals were created by our ancestral spiritual beings. They created the rivers, lakes, plants, land formations and living creatures. Dreaming tracks crisscross Australia and trace the journeys of our ancestral spirits as they created the land, animals and lores. These dreaming tracks are sometimes called Songlines as they record the travels of the ancestral spirits who 'sung' the land into life. These Songlines are recorded in traditional songs, stories, dance and art. They carry significant spiritual and cultural connection to knowledge, customs, ceremony and Lore of many Aboriginal nations and Torres Strait Islander language groups.

Songlines are represented as intricate maps of land, sea and country. They describe travel and trade routes, the location of waterholes and the presence of food. In many cases, Songlines on the earth are mirrored by sky Songlines, which allowed people to navigate vast distances of this nation and its waters.

In July, AHCSA held its first NAIDOC Open Day in their new building. The Open Day Committee worked hard to ensure that the day was filled with fun and educational activities with stories, artwork, basket weaving, and singing that reflected the National NAIDOC week theme of Songlines: The living narrative of our nation. The Committee arranged for special shirts for the occasion to coordinate with the colour theme of the NAIDOC week posters.

The event began with Taylor Power welcoming everyone to Country on behalf of her mother, Aunty Katrina Power. Garry Goldsmith was MC and introduced Chief Executive Officer Shane Mohor, storytellers and facilitated the award ceremony, which included performances by: Allan Sumner: story and song, Eddie Peters: dance and song, and Aunty Stephanie Gollan: story and artwork.

AHCSA NAIDOC AWARDS CEREMONY

The 2016 AHCSA NAIDOC Awards, was the perfect opportunity to honour former Chief Executive Officer, the late Mary Buckskin with the establishment of two awards in her name: the Inaugural Mary Buckskin Aboriginal Health Worker Award Female and Male Awards.

AHCSA would like to acknowledge and thank the Buckskin family, Professor Peter Buckskin, Peter Buckskin Junior, Lorraine Buckskin, Denise Karpany and Haymish Smith, for attending the Open Day and for presenting the Inaugural Mary Buckskin Aboriginal Health Worker Female and Male Health Awards, which honour AHCSA's former Chief Executive Officer, mentor and close friend, Mary.

They were created to acknowledge her contribution to AHCSA, our Members and her contribution to Aboriginal health in general. These Awards are a continuation of the legacy that Mary started as a nurse, midwife and leader in Aboriginal health.

There were four categories and awards given out on the day:

Outstanding Leadership Excellence Award
Uncle Harold Stewart

Inaugural Mary Buckskin Aboriginal Health Worker Award Female
Kerryn Dadleh

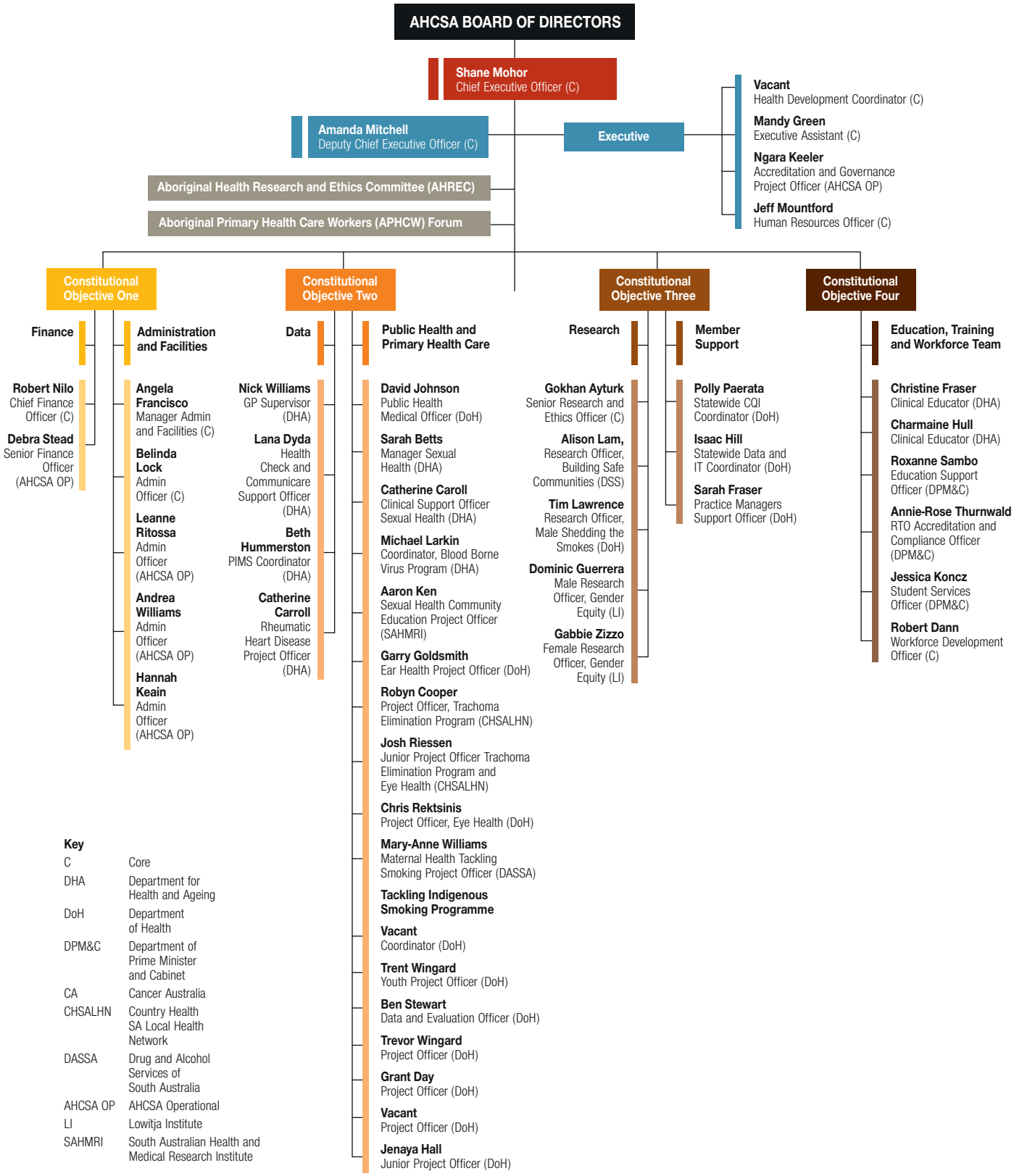
Inaugural Mary Buckskin Aboriginal Health Worker Award Male
Damian Rigney

Outstanding Health Program/ Project Award
Rosemary Wanganeen

As part of the festivities, AHCSA hosted an artist showcase featuring work from Felicia Wilson, Audrey Brumby, Allan Sumner, and jewellery from Aunty Stephanie Gollan. Vicki Hartman provided weaving demonstrations and Miraede Bhatia provided face painting for the children.

Guests were invited to stay on for informal networking, cultural activities and visit the various artists. They were also invited to have a health check in the Simulated Learning Environment with staff and Aboriginal Health Worker students.

AHCSA ORGANISATION STRUCTURE 2016-2017



Key

C	Core
DHA	Department for Health and Ageing
DoH	Department of Health
DPM&C	Department of Prime Minister and Cabinet
CA	Cancer Australia
CHSALHN	Country Health SA Local Health Network
DASSA	Drug and Alcohol Services of South Australia
AHCSA OP	AHCSA Operational
LI	Lowitja Institute
SAHMRI	South Australian Health and Medical Research Institute

AHCSA STRATEGIC DIRECTIONS 2016-2017

OUR VISION

All Aboriginal people enjoy a high quality of health and wellbeing.

OUR MISSION

The Aboriginal Health Council of South Australia Ltd. will work in ways that maximise the capacity of the Aboriginal community in determining their health and wellbeing by ensuring:

- Community participation
- Community ownership

OUR VALUES

We will do this in ways that ensure the Aboriginal Health Council of South Australia Ltd. values:

- Cultural diversity
- Community history and knowledge
- Community strength

AHCSA CONSTITUTIONAL OBJECTIVES

AHCSA will achieve our vision through the objectives set forth in the AHCSA Constitution as the foundation document of the Company.

These Objectives support the activities of the AHCSA Board and Secretariat:

1. Operate as Peak Body for Aboriginal health in South Australia, including by:
   i. Being the peak organisation consulted by Governments in relation to issues of Aboriginal Health;
   ii. Providing leadership in the development of policy affecting Aboriginal communities and their health needs;
   iii. Advocating on behalf of Members and those communities without representation;
   iv. Providing regulatory assistance and enforcement for Members; and
   v. Developing leadership within the South Australian Aboriginal community, including developing youth leaders.
2. Provide support to Members to improve health outcomes for all Aboriginal people of South Australia, promoting and advancing the community's commitment to physical, social and emotional wellbeing and quality of life.
3. Provide support to Members to build their capacity to create a strong and enduring Aboriginal Community Controlled health sector and contribute to improving the capacity of mainstream health services to respond appropriately to the health needs of the Aboriginal community within South Australia.
4. Contribute to the development of a well qualified and trained Aboriginal health sector workforce.

AHCSA IS MOVING FORWARD WITH LOVE AND A DEEP RESPECT FOR OUR COMMUNITIES AND OUR WORK

CONSTITUTIONAL OBJECTIVE 1

OPERATE AS THE PEAK BODY FOR ABORIGINAL HEALTH IN SOUTH AUSTRALIA

CONSTITUTIONAL OBJECTIVE 1

FINANCE AND ADMINISTRATION

MANAGER OF ADMINISTRATION AND FACILITIES REPORT

2016-2017 was a busy and challenging but successful year for the Administration and Facilities Team. In addition to the executive and administrative support provided to Board of Management, secretariat staff, students and various sub-committees, there were many workshops, forums, and sub-committee meetings that were coordinated during the year.

Administration

The Administration Team for the year comprised of:

Name	Position
Leanne Ritossa	Administration Officer
Jessica Koncz	Administration Officer
Mandy Green	Executive Assistant
Lois Multa	Receptionist
Belinda Lock	Administration Officer
Andrea Williams	Administration Officer
Hannah Keain	Administration Officer
Jenaya Hall	Administration Officer

Training, Professional and Personal Development

Members of the Administration Team were supported with the following training, professional or personal development opportunities:

- NetSuite training
- Yammer training
- Alfresco training
- Minute taking training
- Child Safe Environment training
- Assist Finance Team
- Participation in:
  - Trachoma Elimination Program
  - Sexual Health Program
  - Tackling Indigenous Smoking Programme
- Attend AHCSA promotional activities

Quality Improvement and Compliance

Administration personnel and Manager, Administration and Facilities contributed to organisational and departmental continuous quality improvement and compliance. This was achieved by:

- Monthly team meetings
- Bi-monthly staff meetings
- Reviewing records management
- Reviewing organisational policies and procedures
- Reviewing administrative systems and processes
- Reviewing commercial contracts
- Reviewing information and communication devices
- Reviewing fleet vehicles
- Reviewing AHCSA's insurances

Acknowledgements

I'd like to acknowledge Lois Multa's contribution to AHCSA and the Administration Team that spanned many years. Due to personal reasons, Lois ceased employment at AHCSA in September 2016.

I'd also like to take this opportunity to congratulate the following:

- Jenaya Hall, on her appointment as AHCSA's Tackling Indigenous Smoking Programme, Junior Project Officer
- Jessica Koncz, appointment as AHCSA's RTO Student Support Officer
- Mandy Green, who celebrated 15 years' of service in March 2017
- Leanne Ritossa, who celebrated 10 years' of service in July 2017
- Belinda Lock, who celebrated 5 years' of service in June 2017

I'd also like to acknowledge the hard work, commitment, and reliability of all members of the Administration Team. To Leanne, Mandy, Belinda, Jenaya, Jessica, Hannah, and Andrea, the wonderful work you do behind the scenes contributes immensely to AHCSA's achievements. Many thanks to the Administration temping staff, Kerrin Watts, Lauren Young and Molly Dixon.

Facilities Management

August 2016 marked AHCSA's one-year anniversary in its new home at 220 Franklin Street. The event was celebrated with a special birthday cake to mark the occasion.

Over the last 12 months, significant building and facility improvements have been undertaken, as follows:

- Painting of building exterior
- Installation of new roof
- Installation of new car park roller door
- Installation of sound proof windows
- Installation of PA system
- Installation of additional security doors
- Installation of PIN pad at reception
- In-house gym
- Installation of mobile charging stations

Angela Francisco
Manager, Administration and Facilities

CONSTITUTIONAL OBJECTIVE 1

FINANCE AND ADMINISTRATION

MANAGER OF FINANCE REPORT

AHCSA registered a statutory surplus of $72,985 for the FY 2016-2017 compared to a deficit of $523,604 for the FY 2015-2016. The surplus is attributable to the higher number of grants received during the financial year. The surplus could have been higher if not for the accounting treatment of the following, which are expensed for the year instead of being treated as assets:

Roof Replacement	$110K
Deadly Choices	$21K
Merchandise in Stock	$20K

Grants increased by 14% and expenses by 6% respectively during the financial year. The 6% increase in expenses is attributable to the following:

Employment Cost	12%	$476,956
Goods and Services	2%	$68,472
Depreciation	(7%)	($43,467)
Total	**6%**	**$501,961**

Employment cost is higher compared to last financial year as the result of the increase in FTE staff from 39 last financial year to 44 for the current financial year. In view of this, travel costs increased from $807K to $886K. The decrease in operating costs is a result of the lesser amount of write-off for the current financial year.

Financial Position

The overall equity position has increased from $3.082M in FY 2016 to $3.155M in FY 2017 attributable to the recorded surplus for the financial year. Nett Property, Plant and Equipment decreased from $8.711M in FY 2016 to $8.453M in FY 2017 basically due to the depreciation/ amortisation charges during the financial year. Total liabilities decreased from $6.533M in FY 2016 to $6.363M in FY 2017. This decrease is mostly attributable to the reduction in trade payables and employee benefits.

Information Technology and Communication

Hood Sweeney assisted AHCSA with ICT upgrades to each desktop PC, laptops in the loan pool and a new, larger and improved server.

Intellectual Property

The amount of $59,150 was capitalised as intellectual property in developing course materials for the Education and Training Team to be compliant with APHRA requirement to provide training for APHC Certificate III and IV and other related website and NetSuite configurations.

Member Support

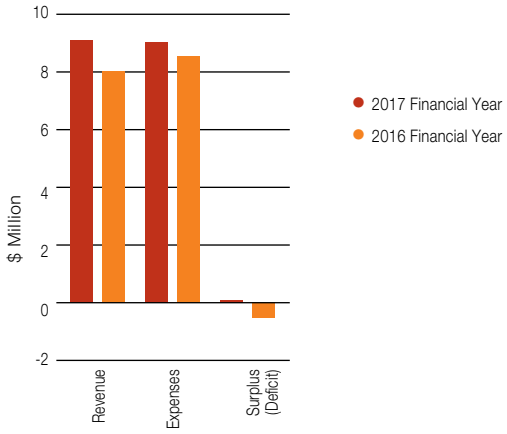
AHCSA continues to provide support when requested by its Member ACCHSs to resolve finance and accounting issues affecting its operations. It includes system configuration, applying accounting standards, acquittals, and any other finance related issues, including GST and FBT.

Other Matters

AHCSA is exploring the prospect of other business opportunities in the immediate future to be less reliant on both the state and federal governments' funding. It entered into partnership with the Institute of Urban Indigenous Health (IUIH) in Queensland in the provision of the Deadly Choices Program in South Australia. The aim of the Program is to empower Aboriginal and Torres Strait Islander people to take control of their health. Although still in the early stages, AHCSA is considering building a medical clinic in the vicinity of Salisbury, South Australia. Practical and financial viability is now being explored.

