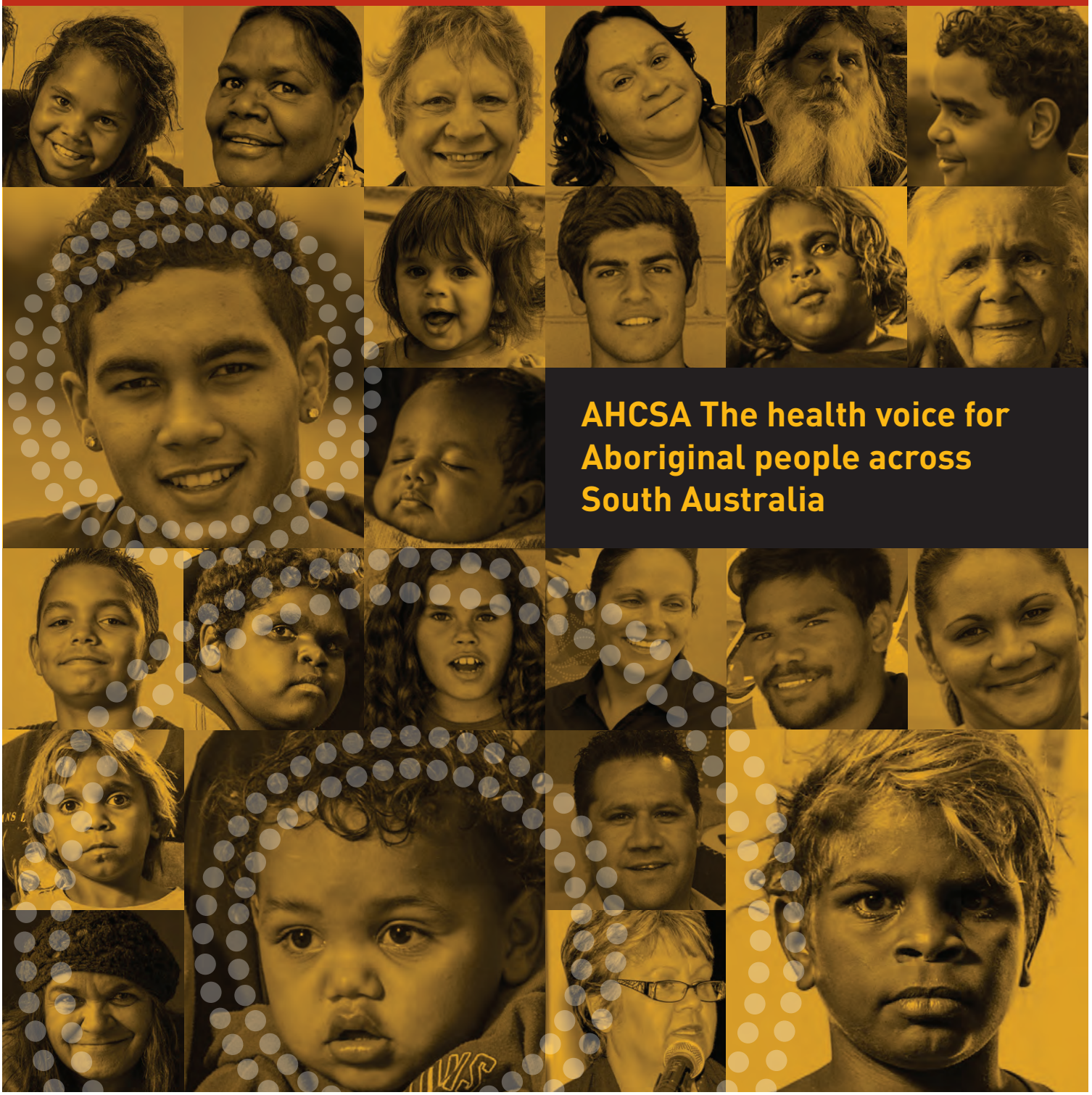
Aboriginal Health Council
of South Australia Inc.

Annual Report 2014 | 2015



AHCSA The health voice for Aboriginal people across South Australia

Our Members

Aboriginal Health Council of South Australia Inc.

Key

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

Aboriginal Health Council
of South Australia Inc.

About AHCSA

Aboriginal Health Council of South Australia Inc. (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 34 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 our 10th anniversary as an independent Aboriginal Community Controlled Health Organisation.

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

AHCSA Members

Aboriginal Health Council of South Australia Inc.

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 Inc.

Pangula Mannamurna 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.

Aboriginal Health Council
of South Australia Inc.

Contents

Aboriginal Health Council of South Australia Inc.

Chairperson's Report

Thanks to our funding bodies, partners and stakeholders for their continued support. The funding and advocacy they provide within their organisations enables our valuable programs to continue

The 2014-2015 financial year was a challenging one for the whole sector, from the announcement of the Federal Budget in May 2014, to the subsequent disclosure of changes to how the Aboriginal Community Controlled Health Services (ACCHS) and peak bodies would be funded, post June 2015.

As Chairperson of AHCSA, my role involved advocating with the National Aboriginal Community Controlled Health Organisation (NACCHO) Board, and the Chairs and CEOs from other State peak organisations, including parliamentary events with the Australian Council of Social Services (ACOSS).

At State level, the AHCSA CEO, Deputy CEO and I met with Senators and Ministers to discuss the impacts and ramifications on our sector, such as the Medicare Co-payment, links between health and unemployment and why the government should invest in the ACCHSs.

Aboriginal Community Controlled Health Organisations (ACCHOs) are the second highest employers of Aboriginal people outside of the mining industry. This is in addition to providing a comprehensive primary health care service to over 150 communities, which demonstrates to the government, universities and non-government organisations why continued funding to the sector is essential to close the gap in Aboriginal health inequality.

At the AHCSA AGM last December, I was elected Chairperson for another two years with Polly Sumner-Dodd as Deputy Chairperson. This reaffirms my commitment to continue supporting our Members across the State and advocate for further and continued funding, especially in areas without ACCHS. This is especially important after it was announced that the Aboriginal Health Advisory Committees (AHACs), would no longer exist or function, following a statewide review in October 2014. The Premier reviewed over 200 committees. The AHACs, which are not incorporated organisations, were constructed under the Country Health SA Local Health Network. Under this classification, they were wound up, and ceased to operate. This emphasises the importance of AHCSA as the peak body for Aboriginal health in South Australia.

One of AHCSA's most rewarding achievements this year was the purchase of our own building in the city last October. This was a result of saving for over five years, and renting for the past 14, since becoming incorporated. This further strengthens AHCSA's foundations for its Members and allows equity for the development of ACCHSs in the future. The new premises also allows for a world class simulated learning environment for the Registered Training Organisation (RTO) division of the organisation, bringing it on par with State universities.

I would like to thank all of our funding bodies, partners and stakeholders through the State, Minister for Health and Ageing, Jack Snelling and Commonwealth, Minister for Health, Susan Ley, for their continued support to the organisation. The funding you provide for our programs enable us to continue the advocacy for our Members and communities in South Australia.

Thank you to our Members for supporting AHCSA as the peak body for Aboriginal health. We will continue to provide support in 2016 and beyond, with program delivery, governance, accreditation and advocacy for further funding, where required.

The Board of Management and I would like to thank the staff of the secretariat for their continued dedication and support to our Members and their staff. It has been a challenging year and a high degree of resilience has been shown by those who travel across the State to undertake key roles and responsibilities, demonstrating their commitment to the organisation.

I conclude my report by acknowledging our Chief Executive Officer, Mary Buckskin, who passed away in July 2015, and with whom I formed a strong and respectful relationship for more than a decade. A strong leader at the State and National level and mentor to our organisation and Aboriginal people across the State, Mary provided strength and guidance to the AHCSA Board, Members and staff for 12 years, with nine of these as CEO.

We know Mary's memory and strength will continue to live on in AHCSA indefinitely. Her legacy is strengthened by the realisation of the vision to have our own building. This has supported our transition to the next chapter, with dedicated leaders who continue to be inspired by Mary's guidance and teachings, carrying us into the future for generations come.

John Singer
Chairperson

TRIBUTE TO MARY BUCKSKIN

In Memory of our Mary

With this Annual Report, we would like to honour the life and work of our Chief Executive Officer, Mary Buckskin and pay our respects to her family. Over the past 12 months, the AHCSA Board and staff have had to endure the shock and sadness of Mary's illness and untimely passing. It is fitting to share the many wonderful memories, stories and images of our time with Mary whilst she was at AHCSA.

Mary worked tirelessly for her community in Aboriginal health for over 30 years at both the State and National level. Mary's work experience began with qualifications in general nursing and midwifery. Other positions she held throughout her career in Aboriginal health included clinic nurse, community health nurse, senior policy officer, Aboriginal hospital liaison officer and clinical educator. She was also a respected Board Member for many organisations, such as Nunkuwarrin Yunti of SA Inc., Aboriginal Elders and Community Care Services Inc. She was also the Chairperson of the Winnunga Nimmityjah Aboriginal Health Service in Canberra.

It's this experience, at the grass roots level, that paved the way for Mary to become the great leader that she was. Many of you may

Mary wanted to be a midwife from a very young age, taking after her role model, her Grandmother

not know that Mary wanted to be a midwife from a very young age, taking after her role model, her Grandmother. She left the family home when she was still very young, to begin nursing and in turn became a role model for her brothers and sisters.

When Mary joined AHCSA in 2002, as Senior Policy Officer, it wasn't her first time working for the organisation. Mary worked at AHCSA in 1983, as a nurse when it was previously the Aboriginal Health Organisation (AHO), spending time visiting the communities that would grow to become independent ACCHSs.

After leaving the AHO, Mary moved to Canberra with her family and paved the way for Aboriginal people with her future direction across the Government and non-Government Sectors of health. Mary was the first Aboriginal Hospital Liaison Officer at the Woden Valley Hospital (now the Canberra Hospital).

With the demise of Aboriginal and Torres Strait Islander Commission (ATSIC) and the formation of the Office of Aboriginal and Torres Strait Islander Health (OATSIH), Mary was the first Aboriginal person to work in the Department as their Senior Policy Officer. Mary's next role was at the National Aboriginal Community Controlled Health Organisation (NACCHO), as their National Workforce Officer.

At the time of her return to AHCSA in 2002, the organisation was transitioning from Government, after becoming incorporated as an Aboriginal Community Controlled

Aboriginal Health Council
of South Australia Inc.

TRIBUTE TO MARY BUCKSKIN

In Memory of our Mary

Health Service, and it was the beginning of the new phase of Aboriginal health in South Australia. Mary brought the knowledge and experience of National policy development, including understanding and interpreting organisational constitutions, which would become invaluable to AHCSA and its Members.

Mary knew what to say and when to say it. Her understanding of Aboriginal issues, not just in health, but also across the social determinants of health, allowed her to advocate at State and National levels as the CEO of the State peak body. Mary had a vast collection of memories associated with the history of Aboriginal health at National and State levels and she was always willing to share this knowledge with people who were interested. This history is important and should never be forgotten. AHCSA has been fortunate to have documented this in various reports over the years, including a contribution to the *2007 Aboriginal Legal Rights Movement publication: Reflections: 40 Years on from the 1967 Referendum.*

With every year that Mary was at AHCSA, and with her changing roles from Policy Officer to Senior Governance Officer and Team Leader to ultimately the CEO, she became a great leader, confidante, friend and surrogate mother to many staff who were involved with the organisation. Many who knew her were touched and inspired by her caring nature. That warmth and affection was reciprocated towards Mary, from her family, to her colleagues, to people across the various communities and nation. This was evident at Mary's service and she would have been very humbled that there were so many people in attendance.

We would like to thank the Buckskin and Karpany Families for sharing Mary with AHCSA for over 12 years. Thank you to Mary for guiding, nurturing and teaching each of us in her special way. We are better people for it.

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Everyone who was associated with AHCSA and Mary will miss her dearly and it will take time to heal and grieve our loss.

We take comfort in the memories we have and share, and know that Mary will remain with us always, both in our hearts and in AHCSA forever. We know she is still with us every day.

Acting Chief Executive Officer's Report

This past financial year saw a change in my role due to unfortunate circumstances. As a result, I have been in AHCSA's Acting CEO role since August 2014.

I have been fortunate to have had the opportunity to develop and build relationships with our Board Members, the Member CEOs as well as the CEOs of the other State affiliates. In October 2014, we were informed that the Aboriginal Health Advisory Committees (AHACs) would be disbanded from the Country Health SA Local Health Network Inc. (CHSALHN), and as a consequence, AHCSA needed to have several Member workshops that have led to the changes in AHCSA's constitution. The constitution was worked through with the Board for 6 months. This included Member service Board consultation by senior staff and Board representatives, where appropriate. It has also been highlighted in this process that AHCSA will always continue to advocate the importance of continued support to the areas that do not have Aboriginal Community Controlled Health Service (ACCHS) representation.

At a National level, there have been many meetings with the National Aboriginal Community Controlled Health Organisation (NACCHO), and other State Affiliates, to negotiate the new standard funding agreement, with the Commonwealth and the National Key Performance Indicators (NKPIs), within it. There is now the new 18 month agreement to take us through until December 2016, whilst the Peak bodies undertake a review. The Tackling Smoking programs are all involved in the new National and State tender process.

The AHCSA Registered Training Organisation has been working closely with the Aboriginal Medical Services of Northern Territory (AMSANT) and Central Australia Aboriginal Congress (CAAC) to support the delivery of training to the Aboriginal Health Workers across the sector.

This year has been really exciting in relation to working towards the refurbishment and move into our own building. With the support of a great team and Board here at AHCSA, we were able make this a reality and prepare to move in August 2015

At State level, the Close the Gap programs have continued on with funding secured in the 2012-2013 financial year, which provided substantial peace of mind to both the staff in these programs and the AHCSA Members the program supports on the ground. We have started conversations with the Department of Health to look at opportunities for the continuation of this program, given its significant success.

At an organisational level, we have undergone changes resulting from a reduction in funding to many of our programs, this has required us to regularly review systems within the organisation. Through our tender processes, we are fortunate to have found organisations in Adelaide, who specialise in areas where we required specialist expertise. It has been exciting to see modern and creative ideas flow from the multiple years of expertise these organisations are offering AHCSA.

This year has been really exciting in relation to working towards the refurbishment and move into our own building. With the support of a great team and Board here at AHCSA, we were able make this a reality and prepare to move in August 2015.

We continue to ensure that the foundation of this organisation continues to be based upon our constitutional objectives. The organisational structure is our next step in linking to our Strategic Directions and Organisational Plan. With our new building and changes to funding, we look forward to continuing to provide strong leadership in addressing Aboriginal health needs for our Members and advocating for our community across this State.

Thank you to all staff, Board and Members for their continued support and commitment to AHCSA, which ensures that AHCSA continues to be the peak body for Aboriginal health in South Australia.

Shane Mohor
Acting Chief Executive Officer

Aboriginal Health Council
of South Australia Inc.

Acting Deputy Chief Executive Officer's Report

As the Acting CEO mentioned, it was due to unfortunate circumstances that I have filled this role since January 2015.

My main objective has been to support the CEO and Acting CEO, AHCSA Board of Directors, AHCSA Members and staff to ensure that the day-to-day business of the organisation continues and fulfils its funding requirements.

There have been three major targets to meet before the end of the financial year:

- Review of the AHCSA Constitution with the AHCSA Members and representatives.
- Negotiate the various funding agreements with key stakeholders and partners in Government and non-Government departments.
- Financial planning and forecasting for the next 18 months, in conjunction with both funding agreements and human resource management.

It has been a very challenging time for the organisation, with uncertainty about whether many agreements would be re-signed and with some of the existing programs coming to an end. It has been the first time in AHCSA's history that we have had five staff retire at one time, as well as having 15 positions finish, with contracts ceasing as a consequence of not receiving further funding or agreements before 30 June.

AHCSA is a resilient organisation that continues to lead and thrive as the peak body for Aboriginal health in the State. Although by the end of June, we had halved in staff numbers, at the time of writing this report, we had recruited staff for 10 positions. These appointments incorporate previous programs that AHCSA delivered, with more program support planned for the Members in the next 18 months. AHCSA has many great advocates amongst our partners, who have ensured funding continues for program delivery. Thank you to all of you.

AHCSA is a resilient organisation that continues to lead and thrive as the peak body for Aboriginal health in the State

It will take time for all of us to heal with the grief and loss we have endured. As we continue with our work in representing AHCSA, I ask for our key stakeholders and partners to be patient and walk beside us over the next 12 months, until we heal further.

AHCSA continues to have a strong connection, relationship and partnership with our National peak body, NACCHO and the other Jurisdictional Peaks as we all work in advocating for our Members towards comprehensive primary health care delivery and closing the gap in Aboriginal health. ACCHSs have been in existence for over 44 years and we are still here, whilst other organisations, such as the Medicare Locals, have come and gone. United we stand.

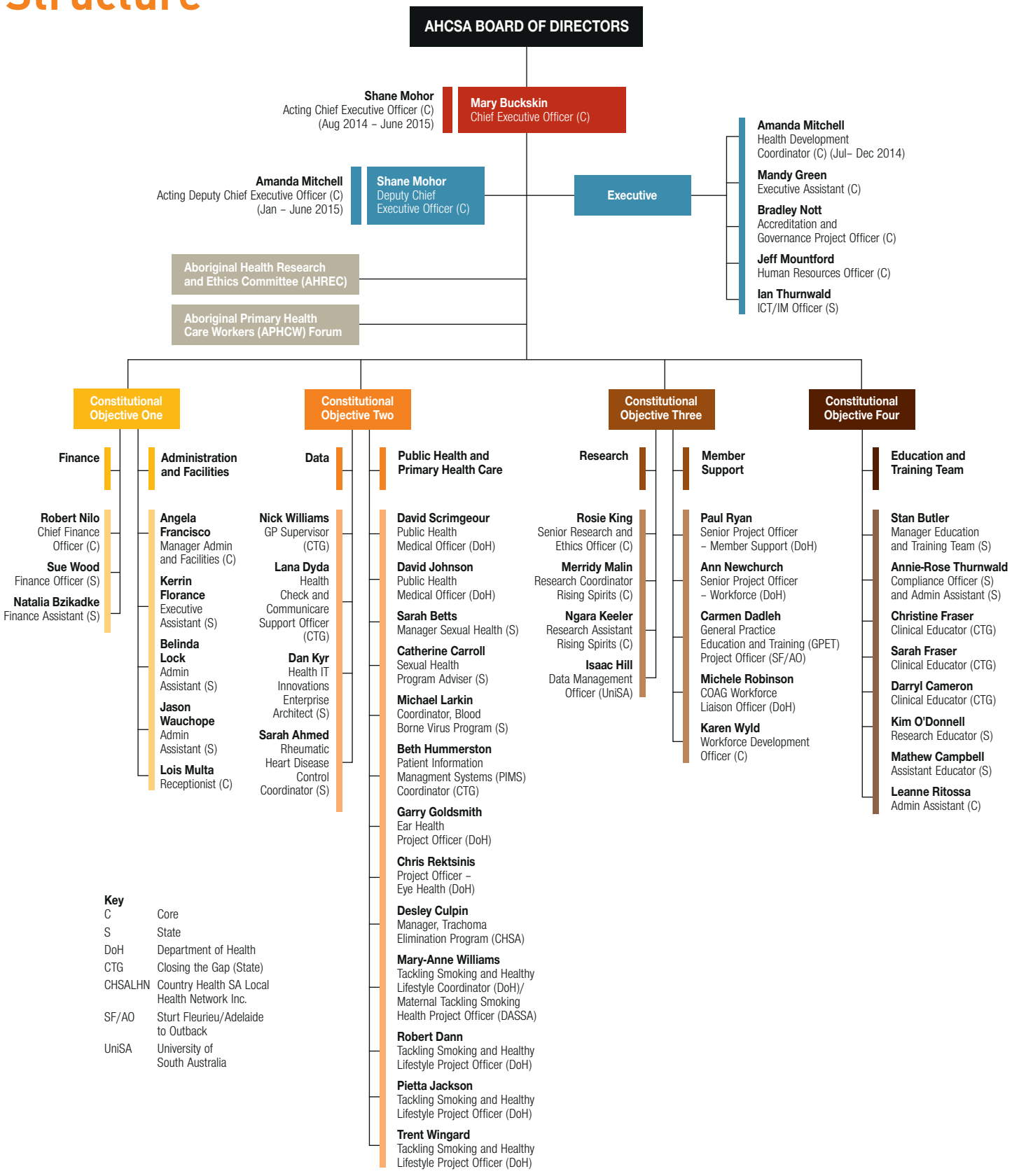
To the wonderful staff of AHCSA, I thank you for continuing to support the organisation, our Members and communities with your program delivery and the extra things you do for the organisation.

Thank you to the AHCSA Board and Member staff for your continued support to the AHCSA Secretariat over the last 12 months. It has been a tough time for everyone and the guidance and mentoring you provide to the organisation, each in your own special way, have been gratefully received by us all.

We enter a new era with the move to our own building with its first class training facility. This is what our Aboriginal Health Workers deserve. I implore you to continue your journey with us and be a part of our exciting future.

Amanda Mitchell
Acting Deputy Chief
Executive Officer

Organisational Structure



Aboriginal Health Council
of South Australia Inc.

Strategic Directions

AHCSA is moving forward with love and a deep respect for our communities and our work.

Our Vision

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

Our Mission

The Aboriginal Health Council of South Australia 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 values:

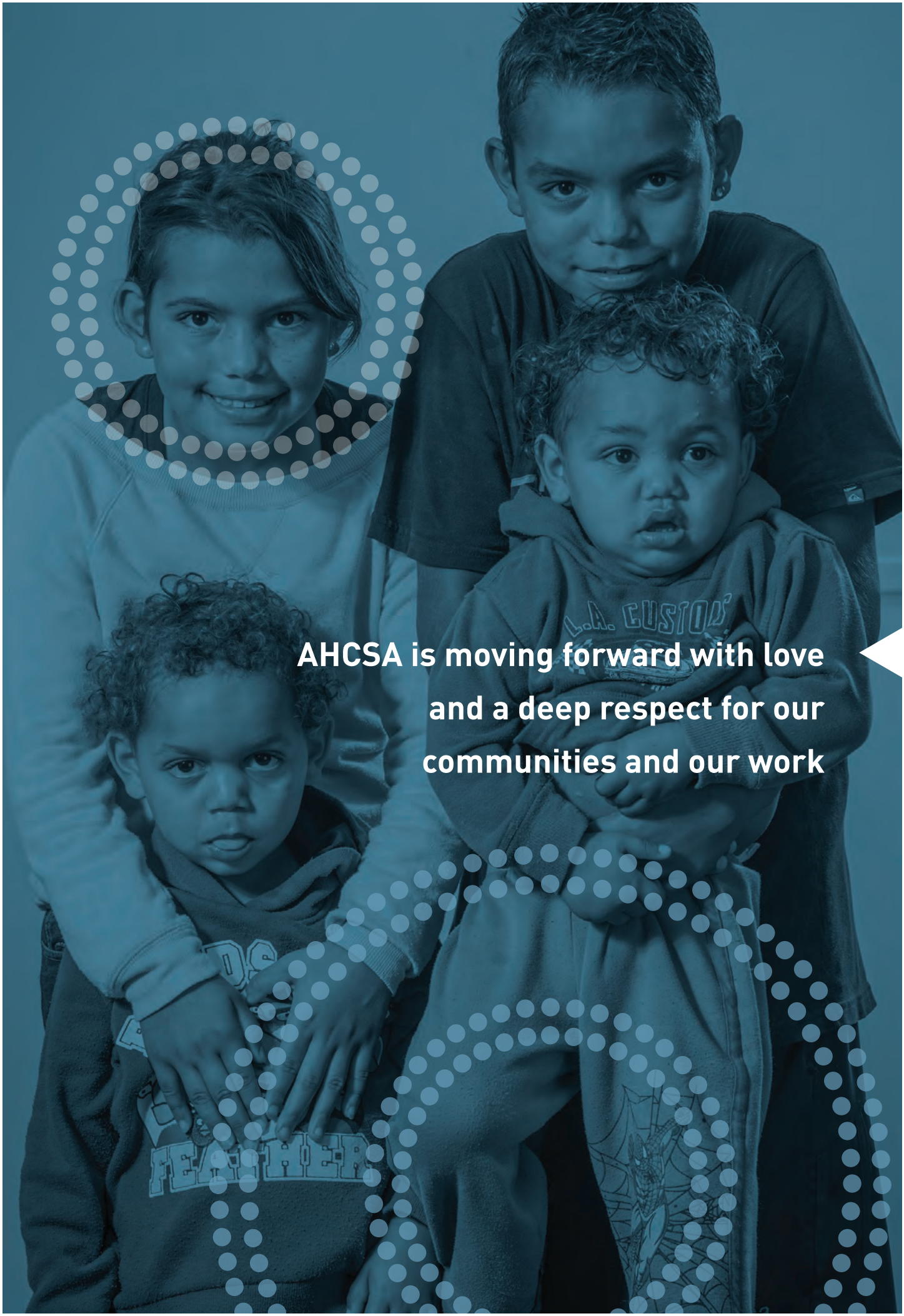
- Cultural diversity
- Community history and knowledge
- Community strength

AHCSA Constitutional Objectives

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

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

1. Operate as the peak body for Aboriginal Health in South Australia.
2. Improve the 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. 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.
4. Contribute to the development of a well qualified and trained Aboriginal health sector workforce.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Constitutional Objective

Operate as the peak body for Aboriginal Health in South Australia

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 1

Finance and Administration

Manager of Administration and Facilities Report

Administration

Once again, the 2014-2015 financial year has been a busy one for the Administration team. Executive and administrative support during the year was provided to the Board of Management, secretariat, students and various sub committees and forums. Several workshops were coordinated throughout the year, as well as AHCSA's Board meetings and AGM, Student Induction Day, Student Graduation and AHCSA's NAIDOC Open Day.

Administration personnel were:

Position	Team
Administration Assistant	Education & Training
Administration Assistant & Receptionist	Workforce
Administration Assistant	Education & Training
Executive Secretary	Executive Services
Executive Secretary	Executive Services
Administration Assistant	Public & Primary Health Care
Receptionist & Administration Assistant	Administration
Administration Assistant	Strategic Planning

Training and Professional Development

During the year, members of the Operations team were supported with the following training and professional development opportunities:

- Netsuite training
- Yammer training
- Excel training
- Report writing workshop
- Administration Assistant conference
- Certificate III AHW training
- Attend and contribute to coordination of promotional events
- Contribute to Trachoma Elimination program and Sexual Health program

Quality Improvement and Compliance

During the year, administration personnel and Manager, Administration & Facilities continued to contribute to organisational and departmental continuous quality improvement and compliance. This was achieved as follows:

- Six-weekly operations team meetings
- Review of organisational policies and procedures
- Support of administrative systems and processes
- Monitoring commercial contracts
- Survey communication devices
- Review of fleet vehicles
- Assess AHCSA's insurances
- Provide support to Registered Training Organisation (RTO)

Facilities

In April 2014, AHCSA purchased its own premises (220 Franklin Street, Adelaide), with settlement taking place on 2 October 2014. The fit-out is currently in progress and commenced on 18 May 2015. Project completion date for the fit-out is 21 August 2015 and AHCSA goes 'live' from its new home on 31 August 2015.

AHCSA's office accommodation located at Suite 3, 13-15 King William Road, Unley was no longer required, with the premises successfully handed back to the landlord on 31 May 2015.

The lease of the premises located at 9-11 King William Road, Unley expires on 30 September 2015 with AHCSA currently negotiating handover with the landlord.

Achievements and Acknowledgements

Lois Multa completed Cert III in APHC with AHCSA's RTO in December 2014 and graduated in May 2015. The following staff have departed:

- Alison Hambour (retired)
- Kerrin Florance (funding limitations)

I'd like to take this opportunity to acknowledge the wonderful contribution Alison and Kerrin have both made to AHCSA – farewell and thank you.

In addition, thanks to Lena-Pearl Bridgland for her contribution during the year to the Administration team. She is currently in a junior Project Officer role at AHCSA.

Many thanks to the rest of the Administration team: Lois Multa, Mandy Green, Jason Wauchope, Belinda Lock, Annie Thurnwald and Leanne Ritossa for their valued contribution and ongoing commitment to those to whom they provide executive and admin support.

Thanks also to the temping personnel who make themselves available at short notice – Justine Bromley and Krystina Mallet.

Angela Francisco
Manager, Administration
and Facilities

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 1

Finance and Administration

Manager of Finance Report

Financial Performance

Despite the reduction in the amount of Revenue of $1.7m for the FY 2014-2015, AHCSA registered a lower audited statutory loss of $237,357 from a statutory loss of $295,864 for the FY 2013-2014.

This could have been a statutory income if not for the end of year adjustments and audit reclassification:

Adjustments and audit reclassification	2014-15 $
CHSALNH written off (grant did not push through)	76,000
Resource training materials adjusted to equity	155,000
Incidental cost for purchase of new building reclassified as operating cost	29,000
DoH acquittal surplus reclassified as balance sheet item	70,000

The reduction in the following expenses also contributed to the lower statutory loss:

Reduced expenses	2014-15 $
Travel	462,000
Employment	607,000
Consultancy	353,000
Meetings	142,000

Employment cost is lower compared to last year as a result of the reduction in FTE staff due contracts ceasing in line with their respective funding agreement. This resulted from the non-renewal of programs; CRTON and STTOB in particular. Several staff finished their contracts in March 2015 with further staff retirement in April 2015 and June 2015.

There has been significant reduction in travel costs resulting from the reduction in membership from 19 to 13, due to the disbandment of the Aboriginal Health Advisory Committees (AHACs) and the reduction in the number of RTO-ETT students.