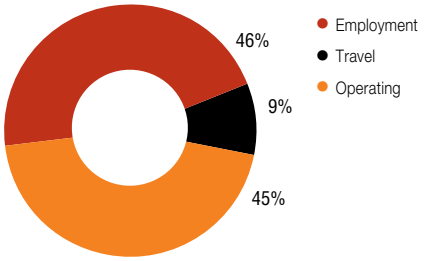
Robert Nilo CPA
Chief Finance Officer

Comparative Annual Revenue and Expenses



	Financial Year		Variance
	2017	2016	Amount
Revenue	$9,112,092	$8,013,542	($1,098,550)
Expenses	$9,039,107	$8,537,146	($501,961)
Surplus (Deficit)	$72,985	($523,604)	($596,589)

Comparative Costs and Expenses



	Financial Year		Variance
	2017	2016	Amount
Employment	$4,370,278	$3,893,322	$476,956
Travel	$886,216	$807,027	$ 79,189
Operating	$3,782,613	$3,836,797	($54,184)

Comparative Financial Position

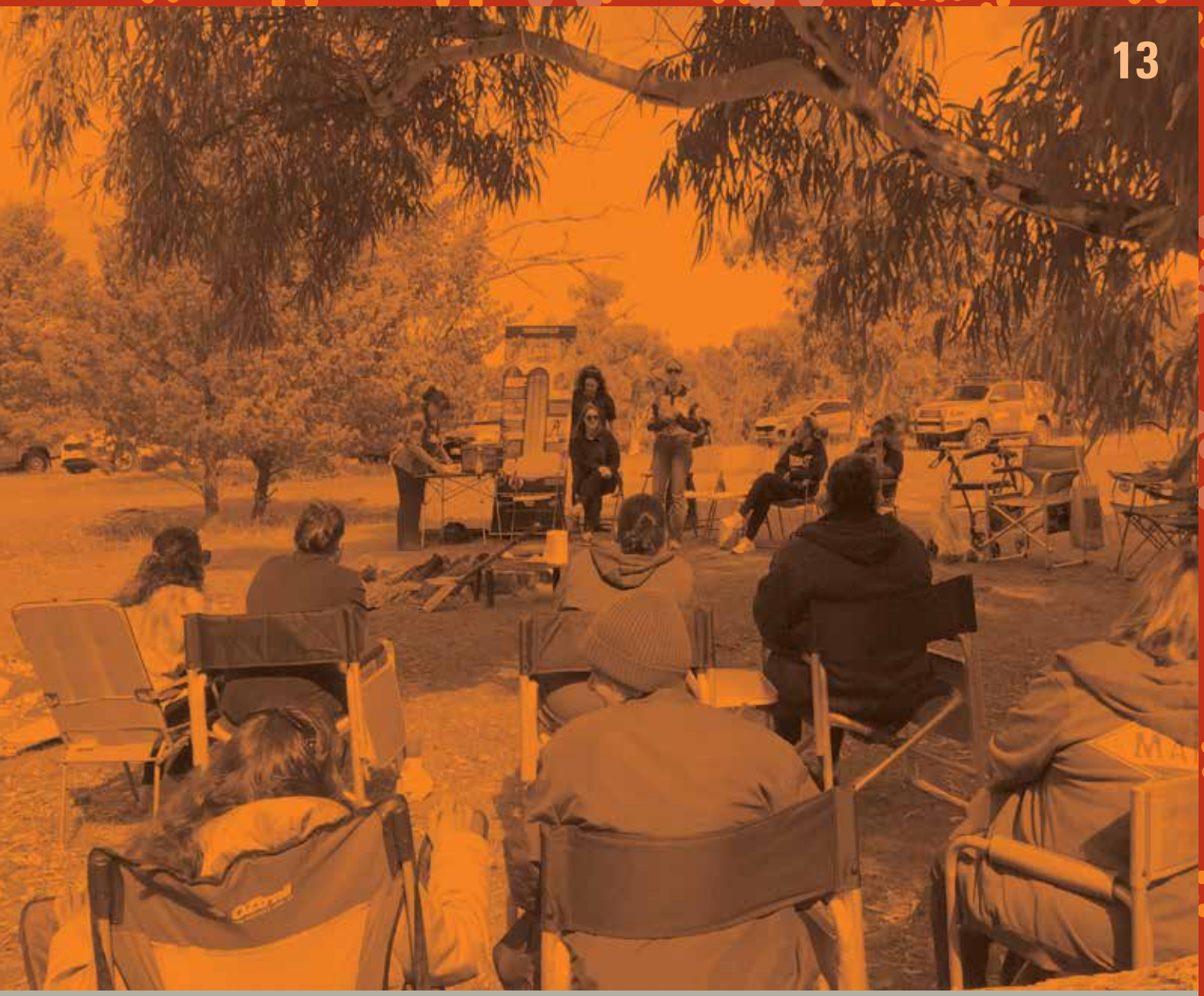
	Financial Year		Variance
	2017	2016	Amount
Total Assets	$9,517,633	$9,614, 695	($97,062)
Total Liabilities	$6,363,114	$6,533,162	($170,048)
Nett Assets	$3,154,518	$3,081,533	$ 72,985

Property Plant and Equipment

	Financial Year		Variance
	2017	2016	Amount
Nett Value	$8,453,168	$8,710,994	($257,826)

Earnings Before Depreciation and Amortization (EDBA)

	Financial Year	
	2017	2016
Comprehensive Income (Loss) for the Year	$72,985	($523,604)
Depreciation/Amortisation	$541,225	$584,692
Comprehensive Income (Loss) Before Depreciation and Amortisation	$614, 210	$61,088



SUPPORTING OUR MEMBERS TO BUILD STRONG AND ENDURING COMMUNITIES

CONSTITUTIONAL OBJECTIVE 1

EXECUTIVE

HUMAN RESOURCES

It has been a busy year of staff recruitments over the past twelve months, especially with the new Research Officer positions and the restructure in the Education, Training and Workforce Team. There were 18 positions advertised, with eight new positions created. Fifteen positions were filled and three had no appointment made.

Following the AHCSA Recruitment Policy, each position from Level 5 and upwards has a Board Director as part of the interview panel and of the 18 positions, 15 panels required a Board Director to participate. We would like to take this opportunity to acknowledge the time and commitment of the Board Directors for each interview panel convened as well as to the AHCSA staff who were involved with each panel.

Each panel convened is composed with a majority of Aboriginal people, making it truly Aboriginal community controlled.

STAFF RECRUITMENTS	2016
Senior Finance Officer	3 Aug
Building Safe Communities Research Officer	5 Sep
Health Development Coordinator	Not Filled
Clinical Educator	Not Filled
Education Support Officer	5 Dec
Student Services Officer	5 Dec
STAFF RECRUITMENTS	**2017**
Administration Officers x 2	9 Jan
Clinical Educator	9 Feb
Tackling Indigenous Smoking Project Officer	27 Mar
Research Officer 1 – Gender Equity	26 Apr
Research Officer 2 – Gender Equity	27 Apr
Research Officer – Shedding the Smokes	8 May
Student Services Officer	8 May
Tackling Indigenous Smoking Coordinator	Not Filled
Sexual Health Community Education Project Officer	26 Jun
Administration Officer	15 Jun
StatewideTackling Indigenous Smoking Coordinator	26 Jun
Tackling Indigenous Smoking Project Officer	14 Aug
HR ASSISTED RECRUITMENT	**2017**
ADAC Mental Health Clinician	
Chief Executive Officer for Moorundi ACCHS	

Recruitment Metrics

In the recruitments that occurred since 1 January 2017, the average time it has taken to fill a position has been 57.4 days. This human resources metric is the total number of days that a position is available in the organisation and goes unfilled. For ease of calculation, AHCSA calculates this measure from the time the advertising for a staff vacancy goes live until the successful candidate, determined by the recruitment process, commences their employment at AHCSA.

Staff Metrics

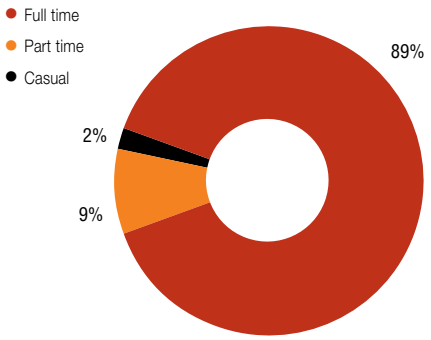
As at the 30 June 2017, AHCSA had 44 staff members. Of these, 39 were full-time employees, while four staff positions were part-time, and one was a casual position. Of the 44 staff, 25 were female and 19 were male. There were 20 Aboriginal staff members and 24 staff were non-Aboriginal. The average number of staff for the period was 43. Therefore, staff turnover from July 2016 to June 2017 was 11.62% with five staff departures during those 12 months.

Enterprise Agreement Update

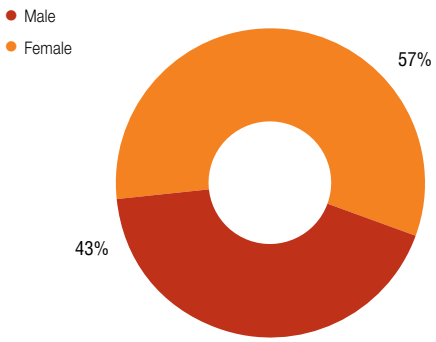
The process of negotiating a new agreement with AHCSA staff began in late 2015, and is a continuing negotiation at the time of writing. Staff representatives involved in the negotiations with executive management included Robert Dann, Beth Hummerston, Michael Larkin and Chris Rektsinis, with the Health Services Union having some representation. AHCSA staff take this opportunity to thank all of their staff representatives. Business SA have been assisting management with this process. I would also like to acknowledge the following Directors, Wilhelmine Lieberwirth and Uncle Les Kropinyeri, representing management with the Chief Executive Officer and the Deputy Chief Executive Officer.

Jeff Mountford
Human Resources Officer

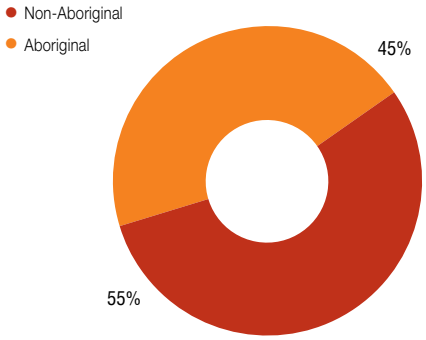
Total AHCSA Employees – 44 Staff



Gender

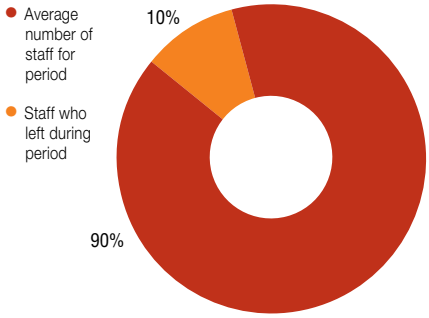


Aboriginal or non-Aboriginal



Staff Turnover - 11.62%

July 2016 – June 2017



AHCSA ACCREDITATION QUALITY AND COMPLIANCE

AHCSA is an accredited organisation to the Quality Improvement Council (QIC) – 'Health and Community Service Standards 6th Edition' and is committed to continuous quality improvement (CQI).

Notable CQI Projects

- Significant improvements have been made to AHCSA's Feedback process through a review of policy and inclusion of guidelines in feedback, complaints, and compliments handling. In addition, online NetSuite feedback has been implemented on the AHCSA website. The online form has enabled the organisation to proactively track the status of feedback and record improvements arising from feedback received. This has been an important management and reporting tool and is used to report to the AHCSA Board on a quarterly basis.
- AHCSA has been working towards upgrading our Document Management System with the upgrade of Alfresco and NetSuite Connector to ensure integration of systems. Various partnerships with Grant Thornton, Hood Sweeney, Parashift and Annexa have assisted in facilitating this process and the improved system will see the organisation in to 2018.
- Facilitation of routine trial crisis to test AHCSA's Business Continuity Plan (BCP) has identified areas for improvement. The BCP is a living document and is reviewed on a regular basis.
- The development and implementation of the NetSuite travel allowance app has provided considerable savings in time. In addition, further improvements have been made to the travel request form to ensure workplace health and safety, identify additional remote travel requirements and improve service coordination.

AHCSA IS QUALITY ACCREDITED AGAINST THE QIC HEALTH AND COMMUNITY SERVICE 6TH EDITION STANDARDS

CONSTITUTIONAL OBJECTIVE 2

PROVIDE SUPPORT TO MEMBERS TO IMPROVE HEALTH OUTCOMES FOR ALL ABORIGINAL PEOPLE OF SOUTH AUSTRALIA, PROMOTING AND ADVANCING THE COMMUNITY'S COMMITMENT TO PHYSICAL, SOCIAL AND EMOTIONAL WELLBEING AND QUALITY OF LIFE

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

PUBLIC HEALTH

The Public Health Medical Officer (PHMO) role continues to provide public health advice and support to AHCSA and its Member services, with involvement in a wide range of activities and initiatives.

Advice and Support

The PHMO provides team leadership to a range of AHCSA programs/programmes, including those addressing Sexual Health, Blood Borne Viruses, Eye Health including Trachoma, Ear Health, and Rheumatic Heart Disease. The PHMO also provides public health and clinical support to the Quality Systems Team.

This has included co-leading (with the Quality Systems Team) a project with SA ACCHSs to define the concept of clinical governance and develop resources that ACCHSs can use to strengthen clinical governance activities. In addition, providing support to the Quality Systems Team to deliver the SA Quality Improvement Data (SQID) cycles program to provide facilitated support to ACCHSs to review the data and processes of care related to diabetes in a Plan, Do, Study, Act cycle webinar series.

The PHMO convenes a monthly AHCSA Public Health Network teleconference involving all ACCHSs in SA, allowing topical public health issues to be discussed and information to be shared between AHCSA and health services.

Specific support provided to Member ACCHSs has also included ongoing health service planning support for Moorundi Aboriginal Community Controlled Health Service as well as GP workforce support to Port Lincoln Aboriginal Health Service, Nunyara Aboriginal Health Service and Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation.

Related to the outbreak of infectious syphilis in SA, the PHMO has been involved in a range of activities, including participation in a state-based outbreak response team and the provision of ongoing support to ACCHSs, particularly in the north and west of SA to ensure increased testing for syphilis.

Sector Advocacy

Working with the Quality Systems Team, the PHMO has provided ACCHSs with information to assist understanding the implications of the proposed Indigenous Australians Health Programme (IAHP) funding model and use of nKPIs for funding calculations as well as raising sector concerns at national level. The PHMO also coordinated a submission on behalf of the SA ACCHS sector to the Department of Health for the Practice Incentive Program redesign and also advocated on behalf of ACCHSs with the PHNs in relation to the transition of Integrated Team Care funding to the ACCHS sector.

The PHMO was the lead investigator for an AHCSA research project assessing the accuracy of extraction of national KPI data from Communicare as part of the OCHREStreams Program. The findings of this paper were published in the *Australian Health Review* in May 2017 and have already led to the Department of Health changing the definition of active clients.

Public Health Medicine Registrar Supervision

The PHMO supervises a Public Health Medicine Registrar (a doctor undertaking specialist training in public health). Projects over the past 12 months have included analysing trends in Sexually Transmitted Infection (STI) testing and positivity rates at ACCHSs in SA from 2008-2017, to better understand the epidemiology of STIs in SA for Aboriginal people.

This will inform quality improvement and better program planning and evaluation. In addition, a project to identify novel strategies to manage iron deficiency anaemia in children as well as a project to support the development, implementation and evaluation of a program to increase human papilloma virus (HPV) vaccination rates, aimed at reducing the incidence of cervical cancer in Aboriginal women, have been supported.

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

BLOOD BORNE VIRUS

The AHCSA Blood Borne Virus (BBV) Program works with Aboriginal health services and the broader health sector across South Australia to strengthen public health and primary health care systems for the management of viral hepatitis.

STI and BBV Workshop

The 2017 AHCSA Sexually Transmitted Infection (STI) and BBV two-day workshop, Taboo or Not Taboo 2 was co-delivered with the AHCSA Sexual Health Program. This was attended by 27 health professionals from 10 health services across the state.

The workshop focussed on viral hepatitis, and included a panel presentation on the importance of harm reduction programs in preventing the spread of BBVs. Funding and support with training materials for day two of the workshop was provided by the Australasian Society for HIV Medicine (ASHM).

Hepatitis C

AHCSA co-presented with Hepatitis SA on the new hepatitis C treatments at the 4th National Indigenous Drug and Alcohol Conference, and presented at the 2016 Australasian HIV & AIDS Conference on strategies to increase access to needle and syringe programs for Aboriginal people who inject drugs.

AHCSA has worked with Nunkuwarrin Yunti and SA Health to develop a short promotional video for the new hepatitis C treatments. This video can be accessed via the AHCSA web page.