Financial Position

The overall equity position has decreased from $1.46m in FY 2014 to $1.38m in FY 2015, attributable to the reported statutory loss for the year.

Nett Property, Plant and Equipment increased from $993K in FY 2014 to $5.152m, basically due to the purchase of 220 Franklin Street, and the capitalisation of the Netsuite Development cost and the expenses incurred in developing resources for the Education and Training team.

Total liabilities increased from $1.7m in FY 2014 to $4.7m in FY 2015. This increase is due to the $2.5m in loan taken for 220 Franklin Street and increase in current liabilities.

The cash balance at the end of FY 2015 has dropped considerably low, which is the result of the lesser amount of grants received and compounded by continuous subsidy to the RTO; approximately $610K for the year.

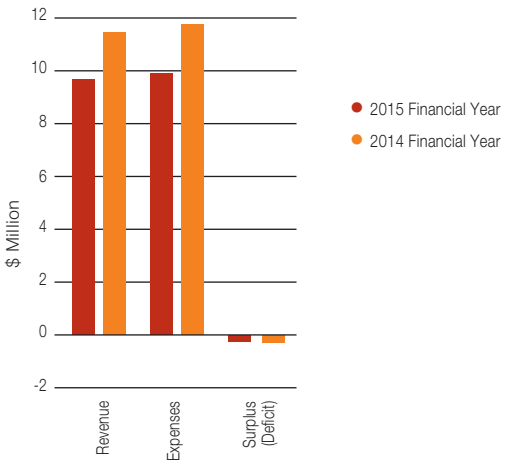
This is due to the delay in receipt of grants from the Department of Prime Minister and Cabinet because of technical issues accounting for the number of graduates between AHCSA and The National Centre for Vocational Education Research (NCVER). AHCSA is estimating this amount to be about $682K.

Information Technology

Further ICT enhancement was undertaken with the internally developed Netsuite system to provide better transparency, accountability, management and governance. This includes the Alfresco electronic filing system and Business Analytics.

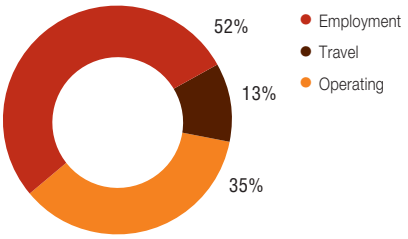
Further configuration was also undertaken to improve reporting on Residential and Reverse Block training under the Away from Base (AFB) funding.

Comparative Annual Revenue and Expenses



	Financial Year		Variance
	2015	2014	Amount
Revenue	$9,665,295	$11,449,685	($1,784,390)
Expenses	$9,902,652	$11,745,549	($1,842,897)
Surplus (Deficit)	($237,357)	($295,864)	$58,507

Comparative Costs and Expenses



	Financial Year		Variance
	2015	2014	Amount
Employment	$5,102,906	$5,710,266	($607,360)
Travel	$1,323,674	$1,785,448	($461,774)
Operating	$3,476,072	$4,249,834	($773,762)

Comparative Financial Position

	Financial Year		Variance
	2015	2014	Amount
Total Assets	$6,106,041	$3,214,037	$2,892,004
Total Liabilities	$4,727,278	$1,753,405	$2,973,873
Nett Assets	$1,378,763	$1,460,632	($81,870)

Internally Developed RTO-ETT Training Resources

The amount of $371,345 was capitalised as intellectual property in developing course materials for the Education and Training team to be compliant with ASQA requirement to provide training for APHC Certificate III and Certificate IV.

Robert Nilo CPA
Chief Finance Officer

ICT enhancement was undertaken with the internally developed Netsuite system to provide better transparency, accountability, management and governance

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 1

Executive

AHCSA Accreditation

AHCSA is an accredited organisation to the Quality Improvement Council (QIC) – 'Health and Community Service Standards 6th Edition'. Throughout this reporting period, AHCSA continued to implement its Quality Work Plan (QWP) in an environment of change precipitated by a range of both external factors and internal influences, created from QWP itself.

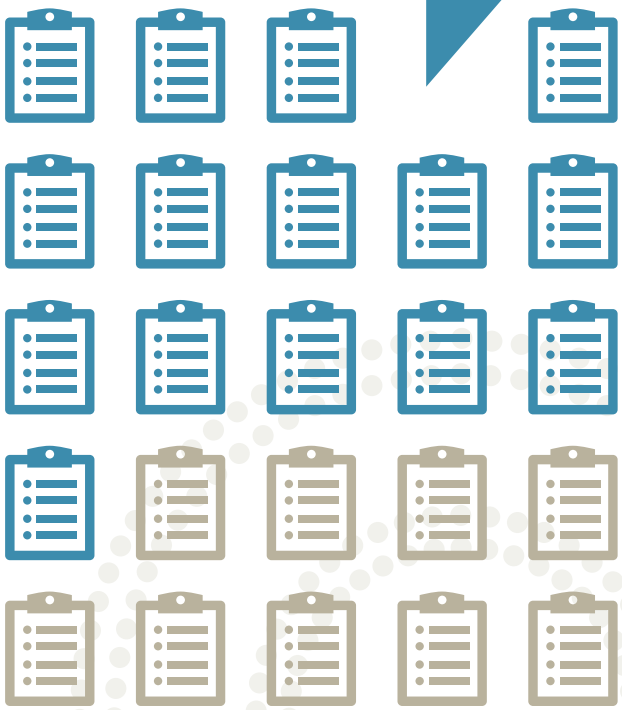
AHCSA successfully completed its mid-cycle assessment in late February 2015, with 15 out of 24 improvement projects being achieved or substantially achieved.

A major improvement to note has been the development of the Management and Communication Framework that links key functional elements of the organisation; such as the Business Management Group, Senior Operations Group, team and staff meetings. This is key to ensuring that AHCSA works to the Members' priorities and that AHCSA's resources are utilised in an efficient manner.

The maturity of AHCSA's governance is growing as business systems are implemented and stabilised. The use of Netsuite, as an integrated business system, has underpinned this success, particularly through the use of the Risk and Compliance modules.

The remaining improvement projects focus on strengthening the relationship between AHCSA, its Members and key stakeholders. AHCSA's three year accreditation is due for renewal in June 2016.

AHCSA successfully completed its mid-cycle assessment in late February 2015, with 15 out of 24 improvement projects being achieved or substantially achieved



A key responsibility for health development is the engagement, relationship development and liaison with key partners and stakeholders

Health Development

The Health Development Coordinator supports the CEO, Deputy CEO and Board of AHCSA, including the AHCSA Members and other staff, when required. Support is provided to strategic and business planning development, policy writing, recruitment to AHCSA, contract and agreement development and negotiations, annual report and newsletter coordination and development and attendance at various committee and reference group meetings representing AHCSA.

Another key responsibility of this position is the engagement, relationship development and liaison with key partners and stakeholders such as the Department of Health and Ageing, Department of Health, Country Health SA Local Health Network, Cancer Council SA, Wardliparingga Aboriginal Health Unit (WARU) at the South Australian Health and Medical Research Institute, the Drug and Alcohol Services of South Australia and the Murdoch Children's Research Institute.

AHCSA has been working with the WARU for the past two years on various research projects and the Health Development Coordinator has been working with the team, the CEO and Deputy CEO, representing AHCSA on the Cancer Data and Aboriginal Disparities (CanDAD) project and the South Australian Aboriginal Heart and Stroke Plan.

This position was vacant from January to June 2015 whilst the incumbent was backfilling another position in the organisation.

Constitutional Objective 2

Improve the 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

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Public Health

One of the unique features of the Aboriginal Community Controlled Health Organisation (ACCHO) sector is that it has developed a holistic, comprehensive vision of Primary Health Care (PHC). As such, the sector is notable for taking a public health approach to primary health care, which is reflected in the fact that the ACCHO sector employs public health physicians to advise and support PHC activities. This has contributed to the success of ACCHOs in achieving better health outcomes compared to other parts of the PHC sector. It is the employment of public health physicians within the sector which has led to the collection and analysis of data to demonstrate this success.

The role of the AHCSA Public Health Medical Officer (PHMO) includes:

1. Supporting Member services with public health and PHC activities
2. Supporting the implementation, development and sustainability of AHCSA programs, aimed at providing public health and PHC support to Member services
3. Providing public health expertise on AHCSA's behalf on various jurisdictional and National bodies
4. Supervision of registrars and students undertaking public health training in the area of Aboriginal health
5. Assisting AHCSA to respond to Government policy and planning initiatives

Other public health issues without specific AHCSA programs which have had active PHMO involvement include alcohol and drug issues and dental health

In 2014-2015, David Scrimgeour continued in his role as PHMO, with David Johnson sharing the role from January-June 2015. Direct public health support to AHCSA's Member services has been through convening and maintaining the AHCSA Public Health Network (PHN), and through individual projects, which take a public health approach to primary health care (particularly projects involving the AHCSA Public Health Registrar).

A key role of the PHMO is providing public health medical advice and support to the Public Health and PHC team within AHCSA. These programs recognise that high quality comprehensive PHC requires a public health approach, and use this integrated approach to supporting and developing capacity in ACCHOs in South Australia. These programs include sexual health, blood borne viruses, trachoma, ear health, information management systems, data/CQI, GP workforce support and rheumatic heart disease. Most of these AHCSA programs received funding as a result of advocacy by the PHMO.

Other public health issues without specific AHCSA programs which have had active PHMO involvement include alcohol and drug issues and dental health. The PHMO has also assisted AHCSA to respond to changes to the OCHRE Streams program, Medicare billing as well as providing input into the development of a National framework for continuous quality improvement in Aboriginal PHC.

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Blood Borne Virus

2014-2015 has been a busy year for the AHCSA Blood Borne Virus (BBV) program, working across the State, supporting our member Aboriginal community controlled health services by strengthening their public health and primary health care systems for managing viral hepatitis. Program activity has included a coordination role within the BBV sector to improve access to services for Aboriginal people, and working directly with ACCHS to support clinical services, information systems, workforce knowledge, and health promotion. Some specific strategies have included:

- Workforce education provided to staff of ACCHS and AHCSA students (Certificate III and Certificate IV Aboriginal and Torres Strait Islander Primary Health Care). Education sessions are tailored to best meet locally identified needs, but in general, have covered the following topics for both hepatitis B and hepatitis C: transmission, prevention, health impact, symptoms, testing and treatment. When discussing prevention, specific attention was given to the role clean needle programs play in preventing the spread BBVs such as hepatitis C and HIV, the concept of 'safer injecting', and the principles of harm reduction.
- In partnership with the Australasian Society for HIV Medicine (ASHM), we have developed a Communicare user manual for viral hepatitis. This resource provides a guide for health services to identify clients living with viral hepatitis, and ensure health professionals are informed of best practice management to reduce risks of complications such as cirrhosis and hepatocellular carcinoma.

Working across the State to support our Member ACCHSs by strengthening their public health and primary health care systems

Along with our fantastic Member services, the AHCSA BBV program would like to thank the following organisations and groups who have worked with the program across the 2014-2015 financial year: SA Health Communicable Disease Branch, Drug and Alcohol Services SA, ASHM, Relationships Australia SA, Viral Hepatitis Support Nurses, Hepatitis SA, SHine SA, Aboriginal Drug and Alcohol Council and the SA Health and Medical Research Institute.

The AHCSA BBV program is looking forward to working with all our Member services and key partners during 2015-2016, and building on the outcomes we have achieved together.

Ear and Hearing Health

The focus of the Ear Health program has been to ensure individual Member services have been provided with the required support and assistance to continually apply and deliver the systems approach. This approach strengthens the capacity of staff and encourages the provision of comprehensive ear and hearing health assessments and services.

The Ear Health Project Officer has offered and provided standard and continuous education and training to all Member services on the following key areas that are the fundamentally required for the systems approach:

- AHCSA ear health flowchart
- Middle ear conditions
- Identifying middle ear conditions (equipment training)
- Communicare ear tab

These key areas enable staff to identify clients with issues early and provide medical interventions and management according to the AHCSA ear health flowchart and Communicare Patient Information Management System (PIMS).

Continued support and assistance by the Ear Health Project Officer will ensure the establishment of systematic ear and hearing health services within Member services and the development of transparent and appropriate referrals pathways to secondary and tertiary specialists services to resolve middle ear conditions and rectify loss of hearing.

The Ear Health project has also provided ongoing advocacy and support in acquisition of equipment on behalf of Member services, to ensure the continuity and standardisation of comprehensive ear and hearing health services. More recently, the Ear Health Project Officer has initiated mapping exercises with individual Member services with the recent influx of external secondary and tertiary specialist services being offered. This ensures that these compliment internal systems of the Member service and provide relevant and tangible outcomes for the clients.

The Ear Health program presence and promotions of the systems approach, over the past 12-24 months, has only now resonated with Member services. They have only now realised the importance of and necessity for comprehensive ear and hearing health services.

However, for these to come to fruition, the continual coordination, support and assistance from the Ear Health program is essential for its success.

The Ear Health Program presence and promotions of the systems approach over the past 12-24 months has only now resonated with Member services

12-24

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Eye Health

The Eye Health program continues to deliver eye specialist services to a number of rural and remote Aboriginal communities around South Australia, in partnership with AHCSA Member health services.

In the past year, results have been particularly outstanding:

- Clients were seen by optometrists and ophthalmologists in record-breaking numbers
- Of those clients, over 90% were identified as 'high priority' for specialist eye health care
- 'High priority' clients include:
  - Those with chronic diseases requiring eye specialist care as part of coordinated care plans
  - Those overdue for recall to see an optometrist/ophthalmologist
  - Those who have never had an eye examination or vision test
  - Those with existing conditions, eg: diabetic retinopathy, requiring urgent treatment or close monitoring
  - Those due for follow-up consultation after surgery/treatment

These successes are attributed to the dedication, adaptability and team work between the visiting eye health team, clinic staff, other visiting or resident health practitioners, and key community members.

Sustaining these efforts and a collaborative approach can in turn reduce the number of clients 'falling through the cracks', and the number of clients receiving adequate, timelier eye health care will increase. Vision impairment, or loss, affects quality of life. Treatment can be anything from the simple issue of corrective glasses to major surgery.

The Eye Health program also continues toward capacity building and strengthening self-sufficiency in eye health within the Aboriginal Community Controlled Health Services (ACCHS), with locally housed equipment and supplementary training of clinic staff in vision testing, basic eye examinations and retinal imaging.

Challenges

Accurate gathering of statistics and needs analyses – limited resources and frequent transience between communities makes this difficult.

Long term sustainability and adequate funding – SA's indigenous eye health coordination and service delivery has historically been severely underfunded, limiting its capabilities.