Clean Needle Program

AHCSA and Drug and Alcohol Services of South Australia (DASSA) have worked with Nunyara Aboriginal Health Service to establish their new Clean Needle Program (CNP). CNPs are an important harm reduction service that help to keep rates of blood borne virus, such as hepatitis C and HIV, low across the community. Providing a CNP helps to reduce the stigma associated with injecting drug use, and displays a strong commitment to improving access to health care for people for who inject drugs.

Partnerships

AHCSA has worked with Nganampa Health Council to increase access to specialist liver services. Currently, eight South Australian ACCHSs are receiving funding for visiting specialist liver clinics via the Rural Doctors Workforce Agency Medical Outreach — Indigenous Chronic Disease Program.

AHCSA would like to acknowledge the following key partners who have supported the objectives of the 2016-2017 Blood Borne Virus Program:

- South Australian ACCHSs
- Kakarrara Wilurrara Health Alliance
- SA Health Communicable Disease Branch and Viral Hepatitis Nursing Workforce
- Drug and Alcohol Services SA
- Hepatitis SA
- Hepatitis Australia
- Aboriginal Drug and Alcohol Council
- Relationships Australia South Australia
- South Australian Health and Medical Research Institute
- Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

EAR AND HEARING HEALTH

The Ear and Hearing Health Programme has continued providing support and assistance to our ACCHSs, working towards delivery of comprehensive primary ear and hearing health services. This year, a renewed approach has been taken with Programme delivery, with a positive response from the ACCHS sector. Three have reached the third and fourth phases of implementation, while the remaining ACCHSs are at different stages. The aim is to work in collaboration with AHCSA to complete and develop tailored ear health services that achieve the best possible outcome for our communities.

Deadly Sounds

The Ear and Hearing Health Programme has reconsidered the profile and perception of the Programme within the community, and how it could be improved to increase uptake of ear health checks. An internal review of the profile has seen the strategic renaming and rebranding of the Programme to Deadly Sounds. The Deadly Sounds identity, Yuri Pamanthi, is a Kaurna phrase meaning 'to reach one's ear'.

The Programme aims to support ACCHSs to develop and deliver comprehensive primary ear and hearing health services to reduce the prevalence of otitis media in our communities. In addition, through the renaming of the Programme, Deadly Sounds will appeal to the wider community, resulting in greater awareness amongst parents and teachers about the importance of ear health checks. The overall effect will be an increased profile and priority of the Programme, resulting in better outcomes for ear health within our communities.

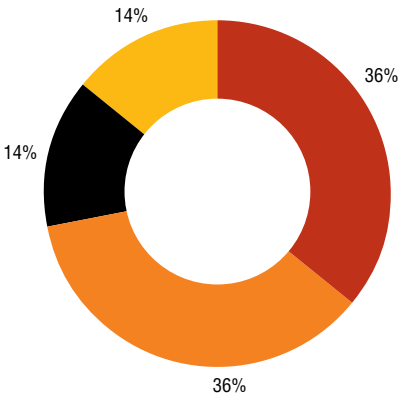
The Deadly Sounds artwork depicts the journey of how the Programme will assist and support the development and enhancement of ear health services, ensuring that Members services have the knowledge and capacity to identify, monitor, manage and resolve middle ear conditions, ensuring that our children have good ear and hearing health. Deadly Sounds will be officially launched later this year.

Communicare

The Team has also reviewed and rebranded the Ear Health Communicare Manual to provide a more visual, user-friendly resource that combines clinical, practical and technical information. The updated resource still features key information, including the ear health flowchart and tab guide, with the addition of the newly developed MBS revenue chart to complement existing systems and best practice.

Partnerships

The Ear and Hearing Health Programme continues to advise external organisations and programmes to ensure specialist and allied ear health services complement ACCHS programmes. Ongoing support is provided to ACCHSs for each phase of the process, and to develop CQI practices that will ensure best practice ear health services.



Ear and Hearing Health Programme Delivery

- Phase 1 Report
- Phase 2 Workforce
- Phase 3 Coordination
- Phase 4 Support

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

EYE HEALTH

The Eye Health Programme provides the overall support and advocacy to AHCSA's Member health services around SA, with regards to capacity building, development, implementation, and evaluation of health promotion strategies and resources, as well as staff training in primary eye health care and vision testing. The Project Officer also represents the Aboriginal Community Controlled Health Sector for SA and coordinates networking and stakeholder collaborations.

The Programme provides direct, on-the-ground service delivery, including the planning, coordination, attendance, and facilitation of visits to eye clinics with visiting optometrists and ophthalmologists. This includes visits to the most remote community clinics within AHCSA's Membership. The Programme monitors and assists patient pathways from primary to tertiary eye care and wherever possible, improves access to low-cost prescription glasses.

Core Programme visits are currently run twice yearly to 12 clinics, including Ceduna, Yalata, Oak Valley, Tjuntjuntjara (WA), Coober Pedy, and seven communities within the APY Lands. The Programme also supports the visiting optometry services to Whyalla, Murray Bridge, and Raukkan.

Community client consultations provide:

- Vision testing and eye examination
- Prescriptions for corrective eyewear
- Taking retinal photos
- Issuing reading glasses and/or sunglasses
- Arranging prescription glasses
- Onsite treatment where possible, eg: lasering for diabetic retinopathy
- Referral for surgery or further treatment
- One-on-one education on diabetes and eye disease

Programme Visit Outcomes 2016-17

Community	Total clients attended	Aboriginal clients	New clients	Diabetic/ high priority clients	Referrals for surgery or further treatment	On site treatment eg: lasering	Reading glasses issued on same day	Prescription glasses arranged	Retinal photos taken
Fregon	37	37	7	21	2	4	20	7	23
Mimili	39	37	17	22	0	3	22	12	28
Iwantja	64	62	12	30	7	6	21	18	33
Pipalyatjara	59	58	8	37	2	2	30	18	36
Nyapari	12	12	2	6	1	0	6	3	4
Pukatja	86	85	11	49	6	3	44	20	48
Amata	83	82	19	56	6	4	44	19	30
Coober Pedy	77	63	17	37	11	4	34	26	25
Yalata	32	31	7	18	1	3	16	1	7
Oak Valley	30	30	2	13	3	1	16	4	14
Tjuntjuntjara	39	34	13	22	1	1	23	3	5
Ceduna	34	32	11	20	9	5	10	5	15
TOTAL	**592**	**563**	**126**	**331**	**49**	**36**	**286**	**136**	**268**

Most common eye conditions found on Programme visits were:

- Diabetic Retinopathy (deterioration of blood supply to the retina/macula).
- Refractive Error (blurred vision simply requiring glasses/corrective eyewear).
- Cataracts (clouding of eye lens fillings which inhibits clear vision).
- Trachoma (bacterial infection easily treated but can otherwise lead to preventable blindness).

Challenges associated with reducing the prevalence of diabetic retinopathy:

- Early stages are asymptomatic therefore undetectable without an eye examination.
- Clients are unlikely to present for eye checks unless experiencing vision problems.
- Advanced cases are much harder or sometimes impossible to treat.
- Some treatments are difficult or ineffective unless done frequently.
- Diabetes is on the rise, with more reported cases than ever.
- Co-morbidities, coupled with chronic disease, and/or other related factors such as grief, depression, mental/emotional challenges, and life circumstances.

Achievements

Increased government funding has generated several exciting initiatives, for both the AHCSA Eye Health Programme and the Indigenous eye health sector as a whole. This has enabled the following:

- Two extra Programme visits per year, for up to six recipient communities, in addition to the existing twice yearly visits.
- The implementation of the National Eye Health Equipment and Training project to procure and distribute diagnostic equipment (retinal cameras and slit lamps) and operator training to ACCHS nationwide. AHCSA is the only Aboriginal organisation in the consortium to be awarded the government tender.
- An increased delivery of staff training in Primary Eye Health Care and Vision Testing, and assistance in procuring AHW eye health clinical resources.
- An active partnership with the SAHMRI Diabetes Study.

HERO SEXUAL HEALTH

AHCSA's Sexual Health Program promotes Sexually Transmitted Infection (STI) prevention, screening, and treatment of chlamydia, gonorrhoea and trichomonas, and continues to raise awareness for HIV and syphilis prevention, screening and treatment.

Achievements

In collaboration with AHCSA's Blood Borne Virus Project and Australasian Society for HIV Medicine (ASHM), the Sexual Health Program (SHP) delivered Taboo or Not Taboo 2, the annual training workshop to over 48 workers and students, predominantly from ACCHSs across SA, including Footsteps Drug and Alcohol Service in Port Augusta. This two-day workshop for Aboriginal Health Workers and clinical staff was held in April.

The workshop aimed to strengthen the capacity of participants to provide testing and treatment for a range of BBVs and STIs, including hepatitis B, hepatitis C, HIV, chlamydia, gonorrhoea, trichomonas and syphilis.

It was encouraging to have workers in the field actively participate in important discussions around what can be very sensitive and difficult to talk about issues.

Opportunistic screening of all people at risk of STIs was encouraged and supported throughout the year as well as placing an emphasis on the annual community-wide STI screening program particularly aimed at people in the 16-35 age range each year.

During the 2016-2017 STI screening period, the SHP team visited most ACCHSs in South Australia, with the exception of Nganampa Health Council, which has its own sexual health program. This provided an opportunity for education, sharing, and discussion of reports on each service's STI screening data and follow up.

DELIVERING EDUCATION AND HEALTH RESOURCES TO ASSIST THE AWARENESS ABOUT SEXUAL HEALTH

The visits also provided a face-to-face opportunity for planning and questions relevant to implementation of ACCHS sexual health programs at a local level. The AHCSA team visits support culturally appropriate sexual health services, including promotion of local activities aimed at reducing the risk of STIs, and clinical activities including screening and management of STIs.

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

MATERNAL HEALTH TACKLING SMOKING

AHCSA is celebrating seven years of the Maternal Health Tackling Smoking Program (MHTS), which is funded by the Drug and Alcohol Services of South Australia (DASSA). Research shows that smoking rates amongst pregnant Aboriginal women continue to decline. In 2009, statistics indicated that 52.9% of Aboriginal women smoked during pregnancy but this has now decreased to 42.6%.

The increased number of Aboriginal women making successful quit attempts during pregnancy has been assisted by the effective and popular Stickin' It Up the Smokes social marketing campaign, and the ongoing popularity of the MHTS pamper days across South Australia.

Achievements

In the past year, 15 group-quit support activities have been facilitated through pamper days, 'mums and bubs' groups and community events. These activities have been delivered in Whyalla, Murray Bridge, Port Pirie, Point Pearce, Port Lincoln, Port Victoria at the Gynburra festival, Mount Gambier, Port Augusta, Ceduna/Koonibba, Kaurna Plains childhood centre, Port Adelaide, and at youth and children's expos.

A recent pamper day in Port Lincoln added a new twist to the conventional pamper days, where partners of pregnant women and parents of newborns were also invited to attend the pamper day to launch the Maternal/Paternal Tobacco Quit Challenge.

This is a new initiative where the staff from Port Lincoln Aboriginal Health Service (PLAHS), with assistance from the MHTS Program, will support Aboriginal families in Port Lincoln to have healthy babies, born to smoke-free mothers in a smoke-free environment. Major draw prize incentives such as prams, car seats, baby backpacks as well as gym memberships and sports store vouchers for the men are being considered as a way to encourage women and their partners to make quit attempts or at least to remain smoke-free during pregnancy. Based on the evaluation and success of this tobacco quit challenge in Port Lincoln, the initiative could be rolled out in other South Australian regions.

The South Australian Government sees it as a priority to support Aboriginal women to make quit attempts during pregnancy to ensure that we have healthy Aboriginal babies born to healthy mothers in a smoke-free environment.

Although there have been positive results to date in reducing the rates of Aboriginal women smoking during pregnancy, there is still much work to be done to comply with the SA Tobacco Control Strategy 2017-2020. This initiative has set a target to further reduce smoking during pregnancy among Aboriginal women to 35% by 2020.

The MHTS Program continues to collaborate with regional Tackling Indigenous Smoking (TIS) teams, Aboriginal Maternal and Infant Care (AMIC) workers, maternal health staff, the Cancer Council Quitline and Aboriginal health services to reduce smoking rates in pregnant Aboriginal women, their partners and families in South Australia.

Data Snap Shot

- **81 Aboriginal pregnant women** were provided with individual or group quit support activities.
- **51 participants** were contacted post-quit support activities to access smoking status and continue to support quit attempts.
- **15 face-to-face group quit support activities** were facilitated through pamper days, 'mums and bubs' groups and community events.
- **104 staff and students** were provided with information on MHTS Program and trained in using the smokerlyser tool to assist with monitoring smoking status.
- **16 community events** were attended to promote smoke-free pregnancies and the MHTS Program.
- **8 school visits** to educate children on the importance of having smoke-free pregnancies and the importance of not smoking near pregnant women or children.
- **5 AHCSA Primary Health Care student placements** were facilitated in the MHTS Program.

PROVIDING PREGNANT WOMEN WITH QUIT SUPPORT ACTIVITIES

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

TRACHOMA ELIMINATION

The AHCSA Trachoma Elimination Program (TEP) is funded through Country Health SA Local Health Network (CHSALHN) and continued to strive towards eliminating trachoma in SA by working with and supporting the ACCHSs in Yalata, Oak Valley and Coober Pedy, plus CHSA in Oodnadatta.

Achievements

Trachoma and trichiasis screening was carried out in all four communities as per the Communicable Diseases Network Australia (CDNA) National Guidelines for the Public Health Management of Trachoma.

The TEP continued to provide training to AHCSA's primary health care students, Aboriginal Health Practitioners and workers, registered nurses, Allied Health staff, aged care staff, teachers, childcare staff and community members about the prevention, detection and treatment of trachoma and trichiasis.

Health promotion activities to encourage clean faces and good hygiene continued in a variety of ways, with input from community members. Hygiene packs, towels, and face washes were given out to community members, childcare centres, and schools. So that children can see if their faces are clean, mirrors were donated by Bunnings and delivered to health services, schools and childcare centres in the APY Lands, Coober Pedy, Oak Valley, Oodnadatta, Port Augusta, Tjuntjuntjara and Yalata.

To promote the Clean Faces Strong Eyes message in the four communities, Milpa, the Trachoma Goanna, made numerous appearances at events and the Team conducted various activities with the children, such as soap making.

Environmental Health developments include the refurbishment of Yalata's community laundry, the construction of a Yalata community amenities building and partnership building with relevant government and non-government organisations. Negotiations are underway with CHSALHN on the next funding agreement.

Data Snapshot

- **166 children** between the ages of 0-14 years old were screened for trachoma.
- **Only 9 cases** of active trachoma were found.
- **4% decrease in trachoma rate** across the communities, compared to last year.
- **99% of children screened** had clean faces, which is a great improvement from 86% in 2015-2016.
- **281 adults** were screened for trichiasis, with only 2 cases found.

166 CHILDREN AGED 0-14 WERE SCREENED FOR TRACHOMA, ONLY 9 CASES WERE FOUND

PUYU BLASTER TACKLING INDIGENOUS SMOKING

AHCSA's Puyu Blaster Tackling Indigenous Smoking (TIS) Programme, funded by the Department of Health and supported by the Ninti One National Best Practice Unit, has worked collaboratively with communities and organisations across South Australia to provide a number of programs and support.

These have included community-based tobacco education and awareness aimed at the youth, men and women, including pregnant women. In addition, they have provided quit information and advice. Workplace support has included in-service education for health and community workers as well as developing and strengthening smoke-free environments. General good health promotion has also been a focus.

Support

The TIS Programme has enabled outreach workers within the following organisations to support tobacco reduction: Nunyara Aboriginal Health Service (Whyalla), Umoona Tjutagku Health Service Aboriginal Corporation (Coober Pedy), Pika Wiya Aboriginal Health Service Aboriginal Corporation (Port Augusta), and Tullawon Health Service (Yalata).

Community Engagement

TIS is youth and whole of community focussed, enabling men, women, Elders, young people, and pregnant women to have access to the Programme through activities and events undertaken by the TIS Team. The reach of the Puyu Blaster's Facebook page continues to grow and is testament to the extent of community engagement.

Join the Mob Pledge

Join the Mob Pledge activities build on AHCSA's partnership with the Australian Football League's Port Adelaide Football Club (PAFC). The Club granted the TIS Team exclusive use of their Indigenous Round guernsey design by Nathan Krakouer. These tops were offered to community members who attended the events and took the Pledge to identify their smoking status, including smoking during pregnancy.

They pledged to protect vulnerable people, including unborn babies, children, elderly and those with respiratory illnesses, from environmental and second-hand smoke, as well as share quit referrals and smoking information. Pledge drives were held at:

- Aboriginal Power Cup
- Port Power vs Hawthorn football game
- AHCSA's Youth Expo
- Pledge Drives were also held at various other locations across the state

Activities and Events

The TIS Team continues to engage with AHCSA Member Services, through providing smoke-free in-service sessions, participating in service-level events and also providing tobacco support, information, education and resources.

- Point Pearce Community Council, Yorke Peninsula
- Taperi Wellbeing Group, Port Pirie
- Port Augusta Youth Centre, Port Augusta
- Footsteps to Recovery, Port Augusta
- Pika Wiya Health Service Aboriginal Corporation, Port Augusta
- Headspace, Murray Bridge
- HOPE Collective, Whyalla
- Kindergartens and Schools, Whyalla
- Nunyara Aboriginal Health Service, Whyalla
- Schools and Kindergartens, Murray Bridge
- Moorundi Aboriginal Community Controlled Health Service, Raukkan and Murray Bridge
- Yalata Community Council, Yalata
- Tullawon Health Service, Yalata
- The Heart Foundation, Adelaide
- Berri Nunga Clinic, Berri Riverland
- Aboriginal Sobriety Group, Berri
- Country Health SA LHN, Barmera
- Renmark Aboriginal Community Connect, Renmark
- Moonta Area School, Moonta, Yorke Peninsula
- Mallee Park Sporting Club, Port Lincoln
- Port Lincoln Aboriginal Health Service, Port Lincoln
- Harmony Day, Coober Pedy

Partnerships and Collaborations

AHCSA have formed positive partnerships that are vital to the Programme's success. We continue to work in partnership with organisations and programs including:

- Port Adelaide Football Club
- Aboriginal Basketball Academy
- Nunkuwarrin Yunti of SA Inc.
- Ninti One, National Best Practice Unit
- Involvement and collaboration with the Department's nominated evaluator - Cultural and Indigenous Research Centre Australia (CIRCA)

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

PUYU BLASTER TACKLING INDIGENOUS SMOKING

Capacity Building

- The current TIS workforce is skilled in brief intervention and Quit Skills Training.
- The new Communicare Tackling Indigenous Smoking tab and user guide is now complete. The tab will be installed on select services for testing and upon completion of the trial period, the plan is to make the tab available to interested services.
- The TIS workers have been involved in providing capacity building to support quitting in the following ways:
  - In service training to ACCHSs
  - Advocating, facilitating, and providing resources and advice on designated smoke-free environments
  - Education and Tobacco Awareness Sessions to community groups and clubs
  - Peer support to TIS Outreach Project Officers
  - Established a regular TIS network meeting (via phone link up)

Quit Support Referrals

- The TIS Team has seen a substantial increase in the number of people seeking information about quitting and electing to be contacted about assistance to quit.
- The data collated suggests that of the 953 people who took the Pledge during the Pledge activities in May and June, 183 people said they would like more information on smoking and/or services available to support quitting and 55 of those current smokers asked to be contacted about services available to quit.
- The Quitline number is included on all of the Puyu Blaster promotional material, resources, and merchandise.

Supporting Smoke-Free Environments

- TIS Project Officers have supported services to begin their journey to protect vulnerable people from environmental or second-hand smoke, including support and advice about smoke-free environments. The Tackle the Trigger Tool Kit is utilised to educate organisations and their workforce about the triggers that prompt workers to smoke and how to avoid smoking.
- Outreach workers have been instrumental in advocating for smoke-free environments in Yalata, Whyalla, Port Lincoln, and Ceduna.
- AHCSA is currently reviewing their own policy, and the TIS Team will recommend improvements and changes to be approved by the Board of Directors and implemented by senior staff.
- The TIS Team has had great success with promoting smoke-free environments using the Puyu Blaster Archway, banners and customised marquees. The Archway was displayed at centre stage during the AFL game between Port Adelaide and Hawthorn.

PUYU BLASTER
EDUCATING OUR YOUTH ACROSS SA WITH THE ANTI-SMOKING MESSAGE

CONSTITUTIONAL OBJECTIVE 2

PUBLIC HEALTH AND PRIMARY HEALTH CARE

ABORIGINAL DENTAL

AHCSA receives funding from the Department of Health for the Aboriginal Dental Programme, which it provides to the South Australian Dental Service through a memorandum of administrative arrangement.

It assists in the provision of oral health programmes for Aboriginal and Torres Strait Islander children and eligible adults. An adult is eligible for government-funded dental services if he or she is a holder or adult dependent of a holder of a current Centrelink Pensioner Concession Card or Health Care Card.

AHCSA provides the funding with an emphasis on the provision of oral health programmes as part of a whole-of-health, primary health care approach for Aboriginal and Torres Strait Islander people.

The Aboriginal Dental Programme provides general emergency and course of care to Aboriginal people, which can include extractions, restorative work, dentures and other services needed.

The areas covered include Balaklava, Barossa Valley, Ceduna, Coober Pedy, Fleurieu, Leigh Creek, Meningie, Murray Bridge, Port Augusta, Port Lincoln, Port Pirie, Riverland, South East, Streaky Bay, Whyalla and Yorke Peninsula.

The Aboriginal Oral Health Programme provided through the SA Dental Service has both increased the services to Aboriginal people in South Australia and alleviated the demand for resources on the Aboriginal Dental Programme.

Key Features

- The Aboriginal Dental Scheme (ADS) only operates where clients cannot access the Aboriginal Liaison Program (ALP) through local SA Dental Service Clinics in rural and remote areas.
- This has resulted in a reduced demand for Aboriginal Dental Scheme funded care over recent years while the total number of Aboriginal clients treated continues to rise.
- There is no wait time for care under the Aboriginal Dental Scheme.

Aboriginal clients who receive care under either the ADS or ALP receive the following benefits:

- Immediate access to emergency care
- Priority (ie: no waiting list or waiting time) access to general dental care
- Priority access to dentures
- Pathway facilitated through the local ACCHS/AHW in some cases
- No client fees

CONSTITUTIONAL OBJECTIVE 2

DATA

GP WORKFORCE

The GP Workforce Team continues to enhance the uptake of Aboriginal Health Checks in Aboriginal Community Controlled Health Services (ACCHS). The Program increases the GP workforce in Aboriginal Community ACCHSs in SA in order to increase the number of Aboriginal Health Checks (AHCs) and resource the appropriate follow-up.

Although this continues to be a high performing, successful Program, State Government funding as part of Closing the Gap ceased at the end of September 2017.

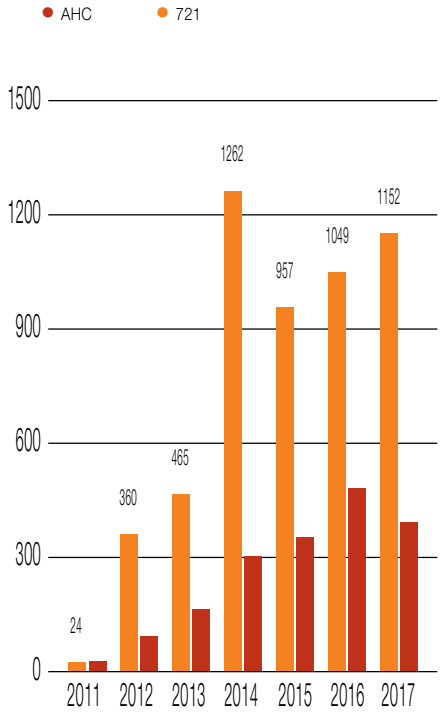
In the participating health services, which included Pika Wiya Health Service Aboriginal Corporation (PWHSAC), Pangula Mannamurna Aboriginal Corporation (PMAC) and Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation (CKAHSAC), there has been a sustained increase in the number of Aboriginal Health Checks (AHC), GP Management plans (Item **721**) and systems established to ensure continued best practice.
(Note: PLAHS statistics are not reported within this Program).

Achievements

A total of 656 days of extra General Practice services were provided across eight rural ACCHS during this financial year, there were 9 individual GP Registrars employed across 6 rural ACCHSs, 2.5 FTE at PWHSAC, 2 FT at PMAC, 2 FT at PLAHS and 2 FT Roving Registrars across the following four sites: Umoona Tjutagku Health Service Aboriginal Corporation, Pika Wiya Health Service Aboriginal Corporation, Oak Valley Health Service Aboriginal Corporation and Tullawon Health Services.

Prior to the commencement of this Program, there were no GP Registrars in rural ACCHS.

Number of Aboriginal Health Checks and GP Management Plans



CONSTITUTIONAL OBJECTIVE 3

BUILD THE CAPACITY OF MEMBERS TO CREATE A STRONG AND ENDURING ABORIGINAL COMMUNITY CONTROLLED HEALTH SECTOR AND **CONTRIBUTE TO IMPROVING** THE CAPACITY OF MAINSTREAM HEALTH SERVICES TO **RESPOND APPROPRIATELY** TO THE HEALTH NEEDS OF THE ABORIGINAL COMMUNITY OF SOUTH AUSTRALIA

CONSTITUTIONAL OBJECTIVE 3

RESEARCH

ABORIGINAL HEALTH RESEARCH ETHICS COMMITTEE

Each year, the Executive Officer of AHREC submits a report to the National Health and Medical Research Council (NHMRC) to demonstrate compliance with NHMRC's ethical guidelines. Submitted in March 2017, the 2016 report presented stability in both the membership of the Committee and the number of research proposals reviewed. AHREC continued to demonstrate compliance with the National Statement and Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research as one of only three Aboriginal-specific full HRECs in Australia.

Research Proposals Submitted

In addition to proposals that were awaiting decision or researchers' response to concerns raised, a total of 47 new research proposals were submitted to AHREC (compared to 45 in FY14-15 and 55 in FY15-16).

- AHREC continued to provide researchers with an opportunity to respond to concerns such as the appropriateness of the research methodology and data collection and partnership with Aboriginal people and organisations involved in the study, and benefit to the community. The areas of particular attention that the researchers were required to thoroughly justify included the potential benefits of research outcomes to Aboriginal people and the need to go through appropriate community consultation evidenced by support letters from services involved.

New Research Topics

The 47 new proposals submitted to AHREC related to a wide range of health topics that significantly impact on Aboriginal health and wellbeing. With varied research methods, goals and target groups these included, but were not limited to:

- Bowel cancer screening
- Child protection
- Aboriginal perspectives to disability services
- Well-being of young people
- Resources to prevent methamphetamine-related harm
- BBV and STI prevention and education programs
- Sexual health knowledge and behaviour
- Kidney transplant function amongst kidney transplant recipients
- Molecular epidemiology of hepatitis B
- Mortality patterns
- Quit-smoking campaigns
- Review of pharmacy programs
- Impact of language reclamation among the Barngarla
- The impact of fish oil on cardiovascular inflammation
- Experiences of hearing-impaired and deaf people
- Remote community experience of medical students
- Improvements to the mortality data collection systems
- Aboriginal families and babies
- Valve surgery registry
- Activity levels and service utilisation post-discharge from a cardiac event
- Supported decision-making for adults under guardianship
- Organisational cultural competence in maternity care
- Systemic racism
- Tackling Indigenous smoking
- Suicide
- Influenza immunisation
- Indigenous workforce
- Methamphetamine use
- Residential rehabilitation
- Problem gambling
- Drug pharmacokinetics in kidney transplantation
- Childhood rheumatic heart disease
- Interventions for methamphetamine use
- Childhood developmental screening
- Close the gap policy implementation
- Strategies to reduce harm from alcohol use
- Well-being of older Aboriginal people
- Prison entrants' blood borne virus and risk behaviour

Of the 47 new research proposals reviewed, 38 were granted ethical approval and the remaining proposals the following results were returned:

- Two were not approved.
- One did not further respond to queries and was considered withdrawn.
- Two were considered out-of-scope.
- One was not reviewed due to poor application standards.
- One was not reviewed due to the researcher making changes to AHREC's application form.
- The review process is not finalised (as of August 2017) in relation to two proposals submitted in the 4th quarter of FY16/17.

AHREC continued to serve as a protection for the community and advocate for the NHMRC Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research. In particular, the values that researchers are required to demonstrate in their research practice and methodologies such as spirit and integrity, reciprocity, respect, equality, responsibility, survival and protection continue to be closely scrutinised as part of the ethical review process.

AHREC's guidance to researchers continues to highlight the holistic and interconnected nature of Aboriginal health, for any research activity to yield benefit for the Aboriginal communities in SA in partnerships with AHCSA's Member services.

CONSTITUTIONAL OBJECTIVE 3

RESEARCH

BUILDING SAFE COMMUNITIES FOR WOMEN

Research carried out by the Building Safe Communities for Women Programme has shown that violence against women and their children is a major contributor to high Aboriginal morbidity and mortality rates in Australia. Aboriginal women experience domestic and family violence (DAFV) at 45 times the rate of non-Indigenous women and are 35 times more likely to be hospitalised as a result of this violence.

Aboriginal women continue to experience alarmingly high rates of violence and remain one of the world's most disadvantaged groups, despite growing recognition of DAFV as both a public health and human rights issue.

Funded by the Department of Social Services, the Building Safe Communities for Women Programme aims to create sustainable practices to help reduce violence against Aboriginal women and their children by improving engagement between government and non-government organisations and the broader community.

Achievements

Findings were gathered via a literature review, scoping exercise and needs analysis. Best practice for preventing and ending violence against Aboriginal women and their children was investigated through the analysis of peer-reviewed journal articles, State and Commonwealth Government policies, and findings of the Australian Bureau of Statistics.

The scoping exercise and needs analysis were conducted over a 12-month period, and involved visits to ACCHSs, government and non-government services in metropolitan Adelaide, Anangu Pitjantjatjara Yankunytjatjara (APY Lands), Ceduna, Coober Pedy, Mount Gambier, Murray Bridge, Oodnadatta, Point Pearce, Port Augusta, Port Lincoln, Port Pirie, Riverland (SA), Whyalla and Yalata. Phone conversations occurred where face-to-face meetings could not be arranged.

The Programme findings and recommendations recognise that past approaches to addressing Aboriginal family violence have been largely ineffective. Family violence negatively impacts victims, families and communities, and as such, keeping Aboriginal women and their children safe, requires a whole community approach. This approach is ideally holistic, addressing social and emotional wellbeing and socio-economic disadvantage alongside family violence, and preventing future violence with education and awareness campaigns.

The Programme team acknowledges its funding body, the Department of Social Services, as well as Pika Wiya Health Service Aboriginal Corporation, Port Lincoln Aboriginal Health Service Inc., Nunkuwarrin Yunti of South Australia Inc., Nunyara Aboriginal Health Service Inc., Tullawon Health Service Inc., Umoona Tjutagku Health Service Aboriginal Corporation, Pangula Mannamurna Aboriginal Corporation, Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation and Tarpari Wellbeing Centre for participating in the scoping exercise. They also acknowledge the input of Australia's National Research Organisation for Women's Safety Limited (ANROWS), the AHCSA Secretariat and Steering Committee, AHCSA Members, and all other government and non-government organisations involved in the project.

KEEPING ABORIGINAL WOMEN AND THEIR CHILDREN SAFE, REQUIRES A WHOLE OF COMMUNITY APPROACH

CONSTITUTIONAL OBJECTIVE 3

RESEARCH

GENDER EQUITY

Funded by the Lowitja Institute, the Aboriginal Gender Equity Project is a joint research initiative between AHCSA, SAHMRI and The Fay Gales Centre for Research on Gender from Adelaide University. To carry out this Project, AHCSA employed two research officers, Dominic Guerrera and Gabbie Zizzo, in late April.

Aims of the Project

The Project aim is to explore the diversity of current views and understandings of gender roles, gender equity, and the role of gender relations in developing respective relationships in three South Australian Aboriginal communities. This project will be the first study to describe contemporary views of gender equity and its role in healthy relationships in Aboriginal communities.

This will provide foundational research to define what gender equity looks like in an Aboriginal and Torres Strait Islander context, and build the evidence base for strategies to enable gender equity within a strong cultural identity.

Port Lincoln, Murray Bridge and Adelaide have been chosen as the three sites for the data collection. Partnership-building with local Aboriginal Community Controlled Health Services has begun with the Port Lincoln Aboriginal Health Service, Moorundi Aboriginal Community Controlled Health Service and Nunkuwarrin Yunti of SA.