Additional funding would enable increased:

- Access to specialists
- Specialised equipment/training
- Retinal screenings, data collection
- Education and health promotion

Of clients who were seen by optometrists and ophthalmologists, over 90% were identified as 'high priority' for specialist eye health care

HERO Sexual Health

The Sexual Health program continued the theme of Respect Our Mob in workshops with Aboriginal Health Workers across SA, and regional peer education workshops with young people. The program continues to promote Sexually Transmitted Infection (STI) prevention, screening and treatment of chlamydia, gonorrhoea, trichomonas, blood borne viruses and HIV.

Workshops also explore issues related to sex and consent, safety in sexual relationships, including 'sexting', and the use of social media.

This included Respect Our Mob peer education workshops, with approximately 50 young Aboriginal people in collaboration with Shine SA's Yarnin' On team in:

- Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation
- Pika Wiya's Well Women's House, Port Augusta
- Umoona Tjutagku Health Service Aboriginal Corporation, Coober Pedy
- Pangula Mannamurna Inc., Mount Gambier

Another highlight of this year's health promotion activities has been the support and production of Nunkuwarrin Yunti's 'Get a Respect Test' posters and postcards which continues to be the central theme of the message for young people when talking about respectful relationships, sexually transmittable infections and safer sex messages being more than using condoms.

The AHCSA Sexual health web page has been updated this year and continues to be reviewed with new links being added as necessary. This is used as an essential, ongoing resource referred to by Aboriginal Health Workers within ACCHS across SA. http://ahcsa.org.au/?s=Sexual+health

Respect Our Mob peer education workshops, run in collaboration with Shine SA's Yarnin' On team, were attended by approximately 50 young Aboriginal people

Continuous Quality Improvement: AHCSA-SA Pathology STI (ASAP-STI) Data Partnership

Development of improved processes of data collection and analysis with key partners, ACCHS and IMVS; identified data and reporting to services is operational and being presented back to ACCHS quarterly by the Public Health Medical Registrar.

Data is received monthly from SA Pathology; reports get sent to health services quarterly and State reports are produced for both the six-week community screen and the summary for the entire year. The results were presented at the workshop for Aboriginal Health Workers preparing for the 2015 annual screen to improve their understanding of local patterns of STIs in the community.

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Maternal Health Tackling Smoking

Over the past year, pregnant Aboriginal women and young mothers from our communities have been made to feel very special at a range of women's health pamper days facilitated by the Maternal Health Tackling Smoking (MHTS) program.

Yoga, mindfulness, massage, hair and beauty treatments with healthy lunches were on the agenda, with the women just loving the feel-good relaxed mood at the events, but it wasn't all about scented oils and quinoa salads. There were strict messages about the risks of smoking, especially during pregnancy and around babies and children.

Pregnant women attending the pamper days stated that 'they feel more supported and keen to make quit attempts after being educated on the risks of smoking in a relaxed atmosphere, appreciating also the follow up support from AHCSA staff to make quit attempts or stay quit'. Stickin' it up the smokes posters and resources continue to motivate positive messages for pregnant women and their families to make quit attempts and maintain smoke free homes and cars. Local campaign ambassadors have been useful in assisting in promoting smoke free pregnancies by sharing their successful quit stories and the associated health benefits, not only for themselves, but also for their unborn babies.

Kiarni Coleman is the new ambassador from Yalata Aboriginal Community. Kiarni's poster is printed in language sending out a powerful message to community not to smoke around pregnant women, clearly stating 'If I breathe in your cigarette smoke my baby breathes it too, it's not only smokers who get sick'.

The MHTS program aims to reduce the rate of tobacco smoking in order to increase the proportion of healthy-birth weight babies in SA. Statistics indicate that smoking rates of pregnant Aboriginal women in SA have dropped from 53% to 48% in recent years.

Junior Project Officer Lena Bridgland has been working with Project Officer Mary Anne Williams in the first half of the financial year which has been beneficial to the program, as Lena is a young Aboriginal mother with many connections with Aboriginal families in SA.

The MHTS Project Officers, in support of the Tackling Smoking and Healthy Lifestyle Initiative (TS&HLI) team, delivered education to over 35 schools, promoting the importance of smoke-free pregnancies, homes and cars.

Teenagers at schools continue to be tested with the smokerlyser carbon monoxide tool, demonstrating the harm that smoking can cause to their bodies and also clearly demonstrating to the young girls how smoking can affect unborn babies.

Within this reporting period, 171 pregnant Aboriginal women have been provided with individual or group quit support activities by AHCSA staff. 92% of these women had a one month follow up, 62% had cut down their smoking and 38% had successfully stopped smoking.

ACCHS staff (98) have been provided with information on the importance of smoke free pregnancies through face-to-face engagement during training at AHCSA or within Member services.

AHCSA's MHTS program is unique to South Australia. This statewide program has been funded since 2010 by Drug and Alcohol Services of South Australia (DASSA), through the Closing the Gap program. Currently, the program is being evaluated by the Cancer Council to demonstrate its importance to ensure funding is continued beyond June 2016.

171

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- **92% of these women had a one month follow up**
- **62% had cut down their smoking**
- **38% had successfully stopped smoking**

Rheumatic Heart Disease

The Rheumatic Heart Disease (RHD) program has been operating in SA since 2012. The aims of the program are to maintain our statewide register, support PHC to manage their patients with acute rheumatic fever (ARF) and/or RHD and undertake training and education of the clinical workforce and Aboriginal community.

Ongoing activities involve weekly and monthly telephone catch ups, and quarterly reports. RHD register awareness has subjectively increased across health service staff, but most are still reliant on program staff to access it, citing a lack of time or preference for verbal methods of patient follow up and ongoing management.

Continued support is provided via remote login and telephone to troubleshoot queries relating to RHD and recall systems from staff. Rescheduling reports and recalls to three weekly, have allowed staff time to locate patients. This might also help with improving adherence to prophylaxis amongst younger patients.

Prophylaxis adherence climbed early in the year followed by a fall from March – July. Post July, adherence rates appear to be improving; magnitude of any improvement will be reported at the end of the year.

This year we would like to submit for ARF and RHD to be notifiable conditions under the Public Health Act. This means doctors would legally have to tell us about someone who has ARF or RHD. We think this will provide a greater chance of picking up cases that may have slipped through the cracks or been lost to follow up, and are receiving suboptimal care. It will also help us support primary health care better as we will know which of their patients has ARF or RHD.

We submit for ARF and RHD to be notifiable conditions under the Public Health Act. This means doctors would legally have to tell us about someone who has ARF or RHD

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Trachoma Elimination

Prodigious work is being carried out in the Yalata and Oak Valley Community between the program, the church, the school, the health service, the youth centre and the community, working together in a very successful alliance, as per feedback from the communities. The Trachoma Elimination program follows the NACCHO Aboriginal Health Promotion Guidelines:

'Health promotion for Indigenous people needs to take into account culture, diversity within the population; socioeconomic circumstances; numerous languages and dialects, geographic location, and, importantly, the consequences of colonisation (which have impacted on the social, economic, and physical living conditions of Indigenous people).

Health is viewed holistically in the Indigenous population, and is inclusive of the physical, social, emotional and cultural wellbeing of individuals and communities. Relationships within the community (particularly those with elders), and spiritual connections to the land and ancestors need to be considered in the interpretation of health issues. Specific health issues and their contributing factors need to be assessed in the context of Indigenous people's lives and the disproportionate burden of disadvantage they bear compared with the non-Indigenous population.'

Trachoma is a contagious eye infection which can cause blindness and the Trachoma Elimination program ensures that appropriate and culturally safe consultation and engagement is provided to the rural and remote Aboriginal communities of South Australia. The program ensures that the communities are adequately consulted and presented with education and health promotion related to trachoma (including trichiasis) and eye health awareness.

The Trachoma Elimination program continues to work towards reducing the prevalence and transmission of active trachoma in the 'at risk' communities

Trichiasis is mostly found in adults over 40 years' of age and is characterised by abnormally positioned eyelashes that grow back toward the eye, touching the corneas or outer cover/glass. It is mostly caused by scarring under the eyelids from many episodes of trachoma as a child.

The AHCSA Trachoma Elimination program continues to work towards reducing the prevalence and transmission of active trachoma in the 'at risk' communities of Yalata and Oak Valley by undertaking comprehensive screening for active trachoma in all children aged predominantly between five and nine years' of age. The program ensures that all individuals and families requiring treatment are treated according to the *Guidelines for the public health management of trachoma in Australia*.

The Trachoma Elimination program aims to continue to educate the health workforce by establishing and maintaining one with knowledge, skills and experience in trachoma control. AHCSA reached the KPIs outlined in the agreement signed by both institutions in the communities classified 'at risk' of trachoma during this period which included Yalata and Oak Valley.

Tackling Smoking and Healthy Lifestyle

The team officially launched the Puya Blaster (smoking blaster) healthy lifestyle campaign, which promotes the small changes we can make to eat healthy, move more, or make a quit attempt. The campaign is based on a superhero character, the Puya Blaster, who combats tobacco use and spreads messages about smoking prevention and cessation. The campaign features 12 Aboriginal ambassadors who are the other heroes of the campaign, including young people and Elders from communities around South Australia.

Each ambassador has their own story and a different motivation for being healthy. In sharing their knowledge, our ambassadors inspire and encourage us to eat a healthier diet, exercise more regularly, and make quit attempts. The Puya Blaster and ambassadors feature on posters and pull-up banners which are displayed at local events and when the team deliver information sessions. The team developed more Puya Blaster resources including bucket hats, footballs, netballs and some communities now also have Puya Blaster backboards to play basketball.

The campaign is supported by the Puya Blaster website, which highlights the benefits of making healthy lifestyle choices and provides information and strategies on how to make and maintain these choices. The Puya Blaster is a very popular character, particularly when he makes appearances at local schools. This has been a fun and interactive way to raise awareness of the health impacts of smoking and encourage young people to remain non-smokers.

Over the past year, the team have presented information sessions and activities in 31 primary and secondary schools in South Australia. Information sessions are designed to be interactive and include the use of hand held resources, short videos and practical demonstrations. Other highlights throughout the year included being able to support the Gynburra Fishing Festival, the Yalata Annual Festival, an Aboriginal Elders and Youth Mentoring Camp and the Aboriginal Power Cup.

31

Over the past year, the team have presented information sessions and activities in 31 primary and secondary schools in South Australia

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Public Health and Primary Health Care

Aboriginal Dental

AHCSA receives funding from the Department of Health for the Aboriginal Dental program, which it provides to the South Australian Dental Service through a memorandum of administrative arrangement which 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 program provides general emergency and course of care to Aboriginal people, which can include extractions, restorative work, dentures and other services needed. The areas covered are: 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.

AHCSA and the SA Dental Service have a strong partnership, and have participated in a memorandum of administrative arrangement since 2008, meeting biannually to honour this agreement. There is also strong representation from both parties on the Aboriginal Oral Health Advisory Group, hosted by the University of Adelaide, Australian Research Centre for Population Oral Health.

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

The Aboriginal Dental program provides services to 16 regions across the State

$160,790

Total expenditure for the Aboriginal Dental Scheme

273

Courses of care across remote areas covered

728

Diagnostic and preventive dental service provided

215

Extractions carried out

257

Restorative (fillings) procedures performed

31

Prosthetic (denture items) services provided

Our aim is to continue to provide Public Health and Primary Health Care and support to our Member services

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 2

Data

Patient Information Management System

The enhancement of the Patient Information Management System (PIMS) program in the Aboriginal Community Controlled Health Sector in South Australia has focussed on a number of areas this year. These are as follows:

- Engaged and maintained linkages with Member services to establish Communicare training requirements
- Delivered Communicare orientation and training to staff of the AHCSA, Member services and mainstream agencies
- Identified how Communicare can best support clinical processes and procedures by improving patient data quality
- Investigated how Communicare can best be used to support the organisational reporting requirements of Member services to reduce the burdens associated with this.

Staff working with this program have made a number of visits to Pangula Mannamurna Inc. in Mount Gambier, Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation at Ceduna, Tullawon Health Service at Yalata, Nunkuwarrin Yunti of South Australia Inc. at Adelaide, Oak Valley Health Service at Oak Valley and Spinifex Health Service at Tjuntjuntjara, Western Australia.

Support has also been provided to the following positions/teams within AHCSA: Education & Training team, Public Health Medical Officer, Public Health Registrar, Trachoma and Eye Health team, Blood Borne Virus Coordinator, Ear Health Project Officer, Data Management Officer and HERO team (Sexual Health).

A major achievement of the program this year has been its collaboration with AHCSA's Blood Borne Virus Coordinator, Public Health Medical Officer and the Australasian Society of HIV Medicine, in a project to develop and publish a Communicare User Manual and accompanying Communicare Administrator Manual to support health services to manage viral Hepatitis. These manuals guide the user as to how to document information on Communicare to effectively communicate between health providers the services clients should be offered based on best practice guidelines. The Administrator Manual enables services to implement changes on their PIMS to support the use of Communicare in the way recommended. The objective was to empower ACCHOs with the information to implement this process independently and with the support of AHCSA staff. The documents will be printed and available in October 2015.

Quarterly Period	Training sessions per quarter	Number of staff attended
Jul – Sep 2014	32	67
Oct – Dec 2014	28	49
Jan – Mar 2015	19	68
Apr – Jun 2015	36	121
Total for year	**115**	**305**

A total of 305 staff attended Communicare training sessions held between July 2014 and June 2015

155 training session were held within the reporting period

305

GP Workforce

In the participating Health services, there has been a large increase in the number of Aboriginal Health Checks and GP Management plans and systems established to ensure continued best practice.

This program increases the GP workforce in Aboriginal Community Controlled Health Services (ACCHSs) in SA in order to increase the number of Aboriginal Health Checks (AHCs) and resource the appropriate follow-up. This continues to be a high performing, successful program.

A total of 785 days of extra General Practice services were provided across five rural ACCHS in 2014-2015. There were six individual GP registrars employed across four rural ACCHSs – two full time at Pika Wiya Health Service Aboriginal Corporation, one full time at Pangula Mannamurna Inc., one full time at Port Lincoln Aboriginal Health Service and one full time roving registrar across four sites (Umoona Tjutagku Health Service Aboriginal Corporation, Oak Valley, Pika Wiya and Nunkuwarrin Yunti Inc.). Prior to the commencement of this program, there were no GP Registrars in rural ACCHS.

In the participating Health services, there has been a large increase in the number of Aboriginal Health Checks and GP Management plans and systems established to ensure continued best practice.

Improved clinical practice follows on from increased health checks and management plans. 71% of patients with diabetes have had appropriate HBA1c checks in the past year. The program is funded by the State Government until July 2016.

PROGRAM OBJECTIVE 1 Recruitment of suitably qualified 1.0 FTE General Practitioner (GP) Aboriginal Health Supervisor to support GP Services in rural and remote areas in the undertaking of AHCs and the provision of follow-up primary health services.