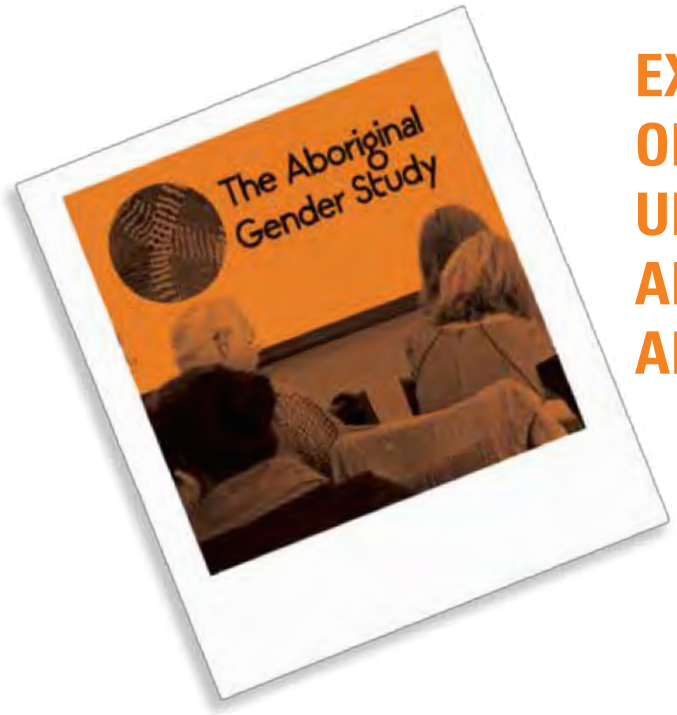
The Research Officers have begun community consultation with each site, which includes presentations and conversations with staff at health services and local Aboriginal community groups.

The project aims to involve Aboriginal people at all levels including leadership, research, and writing.

An Aboriginal Advisory Group has been established, entirely made up of Aboriginal members to guide and direct the project on a number of matters, including:

- Engagement with Aboriginal health services
- Development of research methodologies and yarning circle structure
- Handling of the research findings and publications
- Knowledge translation strategy

Local Aboriginal artist Anna Dowling, who has drawn inspiration from the Rainbow Lorikeet's spectrum of bright shimmering colours as they reflect the multidimensional and diverse nature of gender, has designed an identity for the Project. It is anticipated that the final report of findings will be released by mid-2018.



EXPLORING THE DIVERSITY OF CURRENT VIEWS AND THE UNDERSTANDING OF EQUITY AND GENDER ROLES IN ABORIGINAL COMMUNITIES

MALE SHEDDING THE SMOKES

Whilst still in its formative stages, the Male Shedding the Smokes Programme is an innovative and new approach to helping Aboriginal males deal with smoking cessation whilst simultaneously guiding them towards other services for a healthier life. This Programme is funded through the Department of Health and is a research partnership with Dr Margaret Cargo and Dr Mark Daniels from the University of Canberra. In March 2017, AHCSA employed a Research Officer, Tim Lawrence to work on the Programme.

Purpose of the Programme

It is not uncommon for men to feel uncomfortable about going to their local health clinic. Most of the time, women are present, which can make it difficult for men to talk openly about their health. By establishing a Male Health Shed within a community, it provides a place where males can go to yarn and talk about what is important to them. If they are doing a good job of being healthy, like giving up the smokes, they can go there to help others give up smoking by talking about how they managed to quit.

In order to be successful, it's important that the local males from within the community choose the location of the Health Shed. It is their place to get away and it needs to be where they would want to go.

When the local males get together at the Health Shed, they get the opportunity to talk about having a solid future by being healthy inside their body and mind and by doing so, making sure that their family and community is also healthy.

PROVIDING ABORIGINAL MALES WITH A MULTIFACETED, HOLISTIC TOBACCO CESSATION PROGRAMME THAT MEETS THEIR INDIVIDUAL NEEDS

Aims of the Programme

- Support Member services to develop their own culturally safe spaces to engage Aboriginal males aged 15 years and older in an Aboriginal Male Health Shed Programme that provides active support for tobacco cessation. The Member services involved are Umoona Tjutagku Health Service Aboriginal Corporation, Coober Pedy and Tullawon Health Service, Yalata.
- Build the capacity of health practitioners and service providers to deliver culturally competent tobacco cessation strategies for Aboriginal males.
- Provide Aboriginal males with a multifaceted, holistic tobacco cessation Programme that meets their individual needs.
- Provide Aboriginal males with a culturally safe environment to yarn about their health while engaging in arts, social and culture-based activities to support their efforts to stop using tobacco.
- Promote Aboriginal males as positive role models and ambassadors for smoking cessation in the broader community.

The Programme will employ a local male Aboriginal Health Worker co-jointly with our Member services and there is a strong focus for the Programme and its encompassing activities to be driven by the participants and the local community. Currently, both communities are actively engaged with great enthusiasm from everyone involved.

CONSTITUTIONAL OBJECTIVE 3

MEMBER SUPPORT

QUALITY SYSTEMS

The Quality Systems Team provides comprehensive clinical and organisational support to Members by applying a Continuous Quality Improvement (CQI) focus to patient information management systems, data collection and analysis, and clinical governance. The Team now incorporates Statewide Continuous Quality Improvement, Statewide Data and IT, Practice Managers' Support and Patient Information Management Systems (PIMS). Funding for these positions is received from the Department of Health and for the PIMS Officer, from the Department for Health and Ageing.

Clinical Governance Project

In consultation with the AHCSA Membership, the team is currently working with Dr Jenny Hunt on the Clinical Governance Project, which aims to de-mystify the concept of Clinical Governance. It will provide a take-home practical resource that identifies and details elements of Clinical Governance specific to the SA ACCHSs' models of care, including practical examples on how services might achieve this.

The aim is to provide an understanding of how Clinical Governance fits within other Quality and Safety frameworks (Accreditation, CQI, etc.) as well as service models of care, action plans and comprehensive primary healthcare. The Project will support Members in understanding the barriers and enablers of good Clinical Governance within a health service. Meetings have been held throughout the year with the Clinical Governance Working group and the toolkit is now in the final stages of development and will be piloted at two services.

AHCSA Member Portal

The newest addition to the AHCSA website is a specific Members' Portal which will be available to all Members early next year. The secure portal is divided into three main sections:

- **General Information** A repository for Member Services to access a range of resources, covering areas such as best practice guidelines, recruitment support, Patient Information Management Systems (PIMS) and PenCAT/OCHREStreams how-to guides, and SA Quality Improvement Data (SQID) Cycle webinars, as well as CQI templates.
- **My Health Service** This area has been created especially for Member services. All SQID, Sexually Transmitted Infection (STI), and Rheumatic Heart Disease (RHD) Reports will be housed here along with other specific reports as they become available. AHCSA plans on transferring over three years' worth of information onto this portal so that Member services will be able to access the information at any time.
- **AHCSA Community** In developing stronger communication tools with, and between Member services, AHCSA will also include a forum area where Members can log in and begin a new conversation, or join into one already taking place. The AHCSA Community page aims to encourage open and productive discussion in a safe and secure environment for Member services.

SQID Cycles

In early 2017, the Quality Systems Team, in collaboration with participating ACCHSs developed the AHCSA SQID Cycles; a state-based, three-monthly, interactive clinical quality improvement cycle.

As demonstrated in the program model (above), the SQID Cycles work directly with participating ACCHSs in the collection of de-identified baseline health data, followed by webinar presentations that aim to explore the underpinning processes, procedures and data entry methods associated with the cycle topic. De-identified health data is then collected again after three months and compared with the baseline data to assess health service improvement.

The first SQID Cycle began in June 2017 and focussed on improving HbA1c testing in ACCHSs. The webinar series began by introducing participants to the concept of CQI and Plan, Do, Study, Act (PDSA) cycles, before reviewing statewide HbA1c testing data.

Webinars two and three then explored some of the key barriers to testing, correct entry and review of HbA1c data in Communicare, the Diabetes Annual Cycle of Care with linkages to Medicare, and workshopping how the PDSA method can be applied to improving HbA1c testing within an ACCHS.

Patient Information Management

PIMS Coordinators, Beth and Lana have conducted 215 training sessions in the last financial year. These have been attended by 246 staff to optimise the use of Communicare within ACCHSs, as requested by staff at Nunyara Aboriginal Health Service Inc., Umoona Tjutagku Aboriginal Health Service Aboriginal Corporation, Oak Valley Health Service, Moorundi Aboriginal Community Controlled Health Service, Tullawon Health Service, Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation, Nunkuwarrin Yunti of SA Inc., Pangula Mannamurna Aboriginal Corporation and Pika Wiya Health Service Aboriginal Corporation.

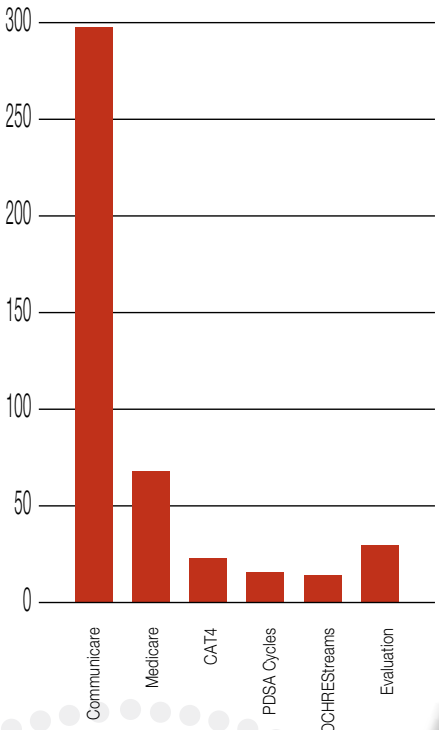
There have been onsite visits to Moorundi Aboriginal Community Controlled Health Service at Standen Street Clinic and Raukkan, Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation and Nunkuwarrin Yunti of SA Inc., Nunyara Aboriginal Health Service Inc. and Pangula Mannamurna Aboriginal Corporation.

Training has focused on many different aspects of Patient Information Management, such as recall management, the administrative aspects of Communicare, the entire care plan process, optimising Medicare revenue, MyHealth, meeting reporting requirements, and establishing data input processes to ensure data output is meaningful and representative of actual health service activity.

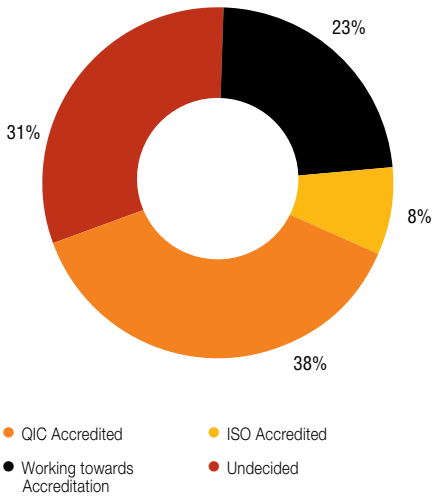
Medicare Resource

AHCSA's Quality Systems Team has been developing a Medicare toolkit developed specifically for Members. The toolkit will act as both a training and information manual with customised instructions for Communicare. It will be launched in 2018.

Training Provided to ACCHS Staff



Organisational Accreditation



CONSTITUTIONAL OBJECTIVE 4

CONTRIBUTE TO THE DEVELOPMENT OF A WELL QUALIFIED AND TRAINED ABORIGINAL HEALTH SECTOR WORKFORCE

CONSTITUTIONAL OBJECTIVE 4

EDUCATION TRAINING AND WORKFORCE

REGISTERED TRAINING ORGANISATION

In late 2016, the staff structure within the Education, Training and Workforce Team was reviewed and resulted in positions being adjusted and the addition of a new position. The previous role of Administration Assistant was reviewed and adjusted into the more student-focussed position of Student Services Officer. The adjusted role and new staff appointment has been very positive. The introduction of a new position, the Education Support Officer, has also been well received and enables the provision of more one-on-one support to students within the classroom setting.

Finally, with two Educator positions for all classes, the need for both positions to be clinical-focussed was identified. The second Educator role was adjusted to Clinical Educator to meet this requirement.

In addition to the members of the Education, Training and Workforce Team, the Registered Training Organisation (RTO) receives significant support from other program staff across the organisation. During the 2016-2017 period, AHCSA's Ear and Hearing Health, Eye Health and Trachoma Elimination, Blood Borne Virus, Maternal Health Tackling Smoking and Sexual Health Programmes have provided education delivery to RTO students.

Educators also seek support from industry specialists to provide current information to students in a range of health areas. Special thanks goes to the following industry partners for their ongoing support of AHCSA's Primary Health Care training:

- Heart Foundation
- Hepatitis SA
- Diabetes SA
- Kidney Health Australia
- Drug and Alcohol Services South Australia
- South Australian Health and Medical Research Institute
- Rheumatic Heart Disease Control Program, SA Health

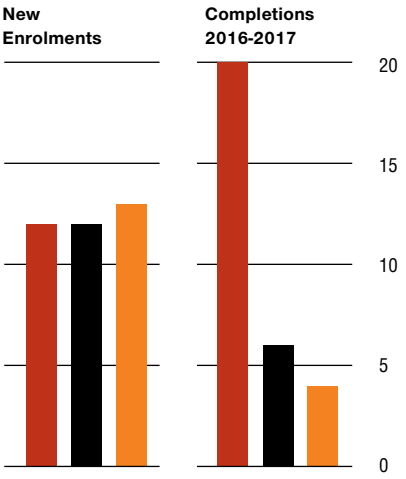
Courses	New Enrolments	Completions 2016-17
HLT30113 – Certificate III Aboriginal and/or Torres Strait Islander Primary Health Care	13	20
HLT40113 – Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care	12	6
HLT40213 – Certificate IV Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)	12	4
TOTAL	**37**	**30**

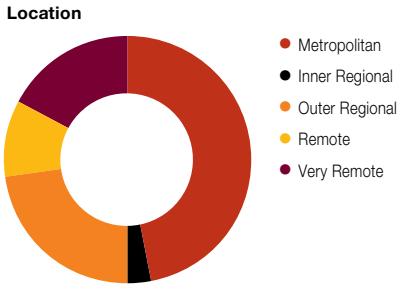
Cultural Advisory Team

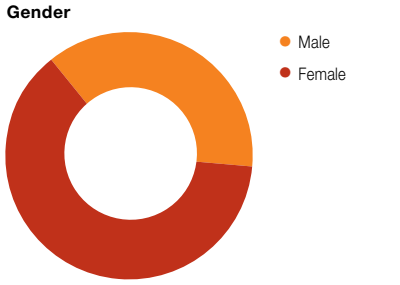
To ensure appropriate cultural consideration, AHCSA operates the RTO Cultural Advisory Team (CAT). The Team is made up of Aboriginal staff from across the organisation, who bring a wide range of experience, knowledge and skills to the group. The CAT continued its involvement in the development and delivery of training services at AHCSA over this period and is currently working on some exciting projects within the RTO.

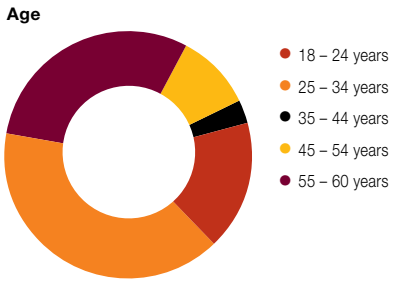
Achievements

Training for 2017 consisted of three new class intakes, one in each qualification, at the beginning of the year. In addition to the new enrolments, the RTO also saw the continuation of the Certificate IV classes from 2016. With the introduction of longer course periods, each Certificate IV intake carries over to the following calendar year. This has resulted in a reduction of new enrolment numbers, as the continuation increases student numbers and delivery workload for RTO staff each year.









CONSTITUTIONAL OBJECTIVE 4

EDUCATION, TRAINING AND WORKFORCE

WORKFORCE DEVELOPMENT

Workforce Development supports and assists Member Services to develop relevant links to Continued Professional Development (CPD) for Aboriginal Health Practitioners. The Workforce Development Officer (WDO) also provides support to the development of the ACCHO Workforce Scope of Practice for Aboriginal Health Practitioners (AHPs). The role is supported with national linkages to the National Aboriginal and Torres Strait Islander Health Worker Association, as well as providing supports to external healthcare providers including the Australian Health Practitioner Regulation Agency, Palliative Care SA, and Anangu Ngangkari Tjutaku Aboriginal Corporation (ANTAC).