KEY PERFORMANCE INDICATOR 1 Number and proportion of Aboriginal and Torres Strait Islander people receiving an MBS defined Aboriginal Health Check, analysed by age and gender, aggregated across sites involved in the program;

941

Total number of Aboriginal Health Checks

2947*

Population

* Denominator changes over time

31.9%

Percentage of population – up from 22.6%

The clients below received MBS defined AHCs

YEARS OF AGE

<15

122 Males
116 Females

YEARS OF AGE

15-54

243 Males
324 Females

YEARS OF AGE

55+

65 Males
71 Females

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 Aboriginal Health Research Ethics Committee (AHREC) submits an annual report to the National Health and Medical Research Council (NHMRC) to demonstrate compliance with the NHMRC's ethical guidelines. Submitted in March 2015, the 2014 annual report presented stability in both the membership of the Committee and the number of research proposals reviewed.

AHREC continued to meet on the first Thursday of every month, excluding January. The snapshot of key figures and activities of AHREC in the reporting period is as follows:

- As confirmed by the National Health and Medical Research Council (NHMRC) in July 2015, 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 the only three Aboriginal-specific HRECs in Australia.
- In addition to proposals that were awaiting decision or researchers' response to concerns raised by AHREC, a total of 52 new research proposals were submitted to AHREC (compared to 55 in 2013).
- AHREC continued to provide researchers with an opportunity to respond to concerns such as the appropriateness of the research methodology and data collection, acknowledgement of Aboriginal organisations involved in the study, privacy and consent. 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.
- Out of those awaiting decision plus 52 new research proposals, a total of 51 research proposals were granted ethical approval (compared to 45 in 2013).
- During the same period, researchers withdrew two research proposals. Due to significant concerns, AHREC's explicit disapproval was relayed to one research proposal.
- The approved research proposals related to a wide range of health topics, including, but not limited to, service awareness, salt intake, data collection methods, childhood resilience, chronic kidney disease, cervical cancer prevention, suicide prevention, atrial fibrillation, obesity prevention, burn injury, training evaluation, immunisation, infection management, anti-smoking campaign evaluation, surgical site infection, hepatitis A vaccination and cultural competence.

AHREC continued to advocate the NHMRC Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research and, 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. AHREC's guidance to researchers and partnerships with research institutions continues to highlight the holistic and interconnected nature of Aboriginal health.

A total of 51 research proposals were granted ethical approval (compared to 45 in 2013)

51

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 3

Research

Next Steps for Aboriginal Health Research

Following robust data collection and analysis of community needs and also audit of the Aboriginal Health Research Ethics Committee (AHREC) database, the *Next Steps for Aboriginal Health Research: Exploring how research can improve the health and wellbeing of Aboriginal people in South Australia* report was published in February 2015. The report is publicly available at: http://ahcsa.org.au/content/uploads/2014/11/AHCSA_Next_Steps_2015.pdf

Next Steps was a joint project of the AHCSA and the South Australian Health and Medical Research Institute (SAHMRI) and aimed to identify and prioritise the main public health research areas that align with the needs and interests of the Aboriginal community in SA and the Aboriginal Community Controlled Health Organisations.

The report represents a significant milestone in terms of ethical code of conduct in Aboriginal Health Research as evidenced by the Lowitja Institute's Aboriginal and Torres Strait Islander health research ethics award, *Tarrn doon nonin*.

Next Steps for Aboriginal Health Research: Exploring how research can improve the health and wellbeing of Aboriginal people in South Australia

Next Steps awarded National recognition

Next Steps was the inaugural recipient of the *Tarrn doon nonin* Award from the Lowitja Institute, Australia's National Institute for Aboriginal and Torres Strait Islander Health Research. This award recognises excellence in Aboriginal and Torres Strait Islander health research ethics.

South Australian Quality Improvement Data

The South Australian Quality Improvement Data (SQID) program has now moved into its second year. As data custodians, the program continues to collect National Key Performance Indicator (nKPI) data of participating Member services and deliver quarterly reports back to services to inform their progress over a wide range of clinical areas.

These reports highlight Member service progress partnered with their totals from the previous reporting period and overall AHCSA average. We are currently developing the SQID nKPI Annual Reports that will compliment quarterly reports by assessing age group and gender trends.

Moreover, the AHCSA CQI team are in the preliminary stages of assessing the accuracy of nKPI data housed within Communicare. This research project will compare Communicare, PenCAT and OCHREStreams nKPI data with clinical audit numerator and denominator totals. Upon completion, we should have a greater reassurance that these methods accurately reflect Member service activity.

Over the previous 12 months, these reports have captured a vast array of improvements across areas of women's and children's health, diabetes assessment and lifestyle risk factors.

The SQID program has enabled the community controlled sector to proactively keep updated on their service's progress. In the future, we aim to expand these reports to incorporate a new denominator definition that will allow clinical data of greater accuracy and relevance to be captured, and thus inform areas of quality improvement to a higher degree.

Women's and Children's Health

18% Child health assessments 0-4 years

5% Child immunisations (12, 24, 60 months – average)

8% Cervical screening rates (previous 2 years)

Diabetes Assessment

6% HbA1c tests performed (previous 6 months)

5% HbA1c result < 7%

6% BP checks performed (previous 6 months)

Lifestyle Risk Factors

10% Smoking status recorded

8% BMI calculations < 25

6% Alcohol consumption recorded

The above graphics illustrate the aggregated average improvements made by participating Member services of the AHCSA SQID program. Improvements are based on data collected in the previous financial year from June 2014 – June 2015

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 3

Research

Rising Spirits Community Resilience

The Rising Spirits Community Resilience project (April 2013 to June 2015), funded by beyondblue, investigated what supports Aboriginal people need during bereavement, what is available that is being utilised by Aboriginal people, where the gaps are and the readiness of communities and the State to address grief and loss.

134 people were interviewed (82% being Aboriginal and 66% being female) in all geographic regions of South Australia. Interviewees included CEOs and Board Members of ACCHS, Elders, Aboriginal community Members, Aboriginal health workers and liaison officers, social and emotional wellbeing (SEWB) workers, counsellors, psychologists, psychiatrists, social workers, trainers, youth workers and workers in the criminal justice system.

Everyone interviewed stated that bereavement-related grief is prevalent and constant in all Aboriginal communities and that it has devastating impacts on families and communities. Bereavement contributed to people's loss of confidence, depression and anxiety, family conflict and addictions. The type of support that people found to be most important was the opportunity for 'healthy' grieving with family and friends, shared time, yarning and comfort. However, people recommended several programs and services which provided invaluable bereavement support.

Twenty SEWB programs were identified, which successfully engaged with Aboriginal people, including eight Aboriginal controlled programs and nine Government services. All these programs were developed and delivered in consultation with local Aboriginal communities and employed Aboriginal and culturally sensitive non-Aboriginal practitioners.

Because of their close links to the local community, Aboriginal community controlled programs ranging from the small one-person or family-based programs to the larger ACCHS provided 'wrap-around' support, despite being under-staffed and under-resourced.

The greatest barriers to Aboriginal people accessing existing programs included Aboriginal SEWB worker burn-out and the consequent high staff turn-over and funding insecurity resulting from constantly changing funding priorities and short-term cycles.

The two practical outcomes of the project are the *Grief and Loss* booklet, which is available through AHCSA and the Grief and Loss website www.ahcsa.aboriginalgriefandloss.org.au.

The website contains important information which people requested including:

- What is grief and how people, including children, often behave when grieving
- Ways to grieve
- Pathways to healing, including people's healing stories
- How and where to get help including a directory of services in SA
- Funeral information including about how to organise a funeral, financial support, funeral insurance and travel assistance
- Worry about suicide, suicide prevention, postvention and related training programs and resources
- Information for service providers including all of the above, and ways for looking after themselves
- Links to many video and written resources
- How music, song and dance can help with healing

The *Grief and Loss* booklet can also be downloaded from this site. Our partners in this AHCSA-directed project included the University of South Australia and the South Australian Health and Medical Research Institute.

134 people were interviewed for the Rising Spirits Community Resilience project

82% were Aboriginal

66% were female

Partnering to understand and deliver relevant, quality Aboriginal primary health care services in South Australia

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 3

Member Support

The Senior Project Officer - Member Support (SPOMS) was responsible for the provision of support to Member organisations, particularly in the areas of governance and accreditation and continuous quality improvement (CQI).

During this financial year, much of the AHCSA membership faced challenges with changes to funding arrangements and subsequent requirements for changes to incorporation types. The SPOMS worked with Members to provide information to assist them with managing this process and the development of constitutional or rule book changes. Significant work was also undertaken with several Members to meet challenges faced in governance practices and providing support to access advice and expertise in this area.

The SPOMS continued to support the membership with engaging and managing clinical and organisational accreditation processes. The AHCSA membership maintained 100% RACGP accreditation for eligible organisations (ie: those undertaking medical services) and by the end of the financial year, six Members were accredited against whole of organisation standards, with a further three Members in early stages of their journey.

100

The AHCSA membership maintained 100% RACGP accreditation for eligible organisations

The SPOMS has been engaging with an important project to support CQI in the sector, the development of a National CQI Framework for the Indigenous Health Sector, a Commonwealth funded initiative that will support the further embedding of CQI practices from the funding to service level. This project should be completed early in the 2015-2016 financial year, and will inform funding priorities from a Commonwealth perspective.

Lastly, an important activity for the membership was the May 2015 AHCSA CQI Workshop. The event provided information to the sector on the current and future CQI support activity undertaken by AHCSA and sought input from the Members as to the priorities and needs in the area of CQI practice. This work will inform AHCSA support into the future and will continue to drive support from a local level perspective.

Moorundi Aboriginal Community Controlled Health Service Inc.

The establishment of Moorundi Aboriginal Community Controlled Health Service (MACCHS) continues to progress with a number of key achievements in this financial year.

The MACCHS Interim Board advertised for a Chief Executive Officer in November 2014, which resulted in the appointment of Darrien Bromley in March 2015. Following this appointment, John Evans resigned from the position of Transition Manager and handed over responsibility for continuing the establishment process to Darrien.

In April 2015, Darrien relocated to Murray Bridge and commenced working from the Ngarrindjeri Regional Authority office. This provided the opportunity for Darrien to become more familiar with the Ngarrindjeri community and other key stakeholders in the region.

Prior to leaving AHCSA, John Evans lodged a revised set of plans and budgets with the Commonwealth Department of Health. These plans were processed through the department and submitted to the Federal Minister for Health for approval.

Meanwhile, the MACCHS Interim Board continued progress towards the establishment of the health service by securing its main site in Murray Bridge, commencing negotiations with the Raukkan Community Council for access to their health clinic and holding discussions with the Alexandrina Council to identify potential accommodation in Victor Harbour.

Key achievements include: regular Board meetings, building linkages with health delivery stakeholders and meeting with Ngarrindjeri community groups

MACCHS has marked other achievements in the process of its establishment, including registration with the Australian Tax Office (payroll tax and GST), application for Public Benevolent Institution status, implementing a financial management system, obtaining a post office box, holding regular Board meetings, building linkages with health delivery stakeholders, meeting with Ngarrindjeri community groups and undertaking some minor works at the Murray Bridge site.

The MACCHS Interim Board continues to meet regularly and progress towards establishment. In the 2014-2015 financial year, the Interim Board held 10 out of 11 scheduled meetings (no meeting was scheduled for December 2014).

The MACCHS Interim Board and CEO continue to work with AHCSA and the Commonwealth Department of Health in the establishment of the Moorundi Aboriginal Community Controlled Health Service.

Aboriginal Health Council of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 3

Member Support

COAG Workforce Liaison

The COAG Workforce Liaison Officer (CWLO/ Indigenous Health Project Officer) position has played a pivotal role within the AHCSA Member support team. The role has evolved over time, in line with the changes to the Indigenous Chronic Disease Package, the Chronic Disease Fund and to the current Indigenous Australian Health Programme. The needs and knowledge required on the ground, with a move from implementation to consolidation, has required the CWLO to undertake a broad range of activities. Therefore, coordination and advocacy across a number of programs and organisations has been a core function of this position.

The capacity to coordinate and engage numerous stakeholders across the Closing the Gap programs has ensured more effective service delivery on the ground. This program has taken an active role in providing support and statewide coordination to assist organisations in implementing the range of Closing the Gap measures as part of the Australian Indigenous Health Programme.

The role has focussed on sharing of information and building on skills required for the Closing the Gap workforce, both in the Aboriginal Community Controlled and Medicare Local Sector, to undertake their various positions effectively. This has included the development and sharing of Medicare Benefits Schedule resources and education sessions for the Aboriginal and Torres Strait Islander Outreach Worker, Aboriginal Health Worker and Practitioner training and professional development. The CWLO has continued to work in partnership with both Aboriginal Community Controlled Health Services and Medicare Local Closing the Gap teams to support and co-facilitate the Closing the Gap workforce network. Network meetings are held twice a year and have provided an opportunity for professional development, information sharing and networking with Aboriginal and Torres Strait Islander Outreach Workers, Indigenous Health Project Officers and Care Coordinator Supplementary Services workers.

The capacity to engage numerous stakeholders across the Closing the Gap programs has ensured more effective service delivery on the ground

The CWLO has worked with individual Medicare Locals to continue this support and has held teleconferences for the Closing the Gap teams. The CWLO program has achieved formal partnership agreements with Medicare Locals and AHCSA, and has been successful in convening joint meetings with AHCSA Members and Medicare Local management. This has resulted in accomplished joint activities contributing to improved access and service delivery for community Members.

In 2015, the CWLO managed the development of Closing the Gap magazine. A one-off initiative of AHCSA, the magazine showcased activities from Closing the Gap teams across South Australia, who provide direct service delivery to Aboriginal and Torres Strait Islander communities. Stories were submitted from AHCSA Member services and Medicare Local Closing the Gap teams. The Closing the Gap workforce network felt that good news stories and positive outcomes weren't being shared with the wider community, and considered it to be a positive exercise to share these Closing the Gap stories and activities in a publication. The publication was also used as a tool to advocate for the program's continuation. The magazine launch was held at AHCSA in April, all contributors and CEOs attended.

Approximately 80 people attended AHCSA's Close the Gap Day at the Unley office. The event was co-hosted by Oxfam Australia and Reconciliation SA. Included in the attendees were representatives from the Aboriginal Community Controlled Health Service (ACCHS), Medicare Locals, community organisations, key stakeholders, Government and non-Government agencies. Presentations from organisations were given on National activities for the campaign, the launch of the Healthy Futures report and discussion on the commitment from key partners to join the ACCHS in the resigning the Statement of Intent. Feedback from attendees at the event was positive, with partnerships formed and commitments made. It was reiterated that through continued efforts and evidence-based, community-led approaches, the shared vision to close the gap in health and wellbeing is highly achievable for Aboriginal and Torres Strait Islander people.

The CWLO role will continue with these activities beyond the transitioning into the Primary Health Care Networks, with the focus on advocacy, building and maintaining partnerships and strategic planning for current and future Closing the Gap programs.

General Practice Education & Training

After the General Practice Education & Training (GPET) Project Officer returned from maternity leave in April, one day per week was spent at AHCSA and one day each at Regional Training Providers (RTP) – Adelaide to Outback GP training program (AOGP) and Sturt Fleurieu Education & Training (SFET). General Practice Registrar (GPR) placements have increased at both RTPs and there was an increased number of Aboriginal Health Training Posts in SA between April and June.