Priorities

- Strong communication between AHCSA, its Members and SA Health in a partnership approach with workforce and training needs and issues for the Aboriginal workforce in South Australia.
- The WDO aims to identify workforce challenges and collaborate with sector and cross sector organisations to address these priorities.
- Facilitate jurisdictional networking and professional development opportunities.
- The WDO provides support to AHCSA's primary health services and staff positioned within their service.
- Support Members with recruitment and retention activities when necessary.
- The WDO also identifies workforce challenges and collaborates with cross-sector organisations to address these priorities.

Achievements

The Aboriginal Primary Health Care Worker Forum (APHCWF) has continued to support the AHW and AHP workforce, with four meetings across the reporting period, and the APHCWF will attend the National NATSIHWA Forum in November.

The WDO works closely with the AHCSA RTO to promote the role of the AHW and AHP. This includes monitoring existing training opportunities and resources for the Primary Health Care workforce.

The WDO has recently launched an SA Workforce Needs Survey to explore the Primary Health care training needs across our sector.

RURAL ABORIGINAL HEALTH WORKER

The Rural Aboriginal Health Worker Programme (RAHWP) continues in its role to support the delivery of primary health in regional areas that do not have full access to ACCHS services. It is vital to ensure that primary health care delivery for the Aboriginal communities is maintained in these areas.

This Programme employs 12 AHWs in the Riverland, Mount Gambier, Oodnadatta, Whyalla, Point Pearce, Raukkan, Murray Bridge, and Meningie and AHCSA continues to monitor and manage the funds and administration associated with this Programme, including negotiation and liaison with mainstream country hospitals and health services.

AHCSA receives funding from the Department of Health which provides support to Country Health SA Local Health Network, Pangula Mannamurna Aboriginal Corporation and Nunyara Aboriginal Health Services.

ABORIGINAL PRIMARY HEALTH CARE WORKERS FORUM

The Aboriginal Primary Health Care Workers Forum (APHCWF) is a subcommittee of AHCSA, which supports Aboriginal Health Workers, Aboriginal Health Practitioners, Substance Misuse and Mental Health Workers, as well as Aboriginal Maternal Infant Care workers and Aboriginal Hospital Liaison Workers.

The South Australian APHCWF is very unique in that it is one of few across Australia that represents the Aboriginal Health Worker and Practitioner within South Australia and further afield. The Forum allows its members to collectively draw attention to the circumstances that impact on the recognition growth and development of our workforce while also promoting value and necessity of the underpinning knowledge of the community they serve.

Sharing of promotional resources, seeking models of best practice and information sharing through networking are some of the functions for the Forum. They also assist with issues including wage parity and career pathways, as well as scope of practice for Aboriginal Health Practitioner registration.

APHCWF rotates the location of its meetings to incorporate regional areas, allowing as many Aboriginal Workforce members as possible to attend, give AHWs in that location the opportunity to attend, and for Members to visit health services in other areas.

FORUM MEMBERS HIGHLIGHT ISSUES THAT IMPACT ON GROWTH AND DEVELOPMENT OF OUR WORKFORCE, WHILE PROMOTING THE NECESSITY OF KNOWING THE COMMUNITY THEY SERVE

CONSTITUTIONAL OBJECTIVE 4

EDUCATION, TRAINING AND WORKFORCE

CANCER AUSTRALIA

The Cancer Australia Project (CAP) continued, with AHCSA delivering the Women's Business and Our Lungs, Our Mob workshops between February and December last year. As established in the key objectives for the project, the minimum reporting requirements have been met.

In total, 32 Our Lungs, Our Mob and 31 Women's Business workshops were held across Australia. The total number of participants at these workshops was 340 for Our Lungs, Our Mob and 277 for Women's Business. These numbers were made up of community Members, Aboriginal Health Workers and other health professionals or interested people.

The average number of participants per workshop for Our Lungs, Our Mob was 10.8. The objective at the start of the project was to have between 10 and 15 participants per workshop. AHCSA's presentation and participation at the Aboriginal Tobacco Resistance and Council of New South Wales (A-TRAC) conference boosted the overall total average. The average number of participants for Women's Business workshops was 8.9. The objective was the same as Our Lungs Our Mob, with AHCSA aiming for at least 10 to 15 participants attending each workshop. With adequate time available for recruitment and engagement, a higher participation rate was achieved at workshops held later in 2016.

Extent to which the workshops increased awareness, knowledge, and understanding among Aboriginal and Torres Strait Islander people of the risk factors, symptoms and benefits of early diagnosis was measured using questionnaires. Participant data from the Our Lungs Our Mob workshops presented highly positive results.

32 OUR LUNGS, OUR MOB AND 31 WOMEN'S BUSINESS WORKSHOPS WERE HELD IN 2016-2017

Our Lungs, Our Mob

283 immediate responses were collected from 340 total participants, who reported the following:

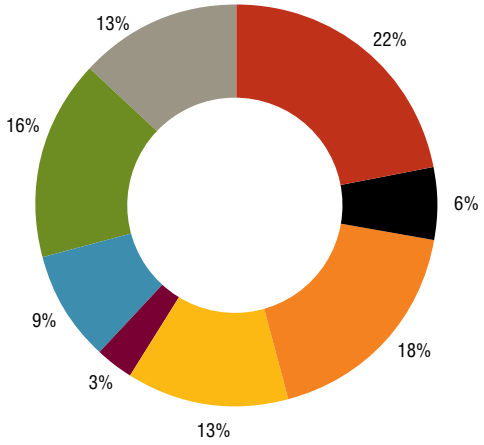
- 96% were more informed about the symptoms of lung cancer.
- 98% understood the risk factors of lung cancer.
- 98% understood the importance of speaking with their doctor or health worker about their health and the importance of early diagnosis.
- 99% reported that the information presented was easy to understand.

Women's Business

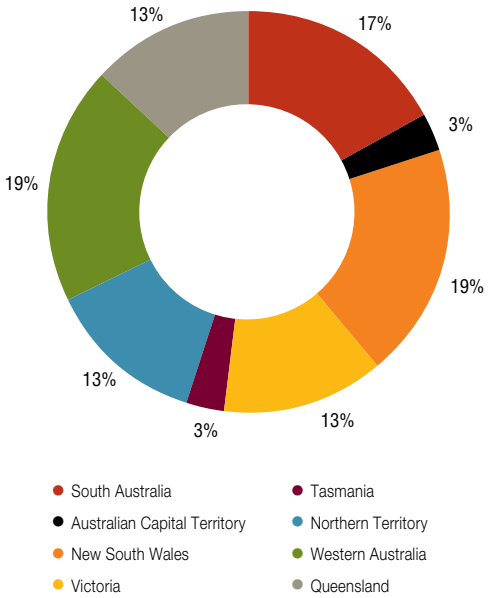
205 immediate responses were collected from 277 total female participants who now know more about the following:

- 98.5% knew why it is important to look for changes in their body and why breast screening is required every two years.
- 99.5% know why pap smears are required every two years.
- 96.5% know more about the symptoms of women's business cancers.
- 96% stated that they know more about the HPV vaccine.
- 98.5% know why is it important to speak with their doctor or health worker about their health, and found the information presented easy to understand.

Number of Workshops Held Nationally – Our Lungs Our Mob



Number of Workshops Held Nationally – Women's Business



Workshop Delivery

Health services were able to be a part of the Our Lungs, Our Mob Support Initiative through Aboriginal Health Workers and Aboriginal Health Practitioners due to existing programs for quitting smoking and healthy lifestyles. Health workers involved in the delivery of the workshops already had some knowledge on lung cancer but felt the workshop provided additional knowledge and filled in many gaps they had on the subject.

Time spent with Aboriginal staff from AHCSA encouraged them to feel safe and confident to co-facilitate the workshops. The resource was simple and easy for them to understand and they indicated that they would be able to hold another workshop without additional support.

Aboriginal Health Workers and Aboriginal Health Practitioners involved in the organisation, promotion and delivery of the Women's Business workshop found them to be a great incentive for their community. It was an opportunity for women to get together and talk about issues they generally find hard to talk about. Health workers found that working in collaboration with AHCSA and learning the material in the resource provided adequate information on how they could run the workshop again on their own.

Co-facilitation with AHCSA was helpful for the health workers to feel confident in the delivery of the resource as they were fully supported by the AHCSA staff. The majority of responses from health workers conveyed that the support and time spent with the AHCSA staff member helped to increase their knowledge and understanding on the subject of Women's Business. After holding the workshop within their service health workers, felt more confident and encouraged to organise additional workshops and provide clients with better knowledge on risks, symptoms and screening.

Workshop Factors

AHCSA achieved significant success in running the Our Lungs Our Mob and Women's Business workshops, although there were a handful of earlier workshops with low attendance.

The number one success factor was the receptiveness of the Aboriginal service to the needs of local services, and having adequate time invested into engaging with local requirements. Other contributing factors included:

- Establishing a thorough understanding of the purpose to raise community awareness.
- Clarification regarding collaboration with local staff to implement workshops.
- Highlighting the quality of the community education resource, particularly how easy it is to understand for both health workers and community members.
- Talking through the cultural appropriateness of the resources.
- Time invested by AHCSA facilitators to establish a relationship with the service and health workers prior to the workshop.
- Promotion by both the health service and AHCSA to attract people from each community.
- Willingness and enthusiasm from individual health workers and services who could see the benefits of the resource and how it would enhance community awareness on cancer.
- AHCSA's strategic engagement with CEOs and state affiliates to raise awareness about the project and acquire permission to visit their services.
- Incentives to attend workshops were also a success measure. The incentives included gift cards, an opportunity to win an iPad and pampering for the Women's Business workshops.

The workshops with low attendance occurred early in the project with unrealistic delivery timeframes. Contributing factors to less successful workshops included:

- Health workers organising the workshop were not yet confident in co-facilitating the workshop. However, after the workshop, face-to-face time was invested to reflect on the workshop with AHCSA facilitators and this led to local health workers becoming more confident in holding additional workshops, despite their initial hesitation.
- It was initially unclear to some services and health workers supporting the workshop that the workshops were also targeted at community members, which led to lower attendance rates. After the workshop, these services had gained a better understanding and invited AHCSA to return, where they would guarantee higher attendance rates from community.
- Due to pressures at local service level, a key contact person to help plan workshops in advance was not always available. This lead to confusion at the local service in understanding the need to co-facilitate and promote workshops.
- Attendance rates were higher in instances where AHCSA assisted with promotion of the workshop.
- The overall engagement strategy with health services could have been improved through stronger relationship building. Insufficient email and phone calls led to many services not understanding the purpose of workshops. Adequate time and a long-term budget would have enabled face-to-face consultation to occur in the Aboriginal ways.

CONSTITUTIONAL OBJECTIVE 4

EDUCATION, TRAINING AND WORKFORCE

Workshop Impact

Three months following the workshops, feedback from services reported an increase in clients attending the clinic to access information on lung cancer, assistance with quitting smoking, check-ups with the AHWs and to have pap tests. It was also reported that clients have joined smoking and healthy lifestyle groups and made small changes to their lifestyles.

The highlight of the three month evaluation data was the number of women who have had pap smears and mammograms carried out since attending a workshop. Of the 74 returned three-month participant evaluations; 31 women had had a pap smear and 25 had had a mammogram. This represents 16% and 11% respectively of the total community participants (198).

The Our Lungs, Our Mob immediate participant evaluation identified 181 smokers out of 340. 150 of the smokers would like to quit smoking, however only 7 people attempted to quit and 1 person is on their journey to being smoke-free.

Cost of Workshops

The total cost for the Our Lungs, Our Mob and Women's Business workshops was $120,676.25, which equates to an average cost of $1,915.49 per workshop.

Travel expenditure, especially to remote areas, was a significant cost, which led to workshops becoming more expensive to run than the projected cost. However, the costs stated above, do not include costs for AHCSA staff facilitating workshops; therefore the real cost of workshops to AHCSA is significantly higher as relayed in Advisory meetings throughout the project.

Sustainability of Delivering Key Cancer Messages

To ensure that key messages relating to signs, symptoms, and prevention of cancer are delivered to the Aboriginal and/or Torres Strait Islander communities, the best approach was found to be meaningful engagement with local service providers. In terms of sustainability, it is best practice to have local workers deliver education within their communities as the Team have found that people are more willing to listen and feel comfortable attending sessions if they know the facilitators. However, the support required by local workers is much higher than anticipated and the requisite engagement to achieve this needs to be planned with a long-term approach.

WORKSHOPS INCREASED AWARENESS, KNOWLEDGE, AND UNDERSTANDING OF THE RISK FACTORS, SYMPTOMS AND BENEFITS OF EARLY DIAGNOSIS

AHCSA FINANCIAL REPORT 2016-2017

STATUTORY FINANCIAL REPORT 2016-2017

Board of Directors' Report

AHCSA Board of Directors submits the financial report of the Aboriginal Health Council of South Australia Limited for the period 1 July 2016 to 30 June 2017.

Board of Directors

Full voting Membership of the Aboriginal Health Council of South Australia Limited ('the Company') is made up of ten independently constituted Aboriginal community controlled health and wellbeing services and two Aboriginal community controlled substance misuse services.

From 1 July 2016 to 29 November 2016:

EXECUTIVE MEMBERS

John Singer (Chairperson)
Independent Chair

Polly Sumner-Dodd (Deputy Chairperson)
Aboriginal Sobriety Group

Les Kropinyeri (Treasurer)
Port Lincoln Aboriginal Health Service

Rameth Thomas (Secretary)
Umoona Tjutagku Health Service Aboriginal Corporation
(to August 2017)

Vicki Holmes (Executive Member)
Nunkuwarrin Yunti of South Australia Inc.

Roderick Day
Tullawon Health Service

Narelle Unmeopa
Pangula Mannamurna Aboriginal Corporation

Josie Warrior
Umoona Tjutagku Health Service Aboriginal Corporation
(from November 2016)

Wilhelmine Lieberwirth
Nunyara Aboriginal Health Service Inc.

Debra Miller
Ceduna/ Koonibba Aboriginal Health Service Aboriginal Corporation

Jamie Nyaningu
Nganampa Health Council

Roy Wilson
Kalparrin Community Inc.

Vacant
Pika Wiya Health Service Aboriginal Corporation

Roger Williams
Oak Valley Health Service

Shane Mohor (Public Officer)

From 29 November 2016 to 30 June 2017:

EXECUTIVE MEMBERS

John Singer (Chairperson)
Independent Chair

Polly Sumner-Dodd (Deputy Chairperson)
Aboriginal Sobriety Group

Les Kropinyeri (Treasurer)
Port Lincoln Aboriginal Health Service

Vicki Holmes (Secretary)
Nunkuwarrin Yunti of South Australia Inc.

Jamie Nyaningu (Executive Member)
Nganampa Health Council

Mark Lovett
Pangula Mannamurna Aboriginal Corporation
(from May 2017)

Josie Warrior
Umoona Tjutagku Health Service Aboriginal Corporation

Roderick Day
Tullawon Health Service

Roger Williams
Oak Valley Health Service

Wilhelmine Lieberwirth
Nunyara Aboriginal Health Service Inc.

Leeroy Bilney
Ceduna/ Koonibba Aboriginal Health Service Aboriginal Corporation

Roy Wilson
Kalparrin Community Inc.

Vacant
Pika Wiya Health Service Aboriginal Corporation

STATUTORY FINANCIAL REPORT 2016-2017

Board of Directors' Report

Principal Activities

The Aboriginal Health Council of SA Limited (the 'Company') is the peak body representing Aboriginal community controlled health and substance misuse services in South Australia.

Since the review process and reincorporation as an independent community controlled organisation in September 2001, full-time equivalent secretariat positions have risen to 44.

The role of the secretariat is to provide support to the Company's Board of Directors, its standing and sub committees and to manage the day to day operations of the Company.

The key activities of the Company's secretariat during this period included:

- Appointment of new staff to the Company's secretariat
- Reviewing operational policies and procedures
- Supporting the Members' review of the AHCSA Constitution
- Supporting the members of the Executive and Full Board of Directors
- Collaboration with other agencies on research and other projects
- Advocating on behalf of individuals and groups in relation to Aboriginal health matters
- Responding on behalf of the Board on reviews and reports at State and National levels
- Developing strategies to support the ongoing quality and future of Aboriginal Health Worker Practitioner training and workforce development issues
- Regularly updating the Company's website
- Visiting Aboriginal communities and member organisations
- Participating on the executive and management committee of the South Australian Aboriginal Health Partnership
- Maintain reaccreditation through the Quality Innovation Performance and accreditation through the Australian Health Practitioner Regulation Agency
- Providing administration support and facilitation to the Aboriginal Primary Health Care Workers Forum
- Provide administration and facilitation support to the Aboriginal Research and Ethics Committee
- Responding to requests for information from students and other members of the public
- Presenting information about the organisation to various State and National forums.

Financial Summary

The following Financial Statements and Notes presented in this report have been prepared on an accrual basis with the accompanying notes providing related party information. The Company has moved to the Cloud ERP system and other NetSuite applications for its financials, business functions and electronic filing system. AHCSA continues to outsource the payroll function to Integrated Payroll Systems.

Basso Newman and Co Chartered Accountants remained the Company's appointed Auditors for this financial year, completing the third and final year of its tenure.

Significant Changes

Apart from the implementation of other NetSuite applications, no other significant changes occurred during the year.

Operating Result

In the 2016/2017 financial year, AHCSA posts a statutory surplus of $72,985. There were no abnormal items.

Signed in accordance with a resolution of the members of the Committee.

STATEMENT OF PROFIT OR LOSS

For the year ended 30 June 2017

	Note	2017 $	2016 $
Revenue	2	8,720,579	7,630,632
Other Income	2	391,513	382,910
Employee Benefits Expense		(4,370,278)	(3,893,322)
Depreciation and Amortisation Expense	3	(541,225)	(584,692)
Finance Costs		(216,703)	(245,283)
Repairs, Maintenance and Vehicle Running Expense		(202,343)	(57,056)
Fuel, Light and Power Expense		(83,480)	(107,301)
Training Expense		(267,969)	(207,270)
Audit, Legal and Consultancy Expense		(100,291)	(43,976)
Administration Expense		(223,854)	(148,078)
Other Expenses		(3,032,964)	(3,250,168)
PROFIT (LOSS) BEFORE INCOME TAX		**72,985**	**(523,604)**
INCOME TAX EXPENSE		**–**	**–**
PROFIT (LOSS) FOR THE YEAR		**72,985**	**(523,604)**
PROFIT (LOSS) ATTRIBUTABLE TO MEMBERS OF THE ENTITY		**72,985**	**(523,604)**

The accompanying notes form part of these financial statements.

STATEMENT OF COMPREHENSIVE INCOME

For the year ended 30 June 2017

	Note	2017 $	2016 $
Profit (Loss) for the Year		72,985	(523,604)
OTHER COMPREHENSIVE INCOME Items that will not be reclassified subsequently to profit or loss:			
Gains on revaluation of land and buildings, net of tax		–	**2,226,375**
Items that will be reclassified subsequently to profit or loss when specific conditions are met:			
Fair value gains/(losses) on available-for-sale financial assets, net of tax		–	–
TOTAL OTHER COMPREHENSIVE INCOME FOR THE YEAR		–	**2,226,375**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**72,985**	**1,702,771**
TOTAL COMPREHENSIVE INCOME ATTRIBUTABLE TO MEMBERS OF THE ENTITY		**72,985**	**1,702,771**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

For the year ended 30 June 2017

	Note	2017 $	2016 $
ASSETS			
CURRENT ASSETS			
Cash and Cash Equivalents	4	3,503	(72,335)
Trade and Other Receivables	5	869,058	888,254
Other Assets	6	191,903	87,782
TOTAL CURRENT ASSETS		**1,064,464**	**903,701**
NON-CURRENT ASSETS			
Property, Plant and Equipment	7	8,143,058	8,093,171
Intangible Assets	8	310,110	617,823
TOTAL NON-CURRENT ASSETS		**8,453,168**	**8,710,994**
TOTAL ASSETS		**9,517,632**	**9,614,695**
LIABILITIES			
CURRENT LIABILITIES			
Trade and Other Payables	9	1,591,142	1,681,521
Borrowings	10	321,841	46,341
Provisions	11	416,266	472,060
TOTAL CURRENT LIABILITIES		**2,329,249**	**2,199,922**
NON-CURRENT LIABILITIES			
Borrowings	10	3,891,458	4,213,299
Provisions	11	142,407	119,941
TOTAL NON-CURRENT LIABILITIES		**4,033,865**	**4,333,240**
TOTAL LIABILITIES		**6,363,114**	**6,533,162**
NET ASSETS		**3,154,518**	**3,081,533**
EQUITY			
Retained Earnings		928,143	855,158
Reserves	19	2,226,375	2,226,375
TOTAL EQUITY		**3,154,518**	**3,081,533**

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY

For the year ended 30 June 2017

	Note	RETAINED EARNINGS $	REVALUATION SURPLUS $	TOTAL $
BALANCE AT 1 JULY 2015		**1,378,762**	–	**1,378,762**
Comprehensive Income				
Net Surplus/(Deficit) for the Year		(523,604)	–	(523,604)
Other Comprehensive Income for the Year:				
Gains On Revaluation of Land and Buildings		–	2,226,375	2,226,375
TOTAL OTHER COMPREHENSIVE INCOME		**–**	**2,226,375**	**1,702,771**
Total comprehensive income attributable to members of the entity for the year		(523,604)	2,226,375	1,702,771
BALANCE AT 30 JUNE 2016		**855,158**	**2,226,375**	**3,081,533**
BALANCE AT 1 JULY 2016				
Comprehensive Income				
Profit for the Year		72,985	–	72,985
Total comprehensive income attributable to members of the entity for the year		72,985	–	72,985
BALANCE AT 30 JUNE 2017		**928,143**	**2,226,375**	**3,154,518**

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS

For the year ended 30 June 2017

	Note	2017 $	2016 $
CASH FLOWS FROM OPERATING ACTIVITIES			
Receipts from Operations		9,107,492	8,872,888
Payments to Suppliers and Employees		(8,490,301)	(8,411,954)
Interest Received		2,697	4,429
Finance Costs		(216,703)	(245,283)
Net cash generated from operating activities		403,185	220,080
CASH FLOWS FROM INVESTING ACTIVITIES			
Proceeds from Sale of Property, Plant and Equipment		21,099	23,334
Payment for Property, Plant and Equipment		(302,105)	(2,140,678)
Net cash used in investing activities		**(281,006)**	**(2,117,344)**
CASH FLOW FROM FINANCING ACTIVITIES			
CBA Assets Finance (Net of Repayments)		(46,341)	189,289
CBA Long Term Loan		–	1,550,000
Net cash generated by/(used in) financing activities		**(46,341)**	**1,739,289**
NET INCREASE IN CASH HELD		**75,838**	**(157,975)**
Cash and Cash Equivalents at Beginning of Financial Year		(72,335)	85,640
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR		**3,503**	**(72,335)**

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Preparation

Aboriginal Health Council of South Australia Limited applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: *Application of Tiers of Australian Accounting Standards*.

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board (AASB) and the *Australian Charities and Not-for-profits Commission Act 2012*. The Company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, have been prepared on an accrual basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

The financial statements were authorised for issue on 23 October 2017 by the directors of the Company.

Accounting Policies

(a) Revenue

Non-reciprocal grant revenue is recognised in profit or loss when the entity obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the entity and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before the entity is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the entity incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the state of financial position as a liability until the service has been delivered to the contributor; otherwise the grant is recognised as income on receipt.

Aboriginal Health Council of South Australia Limited receives non-reciprocal contributions of assets from the government and other parties for zero or a nominal value. These assets are recognised at fair value on the date of acquisition in the statement of financial position, with a corresponding amount of income recognised in profit or loss.

Donations and bequests are recognised as revenue when received.

Interest revenue is recognised using the effective interest method, which for floating rate financial assets is the rate inherent in the instrument.

Revenue from the rendering of a service is recognised upon the delivery of the service to the customer.

All revenue is stated net of the amount of goods and services tax.

(b) Property, Plant and Equipment

Each class of property, plant and equipment is carried at cost or fair value as indicated, less, where applicable, accumulated depreciation and any impairment losses.

Freehold Property

Freehold land and buildings are shown at their fair value based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings.

In periods when the freehold land and buildings are not subject to an independent valuation, the directors conduct directors' valuations to ensure the carrying amount for the land and buildings is not materially different to the fair value.

Increases in the carrying amount arising on revaluation of land and buildings are recognised in other comprehensive income and accumulated in the revaluation surplus in equity. Revaluation decreases that offset previous increases of the same class of assets shall be recognised in other comprehensive income under the heading of revaluation surplus. All other decreases are recognised in profit or loss.

Any accumulated depreciation at the date of the revaluation is eliminated against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset.

Freehold land and buildings that have been contributed at no cost, or for nominal cost, are initially recognised and measured at the fair value of the asset at the date it is acquired.

Plant and Equipment

Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and any accumulated impairment losses. In the event the carrying amount of plant and equipment is greater than the estimated recoverable amount, the carrying amount is written down immediately to the estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(f) for details of impairment).

Plant and equipment that have been contributed at no cost, or for nominal cost, are valued and recognised at the fair value of the asset at the date it is acquired.

(c) Depreciation

The depreciable amount of all fixed assets, including buildings and capitalised lease assets, but excluding freehold land, is depreciated on a straight line basis over the assets useful life to the entity commencing from the time the asset is held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease or the estimated useful lives of the improvements.

The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rate
Buildings	2.5%
Plant and equipment	10% – 20%
Medical Equipment	10%
Computing Equipment	33%
Software	40%
RTO	40%

The assets residual values and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting period.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained earnings.

(d) Leases

Leases of fixed assets, where substantially all the risks and benefits incidental to the ownership of the asset (but not the legal ownership) are transferred to the entity, are classified as finance leases.

Finance leases are capitalised, recognising an asset and a liability equal to the present value of the minimum lease payments, including any guaranteed residual values.

Leased assets are depreciated on a straight-line basis over their estimated useful lives

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

where it is likely that the entity will obtain ownership of the asset. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Lease payments for operating leases, where substantially all the risks and benefits remain with the lessor, are recognised as expenses on a straight-line basis over the lease term.

Lease incentives under operating leases are recognised as a liability and amortised on a straight-line basis over the life of the lease term.

(e) Financial Instruments

Initial Recognition and Measurement

Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument. For financial assets, this is equivalent to the date that the Company commits itself to either purchase or sell the asset (ie: trade date accounting is adopted). Financial instruments are initially measured at fair value plus transactions costs except where the instrument is classified "at fair value through profit or loss" in which case transaction costs are recognised immediately as expenses in profit or loss.

Classification and Subsequent Measurement

Financial instruments are subsequently measured at fair value (refer to Note 1(q)), amortised cost using the effective interest method, or cost.

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the effective interest method.

The effective interest method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying amount with a consequential recognition of an income or expense item in profit or loss.

(i) *Financial Assets at Fair Value Through Profit or Loss*

Financial assets are classified at 'fair value through profit or loss' when they are held for trading for the purpose of short-term profit taking, derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying amount included in profit or loss.

(ii) Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iii) Held-to-maturity Investments

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Company's intention to hold these investments to maturity. They are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iv) Financial Liabilities

Non-derivative financial liabilities other than financial guarantees are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Impairment

At the end of each reporting period, the Company assesses whether there is objective evidence that a financial asset has been impaired. A financial asset (or a group of financial assets) is deemed to be impaired if, and only if, there is objective evidence of impairment as a result of one or more events (a "loss event") having occurred, which has an impact on the estimated future cash flows of the financial asset(s).

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered to constitute a loss event. Impairment losses are recognised in profit or loss immediately. Also, any cumulative decline in fair value previously recognised in other comprehensive income is reclassified into profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include: indications that the debtors or a group of debtors are experiencing significant financial difficulty, default or delinquency in interest or principal payments; indications that they will enter bankruptcy or other financial reorganisation; and changes in arrears or economic conditions that correlate with defaults.

For financial assets carried at amortised cost (including loans and receivables), a separate allowance account is used to reduce the carrying amount of financial assets impaired by credit losses. After having taken all possible measures of recovery, if management establishes that the carrying amount cannot be recovered by any means, at that point the written-off amounts are charged to the allowance account or the carrying amount of impaired financial assets is reduced directly if no impairment amount was previously recognised in the allowance account.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated, the Company recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Derecognition

Financial assets are derecognised when the contractual rights to receipt of cash flows expire or the asset is transferred to another party whereby the entity no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised when the related obligations are discharged, cancelled or have expired. The difference between the carrying amount of the financial liability, which is extinguished or transferred to another party, and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

(f) Impairment of Assets

At the end of each reporting period, the entity assesses whether there is any indication that an asset may be impaired. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs of disposal and value in use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss, unless the asset is carried

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

at a revalued amount in accordance with another Standard (eg in accordance with the revaluation model in AASB 116: *Property, Plant and Equipment*). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard.

Where it is not possible to estimate the recoverable amount of an individual asset, the entity estimates the recoverable amount of the cash-generating unit to which the asset belongs.

Impairment testing is performed annually for goodwill and intangible assets with indefinite lives.

(g) Employee Benefits

Short-term Employee Benefits

Provision is made for the Company's obligation for short-term employee benefits. Short-term employee benefits are benefits (other than termination benefits) that are expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service, including wages, salaries and sick leave. Short-term employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled.

The Company's obligations for short-term employee benefits such as wages, salaries and sick leave are recognised as part of current trade and other payables in the statement of financial position.

Other Long-term Employee Benefits

The Company classifies employee's long service leave and annual leave entitlements as other long-term employee benefits as they are not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Provision is made for the Company's obligation for other long-term employee benefits, which are measured at the present value of the expected future payments to be made to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on government bonds that have maturity dates that approximate the terms of the obligations. Upon the remeasurement of obligations for other long-term employee benefits, the net change in the obligation is recognised in profit or loss classified under employee benefits expense.

The Company's obligations for long-term employee benefits are presented as non-current liabilities in its statement of financial position, except where the Company does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period, in which case the obligations are presented as current liabilities.

Retirement Benefit obligations

Defined Contribution Superannuation Benefits

All employees of the Company receive defined contribution superannuation entitlements, for which the Company pays the fixed superannuation guarantee contribution (currently 9.5% of the employee's average ordinary salary) to the employee's superannuation fund of choice. All contributions in respect of employee's defined contribution entitlements are recognised as an expense when they become payable. The Company's obligation with respect to employee's defined contribution entitlements is limited to its obligation for any unpaid superannuation guarantee contributions at the end of the reporting period. All obligations for unpaid superannuation guarantee contributions are measured at the (undiscounted) amounts expected to be paid when the obligation is settled and are presented as current liabilities in the Company's statement of financial position.

(h) Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments with original maturities of three months or less, and bank overdrafts. Bank overdrafts are shown within borrowings in current liabilities on the statement of financial position.

(i) Goods and Services Tax (GST)

Revenues, expenses and assets are recognised net of the amount of GST except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO).

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities, which are recoverable from or payable to the ATO, are presented as operating cash flows included in receipts from customers or payments to suppliers.

(j) Income Tax

No provision for income tax has been raised as the entity is exempt from income tax under *Div 50 of the Income Tax Assessment Act 1997*.

(k) Intangible Assets

Software

Software is initially recognised at cost. It has a finite life and is carried at cost less any accumulated amortisation and impairment losses. Software has an estimated useful life of between one and three years. It is assessed annually for impairment.

RTO Training Resources

The amount spent in developing course materials for the Education and Training for the provision of Aboriginal Primary Health Care training is capitalised and amortised over 3 years.

(l) Provisions

Provisions are recognised when the entity has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured. Provisions recognised represent the best estimate of the amounts required to settle the obligation at the end of the reporting period.

(m) Comparative Figures

When required by Accounting Standards, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

(n) Trade and Other Payables

Trade and other payables represent the liabilities for goods and services received by the Company during the reporting period that remain unpaid at the end of the reporting period. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(o) Critical Accounting Estimates and Judgements

The directors evaluate estimates and judgements incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Company.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

Key Estimates

(i) Valuation of Freehold Land and Buildings

The freehold land and buildings were independently valued at 30 June 2016 by M3 Property. The valuation was based on the fair value less costs of disposal. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current strong demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $2,226,375 being recognised for the year ended 30 June 2016.

At 30 June 2017, the directors have performed a directors valuation on the freehold land and buildings. The directors have reviewed the key assumptions adopted by the valuers in 2016 and do not believe there has been a significant change in the assumptions at 30 June 2017. The directors therefore believe the carrying amount of the land correctly reflects the fair value less costs of disposal at 30 June 2017.