The first semester of this year saw GPET introduce the Roving Registrar position. This placement is based at Nunkuwarrin Yunti Inc. and travels to Pika Wiya Health Service Aboriginal Corporation, Umoona Tjutagku Health Service Aboriginal Corporation and Tullawon Health Services. These services were chosen because GPR supervision would be provided by GPs who regularly visit those services. This has been a successful appointment, with plenty of interest for future placements.

After extensive planning, the Cultural Mentor program has employed, on a part-time basis, three Cultural Mentors. Their main role is to provide cultural advice to the Registrars. GPET expects to increase the program next year, once funding has been confirmed.

Registrars who have indicated their interest in Aboriginal health are encouraged through regular information sessions at Nunkuwarrin Yunti Inc. This allows them to immerse themselves in an Aboriginal Community Controlled Health Service setting, gaining an insight into the functions and services offered. GPET continues to integrate Aboriginal health into all aspects of GP training, rather than as a stand-alone subject.

In future, the Department of Health will conduct a competitive tender process for the delivery of the 2016 Australian General Practice Training (AGPT) program and future cohorts. The current number of Regional Training Providers in Australia is 17. In 2016, there will be 11, with only one RTP in SA.

Our current Aboriginal Health Training posts are Pangula Mannamurna Inc., Nunkuwarrin Yunti Inc., Pika Wiya Health Service Aboriginal Corporation, Port Lincoln Aboriginal Health Service, Watto Purrunna and Gawler Aboriginal Health Service. Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation is also an accredited post, but has been inactive for some time. We aim to expand GPR training across our Member services and look forward to the future of GP training in SA.

We aim to expand GPR training across our Member services and look forward to the future of GP training in SA

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 3

Member Support

Workforce Development

The Workforce Development Officer (WDO) supports and implements the objectives and policies of AHCSA by organising the Aboriginal Health Workers' Forum, contributing to the development of the role and skills of Aboriginal Health Workers and dealing with workforce issues related to Aboriginal Health Workers.

The WDO coordinates and facilitates the Aboriginal Hospital Liaison program and Aboriginal Hospital Liaison Officers (AHLOs) Network which meet bimonthly, including providing a monitoring and support role to the AHLOs across the Metropolitan hospitals.

The WDO supports the AHCSA Education and Training team by assisting with the process of Aboriginal Health Worker registration, representing AHCSA at internal and external committee meetings related to workforce issues. The WDO also identifies and assists in resolving workforce issues related to Aboriginal Health Worker roles.

AHCSA provides funding to Country Health SA Local Health Network and two ACCHSs for the employment of Aboriginal Health Workers (AHWs) through the Rural Aboriginal Health Workers' Programmes, funded by the Department of Health. The WDO supports these 12 positions through regular meetings with the AHWs and their supervisors, developing and negotiating service agreements and assisting in the recruitment process for these positions.

The priority for the next 12 months is assisting the AHCSA Education, Training and Workforce team with Aboriginal Health Practitioner Registration and engaging with the AHCSA Members and key stakeholders in supporting the current Aboriginal health workforce.

AHCSA provides funding to Country Health SA Local Health Network and two ACCHSs for the employment of 12 Aboriginal Health Workers through the Rural Aboriginal Health Workers Programme funded by the Department of Health

Aboriginal Primary Health Care Workers' Forum

The Aboriginal Primary Health Care Workers' Forum (APHCWF) was established in 1990 as a sub-committee of AHCSA to represent South Australian Primary Health Care Workers and provide advice for Aboriginal Health Worker (AHW) issues at the AHCSA Board level.

The other aims of the APHCWF are to:

- Acknowledge and adhere to the four constitutional objectives of AHCSA
- Support the National Aboriginal Health Practitioner profession through the registration process
- Promote Aboriginal Primary Health Care Workers and the Aboriginal Hospital Liaison Officer workforce
- Provide support and advocacy for Aboriginal Primary Health Care Workers
- Provide support and advocacy for Metropolitan Aboriginal Hospital Liaison Officers

The APHCW Forum has 19 positions which represent the metropolitan, rural and remote regions of South Australia. The Forum meets three times per year, with venues rotating around the State, depending on available financial resources.

The APHCWF operates by acknowledging and adhering to the constitutional aims and objectives of AHCSA. This is achieved by working to improve the capacity of the Aboriginal Health Worker and the Aboriginal Hospital Liaison Officers' workforce across SA to deliver appropriate services sensitive to the requirements of community.

APHCWF was established as a sub-committee of AHCSA to represent South Australian Primary Health Care Workers to provide advice for Aboriginal Health Worker issues at the AHCSA Board level

The Forum contributes to the development of a well-qualified and trained health workforce by providing education in the following: palliative care training, dental health awareness, Aboriginal mental health, first aid training, trachoma eye health and chronic disease education. These have all been driven by the membership of the APHCWF and the AHLO network.

The Workforce Development Officer (WDO) continues to advocate for Aboriginal Health Practitioners and AHLO training on a needs basis, to support those who are already members of the workforce, and facilitates the Aboriginal Primary Health Care Workers' Forum three times per year to introduce new and modern education.

This program is continuing to keep key stakeholders supported and informed about the Aboriginal Health Worker workforce, the Aboriginal Health practitioner National registration program, as well as working with and supporting mainstream and non-Government services to assist in guiding delivery of accessible and adequate services to the Aboriginal community.

CONSTITUTIONAL OBJECTIVE 3

Member Support

Metropolitan Aboriginal Hospital Liaison Officers' Network

The intent of the Metropolitan Aboriginal Hospital Liaison (AHL) program is to promote culturally responsive hospital services and improve access to hospital services for Aboriginal and Torres Strait Islander patients. The AHL program includes the employment of Aboriginal Hospital Liaison Officers (AHLOs). AHCSA provides funding to the Metropolitan Local Health Networks to employ seven AHLOs across the Lyell McEwin, Royal Adelaide, Queen Elizabeth and Women's and Children's Hospitals. There is a dedicated AHLO position on the Aboriginal Primary Health Care Workers' Forum.

The Workforce Development Officer (WDO) also supports the AHLO workforce to engage in relevant meeting/forums, in consultation with the unit managers. Due to the difficulty of time constraint with the AHLOs, there were no network meetings held in this period, however the WDO did meet regularly with each individual unit to discuss any concerns and get updates on how the AHLOs were progressing.

From July 2015, the program will be managed by the Local Health Networks that employ the AHLOs.

AHCSA provides funding to the Metropolitan Local Health Networks to employ seven AHLOs across the Lyell McEwin, Royal Adelaide, Queen Elizabeth and Women's and Children's Hospitals

Promoting culturally responsive and improved access to hospital services for Aboriginal and Torres Strait Islander patients

4

Constitutional Objective

Contribute to the development of a well qualified and trained Aboriginal health sector workforce

CONSTITUTIONAL OBJECTIVE 4

Education and Training

The financial year 2014-2015 saw National Vocational Education Training (VET) regulatory and student monitoring initiatives emerge. As with past reporting periods, high level change and exceptional challenges for the Education and Training team (ETT), in meeting the compliance demands of the Registered Training Organisation (RTO), continue.

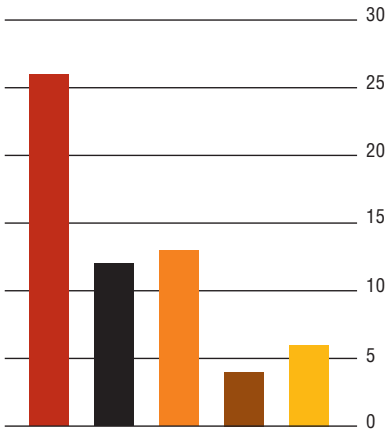
The RTO maintained a focus on ensuring regulation and compliance with Australian Skills Quality Authority (ASQA), and the Australian Health Practitioner Registration Authority (AHPRA) remains high on the RTO agenda.

At the end of 2014, AHCSA and the RTO were well placed to deliver training packages in the Aboriginal Primary Health Care fields of Certificate III and Certificate IV in Practice and Primary Health Care. Significant investment in the development of culturally contextualised training resources, to meet the Aboriginal Primary Health qualification delivery, was completed and the resources were ready for implementation in 2015.

This investment enabled AHCSA and the broader health sector to access and utilise high quality training resources and the attainment of best practice standards in the area of Aboriginal Primary Health Care training delivery.

The commencement of Prime Minster and Cabinet's Indigenous Advancement Strategy (IAS) tender for Aboriginal-specific funding, to deliver employment and training across a broad sector, was released. While IAS represented a significant investment in Aboriginal programs for the next three years, student enrolments were significantly reduced due to the uncertainty of funding and employment contracts in the Aboriginal sector.

Qualification Completions	
Certificate III in Aboriginal and/or Torres Strait Islander Primary Health Care	26
Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care	12
Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)	13
Diploma of Aboriginal and/or Torres Strait Islander Primary Health Care	4
Certificate IV in Indigenous Research Capacity Building	6
Total Completions	**61**

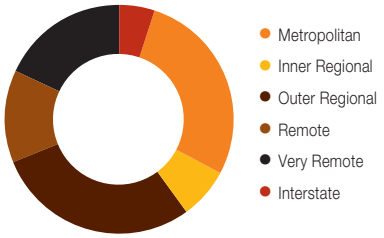


It is anticipated that once the consumer sector confidence in 2015-2016 rebounds, and the IAS funding pathways and providers stabilise, the demand for training and jobs will increase to meet the service and training demands of the Aboriginal community across South Australia.

Student Data and Graduation

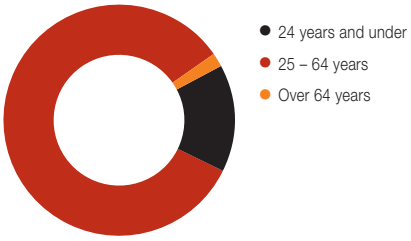
Student data and graduation for this reporting period only represent students who have completed the studies during the reporting period. The RTO has not recorded the student cohort who have not finalised their studies in 2015. The forecast for those studying within the RTO for 2015 is 109 students.

Location



Gender

Age



Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 4

Education and Training

Compliance

Australian Skills Quality Authority (ASQA)

In April 2015, ASQA implemented the new National Standards for Registered Training Organisations (RTOs) 2015 (the 'Standards'). The compliance requirements of ASQA are explained in eight Standards, which fit under three general headings: Training and Assessment, Obligations to Learners and Clients and RTO Governance and Administration. These eight Standards have been developed to ensure quality training across Australia.

With the implementation of the new Standards, AHCSA's RTO has been required to review, amend and update their policies, procedures and processes to ensure continuing compliance.

Australian Health Practitioner Regulation Agency (AHPRA)

The Aboriginal and Torres Strait Islander Health Practice Board of Australia (the Board) have developed mandatory registration standards for Aboriginal Health Practitioners within Australia. These standards outline the requirements for registration as an Aboriginal Health Practitioner and regulate the Aboriginal and Torres Strait Islander health practitioner workforce.

In relation to the accreditation of education providers, the Board has established the Aboriginal and Torres Strait Islander Health Practice Accreditation Committee (the Accreditation Committee). The Accreditation Committee is responsible for the development of accreditation standards and the review and audit of education providers and programs of study, to consider whether they meet the accreditation standards and are eligible for accreditation.

In order to receive accreditation and obtain an 'Approved Program of Study' registration, AHCSA's RTO must meet all AHPRA standards. The Accreditation Standards consist of four main sections: Education Provider and Qualification Registration; Governance, Management, Resourcing and Infrastructure; Qualification Documents and Student Records; and Program Attributes. These sections contain a large number of sub-standards that must be met by the RTO prior to submitting an application for accreditation for an Approved Program of Study with AHPRA.

The application for accreditation is something that AHCSA's RTO is currently working towards, with the goal of achieving this in the first half of 2016. The Approved Program of Study accreditation will have a significant impact on AHCSA's RTO, and the organisation as a whole, and this piece of work will help the RTO to grow and improve its status within the education and health sector.

The Accreditation Standards consist of four main sections:

- **Education Provider and Qualification Registration**
- **Governance, Management, Resourcing and Infrastructure**
- **Qualification Documents and Student Records**
- **Program Attributes**

4

Training Excellence

Unique Student Identifier

On 1 January 2015, the Australian Government introduced the Unique Student Identifier (USI) records management system. AHCSA, in its role as an Australian Skills Quality Authority (ASQA) accredited training provider, was mandated to register as a USI training provider and commenced and attained this accreditation in early 2015.

The USI system was developed to build and sharpen the skills for students undertaking nationally recognised training. From 1 January 2015, all students doing nationally recognised training were required to register using the USI data base. The USI system provided a reference number made up of numbers and letters is used to create a secure, online record of students' nationally recognised training that can be access at anytime and anywhere for life.

The USI is linked to the National Vocational Education and Training (VET) Data Collection, and this means an individual's nationally recognised training and qualifications gained anywhere in Australia, from different training organisations, will be kept all together. The USI will:

- Link a student's VET achievements, regardless of where in Australia they did the course
- Let students easily access secure digital transcripts of their achievements (transcripts will be available from April 2016)
- Give students more control over their VET information

Australian Government USI unique student identifier information: usi.gov.au

The USI system provides a secure online record of students' nationally recognised training that can be access at anytime and anywhere for life

Aboriginal Health Council
of South Australia Inc.

CONSTITUTIONAL OBJECTIVE 4

Education and Training

Simulated Learning Environment

AHCSA's Education and Training team has partnered with the Adelaide University Simulated Learning Environment (SLE) and SA Health (Clin Ed) to establish a tri-part funding submission as a means of providing intensive training and development opportunities for AHCSA Primary Health Care Students. One of the most high-tech medical teaching facilities in South Australia, the Adelaide Health Simulation and Skills Centre, has been developed to address current and future inter-professional learning needs of health and related workforces.

Equipped with a variety of simulation manikins and a fully integrated audio visual system for remote video conferencing, the centre offers the capacity for all levels of simulation education as well as training.

Using state-of-the-art technology to deliver an innovative and effective learning experience, our safe, evidence-based environment supports participants to develop clinical and interpersonal skills as well as the confidence and competence to work effectively within their healthcare teams.

AHCSA partnered with the Adelaide University to establish a means of providing intensive training and development opportunities for AHCSA students

Work Placements

Formal student work placement agreements have been established with the Northern Area Local Health Network (NALHN), Southern Area Local Health Network, Pika Wiya Aboriginal Health Service Aboriginal Corporation and Nunkuwarrin Yunti Inc.

Work placement agreements with NALHN represent a unique opportunity, as no such arrangement has been brokered previously. These partnerships will greatly enhance the ability of students who are unemployed to graduate, seek employment and support the health and wellbeing of the Aboriginal community in SA.

Financial Report

Aboriginal Health Council of South Australia Inc.