Key Judgements

Employee Benefits

For the purpose of measurement, AASB 119: *Employee Benefits* defines obligations for short-term employee benefits as obligations expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service. As the Company expects that most employees will not use all of their annual leave entitlements in the same year in which they are earned or during the 12-month period that follows (despite an informal company policy that requires annual leave to be used within 18 months), the directors believe that obligations for annual leave entitlements satisfy the definition of other long-term employee benefits and, therefore, are required to be measured at the present value of the expected future payments to be made to employees.

(p) Economic Dependence

Aboriginal Health Council of South Australia Limited is dependent on the Department of Health for the majority of its revenue used to operate the business. At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Aboriginal Health of South Australia Limited.

(q) Fair Value of Assets and Liabilities

The Company measures some of its assets and liabilities at fair value on either a recurring or non-recurring basis, depending on the requirements of the applicable Accounting Standard.

'Fair value' is the price the Company would receive to sell an asset or would have to pay to transfer a liability in an orderly (ie unforced) transaction between independent, knowledgeable and willing market participants at the measurement date.

As fair value is a market-based measure, the closest equivalent observable market pricing information is used to determine fair value. Adjustments to market values may be made having regard to the characteristics of the specific asset or liability. The fair values of assets and liabilities that are not traded in an active market are determined using one or more valuation techniques. These valuation techniques maximise, to the extent possible, the use of observable market data.

To the extent possible, market information is extracted from the principal market for the asset or liability (ie the market with the greatest volume and level of activity for the asset or liability). In the absence of such a market, market information is extracted from the most advantageous market available to the entity at the end of the reporting period (ie: the market that maximises the receipts from the sale of the asset or minimises the payments made to transfer the liability, after taking into account transaction costs and transport costs).

For non-financial assets, the fair value measurement also takes into account a market participant's ability to use the asset in its highest and best use or to sell it to another market participant that would use the asset in its highest and best use.

The fair value of liabilities and the entity's own equity instruments (if any) may be valued, where there is no observable market price in relation to the transfer of such financial instruments, by reference to observable market information where such instruments are held as assets. Where this information is not available, other valuation techniques are adopted and, where significant, are detailed in the respective note to the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 2 – REVENUE AND OTHER INCOME	2017 $	2016 $
Revenue		
Revenue from (Non–Reciprocal) Government Grants and Other Grants:		
State/Federal Government Grants	8,720,579	7,630,632
Total Revenue	**8,720,579**	**7,630,632**
Other Income		
Gain on Disposal of Property, Plant and Equipment	2,389	23,334
Interest Received on Financial Assets Not at Fair Value Through Profit or Loss	2,697	4,429
Other	386,427	355,147
Total Other Income	**391,513**	**382,910**
TOTAL REVENUE AND OTHER INCOME	**9,112,092**	**8,013,542**

NOTE 3 – PROFIT FOR THE YEAR	2017 $	2016 $
EXPENSES		
Employee Benefits Expense:		
– Contributions To Defined Contribution Superannuation Funds	341,031	305,655
Depreciation and Amortisation:		
– Land and Buildings	67,000	22,013
– Motor Vehicles	1,018	31,458
– Plant and Equipment	79,855	135,761
– Software	393,352	395,460
Total Depreciation and Amortisation	**541,225**	**584,692**
Financial Costs:		
– Interest Expense on Financial Liabilities Not at Fair Value Through Profit or Loss	216,703	245,283
Bad and Doubtful Debts:		
– Trade and Other Receivables	–	–
Rental Expense on Operating Leases	**144,615**	**157,247**

NOTE 4 – CASH AND CASH EQUIVALENTS	2017 $	2016 $
CURRENT		
Cash at Bank	(4,497)	(80,685)
Cash on Hand	8,000	8,350
	3,503	**(72,335)**

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 5 – TRADE AND OTHER RECEIVABLES	2017 $	2016 $
CURRENT		
Trade Receivables	869,058	846,737
Provision for Impairment	–	–
Total	**869,058**	**846,737**
Other Receivables	–	41,517
Total Current Trade and Other Receivables	**869,058**	**888,254**

NOTE 6 – OTHER ASSETS	2017 $	2016 $
CURRENT		
Prepayments	191,903	87,782
	191,903	**87,782**

NOTE 7 – PROPERTY, PLANT AND EQUIPMENT	2017 $	2016 $
Land And Buildings		
Freehold Land at Fair Value: Directors Valuation in 2017	5,000,000	–
Independent Valuation in 2016	–	5,000,000
Total Land Value	**5,000,000**	**5,000,000**
Buildings at Fair Value: Directors Valuation in 2017	2,720,063	–
Independent Valuation in 2016	–	2,680,000
Less Accumulated Depreciation	(67,000)	–
Total Buildings	**2,653,063**	**7,680,000**
Total Land and Buildings	**7,653,063**	**7,680,000**
Plant and Equipment		
At Cost	1,334,170	1,218,814
Less Accumulated Depreciation	(844,175)	(805,643)
	489,995	413,171
Total Plant and Equipment	**489,995**	**413,171**
Total Property, Plant and Equipment	**8,143,058**	**8,093,171**

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 7 – PROPERTY, PLANT AND EQUIPMENT (cont)

Movements in Carrying Amounts
Movement in the carrying amounts for each class of property, plant and equipment between the beginning and the end of the current financial year:

2017	Land and Buildings $	Plant and Equipment $	Total $
Balance at the Beginning of the Year	7,680,000	413,171	8,093,171
Additions at Cost	40,063	176,409	216,472
Additions at Fair Value	–	–	–
Disposals	–	(18,709)	(18,709)
Depreciation Expense	(67,000)	(80,876)	(147,876)
Carrying Amount at the End of the Year	**7,653,063**	**489,995**	**8,143,058**

Asset Revaluations

The freehold land and buildings were independently valued at 30 June 2016 by M3 Property. The valuation resulted in a revaluation increment of $2,226,375 being recognised in the revaluation surplus for the year ended 30 June 2016.

At 30 June 2017, the directors have performed a directors' valuation on the freehold land and buildings. The directors have reviewed the key assumptions adopted by the valuers in 2016 and do not believe there has been a significant change in the assumptions at 30 June 2017. The directors therefore believe the carrying amount of the land correctly reflects the fair value less costs of disposal at 30 June 2017. Refer to Note 18 for detailed disclosures regarding the fair value measurement of the Company's freehold land and buildings.

NOTE 8 – INTANGIBLE ASSETS

	2017 $	2016 $
RTO Training Resources – at Cost	505,225	446,075
Less Accumulated Amortisation	(326,968)	(148,538)
	178,257	**297,537**
Software – at Cost	713,320	686,834
Less Accumulated Amortisation	(581,467)	(366,545)
	131,853	320,289
Net Carrying Amount	**310,110**	**617,826**

2017	RTO Training Resources $	Software $	Total $
Balance at the Beginning of the Year	297,537	320,289	617,826
Additions at Cost	59,150	26,486	85,636
Additions at Fair Value	–	–	–
Depreciation Expense	(178,430)	(214,922)	(393,352)
Carrying Amount at the End of the Year	**178,257**	**131,853**	**310,110**

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 9 – TRADE AND OTHER PAYABLES	Note	2017 $	2016 $
CURRENT			
Trade Payables		1,294,818	1,306,111
Unspent Grants		296,324	375,410
		1,591,142	**1,681,521**
Financial Liabilities at Amortised Cost Classified as Trade and Other Payables:			
Trade and Other Payables:			
Total Current		1,591,142	1,681,521
Total Non-current		–	–
Less Unspent Grants		(296,324)	(375,410)
Financial Liabilities as Trade and Other Payables	17	**1,294,818**	**1,306,111**

NOTE 10 – BORROWINGS	2017 $	2016 $
CURRENT		
Assets Finance – CBA	46,341	46,341
Secured Loan – CBA	275,500	–
	321,841	**46,341**
NON-CURRENT		
Assets Finance – CBA	96,608	142,949
Secured Loan – CBA	3,794,850	4,070,350
Total Borrowings	**3,891,458**	**4,213,299**

Total borrowings are secured by the underlying Company assets. In August 2017 the Secured Loan has been successfully renegotiated for a further term of 3 years and 2 months on a principal and interest basis.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 11 – PROVISIONS	2017 $	2016 $
CURRENT		
Provision for Employee Benefits – Annual Leave	272,897	472,060
Provision for Employee Benefits – Long Service Leave	143,369	–
	416,266	**472,060**
Non-Current		
Provision for Employee Benefits: Long Service Leave	142,407	119,941
	558,673	**592,001**

ANALYSIS OF TOTAL PROVISIONS	Employee Benefits $	Total $
Opening Balance at 1 July 2016	592,001	592,001
Additional Provisions Raised During Year	235,588	235,588
Amounts Used	(268,916)	(268,916)
Balance At 30 June 2017	**558,673**	**558,673**

Provision for Employee Benefits

Provision for employee benefits represents amounts accrued for annual leave and long service leave.

The current portion for this provision includes the total amount accrued for annual leave entitlements and the amounts accrued for long service leave entitlements that have vested due to employees having completed the required period of service. Based on past experience, the Company does not expect the full amount of annual leave or long service leave balances classified as current liabilities to be settled within the next 12 months. However, these amounts must be classified as current liabilities since the Company does not have an unconditional right to defer the settlement of these amounts in the event employees wish to use their leave entitlement.

The non-current portion for this provision includes amounts accrued for long service leave entitlements that have not yet vested in relation to those employees who have not yet completed the required period of service.

In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based upon historical data. The measurement and recognition criteria for employee benefits have been discussed in Note 1(g).

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 12 – CAPITAL AND LEASING COMMITMENTS

A) Operating Lease Commitments
Non-Cancellable Operating Leases Contracted For But Not Recognised In The Financial Statements

Payable – Minimum Lease Payments:	2017 $	2016 $
– Not Later Than One Year	65,247	124,504
– Later Than One Year and Not Later Than Five Years	56,188	46,504
– Later Than Five Years	–	–
	121,435	**171,008**

NOTE 13: CONTINGENT LIABILITIES AND CONTINGENT ASSETS

The directors are not aware of any contingent liabilities at the end of the reporting period.

NOTE 14 – EVENTS AFTER THE REPORTING PERIOD

The directors are not aware of any significant events since the end of the reporting period.

NOTE 15 – KEY MANAGEMENT PERSONNEL COMPENSATION

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity, is considered key management personnel (KMP).

The totals of remuneration paid to KMP of the Company during the year are as follows:	2017 $	2016 $
Short Term Benefit	835,796	848,096
Post-employment Benefit	79,401	74,673
	915,197	**922,769**

NOTE 16 – OTHER RELATED PARTY TRANSACTIONS

Other related parties include close family members of key management personnel and entities that are controlled or jointly controlled by those key management personnel individually or collectively with their close family members.

Transactions between related parties are on normal commercial terms and conditions no more favourable than those available to other parties unless otherwise stated.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 17 – FINANCIAL RISK MANAGEMENT

The Company's financial instruments consist mainly of deposits with banks, local money market instruments, short-term investments, accounts receivable and payable, and leases.

The carrying amounts for each category of financial instruments, measured in accordance with AASB 139: *Financial Instruments: Recognition and Measurement* as detailed in the accounting policies to these financial statements, are as follows:

	Note	2017 $	2016 $
Financial Assets			
Cash and Cash Equivalents	4	3,503	(72,335)
Loans and Receivables	5	869,058	888,254
Total Financial Assets		**872,561**	**815,919**
Financial Liabilities			
Financial Liabilities at Amortised Cost:			
– Trade and Other Payables	9	1,591,142	1,681,521
– Borrowings	10	4,213,299	4,259,639
Total Financial Liabilities		**5,804,441**	**5,941,160**

NOTE 18 – FAIR VALUE MEASUREMENTS

The Company has the following assets, as set out in the table below, that are measured at fair value on a recurring basis after initial recognition. The Company does not subsequently measure any liabilities at fair value on a recurring basis and has no assets or liabilities that are measured at fair value on a non-recurring basis.

	Note	2017 $	2016 $
Non-financial Assets:			
– Freehold Land/Building (i)	7	7,653,063	7,680,000

(i) For freehold land and buildings, the fair values are based on a directors valuation taking into account an external independent valuation performed in the previous year, which used comparable market data for similar properties.

NOTES TO THE FINANCIAL STATEMENTS

For the year ended 30 June 2017

NOTE 19 – RESERVES

Revaluation Surplus
The revaluation surplus records the revaluations of non-current assets.

NOTE 20 – RELATED PARTY DISCLOSURES	2017 $	2016 $
Total Remuneration Received by Board Members	15,000	24,704
Number of Board Members Receiving Remuneration	1	1

STATEMENT BY THE BOARD OF DIRECTORS

Aboriginal Health Council of South Australia Limited

The directors of the registered entity declare that, in the directors' opinion:

1. The financial statements and notes, as set out on pages 46 to 64, are in accordance with the *Australian Charities and Not-for-profits Commission Act 2012* and:
   a. Comply with Australian Accounting Standards – Reduced Disclosure Requirements; and
   b. Give a true and fair view of the financial position of the registered entity as at 30 June 2017 and of its performance for the year ended on that date.
2. There are reasonable grounds to believe that the registered entity will be able to pay its debts as and when they become due and payable.

This declaration is signed in accordance with subs 60.15(2) of the *Australian Charities and Not-for-profits Commission Regulation 2013*.

Vicki Anne Holmes
Director

Polly Sumner-Dodd
Director

Signed at Adelaide, SA this 23rd day of October 2017.

INDEPENDENT AUDITOR'S REPORT 2016-2017

To the Members of Aboriginal Health Council of South Australia Limited

Qualified Opinion

We have audited the financial report of Aboriginal Health Council of South Australia Limited ('the entity') which comprises the statement of financial position as at 30 June 2017, the statement of profit or loss, statement of comprehensive income, the statement of changes in equity and the statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

In our opinion, except for the effects of the matter described in the Basis for Qualified Opinion section of our audit report, the accompanying financial report of the Aboriginal Health Council of South Australia Limited is in accordance with Div 60 of the Australian Charities and Not-for profits Commission Act 2012, including:

a) Giving a true and fair view of the entity's financial position as at 30 June 2017 and of its financial performance and cash flows for the year then ended; and

b) Complying with Australian Accounting Standards-Reduced Disclosure Requirements and the Australian Charities and Not-for-profits Commission Regulation 2013.

Basis for Qualified Opinion

Included in trade and other receivables at 30 June 2017 is an amount of $682,037 owed by the Department of the Prime Minister and Cabinet. There is significant uncertainty on the level of recoverability of this amount and no provision has been made to allow for a potential collection shortfall of the total amount owed. We were unable to determine whether any adjustment to or provision for non-recoverability of this amount was necessary. Accordingly income has been overstated by $682,037 thus resulting in profit and trade and other receivables being overstated by $682,037 and equity being overstated by $682,037.

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of our report. We are independent of the entity in accordance with the auditor independence requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* ('the Code') that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Report

Management is responsible for the preparation of the financial report that gives a true and fair view in accordance with the Australian Accounting Standards-Reduced Disclosure Requirements and the Australian Charities and Not-for-profits Commission Act 2012 and for such internal control as management determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

In preparing the financial report, management is responsible for assessing the entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intend to liquidate the entity or to cease operations, or have no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Entity's financial reporting process.

INDEPENDENT AUDITOR'S REPORT 2016-2017

To the Members of Aboriginal Health Council of South Australia Limited

Auditor's Responsibilities for the Audit of the Financial Report

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the management.
- Conclude on the appropriateness of the management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

We also provide the those charged with governance with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

Trevor Basso, Director
Basso Newman Audit Pty Ltd
Chartered Accountants
286 Flinders Street, Adelaide

Dated this 30th day of October 2017

AHCSA MEMBER DIRECTORY 2016-2017

Aboriginal Community Controlled Health Services

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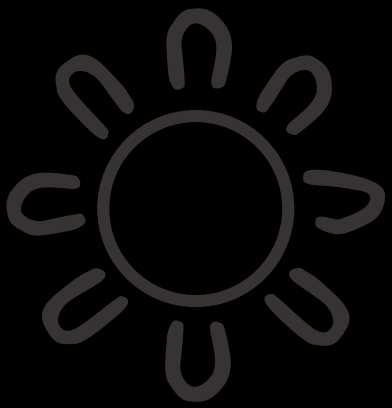

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