Statutory Financial Report

Board of Directors' Report

AHCSA Board of Directors submits the financial report of the Aboriginal Health Council of South Australia Incorporated for the period 1 July 2014 to 30 June 2015.

Board of Directors

Full voting membership of the Aboriginal Health Council of South Australia Inc. ('the Association') is made up of ten independently constituted Aboriginal community controlled health and wellbeing services and two Aboriginal community controlled substance misuse services. Until the 17 October 2014 this also included the seven Aboriginal Health Advisory Committees (AHAC) under the construct of Country Health SA Local Health Network and they ceased to exist as AHCSA Members from this date.

From 1 July 2014 to 26 November 2014:

EXECUTIVE MEMBERS

John Singer, Chairperson
Independent Chair

Bill Wilson, Deputy Chairperson*
Moorundie AHAC

Les Kropinyeri, Secretary
Port Lincoln Aboriginal Health Service

Arlene Burgoyne, Treasurer*
Eyre AHAC

Polly Sumner-Dodd, Executive Member
Aboriginal Sobriety Group Inc.

Leonard Miller, Executive Member
Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation

Vicki Holmes, Executive Member
Nunkuwarrin Yunti of South Australia Inc.

Lucy Evans, Executive Member*
Mid North AHAC

Vacant (July to Sep)
Priscilla Larkins (Sep to 24 Nov)
Rameth Thomas (24 to 26 Nov)
Umoona Tjutagku Health Service Aboriginal Corporation

Yvonne Buza*
Northern AHAC

Darryle Barnes*
Riverland Aboriginal and Islander Health Advisory Group

Helen Smith
Nunyara Aboriginal Health Service Inc.

Wayne Oldfield*
Wakefield AHAC

Jamie Nyaningu
Nganampa Health Council

Marshall Carter
Kalparrin Community Inc.

Roderick Day
Tullawon Health Service

Veronica Milera
Pika Wiya Health Service Aboriginal Corporation

Fiona Wilson*
South East AHAC

Clayton Queama
Oak Valley Health Service

Peter May
Pangula Mannamurna Inc.

**AHACs disbanded by Country Health SA in late October 2015, and formally advised that they are no longer Members of AHCSA from 11 November 2014*

From 26 November 2015 to 30 June 2015:

EXECUTIVE MEMBERS

John Singer, Chairperson
Independent Chair

Polly Sumner-Dodd, Deputy Chairperson
Aboriginal Sobriety Group Inc.

Rameth Thomas, Secretary
Umoona Tjutagku Health Service Aboriginal Corporation

Les Kropinyeri, Treasurer
Port Lincoln Aboriginal Health Service

Vicki Holmes, Executive Member
Nunkuwarrin Yunti of South Australia Inc.

Peter May, Executive Member
Pangula Mannamurna Inc.

Roderick Day, Executive Member
Tullawon Health Service

Clayton Queama, Executive Member
(24 Nov 2014 to 15 June 2015)
Oak Valley Health Service

Helen Smith, Executive Member
Nunyara Aboriginal Health Service Inc.

Debra Miller
Ceduna Koonibba Aboriginal Health Service Aboriginal Corporation

Jamie Nyaningu
Nganampa Health Council

Marshall Carter
(24 Nov 2014 to 29 Jan 2015)

Roy Wilson (29 Jan to 30 Jun)
Kalparrin Community Inc.

Vacant
Pika Wiya Health Service Aboriginal Corporation

Principal Activities

The Aboriginal Health Council of SA Inc. (the 'Association') is the peak body representing Aboriginal community controlled health, substance misuse Services and Aboriginal Health Advisory Committees 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 58.

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

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

- Appointment of new staff to the Association's secretariat
- Reviewing operational policies and procedures
- Progressing with the 2011-2015 Strategic Plan and Business Plan
- Supporting the Members review 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 training and workforce development issues
- Regularly updating the Association's website
- Visiting Aboriginal communities and Member organisations
- Participating on the executive committee of the South Australian Aboriginal Health Partnership
- Providing administration support to the Aboriginal Primary Health Care Workers Forum
- Provide administration 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 Board 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 Association 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 Association's appointed Auditors for the next three financial years including the current one.

Significant Changes

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

Operating Result

In the 2014-2015 financial year, AHCSA posts a statutory deficit of $237,357. There were no abnormal items.

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

Aboriginal Health Council
of South Australia Inc.

Statement of Comprehensive Income

For the year ended 30 June 2015

	Note	2015 $	2014 $
REVENUE			
Grant revenue	2	9,368,402	11,031,764
Other revenues	2	295,882	417,921
Net Gain on Disposal of Non-Current Assets	4	1,011	–
TOTAL REVENUE		**9,665,295**	**11,449,685**
EXPENSES			
Employee benefits expenses		5,102,906	5,710,271
Goods and Services expenses	3	4,520,451	5,866,158
Depreciation expenses	8	279,295	169,120
TOTAL EXPENSES		9,902,652	11,745,549
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(237,357)**	**(295,864)**

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2015

	Note	2015 $	2014 $
CURRENT ASSETS			
Cash and Cash Equivalents	5	85,640	1,931,973
Trade and Other Receivables	6	738,627	211,917
Other Current Assets	7	129,663	76,956
TOTAL CURRENT ASSETS		**953,930**	**2,220,846**
NON-CURRENT ASSETS			
Plant and Equipment	8	5,152,112	993,191
TOTAL NON-CURRENT ASSETS		5,152,112	993,191
TOTAL ASSETS		**6,106,041**	**3,214,037**
CURRENT LIABILITIES			
Trade and Other Payables	9	1,403,209	875,982
Employee Benefits	10	660,559	669,624
Short Term Provisions	11	2,500	10,000
TOTAL CURRENT LIABILITIES		**2,066,268**	**1,555,606**
NON-CURRENT LIABILITIES			
Employee Benefits	10	140,660	161,966
Long Term Provisions	11	–	35,833
Long Term Loan	11	2,520,350	–
TOTAL NON-CURRENT LIABILITIES		**2,661,010**	**197,799**
TOTAL LIABILITIES		**4,727,278**	**1,753,405**
NET ASSETS		**1,378,763**	**1,460,632**
EQUITY			
Building Reserve	12	–	875,700
Retained Surplus		1,378,763	584,932
TOTAL EQUITY		**1,378,763**	**1,460,632**

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2015

	Note	RETAINED SURPLUS $	BUILDING RESERVE $	TOTAL $
BALANCE AT 1 JULY 2013		880,796	875,700	1,756,496
Net surplus/(deficit) for the year		(295,864)	–	(295,864)
Transfer to Building Reserve	12	–	–	–
BALANCE AT 30 JUNE 2014		**584,932**	**875,700**	**1,460,632**
Net surplus/(deficit) for the year		(237,357)	–	(237,357)
Prior Period Adjustment	20	155,487	–	155,487
Transfer to Retained Earnings		875,700	(875,700)	–
BALANCE AT 30 JUNE 2015		**1,378,763**	**–**	**1,378,763**

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2015

	Note	2015 $	2014 $
CASH FLOW FROM OPERATING ACTIVITIES			
Grant receipts		9,625,617	11,627,250
Other cash receipts in the course of operations		241,671	472,884
Cash payments in the course of operations		(9,814,383)	(12,897,721)
Interest received		17,621	60,350
Net cash provided by/(used in) operating activities		**70,526**	**(737,237)**
CASH FLOW FROM INVESTING ACTIVITIES			
Payments for plant and equipment		(4,438,222)	(423,705)
Receipts from disposal of plant and equipment		1,011	–
Net cash used in investing activities		**(4,437,211)**	**(423,705)**
CASH FLOW FROM FINANCING ACTIVITIES			
Long Term Loan		2,520,350	
Net cash provided by financing activities		**2,520,350**	**–**
NET INCREASE/(DECREASE) IN CASH HELD		(1,846,335)	(1,160,942)
Cash at the beginning of the financial year		1,931,972	3,092,914
CASH AT THE END OF THE FINANCIAL YEAR	16	**85,640**	**1,931,972**

The accompanying notes form part of these financial statements.

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The Aboriginal Health Council of South Australia Incorporated ('the Association') is an association incorporated in South Australia under the Associations Incorporation Act 1985.

(a) Basis of Preparation

The Aboriginal Health Council of South Australia Incorporated("the Association') applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010-2: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements and other applicable Australian Accounting Standards - Reduced Disclosure Requirements.

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), the Australian Charities and Not-for-profits Commission Act 2012 and the Associations Incorporation Reform Act 2012. The association 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 to which they apply. 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 accruals 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.

(b) Property, Plant and Equipment

Each class of property, plant and equipment is carried at cost, where applicable, net of any accumulated depreciation. The carrying amounts of plant and equipment are reviewed annually by the Association to ensure they are not in excess of their recoverable amount at balance date. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the assets' employment and subsequent disposal. The expected net cash flows have been discounted to present values in determining recoverable amounts.

(c) Depreciation

All non-current assets have limited useful lives and are depreciated using the straight line method over their estimated useful lives. Assets are depreciated or amortised from the date of acquisition from the time an asset is completed and held ready for use. Leasehold improvements are depreciated over the shorter of either the unexpired period of the lease and expected renewal period or the estimated useful lives of the improvements.

Depreciation and amortisation rates and methods are reviewed annually for appropriateness. When changes are made, adjustments are made prospectively in current and future periods only.

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

Leasehold Improvements	10%
Medical Equipment	10%
Computing Equipment	33%
Other Plant and Equipment	10% – 20%
Software	40%
Artwork	0%
RTO	40%

(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 Association, are classified as finance leases.

Finance leases are capitalised recording 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 where it is likely that the Association will obtain ownership of the asset or over the term of the lease. Lease payments are allocated between the reduction of the lease liability and the lease interest expense for the period.

Lease payments under operating leases, where substantially all the risks and benefits remain with the lessor, are charged as expenses in the periods in which they are incurred.

Lease incentives under operating leases are recognised as a liability and amortised on a straight line basis over the life of the initial lease period and optional renewal period.

(e) Employee Benefits

Provision is made for the Association's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Liabilities for employee benefits and wages and salaries expected to be settled within twelve months of the reporting date together have been measured at their nominal amount based on remuneration rates the Association expects to pay including related on-costs. Other employee entitlements payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those entitlements.

Contributions are made by the Association to a defined contribution employee superannuation fund and are charged as expenses when incurred.

(f) Cash and Cash Equivalents

Cash assets and bank overdrafts are carried at face value of the amounts deposited and drawn. For the purposes of the Cash Flow Statement, cash includes cash on hand, at banks and on deposit.

(g) Revenue and Other Income

Non-reciprocal grant revenue is recognised in the statement of comprehensive income when the association obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the association and the amount of the grant can be measured reliably.

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

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 (GST).

(h) Taxation

The Association is not subject to income tax and therefore no income tax expense or income tax payable is shown in the financial statements.

(i) Trade and other Receivables

The collectability of debtors is assessed at year end and specific provision is made for any doubtful accounts.

(j) Trade and other Payables

Liabilities are recognised for amounts to be paid in the future for goods or services received. Trade accounts payable are normally settled within 60 days.

(k) Goods and Services Tax

Revenues, expenses and assets are recognised net of the amount of goods and services tax, except where the amount of GST incurred is not recoverable from the Australian Tax 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 and 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.

(l) Impairment of Assets

At the end of each reporting period, the association assesses whether there is any indication that an asset may be impaired. The assessment will consider both external and internal sources of information. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of that asset, being the higher of the asset's fair value less costs to sell and its value-in-use, to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is immediately recognised in profit or loss.

(m) 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 Association commits itself to either purchase or sell the asset (ie trade date accounting is adopted).

Financial instruments are initially measured at fair value plus transaction costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are expensed to profit or loss immediately.

Classification and subsequent measurement

Financial instruments are subsequently measured at either fair value, amortised cost using the effective interest rate method or cost. Fair value represents the amount for which an asset could be exchanged or a liability settled, between knowledgeable, willing parties. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as: (i) the amount at which the financial asset or financial liability is measured at initial recognition; (ii) less principal repayments; (iii) plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest method; and (iv) less any reduction for impairment.

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 value with a consequential recognition of an income or expense in profit or loss.

(i) 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.

(ii) Financial Liabilities

Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost.

Impairment

At each reporting date, the Association assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available-for-sale financial instruments, a prolonged decline in the value of the instrument is considered to determine whether impairment has arisen. Impairment losses are recognised in the income statement.

Derecognition

Financial assets are derecognised where the contractual right to receipt of cash flows expires 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 where the related obligations are either discharged, cancelled or expire. The difference between the carrying value of the financial liability 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.

(n) Comparative Figures

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

(o) Critical Accounting Estimates and Judgements

The committee evaluates estimates and judgements incorporated into the financial report 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 externally and within the Association.

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

NOTE 2 – REVENUE	2015 $	2014 $
Grant Revenue		
State Government Grant Revenue	3,558,170	3,651,160
Commonwealth Grant Revenue	3,379,182	3,859,664
Commonwealth DEEWR Grant	1,231,125	1,487,368
Other Grants	1,199,925	2,033,572
Total Grant Revenue	**9,368,402**	**11,031,764**
Other Revenue		
Interest	17,621	60,350
Other	278,261	357,571
Total Other Revenue	**295,882**	**417,921**
TOTAL REVENUE	**9,664,284**	**11,449,685**

NOTE 3 – GOODS AND SERVICES EXPENSES Goods and Services expenditure recorded in the Statement of Comprehensive Income comprises:	2015 $	2014 $
Advertising	8,458	6,449
Bank Fees	97,070	4,615
Bad and Doubtful Debts	–	–
Computing	93,165	79,425
Consultancy	44,414	397,362
Contract Cleaning	42,198	32,723
Contractors, Agency Staff and Salary Recharges	1,383,332	1,460,287
Donations and Ex Gratia Payments	48,188	51,162
Electricity	79,351	55,696
External Auditors Remuneration	13,450	19,614
Fee for Service	82,084	160,000
Insurance	38,385	24,819
Membership – Professional	22,716	27,296
Minor Equipment	4,090	4,601
Motor Vehicle Expense	191,282	239,192
Newsletter, Publicity and Promotions	127,844	418,252
Office Administration and Corporate Expenses	231,963	204,715
Periodicals, Journals and Publications	5,094	15,253
Postage and Courier	15,165	11,062
Printing and Stationery	34,107	41,600
Rental Expense on Operating Lease	243,340	288,455
Repairs, Maintenance and Occupancy Costs	33,844	38,932
Research Project	–	–
Security Service	5,536	5,584
Training and Development	241,733	391,178
Travel Expenses	1,323,674	1,785,449
Telephone	109,968	102,437
TOTAL GOODS AND SERVICES EXPENSES	**4,520,451**	**5,866,158**

NOTE 4 – NET GAIN (LOSS) ON DISPOSAL OF NON-CURRENT ASSETS	2015 $	2014 $
Proceeds from disposal	1,011	–
Less net book value of assets disposed	–	–
NET GAIN (LOSS) ON DISPOSAL OF NON-CURRENT ASSETS	**1,011**	**–**

NOTE 5 – CASH AND CASH EQUIVALENTS	2015 $	2014 $
Cash at bank	(22,225)	1,455,502
Cash on deposit	106,365	474,971
Cash on hand	1,500	1,500
	85,640	**1,931,973**

The Association has provided a bank guarantee of $104,500 in relation to the leasing of premises.
The guarantee is a restriction on cash and can be called upon in the event of default on the lease agreement.

The Association has secured a $200,000 overdraft facility with the Commonwealth Bank to be used as a working capital.
It is secured by First Registered Mortgage by Aboriginal Health Council of South Australia Inc over non-residential real property located at 220 Franklin Street, Adelaide SA.

NOTE 6 – TRADE AND OTHER RECEIVABLES	2015 $	2014 $
Grant funding receivable	702,038	211,917
Other receivables	36,589	–
	738,627	211,917
Less: Provision for Doubtful Debts	–	–
	738,627	**211,917**

Past due but not impaired receivables

As at 30 June 2015, receivables of $712,958 were past due but not impaired. These relate to a number of independent parties for whom there is no recent history of default. The ageing analysis of receivables is:

	Within initial trade terms	Past due but not impaired (days overdue) <30	31-60	61-90	>90	Total
Grant funding receivable	20,000	16,138	–	–	682,037	718,176
Other receivables	5,668	6,898	7,884	–	–	20,451
	25,668	**23,036**	**7,884**	**–**	**682,037**	**738,627**

NOTE 7 – OTHER CURRENT ASSETS	2015 $	2014 $
Prepayments	111,485	76,956
Other Debtors	18,284	–
Staff Cash Advance	(109)	–
	129,663	**76,956**

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

NOTE 8 – PROPERTY, PLANT AND EQUIPMENT	2015 $	2014 $
Computer equipment at cost	315,524	298,617
Less: Accumulated depreciation	(262,310)	(233,282)
	53,214	65,335
Computer software at cost	617,305	299,056
Less: Accumulated amortisation	(119,622)	–
	497,682	299,056
Medical Equipment at cost	254,858	245,970
Less: Accumulated depreciation	(200,480)	(192,321)
	54,378	53,649
Leasehold improvements at cost	716,823	716,823
Less: Accumulated amortisation	(446,044)	(374,357)
	270,779	342,466
Motor Vehicle at cost	160,968	160,968
Less: Accumulated Depreciation	(89,387)	(57,637)
	71,581	103,331
Other Plant and equipment at cost	333,288	312,504
Less: Accumulated Depreciation	(233,435)	(214,386)
	99,853	98,118
Artwork at cost	17,759	17,759
RTO Training Resources	371,345	–
Less: Accumulated amortisation	–	–
	371,345	–
Land and Building at cost	3,715,520	13,477
	5,152,112	**993,191**

Reconciliation

Reconciliation of the carrying amounts for each class of asset are set out below:

	Computing Equipment $	Computing Software $	Medical Equipment $	Leasehold Improvements $	Motor Vehicle $	Other Plant & Equipment $	Artwork $	Land & Building $	RTO Training Resources $	Total $
Balance at 1 July 2013	47,942	–	21,303	414,152	131,275	106,176	17,759	–	–	738,607
Additions	53,160	299,056	36,721	–	3,805	17,480	–	13,476	–	423,698
Disposals	–	–	–	–	–	–	–	–	–	–
Depreciation Expense	(35,767)	–	(4,375)	(71,688)	(31,750)	(25,540)	–	–	–	(169,120)
Balance at 30 June 2014	**65,335**	**299,056**	**53,649**	**342,464**	**103,330**	**98,116**	**17,759**	**13,476**	–	**993,185**
Additions	16,907	318,248	8,888	–	–	20,790	–	3,702,044	371,345	4,438,222
Disposals	–	–	–	–	–	–	–	–	–	–
Depreciation Expense	(29,028)	(119,622)	(8,159)	(71,687)	(31,750)	(19,049)	–	–	–	(279,295)
Carrying amount at 30 June 2015	**53,214**	**497,682**	**54,378**	**270,779**	**71,581**	**99,853**	**17,759**	**3,715,520**	**371,345**	**5,152,112**

The Association has secured a market rate loan for $2,520,350 with the Commonwealth Bank for the purchase of land and building located at 220 Franklin Street, Adelaide SA. The loan is secured by a first registered mortgage by the Aboriginal Health Council of South Australia Inc. over the property.

NOTE 9 – TRADE AND OTHER PAYABLES	2015 $	2014 $
Current		
Trade Creditors and Accruals	1,333,437	673,643
Unspent Grants	69,772	202,339
	1,403,209	**875,982**

NOTE 10 – EMPLOYEE BENEFITS	2015 $	2014 $
Current		
Salary Sacrifice Fees	377	176
Social Club Clearing	40	10
Accrued Wages	109,028	107,835
Annual Leave	361,609	396,161
Long Service Leave	122,155	99,112
Superannuation and Workers Compensation On-Costs	67,350	66,330
	660,559	**669,624**
Non-Current		
Long Service Leave	126,148	145,918
Superannuation and Workers Compensation On-Costs	14,512	16,048
	140,660	**161,966**
Number of Employees		
Number of employees at year end	58	60

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

NOTE 11 – PROVISIONS/LONG TERM LOAN	2015 $	2014 $
Current		
Lease Incentive	2,500	10,000
	2,500	**10,000**
Non-Current		
Lease Incentive	–	35,833
	–	**35,833**
Secured Loan		
CBA Long Term Loan	**2,520,350**	**–**

NOTE 12 – RESERVES	2015 $	2014 $
Building Reserve The building reserve represents funds set aside for future expansion of the Association.		
Opening Balance 1 July 2014	875,700	875,700
Transfer to Retained Earnings	(875,700)	–
Closing Balance 30 June 2015	**–**	**875,700**

NOTE 13 – COMMITMENTS	2015 $	2014 $
Operating Lease Commitments		
Office Rent	64,143	382,896
Motor Vehicle	57,481	102,953
Office Equipment	60,744	26,236
Total Operating Lease Commitments	**182,368**	**512,085**
Operating Lease Commitments are payable:		
- Not later than 1 year	148,385	389,741
- Later than 1 year but not later than 5 years	33,982	122,344
Total Operating Lease Commitments	**182,367**	**512,085**

Operating Lease commitments are shown at GST inclusive values. Office Rent commitments relate to the initial 5 year or 3 year period of the relevant leases. There are options to renew the leases for a further 5 years or 3 years respectively at the conclusion of the initial lease periods.

NOTE 14 – RELATED PARTY DISCLOSURES

Board of Management

The Board of Management for the year ended 30 June 2015 comprised:

From 1 July 2014 to 26 November 2014:

John Singer (Chairperson)	Vicki Holmes (Executive Member)	Veronica Milera
Bill Wilson (Deputy Chair)	Clayton Queama	Wayne Oldfield
Les Kropinyeri (Secretary)	Marshall Carter	Jamie Nyaningu
Arlene Burgoyne (Treasurer)	Helen Smith	Yvonne Buza
Leonard Miller (Executive Member)	Darryle Barnes	Roderick Day
Lucy Evans (Executive Member)	Fiona Wilson	Priscilla Larkin – Sep to 24 Nov
Polly Sumner-Dodd (Executive Member)	Peter May	Rameth Thomas – 24 to 26 Nov

From 27 November 2014 to 30 June 2015

John Singer (Chairperson)	Peter May (Executive Member)	Debra Miller
Polly Sumner-Dodd (Deputy Chairperson)	Helen Smith (Executive Member)	Jamie Nyaningu
Les Kropinyeri (Treasurer)	Roderick Day (Executive Member)	Marshall Carter – 24 Nov to 29 Jan
Rameth Thomas (Secretary)	Clayton Queama (Executive Member)	Roy Wilson – 29 Jan to 30 Jun
Vicki Holmes (Executive Member)	– 27 Nov to 15 Jun	

The Chairperson of the Association is paid an honorarium. The amount is determined by decision of the Board. No other Member of the Board received remuneration from the Association in their capacity as Member in relation to the year ended 30 June 2015. No other entity that the above Members are associated with has received funds other than through dealings with the Association in the ordinary course of business and on normal commercial terms and conditions.

	2015 $	2014 $
Total remuneration received by Board Members	**15,000**	**12,000**
Number of Board Members receiving remuneration	1	1

	2015 $	2014 $
Key Management Personnel Compensation		
Short Term Benefit	906,898	938,300
Post Employment Benefit	80,178	79,555
Total Compensation	**987,076**	**1,017,855**

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

NOTE 15 – AUDITOR REMUNERATION	2015 $	2014 $
Auditor Remuneration		
Audit Services	13,450	19,614
	13,450	**19,614**

NOTE 16 – CASH FLOW INFORMATION	2015 $	2014 $
Reconciliation of cash		
Cash at bank, on deposit and on hand	85,640	1,931,973
	85,640	**1,931,973**

NOTE 17 – ECONOMIC DEPENDENCY
The Association is dependent on funding from the State and Federal Government to maintain its operations.

NOTE 18 – CONTINGENT LIABILITIES
There were no contingent liabilities as at 30 June 2015.

NOTE 19 – ADDITIONAL FINANCIAL INSTRUMENTS DISCLOSURE

The Association's financial instruments consist mainly of deposits with banks, accounts payable and receivable. The Association does not have any derivative financial instruments as at 30 June 2015.

(a) Interest Rate Risk

The Association's exposure to interest rate risk, which is the risk that a financial instrument's value will fluctuate as a result of changes in market interest rates and the effective weighted average interest rates on those financial assets and financial liabilities, is as follows:

2015	Weighted Average Effective Interest Rate	Non–Interest Bearing	Floating Interest Rate	Fixed Interest Rate Maturing			Total
				Within 1 Year	1 Year to 5 Years	More than 5 Years	
FINANCIAL ASSETS							
Cash	1.92%	1,500	(22,225)	106,365	–	–	85,640
Receivables	–	738,627	–	738,627	–	–	738,627
Total Financial Assets		**740,127**	**(22,225)**	**844,992**	–	–	**824,267**
FINANCIAL LIABILITIES							
Payables	–	1,333,437	–	–	–	–	1,333,437
Total Financial Liabilities		**1,333,437**	–	–	–	–	**1,333,437**

2014	Weighted Average Effective Interest Rate	Non–Interest Bearing	Floating Interest Rate	Fixed Interest Rate Maturing			Total
				Within 1 Year	1 Year to 5 Years	More than 5 Years	
FINANCIAL ASSETS							
Cash	2.37%	1,500	1,025,549	904,924	–	–	1,931,973
Receivables	–	192,652	–	–	–	–	192,652
Total Financial Assets		**194,152**	**1,025,549**	**904,924**	–	–	**2,124,625**
FINANCIAL LIABILITIES							
Payables	–	561,163	–	–	–	–	561,163
Total Financial Liabilities		**561,163**	–	–	–	–	**561,163**

The amount of receivables and payables stated above do not include those arising from statutory obligations, including levies, workers compensation liability, staff on-costs, and GST. They are carried at cost.

Notes to and Forming Part of the Financial Statements

For the year ended 30 June 2015

(b) Credit Risk

The maximum exposure to credit risk, excluding the value of any collateral or other security, at balance date on recognised financial assets is the carrying amount, net of any provisions for doubtful debts, as disclosed in the balance sheet and notes to the financial statements.

The Association does not have any material credit risk exposure to any single debtor or group of debtors under financial instruments entered into by the Association other than from the State and Commonwealth government departments.

(c) Net Fair Values

The following methods and assumptions are used in determining net fair value:

For other assets and other liabilities the net fair value approximates their carrying value. No financial assets and financial liabilities are traded on organised markets.

The aggregate net fair values and carrying amounts of financial assets and financial liabilities are disclosed in the balance sheet and in the notes to the financial statements.

(d) Sensitivity Analysis

The Association's cash levels and subsequent impact on profit and equity would not change significantly through an increase of 2% of the interest rate of cash deposits. Therefore no sensitivity analysis has been performed.

NOTE 20 – PRIOR PERIOD ADJUSTMENT
Cost of resource training materials incurred in the Financial Year 2013-2014 was adjusted to equity.

NOTE 21 – ASSOCIATION DETAILS
The principal place of business for the Association is: Aboriginal Health Council of SA Incorporated, 220 Franklin Street, Adelaide SA 5000

NOTE 22 – EVENTS AFTER THE BALANCE SHEET DATE
There have been no material events after the reporting date that have not been recognised in the financial report.

Statement by the Board of Directors

Aboriginal Health Council of South Australia Incorporated

In the opinion of the committee of the Aboriginal Health Council of South Australia Incorporated, the financial report as set out on pages 50 to 66

1. Presents a true and fair view of the financial position of Aboriginal Health Council of South Australia Incorporated and its performance for the year ended on that date in accordance with applicable Australian Accounting Standards;
2. At the date of this statement there are reasonable grounds to believe that the Association will be able to pay its debts as and when they fall due.

This statement is made in accordance with the Australian Charities and Not-for-profits Commission Act 2012 and the Associations Incorporation Act 1985 and by resolution of the committee.

Polly Sumner-Dodd
Deputy Chairperson

Roy Wilson
Board Member

Signed at Adelaide, SA this day of 21st October 2015.

Aboriginal Health Council
of South Australia Inc.

Independent Auditor's Report

To the Members of Aboriginal Health Council of South Australia Incorporated

We have audited the accompanying financial report of Aboriginal Health Council of South Australia Incorporated (the association), which comprises the statement of financial position as at 30 June 2015, statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes comprising a summary of significant accounting policies and other explanatory information, and the statement by the Members of the committee.

Committee's Responsibility for the Financial Report

The committee of the association is responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations), the Australian Charities and Not-for-profits Commission Act 2012 and the Associations Incorporation Act 1985 and for such internal control as the committee determines is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the association's preparation of the financial report that gives a true and fair view, 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 association's internal control.

An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the committee as well as evaluating the overall presentation of the financial report.

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

Basis for Qualified Opinion

Included in Trade and other receivables at 30 June 2015 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.

Auditor's Qualified Opinion

In our opinion, except for the possible effects of the matter described in the Basis for Qualified Opinion paragraph, the financial report of Aboriginal Health Council of South Australia Incorporated is in accordance with the Australian Charities and Not-for-profits Commission Act 2012 and the Associations Incorporation Act 1985 including:

(a) giving a true and fair view of the association's financial position as at 30 June 2015 and of its financial performance and cash flows for the year ended on that date; and

(b) complying with Australian Accounting Standards to the extent described in Note 1, and Division 60 of the Australian Charities and Not-for-profits Commission Regulation 2013 and the Associations Incorporation Act 1985

Trevor Basso, Partner
Basso Newman and Co
Chartered Accountants Adelaide

Dated this 23rd day of October 2015

AHCSA Member Directory

Aboriginal Community Controlled Health Services

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Kalparrin Community Inc.

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